Conceptualising, Engaging, and Acting on the Social Gradient. The Right of Everyone to the Enjoyment of the Highest Attainable Standard of Health

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Abstract

Despite decades of action on global health inequalities by public health and human rights health inequalities have persisted and deepened, with the Covid-19 pandemic highlighting the intractable nature of social, ethnic, gender, socio-economic and cultural inequalities with consequent poorer health outcomes. The social gradient, drawn from social epidemiology, is a correlation of social factors with health outcomes. It articulates a notion of health inequalities for which action has been less well developed. It depicts a graduated relationship between social determinants and health outcomes which suggests that wherever you are placed in the gradient you experience less good health than the persons immediately above you, and slightly better health than the persons immediately below.

The research problem explored is whether and to what extent the right to health has conceptualised, engaged with, and acted upon social gradient health inequalities. This thesis is transdisciplinary in scope by considering the social gradient's relevance to the right to the enjoyment of everyone to the highest attainable standard of physical and mental health. It addresses the need to explore the implications of the social gradient for the right to health and contributes to an interdisciplinary debate about the right to health and health inequalities. It establishes the integral place of the social gradient in the right to health as a social determinant of health and identifies the benefits and limitations of doing so. The thesis concludes with a proposal for Amartya Sen's capability approach to enable collaboration between public health and human rights on conceptualisations of and action on the social gradient.

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> ‘When…you Think of Things, you find sometimes that a Thing which seemed very Thingish inside you is quite different when it gets out into the open and has other people looking at it.’
>
> A.A. Milne, Winnie-the-Pooh

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Contents

Abbreviations

Abbreviation	Full Description
AAAQ	Availability, Accessibility, Acceptability, Quality
AIDS	Acquired Immune Deficiency Syndrome
CA	Capability Approach
CEDAW	Convention on Elimination of all Forms of Discrimination Against Women
CESCR	Committee on Economic, Social and Cultural Rights
CH	Capability to be Healthy
COP27	2022 United Nations Climate Change Conference
COVIS	UNDP
CRC	Convention on the Rights of the Child
CSDH	Commission on Social Determinants of Health
DALY	Disability-Adjusted Life Years
DFLE	Disability-Free Life Expectancy
ECOSOC	Economic and Social Council
EHRC	Equality and Human Rights Commission
EMF	Equality Measurement Framework
ESCR	Economic, Social and Cultural Rights
GDP	Gross Domestic Product
HDI	Human Development Index
HiAP	Health in All Policies
HIV	Human Immunodeficiency Virus
HSS	Health Systems Strengthening
ICCPR	International Covenant on Civil and Political Rights
ICESCR	International Covenant on Economic, Social and Cultural Rights
LGBT	Lesbian, Gay, Bisexual and Trans
LICs	Low-Income Countries
LMICs	Low- and Middle-Income Countries
MICs	Middle-Income Countries
MPI	Multidimensional Poverty Index
NGO	Non-Governmental Organisation
OECD	Organisation for Economic Cooperation and Development
OHCHR	Office of the High Commissioner for Human Rights
ONS	Office for National Statistics
PRISMA-ScR	Preferred Reporting Items for Systematic reviews and Meta-Analyses extension for Scoping Reviews
QALY	Quality-Adjusted Life Years
RCT	Randomised Control Trials
SDG	Sustainable Development Goal
SDH	Social Determinants of Health
SR	Special Rapporteur
SRRH	Special Rapporteur on the right to health
UDHR	Universal Declaration of Human Rights
UHC	Universal Health Coverage

UN	United Nations
UPR	Universal Periodic Review
US	United States
WHO	World Health Organisation
WTO	World Trade Organisation

Tables

Figures

Introduction

This thesis considers the concept of the social gradient in health inequalities, drawn from social epidemiology and public health practice, and its relevance to the right to the enjoyment of everyone to the highest attainable standard of physical and mental health (right to health). The aim of the thesis is to contribute to the debate about the right to health and health inequalities by evaluating the place of the social gradient in, and its implications for, the right to health. The research problem this thesis explores is whether and to what extent the right to health has conceptualised, engaged with, and acted upon social gradient health inequalities. In doing so it addresses three central research questions and proposes a conceptual framework for public health and right to health collaboration to better incorporate social gradient health inequalities.

The thesis makes three important contributions to knowledge: the scoping review chapter two) assesses the understanding of the social gradient in academic literature at the intersection of public health and the right to health; the Special Rapporteur Reports on the right to health are reviewed as a body of work; and the capability approach is offered as a means to conceptualise the social gradient in health. The work also responds to Alicia Ely Yamin's exploration of the roles of income and wealth and the importance of both relative and absolute poverty in creating ill health where she states:

> It is essential for the human rights community to grapple with what is normatively acceptable in terms of a social gradient and with the trade-offs to be made in moving in that direction.[1]

[1] Alicia Ely Yamin, *Power, Suffering, and the Struggle for Dignity. Human Rights Frameworks for Health and Why They Matter* (University of Pennsylvania Press 2016) 195.

A. Health Inequalities, the Social Gradient, and the Right to Health

The last two decades have seen not only a persistence in inequalities but also evidence that inequalities are deepening, widening, and becoming more entrenched. Oxfam claims that inequality contributes to the death of 21,300 people each day, that is at least one person every four seconds.[2] Global life expectancy at birth increased from 66.8 years in 2000 to 73.3 years in 2019. However, health inequalities have persisted with, for example, life expectancy at least 10 years lower in low-income countries (LICs) than in high-income countries (HICs), and higher for women than men by approximately 5 years.[3] The World Inequality Lab has revealed that since 1995, the top 1% have captured 19 times more of global wealth growth than the whole of the bottom 50% of humanity.[4] The Sars-Cov-2 pandemic (Covid-19) has shone a light upon significant existing inequalities with disproportionate morbidity and mortality affecting vulnerable populations including those who are poor, the elderly, minority ethnic groups, and people with existing underlying physical and mental health conditions.[5] Yet, these same population groups continue to have difficulty in accessing vaccination programmes in many countries. Inequalities in contributions and impacts to climate change are being taken up by civil society organisations as well as LICs and small island states.[6] To achieve the Sustainable Development Goals (SDGs) the World Health Organisation (WHO) asserts that '[a]ttention to inequalities between and within countries is critical.[7]

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[2] Nabil Ahmed and others, 'Inequality Kills: The Unparalleled Action Needed to Combat Unprecedented Inequality in the Wake of COVID-19' (Oxfam 2022) 8 <http://hdl.handle.net/10546/621341> accessed 22 January 2022.
[3] World Health Organisation, 'World Health Statistics 2022: Monitoring Health for the SDGs' (World Health Organisation 2022) vii <https://www.who.int/data/gho/publications/world-health-statistics>.
[4] Lucas Chancel and others, 'World Inequality Report 2022' (World Inequality Lab 2021) 61.
[5] World Health Organisation, 'World Health Statistics 2022: Monitoring Health for the SDGs' (n 3) vii.
[6] Lucas Chancel, Philipp Bothe and Tancrède Voituriez, 'Climate Inequality Report 2023: Fair Taxes for a Sustainable Future in the Global South' (World Inequality Lab 2023) 2023/1 <https://wid.world/wp-content/uploads/2023/01/CBV2023-ClimateInequalityReport-3.pdf> accessed 11 April 2023.
[7] World Health Organisation, 'World Health Statistics 2022: Monitoring Health for the SDGs' (n 3) 42.

The social gradient is a correlation of social factors (such as income) with health outcomes (such as life expectancy) that depicts a graduated relationship between the two, expressing a particular type of health inequality. Since Michael Marmot and colleagues presented the concept in the early UK Whitehall studies,[8] a burgeoning body of global evidence demonstrates that social gradients can be identified within and between all countries for a variety of health outcomes.[9] The social gradient suggests that wherever you are in the socio-economic hierarchy you experience less good health than the persons immediately above you, and slightly better health than the persons immediately below.[10] The social gradient is often interpreted as relating to socio-

[8] MG Marmot and others, 'Changing Social-Class Distribution of Heart Disease' (1978) 2 The British Medical Journal 1109; MG Marmot and others, 'Employment Grade and Coronary Heart Disease in British Civil Servants' (1978) 32 Journal of Epidemiology and Community Health (1978) 244; MG Marmot and others, 'Health Inequalities among British Civil Servants: The Whitehall II Study' (1991) 337 The Lancet 1387.

[9] Seung Yong Han and Daniel Hruschka, 'Deprivation or Discrimination? Comparing Two Explanations for the Reverse Income–Obesity Gradient in the US and South Korea' (2022) 54 Journal of Biosocial Science 1; Anteo Di Napoli and others, 'Self-Perceived Workplace Discrimination and Mental Health among Immigrant Workers in Italy: A Cross-Sectional Study' (2021) 21 BMC Psychiatry 85; Rick Hood and Allie Goldacre, 'The Social Gradient in English Child Welfare Services: An Analysis of the National Children's Social Care Datasets' (Kingston University London 2021) <https://www.healthcare.ac.uk/wp-content/uploads/2021/06/The-social-gradient-in-CSC_Full-Report_Final_June-2021.pdf> accessed 9 January 2022; Mika Kivimäki and others, 'Association between Socioeconomic Status and the Development of Mental and Physical Health Conditions in Adulthood: A Multi-Cohort Study' [2020] The Lancet Public Health <https://www.thelancet.com/journals/lanpub/article/PIIS2468-2667(19)30248-8/abstract> accessed 8 February 2020; Ismael G Muñoz, David P Baker and Ellen Peters, 'Explaining the Education-Health Gradient in Preventing STIs in Andean Peru: Cognitive Executive Functioning, Awareness and Health Knowledge' (2020) 46 International Perspectives on Sexual and Reproductive Health 113; Elisabeth Fosse, Nigel Sherriff and Marit Helgesen, 'Leveling the Social Gradient in Health at the Local Level: Applying the Gradient Equity Lens to Norwegian Local Public Health Policy' (2019) 49 International Journal of Health Services 538; Carina Fourie, 'Gender, Status, and the Steepness of the Social Gradients in Health' (2019) 12 International Journal of Feminist Approaches to Bioethics 137; PK Bird and others, 'Income Inequality and Social Gradients in Children's Height: A Comparison of Cohort Studies from Five High-Income Countries' (2019) 3 BMJ Paediatrics Open; Natalia Vincens, Maria Emmelin and Martin Stafström, 'Social Capital, Income Inequality and the Social Gradient in Self-Rated Health in Latin America: A Fixed Effects Analysis' (2018) 196 Social Science & Medicine 115; Michael Pluess and Mel Bartley, 'Childhood Conscientiousness Predicts the Social Gradient of Smoking in Adulthood: A Life Course Analysis' (2015) 69 J Epidemiol Community Health 330; Oliver Hämmig and Georg F Bauer, 'The Social Gradient in Work and Health: A Cross-Sectional Study Exploring the Relationship between Working Conditions and Health Inequalities' (2013) 13 BMC Public Health 1170; For example, Veerle Vyncke and others, 'Does Neighbourhood Social Capital Aid in Levelling the Social Gradient in the Health and Well-Being of Children and Adolescents? A Literature Review' (2013) 13 BMC Public Health 65.

[10] Commission on Social Determinants of Health, 'Closing the Gap in a Generation: Health Equity through Action on the Social Determinants of Health. Final Report of the Commission on Social Determinants of Health' (World Health Organization, Commission on Social Determinants of Health 2008) 31–33.

economic inequalities, but gradients have been demonstrated for factors other than socio-economic status.[11] The social gradient articulates a more complex interrelationship of social determinants of health than a linear correlation between income or wealth and morbidity and mortality might suggest. Social gradients express an interrelationship of both vertical and horizontal inequalities and are ubiquitous at global, national and local levels.

Failure to attend to the social gradient in health inequalities means that the whole range of measures available to ameliorate inequality are not addressed, or that measures are more imprecisely designed or targeted. Attending to social gradient inequality means focusing upon why inequalities are structured in this way. It means attending to what it is that unequally distributes the social determinants of health creating this hierarchical pattern of health inequalities and what the implications of this patterning may be. The implications of the social gradient for health inequalities are far reaching. In his treatise on *Health Justice* exploring the linkages between health inequalities, public health, human rights, and the capability approach (CA), Sridhar Venkatapuram states:

> Ignoring the social gradient in theory and in practice seems to have put the entire world at risk.[12]

[11] Robert Erikson, 'Why Do Graduates Live Longer?' in Jan O Jonsson and C Mills (eds), *Cradle to Grave: Life-course Change in Modern Sweden* (Sociology Press 2001); Renato B Reis and others, 'Impact of Environment and Social Gradient on Leptospira Infection in Urban Slums' (2008) 2 PLoS Neglected Tropical Diseases e228; Rachael Jenkins and others, 'Debt, Income and Mental Disorder in the General Population' (2008) 38 Psychological Medicine 1485; Yvonne Kelly and others, 'What Role for the Home Learning Environment and Parenting in Reducing the Socioeconomic Gradient in Child Development? Findings from the Millennium Cohort Study' (2011) 96 Archives of Disease in Childhood 832; Brent Bezo, Stefania Maggi and William L Roberts, 'The Rights and Freedoms Gradient of Health: Evidence from a Cross-National Study' (2012) 3 Frontiers in Psychology; Marion Devaux and Franco Sassi, 'Social Inequalities in Obesity and Overweight in 11 OECD Countries' (2013) 23 European Journal of Public Health 464; Mariana C Arcaya, Alyssa L Arcaya and SV Subramanian, 'Inequalities in Health: Definitions, Concepts, and Theories' (2015) 8 Global Health Action 27106; Deidre M Anglin and others, 'From Womb to Neighborhood: A Racial Analysis of Social Determinants of Psychosis in the United States' (2021) 178 American Journal of Psychiatry 599.

[12] Sridhar Venkatapuram, 'Social Gradient in Capabilities' (2018) 19 Journal of Human Development and Capabilities 553, 555.

The *International Covenant on Economic Social and Cultural Rights* 1966 (ICESCR) was adopted in 1966 and entered into force in 1976. As of January 2022, the treaty gives rise to binding legal obligations to its 171 state parties.[13] Article 12 of the ICESCR expanded upon the Universal Declaration on Human Rights with the assertion that: 'The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health'.[14] This formulation of the right to health can also be found in other supranational and regional treaties for example: Article 24 of the *Convention on the Rights of the Child (1989)*, and Article 25 of the *Convention on the Rights of Persons with Disabilities (2006)*.[15] It can also be found at a regional level in: the *African Charter on Human and Peoples' Rights (1981)*, the *Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights (Protocol of San Salvador, 1988),* the *Arab Charter on Human Rights (2004)*, and the *European Social Charter (Revised, 1996*).[16]

The right to health in ICESCR Article 12 is expressed as:

> 1. The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.
>
> 2. The steps to be taken by the States Parties to the present Covenant to achieve the full realisation of this right shall include those necessary for:
>
> a) The provision for the reduction of the still-birth rate and of infant mortality and for the healthy development of the child;

[13] Office of the High Commissioner for Human Rights, 'OHCHR Status of Ratification Interactive Dashboard' (January 2022) <https://indicators.ohchr.org/> accessed 8 January 2022.
[14] United Nations, 'Universal Declaration of Human Rights' (1948) GA Resolution 217A (III), UN GOAR, Resolution 71, UN Document A/810; UN General Assembly, 'International Covenant on Economic, Social and Cultural Rights' (1966) (ICESCR) UNGA Resolution 2200A (XXI), 16 December 1966.
[15] UN Committee on the Rights of the Child, 'Convention on the Rights of the Child' (1989) UNGA Resolution A/Res/44/25, 20 November 1989; United Nations, 'Convention on the Rights of Persons with Disabilities (CRPD)' (2006) Committee on the Rights of Persons with Disabilities.
[16] Organisation of African Unity, 'African (Banjul) Charter on Human and Peoples' Rights' (1982) OAU Doc CAB/LEG/67/3 rev 5,21 ILM 58 (1982) art 16; Organization of American States), 'Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights "Protocol of San Salvador"' (1988) art 10; Council of Europe, 'European Social Charter Revised (1996)' (1996) European Treaty Series No, 163 art 11; Office of the High Commissioner for Human and League of Arab States, 'Arab Charter on Human Rights' ([Office of the UN High Commissioner for Human Rights], 2004) art 39.

b) The improvement of all aspects of environmental and industrial hygiene;

c) The prevention treatment and control of epidemic, endemic, occupational and other diseases;

d) The creation of conditions which would assure to all medical service and medical attention in the event of sickness.[17]

However, this delineation of the right to health, whilst encompassing social determinants and health care, appears only partial with its focus on infant morbidity and mortality, environmental hygiene, occupational health, and control of epidemic and endemic diseases. It does not reflect the challenges nor the daily work of any public health practitioner, or the main diseases and health concerns in any country.

The Committee on Economic, Social and Cultural Rights (CESCR) provided further interpretive guidance supporting the implementation of the right to health with *General Comment No. 14 on the Right to the Highest Attainable Standard of Health* (2000), and *General Comment No. 22 on the Right to Sexual and Reproductive Health* (2016).[18]

Certainly, there is now more detail and further social determinants of health are included, but the most noteworthy inclusion, from a public health practitioner viewpoint, is the requirement for an action plan based upon epidemiological evidence to address the health needs of the whole population.

Additionally, from the perspective of inequalities, equality and non-discrimination are presented as fundamental human rights principles. These are cross-cutting human rights principles with articles prohibiting discrimination on a variety of grounds clearly

[17] UN General Assembly, 'ICESCR' (n 14).
[18] UN Committee on Economic, Social and Cultural Rights, 'General Comment No. 14 (Twenty Second Session). The Right to the Highest Attainable Standard of Health (Article 12)' (2000) UN Document E/C12/2000/4; UN Committee on Economic, Social and Cultural Rights, 'General Comment No. 22 (2016) on the Right to Sexual and Reproductive Health (Article 12 of the International Covenant on Economic, Social and Cultural Rights)' (2016) UN Doc E/C12/GC/22.

articulated in number of treaties.[19] In *General Comment No. 3 The Nature of States Parties' Obligations (Art. 2, Para. 1 of the Covenant),* the CESCR affirmed a commitment to equality and non-discrimination for all economic, social and cultural rights.[20]

The right to health, as with public health, seeks to redress health inequalities and the plight of disadvantaged and vulnerable groups. Yet the right to health is the right of *everyone* to the enjoyment of the *highest* attainable standard of physical and mental health. The social gradient suggests that those who are not living in poverty or are not particularly vulnerable are still not achieving the highest attainable standard of physical and mental health. Their right to health is not being met due to inequity in the distribution of resources across the gradient, the squeezing of the circumstances of those in the middle of the gradient, and the negative effects of material inequality for society as a whole It also suggests that the highest attainable standard of health is that achieved by those at the top of the gradient.

B. Research Questions, Aims and Objectives.

This thesis elucidates public health knowledge about the social gradient and its potential explanatory mechanisms. The thesis aims to identify ways in which the social gradient is conceptualised in public health and right to health academic literature in order to identify potential conceptual frameworks for application in the right to health. It seeks to evaluate to what extent the right to health engages with notions of the social gradient in

[19] United Nations, 'International Convention on the Elimination of All Forms of Racial Discrimination' (1965) (ICERD) UN GA Resolution 2106A (XX); United Nations, 'Convention on the Elimination of All Forms of Discrimination against Women' (1979) (CEDAW); United Nations, 'Convention on the Rights of Persons with Disabilities (CRPD)' (n 15); United Nations, 'International Covenant on Civil and Political Rights (ICCPR)' (1966) GA Resolution 2200A (XXI), 16 December 1966.
[20] UN Committee on Economic, Social and Cultural Rights, 'General Comment No. 3 (Fifth Session). The Nature of States Parties' Obligations (Art. 2, Para. 1, of the Covenant)' (1990) UN Document E/1991/23 (111) paras 1, 3 and 5.

right to health treaties and general comments to ascertain whether it is relevant to the existing conceptions of the right to health. It analyses the mission and thematic reports of the United Nations Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health (Special Rapporteur or SRRH) to assess whether the right to health acts upon social gradient health inequalities. Furthermore, this thesis addresses the need for the human rights community to engage with a broader understanding of health inequalities by incorporating social gradient concepts in the right to health.

The thesis responds to Yamin's exhortation for the right to health to engage with the social gradient. The three central research questions are:

1. **To what extent does the right to health conceptualise, engage with, and act upon the social gradient in health inequalities?**
2. **What are the implications for the integration of the social gradient in the right to health?**
3. **How therefore might the right to health strengthen its engagement with the social gradient in health inequalities?**

C. Structure of Thesis

The thesis is organised around conceptualisations of, engagement with, and action on the social gradient by the right to health.

Chapter 1 introduces the concept of the social gradient. Section A discusses health inequalities in public health and examines the use of the terms disparities, inequalities and inequities. Section B introduces the concept of the social gradient as a social determinant of health which distributes health inequalities. Section C considers the implications of the social gradient, the type of health inequalities it articulates, explanatory mechanisms for the social gradient and policy action on health inequalities.

Chapter 2 reviews public health and right to health academic literature to identify how the social gradient is used in discussions of health inequalities and to identify potential conceptual frameworks for its application to the right to health. Section A sets out the scoping review methodology applied and section B the results of the review. Section C sets out the conceptualisations of the social gradient found in the literature. Section D then considers the relationship between the social gradient and the right to health in the literature. The few conceptual frameworks for the social gradient available in public health are topic specific and not easy to apply to human rights. The scoping review seeks any conceptual frameworks to support later analysis of right to health documents for the study. Public health conceptualisations of the social gradient are often not clear and limited and so it is not unreasonable to expect that right to health conceptualisations may repeat the inconsistencies found in public health.

Chapter 3 evaluates engagement with the social gradient in right to health treaties and general comments: Most notably in the ICESCR,[21] General Comment 14[22] and General Comment 22.[23] Section A explores the place of social determinants of health within a holistic understanding of health and implications for conceptions of causation in the right to health. Section B considers how the right to health is the right of everyone, integrating the principles of equality and non-discrimination and notions of horizontal and vertical inequalities. It is essential to ascertain whether the right to health is concerned largely with health care or whether it includes social determinants of health. If the latter, then there is a foundation in the right to health for incorporating the social gradient as a social determinant of health.

[21] Office of the High Commissioner for Human Rights, 'OHCHR Status of Ratification Interactive Dashboard' (n 13).
[22] UN Committee on Economic, Social and Cultural Rights, 'General Comment 14 ICESCR' (n 18).
[23] UN Committee on Economic, Social and Cultural Rights, 'General Comment 22 ICESCR' (n 18) 22.

Chapter 4 analyses the mission and thematic reports of the Special Rapporteur on the right to health (SRRH). Section A describes the role and importance of the SRRH in advocating, explaining and implementing the right to health. Section B describes the Framework Method developed by Jane Ritchie and Liz Spencer used to analyse the mission and thematic reports. [24] It presents the findings using a heat mapping technique developed by Kate Kynoch and colleagues.[25] Section C considers whether the SRRH reports demonstrate action on poverty, the health inequality gap between groups in the population, or social gradient health inequalities using Hilary Graham's policy analysis matrix.[26] The work of the SRRH was chosen because it represents collaboration between public health and the right to health and action taken to implement the right to health in a variety of country contexts.

Chapter 5 brings together the findings of the preceding three chapters and discusses whether the right to health *is* the right of *everyone* to the *highest* attainable standard of health. Section A considers those in the middle of the gradient, the importance of wealth in creating the gradient and the importance of societal health in addition to individual health status. Section B reflects upon the implications for the debate on maximum available resources and minimum core obligations.

Chapter 6 proposes the capability approach, offered in the first chapter as one of a number of potential explanatory mechanisms for the social gradient, as a normative and

[24] Jane Ritchie and Liz Spencer, 'Qualitative Data Analysis for Applied Policy Research' in A Huberman and Matthew Miles (eds), *The Qualitative Researcher's Companion* (SAGE Publications, Inc 2002).
[25] Kate Kynoch and others, 'Information Needs and Information Seeking Behaviors of Patients and Families in Acute Healthcare Settings: A Scoping Review' (2019) 17 JBI Evidence Synthesis 1130.
[26] Hilary Graham, 'Tackling Inequalities in Health in England: Remedying Health Disadvantages, Narrowing Health Gaps or Reducing Health Gradients?' (2004) 33 Journal of Social Policy 115; Hilary Graham, 'Social Determinants and Their Unequal Distribution: Clarifying Policy Understandings' (2004) 82 The Milbank Quarterly 101; Hilary Graham, 'Health Inequalities, Social Determinants and Public Health Policy' (2009) 37 Policy and Politics 463.

evaluative conceptual framework to unite public health and the right to health in their engagement with the social gradient in health inequalities.

Finally, the thesis summarises the main themes of the study and answers the research questions. It concludes with personal reflections upon the current situation with regards to health inequalities.

Chapter 1. The Social Gradient

This chapter introduces the social gradient and explores why the social gradient in health is an important and necessary concept for understanding health inequalities. Firstly, health inequalities are introduced. Then the origins and the notion of the social gradient in health and how it articulates a unique conception of health inequalities is explained. The implications of the social gradient for health inequalities are far reaching. Consequently, an expanded understanding of health inequalities is discussed, arguing that it is a fourth dimension of inequality, in addition to global, vertical and horizontal inequalities, that requires more careful deliberation.

A. Health Inequalities

The Sars-CoV-2 (Covid-19) pandemic has illuminated persisting patterns of global inequality, exacerbated widening socio-economic inequalities and exposed deepening inequalities between groups. Global inequalities are starkly represented by access (or lack of) to Covid-19 vaccination where the global failure to distribute vaccines resulted in 56 low- and middle-income countries being unable to reach the WHO target of 10% vaccine coverage in all countries by September 2021.[27] Only 8.3% of people in LICs had received at least one dose of the vaccine even though full vaccine coverage (two doses) had reached 69% in the UK, 77% in Canada, 78% in Japan and 89% in Portugal, and 91% in United Arab Emirates (UAE) by 27th December 2021.[28] A 2020 UNDP report estimated that 47 million women and girls had been pushed into poverty because of Covid-19.[29] Yet, the wealth of the ten richest men in the world had increased

[27] World Health Organisation, 'Vaccine Equity' (December 2021) <https://www.who.int/campaigns/vaccine-equity> accessed 28 December 2021.
[28] Hannah Ritchie and others, 'Coronavirus Pandemic (COVID-19) Vaccinations' (*Our World in Data*, 27 December 2021) <https://ourworldindata.org/covid-vaccinations> accessed 28 December 2021.
[29] UN Women, 'From Insights to Action: Gender Equality in the Wake of COVID-19' (2020) 3 <https://doi.org/10.18356/f837e09b-en> accessed 28 December 2021.

by £400 billion during the pandemic, enough to vaccinate every person in the world and prevent people falling into poverty as a consequence of the pandemic.[30] Inequalities between groups have deepened. For example, only 14% of the population of England and Wales are from black, Asian and minority ethnic backgrounds.[31] Yet this group accounted for 28.2% of critically ill Covid-19 patients (Sep. 2020 to Apr. 2021).[32] This pattern of health inequality was repeated in other HICs such as the USA for morbidity and mortality.[33] Older people were more susceptible to higher morbidity and mortality in the pandemic, which was exacerbated by already entrenched 'ageism' with the abandonment of older people in residential homes and a dehumanising public narrative around their vulnerability.[34]

1. Health inequalities in public health

Action to ameliorate health inequalities has a long history in public health. Over the last two centuries the fight against slavery, the instituting of poor laws, Victorian philanthropy and policy to improve housing and sanitation, the health impacts of industrialisation and action to reform working conditions, the fight for women's emancipation and control over their own bodies, and anti-colonial movements all point to a growing recognition of

[30] Esmé Berkhout and others, 'The Inequality Virus: Bringing Together a World Torn Apart by Coronavirus through a Fair, Just and Sustainable Economy' (Oxfam 2021) 8 <https://policy-practice.oxfam.org/resources/the-inequality-virus-bringing-together-a-world-torn-apart-by-coronavirus-throug-621149/> accessed 28 December 2021.
[31] Office for National Statistics, 'Population of England and Wales' (*GOV.UK*, December 2021) <https://www.ethnicity-facts-figures.service.gov.uk/uk-population-by-ethnicity/national-and-regional-populations/population-of-england-and-wales/latest> accessed 28 December 2021.
[32] Intensive Care National Audit and Research Centre, 'ICNARC Report on COVID-19 in Critical Care: England, Wales and Northern Ireland 24 December 2021' (ICNARC 2021) 24 <https://www.icnarc.org/our-audit/audits/cmp/reports>.
[33] Brea L Perry, Brian Aronson and Bernice A Pescosolido, 'Pandemic Precarity: COVID-19 Is Exposing and Exacerbating Inequalities in the American Heartland' (2021) 118 Proceedings of the National Academy of Sciences <https://0-www-pnas-org.serlib0.essex.ac.uk/content/118/8/e2020685118> accessed 28 December 2021.
[34] Rosa Kornfeld-Matte, 'OHCHR | "Unacceptable" – UN Expert Urges Better Protection of Older Persons Facing the Highest Risk of the COVID-19 Pandemic' (*OHCHR Stand Up for Human Rights*, 27 March 2020) <https://www.ohchr.org/EN/NewsEvents/Pages/DisplayNews.aspx?NewsID=25748&LangID=E> accessed 1 April 2020.

inequalities impacting health.[35] Public health measures grew alongside as improvements to the environment and sanitation, new vaccines and treatments, and improvements to child health and development through education and services such as health visiting were advanced within sanitary-environmental, biomedical, behavioural, and technological approaches to public health provision.[36]

However, it was social medicine that became the foundation of both public health and human rights action on health inequalities.[37] North American and European notions of the social production of disease and the political economy of health originated from nineteenth century Rudolf Virchow and Friedrich Engels.[38] These ideas resonated with an understanding of medicine as a social science with the roots of disease being unjust social conditions. Latin American critical approaches to social epidemiology highlighted the social and political determinants of poverty and poor health.[39] Social justice became the foundation for public health to achieve equity and attend to issues of social injustice.[40] Public health action became more than health care and embraced policy development, governance and intersectoral action to promote health and prevent disease.

The establishment of the World Health Organisation (WHO) in 1946 with its revolutionary definition of health as more than the 'absence of disease or infirmity'

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[35] Jeannine Coreil (ed), *Social and Behavioral Foundations of Public Health* (2nd ed, Sage 2010) ch 2; Nancy Krieger, *Epidemiology and the People's Health: Theory and Context* (Oxford University Press 2011) chs 3–5; See also Benjamin Mason Meier, Thérèse Murphy and Lawrence O Gostin, 'The Birth and Development of Human Rights for Health' in Lawrence O Gostin and Benjamin Mason Meier (eds), *Foundations of Global Health & Human Rights* (Oxford University Press 2020) <https://doi.org/10.1093/oso/9780197528297.003.0002> accessed 11 March 2023.
[36] Geof Rayner and Tim Lang, *Ecological Public Health: Reshaping the Conditions for Good Health* (Routledge 2012) ch 3.
[37] Meier, Murphy and Gostin (n 38) 26.
[38] Krieger, *Epidemiology* (n 38) 189.
[39] ibid 187.
[40] Barry S Levy and Victor W Sidel (eds), *Social Injustice and Public Health* (Oxford University Press 2006) 8–9.

advanced the human right to health for all, recognising 'The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition'.[41] This notion of health was consolidated with the 1966 UN ICESCR with the specification of the right of everyone to the enjoyment of the highest attainable standard of physical and mental health in Article 12, and cross-cutting commitments to realise the right on the basis of non-discrimination and gender equality in Article 2.2 and 3.[42] The *Declaration of Alma Ata 1978* strengthened the position of 'primary health care accessible to all' as central to the provision of health promotion and prevention alongside curative services.[43] The Commission on the Social Determinants of Health (CSDH) 2008 publication *Closing The Gap in a Generation: Health Equity Through Action on The Social Determinants of Health* firmly placed the social determinants of health on the agenda to address health inequity with clearly specified action..[44] The WHO World Conference on Social Determinants of Health 2011 resulted in the *Rio Political Declaration* which affirmed the place of social determinants of health in addressing health inequity.[45]

Despite such ongoing efforts, health inequalities are deepening and becoming more entrenched. The reasons for this are multiple and complex. As Robert Holton notes: '[t]here is no single prime mover that explains all forms of inequality. A key characteristic

[41] World Health Organisation, 'Constitution of the World Health Organisation' (1946) adopted by the International Health Conference, New York, 19th June to 22nd July 1946, and signed on 22nd July 1946.
[42] UN General Assembly, 'ICESCR' (n 14) art 12.
[43] World Health Organisation, 'Declaration of Alma Ata. International Conference on Primary Health Care.' (1978) 6-12 September 1978, <http://www.who.int/publications/almaata_declaration_en.pdf> accessed 11 January 2015.
[44] Commission on Social Determinants of Health (n 10).
[45] World Health Organisation, 'Rio Political Declaration on the Social Determinants of Health' <https://www.who.int/publications/m/item/rio-political-declaration-on-social-determinants-of-health> accessed 30 July 2017.

of inequality is therefore its complexity.'[46] There is also considerable debate around the use of the terms disparities, health inequalities and health inequities, in both public health and human rights.

2. The terms disparities, inequalities, and inequity

The term 'disparities' is often used in policy and practice. A dictionary definition refers only to the fact that there are differences. In public health it can simply mean health differences between individuals and between groups as a description of an observation in the data, or it can signify worse health in socially disadvantaged groups. Often the meaning is not made clear.[47] Health disparities might be considered inevitable, such as with the health differences between a 22-year-old and an 82-year-old person, or by virtue of some biological condition such as sickle cell disease. In this way it can be interpreted as a neutral term that does not imply inequality or inequity. However, the term 'health disparities' might hide or minimise any causal mechanisms for the differences in health status, and action that might be required. It is important to make this distinction because in some contexts, 'health disparities' is used instead of inequalities. For example, in the United States of America (USA) health disparities are defined as related to disadvantage.[48] In other circumstances use of the term disparities avoids the concept of equality and associated values.[49] The term is unclear given the differences in usage and interpretation. Moreover, it should be noted that most of the publications that use the term disparities are from USA based authors, thus the absence of inequalities language rather reflects the USA context. Authors from other countries,

[46] Robert J Holton, 'Global Inequality', *The Routledge International Handbook of Globalization Studies* (2nd edn, Routledge 2015) 71.
[47] Paula Braveman, 'What Are Health Disparities and Health Equity? We Need to Be Clear' (2014) 129 Public Health Reports 5.
[48] ibid.
[49] *Social Justice and Health Equity - A Talk with Sir Michael Marmot* (Directed by UC Berkeley Events, 2018) <https://www.youtube.com/watch?v=UZlYnE3OhRE> accessed 5 February 2020.

most notably from the UK where discussion of health inequalities has become mainstream, do not use the term disparities.

'Health inequalities' has become a commonly accepted term in global public health, indicating that health differences are caused by social, economic or political disadvantage. The descriptive dimension of inequality demands that we consider *what* is being compared for *whom*, with what *purpose*. Can health inequalities be ameliorated through a more equal redistribution of resources or by developing interventions that are more equally distributed across society?[50] Yet, using health inequalities as a solely descriptive term fails to acknowledge the normative dimensions of equality.[51] Describing health inequalities might enable us to see what needs to be done to correct them but it does not tell us that they *should* be addressed and what *ought* to be done. A great deal of work has focused upon identifying the kind of inequalities that are worthy of attention and that ought to be addressed.[52] The notion of equality is considered a worthy moral pursuit as it embodies both descriptive and normative dimensions.[53]

The term 'equity' might be employed to make the distinction of a normative component to equality, but in public health this notion is unclear.[54] In an effort to identify health inequalities of primary concern, public health practitioners have adopted the term health inequity. Public health resorts to Margaret Whitehead's oft quoted definition of health inequity as being health inequalities that are 'unnecessary, avoidable, unfair and

[50] Jo C Phelan, Bruce G Link and Parisa Tehranifar, 'Social Conditions as Fundamental Causes of Health Inequalities: Theory, Evidence, and Policy Implications' (2010) 51 Journal of Health and Social Behavior S28.
[51] Gillian MacNaughton, 'Untangling Equality and Non-Discrimination to Promote the Right to Health Care for All' (2009) 11 Health and Human Rights 47.
[52] Maxwell J Smith, 'Health Equity in Public Health: Clarifying Our Commitment' (2015) 8 Public Health Ethics 173, 178.
[53] ibid 178–179.
[54] Smith, 'Health Equity in Public Health' (n 55).

unjust'.[55] The term health inequity is used by public health practitioners to signal a preoccupation with social justice, which is shared with the human rights conceptualisation of inequality (which is explored below). Many of the definitions of inequity cite structural influences upon the distribution of health and the distribution of the social determinants of health.[56] That is those determinants of health (policy, governance, cultural values, gender, ethnicity, education, occupation) that distribute vulnerabilities and exposure to risk unequally across the population.[57] For Whitehead, the term inequity 'has a moral and ethical dimension'.[58]

The term inequity remains unclear because an additional judgement is required to ascertain whether an inequality is inequitable. [59] It is not clear using Whitehead's formula how this distinction could be made. For example, what is meant by avoidable? Avoidable by whom and at what level, and ease of avoidability should not determine what is considered inequitable.[60] Moreover, although 'unnecessary and avoidable' are useful in galvanising public opinion around clear issues, they are already implied in 'fair and just' making them redundant in assessing whether an inequality is an inequity.[61] At the same time there are issues with defining when something is unjust and unfair. Whitehead and Goran Dahlgren try to resolve this issue by saying that those inequalities that are 'socially produced' or are caused by 'unjust social arrangements' are unjust and are therefore inequities, and those with natural biological variations and

[55] Margaret Whitehead, 'The Concepts and Principles of Equity and Health' (1992) 22 International Journal of Health Services 429.
[56] For example, Paula Braveman, 'Social Conditions, Health Equity, and Human Rights' (2010) 12 Health Hum Rights 31.
[57] Arcaya, Arcaya and Subramanian (n 11).
[58] Whitehead (n 58) 431.
[59] James Wilson, 'Health Inequities' in A Dawson (ed), *Public Health Ethics: Key Concepts and Issues in Policy and Practice* (Cambridge University Press 2011).
[60] Paula Braveman and Sofia Gruskin, 'Defining Equity in Health' (2003) 57 Journal of Epidemiology and Community Health 254, 255.
[61] ibid.

causes are simply inequalities.[62] Even this is difficult when scientific advances are revealing genetic factors amenable to treatment or that exhibit the persistence of intergenerational inequalities in the causative pathway, thus rendering inequitable some conditions that used to be thought of as just bad luck.[63] The question remains as to how to determine whether health inequalities are health inequities.

The use of the term 'health inequalities' avoids having to make such a judgement. Moreover, inequalities are an important way of measuring inequity.[64] The term 'health inequalities' is inclusive of health inequities. Paula Braveman and colleagues assert that '[b]efore people can achieve health equity they must first be able to fully realise their human rights in all domains essential for health'.[65] In this way we need to have eliminated health inequalities before we can consider whether we have achieved health equity. The role health inequalities play in obstructing the realisation of the right to health is central to the endeavour to achieve health equity, however defined.

When considering the terms used by both public health and the right to health the confusion deepens. Paul Hunt, the first UN Special Rapporteur on the right to health (2002–08), reports that the use of the terms equality or equity proved contentious in his dialogue between right to health and public health communities.[66] He explains that the term equality refers to a fundamental principle of the right to health, such that governments who wish to downplay obligations for equality would use the term equity. However, he continues, in public health the term equality is perceived to mean equal treatment for all and clearly each individual requires treatment specific to their particular

[62] Margaret Whitehead and Goran Dahlgren, 'Levelling up (Part 1): A Discussion Paper on Concepts and Principles for Tackling Social Inequities in Health' 2–3 <http://who.int/social_determinants/resources/leveling_up_part1.pdf> accessed 28 August 2013.
[63] Smith, 'Health Equity in Public Health' (n 55) 177.
[64] Braveman and Gruskin (n 63) 256–257.
[65] Paula Braveman and others, 'What Is Health Equity' (2018) 4 Behavioural Science and Policy 1, 3.
[66] Conversation Paul Hunt to author (11 December 2018)

needs, so they prefer the term equity. The term equity is perceived with distrust by human rights proponents and the term equality not greatly esteemed by public health proponents. Hunt explains that when writing in his role as Special Rapporteur, he would sometimes use the formulae of 'equality, non-discrimination and equity' to overcome this division.

'Health inequalities' has both descriptive and normative dimensions for public health. It refers to differences in health that are caused by social, political and economic factors which may be 'unnecessary, avoidable, unfair and unjust'. It encompasses inequities and attends to issues of social justice. It resonates with human rights practitioners and the conception of inequality in the right to health.

B. The Social Gradient

A social gradient is a correlation of social factors (such as income) with health outcomes (such as life expectancy) that depicts a graduated relationship between the two, expressing a particular type of health inequality. Since Michael Marmot and colleagues presented the concept of the social gradient in the UK Whitehall Studies of the late 1970s and early 1980s, the social gradient has become firmly established in social epidemiology.[67] The social gradient has become a significant concept arising from public health social epidemiology and the study of the social determinants of health – that is the social conditions in which people are born, grow, live, work and age that impact health.[68]

[67] See for example in Commission on Social Determinants of Health (n 10).
[68] ibid.

The UK Institute of Health Equity defines the social gradient as:

> a term used to describe the phenomenon whereby people who are less advantaged in terms of socio-economic position have worse health (and shorter lives) than those who are more advantaged.[69]

The graph below (

Figure 1), taken from Marmot's *Fair Society, Healthy Lives*: *The Marmot Review*, neatly portrays this concept.[70] Each dot in the horizontal axis of the graph represents a neighbourhood in England classified by deprivation percentiles, from the most deprived to the least deprived. Age is represented on the vertical axis. The graph demonstrates both life expectancy at birth and disability-free life expectancy (DFLE). The trend line through the dots is the social gradient. Note that life expectancy and DFLE is 17 years less for those in the most deprived neighbourhoods compared to the least deprived neighbourhoods. Now look to the middle. There are many neighbourhoods where people experience inequality in life expectancy even though they are neither poor nor wealthy. It is the gradient in health inequality that is startling.

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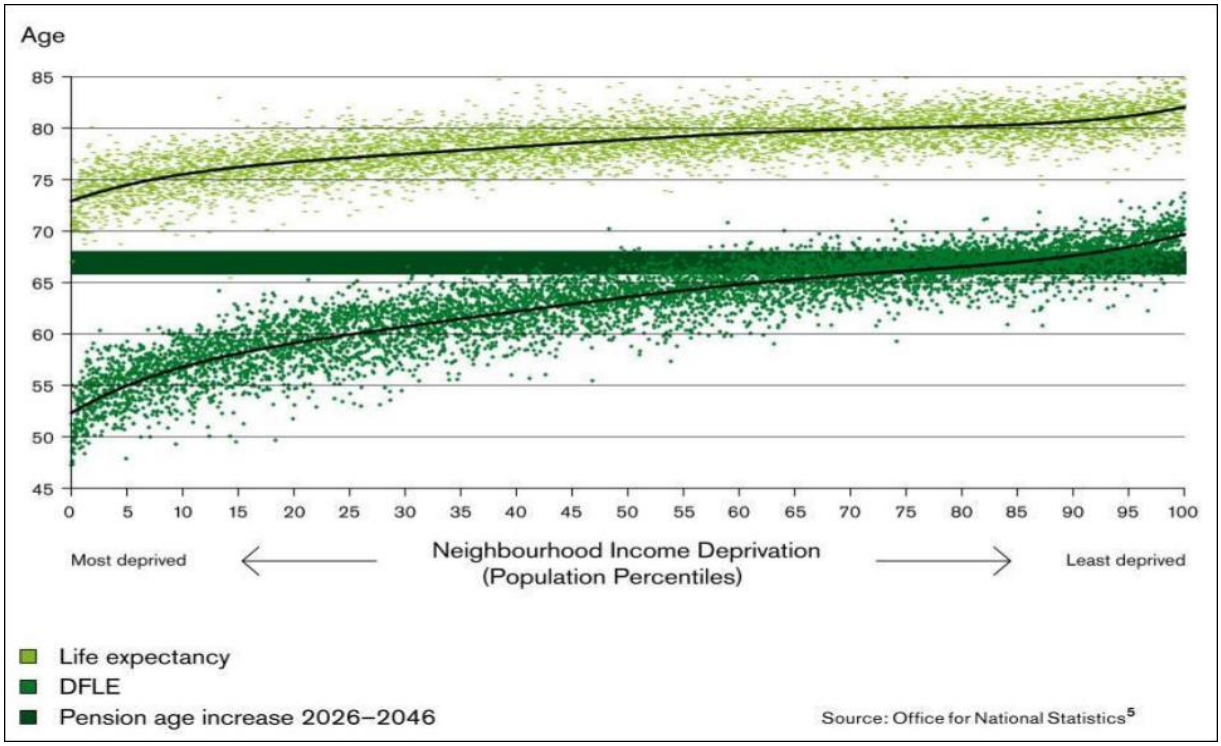
[69] Institute of Health Equity, 'Social Gradient' (*Institute of Health Equity*, 2020) <http://www.instituteofhealthequity.org/in-the-news/articles-by-the-institute-team-/social-gradient> accessed 26 June 2020.

[70] Michael Marmot (ed), 'Fair Society, Healthy Lives. The Marmot Review. Strategic Review of Health Inequalities in England Post-2010' 17.

Figure 1 **Life expectancy and disability-free life expectancy (DFLE) at birth, persons by neighbourhood income level, England 1999–2003.**



Source: Marmot (2010)[71]

The social gradient is most startling because it is ubiquitous, relates to outcomes other than health, and is far from new. A burgeoning body of global evidence demonstrates that social gradients can be identified in all countries whether high, middle, or low

[71] ibid.

income.[72] Data also shows that it relates to outcomes other than health. For example, the UK Millennium Cohort Study was utilised to demonstrate a social gradient in early child development, associating lower socio-economic position with greater socioemotional difficulties and reduced verbal, non-verbal and spatial abilities at five years.[73] A recent study showed how a legacy of structural racism in the United States (US) has contributed to a social gradient in racial inequalities in environmental risk factors and psychosis.[74] Evidence of the social gradient is not new.[75] A social patterning of mortality like the social gradient in health was identified in poor quarters of Paris by French economist and physician Louis-René Villermé as early as 1826 and in the UK in the 1840s lawyer Edwin Chadwick found a social gradient whereby the lower the social class the poorer the health.[76]

1. The social gradient as a social determinant of health

Social determinants of health refer to health-influencing factors situated in social conditions rather than risk factors associated with individual biology and vulnerabilities.[77] The WHO defines social determinants of health (SDH) as:

> The social determinants of health are the conditions in which people are born, grow, live, work and age. These circumstances are shaped by the distribution of money, power and resources at global, national and local levels. The social determinants of health are mostly responsible for health inequities - the unfair and avoidable differences in health status seen within and between countries.[78]

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[72] Commission on Social Determinants of Health (n 10).
[73] Kelly and others (n 11).
[74] Anglin and others (n 11).
[75] Anne-Emanuelle Birn, 'Making It Politic (al): Closing the Gap in a Generation: Health Equity through Action on the Social Determinants of Health' (2009) 4 Social Medicine 166.
[76] Nancy Krieger, 'Historical Roots of Social Epidemiology: Socioeconomic Gradients in Health and Contextual Analysis' (2001) 30 International Journal of Epidemiology 899.
[77] Richard Wilkinson and Michael Marmot (eds), *The Solid Facts: Social Determinants of Health* (2nd ed, WHO Regional Office for Europe 2003).
[78] World Health Organisation, 'WHO | About Social Determinants of Health' (*WHO*, 2018) <http://www.who.int/social_determinants/sdh_definition/en/> accessed 12 May 2018.

Early and influential policy examples of the use of social determinants of health can be found from the 1970s onwards. The Canadian Lalonde report, *A New Perspective on the Health of Canadians* published in 1974, was the first example of a policy document written by a Minister for National Health and Welfare which highlighted the important role of social factors and environment in determining health outcomes.[79] The UK 1980 *Report of the Working Group on Inequalities in Health*, the so-called *Black Report*, and the subsequent UK 1998 Acheson *Independent Inquiry into Inequalities of Health Report* explicitly linked poor socio-economic conditions to increased morbidity and mortality.[80]

There is an important nuance of definition here that must not be lost as the term 'social determinants of health' in practice refers to the harms or risks or causes of poor health,[81] not to the conditions for good health.

The WHO CSDH background document *Conceptual Framework for Action on the Social Determinants of Health Discussion Paper 2 (Policy and Practice)* presents a conceptual framework (Figure 2) which identifies layers of structural and intermediary determinants, and highlights the impacts on health of the social, political and economic contexts in which people live.[82] It brings together an understanding of health as being shaped by structural determinants such as socio-economic position, gender, and race, through more intermediary determinants such as the local environment, schools, workplaces, and access to food and water.

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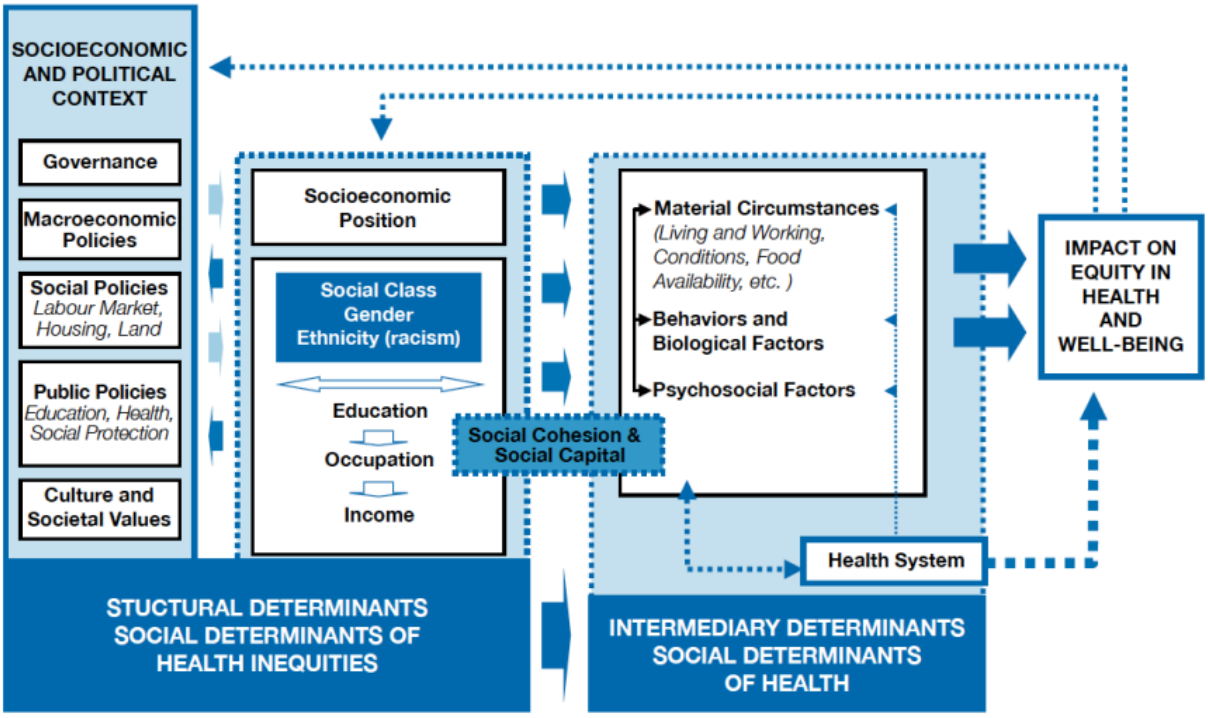
[79] Kelsey Lucyk and Lindsay McLaren, 'Taking Stock of the Social Determinants of Health: A Scoping Review' (2017) 12 PloS One e0177306, 2; See Marc Lalonde, 'A New Perspective on the Health of Canadians. A Working Document' (Minister of Supply and Services, Canada 1974) <http://www.phac-aspc.gc.ca/ph-sp/pdf/perspect-eng.pdf> accessed 22 February 2018.

[80] Douglas Black and others (eds), *Inequalities in Health: The Black Report* (Penguin 1988); Donald Acheson, *Independent Inquiry into Inequalities in Health: Report* (HMSO 1998).

[81] Venkatapuram, 'Social Gradient in Capabilities' (n 12) 554.

[82] Orielle Solar and Alec Irwin, 'Conceptual Framework for Action on the Social Determinants of Health. Social Determinants of Health Discussion Paper 2 (Policy and Practice)'.

Figure 2 **Solar and Irwin's social determinants of health conceptual framework**



Source: Solar and Irwin (2010)[83]

Intermediary determinants of health depicted in the first layer of the diagram are, in Marmot's words, the 'causes' of ill health. The intermediary determinants include biological, psycho-social and behavioural factors, social environmental and psycho-social circumstances, material circumstances, and the health system. Intermediary determinants mediate between the individuals' biological and genetic makeup and the next layer of structural causes of ill health. These social determinants directly influence the biological and genetic processes within the individual. Material circumstances refer to the physical environment within home, neighbourhood and work and the financial means to buy food, clothing and other resources, here '[d]ifferences in material standards are probably the most important intermediary factor.'[84] Social, environmental and psycho-social circumstances refer to determinants such as negative life events,

[83] ibid 6.
[84] ibid 37.

stress, social support, experience of violence, and coping mechanisms and psychological locus of control. Behavioural and biological determinants include factors like smoking, substance misuse, diet and physical exercise, age, and sex distribution of disease. In the Orielle Solar and Alec Irwin conceptual framework health care is included as an intermediary determinant of health.

Structural determinants impacting upon health depicted in the second layer of the framework are the 'causes of the causes' of ill health.[85] In public health they have often been referred to as distal determinants. They include in this layer the structural determinants of social position, gender, ethnicity, education, occupation, and income. Structural determinants more specifically refer to the 'interplay between the socio-economic and political contexts, structural mechanisms generating social stratification, and the resulting socio-economic position of individuals.[86] That is, the ways in which gender, occupation, education, and income shape social hierarchies which in turn shape a group's exposure and vulnerabilities to intermediary determinants and their health opportunities. Each of these variables has their own complexities. For example, income may or may not include an individual's wages from work, pensions, transfers, alimony payments, household income, additional benefits, and household assets. Similar careful consideration of the definition and measurement of other variables is required to identify inequalities in health. Patterns of gender- and ethnic-based discrimination and exclusion can affect every aspect of people's health and contribute to inequalities in health status.

[85] Commission on Social Determinants of Health (n 10) 42.
[86] Solar and Irwin (n 85) 28.

The social gradient is a significant social determinant of health.[87] The WHO booklet *The Solid Facts,* first written in 1998 and updated in 2003, specifically included the social gradient in its list of ten social determinants of health (namely stress, early life, social exclusion, work, unemployment, social support, addiction, food, and transport).[88] The social gradient is identified as the most significant.[89] The WHO CSDH 2008 report *Closing the Gap in a Generation: Health Equity through Action on the Social Determinants of Health* repeatedly refers to the social gradient as central to a holistic view of social determinants of health, a persistent feature of health inequalities, and an important policy concern. [90] Even when access to health care is improved, basic needs for food, sanitation and housing are met and programmes of prevention such as immunisation are implemented, thus changing disease pathways, the social gradient persists.[91] There is something more influencing people's vulnerabilities to risk and inequalities in health outcomes that is being expressed by the social gradient.

As a social determinant of health, the social gradient points us beyond what Marmot terms the 'causes of the causes': it points us to the unequal distribution of the determinants of (ill) health.[92] This unequal distribution is neither random nor associated only with certain groups but is distributed in a stepwise hierarchical fashion across society as demonstrated in the social gradient. This correlates directly with a stepwise

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[87] Yet it must be acknowledged that this is not universally so. For example in Canadian public policy it is not listed as one of fourteen identified social determinants. Toba Bryant and others, 'Canada: A Land of Missed Opportunity for Addressing the Social Determinants of Health' (2011) 101 Health Policy 44.
[88] Richard Wilkinson and Michael Marmot (eds), *Social Determinants of Health. The Solid Facts* (World Health Organisation 1998); Wilkinson and Marmot (n 80).
[89] David Blane, 'The Life Course, the Social Gradient, and Health' in Richard G Wilkinson and Michael Marmot (eds), *Social determinants of health* (2nd ed, Oxford University Press 2006).
[90] Commission on Social Determinants of Health (n 10) 31.
[91] Bruce G Link and Jo C Phelan, 'Social Conditions As Fundamental Causes of Disease' (1995) 35 Journal of Health and Social Behavior 80, 80.
[92] S Venkatapuram, 'A Bird's Eye View. Two Topics at the Intersection of Social Determinants of Health and Social Justice Philosophy' (2009) 2 Public Health Ethics 224; Kimberley Brownlee, 'Do We Have a Human Right to the Political Determinants of Health' in Rowan Cruft, S Matthew Liao and Massimo Renzo (eds), *Philosophical Foundations of Human Rights* (Oxford University Press 2015); Venkatapuram, 'Social Gradient in Capabilities' (n 12).

distribution of ill health. In *Closing the Gap,* Marmot and colleagues attribute the presence of the social gradient in health to the 'toxic combination of poor social policies, unfair economics, and bad politics'.[93] *Closing the Gap* calls for action on the 'inequitable distribution of power, money and resources' because these are the structural drivers of the unequal distribution of the determinants of health.[94]

2. The societal distribution of health inequalities

The conceptual model for the social determinants of health places great emphasis upon the unequal distribution of the social determinants of health which perpetuate health inequalities and undermine social justice. It emphasises the fundamental distinction between the social determinants of health (intermediary) and the drivers determining the distribution of these social determinants across more and less advantaged groups (structural).[95] Solar and Irwin warn that 'conflating the social determinants of health with the social processes that shape those determinants' unequal distribution can seriously mislead policy' and fails to attend to widening inequalities in health.[96] This layer of structural determinants is an important departure from other models of social determinants of health.[97] Power relationships have an important place within this conceptual framework. The subsequent *Closing the Gap* recognised that the unequal distribution of the social determinants of health was influenced by power, wealth and access to resources.[98] The conceptual framework offers a descriptive understanding of health inequalities but also a normative understanding as evidenced in the arresting statement on the back page of *Closing the Gap*.[99]

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[93] Commission on Social Determinants of Health (n 10) 1.
[94] ibid 4.
[95] Solar and Irwin (n 85).
[96] ibid 5.
[97] ibid 36.
[98] Commission on Social Determinants of Health (n 10); Solar and Irwin (n 85).
[99] Commission on Social Determinants of Health (n 10) Backpage.

It fails, however, to sufficiently attend to the hegemony of the wealthy and powerful in perpetuating the structures in society that maintain their own position on the gradient and create inequality.[100] More overtly socio-political theories of disease, with their emphasis upon power relationships and social processes, provide a means to counter the dominance of the bio-psycho-behavioural approaches. Social gradient theories offer an opportunity to 'repoliticise' public health but have been overtaken with more individualistic concerns.[101]

The social determinants of health are themselves unequally distributed and require a more nuanced political analysis. The social gradient is significant in making clear the distinction between action to ameliorate the social determinants of ill health and action on the unfair distribution of those social determinants. Research into the concept has contributed to a growing recognition of the social gradient in health demonstrating that something more structural is happening to influence the unequal distribution of social determinants.[102] The social gradient demonstrates that issues of 'poor social policies and programmes, unfair economic arrangements, and bad politics' play a central role in creating health inequalities and social injustice.[103] Nancy Krieger makes an important distinction that is not always obvious in the definitions and practice of epidemiology - the study of the distribution of disease and its causes is very different than the study of the distribution of health inequalities.[104] Anne-Emmanuelle Birn calls these 'the causes of the "causes of the causes"'.[105] However, despite its appeal to social production of disease theories, Birn argues that *Closing the Gap* lacked any historical and political

[100] Krieger, *Epidemiology* (n 38) 184.
[101] ibid 185.
[102] Marmot, 'Fair Society' (n 73).
[103] Commission on Social Determinants of Health (n 10) 1.
[104] Krieger, *Epidemiology* (n 38) 185.
[105] Birn (n 78) 172.

analysis and failed to consider the issues that create and maintain the inequities in power.[106] Birn calls for a more nuanced political analysis.

Social production of disease and political economy of health theories of ill health distribution offer an alternative political analysis (and are also an explanatory mechanism for the social gradient) that offer potential for ameliorating intractable health inequalities as described above. These theories are concerned with how economic and political systems, institutions and decisions create and perpetuate economic and social privilege.[107] Solar and Irwin's discussion paper for *Closing the Gap*[108] integrated Finn Diderichsen, Timothy Evans and Margaret Whitehead's 2001 model of the social production of disease, with the concept of social position at the core of its explanation for health inequalities.[109] Social position was consequent upon 'unequal distribution of power, income, goods, and services, globally and nationally'.[110] Thus *Closing the Gap* called for action upon the 'deeper social structures and processes'.[111] It recommended equity in all policies, systems, and programmes placing the responsibility for this upon governments; a 'social determinants of health' approach to all health policy and planning; fair financing across all sectors through a social determinants of health framework; government responsibility for market frameworks; and good global and national governance to ameliorate and prevent ill health. The empowerment of communities and groups for full participation in policy making and enabling civil society to 'promote political and social rights affecting health equity' became a corner stone for

[106] ibid.
[107] Krieger, *Epidemiology* (n 38) 167.
[108] Commission on Social Determinants of Health (n 10); Solar and Irwin (n 85).
[109] Finn Diderichsen, Timothy Evans and Margaret Whitehead, 'The Social Basis of Disparities in Health' in Timothy Evans and others (eds), *Challenging Inequities in Health: From Ethics to Action* (Oxford University Press 2001).
[110] Commission on Social Determinants of Health (n 10) 1.
[111] ibid 10.

action.'[112] A social gradient approach facilitates a closer examination of how social determinants of health are unequally distributed across the population, and thus permits different policy actions to ameliorate health inequalities. Such policy actions should acknowledge important implications of the social gradient.

C. Implications of the Social Gradient

Three types of inequalities were identified by the United Nations (UN) High Commissioner for Human Rights, Zeid Ra'ad Al Hussein, in a statement that he delivered at the launch of *The 2030 Agenda for Sustainable Development* in 2015: global, horizontal and vertical.[113] Global inequalities are those identified between countries; horizontal inequalities are those identified between different groups within society; and vertical inequalities are those inequalities between individuals that are identified by income and wealth differentials that highlight the gap between rich and poor, and higher or lower status individuals in society.[114] These inequalities cut across all human rights, including health. This thesis contends that there is a fourth type of health inequality, the social gradient, that is often absent or misconstrued in the broad discussions of health inequalities and in understanding right to health inequalities.

There appear to be at least four reasons for Venkatapuram's comment regarding the serious implications of the social gradient that opened this chapter.[115] Firstly, seeing inequalities as either horizontal or vertical, that is as a consequence of discrimination or

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[112] ibid 18.
[113] Office of the High Commissioner for Human Rights, 'OHCHR | "An Agenda for Equality", Zeid Ra'ad Al Hussein, United Nations High Commissioner for Human Rights, Statement at the Summit for the Adoption of the Post-2015 Development Agenda; 25 September, UN Headquarters, New York' (2015) <https://www.ohchr.org/EN/NewsEvents/Pages/DisplayNews.aspx?NewsID=16514> accessed 10 April 2019.
[114] Frances Stewart, 'Horizontal Inequalities: A Neglected Dimension of Development', *2001 Annual Development Lecture.* (2002) <http://link.springer.com/10.1057/9780230501850_5> accessed 10 April 2019.
[115] Venkatapuram, 'Social Gradient in Capabilities' (n 12) 555.

socio-economic status, fails to address the complexities of the relationship between them. Secondly, those in the middle of the social gradient also experience health inequalities. Moreover, the way wealth is implicated in creating the steepness of the social gradient is central to understanding why this might be. Thirdly, social gradient inequalities are not analogous with socio-economic inequalities but express multidirectional causal pathways between a broad range of different factors. Lastly, a shift in how the public health explanatory mechanisms are adopted is required to understand the social gradient, and therefore to be able to act on it to reduce health inequalities. Acknowledging the importance of the social gradient requires a reframing of the understanding of inequalities and reconsideration of policy action to address them.

1. The interrelationship between horizontal and vertical health inequalities

Horizontal inequalities are those defined by for example, gender, caste, ethnicity, race, religion, disability or sexual identity and also impact health.[116] For example, men own 50% more of the world's wealth than women, and the 22 richest men have more wealth than all the women in Africa.[117] Health-Related Quality of Life at 55 years and over was worse for men and women in 15 (88·2%) of 17 minority ethnic groups in the UK compared to the White British group.[118] Discrimination of minority ethnic groups is one of the most important explanations for health inequalities in minority groups.[119] In

[116] Stewart (n 117).
[117] Oxfam, '5 Shocking Facts about Extreme Global Inequality and How to Even It Up' (*Oxfam International*, 20 January 2020) <https://www.oxfam.org/en/5-shocking-facts-about-extreme-global-inequality-and-how-even-it> accessed 8 February 2020.
[118] Ruth Elizabeth Watkinson, Matt Sutton and Alex James Turner, 'Ethnic Inequalities in Health-Related Quality of Life among Older Adults in England: Secondary Analysis of a National Cross-Sectional Survey' (2021) 6 The Lancet Public Health e145, e145.
[119] Raj S Bhopal, 'Research Agenda for Tackling Inequalities Related to Migration and Ethnicity in Europe' (2012) 34 Journal of Public Health 167; Mirna Safi, 'Immigrants' Life Satisfaction in Europe: Between Assimilation and Discrimination' (2010) 26 European Sociological Review 159.

Europe, poorer self-assessed health, a higher morbidity and shorter life expectancy is observed in minority ethnic groups compared to majority groups.[120]

Vertical health inequalities are inequalities in income and wealth across society which impact health outcomes. According to the *Global Wealth Report 2019* the poorest 50% of adults own less than 1% of global wealth, whilst the richest 10% owns 82% of global wealth, and between 1988 and 2011 their wealth increased 182 times more than the incomes of the poorest 10%.[121] If gross national income was evenly distributed across the globe, then each and every person could be lifted out of poverty.[122] This pattern of income inequality is repeated within countries. For example, in the UK in 2018 the top quintile of the population had an income more than 12 times greater than the lowest quintile.[123] But differences are starker when wealth rather than income is considered. Wealth inequality goes beyond income to include financial assets such as savings, stocks and shares, property, pension rights, and other resources.[124] Vertical inequalities impact upon health status. For example, in the US between 1999 and 2014, the

[120] Signe Smith Nielsen and Allan Krasnik, 'Poorer Self-Perceived Health among Migrants and Ethnic Minorities versus the Majority Population in Europe: A Systematic Review' (2010) 55 International Journal of Public Health 357; Sarah Missinne and Piet Bracke, 'Depressive Symptoms among Immigrants and Ethnic Minorities: A Population Based Study in 23 European Countries' (2012) 47 Social Psychiatry and Psychiatric Epidemiology 97; Thomas de Vroome and Marc Hooghe, 'Explaining the Ethnic Minority Disadvantage in Subjective Well-Being: A Multilevel Analysis of European Countries' in Filomena Maggino (ed), *A New Research Agenda for Improvements in Quality of Life* (Springer International Publishing 2015) <https://doi.org/10.1007/978-3-319-15904-1_5> accessed 30 April 2020; World Health Organisation, 'Driving Forward Health Equity – the Role of Accountability, Policy Coherence, Social Participation and Empowerment' (WHO Regional Office for Europe 2019); World Health Organisation, 'Environmental Health Inequalities in Europe. Second Assessment Report.' (World Health Organisation Regional Office for Europe 2019); Michael Marmot and others, 'Health Equity in England: The Marmot Review 10 Years On' (Institute of Health Equity 2020) <http://www.bmj.com/lookup/doi/10.1136/bmj.m693> accessed 25 February 2020.

[121] Credit Suisse, 'Global Wealth Report 2019' (Credit Suisse Research Institute 2019) 2 <https://www.credit-suisse.com/about-us/en/reports-research/global-wealth-report.html> accessed 12 May 2020.

[122] Gillian MacNaughton, 'Vertical Inequalities: Are the SDGs and Human Rights up to the Challenges?' (2017) 21 The International Journal of Human Rights 1050, 1052.

[123] Equality Trust, 'The Scale of Economic Inequality in the UK | The Equality Trust' (2019) <https://www.equalitytrust.org.uk/scale-economic-inequality-uk> accessed 12 May 2020.

[124] Philip Alston, 'Report of the Special Rapporteur on Extreme Poverty and Human Rights, Philip Alston' (Human Rights Council Twenty-ninth session 2015) UN Doc A/HRC/29/31 para 6.

difference in life expectancy between men in the top 1% of income compared with the bottom 1% was 14.6 years, and for women was 10.1 years.[125] The UK Office for National Statistics (ONS) showed that in England in 2017, 16% of male preventable deaths occurred in deprived areas compared to 6% in the least deprived areas.[126]

As important as horizontal inequalities are, tackling health inequalities between groups is not enough to ameliorate vertical inequalities: inequalities within groups may be more significant and are complex.[127] Vertical inequalities of socio-economic status exist within groups. Intra-group inequality suggests that factors other than discrimination are also implicated in the unequal distribution of poor health.[128] Policy actions to tackle discrimination may not reduce poverty and conversely, targeting pro-poor policies to one group around say gender or ethnicity, fails to recognise that not everyone in that group is poor. Moreover, targeting interventions at specific population groups requires defining those population groups based on some specific feature which then risks stigmatising that population group.[129] The type of intervention selected is then based upon specific characteristics of that population, often with the result that living conditions and behaviours are the selected focus of action.[130]

Conversely, focusing action only upon poverty has its limitations.[131] For example, a study of obesity gradients in the US and South Korea asked the question as to whether

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[125] Raj Chetty and others, 'The Association Between Income and Life Expectancy in the United States, 2001-2014' (2016) 315 JAMA 1750, 1750.
[126] Office for National Statistics, 'Socioeconomic Inequalities in Avoidable Mortality, England and Wales: 2001 to 2017' (1 May 2019) <https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/causesofdeath/articles/measuringsocioeconomicinequalitiesinavoidablemortalityinenglandandwales/2001to2017> accessed 17 April 2020.
[127] Laure-Hélène Piron, 'Rights-Based Approaches to Tackling Discrimination and Horizontal Inequality Background Paper' (Poverty and Public Policy Group Overseas Development Institute 2003) 9.
[128] ibid.
[129] Signild Vallgårda, 'Tackling Social Inequalities in Health in the Nordic Countries: Targeting a Residuum or the Whole Population?' (2010) 64 Journal of Epidemiology and Community Health (1979-) 495.
[130] ibid.
[131] Graham, 'Tackling Inequalities in Health in England' (n 29) 118–120.

it was deprivation or discrimination that contributed to obesity gradients and found that anti-fat discrimination was a key cause of reverse gradients in married women in both countries (but not for married men).[132] The authors conclude that this poses serious challenges to the currently predominant deprivation accounts of obesity that posit that greater income provides greater access to appropriate diet and exercise to maintain a healthy weight. A study of puerperal psychosis in the US found that historical and current structural racism shaped the income and wealth gradients in psychosis risk for Black and Latino women.[133] An observed inverse social gradient correlating income and wealth with self-reported mental health status in working migrants in Italy was then controlled for socio-economic status revealing discrimination and unfair treatment as key factors shaping the gradient.[134]

Moreover, evidence suggests that targeting interventions at the poor also benefits those who are richer, further up the gradient, with the consequence that the gradient simply shifts upwards across the whole of society leaving the steepness of the gradient, and thus inequalities, unchanged.[135] Furthermore, targeting action on poverty can increase stigmatisation of those living in poverty, and increase the social distance between the poor and the non-recipients of those targeted actions.[136] Targeting poverty risks turning socio-economic inequalities from a whole society structural issue (and an issue of extreme wealth) to a problem pertaining to only the poor.[137] In this way there is a risk

[132] Han and Hruschka (n 9).
[133] Anglin and others (n 11).
[134] Di Napoli and others (n 9).
[135] Graham, 'Tackling Inequalities in Health in England' (n 29) 118–120.
[136] Florence Francis-Oliviero and others, 'Theoretical and Practical Challenges of Proportionate Universalism: A Review' (2020) 44 Revista Panamericana de Salud Pública 5 <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7556407/> accessed 10 April 2021.
[137] Graham, 'Health Inequalities, Social Determinants and Public Health Policy' (n 29) 473; Graham, 'Tackling Inequalities in Health in England' (n 29) 119.

that poverty and inequality are conflated and improving the health of other groups does not become a priority. [138]

Targeted actions to ameliorate the health problems of the poor, as worthy and necessary as they are, are not enough to also attend to the health inequalities experienced through other axes of disadvantage or discrimination. The concept of intersectionality moves the debate beyond the unidirectional view presented by horizontal and vertical inequalities.[139] Arising from critical race theory and the work of civil rights advocate Kimberlé Crenshaw, intersectionality describes the structural causes of discrimination experienced by women of colour by virtue of simultaneously held identities.[140] It captures the interplay of different forms of inequality that define inclusion and exclusion and also considers the underpinning structural reasons for it. It provides a means to articulate more of a political analysis of power relations and their influence upon inequalities in health.[141]

Horizontal and vertical inequalities do not exist in isolation. There is a dynamic between groups and across the gradient because the social determinants of ill health are linked, not in linear causal chains, but in complex dynamic systems at multiple levels creating

[138] Graham, 'Tackling Inequalities in Health in England' (n 29) 119–120.
[139] Nancy Lopez and Vivian L Gadsden, 'Health Inequities, Social Determinants, and Intersectionality' [2016] NAM Perspectives <https://nam.edu/health-inequities-social-determinants-and-intersectionality/> accessed 31 August 2020; Aránzazu Hernández-Yumar and others, 'Socioeconomic Differences in Body Mass Index in Spain: An Intersectional Multilevel Analysis of Individual Heterogeneity and Discriminatory Accuracy' (2018) 13 PLOS ONE e0208624; See for example Calum Webb and others, 'Cuts Both Ways: Ethnicity, Poverty, and the Social Gradient in Child Welfare Interventions' (2020) 117 Children and Youth Services Review 105299.
[140] Kimberle Crenshaw, 'Demarginalizing the Intersection of Race and Sex: A Black Feminist Critique of Antidiscrimination Doctrine, Feminist Theory and Antiracist Politics' (1989) 1989 University of Chicago Legal Forum 139; Kimberle Crenshaw, 'Mapping the Margins: Intersectionality, Identity Politics, and Violence against Women of Color' (1990) 43 Stanford Law Review 1241.
[141] Sarah Hill, 'Axes of Health Inequalities and Intersectionality' in Katherine E Smith, Sarah Hill and C Bambra (eds), *Health Inequalities Critical Perspectives* (Oxford University Press 2016); Anuj Kapilashrami, Sarah Hill and Nasar Meer, 'What Can Health Inequalities Researchers Learn from an Intersectionality Perspective? Understanding Social Dynamics with an Inter-Categorical Approach?' (2015) 13 Social Theory & Health 288.

the social gradient.[142] Action on the social gradient benefits both the discriminated groups and the poorest and most disadvantaged.

2. Identifying inequalities for middle-income groups

Those living in poverty are represented at the lower end of the gradient, but there is no clear demarcation between the poor and the rest of society who also experience health inequalities, and poverty thresholds do not account for the patterning of ill health depicted by the social gradient. Moreover, the lower and middle classes of rich countries have lagged behind the poorest in poorer nations and the wealthiest globally in terms of growth. With the rise of the middle class in poorer countries inequality has decreased between the bottom and the middle of the global income distribution creating a squeezed middle of low- and middle-income groups in richer nations.[143] Whilst there is much debate about the definition of poverty, most official definitions use an income threshold to identify those who fall below this threshold as being poor. For some countries, this threshold is an absolute income with those earning less than a specified amount being classed as poor (e.g. US).[144] Others set a relative poverty level below which you might be classed as poor, such as the UK's 60% of median income.[145]

A threshold perspective would command greater allocation of resources to those below the threshold to raise them above the minimum threshold. The social gradient in education is a clear example. Yet, Mariana Arcaya and others observe that if education had a threshold of completion of secondary school or ten years of schooling then we

[142] Graham, 'Health Inequalities, Social Determinants and Public Health Policy' (n 29).
[143] Chancel and others (n 4) 61.
[144] See for example The United States Census Bureau, 'Poverty Thresholds' (*The United States Census Bureau*, 2019) <https://www.census.gov/data/tables/time-series/demo/income-poverty/historical-poverty-thresholds.html> accessed 23 August 2020.
[145] See for example Economic and Social Research Council, 'Definitions of Poverty | Poverty and Social Exclusion' (*PSE Poverty and Social Exclusion*, 2020) <https://www.poverty.ac.uk/definitions-poverty> accessed 6 August 2020.

would observe those below that threshold as having poor health and all those above, whether with further education or post-graduate higher education, as having equally good health. [146] Robert Erikson's research, that more years of study and the higher the qualifications gained the better the health, suggests that the social gradient depicts a 'dose-response' relationship between numbers of years at school or qualifications gained and health.[147] A marginal increase in education results in a marginal improvement in health. We must therefore attend to the whole social gradient and those in the middle of the gradient to understand and act upon both poverty and inequalities.

A range of socio-economic structures impact those in the middle of the social gradient. In 2019 the Organisation for Economic Cooperation and Development (OECD), an intergovernmental organisation with 37 member countries, identified processes creating a squeeze upon middle-income households.[148] They defined the 'squeezed middle' as being those households with incomes ranging between 75%–200% of median income.[149] Whilst the picture is complex across all 37 OECD countries, socio-economic trends include the rising costs of living, poor or stagnating income growth, rising house prices and rental costs, decreased job quality and security, reduced social mobility, and a greater potential for falling into debt and poverty. Social trends include falling standards of living, reduced opportunities for occupational and educational advancement, greater vulnerability, increasing anxiety, and a growing sense of how this

[146] Arcaya, Arcaya and Subramanian (n 11) 4.
[147] Arcaya, Arcaya and Subramanian (n 11); Richard Wilkinson and Kate Pickett, *The Inner Level* (Penguin Random House 2019).
[148] Organisation for Economic Co-operation and Development, *Under Pressure: The Squeezed Middle Class* (OECD Publishing 2019) <https://doi.org/10.1787/689afed1-en.> accessed 21 July 2020.
[149] ibid 19.

situation is unfair. The impacts of this sense of injustice are explained by the psycho-social theory for the social gradient.[150]

The 'squeezed middle' therefore suffer worse health than those further up the gradient. Physical health consequences include obesity, heart disease, hypertension, and teenage pregnancy, to name but a few.[151] Mental health consequences include anxiety, depression, suicide, and misuse of tobacco, alcohol, and drugs, along with other social issues such as reduced empathy, breakdown of relationships, and loss of self-esteem.[152] Their place in the social gradient is created by the toxic combination of 'poor social policies and programmes, unfair economic arrangements, and bad politics',[153] the impact of which on the middle should prompt action for the realisation of the right to health for this population.

Action to ameliorate the health consequences for those in the middle of the gradient would also benefit the poorest and most disadvantaged in society. Addressing the middle of the social gradient brings important benefits and failing to do so brings consequences. The 2019 OECD report noted a range of benefits. A strong middle class is essential for economic growth, for their investment in education, health and housing, for their support and funding of democratic institutions, social protection systems and small and medium enterprises, and for higher levels of social trust and social cohesion, lower crime rates, and increased general social wellbeing.[154] Conversely, a 'squeezed middle' class risks growing discontent and disillusionment resulting in the emergence of

[150] Michael Marmot, *The Status Syndrome: How Social Standing Affects Our Health and Longevity* (Times Books/Henry Holt 2004); Kate Pickett and Richard Wilkinson, *The Spirit Level: Why Equality Is Better for Everyone* (New Edition, Penguin 2010); Wilkinson and Pickett (n 150).
[151] Marmot, *The Status Syndrome* (n 153); Pickett and Wilkinson (n 153).
[152] Kate Pickett and Richard Wilkinson, 'Inequality: An Underacknowledged Source of Mental Illness and Distress' in Lee Knifton and Neil Quinn (eds), *Public Mental Health Global Perspectives.* (McGraw-Hill Education 2013); Wilkinson and Pickett (n 150).
[153] Commission on Social Determinants of Health (n 10) 35.
[154] Organisation for Economic Co-operation and Development (n 151) 17–18.

populism and nationalism, reduced political engagement, political instability, distrust of global and public institutions, and a rising sense of vulnerability and anxiety.[155] For example, Venkatapuram observes that the UK Blairite government focused upon wealth creation at the top of the gradient expecting that this would generate taxes and employment to benefit those at the bottom.[156] But instead, he contends, this led both to a severe recession which prompted austerity that impacted the poor and marginalised provoking a populist uprising and (amongst other things) Brexit, the consequences of which are now playing out with, some would argue, higher food and fuel prices and reduced economic growth.[157]

The social gradient also demands an examination of the relationship between the bottom and the top of the gradient. When expressed in socio-economic terms this requires understanding the relationship between the poorest and the wealthiest. Social gradients can be more or less steep depending on the difference in the size of the gap between the top and the bottom of the gradient. The narrower the difference between the smallest and the largest measures, the flatter the gradient. Steeper gradients reflect greater inequality, and the greater the inequality the worse the consequences for health outcomes.[158] Yet, interventions directed at disadvantaged groups can act as levers to improve social position along the gradient.[159] And, as Signild Vallgårda suggests, 'there

[155] Marmot, *The Status Syndrome* (n 153); Pickett and Wilkinson (n 153); Organisation for Economic Co-operation and Development (n 151).
[156] Venkatapuram, 'Social Gradient in Capabilities' (n 12) 555.
[157] Aida Garcia-Lazaro, Jakub Mistak and F Gulcin Ozkan, 'Supply Chain Networks, Trade and the Brexit Deal: A General Equilibrium Analysis' (2021) 133 Journal of Economic Dynamics and Control 104254; Alejandro Martín García and Graciela Rico Perez, 'The Aftermath of Brexit: Implications for the United Kingdom and European Union' (Universidad Europea 2021); Garcia-Lazaro, Mistak and Gulcin Ozkan; Yu Tian and others, 'The Analysis of Impact of Brexit on the Post-Brexit EU Using Intervented Multivariate Time Series' (2021) 37 Acta Mathematicae Applicatae Sinica, English Series 441; Jane Green, Timothy Hellwig and Edward Fieldhouse, 'Who Gets What: The Economy, Relative Gains and Brexit' (2022) 52 British Journal of Political Science 320.
[158] Wilkinson and Pickett (n 150).
[159] Graham, 'Social Determinants and Their Unequal Distribution: Clarifying Policy Understandings' (n 996) 115.

is the difference that the gap between the most privileged and the least will reveal greater differences than the difference between the excluded and the rest'.[160]

We need to understand the structures that create the steepness of the gradient. High income and wealth inequality means that wealth is concentrated amongst a small elite at the expense of the poorest, not just in the poorest countries but also in high-income countries.[161] In societies with more extreme inequalities between rich and poor, thus steeper social gradients, those with greater wealth are understood to have better access to greater political power, greater influence upon institutions including policy makers, and greater privileges to be able to ensure their position is maintained. Power enables the wealthy to gain disproportionately from economic growth, reproducing inequalities and creating a steeper social gradient.[162] Not only do the rich have so much more wealth than most of the population but they also gain disproportionately from economic growth, leaving the poor behind.[163]

Whilst considering vertical inequalities does help to focus our attention upon the relationship between wealthy and poor and the role of wealth in creating and perpetuating extreme poverty, it omits to attend to the middle of the social gradient and the complexity of the social structures and processes creating the social gradient. The goal of reducing the steepness of health gradients makes clear that health is unequally distributed not only between the poorest groups and the better-off majority but also across all socio-economic groups.[164]

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[160] Vallgårda (n 970) 75.
[161] MacNaughton (n 125) 1052.
[162] ibid 1055.
[163] Deborah Hardoon, 'An Economy for the 99%: It's Time to Build a Human Economy That Benefits Everyone, Not Just the Privileged Few' (Oxfam International 2017) Oxfam Briefing Paper <https://oi-files-d8-prod.s3.eu-west-2.amazonaws.com/s3fs-public/file_attachments/bp-economy-for-99-percent-160117-en.pdf>.
[164] Graham, 'Health Inequalities, Social Determinants and Public Health Policy' (n 29).

3. Expressing multidimensional causal factors for ill health

The social gradient incorporates a multidimensional relationship between a broad range of factors other than discrimination and socio-economic causes of poor health. However, the social gradient is often equated to vertical inequalities of socio-economic status. Whilst the social factors most used to depict a gradient are income, wealth and socio-economic status, social gradients can be demonstrated for a wide range of health and social factors independent of socio-economic status.[165] For example, a study in Brazilian slum dwellings demonstrated a social gradient in Leptospira infection, a disease transmitted by rats, even after controlling for socio-economic ability to secure better housing.[166] Erikson's seminal Swedish study found that mortality rates could be predicated upon educational status independent of income, thus those with a PhD had a longer life expectancy than those with Masters' degrees who had a longer life expectancy than those with Bachelors' degrees.[167] Higher levels of psychiatric disorders have been demonstrated as related to increasing financial debt whatever the level of income.[168]

The relationships between factors and health outcomes are complex and not unidirectional. Marion Devaux and Franco Sassi demonstrated gradients for obesity and overweight correlated with gender, age, education, income, occupation and other factors across eleven OECD countries. [169] They revealed a complex relationship between obesity and gender, occupation and education, and different gradients when comparing countries. They found that education-related inequality measures were higher than socio-economic inequality measures, possibly through the influence of

[165] Arcaya, Arcaya and Subramanian (n 11).
[166] Reis and others (n 11).
[167] Erikson (n 11).
[168] Jenkins and others (n 11).
[169] Devaux and Sassi (n 11).

knowledge and social environment. In a recent study Brent Bezo and colleagues demonstrated that worsening physical and mental ill health have been related to reduced rights and freedoms in a gradient.[170] In order to explain the gradient they developed a complex model of physical and mental health outcomes consequent upon multidirectional relationships between socio-economic status, social capital and human rights. This suggests a complex nuanced investigation of the social gradient more than hitherto is required.

The social gradient is not simply about socio-economic status. It expresses a complex interrelationship of multidirectional pathways between socio-economic status (vertical inequalities), discrimination (horizontal inequalities) and a wide range of other factors. In this way the social gradient adds a fourth dimension to the understanding of health inequalities identified earlier by the UN High Commissioner for Human Rights.

4. Explanatory mechanisms for the social gradient

It is clear to see how poverty and health are related at the lower end of the social gradient, but much harder to understand why a lower position in the hierarchy is related to poorer health outcomes even in those who are not poor. Moreover, it is hard to account for the presence of the social gradient within groups as well as across groups.[171] The social gradient represents an intersection of both horizontal and vertical inequalities: it represents multiple interacting influences upon people's health.

Public health explanatory mechanisms commonly employed, such as biomedical, materialist, behavioural, and fundamental cause theories, fail to sufficiently incorporate these issues (Appendix 1). The **biomedical model** sees the body as the sum of its

[170] Bezo, Maggi and Roberts (n 11).
[171] Bradley R Crammond and Gemma Carey, 'What Do We Mean by "Structure" When We Talk about Structural Influences on the Social Determinants of Health Inequalities?' (2017) 15 Social Theory & Health 84.

parts with innate characteristics vulnerable to malfunctioning.[172] This encourages a population level view of health as an aggregate of individual health functionings with demarcations within populations due to particular innate individual characteristics (gender, age and ethnicity).[173] Health is measured as relative to other groups in society and the choice of comparison groups may determine how inequality is understood. [174] The **materialist approach** argues that income levels influence access to goods and services, which in turn determines health, so attention is directed towards ameliorating poverty and a focus upon vertical health inequalities in terms of the vulnerabilities of the poor.[175] Whilst the **lifestyle model** represented an important shift in paradigms supplanting the biomedical model in the 1974 Canadian Lalonde report,[176] it has a similarly reductionist approach, and as Krieger argues, has negatively influenced epidemiology.[177] It has been translated into an epidemiologic definition of lifestyle as: '[t]he set of habits and customs that is influenced by the lifelong process of socialization'.[178] The predominant public health interventions are therefore through information giving and education to shape beliefs and influence public norms of behaviour especially relating to the use of alcohol and tobacco, dietary habits or exercise.[179]

Such prevailing public health paradigms influence which of the explanatory mechanisms might be favoured. This in turn influences the type of action and policy recommended, even where the complexities and nuances of causation are acknowledged.[180] For

[172] Rayner and Lang (n 39) 83–88.
[173] Krieger, *Epidemiology* (n 38) 138.
[174] Graham, 'Tackling Inequalities in Health in England' (n 996) 120–123.
[175] Solar and Irwin (n 85) 15.
[176] Lalonde (n 82).
[177] Krieger, *Epidemiology* (n 38) 146–148.
[178] Miquel S Porta and others (eds), *A Dictionary of Epidemiology* (Six edition, Oxford University Press 2014) 168.
[179] Rayner and Lang (n 39) 79.
[180] Krieger, *Epidemiology* (n 38) ch 8.

example, the very influential web of causation model, which is wonderfully depicted in the UK Foresight *Tackling Obesities, Future Choices Project Report* which was a careful attempt by public health to recognise the multiplicity of causative factors and their interrelationship and move away from a linear view of causation, portraying determinants such as food production, dietary habits, environmental conditions, individual activity, individual psychology and biology in a tangled web of relationships.[181] Even though this model acknowledges the role of social, environmental, economic and policy determinants, the risk factors for disease remained close to individual biological and behavioural processes and material circumstances with little explanation as to why the connecting strands intersect in the way they do, or the place of social and historical contextual factors, nor why disease prevalence would differ by social group.[182] Public health action is directed towards limiting risk factors and attempts at 'cutting strands' in the web rather than understanding where the web has come from.[183]

Such public health paradigms have been influenced more broadly by **utilitarianism**. Originally formulated in the 19th century by Jeremy Bentham and John Stuart Mill as a progressive theory where everyone's wellbeing counted equally, it has been a powerful influence on public health practice.[184] Not only have many authors argued that utilitarian ethics are deeply ingrained in public health, but also that utilitarianism has an intuitive appeal for public health practice.[185] The notion that public health should act always to produce the greatest good for the greatest number aligns with the population level

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[181] Bryony Butland and others, *Tackling Obesities: Future Choices: Project Report* (Department of Innovation Universities and Skills 2007) <https://www.bis.gov.uk/assets/bispartners/foresight/docs/obesity/obesity_final_part1.pdf> accessed 29 August 2013.
[182] Krieger, *Epidemiology* (n 38) 153.
[183] Nancy Krieger, 'Epidemiology and the Web of Causation: Has Anyone Seen the Spider?' (1994) 39 Social Science & Medicine 887.
[184] Olivier Bellefleur and Michael Keeling, 'Utilitarianism in Public Health' (National Collaborating Centre for Healthy Public Policy 2016).
[185] ibid 1.

purposes of public health policy and practice which seeks to improve the collective health of the population. Despite the many criticisms of utilitarianism and the availability of alternative philosophical perspectives, utilitarianism remains influential. Use of tools such as quality-adjusted life years (QALY) and disability-adjusted life years (DALY), and the notions of effectiveness and efficiency are fundamental to cost/utility evaluations of public health programmes and have their origins in utilitarian thinking.[186] Many actions taken during the Covid-19 pandemic such as imposing a lockdown on the whole population except key workers and imposing mask mandates sought to save the greatest number from mortality and morbidity. Length and quality of life are also important considerations for utilitarian thinking, such that those who would benefit more from treatment are those who have longer to live. In the Covid-19 pandemic this resulted in the imposition of do-not-resuscitate orders and the de-prioritisation of people who were older, or with some degree of pre-existing morbidity.[187] Whilst the principle of utility is not the only principle to be applied in a pandemic, such as was seen with Covid-19, it remains an important means to prioritise public health action.[188]

Alternative explanatory mechanisms are offered for the social gradient in health which reflect the complexities of the interrelationships between social determinants and mitigate against a linear understanding of the causes of ill health. **Fundamental Cause Theory** proposes certain fundamental causes of ill health or social determinants that impact upon how ill health and the causes of and risk factors for ill health are distributed.[189] It has gained much traction in public health as it appeals to a sense of

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[186] ibid 7.
[187] Julian Savulescu, Ingmar Persson and Dominic Wilkinson, 'Utilitarianism and the Pandemic' (2020) 34 Bioethics 620.
[188] World Health Organisation, 'Ethical Considerations in Developing a Public Health Response to Pandemic Influenza' (World Health Organisation 2007) 6 <https://apps.who.int/iris/bitstream/handle/10665/70006/WHO_CDS_EPR_GIP_2007.2_eng.pdf?sequence=1&isAllowed=y> accessed 5 February 2023.
[189] Link and Phelan (n 94).

there being primary underlying causes of morbidity and mortality.[190] Social factors such as economic status and social support can be considered 'fundamental causes' of disease because 'they embody access to important resources, affect multiple disease outcomes through multiple mechanisms, and consequently maintain an association with disease even when intervening mechanisms change.'[191] The **life-course approach** incorporates the dose-response relationship explanation of the social gradient effect and is concerned with how the differential exposures to health risks and specific forms of vulnerability at different stages in a person's life, from foetus to old age, are linked to a person's social orientation, status and health outcomes in later age.[192] These risks not only include biological or behavioural risks but also encompass the impacts of education, socio-economic status and contextual factors. Moreover, an intergenerational view of life-course with the incorporation of genetic explanations is becoming increasingly influential in public health to encompass historical contexts and the intractable persistence of health inequalities across generations.[193]

Psycho-social theory offers partial insights not only into the social gradient effect upon individuals but also upon society and is in part implicated by Venkatapuram's warning of the risks of ignoring the gradient and observations with regards to Brexit. Key proponents of psycho-social theory, including Michael Marmot and Richard Wilkinson, argue that it is the individuals' perceptions of their social conditions and how they respond psychologically, behaviourally and biologically that impacts their health.[194] The

[190] And echoes of this theory can be found in the right to health, with the concept of 'underlying determinants'.
[191] Link and Phelan (n 94) 80.
[192] Yoav Ben-Shlomo and Diana Kuh, *Lifecourse Epidemiology* (Oxford University Press 2010).
[193] MJ Shanahan and JD Boardman, 'Genetics and Behavior in the Life Course: A Promising Frontier' [2009] The Craft of Life Course Research 215.
[194] Michael Marmot, *The Health Gap: The Challenge of an Unequal World* (Bloomsbury Press, an imprint of Bloomsbury Publishing Plc, 2016); Eric Brunner and Michael Marmot, 'Social Organization, Stress, and Health - Oxford Scholarship' in Michael Marmot and Richard G Wilkinson (eds), *Social Determinants of*

psycho-social approach recognises the impact of social issues such as relative rank in the social gradient, position in social hierarchies, low status, lack of opportunity and choice, work stress but understands the mechanisms causing ill health as being physiological through altered neuro-endocrine function and brain-mediated allostatic overload.[195] Michael Marmot entitled this phenomenon *The Status Syndrome*.[196] In *The Spirit Level: Why Equality is Better for Everyone,* Richard Wilkinson and Kate Pickett presented data to demonstrate that this phenomenon is not limited to individuals but impacts the whole of society.[197] They termed this phenomenon 'the sick society'.[198] Greater economic inequality reduces trust, public participation, collaboration, and social cohesion and increases segregation, division and social instability. This can result in higher levels of violent crime and homicide rates, greater prevalence of depressive disorders, increasing discrimination and racism, growing numbers of teen pregnancies and a larger prison population disproportionate to population size.[199] This affects everyone in society – all of us on the social gradient – not just the poor.

The **capability approach** offers an alternative metric to socio-economic status to evaluate health and wellbeing and explains the incremental or hierarchical nature of the social gradient in health in terms of a person's capabilities to achieve a life they value. Economist-philosopher Amartya Kumar Sen developed the capability approach in response to the basic needs debate of the 1970s and 1980s and in opposition to prevalent utilitarian theories of economics, to offer a space other than resource and

Health (2nd edn, Oxford University Press 2005); Pickett and Wilkinson (n 155); Wilkinson and Pickett (n 150).

[195] Krieger, *Epidemiology* (n 38) 191–201.

[196] Marmot, *The Status Syndrome* (n 153).

[197] Pickett and Wilkinson (n 153).

[198] Richard G Wilkinson, *The Impact of Inequality: How to Make Sick Societies Healthier* (1 edition, Routledge 2005).

[199] Pickett and Wilkinson (n 153); Pickett and Wilkinson (n 155); Wilkinson and Pickett (n 150).

utility measurement to evaluate quality of life and human development.[200] The main contention being that the freedom to flourish is of primary moral importance: that is a persons' ability to do and be what they value determines the kind of life they are able to lead, and should be the focus of any discussion of wellbeing or human development.[201] Sen describes capabilities as the opportunities or 'substantive freedoms' a person 'enjoys to lead the kind of life he or she has reason to value'.[202] Capabilities thus provide a means to convert the resources available to a person into functionings. Functionings are 'beings and doings' and can be active such as being able to exercise, avoid disease or participate in the life of the community, or more passive such as being nourished, having good health or having self-respect.[203] Functionings thus contribute to flourishing. The capability approach offers an alternative metric to socio-economic status to evaluate health and wellbeing and explains the incremental or hierarchical nature of the social gradient in health in terms of a person's capabilities to achieve a life they value.

The capability approach provides a broad conceptual framework for assessing individual wellbeing, evaluating social arrangements, and determining social policy across the whole social gradient.[204] It combines horizontal and vertical inequalities taking a nuanced assessment of the role of wealth or discrimination in creating health inequalities. It examines the real-world experiences and actual choices available for people to make decisions that positively affect their health. It directs attention to social,

[200] Amartya Sen, 'Equality of What?' in Sterling McMurrin (ed), *Liberty, Equality, and Law*, vol 1 (1987); Amartya Sen, *Development as Freedom* (Knopf 1999); Sabina Alkire, *Valuing Freedoms: Sen's Capability Approach and Poverty Reduction* (Oxford University Press 2002).
[201] Ingrid Robeyns, 'The Capability Approach' Stanford Encyclopedia of Philosophy <http://plato.stanford.edu/archives/fall2016/entries/capability-approach/> accessed 3 November 2016.
[202] Sen, *Development as Freedom* (n 203) 85.
[203] ibid 72–75.
[204] Robeyns, 'The Capability Approach' (n 204).

political, and economic factors limiting those choices as well as lifestyle, life-course, behavioural and physiological factors.

Intersectional approaches have been offered as an alternative to social gradient approaches to health inequalities in public health. Sarah Hill argues that the public health focus on the gradient in relation to socio-economic status and class diverts attention from the multiple aspects of identity and their interrelationships and role in causing health inequalities.[205] Evidence of inverse or changing gradients, such as with smoking in Hill's analysis, is often related to class or socio-economic inequalities discrimination. However, gradients can be demonstrated for diverse factors other than socio-economic status or class. This combined with observations of changes and inverses of gradients demands a more nuanced exploration of the dynamics of social gradients, such as that developed by Bezo and colleagues, rather than dismissing the gradient.[206] Intersectionality offers an additional perspective for understanding the interrelationship of social determinants such as migration and conflict, ethnicity and gender, and poverty and socio-economic status, that moves beyond the unidirectional view presented by the narrative of horizontal and vertical inequalities

The social gradient is a dominant concept in public health that deserves more careful exploration. Various mechanisms can be used to explain what is happening to create the gradient, each enhancing the other to create a more precise understanding of health inequalities and what is required to ameliorate them.

[205] Hill (n 144).
[206] Bezo, Maggi and Roberts (n 11).

5. Policy action on inequalities

Our understanding of the causal factors in health inequalities and the perspectives we adopt influence the type of policies we might choose to implement to ameliorate those inequalities. Where health inequalities are perceived as horizontal, policy goals favour action for those disadvantaged groups to improve their health.[207] Action aims to remove discriminatory policies and practices, with the disaggregation of socio-economic and epidemiological data an important step to identify disproportionately poor health on the basis of gender, ethnicity, religion and other characteristics.[208] Global responses include, for example, the 'leave no-one behind' agenda of the Sustainable Development Goals (SDGs).[209] Where health inequalities are perceived as vertical, policy action focuses upon socio-economic status, policies around work and income, and wealth redistribution. For example, in the UK, geographic socio-economic inequalities following austerity and exacerbated by the Covid-19 pandemic have precipitated the policy mantra of 'levelling up' by targeting poor regions with action upon economic and social infrastructure in order to raise those regions out of poverty.[210] These findings tell us that social gradients demand a more nuanced approach to tackling both horizontal and vertical inequalities. Often policy development processes see causal relationships

[207] Graham, 'Social Determinants and Their Unequal Distribution: Clarifying Policy Understandings' (n 29); Graham, 'Tackling Inequalities in Health in England' (n 29); Graham, 'Health Inequalities, Social Determinants and Public Health Policy' (n 29).
[208] UN Committee on Economic, Social and Cultural Rights, 'General Comment 14 ICESCR' (n 18) para 12(b)ii, 16, 21, 34, and 20.
[209] United Nations, 'Sustainable Development Goals: Sustainable Development Knowledge Platform' <https://sustainabledevelopment.un.org/?menu=1300> accessed 15 October 2015.
[210] See for example Whitehead and Dahlgren (n 65); Colin Talbot and Carole Talbot, 'On the Level: What Does the Government Mean by Levelling Up?' [2020] *Civil Service World* <https://www.civilserviceworld.com/in-depth/article/on-the-level-what-does-the-government-mean-by-levelling-up> accessed 29 August 2020; Joseph Rowntree Foundation, 'Levelling up the Economy: We Can't Afford Not To' (2020) <https://www.jrf.org.uk/report/levelling-economy-we-cant-afford-not> accessed 29 August 2020; *Levelling up the Economy beyond COVID-19* (Directed by Joseph Roundtree Foundation, 2020) <https://www.youtube.com/watch?v=u2AkaJPqrmA&mc_cid=246727cb9a&mc_eid=3a7553e74c> accessed 27 August 2020.

between social determinants and ill health as linear, which offers simpler policy action but negates the need to engage with the complexities.[211]

Framing health inequalities as vertical or horizontal determines the political agenda, the policies created, and the actions adopted.[212] A social gradient approach expands the policy horizon and provides alternative means to reduce health inequalities. Action to reduce health gradients permits a broader policy focus which incorporates factors leading to both vertical and horizontal inequalities. It enables a policy focus which searches for the causes of inequality and for the unfair and unjust distribution of the social determinants of health across society. [213] In this way using a social gradient approach to tackling inequalities becomes a population-wide endeavour which includes economic inequalities (vertical inequalities), avoiding action to simply 'level up' to an arbitrary average, and expands a narrow focus on certain groups experiencing vulnerability and discrimination (horizontal inequalities) to address broader structural factors.

Concluding Comments

This chapter has argued that the social gradient is an added dimension to our understanding of health inequalities within countries. The social gradient is a social determinant of health associated with the societal distribution of health inequalities. It articulates a complex relationship between vertical and horizontal inequalities. It demonstrates that those in the middle of the socio-economic gradient in health outcomes are also experiencing health inequalities which are not confined to the poor

[211] Gemma Carey and Brad Crammond, 'Action on the Social Determinants of Health: Views from inside the Policy Process' (2015) 128 Social Science & Medicine 134; Crammond and Carey (n 174).
[212] Signild Vallgårda, 'Social Inequality in Health: Dichotomy or Gradient? A Comparative Study of Problematizations in National Public Health Programmes' (2008) 85 Health Policy 71.
[213] Graham, 'Tackling Inequalities in Health in England' (n 996) 123–126.

and discriminated against in society. This has implications for the whole of society as evidenced by psycho-social theories explaining social gradient inequalities. In this way the social gradient demands more nuanced explanatory mechanisms than offered by traditional public health paradigms. However, the social gradient is erroneously often equated with socio-economic status without acknowledgement that gradients can be demonstrated for factors impacting on health or other social, developmental or cognitive outcomes. The social gradient is more than vertical inequalities.

How we understand health inequalities determines how we might choose to ameliorate them. If we ignore the social gradient, as suggested by Venkatapuram, then we will fail to adequately address the problem of inequalities in health. Evidence shows that health inequalities are not resolving after decades of action which suggests that new approaches are required. This therefore has important implications for the right to health, particularly where the right to health and public health need to collaborate on the implementation of the right to health in public health policy and practice. The next chapter explores the nature of existing collaboration between public health and the right to health in academic literature.

Chapter 2. Conceptualising the Social Gradient in the Right to Health in Academic Literature: A Scoping Review.

This chapter explores to what extent and in what ways the academic literature on public health and human rights conceptualises the social gradient. A scoping review methodology was used to allow examination of a broad range of literature, covering a variety of public health and right to health topics to identify how the social gradient is introduced, discussed and explained. Scoping reviews have been conducted in relation to the application of the social determinants of health in public health policy and practice but not specifically concerning the social gradient in health.[214] Although these have touched upon both, this is the first review to specifically address the social gradient as it relates to the right to health. In their 2017 scoping review, Kelsey Lucyk and Lindsay McLaren did not find a conceptual framework for the social gradient in public health literature.[215] This scoping review also extends this search to identify whether a conceptual framework has been developed since their review.

Firstly, the scoping review methodology is described and then the results presented in numerical and tabular form. Supplementary material detailing the methodology can be found in the appendices. Next, the various conceptualisations of the social gradient found in the literature are considered, followed by a discussion of the relationship between the social gradient and the right to health as portrayed in the literature. Finally, the discussion opens out to consider the synergies and divergencies between public health and the right to health.

[214] Judy N Mikhail and others, 'The Social Determinants of Trauma: A Trauma Disparities Scoping Review and Framework' (2018) 25 Journal of Trauma Nursing 266; Leo Pedrana and others, 'Scoping Review: National Monitoring Frameworks for Social Determinants of Health and Health Equity' (2016) 9 Global Health Action; Katrina M Plamondon and others, 'The Integration of Evidence from the Commission on Social Determinants of Health in the Field of Health Equity: A Scoping Review' (2020) 30 Critical Public Health 415.
[215] Lucyk and McLaren (n 82).

A. Scoping Review

A scoping review is 'a form of knowledge synthesis that addresses an exploratory research question aimed at mapping key concepts, types of evidence, and gaps in research related to a defined area or field by systematically searching, selecting, and synthesizing existing knowledge.'[216] This review adopts a scoping review methodology as originally designed by Hilary Arksey and Lisa O'Malley in 2005,[217] advanced by Danielle Levac, and Heather Colquhoun and others,[218] and further developed by the Joanna Briggs Institute and Micah Peters and colleagues, who identify nine steps to the review process (Appendix 2).[219]

The aim of this scoping review of academic literature was to map available literature referring to the social gradient and allied concepts in relation to discussion of the right to health. Specifically, to 1) describe the way the social gradient is portrayed, and 2) explore the relationship between the social gradient and the right to health. The alignment of aim, objectives and question was conducted using the Participant, Concept, Context framework advocated by Peters and colleagues (Appendix 3). A protocol for this review was registered with the Open Science Framework.[220] The review was structured and evaluated using the Preferred Reporting Items for Systematic

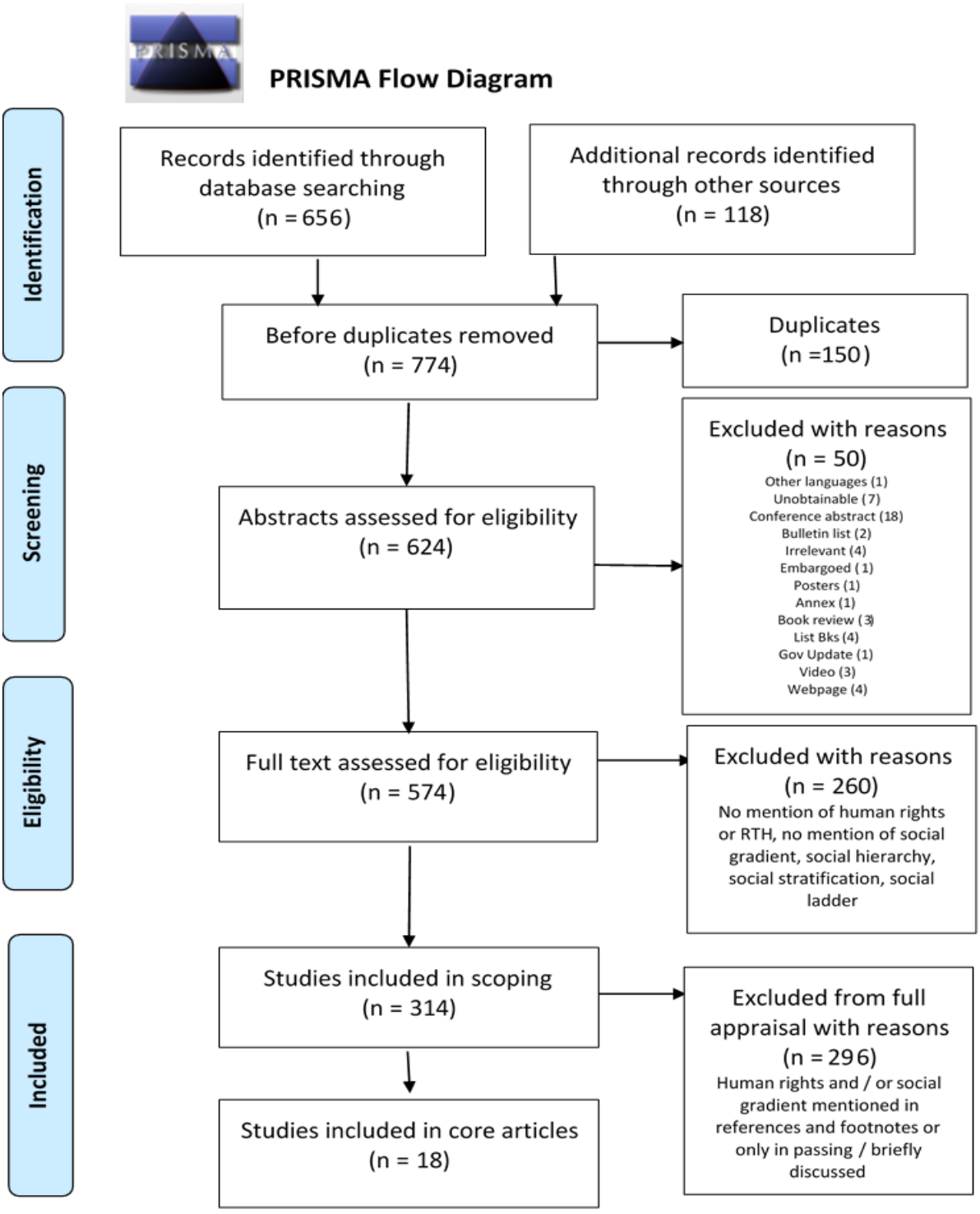
[216] Heather L Colquhoun and others, 'Scoping Reviews: Time for Clarity in Definition, Methods, and Reporting' (2014) 67 Journal of Clinical Epidemiology 1291, 1292–1294.
[217] Hilary Arksey and Lisa O'Malley, 'Scoping Studies: Towards a Methodological Framework' (2005) 8 International Journal of Social Research Methodology 19.
[218] Danielle Levac, Heather Colquhoun and Kelly K O'Brien, 'Scoping Studies: Advancing the Methodology' (2010) 5 Implementation Science 69; Colquhoun and others (n 219); Erin Miller and Heather Colquhoun, 'The Importance and Value of Reporting Guidance for Scoping Reviews: A Rehabilitation Science Example' (2020) 37 Australian Journal of Advanced Nursing 53.
[219] Micah Peters and others, 'Chapter 11: Scoping Reviews' in Edoardo Aromataris and Zachary Munn (eds), *JBI Manual for Evidence Synthesis* (JBI 2020) <https://wiki.jbi.global/display/MANUAL/Chapter+11%3A+Scoping+reviews> accessed 11 February 2021.
[220] Registration number https://osf.io/2kwvu DOI: 10.17605/OSF.IO/YU9BR

reviews and Meta-Analyses extension for Scoping Reviews (PRISMA-ScR) Checklist (Appendix 4).[221]

A search of academic literature was conducted in eleven databases (CINAHL, MEDLINE, APA PsycInfo, APA PsycArticles, OpenDissertations, E-Journals – through EBSCOHost, HeinOnline, JSTOR, SCOPUS, IBSS and Web of Science) cataloguing both human rights and public health resources (Appendix 5). The scoping review, initially conducted in December 2017, was repeated in April 2021 to update findings. Articles had to include both the social gradient and the right to health, even if they were mentioned only in passing or in references and footnotes. 656 articles were found through database searching and 118 through hand searches. 314 articles were included in the mapping and 18 in the core literature summarised in the PRISMA flow diagram (Figure 3).[222]

[221] Andrea C Tricco and others, 'PRISMA Extension for Scoping Reviews (PRISMA-ScR): Checklist and Explanation' (2018) 169 Annals of Internal Medicine 467.
[222] David Moher and others, 'Preferred Reporting Items for Systematic Reviews and Meta-Analyses: The PRISMA Statement' (2009) 6 PLOS Medicine e1000097.

Figure 3 **PRISMA flow diagram of search results.**



Source: Moher and others (2009)[223]

[223] ibid 3.

A framework synthesis approach was adopted to structure the analysis of such a large body of articles and ensure rigour.[224] Coding strategies were applied in NVivo-12 software.[225] A further process of selection identified articles where both the social gradient and the right to health were discussed more substantively. Data analysis adopted an iterative process moving from the small group of 18 articles for detailed appraisal (Appendix 6) to the larger body of literature and back again.[226]

Assumptions

Underlying this study is a normative assumption that health inequalities are unfair and that there are unacceptable differences in health status. These differences are not due to artefact but are a consequence of structural determinates of health that distribute health-supporting resources and health-depleting risks and vulnerabilities unevenly through populations. The social gradient articulates the structured manner of this distribution as a social injustice.[227]

Strengths and limitations of the review

To my knowledge this is the first literature review focusing on the social gradient and the right to health. This review has specifically addressed the relationship between the social gradient and the right to health in public health and human rights academic literature. This review corroborates the findings of the 2017 scoping review by Lucyk and McLaren that whilst the term social gradient is widely used it does not have a clear

[224] Liz Spencer and others, 'Analysis in Practice' in Jane Ritchie and others (eds), *Qualitative Research Practice: A Guide for Social Science Students and Researchers* (Second edition, SAGE Publications Ltd 2014); Sally Parkinson and others, 'Framework Analysis: A Worked Example of a Study Exploring Young People's Experiences of Depression' (2016) 13 Qualitative Research in Psychology 109; Alison Hackett and Karen Strickland, 'Using the Framework Approach to Analyse Qualitative Data: A Worked Example' (2018) 26 Nurse Researcher.
[225] QSR International, 'NVivo 12 Data Analysis Software for Academic Research' (*NVivo*, 2021) <https://www.qsrinternational.com/nvivo-qualitative-data-analysis-software/about/nvivo/who-its-for/academia> accessed 11 June 2021.
[226] Levac, Colquhoun and O'Brien (n 221).
[227] Venkatapuram, 'Social Gradient in Capabilities' (n 12) 555.

conceptual framework.[228] It also concurs with their findings that terms such as disparities, inequalities, equity and equality are used interchangeably by many authors. This earlier review, however, does not make any links to the right to health. This review finds that, not surprisingly, lack of conceptual clarity around terms extends from public health into human rights and right to health literature. Without clarity in the field of public health it is difficult to gain clarity for right to health proponents to adopt the concept of the social gradient.

This scoping review accessed only academic literature from indexed databases to gauge how the topic is being discussed in academic circles. However, a significant source of current thinking and practice on the right to health is being done by international and local human rights organisations and NGOs with a multiplicity of reports addressing issues of health inequalities.[229] Comprehensively finding and searching such reports for discussion of the social gradient in the same manner as the academic literature proved difficult to achieve. The relative absence of references to such literature in the articles reviewed further demonstrates the limited academic engagement with the knowledge production of practice-based researchers, particularly those from LMICs.

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[228] Lucyk and McLaren (n 82).

[229] See for example a small selection of reports: Tom Pollard, 'Pushed to the Edge: Poverty, Food Banks and Mental Health' (Joseph Rowntree Foundation 2023) <https://uploads.strikinglycdn.com/files/dd06f2f2-bea9-46ff-941c-1d8849dce077/Mental%20Health%20Report%20-%20Final%200303.pdf> accessed 2 April 2023; Human Rights Watch, 'In Sheep's Clothing. United States' Nonprofit Hospitals Chase Low-Income Patients on Debts' (2023) <https://www.hrw.org/news/2023/06/15/us-nonprofit-hospitals-chase-low-income-patients-debts> accessed 9 November 2023; Amref Health Africa in Uganda and others, 'Integrated Sexual and Reproductive Health and Rights Programme In High Burden Districts (ISPHD) /Heroes Programme Of Uganda - Baseline Report | 2022' (Heroes for Gender Transformative Action 2022) Baseline Report <https://amref.org/uganda/download/heroes-programme-of-uganda-baseline-report-2022/> accessed 9 November 2023; Ahmed and others (n 2); Amnesty International, 'A Fair Shot. Ensuring Universal Access to COVID-19 Diagnostics, Treatments and Vaccines' (Amnesty International Publications 2020) <https://www.amnesty.org/en/documents/document/?indexNumber=pol30%2f3409%2f2020&language=en> accessed 11 December 2020.

Additionally, it must be recognised that concept of the social gradient is less well recognised in literature developed within the USA, where social class analysis has long been avoided and the association of social gradient with socio-economic inequalities and social class means that the concept has not been easily taken up.

Few synonyms for the social gradient and the right to health were used, papers that did not specifically use the term social gradient were not sought, and grey literature was not searched which does not guarantee the comprehensiveness of the search. Important content may therefore have been missed: although the search did include snowballing and citation tracing. However, the aim was not to be exhaustive but to observe the interrelationship between the concept of the social gradient and the right to health in scholarly literature. Terms for equality and equity were not searched. The scoping review was framed by assumptions about the importance of the social gradient in health, and an understanding that the social gradient articulates a different perspective on health inequalities. It is these specific types of inequality that were of interest. Not the broad concept of equality and equity.

The number of studies included in this scoping review presented challenges for analysis and synthesis by a single author. Complexities in the topic may have been overlooked and may have been teased out through debate between authors. This also presents a challenge to the replicability of the review. However, protocols established by Peters and others for conducting a review were adhered to and supplementary materials are provided in appendices 2–6. Individual studies were not assessed for methodological strength in line with the broad intention of a scoping review to describe an emerging concept and explore its interrelationship with another discipline.

B. Results

As each article was reviewed data were extracted for particular characteristics: year, type of article (public health / human rights / right to health) based on their substantive content and author affiliations, document type (e.g. research paper, commentary etc.), the level of inclusion of the social gradient (footnotes and references / in passing / discussed / substantive) and similarly for the right to health (Appendix 7). Articles were then reviewed for explanatory mechanisms for the social gradient, the inter-relationship between the social gradient and the right to health and for how health inequalities were portrayed.

The categorisation of articles into public health or right to health was based on the journal of publication and the substantive content of the article. Some articles were easy to categorise according to the title of the journal in which they were published (Health and Human Rights, BMC Public Health). Other publications either bridged the two disciplines (Bulletin of the World Health Organisation) or were drawn from other disciplines but had health-related content (Health Sociology Review). In this case the key words and content of the article were evaluated to identify the main focus. Few articles had both right to health and public health as their focus.

Summary of characteristics of articles

As expected, given that the social gradient is a public health concept, the largest proportion of results were of public health articles (69%), with fewer numbers from human rights and right to health (27%), and other disciplines such as sociology and philosophy (4%) (Table 1).

Interest in the social gradient appears to have risen sharply in the 2008–2012 period (29%) immediately after the CSDH report *Closing the Gap* and peaked particularly for

the right to health in 2013–2017 (39%). This has declined in the last four years (20%). This might have been influenced by the predominance of literature related to the Covid-19 pandemic, but also reflects a shorter time period of three and a half years. Conducting further database searches did not reveal any association between the social gradient AND right to health AND the Covid-19 pandemic.

A broad range of sources were found including letters, editorials, interviews, and book chapters to capture any discussion of both topics. Research articles predominated public health literature (37%), particularly quantitative methodologies reflecting an epidemiological focus, and were less well represented in human rights (17%) and right to health articles (10%). Literature reviews featured in public health literature especially systematic and scoping reviews (14%), but hardly featured at all in the human rights and right to health literature (2%). Policy analysis was represented quite equally across disciplines (11%–18%). Theoretical essays provided the mainstay of writing in human rights (51%) and right to health literature (45%) and were a less common feature of public health articles (25%). The approach adopted to human rights research remains largely doctrinal,[230] with approaches grounded in legal norms and obligations.[231] More recently a growing diversity of research epistemologies and methodologies are being adopted, particularly from the social sciences,[232] but little of this is interdisciplinary and caution is required in adopting poorly understood research methodologies from other

[230] Damian Gonzalez-Salzberg and Loveday Hodson, *Research Methods for International Human Rights Law: Beyond the Traditional Paradigm* (Routledge 2019) 2 <https://0-www-taylorfrancis-com.serlib0.essex.ac.uk/books/e/9780429468971> accessed 7 October 2020.
[231] Laura Ferguson, 'Assessing Work at the Intersection of Health and Human Rights: Why, How, Who?' in Bård-Anders Andreassen, HO Sano and Siobhán Mclnerney-Lankford (eds), *Research Methods in Human Rights: A Handbook* (Edward Elgar Publishing 2017) 410.
[232] Gonzalez-Salzberg and Hodson (n 233) 3.

disciplines.[233] Given the multiplicity of factors that influence human health this remains a challenge.[234]

A myriad of topics was covered and although recorded, not represented here as they were too numerous and without any particular clustering or pattern. This highlights that both the social gradient and the right to health are considered to be relevant to a wide range of health issues. Articles predominantly discussed topics related to either high-income countries (36%) or global issues (47%). Research pertaining to or from LICs represented only 4% of all articles illustrating the inexcusable scarcity of voices and evidence drawn from a range of countries where poverty, human rights abuses and health inequalities persist to a high degree.

[233] Fons Coomans, F Grunfeld and Menno T Kamminga, 'Methods of Human Rights Research: A Primer' (Social Science Research Network 2009) SSRN Scholarly Paper ID 1395689 <http://papers.ssrn.com/abstract=1395689> accessed 9 January 2014.
[234] Ferguson (n 234).

Table 1 **Summary of characteristics of articles found for mapping.**

		All Articles (n=314)		Public Health Articles (n=216)		Human Rights Articles (n=41)		Right to Health (n=43)		Other (n=14)	
		No	%	No	%	No	%	No	%	No	%
Year	1997–2002	**13**	*4*	**8**	*4*	**2**	*5*	**3**	*7*	**0**	*0*
	2003–2007	**35**	*11*	**23**	*11*	**7**	*17*	**5**	*11*	**0**	*0*
	2008–2012	**92**	*29*	**66**	*31*	**14**	*34*	**10**	*23*	**2**	*17*
	2013–2017	**112**	*36*	**77**	*36*	**13**	*32*	**17**	*39*	**5**	*42*
	2018–2021	**62**	*20*	**42**	*20*	**5**	*12*	**8**	*18*	**7**	*58*
Type of Article	Quantitative Research	**73**	*23*	**64**	*30*	**5**	*12*	**2**	*5*	**2**	*17*
	Qualitative Research	**14**	*4*	**9**	*4*	**2**	*5*	**2**	*5*	**1**	*8*
	Mixed Methods	**6**	*2*	**6**	*3*	**0**	*0*	**0**	*0*	**0**	*0*
	Literature Review	**33**	*11*	**31**	*14*	**0**	*0*	**1**	*2*	**1**	*8*
	Essay	**99**	*31*	**52**	*24*	**21**	*51*	**20**	*45*	**6**	*50*
	Commentary	**25**	*8*	**16**	*7*	**4**	*10*	**4**	*9*	**1**	*8*
	Policy Analysis	**39**	*12*	**24**	*11*	**6**	*15*	**8**	*18*	**1**	*8*
	Other	**25**	*8*	**14**	*7*	**3**	*7*	**6**	*14*	**2**	*17*
Global Focus	High-Income Country	**112**	*36*	**85**	*40*	**16**	*39*	**8**	*18*	**4**	*33*
	Middle-Income Country	**24**	*8*	**20**	*9*	**2**	*5*	**1**	*2*	**1**	*8*
	Low-Income Country	**11**	*4*	**8**	*4*	**2**	*5*	**1**	*2*	**0**	*0*
	Region	**18**	*6*	**13**	*6*	**3**	*7*	**1**	*2*	**1**	*8*
	Global / General	**148**	*48*	**90**	*42*	**18**	*44*	**32**	*73*	**8**	*67*
Inequalities	Disparity	**106**	*34*	**70**	*33*	**16**	*39*	**19**	*43*	**1**	*8*
	Inequality	**157**	*51*	**107**	*50*	**26**	*63*	**23**	*52*	**1**	*8*
	Equity	**136**	*44*	**92**	*43*	**22**	*54*	**21**	*48*	**1**	*8*
Refers to	CSDH	**132**	*43*	**92**	*43*	**14**	*34*	**23**	*52*	**3**	*25*
	Special Procedures	**34**	*17*	**13**	*6*	**7**	*17*	**14**	*32*	**0**	*0*

Only 7% (n=18) of articles address both the social gradient and the right to health either as a part of their argument (discussed) or as foundational to the topic under discussion (substantive) (Table 2). This core of 18 articles was reviewed to establish a framework to then follow up in the larger body of mapped literature following the iterative process as recommended by Levac and colleagues.[235] Three themes were addressed: how the social gradient was portrayed, the relationship between the right to health and the social gradient, and conceptualisations of health inequalities.

Table 2 **Inclusion of the right to health and the social gradient**

Ways in which articles manage the two concepts. *(% rounded)*		Inclusion of right to health				
		Substantive	Discussed	Passing	Footnotes/ References	*Total*
Inclusion of social gradient	Substantive	8 *(2.5%)*	5 *(2%)*	19 *(6%)*	7 *(2%)*	*39 (12%)*
	Discussed	5 *(2%)*	14 *(4%)*	15 *(5%)*	3 *(1%)*	*37 (12%)*
	In Passing	77 *(25%)*	17 *(5%)*	85 *(27%)*	15 *(5%)*	*194 (62%)*
	Footnotes/ References	10 *(3%)*	7 *(2%)*	15 (5%)	12 *(4%)*	*44 (14%)*
	Total	*100 (32%)*	*42 (14%)*	*133 (42%)*	*37 (12%)*	*314 (100%)*

C. Summary of Main Results

The social gradient tended to be included simply in reference to a discussion of social determinants of health or to emphasise that health inequalities exist (Table 2). A small number of articles (14%) referred to the social gradient only in footnotes or references to support a comment about health inequalities in tex.t This lack of recognition of the social gradient could be attributed to the topic under discussion. However, social gradients in health have been demonstrated for a huge range of different social factors

[235] Levac, Colquhoun and O'Brien (n 221).

and for a variety of health outcomes. Many authors from both public health and human rights disciplines did not recognise the particular value of the social gradient to their topic. Both public health and right to health scholars need to fully engage with the concept of the social gradient.

1. Lack of conceptual clarity

Where the social gradient was briefly discussed (12%), it was simply used to demonstrate health inequalities related to socio-economic status. The articles largely discussed poverty and material disadvantage in both public health and human rights literature with some 6,135 references to poor, poverty, deprived and deprivation found in 275 articles. For example, in human rights literature Audrey Chapman acknowledged that the human rights community has a strong commitment to improving the status of the poorest and most disadvantaged populations.[236] Similarly Philip Baker and colleagues noted the importance of poverty and deprivation as a policy driver.[237]

Correlations between other determinants and health were very rarely considered, but where this occurred it opened the discussion to new and important observations. Reformulating conceptualisations of gradients away from only socio-economic factors might reap benefits. For example, Susan Prescott and Alan Logan saw the social gradient in health as a prism to understand environmental impacts on health.[238] Thomas considered the social gradient in educational outcomes as a means towards envisioning

[236] Audrey R Chapman, 'Missed Opportunities: The Human Rights Gap in the Report of the Commission on Social Determinants of Health' (2011) 10 Journal of Human Rights 132, 140.
[237] Phillip Baker and others, 'What Enables and Constrains the Inclusion of the Social Determinants of Health Inequities in Government Policy Agendas? A Narrative Review' (2018) 7 International Journal of Health Policy & Management 101.
[238] Susan L Prescott and Alan C Logan, 'Transforming Life: A Broad View of the Developmental Origins of Health and Disease Concept from an Ecological Justice Perspective' (2016) 13 International Journal Of Environmental Research And Public Health.

more inclusive education,[239] Haddad and others observed a social gradient in health correlated with tribal allegiances in Kerala that was not changed by household economic status,[240] and similarly Daniel La Parra Casado and others demonstrated a social gradient between different social classes and Roma in Spain,[241] and Bezo and colleagues demonstrated a social gradient between human rights and health outcomes.[242] Public health, human rights and right to health engagement with the social gradient would benefit from broadening the view of the social gradient to other important determinants that correlate with ill health.

2. Paucity of conceptual frameworks and models for the social gradient

One of the potential reasons for this lack of conceptual engagement is the absence of a unified or broadly accepted conceptual framework for the social gradient. None of the literature referenced any form of model or framework explicitly for the social gradient. Instead, 133 papers (43%), both public health and human rights, referenced the CSDH conceptual framework for social determinants of health, with twelve papers depicting the diagram. Others referenced the Rainbow Model of social determinants from Dahlgren and Whitehead, and a few lesser-known models (n=14). This provides clear evidence of the salience of social determinants of health across public health, human rights and right to health disciplines.

Where conceptual models were developed, they were diverse and had few common features most notably the inclusion of power relationships as significant for the

[239] Gary Thomas, 'A Review of Thinking and Research about Inclusive Education Policy, with Suggestions for a New Kind of Inclusive Thinking' (2013) 39 British Educational Research Journal 473.
[240] Slim Haddad and others, '"Health Divide" between Indigenous and Non-Indigenous Populations in Kerala, India: Population Based Study' (2012) 12 BMC Public Health 390.
[241] Daniel La Parra Casado, Diana Gil González and María de la Torre Esteve, 'The Social Class Gradient in Health in Spain and the Health Status of the Spanish Roma' (2016) 21 Ethnicity & Health 468.
[242] Bezo, Maggi and Roberts (n 11).

distribution of health inequalities. Thirteen public health articles used quantitative data analysis to demonstrate socio-economic gradients but did not go on to apply or develop a conceptual framework or model for the social gradient. Ten others developed their own models for social determinants for their particular topic. For these scholars, one common feature stood out above others. All articles looked to the issue of power relationships in some way: from the point of view of policy development,[243] knowledge of policy and municipal processes and participation,[244] caste systems and stigmatisation,[245] social hierarchies and domination,[246] social power and obesity,[247] and societal structural determinants more generally.[248] Braveman used Diderichsen's theoretical framework for social stratification to explain how power relationships in terms of the social and policy context leads to differential exposures to individual risks and vulnerabilities.[249] This theoretical framework underpins the social determinants of health conceptual model in the CSDH report.[250]

Any conceptual model of the social gradient must therefore incorporate the social determinants of health, some understanding of the impact of power relationships, and of processes that contribute to the distribution of populations along the gradient.

[243] Graham, 'Health Inequalities, Social Determinants and Public Health Policy' (n 29); Annie McEwen and Jennifer M Stewart, 'The Relationship between Income and Children's Outcomes: A Synthesis of Canadian Evidence' (2014) 40 Canadian Public Policy 99.
[244] Theresa L Grant and others, 'Inequitable Walking Conditions among Older People: Examining the Interrelationship of Neighbourhood Socio-Economic Status and Urban Form Using a Comparative Case Study' (2010) 10 BMC Public Health 677.
[245] Sanghmitra S Acharya, 'Socio-Economic Correlates of Bereavement among Women - Examining the Differentials on Social Axes' (2018) 148 The Indian Journal of Medical Research S27.
[246] Matthew Thomas Johnson and Elliott Johnson, 'Stress, Domination and Basic Income: Considering a Citizens' Entitlement Response to a Public Health Crisis' (2019) 17 Social Theory & Health 253.
[247] Gemma Carey and others, 'Can the Sociology of Social Problems Help Us to Understand and Manage "Lifestyle Drift"?' (2017) 32 Health Promotion International 755.
[248] Mikhail and others (n 217).
[249] Braveman, 'Social Conditions, Health Equity, and Human Rights' (n 59) 36.
[250] Commission on Social Determinants of Health (n 10).

Only one article developed a model specific to understanding the social gradient for their particular health determinant. Bezo and colleagues developed complex pathway models to examine the interrelationship of socio-economic status, social capital and human rights.[251] They identified a social gradient demonstrating improved physical and mental health outcomes where people had higher levels of access to human rights provisions. They termed this the 'rights and freedoms gradient in health' and suggested psycho-social theory as the main explanatory mechanism.

3. Explanatory mechanisms for the social gradient

The central importance of psycho-social explanations to Bezo and colleagues rights and freedoms gradient prompted a search of the literature for various explanatory mechanisms (Table 3). Three theoretical explanatory mechanisms for the social gradient stood out.

Table 3 **Explanatory mechanisms for the social gradient by discipline**

	All (N=314)	Public Health (n=216)	Human Rights (n=41)	Right to Health (n=43)	Other (n=14)
Diderichsen's social stratification theory	19 *(6%)*	16 *(7%)*	0 *(0%)*	3 *(7%)*	0 *(0%)*
Life-course approach	54 *(17%)*	45 *(21%)*	6 *(15%)*	2 *(5%)*	1 *(7%)*
Psycho-social theories	75 *(24%)*	50 *(23%)*	12 *(29%)*	12 *(28%)*	1 *(7%)*
Political economy of health	30 *(10%)*	22 *(10%)*	3 *(7%)*	5 *(12%)*	0 *(0%)*
Fundamental cause theory	21 *(7%)*	16 *(7%)*	3 *(7%)*	2 *(5%)*	0 *(0%)*
Capability approach	88 *(28%)*	51 *(24%)*	14 *(34%)*	17 *(40%)*	6 *(43%)*

Firstly, the capability approach was the most frequently mentioned theoretical approach being included in 28% of all articles and 40% of those with a right to health focus. Some

[251] Bezo, Maggi and Roberts (n 11).

related the capability approach to health justice and human rights;[252] some to policy development and priority setting;[253] some to health agency;[254] some to wealth and income not being an appropriate space for measurement;[255] and some specifically related the capability approach to the CSDH or Fair Society Health Lives reports.[256] Others accorded more significance or depth to the capability approach. Venkatapuram, Bell and Marmot noted the affinity between the capability approach, public health and human rights, with Marmot asserting that the capability approach is important to the social gradient in health.[257] Fox and Thompson provided an extensive discussion of the

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[252] Emily A Benfer, 'Health Justice: A Framework (and Call to Action) for the Elimination of Health Inequity and Social Injustice' [2015] American University Law Review <https://papers.ssrn.com/sol3/papers.cfm?abstract_id=2694873> accessed 6 June 2017; Braveman, 'Social Conditions, Health Equity, and Human Rights' (n 59); Norman Daniels, 'The Ethics of Health Reform: Why We Should Care about Who Is Missing Coverage Keynote Address' (2012) 44 Connecticut Law Review 1057; Octavio LM Ferraz, 'The Right to Health in the Courts of Brazil: Worsening Health Inequities?' (2009) 11 Health & Human Rights: An International Journal 33; Toni Schofield, 'Health Inequity and Its Social Determinants: A Sociological Commentary' (2007) 16 Health Sociology Review 105.

[253] David Craig and Doug Porter, 'The Third Way and the Third World: Poverty Reduction and Social Inclusion Strategies in the Rise of "Inclusive" Liberalism' (2005) 12 Review of International Political Economy 226; Ruth Bell, Sebastian Taylor and Michael Marmot, 'Global Health Governance: Commission on Social Determinants of Health and the Imperative for Change' (2010) 38 The Journal Of Law, Medicine & Ethics 470; Alicia Ely Yamin, 'Shades of Dignity: Exploring the Demands of Equality in Applying Human Rights Framework to Health' (2009) 11 Health and Human Rights 1.

[254] Lawrence O Gostin, 'Health of the People: The Highest Law?' (2004) 32 Journal of Law, Medicine & Ethics 509; Linden Farrer and others, 'Advocacy for Health Equity: A Synthesis Review' (2015) 93 The Milbank Quarterly 392; Su-ming Khoo, 'Health Governance and "Wicked Problems": Facing Complex Developmental Transitions Using a Rights-Based Approach' (2013) 24 Irish Studies in International Affairs 259.

[255] Marion Danis and Amy Sepinwall, 'Regulation of the Global Marketplace for the Sake of Health Symposium Articles - Part III: Legal and Human Rights Intervention for Health' (2002) 30 Journal of Law, Medicine and Ethics 667; Björn Kauder and Niklas Potrafke, 'Globalization and Social Justice in OECD Countries' (2015) 151 Review of World Economics 353; Rüdiger Krech, 'Healthy Public Policies: Looking Ahead' (2011) 26 Health Promotion International ii268; Kenneth Stuart and EJL Soulsby, 'Reducing Global Health Inequalities. Part 1' (2011) 104 Journal Of The Royal Society Of Medicine 321; Alicia Ely Yamin and Ole Frithjof Norheim, 'Taking Equality Seriously: Applying Human Rights Frameworks to Priority Setting in Health' (2014) 36 Human Rights Quarterly 296.

[256] Kumanan Rasanathan, Johanna Norenhag and Nicole Valentine, 'Realizing Human Rights-Based Approaches for Action on the Social Determinants of Health' (2010) 12 Health and Human Rights 49; Merrill Singer and Nicola Bulled, 'Interlocked Infections: The Health Burdens of Syndemics of Neglected Tropical Diseases' (2012) 36 Annals of Anthropological Practice 328; M Whitehead, 'A Typology of Actions to Tackle Social Inequalities in Health' (2007) 61 Journal of Epidemiology & Community Health 473; Lisa Whiting, Sally Kendall and Wendy Wills, 'The Importance of Research and Participation in Formulating Child Health Policy' (2012) 24 Nursing Children & Young People 18.

[257] Michael Marmot, 'Health in an Unequal World' (2006) 368 Lancet 2081; Sridhar Venkatapuram, Ruth Bell and Michael Marmot, 'The Right to Sutures: Social Epidemiology, Human Rights, and Social Justice'

place of the capability approach for social justice in public health policy and law with the conclusion that:

> [w]e suggest that domestic law and international human rights provisions, in particular the emerging human right to health, offer mechanisms to promote capabilities, and foster a robust and inclusive conception of social justice.[258]

Secondly, psycho-social theories such as those proposed by Wilkinson and Pickett were represented equally across all disciplines: more generally related to social determinants of health rather than the social gradient. Gradient-related examples of psycho-social mechanisms included: family relationships in child development,[259] responses to and recovery from violence and trauma,[260] and in the role of social identity and self-image in responses to pregnancy bereavement.[261] Individual psycho-social aspects of health and their influence on lifestyle remain important but are increasingly understood as embedded in societal values and social inequalities.

Thirdly, the life-course approach was found to be an influential theory well represented in public health (21%) but less so in right to health literature (5%). The life-course perspective was central to Marmot's influential report *Fair Society Healthy Lives* and helped to identify areas of action to mitigate the accumulation of effects on health through significant stages in the life-course.[262] Bezo and colleagues engaged with the life-course approach more substantively in constructing their 'rights and freedoms gradient', and Chapman in discussing the CSDH report from a right to health perspective. The life-course approach was less evident in human rights articles where it

(2010) 12 Health and Human Rights 3, 9; Michael Marmot, 'Social Determinants of Health Inequalities' (2005) 365 Lancet (London, England) 1099, 1102.
[258] Marie Fox and Michael Thomson, 'Realising Social Justice in Public Health Law' (2013) 21 Medical Law Review 278, 278.
[259] McEwen and Stewart (n 246).
[260] Mikhail and others (n 217).
[261] Acharya (n 248).
[262] Marmot, 'Fair Society' (n 73) 20.

was mentioned only in passing or in references, even in literature exploring child health issues (15%).

The capability approach offers the most comprehensive theoretical approach to and explanatory mechanism for the social gradient that could bridge the right to health and public health disciplines, compared to psycho-social and life-course theories. Psycho-social and life-course approaches, and other explanatory mechanisms, need to be conceptualised along with social determinates of health, understandings of power relationships, and with processes for distributing social determinants across the population to contribute to a model or framework for the social gradient. The capability approach has the potential to do this.

Beyond this review there is a huge body of literature evidencing and discussing the social gradient in health. However, I am not aware of any definitive conceptual model for the social gradient, though there are many issue-based models that examine the relationship between specified social determinants and ill health such as those offered by Bezo and colleagues.[263]

4. Health disparities, inequalities, or equity

All 314 articles addressed issues of health disparities, health inequalities, health equity and social justice. Hence the inclusion of the social gradient in their discussion. However, there were diverse understandings of health inequalities which were largely unrelated to how the social gradient was discussed. There were huge discrepancies in both the terms used and the way they were used to talk about health inequalities. In public health the difference between health disparities and health inequalities is that the

[263] Bezo, Maggi and Roberts (n 11).

former refers to general perhaps even inevitable disparities in health and the latter to those 'unnecessary, avoidable, unfair and unjust' differences in health consequent upon the 'unequal distribution of power, income, goods, and services, globally and nationally.' [264] Yet this distinction does not necessarily hold true in the literature: the term 'health disparities' is subject to interchangeable use. For example, in this statement by Sean Clouston and colleagues both terms were used to mean the same thing in the same sentence: 'The following sections first situate this discussion within the context of the theory of fundamental social causes of health disparities and then detail four hypotheses about how inequalities might change in relation to the fundamental causes over time.'[265] Braveman specifically states she is using the terms interchangeably: 'Health inequalities or disparities (used synonymously here) are the metric by which health equity (see above) is assessed.'[266] This is further complicated by the use of the term 'health inequities' as for example in this quote from Sherry Baron and colleagues: 'These disparities in health are also considered to be health inequities, because they often arise from social disadvantage'.[267] However, in this scoping review the literature reflects a much more mixed use of terms. Human rights using the terms equity, equality, disparities, and inequalities in more or less equal measure and similarly to public health (Table 1).

Power relationships are a key component of the concept of the social gradient and the inequalities it articulates. Yamin stated that: '[i]interpretations of equality and non-discrimination necessarily reflect deeply held understandings about justice, power, and

[264] Commission on Social Determinants of Health (n 10) 1.
[265] Sean Clouston and others, 'A Social History of Disease: Contextualizing the Rise and Fall of Social Inequalities in Cause-Specific Mortality' (2016) 53 Demography 1631, 1633.
[266] Braveman, 'Social Conditions, Health Equity, and Human Rights' (n 59) 33 parenthesis in original.
[267] Sherry L Baron and others, 'Promoting Integrated Approaches to Reducing Health Inequities among Low-Income Workers: Applying a Social Ecological Framework' (2014) 57 American Journal of Industrial Medicine 539, 2.

how we are the same or different from one another.'[268] Yamin's discussion is necessarily complex (the details of which will not be unpacked here) but she explored the varying conceptualisations of equality and of equity in public health and in human rights disciplines. She argued that CESCR General Comment 14 goes beyond the idea of equity 'used in the common law legal sense to mean justice administered according to fairness as contrasted with strictly formulated rules' to incorporate more public health notions of equity.[269] However, she qualified this with the comment that public health is itself unclear as to the meaning of these notions and argued that approaches to health policy have failed to address the hegemony of the wealthy and powerful in perpetuating the structures in society that maintain their privileged position on the gradient and create inequity.[270] Yamin contended that using a human rights approach highlights or 'denaturalizes the inequalities that pervade our societies and our world' through attending to every person's rights because '[i]n a human rights framework, health is a reflection of power relations as much as behavioural or biological factors'.[271] However, again with a qualification: '[i]t is far from clear that we have a consensus in the human rights community about which inequalities in health constitute inequities.' [272]

[268] Yamin, 'Shades of Dignity' (n 256) 1.
[269] ibid 4 and 9.
[270] Yamin, 'Shades of Dignity' (n 256).
[271] ibid 13.
[272] ibid 1.

D. Discussion - The Relationship Between the Social Gradient and the Right to Health

To examine the relationship between the right to health and the social gradient we must turn to the core literature where both these topics were discussed substantively.

In the core literature synergies between social determinants of health approaches and the right to health were highlighted. Key observations included: the interrelationship of social determinants of health reflecting the indivisibility of rights,[273] many social determinants (standard of living, education, food, etc.) are recognised as human rights,[274] the importance of the role of participation and civil society action in public health and human rights,[275] and both human rights and public health being concerned with equity and social justice.[276] There were also divergences noted between public health and the right to health: public health ethics not having the weight of law as human rights do,[277] public health having a better understanding of social determinants of health than the right to health does for underlying determinants,[278] and a lack of recognition of human rights in public health.[279]

Synergies between the social gradient and the right to health were less obvious. Chapman observed that some of the actions recommended in the CSDH report intersect with those of human rights, such as the focus on policy action to support early childhood health and development consistent with the rights of the child, reflecting the life-course approach associated with the social gradient.[280] Braveman observed that the

[273] Braveman, 'Social Conditions, Health Equity, and Human Rights' (n 59).
[274] Audrey R Chapman, 'The Social Determinants of Health, Health Equity, and Human Rights' (2010) 12 Health and Human Rights 17.
[275] Bell, Taylor and Marmot (n 256).
[276] Chapman, 'The Social Determinants of Health, Health Equity, and Human Rights' (n 277); Braveman, 'Social Conditions, Health Equity, and Human Rights' (n 59).
[277] Braveman, 'Social Conditions, Health Equity, and Human Rights' (n 59).
[278] Chapman, 'The Social Determinants of Health, Health Equity, and Human Rights' (n 277).
[279] Bell, Taylor and Marmot (n 256).
[280] Chapman, 'Missed Opportunities' (n 239).

level of health achieved by those near and at the top of the gradient should represent the highest attainable standard of health.[281] In this way progressive realisation of the right to health can be monitored against this benchmark rather than through thresholds of minimum core obligations lower down the gradient. An important tool, Braveman notes, for accountability.

There were also points of divergence which present significant challenges to incorporating the social gradient in the right to health. Firstly, the social gradient and related inequities are substantial issues that cannot be addressed simply by focusing on the poorest and most marginalised. Whereas, the health and human rights community have been particularly preoccupied with the poorest and most marginalised.[282] Yet, the grounds for non-discrimination do include socio-economic resources and social position (social origin, property, birth and other status in ICESCR General Comment 20), but priority is given to those living in the most marginalised and disadvantaged circumstances.[283] Secondly, the right to health focuses on improving health outcomes and as has yet still to develop a robust means to address root causes.[284] Public health recognises that causal relationships and mechanisms through which the social gradient is created are complex and not easily defined, but provide important points for action.[285] Human rights needs to address these 'underlying causes' but in order to do so need to develop a better understanding of them.[286]

[281] Braveman, 'Social Conditions, Health Equity, and Human Rights' (n 59) 42.
[282] Chapman, 'The Social Determinants of Health, Health Equity, and Human Rights' (n 277) 24.
[283] Braveman, 'Social Conditions, Health Equity, and Human Rights' (n 59) 39.
[284] Chapman, 'Missed Opportunities' (n 239) 140.
[285] Bell, Taylor and Marmot (n 256) 478; Braveman, 'Social Conditions, Health Equity, and Human Rights' (n 59) 36.
[286] Chapman, 'The Social Determinants of Health, Health Equity, and Human Rights' (n 277); Chapman, 'Missed Opportunities' (n 239).

There are synergies between the social determinants of health and the right to health upon which to build a better understanding of the relevance of the social gradient to the right to health. This will require overcoming some significant conceptual obstacles.

1. Human rights as explanatory of the social gradient

Several authors recognised human rights law as a social determinant of health, as being involved in a causative process.[287] Few, however, related this specifically to the social gradient.

Bezo and colleagues' secondary data analysis of global data sources resulted in the development of a 'rights and freedoms gradient of health'.[288] Building upon the 'rights and liberties argument' which proposes that political rights, civil liberties and democratic processes contribute substantially to improvements in life expectancy and child survival, Bezo and colleagues examine the influences of rights and freedoms upon health status. Using path analysis of indicators of political rights and civil liberties from the Freedom House database, and measures of perceived corruption from the Transparency International database with data regarding suicide rates and alcohol and tobacco consumption from the WHO Global Health Observatory Data Repository, they develop conceptual path models demonstrating significant direct and mediating effects of rights and freedoms upon mental health status in 34 countries. They cautioned that because their data is cross sectional, causation cannot be inferred but do assert political rights

[287] Scott Burris and others, 'Racial Disparities in Injection-Related HIV: A Case Study of Toxic Law' (2009) 82 Temple Law Review 1263; Gwendolyn Roberts Majette, 'Global Health Law Norms and the PPACA Framework to Eliminate Health Disparities' (2011) 55 Howard LJ 887; Liz Tobin Tyler, '"Small Places Close to Home": Toward a Health and Human Rights Strategy for the US' (2013) 80 Health and Human Rights; Robin L Nobleman, 'Addressing Access to Justice as a Social Determinant of Health' (2014) 21 Health LJ 49; ibid; Benfer (n 255).
[288] Bezo, Maggi and Roberts (n 11).

and freedoms to be important social determinant of health countering any purely psycho-social or biomedical explanations of ill health.

However, Venkatapuram and colleagues caution against seeing human rights and the right to health as explanatory of causation or as a link in the causal chain.[289] They argue that many social determinants could be framed as a health right, but this does not stand up to epidemiological analysis. Whilst Bezo and colleagues have begun to explore this the caution is still valid. Giving the example of the absence of sutures as contributory to post-natal morbidity in hospitals in Malawi, Venkatapuram and colleagues explain that it is not possible to have a right to sutures, and every other single item required. The absence of something cannot be conflated with a right to that something, and the lack of a right to sutures cannot be the cause of the maternal mortality. Rather Venkatapuram and colleagues suggest that the right to health and human rights law provides a powerful means to act to remediate ill health, should not be confined just to the poor and marginalised, and should address the social gradient.

The right to health and human rights-based approaches have not been offered as explanatory of the social gradient but have begun to be referenced in social epidemiological literature. The right to health could learn much from public health. The explanatory theories for the social gradient briefly presented in chapter one are important and influential concepts in public health, and as the right to health collaborates with public health these deserve attention. However, there are more pressing reasons for the right to health to take note of the social gradient. The social gradient signifies issues of health inequities and social injustice and demands action to address the power structures that contribute to and maintain the unequal distribution of

[289] Venkatapuram, Bell and Marmot (n 260).

the social determinants of health within and between societies. Observers would argue that public health would benefit from an explicitly human rights-based approach.[290] Krieger comments how violations of rights impact population health but laments that human rights are only just beginning to influence epidemiology and this in a limited way through 'policy-orientation or case based, rather than epidemiologic analysis'.[291] Human rights-based approaches as proposed most notably by Jonathan Mann, Paul Hunt, Sofia Gruskin, and Daniel Tarantola, have much to offer public health with their focus on government obligations to respect, protect and fulfil a variety of civil, political, social, economic and cultural rights, with the manner in which they support individuals and groups experiencing discrimination and rights violations to demand fulfilment and protection of their right to health, and with recourse to a legal framework.[292]

2. Right to health action on the social gradient

Reference to the social gradient generally indicates engagement with social determinants of health epidemiology. Some articles relate social determinants of health to various rights encompassed in the economic, social, and cultural rights or human rights principles.[293] Many particularly focus upon poverty and discrimination as

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[290] Paul Hunt, 'Missed Opportunities: Human Rights and the Commission on Social Determinants of Health' (2009) 16 Global Health Promotion 36; Paul Farmer and others (eds), *Reimagining Global Health: An Introduction* (1st edn, University of California Press 2013); Levy and Sidel (n 43); Krieger, *Epidemiology* (n 38); Yamin, *Struggle for Dignity* (n 1).

[291] Krieger, *Epidemiology* (n 38) 191.

[292] Jonathon M Mann and others (eds), *Health and Human Rights: A Reader* (Routledge 1999); Sofia Gruskin and others (eds), *Perspectives on Health and Human Rights* (Routledge 2005); Sofia Gruskin and Daniel Tarantola, 'Bringing Human Rights into Public Health' in Michael A Grodin and others (eds), *Health and Human Rights in a Changing World* (Routledge 2013); Paul Hunt and Sheldon Leader, 'Developing and Applying the Right to the Highest Attainable Standard of Health. The Role of the UN Special Rapporteur (2002-2008)' in John Harrington and Maria Stuttaford (eds), *Global Health and Human Rights Legal and Philosophical Perspectives* (Routledge 2010); See a small number of possible examples Paul Hunt, Alicia Ely Yamin and Flavia Bustreo (eds), 'Evidence of Impact of Human Rights-Based Approaches to Health' [2015] Health and Human Rights Journal <http://www.hhrjournal.org/> accessed 11 April 2016.

[293] Ebenezer Durojaye, 'The Approaches of the African Commission to the Right to Health under the African Charter' (2013) 17 Law, Democracy and Development 393; Luke Allen and others, 'Socioeconomic Status and Non-Communicable Disease Behavioural Risk Factors in Low-Income and Lower-Middle-Income Countries: A Systematic Review' (2017) 5 The Lancet Global Health e277.

determinants of health.[294] The conceptualisation of the social gradient as simply indicating health inequalities, poorly defined, often leads to recommended actions on poverty or on discrimination rather than specifically the gradient. Social determinants of health are fundamental to action for both public health and the right to health and demonstrate a synergy between the two disciplines.

A small number of human rights and right to health articles only made inferences to social gradient concepts and mechanisms. Examples include the unfair distribution of social determinants of health as evidenced by the social gradient;[295] action across the whole population rather than just targeted at the lower end of the gradient;[296] multiple pathways implicated in the causes of ill health requiring broad social policy action;[297] redistribution of wealth and resources flowing down the social gradient;[298] implementation of universal basic income which promotes people's rights;[299] and social assistance across the gradient.[300] Others referenced explanatory models or theoretical positions, in particular the move away from biomedical models to social models of disease and psycho-social explanations for ill health.[301] Authors also noted that there

[294] Harry W Arthurs, 'Labour and the Real Constitution' (2007) 48 Cahiers de Droit 43; Mark Henaghan and Ruth Ballantyne, 'Child Poverty in New Zealand - Definitions, Consequences, and Possible Legislative Responses New Zealand' (2014) 2014 International Survey of Family Law 377; Allen and others (n 296); Barry D Adam and J Cristian Rangel, 'Migration and Sexual Health Among Gay Latino Migrants to Canada' (2017) 42 Canadian Journal of Sociology 403.
[295] Marge Berer, 'A New Development Paradigm Post-2015, a Comprehensive Goal for Health That Includes Sexual and Reproductive Health and Rights, and Another for Gender Equality' (2013) 21 Reproductive Health Matters 4.
[296] CL Estes and SP Wallace, 'Older People', *Social Injustice and Public Health* (Oxford University Press 2009).
[297] Gostin (n 257).
[298] Christina S Ho, 'Legislating a Negative Right to Health: Health Impact Assessments' (2020) 50 Seton Hall Law Review 643.
[299] Johnson and Johnson (n 249).
[300] Nobleman (n 290).
[301] Majette (n 290); Jerome Bickenbach, 'Disability, "Being Unhealthy," and Rights to Health' (2013) 41 The Journal of Law, Medicine & Ethics: a journal of the American Society of Law, Medicine & Ethics 821; Elizabeth Tobin Tyler and Bradley Brockmann, 'Returning Home: Incarceration, Reentry, Stigma and the Perpetuation of Racial and Socioeconomic Health Inequity' (2017) 45 The Journal of Law, Medicine & Ethics 545.

were few studies on social gradient largely because few countries that have multilevel monitoring and data collection systems required to identify the gradient.[302] Social gradient concepts and ideas are gaining more traction in the literature on the right to health, but the relationship between the social gradient and the right to health is generally not fully explored.

Few articles strongly advocated action on the social gradient from a human rights perspective. Gostin proposed a rights-based framework convention on global health to reduce health injustices across the gradient.[303] Oppenheimer claimed that the social gradient is more important than a human rights lens simply focused upon poverty:

> As important are those relatively recent analyses that emerged from this [human rights-public health] tradition and have focused on the relationship between mortality and the social gradient – for they have implications that are more radical than those that follow from the human rights perspective. They make clear that it is not just the kind of deprivation that raises human rights concerns that affects life prospects, but hierarchy itself, no matter how subtle the steps of differentiation. To the extent that this is the case, a human rights perspective that can accommodate social gradation - Mozarts and those who cannot carry a tune - and that is not egalitarian in a thoroughgoing way will be inadequate to its own self self-defined challenge of responding to the moral implications of the patterns of morbidity and mortality in contemporary society. [304]

Policy analysis frameworks were offered that enabled differentiation between action on the gap between rich and poor, action on poverty, or action on the social gradient. Graham concluded that policy action was determined by how the social determinants of health are understood,[305] Vallgårda by how social inequalities are problematised,[306] and

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[302] Lawrence O Gostin, 'Meeting Basic Survival Needs of the World's Least Healthy People: Toward a Framework Convention on Global Health' (2007) 96 Geo. LJ 331; Sharon Friel and others, 'Policy Approaches to Address the Social and Environmental Determinants of Health Inequity in Asia-Pacific' (2012) 24 Asia Pacific Journal of Public Health 896.
[303] Lawrence O Gostin and others, 'Towards a Framework Convention on Global Health' (2013) 91 Bulletin Of The World Health Organization 790.
[304] Gerald M Oppenheimer, Ronald Bayer and James Colgrove, 'Health and Human Rights: Old Wine in New Bottles?' (2002) 30 The Journal of Law, Medicine & Ethics 522, 530.
[305] Graham, 'Health Inequalities, Social Determinants and Public Health Policy' (n 29).
[306] Vallgårda, 'Social Inequality in Health' (n 215).

Baker and colleagues combined two political science theories to highlight the complexities of policy processes addressing social determinants of health.[307] None of these authors included right to health action in their analysis, but the lesson for the right to health is that where social determinants of health are understood as a spectrum of different layers and levels of factors influenced by structural determinants, and social inequalities problematised as a gradient, then action is directed at reducing health gradients. Where social determinants of health are understood only in terms of risk factors in the poorest group and inequalities problematised as a dichotomy between rich and poor then the focus is upon poverty.

Concluding Comments

The scoping review of public health and human rights academic literature did not reveal a unified generally agreed conceptual framework for the social gradient. Some authors developed their own framework related to their specific topic but few of these frameworks had corresponding features. The WHO CSDH framework for social determinants of health was most often cited in relation to health inequalities.

Many authors interpreted the social gradient as simply referencing health inequalities without understanding the nature of those inequalities. The implications of the social gradient as discussed in chapter one were largely missed. Most often the social gradient was equated only with socio-economic inequalities of income and wealth rather than a pattern of distribution of inequalities for many different factors. The imperative to address poverty and meet the needs of the most disadvantaged is common to both public health and the right to health so many of the articles in the review focused attention only upon the lower aspect of the gradient, upon poverty.

[307] Baker and others (n 240).

There was a small body of literature that demonstrated a growing synergy between public health epidemiology and the right to health, which presents a platform for further collaboration. For example, the ‘rights and freedoms gradient in health’ and actions that intersect with human rights instruments. For example, drawing upon the rights of the child to support policy action on early childhood health and development. Important explanatory mechanisms for the social gradient have been adopted by right to health scholars. The life-course approach is beginning to be incorporated by the right to health, but psycho-social mechanisms and the capability approach appear to be more readily adopted.

The lack of a clear conceptual framework for the social gradient in public health impedes its incorporation into right to health academic literature. The ubiquitous nature of the social gradient within and between countries and for factors additional to socio-economic status highlights important messages about health inequalities. The next chapter explores to what extent the right to health has engaged with notions of social gradient inequalities in health in right to health treaties and general comments.

Chapter 3. Engagement with the Social Gradient in Human Rights Treaties and General Comments on the Right to Health

This chapter addresses the question as to whether there is any engagement with social gradient health inequalities in right to health treaties and general comments. Without a clear conceptual framework from public health and with only notional recognition of the concept of the social gradient in academic literature it is unlikely that treaties and general comments can engage fully with the social gradient and perhaps only with allied concepts.

The social gradient is a social determinant of health with various explanatory mechanisms, so the chapter commences by exploring the place of social determinants of health within a holistic understanding of health and examining notions of causation in the right to health. Given that the social gradient articulates a particular view of health inequalities the chapter then goes on to explore health inequalities in the right to health based upon the premise that the right to health is the right of everyone.

A. The Right to Health and the Social Gradient

The WHO Constitution, adopted in 1946, was the first international treaty to recognise health as a fundamental human right.[308] It declared in its preamble that 'the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being'.[309] The International Bill of Human Rights, specifically Article 25 (1) of the *Universal Declaration of Human Rights* (UDHR) adopted in 1948 also asserted a right to health with the words: '…everyone has the right to a standard of living adequate for the health and wellbeing of himself and of his family'.[310] As of January 2022, the 1996

[308] World Health Organisation, 'Constitution of the World Health Organisation' (n 44) s Preamble.
[309] ibid.
[310] United Nations, 'UDHR' (n 14); UN General Assembly, 'ICESCR' (n 14).

ICESCR gives rise to binding legal obligations to its 171 state parties.[311] Article 12 of the ICESCR expanded upon the UDHR with the assertion that: 'The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health'.[312]

United Nations (UN) Human Rights Treaty Bodies are committees of independent experts that monitor implementation of core human rights treaties. The Committee on Economic Social and Cultural Rights (CESCR) is the treaty body for the ICESCR. One role of a treaty body is to adopt general comments to guide the interpretation of substantive provisions and the normative development of particular aspects of their respective treaty. General comments are both seminal authoritative documents with significant legal weight (even though not in themselves legally binding) and important guidance as broad policy statements to states, policy makers and non-governmental organisations (NGOs).[313] The majority of general comments set out the interpretation of substantive provisions and obligations outlined in treaties, including general comments focused on particular rights, such as the right to health, through to general guidance on particular themes such as gender and rights of groups such as indigenous populations.[314] They provide the foundations for an ongoing development for such issues.[315] General comments are often drafted by a body of experts, so can reflect the changing landscape and understandings of the issues they raise.[316] They also reflect

[311] Office of the High Commissioner for Human Rights, 'OHCHR Status of Ratification Interactive Dashboard' (n 13).
[312] United Nations, 'UDHR' (n 14); UN General Assembly, 'ICESCR' (n 14).
[313] Philip Alston, 'The General Comments of the UN Committee on Economic, Social and Cultural Rights' (2010) 104 Proceedings of the Annual Meeting (American Society of International Law) 4.
[314] For more information see Office of the High Commissioner for Human Rights, 'Human Rights Treaty Bodies - General Comments' (*UN Human Rights Office of the High Commissioner*, 2019) <https://www.ohchr.org/EN/HRBodies/Pages/TBGeneralComments.aspx> accessed 30 September 2019.
[315] Mátyás Bódig, 'Soft Law, Doctrinal Development, and the General Comments of the UN Committee on Economic, Social and Cultural Rights' in Stéphanie Lagoutte, Thomas Gammeltoft-Hansen and John Cerone (eds), *Tracing the Roles of Soft Law in Human Rights* (Oxford University Press 2016) 70.
[316] ibid.

the periodic reports of countries to the Human Rights Council on their obligations with regards to specific rights,[317] They are used by courts, activists, health policy makers, academics and UN Special Rapporteurs to develop, engage with, advocate for, and implement specific aspects of human rights treaties. [318] For example, the first SRRH, Paul Hunt, reported that the 'process of applying General Comment 14 to specific contexts helped to refine the analytical framework for 'unpacking' the right to health'.[319]

The CESCR provided further interpretive guidance supporting the implementation of the right to health with General Comment 14 in 2000[320] and General Comment 22 in 2016.[321] Representations from international NGOs and UN Organisations, contributions from leading experts, and days of discussion were considered. For example, with General Comment 14, a day of discussion was held, contributions accepted from a range of UN organisations including WHO, draft suggestions from experts such as Brigit Toebes (who had already prepared a conception of such a general comment in her 1999 book *The Right to Health as a Human Right in International Law*) were all brought together and the text drafted and finalised by Eibe Riedel a member of the CESCR and health expert in his own right.[322]

General Comments 14 and 22 have been an important starting point for much scholarly,

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[317] Philip Alston, 'The Historical Origins of the Concept of 'General Comment's in Human Rights Law' in Lawrence Boisson de Chazournes and Vera Golland-Debas (eds), *The International Legal System in Quest of Equity and Universality* (Brill Nijhoff 2021) <https://brill.com/edcollbook/title/10810> accessed 11 November 2023.
[318] Paul Hunt, 'Interpreting the International Right to Health in a Human Rights-Based Approach to Health' (2016) 18 Health and Human Rights 109.
[319] Hunt and Leader (n 295) 31.
[320] UN Committee on Economic, Social and Cultural Rights, 'General Comment 22 ICESCR' (n 18). Thus they are seminal and authoritative documents with significant legal weight,
[321] UN Committee on Economic, Social and Cultural Rights, 'General Comment 14 ICESCR' (n 18).
[322] UN Committee on Economic, Social and Cultural Rights, 'Report on the Twenty-Second, Twenty-Third and Twenty-Fourth Sessions. Supplement No.2' (UNCESCR (UN Committee on Economic, Social and Cultural Rights) 2001) UN Doc E/2001/22-E/C12/2000/21 E/2001/22-E/C.12/2000/21 paras 8, 50, 639 and 640; Brigit CA Toebes, *The Right to Health as a Human Right in International Law* (INTERSENTIA, 1999).

legal and practical work in developing and implementing the right to health.[323] It has been greatly elucidated through the work of the SRRH Professor Paul Hunt (2002–2008), in collaboration with international bodies like the WHO and numerous civil society organisations, and subsequently through the work of Special Rapporteurs Anand Grover and Dainius Pũras.[324] General Comment 14 is frequently referenced in Special Rapporteur reports for the right to health[325] and was crucial to shaping the work of the Special Rapporteur through setting out guiding principles and a basis from which to further develop the right to health.[326] For example, Hunt developed a ten point framework.[327] In turn a UN Common Understanding on a Human Rights-Based Approach for development cooperation situates elements of Hunt's 10 point framework under three broad headings of goal, process and outcome.[328]

1. The holistic nature of health

From its inception the right to health was premised upon a broad understanding of the nature of health, aligned to the WHO Constitution (1946) which conceptualised health as '…a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity.'[329] Whilst the term social determinants of health had not been described at this point, the WHO definition of health was a significant departure

[323] Hunt and Leader (n 295) 30.
[324] UN General Assembly, 'ICESCR' (n 14); UN Committee on Economic, Social and Cultural Rights, 'General Comment 14 ICESCR' (n 18); See Office of the High Commissioner for Human Rights, 'OHCHR | Annual Reports' (2018) <http://www.ohchr.org/EN/Issues/Health/Pages/AnnualReports.aspx> accessed 2 January 2015.
[325] Of 30 SRRH mission reports 18 reference General Comment 14, most often in reports by Hunt and least often in reports by Pũras. 16 other General Comments are referenced from CRC, CEDAW, CAT and HRC – seven of them health-related.
[326] Hunt and Leader (n 295) 30–31.
[327] Paul Hunt and others, 'The Right to the Highest Attainable Standard of Health' in Roger Detels and others (eds), *Oxford Textbook of Public Health* (5th ed, Oxford University Press 2009).
[328] ibid; World Health Organisation and Office of the High Commissioner for Human Rights, 'A Human Rights-Based Approach to Health' <http://www.who.int/hhr/news/hrba_to_health2.pdf> accessed 9 July 2015.
[329] World Health Organisation, 'Constitution of the World Health Organisation' (n 44) Preamble.

from the biomedical model of health that had prevailed as it recognised the multifaceted complexity of the interplay of biological, psychological and social circumstances in the creation of good or poor health.[330] However, the definition was critiqued by many for being unrealistic and unattainable in relation to human rights law.[331] Key questions include how 'complete' might be defined, what is meant by the term 'wellbeing' as opposed to 'health', and how 'social' might be interpreted.

Neither the ICESCR nor General Comment 14 define health or explicitly adopt the WHO definition of health, but health as a human right asserts a similar broad holistic understanding of the nature of health as expressed by the WHO Constitution. The right to health places duties upon States to provide facilities, goods and services to enable all within the States' responsibility to realise the highest attainable standard of health, and to ensure an environment where non-State actors such as communities, families, NGOs, and private businesses can also play their part. Hunt and others explain the right to health in the following way:

> The right of everyone to the enjoyment of the highest attainable standard of health can be understood as a right to an effective and integrated health system, encompassing health care and the underlying determinants of health, which is responsive to national and local priorities, and accessible to all.[332]

Here the right to health is not simply concerned with health *care* but includes all aspects of a health system as an integrated whole. This must therefore include not just treatment aspects of health care but activities that also prevent the conditions that cause ill health, protect people from the risks of ill health, and promote good health.

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[330] Machteld Huber and others, 'How Should We Define Health?' (2011) 343 British Medical Journal d4163, 4163.
[331] See for example, arguments presented in John Tobin, *The Right to Health in International Law* (Oxford University Press 2012) 125–126; Claire Lougarre, 'Clarifying the Right to Health through Supranational Monitoring: The Highest Standard of Health Attainable' (2018) 11 Public Health Ethics 251, 252–253.
[332] Hunt and others (n 330) 347.

In the 1970s, WHO, under the directorship of Halfdan Mahler, began to revitalise its commitment to the right to health.[333] The social embeddedness of health gradually became more accepted, particularly in development circles.[334] Primary Health Care, as opposed to just hospital services, was seen as essential to the advancement of the role of the health sector specifically and to social and economic development in general.[335] This culminated in the historic *International Conference on Primary Health Care* held in Alma Ata in September 1978 and reaffirmed in the *Declaration of Astana Global Conference on Primary Health Care* in 2018.[336] The status of economic, social and cultural rights as fundamental and justiciable rights was challenged on the grounds of their positive nature requiring additional resources and political programmatic action.[337] Thus they were held at this time by many, and particularly by Western States, as less important. Civil and political rights were viewed as immediate rights requiring governments to simply refrain from rights violations and were considered enforceable through the courts. Much legal and scholarly work has successfully discredited this view.[338] What is worthy of note in terms of the social determinants of health is that civil and political rights, as well as other economic, social and cultural rights, are in and of themselves health determinants.[339]

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[333] Alison Snyder, 'Halfdan Mahler' (2017) 389 The Lancet 30.
[334] Virginia A Leary, 'The Right to Health in International Human Rights Law' (1994) Vol. 1 Health and Human Rights.
[335] Snyder (n 336).
[336] World Health Organisation, 'Declaration of Alma Ata' (n 46); World Health Organisation, 'Declaration of Astana Global Conference on Primary Health Care 25-26 October 2018' (World Health Organisation 2018) <https://www.who.int/docs/default-source/primary-health/declaration/gcphc-declaration.pdf> accessed 19 December 2022.
[337] Benjamin Mason Meier, 'The Political Evolution of Health as a Human Right. Conceptualizing Public Health under International Law, 1940s-1990s' in Alex Mold and David Reubi (eds), *Assembling Health Rights in Global Context: Genealogies and Anthropologies* (Routledge 2013).
[338] ibid.
[339] Brownlee (n 95).

The social gradient demands a holistic conception of health. The various explanatory mechanisms discussed in chapter one see health as multifaceted and intersecting, incorporating social, cultural, environmental, psychological, behavioural, physiological and other factors. Social determinants of health, in particular structural determinants that distribute health inequalities, are central to any conception of the social gradient.

2. Social determinants are integral to the right to health

The social determinants of health are central to the right to health yet the social gradient as a social determinant of health is not included. Social determinants of health were incorporated in the right to health from its inception. The UDHR includes several social determinants with the words:

> …everyone has the right to a standard of living adequate for the health and wellbeing of himself *(sic)* and his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age, or other lack of livelihood in circumstances beyond his control.[340]

In this way the right to health clearly refers to certain specified social determinants of health ranging from resources such as food and housing through to determinants including social services and the right to security in the event of certain unfortunate circumstances. Social determinants of health thus need to be an integral part of any action plan to realise the right to health.

General Comment 14 makes multiple references to social determinants (Appendix 8). These were often referred to as ‘underlying determinants’ of health which were often encompassed within the phrase ‘facilities, goods and services’ and were clearly delineated as being:

[340] UN, ‘UDHR’ (n 14).

> …access to safe and potable water and adequate sanitation, an adequate supply of safe food, nutrition and housing, healthy occupational and environmental conditions, and access to health-related education and information, including on sexual and reproductive health…participation of the population in all health-related decision-making at the community, national and international levels.[341]

Other general comments address specified social determinants included in the ICESCR. For example: *General Comment No. 4 (1991) The Right to Adequate Housing (Art. 11(1) of the Covenant)*,[342] and *General Comment No. 15 (2002) The Right to Water (Arts. 11 and 12 of the International Covenant on Economic, Social and Cultural Rights)*.[343] Some address more structural determinants such as *General Comment No. 5 (1994) Persons with Disabilities, General Comment No. 11 (1999) Plans of Action for Primary Education (Article 14 of the International Covenant on Economic, Social and Cultural Rights),* and *General Comment No. 13 (1999) The Right to Education (Article 13 of the Covenant)*.[344] Philip Alston, former Special Rapporteur on extreme poverty, argues that more substantive rights like health and water were addressed in later general comments to allow the committee for ICESCR to first consolidate its role within the human rights system.[345]

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[341] UN Committee on Economic, Social and Cultural Rights, 'General Comment 14 ICESCR' (n 18) paras 11 and 12(a).
[342] UN Committee on Economic, Social and Cultural Rights, 'General Comment No. 4: The Right to Adequate Housing (Art. 11(1) of the Covenant)' (1991) 4.
[343] UN Committee on Economic, Social and Cultural Rights, 'General Comment 14 ICESCR' (n 18) art 11(1); UN Committee on Economic, Social and Cultural Rights, 'General Comment No. 15 (2002) The Right to Water (Arts. 11 and 12 of the International Covenant on Economic, Social and Cultural Rights)' (2002) UN Document E/C12/2002/11 arts 11 and 12.
[344] UN Committee on Economic, Social and Cultural Rights, 'General Comment No. 5: Persons with Disabilities. Eleventh Session (1994)' (1994) UN Doc E/1995/22(SUPP)/4760/E; UN Committee on Economic, Social and Cultural Rights, 'General Comment No. 11 (1999) Plans of Action for Primary Education (Article 14 of the International Covenant on Economic, Social and Cultural Rights)' (1999) UN Doc E/C12/1999/4; UN Committee on Economic, Social and Cultural Rights, 'General Comment No. 13 (Twenty-First Session, 1999) The Right to Education (Article 13 of the Covenant)' (1999) UN Doc E/C12/1999/10.
[345] Alston, 'The General Comments of the UN Committee on Economic, Social and Cultural Rights' (n 316) 5.

Hunt's preliminary report as SRRH in 2003 extends upon General Comment 14 and emphatically includes underlying determinants of health,[346] and his annual reports of September 2005 and August 2007 commented upon meetings with the CSDH.[347] In particular Hunt claimed a 'considerable congruity between the Commission's mandate and the 'underlying determinants of health' dimension of the right to health'.[348] Hunt acknowledges that the development of General Comment 14 was facilitated by a range of other economic, social and cultural factors including for example the growing right to health case law in Latin American countries.[349]

Moreover, the right to health incorporates social determinants of health in law, as attested to by the 445 national, regional and international case summaries with judgements on the right to health provided by the O'Neill Institute *Global Health and Human Rights Database*, and the 1,407 cases therein that deal with health issues include the social determinants of health.[350] The law texts are quite clear that the social determinants of health are intrinsic to an understanding of the right to health.

There is a shift in understanding of underlying determinants in the 16 years between CESCR General Comments 14 and 22. The General Comment 22 in 2016 built upon and advanced features of General Comment 14 and applied them specifically to sexual

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[346] Paul Hunt, 'The Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health. Report of the Special Rapporteur, Paul Hunt, Submitted in Accordance with Commission Resolution 2002/31' (Commission on Human Rights 2003) E/CN.4/2003/58 paras 23, 24, 26, 34, 57, 61, 68.

[347] Paul Hunt, 'Report of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health, Paul Hunt' (UN General Assembly 2005) UN Doc A/60/348 paras 5–7; Paul Hunt, 'Report of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health, Paul Hunt' (UN General Assembly 2007) UN Doc A/62/214 para 8.

[348] Hunt, '2005 Thematic A/60/348' (n 350) para 7.

[349] Hunt, 'Interpreting the International Right to Health in a Human Rights-Based Approach to Health' (n 321) 114.

[350] O'Neill Institute for National and Global Health Law, 'Global Health and Human Rights Database' (*Global Health and Human Rights Database*, 2017) <http://www.globalhealthrights.org/> accessed 13 August 2017.

and reproductive health rights.[351] Significantly section II of General Comment 22 includes both 'underlying' and 'social' determinants of health. This was influenced by the growing discussion and thinking around social determinants of health with for example, the WHO Regional Office for Europe booklets titled *The Solid Facts: The Social Determinants of Health in 1999 and 2003,* the establishment of the CSDH in March 2005[352] and the discussion paper prepared by Solar and Irwin presented at the May 2005 Cairo meeting of the CSDH.[353].[354] Although identified in Marmot's Whitehall studies in the 1970s, notions of the social gradient were in their infancy in the late 1990s and the social gradient did not feature in mainstream debate until the CSDH *Closing the Gap* report. It is therefore not surprising that the social gradient is not mentioned in General Comment 14 as the CSDH report was published some eight years later. But it is remarkable that it is not mentioned in General Comment 22 despite the evident influence of the CSDH report.

The social determinants of health are multiple, interdependent and interrelated. Human rights abuses in terms of the social determinants required for good health (e.g. food, water, shelter, education, employment) contribute to worsening health, and ill health reduces access to not only health care but meaningful utilisation of social determinants (e.g. education, employment, welfare). Social determinants such as nutritious food and the right to food cannot be abstracted from the right to health and reflects the powerful

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[351] UN Committee on Economic, Social and Cultural Rights, 'General Comment 22 ICESCR' (n 18) para 7.
[352] World Health Organisation, 'WHO | Commission on Social Determinants of Health, 2005-2008' (*WHO*, n d) <http://www.who.int/social_determinants/thecommission/en/> accessed 1 August 2019.
[353] Orielle Solar and Alec Irwin, 'A Conceptual Framework for Action on the Social Determinants of Health. A Draft Discussion Paper for the Commission on Social Determinants of Health.' <https://www.who.int/social_determinants/resources/csdh_framework_action_05_07.pdf?ua=1> accessed 1 August 2019.
[354] Michael Marmot, 'The Solid Facts: The Social Determinants of Health' (1999) 9 Health Promotion Journal of Australia 133; Wilkinson and Marmot (n 80).

idea that '[a]ll human rights are universal, indivisible and interdependent and interrelated'.[355]

The concept of prevention in human rights could be viewed as preventing rights violations and that whilst this concept might be inherent in the protect part of 'respect, protect and fulfil' it does not take centre stage. Smith argues that 'there is little evidence that academics consider prevention as a human rights issue, preferring instead to focus upon promotion and protection'.[356] Yet, social determinants of health firmly focus attention on prevention in public health. Human rights violations of all kinds continue in all states and concerted efforts need to be made to prevent them from happening. She argues that mechanisms such as the UN monitoring system, on site visits, UN Special Procedure Mandates, and general data collection are not sufficiently effective as preventive mechanisms and thus a prevention-based approach is required.

Prevention in terms of social determinants of health requires collective action and a nuanced understanding of causation. Both approaches require a more detailed consideration in the right to health.

3. Structural determinants of health

The social gradient is a structural determinant of health as it plays a part in structuring a hierarchy of health inequalities into a stepwise gradient but is not recognised in the ICESCR nor its general comments. However, an understanding of structural determinants as something apart from a general notion of determinants of health can be discerned.

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[355] World Conference on Human Rights, 'Vienna Declaration and Programme of Acion' (1993) para 5 <http://www.ohchr.org/Documents/ProfessionalInterest/vienna.pdf> accessed 28 May 2016.
[356] Rhona Smith, 'Prevention and Human Rights' in Anja Mihr and Mark Gibney (eds), *The SAGE Handbook of Human Rights*, vol 2 (SAGE 2014) 857.

Critics of General Comment 14 claim that it is silent on the more structural determinants of health such as governance, policies and societal values. Kimberley Brownlee, for example, claims that the focus upon availability, accessibility, acceptability and quality naturally turns our attention to the supply of goods and services and thus to health care and to the intermediary determinants of material conditions.[357] Notably the General Comment does not limit itself to biological or physical threats such as lack of food and water, or exposure to diseases and environmental hazards, but also Includes social and economic threats such as lack of education, economic development and health service provision, and importantly raises structural issues such as gender, inequality, culture, violence and conflict.

General Comment 22 refers to CSDH *Closing the Gap,* uses some of the language of that report, and lists key structural determinants as 'social determinants of health'.[358] It makes a much stronger assertion of the relevance and place of structural determinants of health in the right to health. Paragraph 2 of the introduction immediately signals that there are 'numerous legal, procedural, practical and social barriers' that have severely limited full achievement of sexual and reproductive rights for many.[359] Section C that comprises eight elements to paragraph 49 includes core obligations that not only include access to equitable sexual and reproductive health care services and essential medicines but also to 'repeal or eliminate laws, policies and practices that criminalize, obstruct or undermine access' to services. Also required are: to provide sufficient finance to support a transparent and participatory development and implementation of a national action plan, 'legal prohibition of harmful practices and gender-based violence,

[357] Brownlee (n 95) 507.
[358] UN Committee on Economic, Social and Cultural Rights, 'General Comment 22 ICESCR' (n 18) paras 8, Ref 8.
[359] ibid 2.

including female genital mutilation, child and forced marriage and domestic and sexual violence, including marital rape', and effective remedies and redress for violations of the right. Paragraph 8 references the CSDH *Closing the Gap* and provides an extensive list of social determinants including: 'unequal distribution of power based on gender, ethnic origin, age, disability and other factors'; 'social determinants as manifested in laws, institutional arrangements and social practices'; 'systemic discrimination and marginalization'; 'social inequalities', 'income inequality' and 'poverty'.[360]

Poverty, in particular, is recognised as an important structural determinant of health. The CESCR raised serious concerns about poverty which it recognised as both a consequence and cause of ill health.[361] The committee lamented the difficulties of implementing a full enjoyment of the right to health stating that '…the full enjoyment of the right to health still remains a distant goal…especially for those living in poverty, this goal is becoming increasingly remote.'[362] This signals something very important to the structural social determinants of health and that is the issue of poverty, however it may be defined, being a singularly complex and intractable threat to the achievement of health.

4. Understanding causation

Incorporating the social gradient in the right to health requires a clear understanding of causation. The social gradient does not express an individual relationship between causative factors and ill health. Instead, it articulates the distribution of ill health across

[360] ibid 8.
[361] UN Committee on Economic, Social and Cultural Rights, 'Substantive Issues Arising in the Implementation of The International Covenant on Economic, Social and Cultural Rights: Poverty and the International Covenant on Economic, Social and Cultural Rights Statement Adopted by the Committee On Economic, Social and Cultural Rights On 4 May 2001' (2001) UN Doc E/C12/2001/10.
[362] UN Committee on Economic, Social and Cultural Rights, 'General Comment 14 ICESCR' (n 18) s Article 5.

society, within and between countries. It demonstrates an interrelationship between horizonal and vertical inequalities. The explanatory mechanisms articulate a complex interplay of individual and group factors within social systems. Each explanatory mechanism offers points of intervention where different policy actions may help to ameliorate health inequalities.

There is much debate over causation in public health. Multiple causation is a key principle in social epidemiology which underpins public health action.[363] However, a perfect definition of causation is elusive and contested.[364] Oftentimes, it is easier to slip back into dominant public health biomedical, materialist, behavioural and technical paradigms because of a lack of conceptual clarity or lack of careful thought on application.[365] The way epidemiologic theory has grown and developed has important implications for its practice today. In a detailed analysis of the underpinning theoretical frameworks in her field, epidemiologist Krieger takes a critical view of the development of epidemiology and thus public health.[366] Indeed she argues that very little attention is paid to underpinning concepts and theories and provides examples of harm done to individuals and populations because of this failing.[367] Many theories have entered into epidemiology from other fields and bring with them an ontology and epistemology that contain concepts and assumptions which remain untested within their adoptive field.[368] Conceptual and theoretical clarity is also essential for public health practice as Paul Farmer and colleagues have argued: purposive action without careful theoretical

[363] Krieger, 'Epidemiology and the Web of Causation' (n 186).
[364] Parascandola and Weed (n 83).
[365] Krieger, *Epidemiology* (n 38) ch 6.
[366] Krieger, *Epidemiology* (n 38).
[367] ibid 8 Examples include: 1960's use of hormone therapy for menopause as preventive for cardiovascular disease in women based upon low rates of the disease in women seen in epidemiological data; high incidence of diabetes in indigenous peoples being attributed to 'diabetes genes' rather than historical socio-economic structural factors.
[368] ibid 126.

thought leads to unintended negative consequences.[369] More than this Sabina Alkire claims that a 'misconceived theory can kill'.[370]

Human rights have not dealt with causation in a cogent manner. Susan Marks traces an understanding of causation in human rights abuses arguing that a commitment to impartiality and neutrality disconnected abuses from the background contexts in which they were happening.[371] For example, legal systems traditionally wish to identify those accountable for human rights abuses but do not dig any deeper into the social, political, or economic systems that permit such abuses. Yet, she argues, understandings of causation do not reach backwards far enough in the chain of causation with the result that effects are treated as causes. Poverty causes various vulnerabilities and human rights violations but what are the causes of poverty in each context? Where such causes are identified, recommended actions fall far short from dealing with the root causes which lie in social, political, and economic power structures.[372]

If epidemiologic theories are to be incorporated into the right to health, they require careful theoretical thought and application. It will not be enough to simply adopt prevailing paradigms which have failed to address health inequalities. Analysis, using NVivo qualitative data analysis software, reveals that the ICESCR and related general comments rarely expound theories related to causation. General Comment 14 asserts that states cannot 'provide protection against every possible cause of human ill health'.[373] Implying that whilst it recognises multiple causes of ill health and the social

[369] Farmer and others (n 293).
[370] Sabina Alkire, 'A Misconceived Theory Can Kill' in Christopher W Morris (ed), *Amartya Sen* (Cambridge University Press 2010).
[371] Susan Marks, 'Human Rights and Root Causes' (2011) 74 The Modern Law Review 57.
[372] See for example arguments detailed in Samuel Moyn, *Not Enough. Human Rights in an Unequal World* (Harvard University Press 2018) <http://www.hup.harvard.edu/catalog.php?isbn=9780674737563> accessed 11 April 2018.
[373] UN Committee on Economic, Social and Cultural Rights, 'General Comment 14 ICESCR' (n 18) para 9.

determinants of health, it sees them as individual causes in a linear cause and effect process without an overarching understanding of epidemiologic theory.

Epidemiologic theories began to appear at a later stage, though still rarely. For example, the 2013 *General Comment 15 on the Right of the Child to the Enjoyment of the Highest Attainable Standard of Health* of the 1989 *UN Convention on the Rights of the Child* (CRC) devotes a section to the implications of childhood for their life-course into adulthood (section F) and highlights violence as a particular cause of mortality and morbidity in children (section III).[374] The 2016 General Comment 22 of the ICESCR devotes a whole subsection to 'intersectionality and multiple discrimination' highlighting the lack of access to sexual and reproductive health rights through the intersection of a number of factors such as discrimination, trafficking, violence, coercion, lack of legal status, working in the sex industry, and forced pregnancy and sterilisation.[375]

B. The Right to Health is the Right of Everyone

The right to health applies to *everyone* in society within countries and has a global reach. The foundational principle of human rights is that '[a]ll human beings are born free and equal in dignity and rights'.[376] The social gradient tells us that everyone is subject to some degree of health inequalities and have poorer health outcomes than those above them on the gradient. Their right to health is in some way compromised. The principles of equality and non-discrimination in the right to health seek to ensure that everyone does have access to the right.

[374] The United Nations Convention on the Rights of the Child is an international human rights treaty that sets out the social, economic, cultural and civil and political rights of children. UN Committee on the Rights of the Child (n 15).
[375] ibid 30–32.
[376] United Nations, 'UDHR' (n 14) Art. 1.

1. Equality and non-discrimination

Equality and non-discrimination are fundamental cross-cutting human rights principles underlying the right to health. Articles prohibiting discrimination on a variety of grounds can be found in treaties, such as the *Convention on the Elimination of All Forms of Racial Discrimination 1965 (CERD)*, the *Convention of the Elimination of All Forms of Discrimination against Women 1979 (CEDAW), the Convention on the Rights of Persons with Disabilities 2006 (CRPD)*, and in the *International Covenant on Civil and Political Rights 1966 (ICCPR)*.[377] In General Comment 3 the CESCR affirmed a commitment to equality and non-discrimination for all economic, social and cultural rights.[378]

In common with other human rights treaties the ICESCR affirms states must realise rights without discrimination. ICESCR Article 2.2. confirms that:

> The States Parties to the present Covenant undertake to guarantee that the rights enunciated in the present Covenant will be exercised without discrimination of any kind as to race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status.[379]

In Article 3 it also recognises states must ensure the equal right of men and women to the realisation of all the rights set forth in the Covenant.[380]

General Comment 14 particularly highlights women, older persons, children and adolescents, and indigenous populations who may be marginalised or discriminated

[377] United Nations, 'International Convention on the Elimination of All Forms of Racial Discrimination' (n 21); United Nations, 'CEDAW' (n 21); United Nations, 'Convention on the Rights of Persons with Disabilities (CRPD)' (n 15); United Nations, 'International Covenant on Civil and Political Rights (ICCPR)' (n 21).
[378] UN Committee on Economic, Social and Cultural Rights, 'General Comment 3 ICESCR' (n 22) paras 1, 3 and 5.
[379] UN General Assembly, 'ICESCR' (n 14) art 2.2.
[380] ibid 3.

against and asserts their entitlement to all aspects of the right to health.[381] However, the prohibited grounds of discrimination are numerous, broad and not fully conceived, and even include 'other status' in recognition of changes over time in what might constitute discrimination. For example, General Comment 14 states:

> By virtue of article 2.2 and article 3, the Covenant proscribes any discrimination in access to health care and underlying determinants of health, as well as to means and entitlements for their procurement, on the grounds of race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth, physical or mental disability, health status (including HIV/AIDS), sexual orientation and civil, political, social or other status, which has the intention or effect of nullifying or impairing the equal enjoyment or exercise of the right to health.[382]

General Comment 14 links the term equality with non-discrimination, with for example the phrase 'non-discrimination and equal treatment'.[383] Other references to non-discrimination relate largely to access to services[384] but also access to underlying determinants of health[385] including socio-economic factors.[386] In particular, the principle of equal access in relation to the poor, gender equality and other marginalised groups requiring monitoring through the collection of disaggregated data.[387]

The terms 'equality' and 'non-discrimination' have been much debated in human rights. The notion of 'formal equality' arises from Aristotle's formulation of the equal treatment principle whereby likes should be treated alike, whatever the outcome, for example, equal pay for work of equal value when addressing the gender pay gap between men and women.[388] In reality, people are treated differently according to their age in

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[381] UN Committee on Economic, Social and Cultural Rights, 'General Comment 14 ICESCR' (n 18) paras 18–29.
[382] ibid 18.
[383] ibid 18 and 19.
[384] ibid 17, 18, 19, 35, 43, and 52.
[385] ibid 8, 12(b)ii, and 36.
[386] ibid 4 and 9.
[387] ibid 12(b)ii, 16, 21, 34, and 20.
[388] Daniel Moeckli, '8. Equality and Non-Discrimination' in Daniel Moeckli and others (eds), *International Human Rights Law* (3rd edn, Oxford University Press 2017) 149–150 <https://0-www-oxfordlawtrove-

protections of minors, or according to their income for purposes of taxation. Daniel Moeckli argues that in recent years the notion of non-discrimination has come to correspond to the more limited concept of formal equality with the term 'equality' encompassing a more positive approach aimed at substantive equality.[389]

Thus, General Comment 22 calls for substantive equality when discussing the physical accessibility of 'health facilities, goods, information and services' in rural and remote areas, requiring 'positive measures to ensure that persons in need have communication and transportation to such services'.[390] It also warns that '[f]ailure to ensure formal and substantive equality in the enjoyment of the right to sexual and reproductive health constitutes a violation of this right'.[391] However, there are no clarifications or references provided in the footnotes to explain the exact meaning of 'substantive equality' in this instance. This is an important omission given the multiple interpretations of formal and substantive equality.

Sandra Fredman critiques formal equality questioning its underpinning values and its perverse outcomes, and recognising that a merely formal notion of equality as procedural fairness can in fact perpetuate existing patterns of disadvantage.[392] She argues that equality must go beyond consistent treatment of like for like and offers the notion of substantive equality as an analytical framework with four dimensions: 'to redress disadvantage; address stigma, stereotyping, prejudice and violence; enhance voice and participation; and accommodate difference and achieve structural change'.[393]

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com.serlib0.essex.ac.uk/view/10.1093/he/9780198767237.001.0001/he-9780198767237-chapter-8> accessed 23 December 2021.

[389] Moeckli (n 391).

[390] UN Committee on Economic, Social and Cultural Rights, 'General Comment 22 ICESCR' (n 18) para 16.

[391] ibid 55.

[392] Sandra Fredman, 'Substantive Equality Revisited' (2016) 14 International Journal of Constitutional Law 712.

[393] ibid 727–738.

These four dimensions enhance notions of equality and provide a framework to understand inequalities and the points where interventions can make a difference.

However, there is much debate about the use of the term inequality and inequity in public health and the confusion in understandings of these terms between public health and the right to health (see Chapter 1A.2) is echoed in human rights. In an article defining equity in human rights, Braveman and Gruskin argue that equity signals systematic differences or inequalities that are created by unfair social, political, economic or cultural processes and can thus be prevented.[394] Inequalities, on the other hand, may not signal an injustice, such as with the difference in health between a young person and an elderly person. This follows the reasoning proposed earlier by Whitehead and as discussed, requires judgements to be made to determine when an inequality is inequitable. Braveman and Gruskin then contend that '[e]quity is an ethical principle; it is also consonant with and closely related to human rights principles.'[395] The human rights principles of equality and equal rights is 'central and indispensable' to the notion of equity. Where equity requires a judgement which is open to interpretation, equality can be more easily demonstrated, identified and addressed and thus support the implementation of the right to health.

Approaches to understanding equality and non-discrimination in the right to health need to be expanded to accommodate the social gradient and address health inequalities along the whole gradient. It is not enough to treat like as like or to address horizontal inequalities between groups. Fredman's analytic framework recognises the interplay of structural determinants of health such as the social gradient. [396] It incorporates

[394] Braveman and Gruskin (n 63) 254–255.
[395] ibid 254.
[396] Sandra Fredman, Jaakko Kuosmanen and Meghan Campbell, 'Transformative Equality: Making the Sustainable Development Goals Work for Women' (2016) 30 Ethics & International Affairs 177.

explanatory mechanisms for the social gradient such as intersectional perspectives on interlocking disadvantage and the capability approach when discussing women's capability sets and decision making.

2. Right to health as a collective right

The social gradient expresses a collective understanding of health inequalities requiring a collective population-level public health approach to addressing those inequalities. However, human rights have traditionally had an individualist focus.[397] In *Conceptualising a Human Right to Prevention in Global HIV/AIDS Policy* Benjamin Mason Meier states: 'a rights-based focus on access to health services has reduced the unit of analysis to the individual, advancing an individual right at the expense of collective health promotion and disease prevention programmes'.[398] The right to health has not always been viewed as a collective right and alternatives have been proposed.[399] For example, Meier advances collective rights as a solution. Meier and others, in tracing the shift from preventive human rights-based approaches to HIV/AIDs to a treatment focus, explore the failure of litigation and individual rights claims in contributing to a reduction in prevalence of the disease, and emphasise the importance of prevention measures when behavioural, biomedical and structural approaches are delivered as 'combination prevention'.[400] They alert us to the success of collective rights

[397] Chuan-Feng Wu, 'Implications of the Health Equity Perspective for the Right to Health' in Gillian MacNaughton, Diane Frey and Catherine Porter (eds), *Human Rights and Economic Inequalities* (1st edn, Cambridge University Press 2021) 347–348.
[398] BM Meier, KN Brugh and Y Halima, 'Conceptualizing a Human Right to Prevention in Global HIV/AIDS Policy' (2012) 5 Public Health Ethics 263, 269.
[399] See for example, Benjamin Mason Meier and Larisa M Mori, 'The Highest Attainable Standard: Advancing a Collective Human Right to Public Health' (2005) 37 Columbia Human Rights Law Review 101; Benjamin M Meier and Ashley M Fox, 'Development as Health: Employing the Collective Right to Development to Achieve the Goals of the Individual Right to Health' (2008) 30 Human Rights Quarterly 259; Benjamin Mason Meier and Ashley M Fox, 'International Obligations through Collective Rights: Moving from Foreign Health Assistance to Global Health Governance' (2010) 12 Health and Human Rights 61; Meier, Brugh and Halima (n 401).
[400] Meier, Brugh and Halima (n 401) 265.

claims in relation to ‘development, environmental protection, humanitarian assistance, peace and common heritage’ and suggest that such claims have sufficient conceptual power and benefit to develop a collective right to public health goods.[401] What is particularly interesting about this exposition is the way they reframe collective rights holders as including those who are HIV negative, rather than those who as a group have a HIV/AIDS diagnosis. In this way we are required to think about prevention not treatment; to think about how we can support peoples’ ability to keep themselves free of the virus. Meier and others offer a range of public health preventive measures, with a focus on vaccination, to achieve this. What is not clear in this piece is how we should understand the foundations of collective rights of whole populations whose defining feature may simply be an absence of disease.

Yet, the right to health is a collective right not just an individual right. Chapman draws our attention to five dimensions of the right to health that underscore its collective approach.[402] These dimensions include the provision of health services, goods and facilities to communities and populations as core social institutions; a human rights approach which is particularly concerned with vulnerable groups, and people experiencing discrimination by virtue of them belonging to a specific group; processes of participation and empowerment that require bringing people together in a collective to understand and advance their rights; and the risks of pursuing individualistic litigation to obtain access to expensive health goods and services that undermine the collective access to basic provisions for health. In Chapman’s words: ‘an “absolutist focus” on the

[401] ibid 271.
[402] Audrey R Chapman, *Global Health, Human Rights, and the Challenge of Neoliberal Policies* (Cambridge University Press 2016) 55–59.

right to health as an individual right is inimical to addressing population health outcomes, [and] the role of the social determinants of health'.[403]

The collective approach needs to be strengthened in the right to health and there are examples across the globe where this is happening. Daniel Brinks and Varun Gauri found that in both India and South Africa pro-poor policies, collective litigation (such as with school dinners in India), and the organisational power of NGOs (such as with HIV/AIDS in South Africa) ensured the benefits, whoever the litigant, were felt across the population.[404] Civil society movements across the globe have challenged the discourse around individualisation of mental ill health and disability.[405] The Latin American Collective Health movement has a long tradition of social activism and social participation whereby personal needs and those of a community mutually reinforce each other in the attainment of collective health rights, particularly in terms of mental health.[406]

3. Horizontal and vertical inequalities in the right to health

The right to health is clearly concerned with inequalities in health. Braveman and Gruskin explore the concept of equity as both an ethical principle and a human rights principle, that 'equity means social justice' and 'social justice is a matter of human rights'.[407] They define equity in health as 'the absence of disparities in health (and in its key social determinants) that are systematically associated with social advantage/disadvantage'.[408] Thus, human rights that specifically address the needs of

[403] ibid 258.
[404] Daniel M Brinks and Varun Gauri, 'The Law's Majestic Equality? The Distributive Impact of Judicializing Social and Economic Rights' (2014) 12 Perspectives on Politics 375.
[405] Audrey R Chapman and others, 'Reimagining the Mental Health Paradigm for Our Collective Well-Being' (2020) 22 Health and Human Rights 1.
[406] Sara Ardila-Gómez and others, 'The Mental Health Users' Movement in Argentina from the Perspective of Latin American Collective Health' (2019) 14 Global Public Health 1008, 1008.
[407] Braveman and Gruskin (n 63) 254.
[408] ibid 256.

the disabled, of women and children, indigenous peoples and migrants have a special role to play in promoting access to social determinants of health. The CSDH report *Closing the Gap* provides clear evidence of the negative impact of discrimination upon health and suggests discrimination is a structural determinant of health. Consequently, it is important to address horizontal health inequalities because they signal discrimination.

Human rights have focused largely on non-discrimination or horizontal inequalities. As described above international human rights law includes non-discrimination on the grounds of a broad range of factors in every treaty with specific treaties focusing upon the elimination of discrimination on the grounds of race, gender and disability.[409] In this way the international human rights community has focused almost exclusively on horizontal inequality to the detriment of attention upon vertical inequalities.[410]

Despite their early predominance in development circles, vertical inequalities have 'yet to be addressed in human rights law'.[411] The Agenda 2030 goal of ending extreme poverty by 2030 is challenged by increasing levels of vertical inequality, and whilst human rights have much to offer the Sustainable Development Goals (SDGs) in terms of understanding horizontal inequalities they provide little to help with vertical inequalities.[412] In a 2017 paper, Gillian MacNaughton asked whether the SDGs and human rights were up to the challenges of vertical inequalities.[413] She builds a compelling case based upon a range of evidence that vertical inequalities are an

[409] MacNaughton (n 125) 1064.
[410] Gaby Ore Aguilar and Ignacio Saiz, 'Introducing the Debate on Economic Inequality: Can Human Rights Make a Difference?' (*openDemocracy*, 2015) <https://www.opendemocracy.net/en/openglobalrights-openpage/introducing-debate-on-economic-inequality-can-human-ri/> accessed 10 October 2020; Ignacio Saiz, 'Economic Inequality and Human Rights: Towards a More Nuanced Assessment' (*Center for Economic and Social Rights*, 26 April 2018) <https://cesr.org/> accessed 21 December 2021.
[411] MacNaughton (n 125) 1051.
[412] ibid 1054.
[413] MacNaughton, 'Vertical Inequalities' (n 272).

essential component of human rights concluding with an exhortation for the human rights community to act on vertical inequalities:

> From a human rights perspective, vertical inequalities of income and wealth impact negatively on a wide range of economic, social, cultural, civil and political rights. In short, extreme vertical inequalities are detrimental to realising human rights.[414]

It is not only that vertical inequalities evidence unfair and unjust differences in income but also in wealth. Wealth inequality goes beyond income to include financial assets such as savings, stocks and shares, property, pension rights, and other assets. Inequalities in income and wealth have important consequences relevant to human rights. If the gross national income for each country was evenly distributed across the globe, then each and every person could be lifted out of poverty.[415] In unequal societies with more extreme differences between rich and poor, those with greater wealth have access to greater political power, greater influence upon institutions including policy makers, and greater privileges to be able to ensure their position is maintained. 'The unequal distribution of wealth tends to cause the unequal distribution of political power.'[416] Furthermore, drawing upon the work of Wilkinson and Picket,[417] MacNaughton argues that higher levels of income inequality within a country result in higher levels of violent crime, homicide rates, greater prevalence of depressive disorders, higher levels of discrimination and racism, increased numbers of teen pregnancies and a larger prison population disproportionate to population size.[418] She is careful to point out that this affects everyone in society – all of us on the social gradient not just the poor. Greater economic inequality reduces trust, public participation,

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[414] ibid 1055.
[415] MacNaughton, 'Vertical Inequalities' (n 272) 1052.
[416] MacNaughton, 'Vertical Inequalities' (n 272) 1055.
[417] Richard G Wilkinson, *The Impact of Inequality: How to Make Sick Societies Healthier* (1 edition, Routledge 2005); Pickett and Wilkinson (n 59).
[418] MacNaughton, 'Vertical Inequalities' (n 272) 1054–1055.

collaboration and social cohesion and increases segregation, division, social instability, and potentially civil unrest which affects all in society.

More than these instrumental reasons however, MacNaughton argues that there is an intrinsic value to the notion of equality as it is a matter of social justice. Extreme inequalities in income and wealth have been termed 'alarming, intolerable and obscene'.[419] If discrimination and thus horizontal inequalities are a matter of social justice then so are vertical inequalities. Inequalities are important to human rights. Philip Alston, former UN Special Rapporteur on Extreme Poverty and Human Rights asserted that '[i]t must be accepted that extreme inequality and respect for the equal rights of all persons are incompatible.'[420] Social and economic inequalities are still to be addressed if the right to health is to reduce the social gradient itself. In the words of Alicia Ely Yamin:

> It is essential for the human rights community to grapple with what is normatively acceptable in terms of a social gradient and with the trade-offs to be made in moving in that direction.[421]

Here Yamin is referencing socio-economic inequalities and the 'case for income inequality from public health' but is drawing upon Wilkinson and Picket's psycho-social explanations for the societal impacts of extreme inequalities in income and wealth.[422] The social gradient is articulating much more than inequalities of income and wealth as it can be demonstrated for other factors (see Chapter1C.3). It also emphasises the interrelationship of horizontal and vertical inequalities with such explanatory mechanisms of intersectionality and the capability approach.

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[419] MacNaughton, 'Vertical Inequalities' (n 272) 1054.
[420] Alston, '2015 Thematic A/HRC/29/31' (n 30) para 49.
[421] Yamin, *Struggle for Dignity* (n 1) 195.
[422] ibid 194–195.

Concluding Comments

From the start the right to health has demonstrated a clear engagement with the social determinants of health within a holistic understanding of physical and mental health. A distinct category of social determinants as being structural or root causes has developed over the last two decades, particularly following the CSDH report *Closing the Gap* with its own delineation of intermediary and structural causes. Whilst intersectionality and the life-course approach are referenced, the mechanisms by which social determinants impact health and notions of causation are poorly understood.

There is no engagement with social gradient health inequalities in right to health treaties and general comments. The centrality of the principles of equality and non-discrimination skewed attention towards horizontal inequalities to the detriment of action on socio-economic or vertical inequalities, and health inequalities articulated by the social gradient are entirely missed.

The social gradient is an important concept in public health that is ubiquitous and can be demonstrated across and within countries, and between and within different groups. How inequalities are framed and understood determines what action can be taken and what policies are developed. Given that much action on health inequalities has failed significantly, as evidenced by widening inequalities and further exacerbated by the Covid-19 pandemic, we ignore the social gradient at our peril.[423]

The following chapter considers whether the right to health acts on social gradient inequalities even without any conceptual framework to guide an understanding of the social gradient or any engagement with social gradient inequalities in foundational right to health treaties and general comments.

[423] Venkatapuram, 'Social Gradient in Capabilities' (n 12) 555.

Chapter 4. Acting on the Social Gradient in Special Rapporteur Reports on the Right to Health

The social gradient is an important concept in public health as it articulates a fourth dimension in health inequalities that interrelates horizontal and vertical health inequalities within and between countries. Yet conceptually the social gradient lacks clarity in both public health and therefore also in the right to health. The right to health unequivocally incorporates the social determinants of health as a central feature but does not engage with the social gradient as a social determinant of health. The question for this chapter is to what extent the implementation of the right to health incorporates action on the social gradient. To answer this question this chapter examines the work of the Special Rapporteurs on the right to health (SRRH) (2002–2020) who have played an important role in unpacking, explaining, advocating for and implementing the right to health.

This chapter begins by explaining the role of the SRRH and then outlines how the analysis of the reports was undertaken. To my knowledge, the reports of the SRRH have not been studied as a whole body of literature in a systematic way to address a public health question. Nor has there been any systematic analysis of the concept of the social gradient in the right to health. Using Graham's policy analysis matrix, the chapter then evaluates whether the recommendations, themes and contents of the SRRH reports focus action on poverty, the gap between groups, or social gradient health inequalities.

A. The Special Rapporteur on the Right to Health

The 1967 Economic and Social Council Resolution 1235 (XLII) provided the legal basis for the establishment of the Special Procedures which authorised the Commission on Human Rights to 'examine information relevant to gross violations of human rights and

fundamental freedoms'.[424] Prior to this the Commission on Human Rights did not have any power to act on complaints of violations of human rights. With initial mechanisms focused on countries, the first thematic Special Rapporteur mandate was established in 1982 by the Commission on Human Rights to address Extrajudicial Executions. The first ESCR mandate on education in 1998 was quickly followed by others including, poverty, food, development, structural adjustment, housing and then health in 2002.[425] As of 1st October 2022, the Office of the United Nations High Commissioner for Human Rights (OCHCR) website lists 45 thematic mandates and 14 country mandates, of which 43 of these are Special Rapporteurs.[426]

The Human Rights Council's Special Procedures mandate holders include Special Rapporteurs, Independent Experts, and Working Groups who all contribute to the development or global oversight of human rights standards for particular thematic issues or oversight of particular country situations.[427] Special Procedures mandate holders help to: interpret norms and standards for human rights; undertake thematic and technical studies in collaboration with other experts; conduct fact finding missions to countries; receive petitions and send communications to states and non-state actors regarding allegations of human rights abuses; provide human rights advocacy through public and press statements, and report to the Human Rights Council.[428] UN Secretary-

[424] Marc Limon and Hilary Power, 'History of the United Nations Special Procedures Mechanism. Origins, Evolution and Reform' (Universal Rights Group 2014) 4 <https://www.universal-rights.org/wp-content/uploads/2015/02/URG_HUNSP_28.01.2015_spread.pdf> accessed 17 February 2023.
[425] Theodore J Piccone, *Catalysts for Change: How the UN's Independent Experts Promote Human Rights* (Brookings Institution Press 2012) 14.
[426] Office of the High Commissioner for Human Rights, 'Current and Former Mandate Holders (Existing Mandates)' (*OHCHR*, 2022) <https://www.ohchr.org/en/special-procedures-human-rights-council/current-and-former-mandate-holders-existing-mandates> accessed 11 February 2023.
[427] UN Human Rights Council, 'What Is the Human Rights Council?' <https://www.ohchr.org/Documents/HRBodies/HRCouncil/HRC10/Leaflet.pdf> accessed 27 November 2018.
[428] Office of the High Commissioner for Human Rights, 'OHCHR | HRC Special Procedures (Human Rights Experts)' (2018) <https://ohchr.org/EN/HRBodies/HRC/Pages/SpecialProcedures.aspx> accessed 1 April 2019.

General Kofi Annan referred to the 'indispensable role' of Special Rapporteurs 'as front-line protection actors' and described them as 'the crown jewel' of the UN human rights system.[429]

In 2002, the UN Commission on Human Rights established a new 'special procedure' appointing a United Nations Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health (Special Rapporteur on the right to health or Special Rapporteur) with an independent mandate to support States with the implementation of the right to health.[430] Special Rapporteurs on the right to health publish thematic reports, country reports and 'communications' (letters of complaint), and report directly to the General Assembly and Human Rights Council (previously Commission).[431] The Special Rapporteurs on the right to health include: Professor Paul Hunt 2002–2008, Mr Anand Grover 2008–2014, Mr Dainius Pũras 2014–2022 and Dr Tlaleng Mofokeng 2022–present.[432]

The SRRH has a unique insight into the intersections between the disciplines of human rights and public health. The role of the SRRH is to: gather information, develop dialogue and report on the status of the right; make recommendations to advance and promote the right; clarify the 'contours and content' of the right in legal terms: and to identify and share good practice in operationalising the right to health.[433] Demonstrating how the right to health could be operationalised and applied in health care, public policy

[429] United Nations, 'Secretary General, in Message to Human Rights Council, Cautions Against Focusing on Middle East at Expense of Darfur, Other Grave Crises | Meetings Coverage and Press Releases' (29 November 2006) <https://www.un.org/press/en/2006/sgsm10769.doc.htm> accessed 17 December 2018.
[430] Office of the High Commissioner for Human Rights, 'The Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health. Commission on Human Rights Resolution 2002/31' (2002) UN Doc E/CN4/RES/2002/31.
[431] Hunt and Leader (n 295).
[432] The work of Dr Tlaleng Mofokeng will not be addressed in this thesis as it post-dates the original report analysis.
[433] Paul Hunt, 'The UN Special Rapporteur on the Right to Health: Key Objectives, Themes, and Interventions' (2003) 7 Health and Human Rights 1.

and public health practice is a distinctive feature of the work of the SRRH.[434] Hunt observes that high-level treaties and interpretive documents such as the ICESCR, general comments, Special Rapporteur reports and case law may be difficult to interpret for health practitioners delivering health interventions and services on the ground.[435] Operationalisation of the right to health could only be achieved through inclusivity of and collaboration with ministries of health, public health practitioners, health workers, and civil society, along with the WHO and other UN bodies.[436] Special Rapporteurs also make strenuous efforts to meet with and listen to the individuals and groups most affected by human rights violations and the impact of policy and legal processes, including the most marginalised and disadvantaged.[437] This process of listening and cooperating with health workers, as well as rights holders, has greatly influenced the SRRH mandate and helped to elucidate the content and scope of the right.[438]

Furthermore, the work of the SRRH is selected because it can be influential in bringing about change. It might result in 'human rights standard setting, the adoption of a resolution or a declaration by the UN General Assembly', or the development of an international instrument or law.[439] Their work is cited by a range of actors including 'national and international courts and tribunals, civil society organizations, development partners or donor agencies, academics, researchers, human rights defenders, and

[434] Hunt and Leader (n 295) 29.
[435] Hunt, 'Interpreting the International Right to Health in a Human Rights-Based Approach to Health' (n 321).
[436] UN Committee on Economic, Social and Cultural Rights, 'General Comment 14 ICESCR' (n 18); Hunt and Leader (n 295) 29; Brigit Toebes, 'Health and Human Rights: In Search of the Legal Dimension' (2015) 9 Hum. Rts. & Int'l Legal Discourse 212; Thérèse Murphy and Amrei Müller, 'The United Nations Special Procedures Peopling Human Rights, Peopling Global Health' in Benjamin Mason Meier and Lawrence O Gostin (eds), *Human Rights in Global Health: Rights-Based Governance for a Globalizing World* (Oxford University Press 2018) 499.
[437] Hunt and Leader (n 295) 30.
[438] Murphy and Müller (n 439) 494.
[439] Surya P Subedi, 'The UN Human Rights Special Rapporteurs and the Impact of Their Work: Some Reflections of the UN Special Rapporteur for Cambodia' (2016) 6 Asian Journal of International Law 1, 3.

governments…and used by prosecutors in international criminal courts.'[440] Some Special Rapporteur reports have created extensive media coverage and raised concerns in governments, have been taken up by a range of actors, and played an important role in agenda setting.[441] A wide variety of national and international NGOs and health bodies have utilised the work of the Special Rapporteurs to develop guidelines and to support programmatic interventions and policies.[442]

B. Analysis of Special Rapporteur Reports

This section describes and explains the approach to the analysis of the Special Rapporteur reports and presents a summary of the findings using diagrammatic and verbal methods.

1. Special Rapporteur mission and thematic reports

The 32 mission reports (Appendix 9) following country visits were analysed as these provide valuable insights into the relationship between public health and the right to health for a wide range of issues in diverse contexts. Special Rapporteurs carry out country visits to assess the situation of human rights for their mandate at the national level.[443] Recommendations for action on rights issues may have considerable impact on triggering policy action for improvement in health at the government and ministry level. They can galvanise civil society to follow up on actions required and raise awareness of

[440] ibid.
[441] Philip Alston, 'Hobbling the Monitors: Should U.N. Human Rights Monitors Be Accountable?' (2011) 52 Harvard International Law Journal 563, 577.
[442] See for example Hunt, 'Interpreting the International Right to Health in a Human Rights-Based Approach to Health' (n 321); Judith Paula Asher, *The Right to Health: A Resource Manual for NGOs* (Martinus Nijhoff Publishers 2010); Actionaid Country Office, Pakistan, 'Actionaid Pakistan HRBA Training Report' (Actionaid 2012) <http://www.actionaid.org/sites/files/actionaid/actionaid_pakistan_hrba-tot_report_1.pdf> accessed 22 November 2018.
[443] OHCHR (Office of the High Commissioner for Human Rights), 'OHCHR | Country and Other Visits of Special Procedures' (2019) <https://www.ohchr.org/EN/HRBodies/SP/Pages/CountryandothervisitsSP.aspx> accessed 7 January 2020.

human rights in the population more broadly.[444] The 39 thematic reports provide a useful backdrop to the development of the right to health with more detailed analysis of specific issues and are used as a counterpoint to the analysis of country reports in this thesis. The thematic reports of the SRRH have unpacked topics as diverse as right to health indicators, poverty, health systems, guidelines for pharmaceutical companies, occupational health, development and human rights, health system financing, drug control, sports and healthy lifestyles, and mental health, which are all examined through the lens of the right to health.[445] Interviews with Special Rapporteurs and their researchers were undertaken to check interpretations and conclusions, and to extend the discussion into an exploration of potential areas for action.

2. The Framework Method

The Framework Method of qualitative data analysis was developed for applied social policy research in the 1980s by Jane Ritchie and Liz Spencer from the UK National Unit of Social Research, and has increasingly been adopted in health research more broadly.[446] It sits within an overarching content analysis approach.[447] The Framework Method is not aligned to any particular epistemological perspective or theoretical

[444] Alston, 'Hobbling the Monitors' (n 444) 576; Subedi (n 442).
[445] OHCHR (Office of the High Commissioner for Human Rights), 'OHCHR | Annual Reports to the Human Rights Council' (2019) <https://www.ohchr.org/EN/HRBodies/SP/Pages/AnnualreportsHRC.aspx> accessed 7 January 2020.
[446] Ritchie and Spencer (n 27); Robyn Smyth, 'Exploring the Usefulness of a Conceptual Framework as a Research Tool: A Researcher's Reflections' (2004) 14 Issues In Educational Research; Aashish Srivastava and S Bruce Thomson, 'Framework Analysis: A Qualitative Methodology for Applied Policy Research' (2009) 4 8; Joanna Smith and Jill Firth, 'Qualitative Data Analysis: Application of the Framework Approach' (2011) 18 Nurse Researcher 52; Deborah J Ward and others, 'Using Framework Analysis in Nursing Research: A Worked Example' [2013] Journal of Advanced Nursing 2423; Nicola K Gale and others, 'Using the Framework Method for the Analysis of Qualitative Data in Multi-Disciplinary Health Research' (2013) 13 BMC Medical Research Methodology 117; Parkinson and others (n 227); Hackett and Strickland (n 227).
[447] Gale and others (n 449).

approach.[448] Moreover, it can be adapted for use with both an inductive analysis as required in qualitative studies or a deductive analysis, such as that in epidemiology.[449] It additionally permits the depiction of quantitative aspects of the data in terms of frequencies which may make it useful for more quantitative approaches.[450] This provides a useful means for this thesis to research across and appeal to the two disciplines of public health and human rights, and to develop an interdisciplinary method.

The Framework Method is characterised by a series of six steps including: familiarisation with the reports; coding, indexing and sorting data; the development of an analytical framework matrix with summaries of the data within each cell of the matrix; developing categories; abstracting themes; followed by interpretation (Appendix 10).[451] This provides a systematic structure to a comprehensive analysis of the data, affording greater transparency, robustness and rigour with its step by step approach to the analysis and visualisation of the data.[452] A key feature of the Framework Method is the development of a framework matrix generated by codes in columns and cases in rows, which is useful for the analysis of more structured interview and other data (examples of coding processes can be found in Appendix 11 and Appendix 12).[453] This permitted easy within case and across case analysis important to revealing the emergence of ideas and concepts over time and between mandates in the SRRH reports. It provided a means to visualise emerging themes for a thematic analysis and look at each individual

[448] ibid; Hackett and Strickland (n 227); Liz Spencer and others, 'Analysis: Principles and Processes' in Jane Ritchie and others (eds), *Qualitative Research Practice: A Guide for Social Science Students and Researchers* (Second edition, SAGE Publications Ltd 2014).
[449] Gale and others (n 449); Hackett and Strickland (n 227).
[450] Spencer and others (n 451) 274–275.
[451] Spencer and others (n 451).
[452] ibid; Gale and others (n 449); Hackett and Strickland (n 227).
[453] Hackett and Strickland (n 227) 2.

report for within case analysis.[454] NVivo 12 Plus software was utilised for the analysis of the SRRH reports because it embeds the framework matrix as a tool, which helped to facilitate the management of long report transcripts.[455]

3. Interviews and ethical considerations

Documentary research is perceived to have less severe consequences to individuals as compared to biomedical research undertaken with patients or social research with end users of health and social care services. However, it is essential to uphold the four basic prima facie tenets for health research: autonomy (avoiding deceit on the purpose of the research, ensuring all work is the author's own); beneficence (ensuring the research brings benefit); non-maleficence (informed consent and confidentiality and preventing harm); and justice. The analysis was reported and details of the processes applied were recorded in NVivo for auditability, and were password secured.

Interviews with Special Rapporteurs and members of their research and report writing teams were undertaken following the analysis of the reports to be able to check interpretations and provide additional context. University of Essex ethical clearance was secured prior to the interviews, and standard research protocols followed to reduce the possibility of harm arising from comments and opinions (Appendix 13). The Special Rapporteurs agreed to be quoted in-person, but numbers were allocated to all respondents and the comments of researchers were anonymised. However, given that the comments relate to a specific set of reports or a particular time in the history of the SRRH it may still be possible to discern their source.

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[454] Ward and others (n 449); Spencer and others (n 227); Parkinson and others (n 227); Hackett and Strickland (n 227).

[455] QSR International, 'Data Analysis Software for Academic Research | NVivo' (2021) <https://www.qsrinternational.com/nvivo-qualitative-data-analysis-software/about/nvivo/who-its-for/academia> accessed 16 January 2021.

4. Mapping the content of the reports – visualising the data

Heat mapping following a method used by Kynoch and colleagues portrays the strength of areas of engagement and action on social gradient allied concepts in the reports.[456] The heat map depicts the frequency with which key issues and concepts appeared in the data: the darker the hexagon the more frequently that issue or concept is discussed (Figure 4). Blue hexagons correspond to health care provision, green to the terminology for and concepts related to the social gradient and social determinants of health, and maroon to key actions and recommendations.

The social gradient was not explicitly mentioned in any mission reports. There were only six occasions where the social gradient was hinted at, perhaps indicating some engagement with the notion of a gradient in health outcomes. For example, Hunt's 2010 India mission report mentions the lowest wealth quintile where illiterate mothers have less access to basic maternal health care.[457] Grover's 2011 Guatemala report identifies the 'lowest two quintiles' in the national survey of living conditions as having poor access to health care.[458] He also makes a comparison between the lowest and highest quintiles of children and vaccination coverage in his Azerbaijan report.[459] Pūras compares child mortality rates between highest and lowest quintiles in the 2019 Kyrgyzstan report.[460]

[456] Kynoch and others (n 28).
[457] Paul Hunt, 'Report of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Health, Paul Hunt. Mission to India' (Human Rights Council Fourteenth session 2010) UN Doc A/HRC/14/20/Add.2 para 36.
[458] Anand Grover, 'Report of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health, Anand Grover. Mission to Guatemala' (Human Rights Council Seventeenth session 2011) UN Doc A/HRC/17/25/Add.2 para 48.
[459] Anand Grover, 'Report of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health, Anand Grover Addendum Mission to Azerbaijan (16–23 May 2012)' para 5.
[460] Dainius Pūras, 'Report of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health. Visit to Kyrgyzstan' (Human Rights Council Forty-first session 2019) UN Doc A/HRC/41/34/Add.1 para 15.

All mission reports addressed issues of health inequalities as a central concern across a wide range of different topics. The topics did not determine whether or not the social gradient might or might not be included.

A range of topics are included because each mission would have a particular focus depending upon the specific health profile in the country visited and the expertise of the Special Rapporteur. So, for example, Hunt's 2005 mission to Uganda focused upon neglected diseases, Grover's 2009 mission to Australia upon the plight of indigenous peoples and detention, and Pũras' 2016 mission to Nigeria addressed concerns with regards to the rehabilitation and reintegration of women and children liberated from Boko Haram captivity.[461] Moreover, the particular interests of the Special Rapporteurs reflected both their expertise and priorities of their mandate. Hunt's 2003 preliminary report, as the first of the mandate identified broad objectives to promote the right to health.[462] As a lawyer, Grover often addressed topics of criminalisation of sex work or drug use as can be seen for example in his 2010 mission report to Poland, and his 2012 mission to Vietnam.[463] Pũras, as a psychiatrist, was greatly interested in the right to mental health and child and adolescent health, community based mental health services and the promotion and protection of positive mental health (Appendix 9).

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[461] Paul Hunt, 'Report of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health, Paul Hunt. Mission to Uganda' (Commission on Human Rights Sixty-second session 2006) UN Doc E/CN.4/2006/48/Add.2; Anand Grover, 'Report of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health, Anand Grover Addendum Mission to Australia'; Dainius Pũras, 'Report of the Special Rapporteurs on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health, on the Sale of Children, Child Prostitution and Child Pornography and on Contemporary Forms of Slavery, Including Its Causes and Consequences, on Their Joint Visit to Nigeria' (Human Rights Council Thirty-second session 2016) UN Doc A/HRC/32/32/Add.2.

[462] Hunt, '2003 Prelim E/CN.4/2003/58' (n 349).

[463] Anand Grover, 'Report of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health, Anand Grover Addendum Mission to Poland'; Anand Grover, 'Report of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health, Anand Grover Addendum Mission to Viet Nam' (UN Human Rights Council Twentieth session 2012) A/HRC/20/15/Add.2.

Unsurprisingly, resolving problems in health care provision was frequently raised in all the SRRH reports, with a particular focus on improving access to health care, elements of availability, accessibility, acceptability and quality (AAAQ), and health systems.

Given that there was no explicit or implicit inclusion of the social gradient, the reports were searched for specific references to structural determinants of health inequalities, socio-economic inequalities (as these are often used as a proxy for the social gradient), and public health explanatory mechanisms for the social gradient.

Socio-economic status or position was mentioned occasionally but often in relation to poverty, not the social gradient, nor to wealth which creates the steepness of the gradient. Only four of Hunt's eleven mission reports contained any reference to socio-economic status,[464] socio-economic groups,[465] or socio-economic consequences.[466] Yet, he was mindful of socio-economic issues as evidenced most notably in his 2006 thematic report on human rights indicators where he advocates for disaggregated data on the basis of socio-economic status as well as other group identification in order to be able to identify socio-economic inequalities in health outcomes.[467]

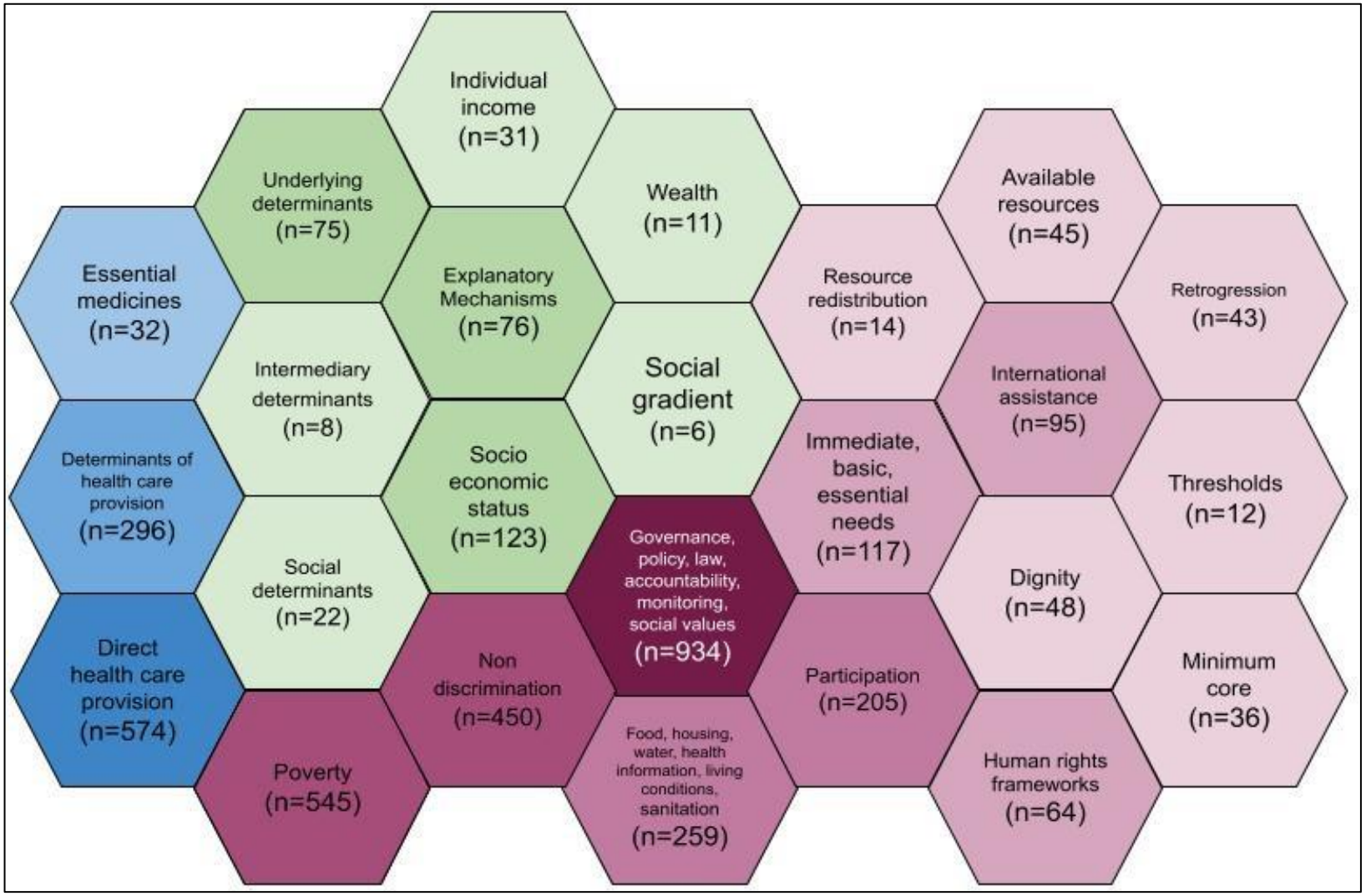
[464] Paul Hunt, 'Report Submitted by the Special Rapporteur on the Right of Everyone to the Highest Attainable Standard of Physical and Mental Health, Paul Hunt. Mission to Peru' (Commission on Human Rights Sixty-first session 2005) UN Doc E/CN.4/2005/51/Add.3 24 and 81; Paul Hunt, 'Report of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health, Paul Hunt Mission to Sweden' (Human Rights Council Fourth session 2007) UN Doc A/HRC/4/28/Add.2 117.

[465] Paul Hunt, 'Report of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Health, Paul Hunt Annex Mission to GlaxoSmithKline' (UN Human Rights Council Eleventh session 2009) UN Doc A/HRC/11/12/Add2 A/HRC/11/12/Add.2 61 and 64.

[466] Hunt, '2006 Uganda E/CN.4/2006/48/Add.2' (n 464) para 50.

[467] Paul Hunt, 'Report of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health, Paul Hunt' (UN Commission on Human Rights Sixty-second session 2006) UN Doc E/CN.4/2006/48 paras 34, 49(b) and 66(b).

Figure 4 **Heat map of intensity of coding Special Rapporteur mission reports.**



Five of the nine mission reports by Grover address socio-economic issues but related mainly to access to maternal health services. For example, the 2012 Ghana report requires consideration of the socio-economic determinants of access to maternal health care,[468] and the 2010 Poland mission report conveys concern that the revocation in law of socio-economic grounds for the termination of pregnancy was resulting in dangerous clandestine abortions.[469] More often the mention of socio-economic factors is in relation to data collection as in Pũras' Algeria, Indonesia, Kyrgyzstan and Canada reports,[470] or general actions to consider 'socio-economic, cultural and environmental factors' as in Pũras' Paraguay, Algeria, Croatia, and Indonesia reports.[471]

Actions on, what might now be termed, the structural determinants of health are all pervasive in the reports and represent a deep concern with what are now understood to be the social structures that contribute to the social gradient. The SRRH mission reports include action on many of these: for example, to develop and implement a strategic plan and coherent intersectoral policy framework to realise the right to health; introduce new legal and regulatory frameworks or rescind discriminatory laws; ensure community and

[468] Anand Grover, 'Report of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health, Anand Grover Mission to Ghana' (Human Rights Council Twentieth session 2012) UN Doc A/HRC/20/15/Add.1 paras 31 and 37.
[469] Grover, '2010 Poland A/HRC/14/20/Add.3' (n 466) para 83.
[470] Dainius Pũras, 'Report of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health, Dainius Pũras on His Visit to Algeria' (UN Human Rights Council 2017) UN Doc A/HRC/35/21/Add.1 para 35; Dainius Pũras, 'Report of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health, Dainius Pũras, on His Mission to Indonesia' (UN Human Rights Council 2018) UN Doc A/HRC/38/36/Add.1 para 40; Pũras, '2018 Kyrgyzstan A/HRC/41/34/Add.1' (n 463) para 26; Dainius Pũras, 'Report of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health. Visit to Canada' (Human Rights Council Forty-first session 2019) UN Doc A/HRC/41/34/Add.2 para 10.
[471] Dainius Pũras, 'Report of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health on His Visit to Paraguay' (Human Rights Council Thirty-second session 2016) UN Doc A/HRC/32/32/Add.1 para 130; Pũras, '2017 Algeria A/HRC/35/21/Add.1' (n 473) para 126; Dainius Pũras, 'Report of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health, Dainius Pũras on His Visit to Croatia' (Human Rights Council Thirty-fifth session 2017) UN Doc A/HRC/35/21/Add.2 para 116; Pũras, '2018 Indonesia A/HRC/38/36/Add.1' (n 473) para 126.

civil society participation in policy planning and implementation of health-related services; utilise technical and financial international assistance to realise recommended actions; and address inequalities. The most important structural determinants of health addressed in the SRRH mission reports were discrimination (and related stigma, inclusivity, gender equality) and poverty (and related marginalisation).

Oftentimes the SRRH use the term underlying determinants and in later reports they use this term interchangeably with social determinants. Over time the mission reports have become more expansive with regard to what 'underlying determinants' should include. This gradual expansion of underlying determinants comes to encompass 'social' determinants of health. From the outset Hunt in his 2005 report linked underlying determinants with the CSDH anticipating 'scientific evidence on social mechanisms that shape health' and noting 'considerable congruity between the commission's mandate and underlying determinants'.[472] This was carried forward in Hunt's 2006 report where underlying determinants specifically incorporate social determinants of health as espoused by CSDH.[473] Grover takes up this theme in his 2013 thematic report on conflict: 'The right to health framework comprises a range of socio-economic aspects, termed as underlying determinants such as nutritious food, […] and situations of violence and conflict.'[474] An extensive range of underlying determinants of adolescent mental health are listed in a 2016 thematic report by Pũras:

> States must take legal, policy and other measures to address the underlying and social determinants of adolescent health, including: road and environmental safety; racial prejudice; access to education; persistence of forced and early marriage; corporal punishment; social, economic, political, cultural and legal barriers to health services, including

[472] Hunt, '2005 Thematic A/60/348' (n 350) para 6.
[473] Hunt, '2006 Thematic E/CN.4/2006/48' (n 470) para 9.
[474] Anand Grover, 'Right to Health in Conflict Situations. Report of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health, Anand Grover' (UN General Assembly 2013) UN Doc A/68/297 para 8.

> sexual and reproductive health services; inadequate social protection; institutionalization; punitive drug laws; absence of comprehensive sexuality education; criminalization of exposure, non-disclosure of HIV status and transmission of HIV; criminalization of same-sex relationships; and lax legal frameworks governing the sale of tobacco, alcohol and fast foods.[475]

References to public health paradigms and explanatory mechanisms included biomedical technical approaches, behavioural lifestyle explanations, psycho-social theories, fundamental cause theory or root causes, environment materialist paradigms, the capability approach, and in particular the life-course approach and intersectionality. These have of course been in line with the development and acceptance of these explanatory mechanisms in public health and in policy making more generally. Two aspects were notable. Firstly, the generally vague application of the theories with reference to seminal writers but without any particular development or structured integration of the theories into the reports. Secondly, an exhortation to paradigm shifts. Hunt championed the integration of social determinants of health from the beginning of his mandate in order to emphasise that achieving good health is not simply about health care provision. Pūras challenged predominant biomedical understandings of mental ill health and strengthened and expanded notions of social determinants of health as applied to mental health.

Public health terminology is rarely employed explicitly and unambiguously, so it is not surprising that a concept such as the social gradient is missing. The rather confusing use of the terminology 'underlying determinants' is maintained even in later SRRH mission reports.[476] However, more recent inclusion of the explanatory mechanisms for

[475] Dainius Pūras, 'Report of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health' (UN Human Rights Council Thirty-second session 2016) UN Doc A/HRC/32/32 para 36.
[476] Except for: Hunt, '2007 Sweden A/HRC/4/28/Add.2' (n 467); Dainius Pūras, 'Report of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and

the social gradient demonstrates that the SRRHs are increasingly engaging with social epidemiological concepts and frameworks, and there are assertive calls in all SRRH mission reports for action on the structural determinants of ill health.

5. Limitations, challenges, and innovations

This thesis presents the only study on the topic of the social gradient and the right to health and chose to undertake a detailed analysis of SRRH reports as a case study. This study's use of Framework Method to structure the coding of SRRH reports contributes to a novel approach to the analysis of UN human rights monitoring documents. As Benjamin Mason Meier and Yuna Kim observe, previous analyses have adopted largely linguistic documentary approaches, and their qualitative analytic coding of CESCR reports, using a coding frame based around indicators of the rights to water and sanitation, facilitated a more 'in-depth analysis' capturing the 'thematic complexity' of human rights reporting.[477] Such empirical studies provide an evidence base to operationalise human rights.[478] Framework analysis was a useful method for a new researcher as it enabled a close adherence to the research question, and this study provides a useful example for human rights researchers going forward. It would be difficult to undertake a thematic analysis without a framework as the reports cover so many topics and issues. The additional interviews provided a means to check the analysis of the content of the reports.

Using the framework analysis approach presented some challenges. As with all qualitative data analysis, it was time consuming and complicated to create the

Mental Health, Dainius Pūras. Visit to Malaysia (19 November–2 December 2014)' (Human Rights Council Twenty-ninth session 2015) UN Doc A/HRC/29/33/Add.1.

[477] Benjamin Mason Meier and Yuna Kim, 'Human Rights Accountability through Treaty Bodies: Examining Human Rights Treaty Monitoring for Water and Sanitation' (2016) 26 Duke Journal of Comparative and International Law 139, 171.

[478] ibid 230.

theoretical framework, construct thematic charts, summarise the data and develop the thematic analysis.[479] The terminology used added difficulty to this process, as did the overlapping and iterative nature of each step in the process.[480] Spencer and colleagues acknowledged there is a lack of agreement about the use of terms 'codes', 'themes' and 'categories'.[481] This was compounded by the use of the terms nodes and codes in NVivo. A number of rounds of coding and recoding were required. A notebook and NVivo memos were used to record the development of this process. This provided some continuity and improved consistency in the coding process. All the coding, including the initial abandoned process, was retained to add depth to the development of themes. The thematic analysis could have taken several different directions, so it was necessary to be mindful of the aims of the research and the research questions throughout the analysis.[482]

The strengths of the Framework Method outweighed these challenges. It is a systematic and flexible method, providing a framework to guide the novice researcher through analysis of data.[483] It provided clear guidance on the stages that needed to be followed. The development of a coding frame, applied to the mission reports, provided consistency and helped to develop the initial thematic diagrams. Grouping clusters of codes and using diagrammatic representations of these clusters facilitated the development of themes (Appendix 12).

This study would have gained more contextualised insights from a) further interviews with Special Rapporteurs and researchers, and b) participant observation of discussion

[479] Gale and others (n 449); Hackett and Strickland (n 227).
[480] Hackett and Strickland (n 227).
[481] Spencer and others (n 451).
[482] Parkinson and others (n 227).
[483] Hackett and Strickland (n 227).

groups for the development of thematic reports and of country visits for the mission reports. Limited availability of researchers and special rapporteurs meant that further interviews were difficult to arrange. However, the interviews provided a means to check the analysis of their reports. The practicalities of funding and time prohibited participation in country missions but interviews undertaken did help to contextualise the way the reports were prepared. A discussion day on social determinants of mental health was attended and illuminated the analysis of that particular thematic report but the learning might not apply across all thematic reports.

It must be noted that the social gradient within a country is affected by both domestic *and* international factors and SRRH country reports reflect the concerns of citizens against their states. The impact of global factors on such concerns has not been addressed in this thesis and provides a potential source for further research.

The analysis was limited by the lack of a conceptual framework specifically for the social gradient which could provide particular components to be identified, a means to structure the analysis and a definitive means to assess whether the gradient was being addressed. The alternative framework of the CSDH conceptual framework was adapted required the use of structural determinants of health and explanatory mechanisms for the social gradient as a proxy for the gradient. The study did not attempt to create such a conceptual framework as some authors have done for their specific topics.

This thesis bridges the divide between public health and the right to health. Working across disciplines proved challenging. Human rights and public health studies adopt different approaches and methodologies and have different purposes. Human rights law seeks to evaluate State's compliance with legal human rights obligations whereas public

health is concerned with the evidence of impact upon health outcomes.[484] Standard public health approaches of literature review, statistical studies and collection and analysis of experimental data do not fit well with usual human rights approaches However, it is important to not set up the two disciplines as dichotomous, conflicting paradigms.[485] Research in human rights that crosses disciplinary boundaries (economics, history, philosophy, anthropology, health etc.) has contributed to the variety of research paradigms available to human rights researchers.[486] Public health has in recent decades begun to value qualitative research as an adjunct to epidemiological or quantitative studies to provide richly nuanced data sensitive to context.[487] This thesis combines the two approaches with features that would be recognisable to public health practitioners such as a scoping review of academic literature and a detailed methodology for the analysis of Special Rapporteur reports, but presented within conceptual chapters focused on different aspects of the right to health.

C. Action on Poverty, Gap, or Gradient?

The purpose of this thematic discussion is to evaluate to what extent the SRRH acts upon the social gradient in health, based upon the analysis of mission reports, assessment of thematic reports and incorporating comments from interviews. Graham's policy analysis matrix is employed to help answer the question as to the type of

[484] Ferguson (n 364).
[485] Jonathan Grix, *The Foundations of Research* (2nd edn, Palgrave Macmillan 2010) 62–63; Todd Landman, 'Social Science, Methods and Human Rights' in Anja Mihr and Mark Gibney (eds), *The SAGE Handbook of Human Rights*, vol 1 (SAGE 2014) 195; Ferguson (n 234) 410.
[486] Andreassen, Sano and McInerney-Lankford (n 358).
[487] Emily E Namey and Robert T Trotter, 'Qualitative Research Methods' in Greg Guest and Emily E Namey (eds), *Public Health Research Methods* (SAGE Publications, Inc 2015) <http://methods.sagepub.com/book/public-health-research-methods> accessed 29 July 2021.

inequalities of most concern in the SRRH reports.[488] Vallgårda's analysis of policy action for inequalities is used to assess the type of actions adopted by the SRRH.[489]

1. Policy frameworks

Graham's matrix for determinants-oriented approaches to tackling health inequalities specifically examines whether action aims to reduce inequalities in poverty or reduce the gap between disadvantaged groups and the main comparator in society or address the whole social gradient.[490] The matrix describes two domains of action on one axis, individual health risks and broader determinants, with three different types of actions to tackle health inequalities on the other axis (

Table 4). The first domain, *individual health risks,* are determinants of health such as material conditions, environment, workplace, behaviour, physiological vulnerabilities, and psycho-social factors. These correspond to intermediary determinants of health in the CSDH conceptual framework. The second domain includes *broader determinants* corresponding to the CSDH structural determinants of health inequities. Different policy action undertaken within each of these domains can result in improving the health of the poorest groups or narrowing health gaps or on reducing health gradients. This matrix can then be used to analyse potential results of policy action: whether they address poverty, the gap or the gradient.

[488] Graham, 'Health Inequalities, Social Determinants and Public Health Policy' (n 29) 473.
[489] Signild Vallgårda, 'Health Inequalities: Political Problematizations in Denmark and Sweden' (2007) 17 Critical Public Health 45; Vallgårda, 'Social Inequality in Health' (n 215).
[490] Graham, 'Tackling Inequalities in Health in England' (n 29).

Table 4 **Tackling inequalities in social determinants.**

Tackling health inequalities…		*…in broader determinants*	*…in individual risk factors*
	…by reducing health gradients	Increase in level of determinants in all groups to match that in most advantaged group	Reduction in prevalence in all groups to match that in most advantaged group
	…by narrowing health gaps	Faster rate of improvements in determinants in disadvantaged group than comparator group	Faster rate of reduction in disadvantaged groups
	…by improving health of poorest groups	Improvement in determinants in poorest group	Reduction in poorest group

Source: Graham (2009)[491]

Graham suggests that her framework can be refined in different ways for policy analysis,[492] so an additional column of social position is added to the matrix to reflect its pivotal position in the CSDH conceptual framework (Table 5).

Following Diderichsen, Evans and Whitehead, the CSDH conceptual framework incorporated causal mechanisms relating to distribution of power, wealth and control that stratify different groups within society and engenders differential exposure to risk factors and in turn determines the health consequences of those exposures.[493] Including social position reflects the central concern with non-discrimination in human

[491] Graham, 'Health Inequalities, Social Determinants and Public Health Policy' (n 29) 473.
[492] ibid 472.
[493] Diderichsen, Evans and Whitehead (n 112).

rights, particularly as discrimination on a variety of grounds is viewed as an important determinant of health in the SRRH reports.

Table 5 **Adapted matrix for analysis of SRRH reports.**

Tackling health inequalities…			
…in structural determinants (determinants of health inequalities)	*…in social position*	*…in poor material circumstances and in individual risk factors (determinants of health)*	*Results in*
1. Increase in level of determinants to match that in most advantaged group	2. Improve social position to match that of the most advantaged group	3. Reduction in prevalence in all groups to match that in most advantaged	*Reducing health gradients*
4. Faster rate of improvement in disadvantaged groups than in comparator group	5. Remove the disadvantages associated with social position (e.g. racism) than comparator group	6. Faster rate of reduction in risk factors in disadvantaged groups than comparator group	*Narrowing health gaps*
7. Reducing determinants of ill health in poorest group	8. Improvement in socio-economic status in poorest group	9. Reduction in risk factors in poorest group	*Improving health of poorest groups*

How health inequalities are framed determines how they are problematised, which causes are identified and the type of solutions selected. For example, in her review of four European countries, Vallgårda demonstrates that if health inequalities are framed as an issue pertaining to the most disadvantaged, causes identified will reflect conceptions of disadvantage.[494] This in some instances relates to individual behaviours or the biomedical needs of poorer people, in others the material living and working

[494] Vallgårda, 'Social Inequality in Health' (n 215).

conditions. Solutions will therefore address those behaviours (health promotion), needs (health care) or material conditions (water and sanitation). A gap approach to difference between groups results in a focus on deprived areas, issues of exclusion and the behaviour and living conditions for certain groups. The 'Levelling Up' agenda of the current UK government is an example of this.[495] Alternatively, Vallgårda demonstrates that if a gradient approach to inequalities is adopted then universal population level solutions may be offered such as in Norway and Sweden.

2. Poverty

There is a strong moral argument for ameliorating poverty in the right to health since poverty negatively impacts health outcomes and is recognised as a social determinant of health. The UN declared a third decade (2018–2027) for the implementation of the eradication of poverty, acknowledging poverty as the 'greatest global challenge'.[496] A UN resolution in 1993 instated an International Day for the Eradication of Poverty, the first observance of which occurred on 17 October 1987.[497] Ending poverty in all its forms is the first of the 17 SDGs of the 2030 Agenda for Sustainable Development.[498] In 1998, the UN Commission on Human Rights established the mandate on extreme poverty and human rights which in June 2006 passed to the Human Rights Council. The goals of the mandate include providing 'greater prominence to the plight of those living

[495] Clare Bambra, 'Levelling up: Global Examples of Reducing Health Inequalities' [2021] Scandinavian Journal of Public Health <https://doi.org/10.1177/14034948211022428> accessed 29 December 2021.
[496] UN General Assembly, 'Implementation of the Third United Nations Decade for the Eradication of Poverty (2018-2027)' (2018) UN Doc A/C2/73/L9 <https://documents-dds-ny.un.org/doc/UNDOC/LTD/N18/327/89/PDF/N1832789.pdf?OpenElement> accessed 10 March 2022.
[497] UN General Assembly, 'Observance of an International Day for the Eradication of Poverty' (1993) UN Doc A/RES/47/196 <https://documents-dds-ny.un.org/doc/UNDOC/GEN/N93/191/46/IMG/N9319146.pdf?OpenElement> accessed 10 March 2022.
[498] UN General Assembly, 'Transforming Our World: The 2030 Agenda for Sustainable Development. Resolution Adopted by the General Assembly on 25th September 2015' (2015) Un Doc A/Res/70/1 (2015) <https://www.un.org/ga/search/view_doc.asp?symbol=A/RES/70/1&Lang=E> accessed 11 May 2020.

in extreme poverty and to highlight the human rights consequences of the systematic neglect to which they are all too often subjected'.[499] The continuing place of poverty on the global agenda speaks to the fact that whilst there has been some progress, poverty persists. Philip Alston, the former Special Rapporteur on Extreme Poverty and Human Rights (2014–2020), has been very vocal in his abhorrence of extreme poverty:

> A world in which the richest 1% owns 48% of global wealth, and in which this imbalance continues to accelerate, is obscene.[500]

Whilst the ICESCR and General Comment 14 are relatively silent on the issue of poverty, it is recognised as fundamental to all economic and social rights. The ICESCR does not specifically mention the term poverty (or poor), General Comment 14 mentions poverty only three times, and poverty alleviation is not included as a minimum core obligation for the right to health. Yet the CESCR Statement on *Substantive Issues Arising in the Implementation of The International Covenant on Economic, Social and Cultural Rights* is clear about the central importance of poverty in its opening statement:

> In 1948, the Universal Declaration of Human Rights established that poverty is a human rights issue.[1] This view has been reaffirmed on numerous occasions by various United Nations bodies, including the General Assembly and Commission on Human Rights.[2] Although the term is not explicitly used in the International Covenant on Economic, Social and Cultural Rights,[3] poverty is one of the recurring themes in the Covenant and has always been one of the central concerns of the Committee. The rights to work, an adequate standard of living, housing, food, health and education, which lie at the heart of the Covenant, have a direct and immediate bearing upon the eradication of poverty. Moreover, the issue of poverty frequently arises in the course of the Committee's constructive dialogue with States parties. In the light of experience gained over many years, including the examination of numerous States parties'

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[499] OHCHR (Office of the High Commissioner for Human Rights), 'OHCHR | Special Rapporteur on Extreme Poverty and Human Rights' (2019) <https://www.ohchr.org/EN/Issues/Poverty/Pages/SRExtremePovertyIndex.aspx> accessed 3 December 2019.

[500] Philip Alston, 'Extreme Inequality as the Antithesis of Human Rights' (*openDemocracy*, 27 October 2017) <https://www.opendemocracy.net/en/openglobalrights-openpage/extreme-inequality-as-antithesis-of-human-rights/> accessed 10 October 2020.

> reports, the Committee holds the firm view that poverty constitutes a denial of human rights.[501]

Poverty predominates action in the SRRH mission reports.[502] Most frequently in Hunt's Mozambique report where he addresses key issues in the country such as health policy frameworks, participation, poverty, disease control, women, and children; in his Peru report with its focus on poverty discrimination and equality and policy frameworks, and in his Uganda report with its topic of poverty-related neglected diseases.[503] Grover's Vietnam report on prevention and control of HIV/AIDS and health systems financing also emphasises issues of poverty.[504]

Table 6 **Action for improvements in the health of the poorest groups**

Tackling health inequalities…			
…in structural determinants (determinants of health inequalities)	*…in social position*	*…in poor material circumstances and in individual risk factors (determinants of health)*	*Results in*
7. Improvement in determinants in poorest group	8. Improvement in economic status in poorest group	9. Reduction in risk factors in poorest group	*Improving health of poorest groups*

Poverty is identified by the Special Rapporteurs as a **structural determinant of health** (Table 6, cell 7). For example, in his preliminary report Hunt determined poverty as an important cross-cutting theme impacting his objectives to promote, clarify and identify

[501] CESCR, 'Substantive Issues Arising in the Implementation of The International Covenant on Economic, Social and Cultural Rights: Poverty and the International Covenant on Economic, Social and Cultural Rights Statement Adopted by the Committee On Economic, Social and Cultural Rights On 4 May 2001' (2001) UN Doc E/C12/2001/10 para 1.
[502] The terms poverty and poor (and synonyms) occur 545 times in 28 reports.
[503] Paul Hunt, 'The Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health Report of the Special Rapporteur, Paul Hunt Addendum Mission to Mozambique' (UN Economic and Social Council Commission on Human Rights Sixty-first session 2005) UN Doc E/CN.4/2005/51/Add.2 n 55 times; Hunt, '2005 Peru E/CN.4/2005/51/Add.3' (n 467) n 61 times; Hunt, '2006 Uganda E/CN.4/2006/48/Add.2' (n 464) n 41 times.
[504] Grover, '2012 Vietnam A/HRC/20/15/Add.2' (n 466) n 46 times.

best practice in the right to health.[505] This he developed in later thematic reports to identify key right to health features of a poverty reduction strategy.[506] Good health enables an escape from poverty and poverty reduction was central to the right to health; 'poverty reduction is a positive force for the right to health and vice versa'.[507] Poverty is also seen as a determinant of health care provision. Recommended actions with regard to poverty often concern payment for health services in some form. Again, this is not surprising given the centrality of AAAQ in the right to health, which includes affordability. Grover's 2012 Vietnam report is quite typical of the type of actions recommended where it recommends:

> …consideration of the effects of privatisation of health services, alternative revenue generating mechanism for health services, expanding the scope of health insurance, subsidisation of costs for those who have to travel a great distance to health services, and free health care for children.[508]

The focus on poverty as an important structural determinant of health leads the SRRH to consider pro-poor strategies and policies. Poverty reduction policies, promulgated in the 1990s, focused upon strategies to increase employment and provision of insurance or safety net systems in the event of unemployment.[509] A shift to a more dynamic understanding of poverty, seen in the early 2000s, required actions to empower people living in poverty to have a political voice, expand opportunities, redistribute material and human assets, build solidarity across communities and broad general measures such as macro-economic stability, an equitable world trading system, environmental

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[505] Hunt, '2003 Prelim E/CN.4/2003/58' (n 349) paras 45 and 46; Hunt, '2007 Thematic A/62/214' (n 350) paras 94–96.
[506] Paul Hunt, 'The Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health Report of the Special Rapporteur, Paul Hunt' (UN Commission on Human Rights Sixtieth session 2004) E/CN.4/2004/49 pt II.
[507] Hunt, '2005 Mozambique E/CN.4/2005/51/Add.2' (n 506) para 33.
[508] Grover, '2012 Vietnam A/HRC/20/15/Add.2' (n 466) para 61.
[509] International Bank for Reconstruction and Development, *World Development Report. Poverty* (Oxford University Press 1990).

sustainability, per capita economic growth, and improved agricultural performance. [510] In Hunt's experience general whole population level interventions did not meet the needs of the poorest.[511] Thus, key right to health features for poverty reduction strategies in SRRH reports proposed: empowerment and participation of the poor in policy making; improving access and affordability of appropriate, quality health services (AAAQ); health education and information for the poorest groups; health care and public health programmes targeted to the poorest and most vulnerable with appropriate impact assessments; essential drugs addressing neglected diseases that afflict the poor; indicators to monitor the health of the poorest, and reducing the financial burden of health care.[512]

SRRH action on inequalities deals largely with improving poor **material circumstances** to bring those living in poverty to a basic standard to meet essential needs and improve the health of the poorest groups (Table 6, cell 9). The SRRH reports rarely make recommendations for risk reduction and behaviour change in individuals such as individual behaviour change through smoking cessation services, teenage pregnancy programmes, and mindfulness courses. Instead, broader statements to amend societal perceptions of individual behaviours such as drug taking, choosing abortion, sexual health, and domestic violence lead to broad policy recommendations. The most frequent individual behaviour-change recommendations relate to the provision of health information to enable people to make informed choices as an important health right.

Few recommendations seek to improve the **social position** in the poorest groups and often such recommendations relate to payment of health care, essential medicines and

[510] Kate Bird and Stefanie Busse, 'Pro-Poor Policy. An Overview' (Overseas Development Institute and Swiss Agency for Development and Cooperation 2006).
[511] Hunt, '2004 Thematic E/CN.4/2004/49' (n 509) para 64.
[512] Hunt, '2003 Prelim E/CN.4/2003/58' (n 349) paras 56, 57, 71, 72, 82, 83 and B.

out-of-pocket expenses to access health care. Wealth is rarely mentioned: sometimes when speaking of wealth quintiles,[513] sometimes in reference to reports such as Wealth of Nations,[514] and sometimes in a list of determinants.[515] Grover's Guatemala mission report is the only report that is specific about the issue of wealth:

> The most apparent manifestation of the colonial legacy in Guatemala is the extremely unequal distribution of both land and wealth between persons of European ancestry (criollos) and the indigenous peoples. Fifty-four per cent of all farms occupy only four per cent of the total area of agricultural land, while 2.6 per cent of larger farms account for nearly two thirds of total arable land. The wealthiest 20 per cent of the population consumes 57.8 per cent of the gross domestic product (GDP).[516]

Similarly, the allied notion of redistribution is rarely mentioned and, when it is, only in relation to health care provision, workforce and funding.[517] But in 2017, Pũras directly speaks of power asymmetries with a whole section dedicated to this topic in his thematic report dealing with prevention and promotion in mental health.[518]

The SRRH mission and thematic reports recommend much to improve the health of the poorest groups. They present clear conceptualisations, sustained engagement and unequivocal action to reduce poverty with a focus on structural determinants of health

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[513] Grover, '2012 Azerbaijan A/HRC/23/41/Add.1' (n 462) para 5; Pũras, '2018 Kyrgyzstan A/HRC/41/34/Add.1' (n 463) para 83.
[514] Grover, '2011 Guatemala A/HRC/17/25/Add.2' (n 461) n 1; Anand Grover, 'Report of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health, Anand Grover. Mission to the Syrian Arab Republic' (2011) UN Doc A/HRC/17/25/Add.3 n 1; Grover, '2012 Ghana A/HRC/20/15/Add.1' (n 471) n 3.
[515] Dainius Pũras, 'Report of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health on His Visit to Armenia' (Human Rights Council Thirty-eighth session 2018) UN Doc A/HRC/38/36/Add.2 para 52.
[516] Grover, '2011 Guatemala A/HRC/17/25/Add.2' (n 461) para 7.
[517] Anand Grover, 'Interim Report of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health, Anand Grover' (2012) UN Doc A/67/302 n 35; Anand Grover, 'Report of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health, Anand Grover' (UN General Assembly 2014) UN Doc A/69/299 n 29; Dainius Pũras, 'Report of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health' (UN Human Rights Council Thirty-eighth session 2018) A/HRC/38/36 para 98b.
[518] Dainius Pũras, 'Report of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health, Dainius Pũras' (UN Human Rights Council 2017) UN Doc A/HRC/35/21 s III B.

and a reduction in risk factors. The structural determinants of health inequalities creating the social gradient in health and leading to poverty are frequently addressed and individual risk factors are rarely considered in favour of broader general societal action on social determinants.

3. Gap

The notion of gaps can be interpreted in two different ways: gaps between different groups in society (women and men, minority ethnic groups and the ethnic majority), or gaps between the richest people at the top of the gradient and the poorest at the bottom of the gradient. Given that the poor are often identified as a group generally in policy and in the SRRH reports, both interpretations will be used and related to discrimination.

Discrimination is a persistent and serious human rights violation and is of fundamental concern to the right to health. There are many universal and regional legal instruments that specifically describe measures to promote the principle of non-discrimination. General Comment 14 identifies non-discrimination and equal treatment as fundamental to the realisation of the right to health, including underlying determinants. [519] Particular groups who may be marginalised or discriminated against include women, older persons, children and adolescents and indigenous populations (see Chapter 3B.1).

As anticipated, discrimination and the principle of non-discrimination features large in the SRRH mission reports. The mission reports specifically examine the plight of discriminated groups in the countries they visit, in line with the 1965 *International Convention on the Elimination of All Forms of Racial Discrimination*.[520] Hunt's Swedish

[519] UN Committee on Economic, Social and Cultural Rights, 'General Comment 14 ICESCR' (n 18) paras 18–29.
[520] United Nations, 'International Convention on the Elimination of All Forms of Racial Discrimination' (n 21).

mission visit considered the special status of the indigenous Sami in the context of health.[521] Grover was concerned for the situation of stateless persons and refugees in his 2011 Syria mission report.[522] Pũras drew attention to the plight of the Roma in his Croatia report.[523] Gender discrimination is repeatedly addressed in mission reports, and all draw upon the *Convention on the Elimination of All Forms of Discrimination against Women, 1979*.[524] For example, Pũras regarding the situation of women and girls in camps for displaced persons in Nigeria[525] and maternal mortality and discrimination of women in Hunt's India report:

> The Special Rapporteur underlines that maternal death is not only a health issue. It is also a human rights issue, relating to - for example - women's rights to life, health, equality and non-discrimination.[526]

The SRRHs recommend actions to disaggregate data to enable identification of issues of discrimination, especially linked to benchmarks and indicators.[527] Data disaggregated on the basis of prohibited grounds for discrimination is mentioned 34 times in 14 reports. It is recommended for ethnic and minority groups in Grover's Syria report,[528] and in his Ghana report he highlights key affected populations, occupational health and safety in the mining sector, maternal mortality, malaria, mental health, and health insurance.[529] The use of disaggregated data is recommended to identify women and children who have experienced violence, for human rights and health impact monitoring, the identification of gaps in coverage of health care, and even in relation to trade deals

[521] Hunt, '2007 Sweden A/HRC/4/28/Add.2' (n 467) paras 51–59.
[522] Grover, '2011 Syria A/HRC/17/25/Add.3' (n 517) para 68.
[523] Pũras, '2017 Croatia A/HRC/35/21/Add.2' (n 474) paras 102–113.
[524] United Nations, 'CEDAW' (n 21).
[525] Pũras, '2016 Nigeria A/HRC/32/32/Add.2' (n 464) para 66.
[526] Paul Hunt, 'Report of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health. Preliminary Note on the Mission to India, Paul Hunt' (Human Rights Council Seventh session 2008) Un Doc A/HRC/7/11/Add.4 para 7.
[527] Hunt, '2007 Sweden A/HRC/4/28/Add.2' (n 467) paras 117–121.
[528] Grover, '2011 Syria A/HRC/17/25/Add.3' (n 517) para 81.
[529] Grover, '2012 Ghana A/HRC/20/15/Add.1' (n 471) para 59(a).

in Hunt's 2004 World Trade Organisation (WTO) report.[530] Disaggregated data is seen as crucial to achieving the goal of equal access to health care *and* the underlying determinants of health.[531] To identify groups experiencing discrimination or unequal access to services for each mission SRRHs will review disaggregated data and sometimes comment on the difficulty of doing so where disaggregated data is not available. For example, in his 2016 Nigeria report, Pũras bemoans the lack of disaggregated data where he says: 'Collection and verification of accurate data on the number and typology of affected women, girls and boys and on the human rights abuses and other violations they have suffered continue to be difficult.'[532]

Table 7 **Action to narrow health gaps**

Tackling health inequalities…			
…in structural determinants (determinants of health inequalities)	*…in social position*	*…in poor material circumstances and in individual risk factors (determinants of health)*	*Results in*
4. Faster rate of improvement in disadvantaged groups than in comparator group	5. Remove the disadvantages associated with social position (e.g. racism) than comparator group	6. Faster rate of reduction in risk factors in disadvantaged groups than comparator group	*Narrowing health gaps*

Recommended actions include addressing **structural determinants of health** (Table *7*, cell 4). For example, law is an important structural determinant of health[533] and is

[530] See for example: Hunt, '2006 Uganda E/CN.4/2006/48/Add.2' (n 464) para 61; Grover, '2012 Ghana A/HRC/20/15/Add.1' (n 471) para 51; Pũras, '2016 Nigeria A/HRC/32/32/Add.2' (n 464) para 91; Paul Hunt, 'The Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health Report of the Special Rapporteur, Paul Hunt Addendum Mission to the World Trade Organization' (UN Commission on Human Rights Sixtieth session 2004) E/CN.4/2004/49/Add.1 para 87.
[531] Pũras, '2018 Indonesia A/HRC/38/36/Add.1' (n 473) para 44.
[532] Pũras, '2016 Nigeria A/HRC/32/32/Add.2' (n 464) para 62.
[533] Kristi Heather Kenyon, Lisa Forman and Claire E Brolan, 'Deepening the Relationship between Human Rights and the Social Determinants of Health: A Focus on Indivisibility and Power' (2018) 20 Health and Human Rights 6.

employed by the SRRH reports to tackle discrimination. Legal mechanisms are often invoked to combat discrimination generally and on the basis of defined characteristics. For example, in his 2006 Uganda report, Hunt recommends the creation of health-related laws to combat discrimination.[534] In Grover's 2010 Australia report, recommended actions include passing legislation to restore the Racial Discrimination Act to protect indigenous people.[535] And Pũras recommends comprehensive anti-discrimination legislation in his 2019 Kyrgyzstan report.[536] Laws to improve access to services are also advised. Hunt's 2005 Peru mission proposes non-discriminatory access to sexual and reproductive health services,[537] and Grover highlights the need for Poland to 'enact legislation enabling minors to consent to certain procedures' in his 2010 Poland mission.[538]

A focus on discrimination means that health is measured as relative to other groups in society, though it is not always clear which groups. The choice of comparison groups may determine how inequality is understood.[539] For example, is it the better off or the average in society that forms the comparator? Is it the majority group against which a minority is compared? This comparator in society is rarely the wealthy and the better off, instead it is some average or minimum threshold. Moreover 'groups that are low income may also be identified in a report according to another characteristic, e.g. persons with psycho-social disabilities, or indigenous peoples'. Many recommendations for the

[534] Hunt, '2006 Uganda E/CN.4/2006/48/Add.2' (n 464) para 53.
[535] Grover, '2010 Australia A/HRC/14/20/Add.4' (n 464) para 100.
[536] Pũras, '2018 Kyrgyzstan A/HRC/41/34/Add.1' (n 463) para 100(k).
[537] Hunt, '2005 Peru E/CN.4/2005/51/Add.3' (n 467) para 74.
[538] Grover, '2010 Poland A/HRC/14/20/Add.3' (n 466) para 85(c).
[539] Braveman, 'What Are Health Disparities and Health Equity?' (n 50).

collection of disaggregated data are made to identify discrimination in access to health care and the underlying determinants for specific vulnerable groups.[540]

Gaps in **social position** between specific groups and the mainstream are tackled in some ways through legal mechanisms mentioned above, and through actions to improve access to education for discriminated groups,[541] or including minority groups in health professional training (Table 7, cell 5).[542]

Discrimination is frequently linked to socio-economic status and poverty, and both are considered to be underlying or social determinants of health. For example, Hunt says in his 2005 Romania report:

> Poverty, stigma and discrimination are root causes underlying these, and other, obstacles to the enjoyment by Roma to the right to health.[543]

In his 2005 Peru report, Hunt contends that 'poverty, discrimination and lack of adequate targeting of the health needs of particular population groups have all contributed to these health-related vulnerabilities.'[544] Pũras links poverty and discrimination with violence in his reports for mission visits (2016–2019) to Paraguay, Algeria, Armenia, and Kyrgyzstan.[545]

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[540] For example, Hunt, '2005 Peru E/CN.4/2005/51/Add.3' (n 855) para 81; Hunt, '2007 Sweden A/HRC/4/28/Add.2' (n 855) paras 117, and 119–121.
[541] Grover, '2010 Australia A/HRC/14/20/Add.4' (n 464) para 100; Grover, '2011 Syria A/HRC/17/25/Add.3' (n 517) para 81(c); Pũras, '2016 Nigeria A/HRC/32/32/Add.2' (n 464) para 95; Pũras, '2017 Croatia A/HRC/35/21/Add.2' (n 474) para 118(g).
[542] Hunt, '2005 Mozambique E/CN.4/2005/51/Add.2' (n 506) para 44; Hunt, '2005 Peru E/CN.4/2005/51/Add.3' (n 467) para 81; Grover, '2011 Guatemala A/HRC/17/25/Add.2' (n 461) para 44; Grover, '2012 Vietnam A/HRC/20/15/Add.2' (n 466) 47.
[543] Paul Hunt, 'Report Submitted by the Special Rapporteur on the Right of Everyone to the Highest Attainable Standard of Physical and Mental Health, Paul Hunt Addendum Mission to Romania' (UN Economic and Social Council Commission on Human Rights Sixty-first session 2005) UN Doc E/CN.4/2005/51/Add.4 para 75.
[544] Hunt, '2005 Peru E/CN.4/2005/51/Add.3' (n 467) para 20.
[545] Pũras, '2016 Paraguay A/HRC/32/32/Add.1' (n 474); Pũras, '2017 Algeria A/HRC/35/21/Add.1' (n 473); Pũras, '2018 Armenia A/HRC/38/36/Add.2' (n 518); Pũras, '2018 Kyrgyzstan A/HRC/41/34/Add.1' (n 463).

Discriminated groups are specified as significant 'also because many of the groups are likely to be more represented among poorer segments of the population'.[546] It is furthermore apparent that people living in poverty and people of a low socio-economic status are often considered as a group who experience discrimination. For example, some recommendations are directed specifically to aid 'the poor' as a group,[547] such as the ameliorating impact of user fees on those living in poverty in Mozambique in 2005,[548] and providing health care cost exemptions for the poor in Paraguay in 2016.[549] The growing number of prohibited grounds for discrimination suggests an ambiguity around who is discriminated against. The lack of action in terms of discrimination on grounds of 'property' indicates more could be achieved to address the socio-economic gap between the richest and poorest.

Tackling issues of poverty and the legal status of individuals and groups with defined characteristics addresses **individual risk factors** (Table 7 cell 6). Such actions include laws to improve protection of certain individuals from specific risks and threats. For example, it was recommended that Guatemala review 'laws with punitive measures against women who have undergone illegal abortions';[550] and for Syria to amend provisions that discriminate against women in instances of gender-based violence.[551] Laws are also included for the decriminalisation of termination of pregnancy,[552] drug users,[553] and sex workers.[554]

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[546] Interview #2
[547] For example, Hunt, '2005 Peru E/CN.4/2005/51/Add.3' (n 855) para 20; Grover, '2012 Vietnam A/HRC/20/15/Add.2' (n 894) op 60(a).
[548] Hunt, '2005 Mozambique E/CN.4/2005/51/Add.2' (n 870) para 52.
[549] Pũras, '2016 Paraguay A/HRC/32/32/Add.1' (n 862) para 131(s).
[550] Grover, '2011 Guatemala A/HRC/17/25/Add.2' (n 461) para 89(e).
[551] Grover, '2011 Syria A/HRC/17/25/Add.3' (n 517) para 82(g).
[552] Pũras, '2016 Nigeria A/HRC/32/32/Add.2' (n 464) para 90(c).
[553] Grover, '2010 Poland A/HRC/14/20/Add.3' (n 466) para 86(c).
[554] Grover, '2012 Vietnam A/HRC/20/15/Add.2' (n 466) para 62(b).

However, the seriousness and persistence of discrimination, the broadening range of prohibited grounds for discrimination, the lack of clarity around some of those grounds, and the intersectoral nature of the experience of discrimination indicates that it is not just about those particular groups but rather about something structural in society as a consequence of the determinants of health inequalities. It is not enough to recommend policies to prevent direct discrimination, but necessary to reveal and remove sources of indirect discrimination.[555] Such hidden barriers to health, for example, could include services not being situated on public transport routes, out-of-pocket payments for medicines, appointment times only available in standard workday times, failure to deliver integrated health services, lack of interpreting facilities, lack of information on health service provision, and late referrals to onward services.[556] Such factors contribute to the creation of the social gradient in health.

4. Gradient

The SRRH mission and thematic reports do not directly discuss or acknowledge the concept of the social gradient in health inequalities. They engage with some public health concepts that are explanatory of the social gradient, most notably the life-course approach and intersectionality, but not in any way that references the social gradient in health inequalities.

The reports do act on **structural determinants of health**, which sometimes increase the level of determinants to match the advantaged group, but most often do not (Table 8 cell 1). Graham provides examples of action on structural determinants including action

[555] Sandra Fredman, 'The Potential and Limits of an Equal Rights Paradigm in Addressing Poverty' (2011) 22 Stellenbosch Law Review 566, 584.
[556] Bart Jacobs and others, 'Addressing Access Barriers to Health Services: An Analytical Framework for Selecting Appropriate Interventions in Low-Income Asian Countries' (2012) 27 Health Policy and Planning 288.

on inequalities in income, labour market protections, and welfare benefits.[557] Some of these are evident in the SRRH reports. Additionally many of the mission reports recommend broad population level actions that will impact all in society such as: ratification of treaties and conventions, and legal provision; creating a strategic plan and coherent intersectoral policy framework to realise the right to health; ensuring community and civil society participation in policy planning, and implementation of health and health-related services; utilising technical and financial international assistance to realise recommended actions; and improving data collection with disaggregated data, accurate birth and death registration and extended epidemiological monitoring. All such actions may benefit the whole population. However, their impact on the social gradient is less certain and less easy to evidence.[558]

Participation, autonomy, and agency are an important means to improve **social position** and participatory mechanisms figure largely in the mission reports (Table 8 cell 2). Civil society and community participation in decision-making processes, the development and implementation of health policy and delivery of health-related programmes are a common requirement in 25 of the mission reports. Oftentimes these refer to specific communities as here in Pūras' Nigeria mission report on contemporary forms of slavery and women and children:

> In line with the human rights-based approach, the development of policies, frameworks and other measures must be participatory, based on consultations with the affected population and aim at promoting agency, hope, aspirations and a positive outlook for the future. In addition, these measures must be well resourced, implemented by trained staff and backed by political will in order to avoid the fate of previous initiatives aimed at addressing inequality.[559]

[557] Graham, 'Social Determinants and Their Unequal Distribution: Clarifying Policy Understandings' (n 29) 116.
[558] Graham, 'Tackling Inequalities in Health in England' (n 29).
[559] Pūras, '2016 Nigeria A/HRC/32/32/Add.2' (n 464) para 85.

Social gradient inequalities are poorly addressed. The top three cells (numbered 1, 2, and 3) for actions to reduce health gradients are all only very lightly shaded. Whilst there is whole population action on the structural determinants of health this is more targeted at the poor and those groups experiencing discrimination.

Table 8 **Action on poverty, gap and gradient**

Tackling health inequalities…			
…in structural determinants (determinants of health inequalities)	*…in social* **position**	*…in poor material circumstances and in individual risk factors (determinants of health)*	*Results in*
1. Increase in level of determinants to match that in most advantaged group	2 Improve social position to match that of the most advantaged group	3. Reduction in prevalence in all groups to match that in most advantaged	*Reducing health gradients*
4. Faster rate of improvement in disadvantaged groups than in comparator group	5. Remove the disadvantages associated with social position (e.g. racism) than comparator group	6. Faster rate of reduction in risk factors in disadvantaged groups than comparator group	*Narrowing health gaps*
7. Improvement in determinants in poorest group	8. Improvement in economic status in poorest group	9. Reduction in risk factors in poorest group	*Improving health of poorest groups*

Using the adaptation of Graham's matrix, we can see the bottom three cells (numbered 7, 8, and 9) for actions to reduce inequalities in the poorest group are shaded. Actions to reduce the determinants of ill health predominate, reduction of individual risk factors less so, and improving socio-economic status receives much less attention and is a minor purpose of any recommendations made. The middle three cells (numbered 4, 5, and 6) for actions to reduce health gaps are equally shaded. SRRH mission and thematic reports demonstrate concerted action to narrow health gaps. They presented

expanding notions of discrimination with grounds for a growing range of vulnerable groups not just women, indigenous people, people living with disability, migrants, and ethnic minorities, but also people who identify as Lesbian, Gay, Bisexual and Trans (LGBT), drug users, prisoners, and people with mental ill health. Concerted action is recommended to protect individuals and groups with defined characteristics from a broad range of risks inherent in the experience of discrimination and stigma. It is the link between poverty and discrimination which results in recommendations that seek to improve the economic status of discriminated groups with additional actions regarding education and employment, for example, cell 5 is therefore more lightly shaded.

5. Influences on the content of SRRH reports

There were several influences upon Special Rapporteur reports that determine their content, particularly mission reports. For example, the particular professions or interests of the Special Rapporteurs themselves, collaboration with public health professionals and other agencies, the Special Procedures mandate, the perceptions and approaches of the country visited or other contextual factors.

The Special Rapporteurs brought their own professional backgrounds and interests to bear on health issues and this was important in determining the public health concepts referenced. Hunt championed the inclusion of social determinants of health in the right to health when there was pressure at the beginning of the mandate to focus on the previously neglected topic of health care.[560] Grover particularly emphasised the health rights of marginalised groups experiencing health inequalities such as people using drugs and sex workers, with recommendations for decriminalisation of drug use and sex

[560] Interview #6

work.[561] Pũras' professional concern with child and adolescent health and awareness of new research linking lower socio-economic status in childhood with greater mental ill health in adulthood supports his adoption of the life-course approach.[562] Indeed, the life-course approach is often referenced in thematic reports with for example an NGO meeting in Geneva in March 2014 to discuss 'Autism and Human Rights throughout the Life-course'[563] and references to the life-course approach advocated in the WHO *Mental Health Action Plan (2013–2020)* as in the 2017 Algeria mission report.[564]

Collaboration with public health practitioners was an important influence. Special Rapporteurs often drew upon their conversations with public health professionals on mission visits and in round table discussions to advance their understanding and support their recommendations with a robust evidence base. Public health practitioners were influential in shaping public health understandings of ill health and often arose out of the SRRH's close engagement with practitioners, as one interviewee expressed:

> Having been involved in writing a number of these reports, they are strongly influenced by practitioner rather than academic literature. So the life-course approach is referred to in some general comments – the one you identify and I think also in CEDAW's General Comment on Women and Health – and the social determinants of health became a practitioner debate as a result of the CSDH focus, and is reflected implicitly (though imperfectly) in the notion of underlying determinants, before social determinants became a more explicit framework of reference, for example, in GC22 of the CESCR.[565]

[561] Interview #4
[562] Mika Kivimäki and others, 'Association between Socioeconomic Status and the Development of Mental and Physical Health Conditions in Adulthood: A Multi-Cohort Study' (2020) 0 The Lancet Public Health <https://www.thelancet.com/journals/lanpub/article/PIIS2468-2667(19)30248-8/abstract> accessed 8 February 2020.
[563] Dainius Pũras, 'Promotion and Protection of All Human Rights, Civil, Political, Economic, Social and Cultural Rights, Including the Right to Development' 21 para 12.
[564] Pũras, '2017 Algeria A/HRC/35/21/Add.1' (n 861) para 119.
[565] Interview #2

Aspects of the Special Procedures mandate itself limits the content of the reports. The reports themselves are in turn constrained by length and format,[566] how actions might potentially be monitored, and expectations of how recommendations may be made:

> And then there is the problem of limited words, and pressure for measurable impact. If you look at the debate on the UPR, there is a lot of emphasis on the value of SMART recommendations and action-oriented recommendations like Edward McMahon, and although I'm not aware of there being a similar guiding ethos for SRs.[567]

Even the number of reports required could become a limiting factor as to what was addressed and how. This could sometimes mean that there was little time for the depth of analysis required to really develop concepts and unpick issues:

> You know, part of what emerges I think now you know thinking back in hindsight is like a kind of very incomplete sort of approach in part because of just the kind of practical implications of having to produce four reports a year and the kind of churn that was necessary to do that. So yeah, I mean, I don't know so I wouldn't necessarily describe it as a like a challenge – more just a product of the moment.[568]

Expectations that a visit from a SRRH would focus on health care rather than a broader conceptualisation of health could direct which issues are selected for evaluation. Descriptive mapping confirms clear concerns with and many recommendations for improvements in health *care* in the right to health. Hunt commented that right to health proponents need to embrace social determinants of health and resist the 'gravitational pull of clinical care'.[569] The question is whether this observed emphasis upon health care and the determinants of health care is at the expense of the social determinants of health as Hunt observed in a 2007 annual report:

> The right to the highest attainable standard of health encompasses medical care and the underlying determinants of health, such as water,

[566] UN Human Rights Council, 'Manual of Operations of the Special Procedures of the Human Rights Council' para 85 <https://www.ohchr.org/Documents/HRBodies/SP/Manual_Operations2008.pdf> accessed 14 April 2021.
[567] Interview #2
[568] Interview #4
[569] Interview #1

> sanitation, food, shelter and freedom from discrimination. There is a regrettable tendency to devote disproportionate attention to medical care at the expense of the underlying determinants of health.[570]

Contextual factors on mission visits such as whether the country visited is low- or high-income, or emerging from war or disaster, determined the type of health inequalities to be addressed. The political context and expectations of a health rights mission influenced the problematisation of health inequalities by individual states, which in turn influenced the actions that the SRRH can realistically recommend. The expectations and responses of governments influenced what might be contained in a mission report. Pressures to include or exclude certain aspects of the right to health and in health provision to make recommendations more likely to be implemented were experienced, as this interview participant observes:

> Anecdotally, and having been on several missions, it is much easier to make recommendations on downstream measures than upstream measures, partly because these tend to be the issues raised and also because even if it is a sticking plaster solution, it is more immediate…it is certainly tempting to make recommendations that do feel like they may have more of an immediate impact and may not fall on deaf ears.[571]

Such influences could determine the content and shape of mission reports and actions recommended. In their thematic reports the SRRH had more freedom to pursue and explore current debates. Days of dialogue were hugely important in the development of thematic reports. Researchers working with the SRRH would identify key experts in the field, important NGOs for the topic to be addressed, representation from civil society organisations, and would bring together people with contrasting opinions. The intention was to have one day of dialogue per report but oftentimes the SRRH and team would review the dialogue, identify missing perspectives and voices and would reconvene a

[570] Hunt, '2007 Thematic A/62/214' (n 761) s Summary.
[571] Interview #2

day of dialogue with a different group.[572] Collaboration was important to lend weight to the final report – the report did not just present the SRRH perspective and interests but were reviewed by those attending the day of dialogue and others in that particular field before being finalised and submitted to OHCHR.[573]

There is little space to develop deep levels of analysis or to raise the hugely problematic notion of causation in the SRRH reports and the Special Rapporteurs are wise to not become entangled in misunderstandings regarding complex multiple influences on health.[574] Moreover, some perspectives on health inequalities were considered too political and contested as captured by this vague comment from one interviewee:

> On sort of political leanings and background…Political work and activity and I think you know that was important for us, and I said because I think that the folks who came through the office, myself included, you know, have that predisposition, in a sense, from a political standpoint, so we had hopes to bring and I think perhaps some of this came up more explicitly in the country reports…We wanted to engage in a kind of deep structural analysis, you know the particular kind of changes in the societies economic programmes and that their impact you know on peoples socio-economic rights and wellbeing.[575]

Or the particular viewpoint and perspective of the Special Rapporteur was resisted by the human rights community who could not see the value of vertical inequalities or socio-economic inequalities, or a reason to use human rights as a lens for understanding inequality:

> For a long time, there was quite a lot of resistance from many people who work on human rights to using human rights to interrogate inequality. Particularly economic inequality. And I think there's been a significant maturation of the discourse on that…because it's become a topic that's essentially unavoidable as far as social problems are concerned. And at that stage, it was still maybe it was like an almost liminal period because I think early on the reason that people weren't maybe looking at that this is

[572] Interview #5
[573] Interview #2
[574] Robyn M Lucas and Anthony J McMichael, 'Association or Causation: Evaluating Links between "Environment and Disease"' [2005] Bulletin of the World Health Organization 4.
[575] Interview #3

> a very casual reading of history. You know as a consequence of, I don't know like an unnecessary split you know ideological split resulting from the Cold War, for example, you know and things being framed perhaps in like this silly way, like dichotomous way, and not simply just like looking at the problem as it is and so there was just a disinterest you know. [576]

External influences on SRRH and their teams circumscribe their reports to some extent. However, the reports demonstrate the gradual development of approaches to health, social determinants of health and public health epidemiology in line with public health over two decades. Pushing the 'conceptual envelope' was an important theme in all the interviews. Hunt championed the inclusion of social determinants of health in the right to health against assertions that to do so would render the right to health too unwieldy and non-specific. Grover foregrounded the role of law as an important determinant of health inequalities. Pũras challenged biomedical approaches to mental health to the extent that at times he felt ostracised and marginalised by his own professional constituency. There was a recognition that topics not traditionally considered to be in the health domain had lessons for an understanding of health inequalities. SRRHs wanted to highlight and extend understandings of issues that negatively impact health and introduce new issues of importance:

> Pushing that sort of conceptual envelope, I think, to some extent, so we were always kind of seeking out topics that perhaps weren't even…you know thought to be health necessarily health related or things of that nature…where there was not necessarily a huge amount of discussion. As far as human rights was concerned, you guys in health and, I think, especially those early reports because the (…) was one of the few organizations, for example, working on the rights of people who use drugs and things of that nature, so those early reports of the special rapporteur were especially kind of forward looking in that sense, and I think some of the earlier contributions to the kind of discourse in the in those particular domains.[577]

[576] Interview #4
[577] Interviewee #4

Concluding Comments

Framework analysis applied to SRRH mission reports, review of thematic reports, and interviews demonstrate that the reports do not act to specifically redress social gradient health inequalities. Recommended actions relating to structural determinants of health responsible for the unfair and unjust distribution of health inequalities do go some way to ameliorating the type of inequalities that contribute to the social gradient. Many of the structural determinants addressed were targeted at reducing poverty and preventing discrimination as fundamental principles of the right to health. Oftentimes the poor were considered a discrete group experiencing discrimination, or those who were discriminated against were found amongst the poor. Targeted actions to ameliorate the health problems of the poor, as worthy and necessary as they are, are not enough to address the health inequalities depicted by the social gradient. Eliding poverty and disadvantage can result in neglecting health differences between more and less advantaged social groups. [578] This fails to recognise that some who are designated as having membership of a disadvantaged group may actually fare better in terms of social and health outcomes. Not every minority ethnic person, not every refugee, has poorer social and health outcomes and may have a health status equivalent to the more advantaged in society.

Collaboration with public health professionals has supported the increasing adoption of epidemiological principles in the right to health. The central place of social determinants of health, and especially structural determinants, in the implementation of the right to health, combined with discussion and debate on conceptualisations of the social gradient in academic public health will provide an opportunity for engagement with

[578] Paula Braveman, 'Health Disparities and Health Equity: Concepts and Measurement' (2006) 27 Annual Review of Public Health 167, 186.

social gradient inequalities in the right to health. Calls to address vertical inequalities and issues of extreme wealth within human rights more generally will add to the momentum for change.

If we are to, using Yamin's words, 'grapple with what is normatively acceptable in terms of a social gradient',[579] one issue that needs to be considered is the issue of what the highest attainable standard of health might be. The following chapter examines this in more detail.

[579] Yamin, *Struggle for Dignity* (n 1) 195.

Chapter 5. Everyone has the Right to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health

The right to health is the right of *everyone* to the enjoyment of the *highest attainable* standard of physical and mental health. The social gradient demonstrates that it is not only the poor and discriminated who are not achieving the highest attainable standard of health, there are those in the middle of the gradient who whilst not poor are less healthy than those further up the gradient. The concept of the social gradient in health inequalities is not acknowledged in treaties and general comments for the right to health and is poorly understood in both public health and right to health discourse. The Special Rapporteurs place great importance on structural determinants of poor health and although some of their proposed actions and recommendations might address social gradient inequalities, they do not include the social gradient in the implementation of the right to health.

This chapter explores the consequences of this failure to conceptualise and engage with the social gradient and whether the right to health is indeed the right of *everyone* and examines what might be considered as the *highest attainable* standard of health.

A. Physical and Mental Health of Everyone

1. The middle of the gradient

Many would argue that the right to health needs to prioritise the poorest and most vulnerable in society. However, attending to poverty or the gap between groups diverts attention away from the middle of the gradient. As necessary and worthy as it is to ameliorate poverty and prevent discrimination health inequalities cannot be fully addressed if those in the middle of the gradient are ignored.

The ignored middle does not achieve the highest attainable standard of health. The health inequalities in societies with greater socio-economic inequalities span the social gradient. Those in the ignored middle suffer worse health than those further up the gradient. Physical health consequences include obesity, heart disease, hypertension, and teenage pregnancy, to name but a few.[580] Mental health consequences include anxiety, depression, suicide, and misuse of tobacco, alcohol and drugs, along with other social issues such as reduced empathy, breakdown of relationships, and loss of self-esteem.[581] Child development consequences include delayed cognitive development, lower educational attainment and reduced quality of social relationships.[582]

Others have proposed that in some contexts, it is this very middle that has benefitted disproportionately from the right to health. It can be argued that judicial interpretations of the right to health as an individual right have favoured the health rights of the wealthy rather than those most in need. Others have proposed that in some contexts, it is this very middle that has benefitted disproportionately from the right to health. Judicial interpretations of the right to health as an individual right have favoured the health rights of the wealthy rather than those most in need. Octavio Ferraz cites the example of Brazil with a constitution embracing both right to health and social determinants approaches.[583] He demonstrates how in Brazil between 2003 and 2009 a whole country

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[580] Marmot, *The Status Syndrome* (n 153); Kate Pickett, 'Wider Income Gaps, Wider Waistbands? An Ecological Study of Obesity and Income Inequality' (2005) 59 Journal of Epidemiology & Community Health 670; Pickett and Wilkinson (n 153); Avner Offer, Rachel Pechey and Stanley Ulijaszek, 'Insecurity, Inequality, and Obesity in Affluent Societies' (Oxford University Press 2012) EconPapers <https://econpapers.repec.org/bookchap/oxpobooks/9780197264980.htm> accessed 31 March 2023; Marmot, *The Health Gap* (n 197).

[581] Pickett and Wilkinson (n 155); Wilkinson and Pickett (n 150).

[582] Arjumand Siddiqi and others, 'Variation of Socioeconomic Gradients in Children's Developmental Health across Advanced Capitalist Societies: Analysis of 22 OECD Nations' (2007) 37 International Journal of Health Services 63.

[583] Octavio Luiz Motta Ferraz, 'Brazil. Health Inequalities, Rights, and Courts: The Social Impact of the Judicialization of Health' in Alicia Ely Yamin and Siri Gloppen (eds), *Litigating Health Rights: Can Courts Bring More Justice to Health?* (Harvard University Press 2011).

average of 85% of right to health claims were filed by the middle class with few claims from the very rich or the disadvantaged.[584] Courts in Brazil awarded medicines often to middle class claimants which skewed the health system away from the poor.[585] Through a combination of awareness of rights, access to judicial processes, and sufficient finance to instruct private lawyers or to obtain prescriptions from private doctors, 'the benefits of litigation accrue mostly to individuals in the middle of the social spectrum'.[586] Ferraz argues that this is also partly due to the judiciary interpreting the right as an individual right.[587] Contrastingly, Daniel Brinks and Varun Gauri found that in both India and South Africa a more population-wide approach combined with the pressure of pro-poor policies, collective litigation (such as with school dinners in India), and the organisational power of NGOs (such as with HIV/AIDS in South Africa) ensured the benefits, whoever the litigant, were felt by the more disadvantaged.[588] Access to judicial processes might suggest that the middle class fare better in terms of the right to health.

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However, we need also to consider the health of those at the top of the gradient. Those at the top of the gradient cannot be assumed to have the best health. For example, Ferraz also argues that the wealthiest in society may be able to purchase medicines and treatments and not need to turn to the courts (thus the data focuses attention upon the middle of the gradient). They experience poor health but are able to secure a remedy, by for example privately accessing health systems overseas. Even those at the top of the gradient could be much healthier. This is highly contextual and dependent

[584] Ferraz, 'The Right to Health in the Courts of Brazil' (n 255).
[585] Ferraz, 'Brazil. Health Inequalities, Rights, and Courts: The Social Impact of the Judicialization of Health' (n 586).
[586] ibid 93.
[587] Octavio Luiz Motta Ferraz, 'Social Rights, Judicial Remedies and the Poor' (2019) 18 Washington University Global Studies Law Review 569.
[588] Brinks and Gauri (n 407).

upon an interplay of a broad range of other structural factors. Wealth and steep gradients

Reducing the social gradient demands an examination of the relationship between the bottom and the top of the gradient, between the poor and the wealthy. Steeper gradients reflect greater inequality and the greater the inequality, the worse the consequences.[589] Social gradients can be more or less steep depending on the difference between the size of the gap between the top and the bottom of the gradient. The narrower the difference between the smallest and the largest measures the flatter the gradient. Yet, interventions directed at disadvantaged groups can act as levers to improve social position along the gradient.[590] And, as Vallgårda suggests, 'there is the difference that the gap between the most privileged and the least will reveal greater differences than the difference between the excluded and the rest'.[591]

We need to understand the structures that create the steepness of the gradient, including the impact of wealth. High income and wealth inequality means that wealth is concentrated amongst a small elite at the expense of the poorest, not just in the poorest countries but also in high-income countries.[592] In societies with more extreme inequalities between rich and poor, thus steeper social gradients, those with greater wealth are understood to have better access to political power, greater influence upon institutions including policy makers, and privileges to be able to ensure their position is maintained. Power enables the wealthy to gain disproportionately from economic growth, reproducing inequalities and creating a steeper social gradient. [593] Not only do

[589] Wilkinson and Pickett (n 150).
[590] Graham, 'Social Determinants and Their Unequal Distribution: Clarifying Policy Understandings' (n 996) 115.
[591] Vallgårda (n 970) 75.
[592] MacNaughton (n 125) 1052.
[593] ibid 1055.

the rich have so much more wealth than most of the population but they also gain disproportionately from economic growth, leaving the poor behind.[594]

Human rights generally, including the right to health, need to address issues of extreme wealth. Human rights are compromised when the political power of the wealthy inflates and the gap in incomes becomes more polarised.[595] In order to address extreme inequalities human rights communities need to address the role of wealth and income distribution, as well as social inequalities (in health, education, political power etc.) in creating poverty. The poorest in society suffer because of their reduced access to political and economic power and rights and increased vulnerability to harms due to the consequences of high levels of inequalities such as social unrest and violence, and to a failure to redistribute the wealth to reduce poverty. Radhika Balakrishnan and James Heintz warn that:

> When the political power of the elites expands as the income and wealth distribution becomes more polarized, this compromises the entire range of human rights.[596]

For their part, human rights have failed to address the relationship of poverty to wealth and vertical inequalities. A number of 'myths' have been pervasive in this regard.[597] When economic issues are raised in the Human Rights Council, they are pushed back with the claim that economic issues have no place in human rights.[598] There is a common belief that resourcing and redistribution are not relevant to considerations of

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[594] Hardoon (n 166).
[595] Radhika Balakrishnan and James Heintz, 'How Inequality Threatens All Human Rights' (*OpenDemocracy*, 29 October 2015) <https://www.opendemocracy.net/en/openglobalrights-openpage/how-inequality-threatens-all-human-rights/> accessed 8 April 2019.
[596] ibid.
[597] For a more detailed discussion see Diane F Frey and Gillian MacNaughton, 'Fair Wages and a Decent Living: Paths to Greater Vertical Equality' in Gillian MacNaughton, Diane Frey and Catherine Porter (eds), *Human Rights and Economic Inequalities* (1st edn, Cambridge University Press 2021) <https://www.cambridge.org/core/product/identifier/9781009006545%23CN-bp-11/type/book_part> accessed 16 December 2021.
[598] Alston, 'Extreme Inequality as the Antithesis of Human Rights' (n 503).

States compliance with human rights norms.[599] The International Bill of Human Rights has conflated equality rights with status-based rights.[600] There has been too much focus on poverty as opposed to the whole gradient and the structures that create poverty.[601] Violations driving economic inequalities such as tax evasion, commodifying and privatising housing and health, reducing the power and impact of activism and trade unions have been side-lined in human rights.[602] Neoliberalism and fundamentalist market ideology, antithetical to human rights, have been normalised.[603] The so-called 'neutrality doctrine' expressed by the CESCR in General Comment 3,[604] whereby the ICESCR is considered neutral to issues of socialist or capitalist political and economic systems and through which economic models are not subject to the level of scrutiny required to address extreme differences in income and wealth.[605]

More recently the negative impacts of economic inequalities have attracted the attention of a broad range of disciplines including economists, policy makers, NGOs, social scientists, and human rights. [606] Economists have come to realise the negative impacts

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[599] ibid.
[600] MacNaughton (n 54).
[601] Frey and MacNaughton (n 600) 273.
[602] ibid 274.
[603] Chapman, *Global Health, Human Rights, and the Challenge of Neoliberal Policies* (n 405); Chik Collins, Gerry McCartney and Lisa Garnham, 'Neoliberalism and Health Inequalities' in Katherine E Smith, Sarah Hill and C Bambra (eds), *Health Inequalities: Critical Perspectives* (Oxford University Press 2016); Ted Schrecker, 'Neoliberalism and Health: The Linkages and the Dangers' (2016) 10 Sociology Compass 952; AE Yamin, 'Struggles for Human Rights in Health in an Age of Neoliberalism: From Civil Disobedience to Epistemic Disobedience' (2019) 11 Journal of Human Rights Practice 357; Gillian MacNaughton and Diane Frey, 'Challenging Neoliberalism: ILO, Human Rights, and Public Health Frameworks on Decent Work' (2018) 20 Health and Human Rights 43; Frey and MacNaughton (n 600).
[604] UN Committee on Economic, Social and Cultural Rights, 'General Comment 3 ICESCR' (n 22) para 8.
[605] For a more detailed explanation see Joo-Young Lee, 'Distributive Justice, and Economic and Social Rights' in Gillian MacNaughton, Diane Frey and Catherine Porter (eds), *Human Rights and Economic Inequalities* (1st edn, Cambridge University Press 2021) 249–251 <https://www.cambridge.org/core/product/identifier/9781009006545%23CN-bp-10/type/book_part> accessed 16 December 2021.
[606] Ted Schrecker, 'Was Mackenbach Right? Towards a Practical Political Science of Redistribution and Health Inequalities' (2017) 46 Health and Place 293; Alicia Bárcena, 'We Are Calling for Adoption of Universal, Redistributive and Solidarity-Based Policies with a Rights-Oriented Approach to Leave No One Behind' (2020) 22 MEDICC Review 8; Lee (n 608); Frey and MacNaughton (n 600); See for example Sylvain Aubry and others, 'What the UN Human Rights Treaty Bodies Tell Us about Economic Inequalities and Human Rights: An Empirical Analysis of Twenty Years of Practice' in Gillian

of economic inequality upon the economy (such as 'elite capture of financial markets'), and upon governance (limits funding of health and education leading to political instability, weakens democracy).[607] The failure of the Millennium Development Goals to address inequality has been, to some extent, corrected by Sustainable Development Goal 10 to reduce inequality within and between countries.[608]

Although the human rights community has entered this debate quite late, the constantly evolving human rights framework has been employed by a range of agencies to respond to economic inequalities. Global agencies such as Oxfam have marshalled human rights norms and language to challenge extreme economic inequality.[609] There have been more localised responses such the challenge to regressive sales taxes in Columbia.[610] Historically, the human rights community has mitigated issues of economic inequality through the promotion of workers' rights, social security and gender inequalities.[611] Now extreme inequalities and wealth have come to the forefront in human rights with, for example, the pioneering mandate of the Special Rapporteur on Extreme Poverty and Human Rights.[612] Alston, mandate holder from 2014–2019, exhorts the human rights community to tackle tax policy because tax policy is at the heart of government decision-making processes, claiming that '[t]ax policy is human rights policy'.[613] Political rights activists are beginning to recognise the implications of 'the capture of the political processes by the extreme rich' as presenting a challenge to

MacNaughton, Diane Frey and Catherine Porter (eds), *Human Rights and Economic Inequalities* (1st edn, Cambridge University Press 2021).

[607] Gillian MacNaughton, Diane F Frey and Catherine Porter, 'Introduction' in Gillian MacNaughton, Diane Frey and Catherine Porter (eds), *Human Rights and Economic Inequalities* (1st edn, Cambridge University Press 2021) 2–3.

[608] ibid 3.

[609] Saiz (n 413).

[610] ibid.

[611] ibid.

[612] Alston, 'Extreme Inequality as the Antithesis of Human Rights' (n 503).

[613] *Tax as a Human Rights Issue* (Directed by Philip Alston, CESRVideo 2017) <https://cesr.org/> accessed 29 July 2022.

rights.[614] Moreover, the wealth of the wealthiest has often been accumulated through processes of privatisation of public services reducing available resources to meet economic and social rights.[615] The Centre for Economic and Social Rights has researched, reported and campaigned on austerity measures and tax havens.[616] A 'more nuanced assessment' of economic inequalities is now being debated.[617]

Wealth and taxation should be of concern to the right to health. Wealth and taxation effects more than just the resources available for health care spending by governments or by individuals: it influences the unfair distribution of social determinants of health.[618] To not address the unfair distribution of the social determinants of health means that the right to health is '[f]ailing to guarantee the fair distribution of social determinants of health, which leaves the socio-economic vulnerable at greatest health risk, that seems to deviate from the core conception of the right to health.'[619] Addressing the social determinants of health requires challenging the structures that maintain the unfair distribution of 'power, money and resources' through, amongst other things, fair financing, market responsibility and political empowerment.[620]

Action to address the health consequences for the ignored middle would also benefit the poorest and most disadvantaged. Addressing the middle of the social gradient brings important benefits. [621] The 2019 OECD report noted that ensuring a strong middle class is essential for economic growth, for their investment in education, health

[614] Alston, 'Extreme Inequality as the Antithesis of Human Rights' (n 503).
[615] Koldo Casla, 'Social Rights and Situational Vulnerability in the UK: Theory and Practice', *Law, Responsibility and Vulnerability* (Routledge 2021) 134.
[616] Saiz (n 413); Nicholas Lusiani and Sergio Chaparro, 'Assessing Austerity: Monitoring the Human Rights Impacts of Fiscal Consolidation' [2018] Centre for Economic and Social Rights <https://www.ssrn.com/abstract=3218609> accessed 29 July 2022.
[617] Saiz (n 413); MacNaughton, Frey and Porter (n 610).
[618] Wu (n 400).
[619] ibid 341.
[620] Commission on Social Determinants of Health (n 10) pt 4.
[621] Organisation for Economic Co-operation and Development (n 151).

and housing, for their support of democratic institutions, the funding of social protection systems, the fostering of small and medium enterprises, higher levels of social trust and social cohesion, lower crime rates, and increased general social wellbeing.[622] This points to the potential good factors that contribute to better health. The impact of which on the middle of the gradient should prompt action for the realisation of the right to health for this population.

2. Societal health

An ignored middle incurs negative impacts on populations and societal health. Growing resentment and disillusionment results in the emergence of populism and nationalism, reduced political engagement, political instability, distrust of global and public institutions, and a rising sense of vulnerability and anxiety.[623] The intersections of various social and structural determinants of health impact those in the middle of the social gradient. In 2019, the OECD revealed a complex picture of socio-economic trends across all 37 OECD countries including the rising costs of living, poor or stagnating income growth, rising house prices and rental costs, and a greater potential for falling into debt and poverty (all of which have become more pronounced post-Covid-19 and with the cost-of-living crisis). [624] Social trends identified included falling standards of living and reduced opportunities for occupational and educational

[622] ibid 17–18.
[623] Christopher T Whelan, Brian Nolan and Bertrand Maitre, 'Polarization or "Squeezed Middle" in the Great Recession?: A Comparative European Analysis of the Distribution of Economic Stress' (2017) 133 Social Indicators Research 163; Lorenza Antonucci and others, 'The Malaise of the Squeezed Middle: Challenging the Narrative of the "Left Behind" Brexiter' (2017) 21 Competition & Change 211; Lorenza Antonucci, 'The Revolt of the Squeezed Middle' (2017) 25 Renewal <https://core.ac.uk/reader/267317168> accessed 21 July 2020; Olga Salido and Julio Carabaña, 'An Increasingly Squeezed Middle Class? Changing Income Distributions and Inequality in the EU15 through the Last Economic Cycle' (2019) 27 Journal of Contemporary European Studies 343; Bruce Curtis, Angela Maynard and Nicky Kanade, 'Exploring the Squeezed Middle: Aucklanders Talk about Being "Squeezed"' (2020) 15 Kōtuitui: New Zealand Journal of Social Sciences Online 8; Rosie R Meade and Elizabeth Kiely, '(Neo)Liberal Populism and Ireland's "Squeezed Middle"' (2020) 61 Race & Class 29.
[624] Organisation for Economic Co-operation and Development (n 151).

advancement, decreased job quality and security, reduced social mobility, greater vulnerability and increasing anxiety, and a growing sense of how this situation is unfair. Wilkinson and Pickett argue that social cohesion is weakened by greater levels of inequality as social distance between people increases and social trust decreases.[625] This they contend results in increased self-interest and reduced levels of reciprocity that in turn increases social stress tiggering biosocial pathways to poorer mental health. For example, an increased level of aggression and violence in society results in an increase in threat perception and anxiety triggering compulsive behaviours such as substance and alcohol misuse, with inevitable physical and mental harms.[626]

Epigenetic research confirms biological expressions of inequalities. For example, Krieger's ecosocial theory in social epidemiology proposes that we internalise and embody social inequalities with consequent harms to health.[627] The impact of stress on the epigenome can persist across generations and is expressed in an individual's genetic makeup, maternal transmission of stress to the foetus, and an increased risk of a child's development being impacted by parental stressors. Social epigenetics is an emerging discipline accruing evidence of the intergenerational impacts of socio-economic position (income, education, occupation), racism and discrimination, and social adversity (such as abuse, war, exposure to violence, adverse childhood events) contributing to the development and persistence of health inequalities.[628] Whilst the

[625] Richard G Wilkinson and Kate E Pickett, 'The Enemy between Us: The Psychological and Social Costs of Inequality' (2017) 47 European Journal of Social Psychology 11, 17–18.
[626] Wilkinson and Pickett (n 628); Richard Wilkinson, 'Why Is Violence More Common Where Inequality Is Greater?' (2004) 1036 Annals of the New York Academy of Sciences 1.
[627] Nancy Krieger, 'Embodying Inequality: A Review of Concepts, Measures, and Methods for Studying Health Consequences of Discrimination' (1999) 29 International Journal of Health Services 295; Nancy Krieger, 'Theories for Social Epidemiology in the 21st Century: An Ecosocial Perspective' (2001) 30 International Journal of Epidemiology 668; N Krieger, 'Embodiment: A Conceptual Glossary for Epidemiology' (2005) 59 Journal of Epidemiology & Community Health 350; J Beckfield and N Krieger, *Political Sociology and the People's Health* (Oxford University Press 2018).
[628] Chantel L Martin and others, 'Understanding Health Inequalities Through the Lens of Social Epigenetics' (2022) 43 Annual Review of Public Health 235.

evidence for biological embedding in this way is substantial, the mechanisms by which this leads to inequalities and the social gradient are still to be validated.[629] Moreover, the interpretation of such findings must avoid reducing such evidence to some form of biological determinism.[630]

The social gradient expresses a notion of societal health. The explanatory mechanisms for the social gradient direct us to broader social understandings of ill health that are not simply concerned with the aggregation of individuals' morbidity and mortality. The social gradient does not just describe the interrelationship of a multiplicity of social determinants of health. The social gradient is a social determinant of health in the way it evidences the hierarchical distribution of health inequalities across the population. If we are to reduce social gradient health inequalities, we have to address the whole social gradient itself. The CSDH report offers us a starting point. It emphasises that one's place in the social gradient is created by the toxic combination of 'poor social policies and programmes, unfair economic arrangements, and bad politics'.[631]

B. The Highest Attainable Standard of Physical and Mental Health

Braveman and Gruskin observe that the highest attainable standard of health should be benchmarked against those in the population who achieve good health.[632] The standard of health, Braveman says, that is 'enjoyed by a society's socially privileged persons

[629] Clyde Hertzman and Tom Boyce, 'How Experience Gets Under the Skin to Create Gradients in Developmental Health' (2010) 31 Annual Review of Public Health 329; Maria J Aristizabal and others, 'Biological Embedding of Experience: A Primer on Epigenetics' (2020) 117 Proceedings of the National Academy of Sciences of the United States of America 23261.
[630] Joseph L Graves, 'Great Is Their Sin: Biological Determinism in the Age of Genomics' (2015) 661 The Annals of the American Academy of Political and Social Science 24.
[631] Commission on Social Determinants of Health (n 10) 35.
[632] Paula Braveman and Sofia Gruskin, 'Poverty, Equity, Human Rights and Health' (2003) 81 Bulletin of the World Health Organization 539, 255; Braveman, 'Social Conditions, Health Equity, and Human Rights' (n 59).

such as those who are affluent, well educated, well accepted, politically influential, and from privileged families.' [633] The highest attainable standard of health is therefore that standard experienced by those at the top of the gradient. This, however, does not infer a right to be healthy. General Comment 14 is clear in this regard when it states that the normative content of Article 12 is 'not to be understood as a right to be healthy' but is instead 'the right to a system of health protection which provides equality of opportunity for people to enjoy the highest attainable level of health.'[634] The social gradient articulates a situation where people do not have equality of opportunity to enjoy the highest attainable standard of health.

However, in the ICESCR and in General Comments 14 and 22 it is not clear what the highest attainable standard of health is meant to be. Treaties and general comments do not attempt to define health. Rather General Comment 14 notes that the WHO definition of health was not adopted by the General Assembly.[635] Whilst General Comment 14 expands upon the ICESCR delineation of the right to health, it does so in order to provide an understanding of what should be incorporated as a minimum core of the right, with paragraphs 43 and 44 included in the section titled 'Core obligations'. It does not, therefore, describe what is meant be the highest attainable standard of health.

The scope and content of the right to health has been hotly contested and debated since its inception. Some critics point to the indeterminate nature of the content of the right to health to assert that inclusion of social determinants of health lays an intolerable burden upon the duty bearer to provide an inordinate quantity of resources, so the right

[633] Braveman, 'Social Conditions, Health Equity, and Human Rights' (n 59) 42.
[634] UN Committee on Economic, Social and Cultural Rights, 'General Comment 14 ICESCR' (n 18) para 8.
[635] ibid 4; See also detail on the history of this development in Tobin, *The Right to Health in International Law* (n 334) 125–132.

to health is indeterminate and unachievable.[636] Some point to the principle of rights being 'indivisible, interrelated and interdependent' to suggest that social determinants of health are addressed by other rights and do not need to be incorporated into the right to health.[637] Claire Lougarre argues that the ICESCR provides an 'unprincipled' delineation of the scope and content of the right to health as it did not at that time reflect WHO priorities and the main causes of ill health globally, and it preferenced certain fields of health above others without any supporting rationale.[638] Lougarre suggests that the highest attainable standard of health could be defined as the right to an adequate health system.[639] She observes that no UN document explicitly entitles individuals to the right to an adequate health system, except for Hunt's definition of the right to health in his SRRH 2006 annual report.[640]

The SRRH take a holistic view of the scope and content of the right to health as incorporating social determinants, ill health prevention, and public health as part of the health system. Analysis of the SRRH reports reveals that they make fewer recommendations for determinants such as food and sanitation as these are addressed by other rights (

[636] Philip Barlow, 'Health Care Is Not a Human Right' (1999) 319 BMJ: British Medical Journal 321; Timothy Goodman, 'Is There A Right to Health?' (2005) 30 The Journal of Medicine and Philosophy: A Forum for Bioethics and Philosophy of Medicine 643; Christine Chinkin, 'Health and Human Rights' (2006) 120 Public Health 52; James Griffin, *On Human Rights* (Oxford University Press 2008) 208.
[637] See the debate on this principle in Daniel J Whelan, 'Indivisible, Interdependent, and Interrelated Human Rights', *Indivisible Human Rights: A History* (University of Pennsylvania Press 2011) ch 1.
[638] Lougarre (n 334) 253–254.
[639] Lougarre (n 334).
[640] ibid 255.

Table 4). Instead, they consistently make recommendations dealing with the policy and governance determinants of health care provision and broader structural determinants of the health. Several of their thematic reports demonstrate concern with public health and health care systems. For example, health systems, health system financing and public health policies.[641]

This is in line with the WHO, who have adopted a broad definition of a health system as 'all the activities whose primary purpose is to promote, restore or maintain health'.[642] Health systems strengthening (HSS) is currently a key WHO strategy for improvement of health outcomes and achievement of Universal Health Coverage (UHC) at the global and national levels.[643] For example, *The Tallinn Charter: Health Systems for Health and Wealth*, endorsed by all WHO European member states in 2008 (resolution EUR/RC58/R4), sets out the principles for HSS including social determinants of health and public health.[644] However, these documents do not explicitly adopt the right to health until a more recent 2022 WHO document *Health Systems Performance*

[641] Paul Hunt, 'Report of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health, Paul Hunt' (Human Rights Council Seventh session 2008) UN Doc A/HRC/7/11; Grover, '2012 Thematic A/67/302' (n 520); Dainius Pūras, 'Promotion and Protection of All Human Rights, Civil, Political, Economic, Social and Cultural Rights, Including the Right to Development'.
[642] World Health Organization (ed), *The World Health Report 2000: Health Systems: Improving Performance* (WHO 2000) 5.
[643] See for example, Meri Koivusalo and Maureen Mackintosh, 'Global Public Health Security: Inequality, Vulnerability and Public Health System Capabilities': (2008) 39 Development and Change 1163; Bruno Marchal, Anna Cavalli and Guy Kegels, 'Global Health Actors Claim To Support Health System Strengthening—Is This Reality or Rhetoric?' (2009) 6 PLoS Medicine e1000059; Tamara Hafner and Jeremy Shiffman, 'The Emergence of Global Attention to Health Systems Strengthening' (2013) 28 Health Policy and Planning 41; World Health Organisation, 'Towards People-Centred Health Systems: An Innovative Approach for Better Health Outcomes' (WHO Regional Office for Europe 2013) <http://www.euro.who.int/en/what-we-do/health-topics/Health-systems> accessed 5 October 2013; Sundararaman Thiagarajan, 'Health Sector Reform at the COVID Cross-Roads: Public Goods or Health Markets - An Agenda for Health Systems Research' (2021) 65 Indian Journal of Public Health 332.
[644] World Health Organisation, 'The Tallinn Charter: Health Systems for Health and Wealth' (2008) EUR Doc EUR/RC58/R4 para 2.

Assessment: A Framework for Policy Analysis, which includes evaluation against health rights.[645]

A 'health system' is as equally broad a concept as the WHO notion of health, and still does not offer us a solution as to how to define the highest attainable standard of health. Nor does it address the issue that those at the top of the social gradient in health are achieving the highest attainable standard of health, and those below are not. The social gradient therefore directs us to consider what is required for those lower down the gradient to achieve the highest attainable standard of health. Progress improvement of the health system using the maximum available resources will be required to level up the gradient.

1. Maximum available resources and progressive realisation

The state cannot guarantee that everyone is able to achieve good health as there are a multiplicity of factors beyond the state's control that influence health. The resources available to the state are finite and the state may not be able to provide for all factors within its control that enhance health or reduce or eliminate those that negatively impact health. The state can only provide within available resources. ICESCR Part II Article 2(1) speaks of the 'maximum available resources' available to a state to achieve economic, social and cultural rights including the right to health.[646] Some states may have greater available resources and can achieve higher standards of provision whilst other Low and Middle Income Countries (LMICs) may be resource poor and cannot attain such high standards. [647]

[645] Irene Papanicolas and others, 'Health System Performance Assessment: A Framework for Policy Analysis' (World Health Organisation 2022) Health Policy Series No. 57.
[646] UN General Assembly, 'ICESCR' (n 14) pt II Article 2(1).
[647] For the 2015 fiscal year, low-income economies are defined as those with a Gross National Income (GNI) per capita, of $1,045 or less in 2013; middle-income economies are those with a GNI per capita of

How the highest attainable standard of health might be judged within the right to health is contested because of such resource constraints. For example, in the 1998 case of *Soobramoney v Minister of Health* the Constitutional Court of South Africa ruled against the claimant requesting renal dialysis to prolong his life on the grounds of the limitations of scarce resources in the health system in South Africa.[648] Yet, in 2002 the Constitutional Court of South Africa in the case of *Minister of Health v Treatment Action Campaign* agreed with the claimant that failing to distribute the free medicine nevirapine to prevent mother-to-child transmission of HIV infringed section 27(3) of the Constitution of South Africa.[649] The drug was being offered to the state for free, but still required the state to resource the health system for it to be distributed. The court adopted a test of reasonableness which sought to guarantee that those with financial issues would not be excluded from lifesaving treatment. In the first instance the right to health was interpreted as an individual right with no individual demanding resources beyond what would be available to the whole population. In the second instance the right to health was interpreted as a collective right.

Some authors are troubled by the concepts of 'highest attainable' and 'maximum available resources' in the right to health because it could be construed that those in resource poor countries where the burden of disease is highest and health provision is meagre have a very low bar indeed to meet the 'highest attainable' standard. Onora O'Neill, for example, argues that it would be grossly unjust to expect a lower standard of

more than $1,045 but less than $12,746; high-income economies are those with a GNI per capita of $12,746 or more World Bank, 'Country and Lending Groups | Data' (2015) <http://data.worldbank.org/about/country-and-lending-groups> accessed 12 January 2015.

[648] *Soobramoney v Minister of Health (Kwazulu-Natal)* [1998] 1998 (1) SA 765 (CC) (Constitutional Court South Africa).

[649] *Minister of Health v Treatment Action Campaign* [2002] TAC (2002) 5 SA 721 (CC) (Constitutional Court of South Africa).

health in poorer countries than expected in wealthier countries.[650] This argument also applies in terms of the highest attainable standard of health being viewed as that at the top of the social gradient. The health of those at the top of the gradient in HICs far exceeds that of those at the top of the gradient in LICs. By defining the highest attainable standard of health in this way we again set a low bar for those in resource poor, conflict striven, disaster affected, low-income countries.

The ICESCR also speaks of *progressive realisation* whereby all states must progressively improve their provision towards realising the rights in the ICESCR, including health rights.[651] Some critics point to the term progressive realisation as providing a 'get out' clause to states achievement of the highest attainable standard of health, and claim the rights to be merely aspirational.[652] However General Comment 3 of the ICESCR clearly states that this term must be understood as an obligation to move 'as expeditiously and effectively as possible towards that goal' of full realisation, and that any retrogression must be fully justified and temporary with plans for remediation.[653]

Furthermore, climate change has precipitated a debate about the resources available to a state and how they might be used in the context of planetary boundaries and in protecting the environment for future generations. There is an expanding understanding of resources as more than just finance but also planetary. Sigrun Skogly for example points to recent observations made by the CESCR exhorting Norway and Australia to review licences for exploration and mining of new petroleum and natural gas reserves,

[650] Onora O'Neill, 'The Dark Side of Human Rights' (2005) 81 International Affairs 427.
[651] UN General Assembly, 'ICESCR' (n 14) pt II Article 2(1).
[652] John Tobin, 'The Progressive Obligation to Realise the Right to Health', *The Right to Health in International Law* (Oxford University Press 2011).
[653] UN Committee on Economic, Social and Cultural Rights, 'General Comment 3 ICESCR' (n 22) para 9.

thus reversing the increase in greenhouse gas emissions, and pursuing green energy policies.[654] Understanding resources as planetary such as natural gas, minerals, or stocks of fish in the sea requires consideration of ceilings to maximise available resources. Skogly's discussion of the emerging right to the continuous improvement of living conditions challenges the notion of maximum available resources proposing consideration of ceilings to rights.[655] Such a perspective demands not pursuing progressive realisation beyond a ceiling that might then have sustainability concerns and requires redistribution of resources below this ceiling.

2. Minimum core obligations and poverty thresholds

Whilst international human rights law recognises constraints to and progressive realisation of the right to health, there are obligations that must be met with immediate effect. In General Comment 3, the CESCR confirmed that *minimum core* obligations are an important principle of each economic, social and cultural right.[656] It prioritised a minimum essential threshold of facilities, goods and services to be guaranteed for everyone for their enjoyment of the right to health.[657] The concept of the minimum core presents a common legal standard to counterbalance progressive realisation of the right to health; it provides a non-derogable floor which no state should go below (at least in theory);[658] a benchmark against which to monitor retrogression and to compare one

[654] Sigrun I Skogly, 'The Right to Continuous Improvement of Living Conditions and Human Rights of Future Generations – A Circle Impossible to Square?' in Jessie Hohmann and Beth Goldblatt (eds), *The Right to the Continuous Improvement of Living Conditions: Responding to Complex Global Challenges* (Hart Publishing 2021) 158.
[655] Skogly (n 658).
[656] UN Committee on Economic, Social and Cultural Rights, 'General Comment 3 ICESCR' (n 22).
[657] ibid 10.
[658] UN Committee on Economic, Social and Cultural Rights, 'General Comment 14 ICESCR' (n 18) para 47.

state with another;[659] a means to identify immediate action;[660] and it facilitates justiciability of the right.[661]

The CESCR incorporated a broad range of views, including public health perspectives in developing the minimum core for the right to health.[662] Methods for developing the core relied upon treaty texts and jurisprudence, scholarship and teaching, and the influence of global health declarations and programmes such as the Declaration of Alma Ata and the Health for All and Primary Health Care strategies of the WHO.[663] For example, in line with the idea of core content, the Health For All strategy stipulated that 'there is a health baseline below which no individuals in any country should find themselves'.[664]

Moreover, the concept of the minimum core has been normatively justified on the basis of basic needs for survival and life,[665] or alternatively on the basis of fundamental dignity and equality to achieve a flourishing life.[666] The value of the minimum core is that it provides a means to determine action across all human rights obligations and manage

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[659] Katharine G Young, 'The Minimum Core of Economic and Social Rights: A Concept in Search of Content' (2008) 33 Boston College Law School Faculty Papers 64, 71.
[660] John Tasioulas, 'The Minimum Core of the Human Right to Health' (World Bank, Washington, DC 2017) <http://hdl.handle.net/10986/29143> accessed 2 April 2021.
[661] Young (n 663) 71–73; Lisa Forman, 'Can Minimum Core Obligations Survive a Reasonableness Standard of Review under the Optional Protocol to the International Covenant on Economic, Social and Cultural Rights' (2016) 47 Ottawa Law Review 561, 47; Amrei Müller, 'The Minimum Core Approach to the Right to Health Progress and Remaining Challenges' in Sabine Klotz, Martina Schmidhuber and Andreas Frewer (eds), *Healthcare as a Human Rights Issue: Normative Profile, Conflicts and Implementation* (Transcript Verlag, Bielefeld 2017) 58; Lisa Forman and others, 'Conceptualising Minimum Core Obligations under the Right to Health. How Should We Define and Implement the ›Morality of the Depths?' in Sabine Klotz, Martina Schmidhuber and Andreas Frewer (eds), *Healthcare as a Human Rights Issue: Normative Profile, Conflicts and Implementation* (Transcript Verlag, Bielefeld 2017).
[662] Lisa Forman and others, 'Conceptualising Minimum Core Obligations under the Right to Health: How Should We Define and Implement the "Morality of the Depths"' (2016) 20 The International Journal of Human Rights 531, 532–535.
[663] Brigit Toebes, 'The Right to Health' in Asbjørn Eide, Catarina Krause and Allan Rosas (eds), *Economic, Social and Cultural Rights: A Textbook* (2nd rev. ed, M Nijhoff 2001) 176–177.
[664] World Health Organisation, 'Global Strategy for Health for All by the Year 2000' (World Health Organisation 1981) General Assembly A/RES/36/43 ch II para.1.
[665] Henry Shue, *Basic Rights: Subsistence, Affluence, and U.S. Foreign Policy* (Second edition with a New afterword by the author edition, Princeton University Press 1996) 18.
[666] See for example discussion in Young (n 663).

competing human rights claims;[667] it facilitates prioritisation when there are limited resources and it ensures that resources are directed to where they are most needed, in particular the poorest and most marginalised,[668] triggering international assistance and cooperation if required.[669] Minimum core obligations serve as a means to prevent States from delaying implementation of rights such as the right to health by pleading a lack of resources.[670]

General Comment 14 specifies the minimum core for the right to health.[671] Whilst international human rights law recognises constraints to and progressive realisation of the right to health, General Comment 14 clarifies that these obligations must be realised with immediate effect and include the obligation to take concrete, deliberate and targeted steps to the realisation of the right to health with a health strategy and action

[667] John Tasioulas, 'Minimum Core Obligations: Human Rights in the Here and Now' (World Bank, Washington, DC 2017) 14 <https://openknowledge.worldbank.org/bitstream/handle/10986/29144/122563-WP-Tasioulas2-PUBLIC.pdf?sequence=1&isAllowed=y> accessed 2 April 2021.
[668] Young (n 663) 72.
[669] Müller (n 665) 59.
[670] Audrey R Chapman, 'Core Obligations Related to the Right to Health' in Audrey R Chapman (ed), *Core Obligations: Building a Framework for Economic, Social and Cultural Rights* (Intersentia 2002).
[671] General Comment 14 on the right to health para.43 specifies core obligations for the right to health as: 'To ensure the right of access to health facilities, goods and services on a non-discriminatory basis, especially for vulnerable or marginalized groups; To ensure access to the minimum essential food which is nutritionally adequate and safe, to ensure freedom from hunger to everyone; To ensure access to basic shelter, housing and sanitation, and an adequate supply of safe and potable water; To provide essential drugs, as from time to time defined under the WHO Action Programme on Essential Drugs; To ensure equitable distribution of all health facilities, goods and services; To adopt and implement a national public health strategy and plan of action, on the basis of epidemiological evidence, addressing the health concerns of the whole population; the strategy and plan of action shall be devised, and periodically reviewed, on the basis of a participatory and transparent process; they shall include methods, such as right to health indicators and benchmarks, by which progress can be closely monitored; the process by which the strategy and plan of action are devised, as well as their content, shall give particular attention to all vulnerable or marginalized groups.' In addition, para. 44 includes 'obligations of comparable priority': 'To ensure reproductive, maternal (pre-natal as well as post-natal) and child health care; To provide immunization against the major infectious diseases occurring in the community; To take measures to prevent, treat and control epidemic and endemic diseases; To provide education and access to information concerning the main health problems in the community, including methods of preventing and controlling them; To provide appropriate training for health personnel, including education on health and human rights'.

plan, and to ensure equitable non-discriminatory access to basic prerequisites of health, essential drugs and various essential health goods and services.[672]

The concept of the minimum core is contested however.[673] Issues relate to being able to determine a realistic minimum core given the lack of clarity with regards to the CESCR position on minimum core obligations.[674] That it necessitates contextual interpretation and can be applied differently for different states (e.g. high or low income).[675] Focusing upon the minimum core side-lines progressive realisation and continuous improvement in living conditions.[676] The social gradient highlights, in particular, the critique that the minimum core channels the right to health towards material deprivation rather than the broader structures in society that perpetuate inequalities and poverty.[677] Katharine Young cautions that defining the minimum core as the lowest common denominator threatens the broader goals and aspirations of economic, social and cultural rights.[678] Samuel Moyn goes further, in his book *Not Enough: Human Rights in an Unequal World*, arguing that a sufficiency approach renders the human rights community complicit with inequality.[679] Though critics of his position do point to increasingly significant social rights activism and the roles played by alliances between international and local NGOs using human rights language and tools to raise awareness of and fight against economic inequalities.[680]

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[672] UN Committee on Economic, Social and Cultural Rights, 'General Comment 14 ICESCR' (n 18) paras 30 and 43–45.
[673] Forman and others (n 665).
[674] Müller (n 665) 56.
[675] Katharine G Young, *Constituting Economic and Social Rights* (Oxford University Press 2012) 69–70.
[676] Jessie M Hohmann, 'The Forgotten Right to Continuous Improvement of Living Conditions in Article 11(1) of the International Covenant on Economic, Social and Cultural Rights: Seeking the Roots of the Right in International Law' (Social Science Research Network 2020) SSRN Scholarly Paper ID 3668638 <https://papers.ssrn.com/abstract=3668638> accessed 30 April 2021.
[677] Young (n 663) 114.
[678] Young (n 663).
[679] Moyn (n 375).
[680] Saiz (n 413).

The social gradient challenges notions of the minimum core in the right to health. A basic needs approach suggested by the minimum core fails to address the inequalities in the middle of the gradient and the inclusion of social determinants of health in the minimum core demands consideration of the complexities of their interrelationship articulated by the social gradient.

Minimum core and thresholds of provision

The minimum core focuses attention upon immediate and basic needs. The debate then concerns how to identify and define what basic needs should be met to raise which people above what threshold. Ascertaining what basic needs are can become a technical exercise without recourse to understanding the complexity of people's needs or the differences in needs for different population groups.[681] There is a risk that basic becomes so minimal it is interpreted as the absolute bare minimum required for survival.[682]

This suggests action is required to provide a basic minimum to those most at risk, often believed to be the poorest in society. Targeted action on the poor requires an ability to identify who the poor are and where they are situated. Whilst there is much debate about the definition of poverty, most official definitions use an income threshold to identify those who fall below this threshold as being poor. For some countries, this threshold is an absolute income with those earning less than a specified amount being classed as poor (e.g. US).[683] Others set a relative poverty level below which you might be classed as poor, such as the UK's 60% of median income.[684] SRRH mission reports make occasional mention of thresholds, most notably the World Bank poverty line and

[681] Young (n 663) 132.
[682] Forman and others (n 666) 536.
[683] See for example The United States Census Bureau (n 147).
[684] See for example Economic and Social Research Council (n 148).

the Multidimensional Poverty Index (MPI), and on occasion SRRHs reference the near poor. SRRH thematic reports do not substantively consider the use of thresholds. Alston's 2020 thematic report points out that using the World Bank's poverty line then some 700 million people are reported as living under $1.90 per day. If using the more realistic basic living cost of $5.50 per day then there are 3.4 billion people living in extreme poverty and the MPI, covering 101 low- and middle-income countries, reveals a global poverty rate of 23%.[685]

Poverty thresholds, however, do not account for the patterning of ill health depicted by the social gradient. The social gradient in education is a clear example.[686] Arcaya and others observe that if education had a threshold of completion of secondary school or ten years of schooling then we would observe those below that threshold as having poor health and all those above, whether with further education or post-graduate higher education, as having equally good health. But we have already seen in Erikson's research that the more years of study and the higher the qualifications gained the better the health.[687] This suggests that the social gradient depicts a dose-response relationship between numbers of years at school or qualifications gained and health.[688] A marginal increase in education results in a marginal improvement in health. We must attend to the whole social gradient to understand and address poverty and inequalities.

The social gradient does not present a clear demarcation between those who are not meeting their basic needs, those who are poor, those who are precarious and could fall into poverty and those who are just above the poverty line. The rise in the use of food

[685] Philip Alston, 'The Parlous State of Poverty Eradication. Report of the Special Rapporteur on Extreme Poverty and Human Rights' (Human Rights Council Forty-fourth session 2020) UN Doc A/HRC/44/40 A/HRC/44/40 para 28 <https://www.ohchr.org/EN/Issues/Poverty/Pages/parlous.aspx>.
[686] Arcaya, Arcaya and Subramanian (n 11) 4.
[687] Erikson (n 11).
[688] Arcaya, Arcaya and Subramanian (n 11); Wilkinson and Pickett (n 150).

banks in the UK is an example. General Comment 14 requires that states: 'ensure access to the minimum essential food, which is nutritionally adequate and safe, to ensure freedom from hunger to everyone'.[689]

In this we might assume that the poorest in society, those at the lower end of the social gradient, might not be able to afford to access minimum essential food and target action to this group with some form of welfare provision. However, the proportion of working age adults in the UK has risen 11 percentage points from 50% in 1996/7 to 61% in 2020/21.[690] People in the middle of the gradient with a wage earner in the household have reduced access to healthy food and are increasingly resorting to foodbanks both in a crisis and to meet ongoing need.[691] Food insecurity causes mental health problems as well as physical health deficits.[692]

Identifying the poor as being below some nominal poverty line and targeting action upon that particular group excludes those above the poverty line in the social gradient. The social gradient tells us that the use of thresholds in directing public policy or health policy making limits the ability to resolve health inequalities.[693] Whilst a percentage of the poor may be lifted out of poverty, inequalities remain unchanged. The poorer health experienced by the near poor, or the middle of the gradient might not be targeted

[689] UN Committee on Economic, Social and Cultural Rights, 'General Comment 14 ICESCR' (n 18) para 43(b).
[690] Joseph Rountree Foundation, 'UK Poverty 2023 The Essential Guide to Understanding Poverty in the UK' (Joseph Rowntree Foundation 2023) 40 <https://www.jrf.org.uk/sites/default/files/jrf/uk_poverty_2023_-_the_essential_guide_to_understanding_poverty_in_the_uk_0_0.pdf> accessed 3 April 2023.
[691] Glen Bramley and others, 'State-of-Hunger 2021. Building the Evidence on Poverty, Destitution, and Food Insecurity in the UK Year Two Main Report' (I-SPHERE Harriot Watt University 2021) 44 <https://www.trusselltrust.org/wp-content/uploads/sites/2/2021/05/State-of-Hunger-2021-Report-Final.pdf> accessed 3 April 2023; Food Foundation, 'From Purse to Plate: Implications of the Cost of Living Crisis on Health' (Food Foundation 2023) 5 <https://www.foodfoundation.org.uk/sites/default/files/2023-03/TFF_Cost%20of%20living%20briefing.pdf> accessed 3 April 2023.
[692] Pollard (n 232).
[693] Francis-Oliviero and others (n 139) 5.

because they have material resources above some nominal poverty threshold, even though they fail to achieve the highest attainable standard of health. Shifts and changes in the social gradient tell us that attention to the lower end of the gradient by provision of essential and basic needs through welfare or free health care does not eliminate the social gradient inequalities. Rather it raises the whole of the gradient without any levelling up. The differences between the lowest and uppermost ends of the gradient remain unchanged or can even be worsened.

Social determinants of health and causation

Moreover, poverty is a more complex issue than simply not having enough money. The poor are not just those without adequate income: income measurements are not sufficient to describe and identify poverty. For Alston, extreme poverty involves a lack of income, a lack of access to basic services and social exclusion.[694] The UNDP Multidimensional Poverty Index (MPI) seeks to measure multiple deprivations at the household level, including in health, education and living conditions.[695] Quoting Sen:

> Human lives are battered and diminished in all kinds of different ways, and the first task, seen in this perspective, is to acknowledge that deprivations of very different kinds have to be accommodated within a general overarching framework.[696]

The incorporation of 'underlying determinants' (as health facilities, goods and services) in the minimum core results in a growing list of determinants of health as the role of different factors in predisposing people to ill health is better understood. Moreover, the

[694] Arjun Sengupta, 'Report of the Independent Expert on the Question of Human Rights and Extreme Poverty' para 13 <https://primarysources.brillonline.com/browse/human-rights-documents-online/promotion-and-protection-of-all-human-rights-civil-political-economic-social-and-cultural-rights-including-the-right-to-development;hrdhrd99702016149> accessed 3 December 2019.
[695] Office of the High Commissioner for Human Rights, 'OHCHR | Special Rapporteur on Extreme Poverty and Human Rights' (2019) <https://www.ohchr.org/EN/Issues/Poverty/Pages/SRExtremePovertyIndex.aspx> accessed 3 December 2019.
[696] Amartya Sen, 'A Decade of Human Development' (2000) 1 Journal of Human Development 17, 18.

core obligation to provide a public health strategy and plan of action in General Comment 14 should be based upon epidemiological evidence and address the health concerns of the population.[697] Each country will therefore require different issues to be addressed based upon public health evidence and community priorities, and these will become actions to meet core obligations. When action is tailored to the specific epidemiological and community needs for each country, the minimum core is then redefined for that country and items for consideration as minimum core extended more broadly.

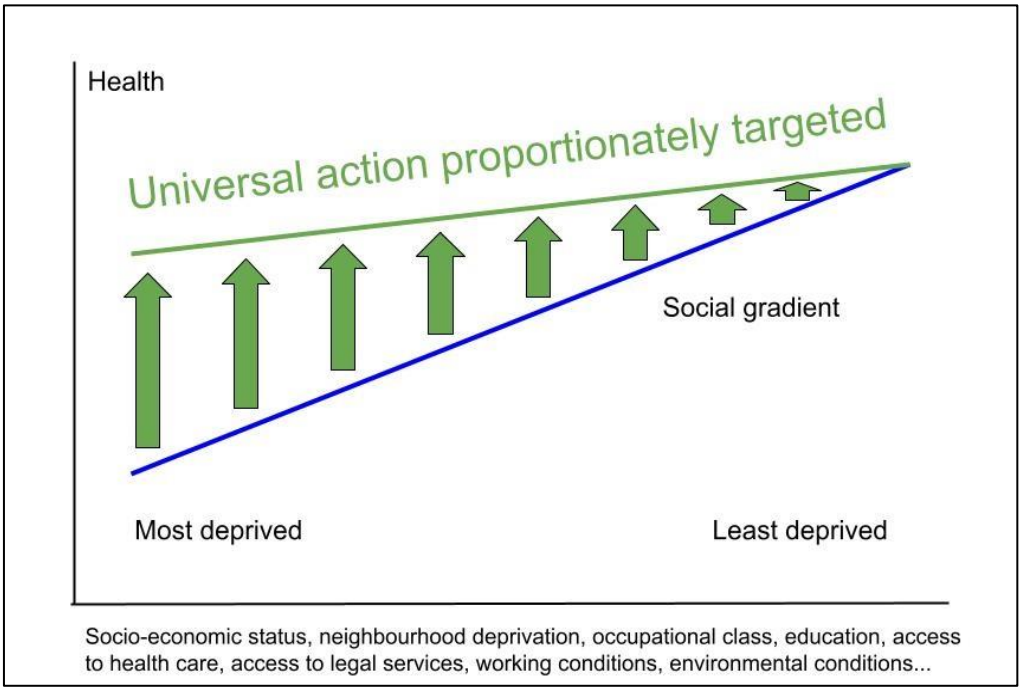
3. Levelling up and proportionate universalism

A social gradient approach to addressing health inequalities could replace the application of a poorly defined minimum core. Proportionate universalism is a policy proposal that adopts a social gradient approach. Joan Benach and others introduce the concept of proportionate universalism as a social gradient approach.[698] Marmot and colleagues went on to present the UK report on health inequalities Fair Society Health Lives (The Marmot Review) where they advocate a policy of proportionate universalism to reduce the steepness of the social gradient.[699] Building upon the work of Walter Korpi and Joakim Palme's 'paradox of redistribution',[700] and Geoffrey Rose's 'strategy for preventive medicine'[701] Marmot and colleagues define proportionate universalism as 'actions of sufficient scale and intensity to be universal but also proportionately targeted

[697] UN Committee on Economic, Social and Cultural Rights, 'General Comment 14 ICESCR' (n 18) para 43.
[698] J Benach and others, 'A New Typology of Policies to Tackle Health Inequalities and Scenarios of Impact Based on Rose's Population Approach' (2013) 67 Journal of Epidemiology and Community Health 286.
[699] Marmot, 'Fair Society' (n 73).
[700] Walter Korpi and Joakim Palme, 'The Paradox of Redistribution and Strategies of Equality: Welfare State Institutions, Inequality, and Poverty in the Western Countries' (1998) 63 American Sociological Review 661.
[701] Geoffrey Arthur Rose, Kay-Tee Khaw and Michael Marmot, *Rose's Strategy of Preventive Medicine: The Complete Original Text* (Oxford University Press 2008).

to reduce the steepness of the gradient'.[702] *Figure 5* illustrates the principle of proportionate universalism: a universal programme with targeted action at different levels and at different intensities within the social gradient 'levelling up' rather than maintaining the steepness of the gradient.

Figure 5 **Proportionate universalism reduces the social gradient.**



Source: Adapted from Allison (2021)[703]

Proportionate universalism could enhance both public health and the right to health as a strategy to reduce social gradient inequalities and has been applied to a variety of public health projects across the globe. For example, Richmond Health (UK) adopted the universalist Health in all Policies (HiAP), an international policy recommendation supported by WHO and the UN and agreed through the Adelaide Statement on Health

[702] Marmot, 'Fair Society' (n 73) 41.
[703] Martyn Allison, 'Proportionate Universalism - Taking the Concept beyond the Theory and into Operational Management' (2021) Sports Think Tank 2021 7.

in All Policies.[704] The programme, aiming to reduce overweight and obesity, was locally applied through six social determinants of health to create targeted interventions in different geographic areas: one plan of action being to promote healthy food store development in urban planning measures.[705] The Human Early Learning Partnership (Canada) developed a universal platform of supports and services made available to all children but with specific actions targeted at those children most vulnerable (identified by family socio-economic status) and which also addressed barriers to access for certain groups (costs, transport, language, culturally appropriate). A 2017 WHO collaboration report suggested proportionate universalism as an evidence-based approach to addressing inequalities in mental health offering it as a policy option in developing their mental health action plan.[706]

Those championing proportionate universalism argue that there is no intention to reduce services and facilities to those at the upper levels of the gradient, nor is there any intention of ignoring the specific barriers and issues experienced by the most deprived.[707] Rather the aim is to provide services and facilities in different ways to meet different needs as a co-ordinated whole system approach. For example, some interventions are universal in their intention but impact the poor because of the gradient in health, such as taxes on sugary drinks or minimum price unit for alcohol. Benach and others observe that for some health problems, depending upon context and the potential effectiveness and efficacy of the solutions, it is necessary to create policies

[704] 'Adelaide Statement on Health in All Policies: Moving towards a Shared Governance for Health and Well-Being: Report from the International Meeting on Health in All Policies, Adelaide 2010.' (World Health Organization; Government of South Australia 2010).
[705] Francis-Oliviero and others (n 139) 6.
[706] World Health Organisation, 'Relevance of the Five Thematic Papers and Related Workshops for the WHO Comprehensive Mental Health Action Plan. Principles, Approaches and Objectives.' (World Health Organization 2017) A WHO-Gulbenkian Mental Health Platform Collaboration <https://www.jstor.org/stable/resrep27876.10> accessed 13 April 2021.
[707] Allison (n 707) 19.

that produce a universal entitlement whose benefits increase because of the social gradient or instead to ensure universal policies that explicitly incorporate criteria to increase resource allocation to populations with higher levels of need.[708] This leads to varying interpretations of proportionate universalism.[709]

However, proportionate universalism still involves setting thresholds for different levels, types and intensities of interventions to ensure fair proportionality. The selection of an index to set thresholds and identify level of need is required and there are questions as to which indices should be used. Gemma Carey and Brad Crammond remark upon the lack of clarity in how disadvantage is to be defined and caution against means testing rather than needs identification of some form.[710] Evaluation of need is critical to the approach. Measures to monitor and gauge success such as appropriate benchmarks and indicators[711] and disaggregated data[712] are important themes throughout the SRRH mission and thematic reports, with two of Hunt's early reports dedicated to this topic.[713] However, health needs and health impact assessments, and human rights impact assessment appear much less often in recommendations to states. Health impact assessment has huge overlap with human rights impact assessment and provides a means to assess all types of policy interventions in terms of their intended and unintended consequences on health.[714] This is an important cornerstone of the HiAP approach. A wide range of processes are involved in health needs assessments

[708] Benach and others (n 702).
[709] Francis-Oliviero and others (n 139).
[710] Gemma Carey and Brad Crammond, 'A Glossary of Policy Frameworks: The Many Forms of "Universalism" and Policy "Targeting"' (2017) 71 Journal of Epidemiology and Community Health 303.
[711] 123 references in 22 mission reports
[712] 34 references in 14 mission reports
[713] Paul Hunt, 'The Right of Everyone to Enjoy the Highest Attainable Standard of Physical and Mental Health' (UN General Assembly Fifty-eighth session 2003) UN Doc A/58/427; Hunt, '2006 Thematic E/CN.4/2006/48' (n 470).
[714] K Salcito and others, 'Experience and Lessons from Health Impact Assessment for Human Rights Impact Assessment' (2015) 15 BMC International Health and Human Rights.

involving consideration not just of needs but also available epidemiological data, types of needs assessed, demands, costs, available resources and contextual issues such as rapid assessment in emergency situations or strategic assessment at higher levels of policy making.[715] However, like health and human rights impact assessments, health needs assessments are only useful if they incorporate values of equity and participation.[716]

Concluding Comments

It is not clear exactly what is meant by the term the highest attainable standard of physical and mental health. The social gradient directs our attention to the top of the gradient as an indicator of what can be achieved in terms of good health outcomes. Venkatapuram warns that we ignore the social gradient at our peril.[717] The individual, societal and intergenerational consequences of ignoring the gradient are significant. Not least because those in the middle of the gradient do not experience the highest attainable standard of health: the right to health is not just for the poor, disadvantaged and discriminated against. The situation is complex as policy interventions can result in improving the health of the richest or access to human rights can advantage those who are wealthy or powerful. How we level up the gradient in health inequalities can result in unintended consequences. Proportionate universalism is one approach to levelling up the gradient to enable everyone to achieve the highest attainable standard of health. How this pertains to the right to health is yet to be explored.

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[715] Public Health Action Support Team, *Public Health Textbook* (Buckinghamshire: PHAST 2010) <http://www.healthknowledge.org.uk/public-health-textbook> accessed 7 October 2013.
[716] A Scott-Samuel and E O'Keefe, 'Health Impact Assessment, Human Rights and Global Public Policy: A Critical Appraisal.' (2007) 85 Bulletin of the World Health Organization 212.
[717] Venkatapuram, 'Social Gradient in Capabilities' (n 12) 555.

Yamin asks that we consider implications of the social gradient for the right to health.[718] In the end we have to ask ourselves what the highest attainable standard of health actually means. In a wealthy society with the means to address health inequalities that could be the health of those at or near the top of the gradient. The minimum core of health care and social determinants of health cannot be seen as a ceiling to aim for. In low- and middle-income countries, and countries that have experienced recent war or disaster, the minimum core of provision might be the best that can be achieved and the trigger for international assistance to prevent falling below a basic minimum. However, the gradient cannot be ignored as there will be extreme wealth even in the poorest countries. There will be those who have greater access to the positive determinants of good health.

How we consider the question of the social gradient in health inequalities depends upon how we understand it to be created. The capability approach is one of a number of perspectives that can help us understand social gradient inequalities. The next chapter will explore the capability approach and what it offers to social gradient, social epidemiology, and the right to health.

[718] Yamin, *Struggle for Dignity* (n 1) 195.

Chapter 6. The Right to Health, the Capability Approach, and the Social Gradient

The social gradient in health inequalities is an important concept in public health (Chapter 1). Firstly, it helps to elucidate a variety of causal processes to explain how social determinants of health impact upon health and is itself a social determinant of health. Secondly, it articulates health inequalities as pertaining not just to specific vulnerable social groups but as distributed across the whole population in a gradient of poorer to better health correlated against a range of social determinants. Examining scholarly literature attending to both public health and the right to health reveals that the social gradient is poorly understood, rarely discussed, and more often mentioned in passing in relation to socio-economic status (Chapter 2). It is not surprising that the right to health does not conceptualise, engage with and act on the social gradient in health inequalities if public health literature at the intersection of the two disciplines fails to provide a clear understanding of the social gradient. Moreover, the historic difficulties between the right to health and public health have impeded the collaborative thinking required to grapple with the concept of the social gradient. One institution of the right to health that has been at the forefront of efforts to clarify the relationship between public health and the right to health is the system of Special Procedures and more specifically the work of the SRRH.

SRRH thematic and mission reports do not conceptualise or engage with the social gradient in health or the social gradient as a social determinant of health (Chapter 4). Nor do the reports act upon social gradient health inequalities. However, analysis of Special Rapporteur reports unequivocally reveals that social determinants of health, most especially structural determinants of health, are fundamental and integral to the right to health. Thus, the right to health is well placed to incorporate the social gradient

as a social determinant of health. Analysis also reveals that action on health inequalities is framed as poverty and non-discrimination and so social gradient inequalities are missed.

In chapter five I responded in part to Yamin's invitation to 'grapple' with the social gradient in terms of how inequalities are framed and acted upon. In this chapter I consider ways of approaching the social gradient in normative and theoretical terms in the absence of any coherent theory or framework for the social gradient. I present the capability approach (as one of several converging explanatory mechanisms for the social gradient) as both a normative foundation and an evaluative framework that would enhance the synergies and overcome some of the barriers between public health and the right to health. I consider how the capability approach might contribute to issues of causation and social determinants of health and provide a different informational base to determine both public health and right to health action, despite the debate regarding the selection of capabilities. The capability approach also highlights the importance of power relationships when considering issues of substantive equality and health justice.

A. The Capability Approach

There are synergies and divergencies between public health and human rights. The purpose and aims of both public health and the right to health are mutually supportive. Both public health and the right to health are dedicated to improvement of health status and outcomes for all members of society; both are committed to improving the status of the vulnerable and disadvantaged (though social medicine has a more statistical and analytic approach compared to the activism of human rights); both have a strong commitment to gender equity; and both have a commitment to UHC (though their

understanding of this is somewhat divergent).[719] Moreover the human rights emphasis on non-discrimination, substantive equality and access to minimum standards of food, clothing, shelter, education, and health resonate with identified structural and intermediary social determinants of health.[720] Different philosophical perspectives and disciplinary language have been highlighted as barriers to understanding between the two disciplines,[721] although 'health and human rights should not be set up as conflicting paradigms'.[722]

The capability approach offers a means to bridge these divides and enhance the synergies. It provides a broad conceptual framework for assessing individual wellbeing, evaluating social arrangements and determining social policy, across the whole social gradient.[723] The capability approach provides both a normative and an evaluative framework that can be used for assessing and measuring a person's ability to do and be what they value: normative in the sense that it is 'freedom focused', and evaluative in that it provides a framework for economic analysis that has important policy and practice applications.[724]

Sen creates an evaluative space other than utility or resources to measure success in promoting and protecting flourishing or wellbeing. Sen's concept of *functionings* 'reflects the various things a person may value doing or being' in order to flourish.[725]

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[719] *Symposium: Human Rights and the Social Determinants of Health. The Potential for Mutual Strengthening. Audrey R. Chapman (5th May 2017)* (Directed by Media Production, 2017) s 1:17:30-1:30:13 <https://www.youtube.com/watch?v=IqIMab-sdro> accessed 22 July 2017.
[720] *Symposium: Human Rights and the Social Determinants of Health. Health and Human Rights: Concepts, History and Potential Contributions to Conversations on the Social Determinants of Health Sofia Gruskin (5th May 2017)* (Directed by Media Production, 2017) s 31:20-42:40 <https://www.youtube.com/watch?v=IqIMab-sdro> accessed 6 May 2017.
[721] Chapman, 'Missed Opportunities' (n 239).
[722] Ferguson (n 234) 410.
[723] Robeyns, 'The Capability Approach' (n 204).
[724] Polly Vizard and Tania Burchardt, 'Developing a Capability List: Final Recommendations of the Equalities Review Steering Group on Measurement' (Centre for Analysis of Social Exclusion London School of Economics 2007) CASE/121 17.
[725] Sen, *Development as Freedom* (n 203) 75.

Functionings are 'beings and doings' and can be active such as being able to exercise, avoid disease or participate in the life of the community, or more passive such as being nourished, having good health, or having self-respect. [726] Functionings thus contribute to flourishing. Sen traces this concept to Aristotle who saw functioning as integral to a person's being.[727] He argues that the Aristotelian view of human good was related to an understanding of what human functions should be and the idea of 'life in the sense of activity' as being the starting point for 'normative analysis.'[728] There are two important aspects to this definition: the achieved functionings must be something that a person values *and* has good reason to value. The functioning must be intrinsically valuable in and of itself. Thus smoking may be valued by an individual but given the health risks it is not valuable in and of itself. Whereas being well nourished will most likely be valued by a person (recognising of course that those with eating disorders may feel differently) and is valuable in and of itself.

Sen describes the abilities or *capabilities* as the opportunities or 'substantive freedoms' a person 'enjoys leading the kind of life he or she has reason to value'.[729] Capabilities thus provide a means to convert the resources available to a person into functionings. These are real concrete options as opposed to notional options and could encompass a whole range of possibilities. This Sen refers to as a 'capability set' which 'represents the freedoms to achieve: the alternative functioning combinations from which this person can choose'.[730] He illustrates this with the example of a kilo of rice which may be sufficient for a person with other available food stuffs but would not provide enough calories for an agricultural labourer or someone with intestinal parasites, or would

[726] ibid 72–75.
[727] ibid 75.
[728] ibid 73.
[729] ibid 85.
[730] ibid 75.

instead provide too many empty calories for a baby, resulting in malnutrition for both and not the functioning of being nourished.[731] Each individual has a different capability set to convert the same basket of 'primary goods' (to borrow a concept from John Rawls which Sen critiques), to different functionings of value.[732] He further provides the example of an affluent person who chooses to fast as having the same functioning achievement as a poor person who is forced to starve, but both having completely different capability sets: the first person choosing from a wide range of options and the second having few or no options at all.[733] The concepts of capabilities and functionings are combined to create an evaluative space: 'the combination of a person's functionings reflects her actual *achievements,* the capability set represents the *freedom* to achieve: the alternative functioning combinations from which this person can choose'.[734]

The capability approach as originally envisaged by Sen has been developed in diverse directions all of which emphasise distinct elements of the original. Martha Nussbaum identifies the main concepts of the capability approach as being: taking each person as an end in themselves, freedom, being pluralist about values, concern with social injustice and tasking governments with action.[735] Séverine Deneulin focuses upon three main concepts: functionings, capabilities and agency.[736] Alkire, in discussing Sen's work identifies four important elements: functionings, freedom, pluralism and incompleteness.[737] Ingrid Robeyns summarises these divergent views and offers a modular conception of the capability approach whereby there are certain core elements

[731] ibid 69
[732] ibid 75–77.
[733] ibid 75.
[734] ibid.
[735] Martha Craven Nussbaum, *Creating Capabilities: The Human Development Approach* (Belknap Press of Harvard University Press 2011) 19–20.
[736] Séverine Deneulin and J Allister McGregor, 'The Capability Approach and the Politics of a Social Conception of Wellbeing' (2010) 13 European Journal of Social Theory 501, 503.
[737] Alkire (n 203) 4–11.

upon which all practitioners must agree (or it is no longer the capability approach). She argues that there are other elements which must be included though perhaps with differing perspectives and elements which are optional depending upon the purpose of the study.[738] Robeyns' key constructs include: capabilities and functionings, conversion factors, the distinction between means and ends to value a person as an end, and value pluralism. Essential elements may differ in their interpretation but need to be included for it to be consider the capability approach and include accounts of human diversity, agency, structural constraints and a selection of dimensions of capability. Robeyns has developed a schematic to understand how these key capability approach attributes interrelate (Appendix 14).

1. Normative dimension

The first task is to establish the normative nature of the capability approach for it to be able to provide a sufficient conceptual framework for both the right to health and public health. Nussbaum argues that the capability approach can be used for various purposes but if it is to be used to establish political or policy principles that enhance social justice, then 'the normative exercise is crucial, difficult though it may be.'[739]

Both human rights and capabilities emphasise the equal moral worth of human beings and the importance of freedoms and social justice. The foundational principle of human rights is that '[a]ll human beings are born free and equal in dignity and rights'.[740] Health is a human right.[741] Nussbaum 'invoke[s] the notion of human dignity and of a life worthy

[738] Ingrid Robeyns, *Wellbeing, Freedom and Social Justice: The Capability Approach Re-Examined* (Open Book Publishers 2017) 74 <https://www.openbookpublishers.com/product/682/> accessed 21 February 2018.
[739] Nussbaum (n 739) 29.
[740] United Nations, 'UDHR' (n 14) Art. 1.
[741] UN General Assembly, 'ICESCR' (n 14) Art. 12.

of it' to create a normative rather than just an evaluative framework.[742] Her understanding of the capability approach includes the concept of human dignity whereby every human being is endowed with an ethical capacity or conscience that requires that all human beings should be treated equally and reverentially, without being made subject to abuse or oppression.[743] The main contention being that the freedom to flourish is of primary moral importance: that is a person's ability to do and be what they value, thus determining the kind of life they are able to lead, should be the focus of any discussion of wellbeing or human development.[744]

The capability approach has substantive overlaps with human rights, but as Sen asserts '[c]apability is…a critically important part of the story, but it cannot claim to occupy the entire space from which human rights are drawn'.[745] Human rights can also provide the site and the means of effective struggle against the powers of vested interests, paternalism or oppression.[746] Importantly human rights command correlative obligations that assign duties and demand accountabilities of States and other actors around which action can be co-ordinated. However, Chapman argues that the capability approach does not.[747] She argues that whilst Nussbaum's ten human capabilities describes a broad conception of human needs and behaviours few of these capabilities are adequately delineated to generate correlative obligations on States.[748] Similarly lacking she argues are Venkatapuram's capability to be healthy (CH) as a cluster of interrelated and basic capabilities or Jennifer Prah Ruger's conceptions of shortfalls in equality. This

[742] Nussbaum (n 739) 29.
[743] ibid 130.
[744] Robeyns, 'The Capability Approach' (n 204).
[745] Forward by Amartya Sen in Diane Elson, Sakiko Fukuda-Parr and Polly Vizard (eds), *Human Rights and the Capabilities Approach: An Interdisciplinary Dialogue* (Routledge 2012) xv.
[746] *Symposium: Human Rights and the Social Determinants of Health. The Potential for Mutual Strengthening. Audrey R. Chapman (5th May 2017)* (n 723).
[747] Audrey R Chapman, 'The Foundations of a Human Right to Health: Human Rights and Bioethics in Dialogue' (2015) 17 Health and Human Rights 6.
[748] ibid 12.

suggests that the capability approach requires human rights to strengthen its claims and human rights, or more specifically, the right to health requires a capability approach to describe its notion of health more fully. Nowhere does the right to health define what is meant by health other than it is not a right to be healthy. Paragraph 4 of General Comment 14 notes that the WHO definition of health was not adopted by the General Assembly.[749]

Many different approaches have been incorporated into public health and epidemiology, such that public health does not have a clear theoretical foundation.[750] Many theories have entered epidemiology from other fields and bring with them an ontology and epistemology that contain concepts and assumptions which remain untested within their adoptive field.[751] Five distinct paradigms have greatly influenced public health theory and practice: sanitary-environmental, social-behavioural, biomedical, techno-economic and ecological.[752] These are drawn from a variety of other disciplines, and although developed chronologically they all influence current public health practice to a greater or lesser degree.

Krieger takes a critical view of the development of epidemiology and thus public health when she argues that very little attention is paid to underpinning concepts and theories.[753] She provides examples of harm done to individuals and populations because of this failing.[754] She details several other approaches to social epidemiology

[749] UN Committee on Economic, Social and Cultural Rights, 'General Comment 14 ICESCR' (n 18) para 4.
[750] Krieger, 'Historical Roots of Social Epidemiology' (n 79).
[751] Krieger, *Epidemiology* (n 38) 126.
[752] Rayner and Lang (n 39).
[753] Krieger, *Epidemiology* (n 38).
[754] ibid 8 Examples include: 1960's use of hormone therapy for menopause as preventive for cardiovascular disease in women based upon low rates of the disease in women seen in epidemiological data; high incidence of diabetes in indigenous peoples being attributed to 'diabetes genes' rather than historical socio-economic structural factors.

that run counter to these dominant theories of public health. The most notable of which is the 'social determinants of health' approach which challenges 'unfair, unjust and avoidable social inequalities' and adopts overtly political and power-related understandings of the systemic and structural conditions of society that impact health.[755] Drawing upon the work of Syme,[756] Venkatapuram argues that the bio-statistical risk factor approach to epidemiology has brought the discipline to crisis point.[757] If only 40% of ill health can be attributed to known factors, Then predominant epidemiological models have limited explanatory power.[758]

Normatively, the capability approach appeals because it shifts the focus of public health action from resources and biomedical interventions to freedom to lead lives of value, and the consequent importance of freedom to choose and democracy.[759] It provides 'a ''freedom focussed" framework for economic analysis that concentrates on the achievement (and lack of achievement) of human capabilities'.[760] It is suffice to say that the principal foundation of the capability approach is the value given to being able to make decisions about one's own life from a wide range of realistic options and choosing a life that is of value to that individual. The capabilities approach is inherently pluralistic: to permit space for the pluralism of peoples, values, beliefs, and views to which it must

[755] ibid 163.
[756] S Leonard Syme, 'Rethinking Disease: Where Do We Go from Here?' (1996) 6 Annals of Epidemiology 463; S Leonard Syme and Jennifer L Balfour, 'Explaining Inequalities in Coronary Heart Disease' (1997) 350 The Lancet 231.
[757] Sridhar Venkatapuram, *Health Justice: An Argument from the Capabilities Approach* (Polity 2011) 74–79.
[758] Acknowledging that Syme asserted this case in 1996 and additional genetic factors have also been identified. These, however, still fail to account for the majority of ill health.
[759] Jean-Michel Bonvin and Francesco Laruffa, 'Towards a Capability-Oriented Eco-Social Policy: Elements of a Normative Framework' (2022) 21 Social Policy and Society 484.
[760] Vizard and Burchardt (n 728) 17.

be applied.[761] This enables its flexibility to be both normative and evaluative and to bridge both public health and the right to health.

2. Evaluative dimension

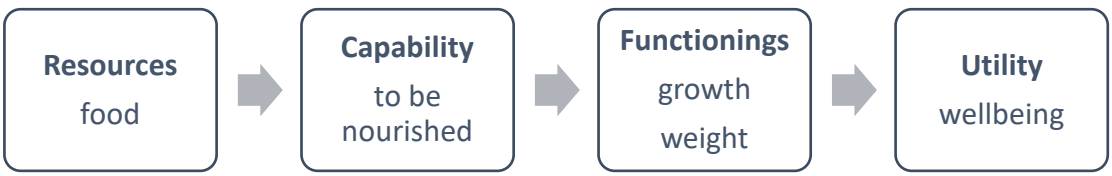
Whilst there is a growing evidence base for the adoption of the capability approach in public health, this is largely for evaluative rather than normative purposes. The evaluative dimension of the capability approach has been most influential in public health, particularly in relation to poverty and social welfare.[762] The appeal of the capability approach to public health is that it offers an alternative framework for evaluation. Utilitarian approaches to health often consider health as an input, a healthy population provides a workforce for economic growth, or health as an output, whereby economic growth permits a healthier population and might be measured in terms of the ends in terms of wellbeing, satisfaction, or utility. [763] An epidemiological focus would evaluate health status in terms of the incidence and prevalence of ill health or disease. For example, the health status of obesity is important because of its limited utility in terms of the negative impacts upon the individual and the costs incurred by the health service. These are valuable ends to highlight where there are issues, but such information does not help us to decide what public health action to implement. The capability approach is an ideal framework for epidemiological studies as it incorporates the interrelationship between a wide range of causative or risk factors.[764] The spaces

[761] David A Clark, 'The Capability Approach: Its Development, Critiques and Recent Advances' (Institute for Development Policy and Management, University of Manchester, UK 2005) ESRC Research Group GPRG-WPS-032.
[762] Paul Mark Mitchell and others, 'Applications of the Capability Approach in the Health Field: A Literature Review' (2017) 133 Social Indicators Research 345.
[763] See discussion in Ariana Proochista and Arif Naveed, 'Health' in Severine Deneulin and Lila Shahani (eds), *An Introduction to the Human Development and Capability Approach: Freedom and Agency* (1st edn, Routledge 2009) <https://www.taylorfrancis.com/books/9781849770026> accessed 7 March 2019.
[764] Ingmar Skoog and others, 'A Multidisciplinary Approach to Capability in Age and Ageing' in Hanna Falk Erhag and others (eds), *The Capability Approach in Epidemiological Studies*, vol 31 (Springer

between resources and health outcomes are crucial because there are a multiplicity of factors, different for each and every individual, that influence the pathway from resource to health.

Sen rejects the measurement of income, commodities or resources as a measure of wellbeing in a population or for an individual: though it is important to point out that he does recognise that goods and resources are necessary contributors to wellbeing.[765] Sen is equally troubled with the measurement of utility in the form of happiness, satisfaction or self-reported health.[766] Particularly because of 'adaptive preferences' (see below) where some may have become inured to their limited freedoms, poverty or marginality and have little expectation that life could be different or that they could have choices, Sen creates an evaluative space other than resources or utility to measure success in promoting and protecting flourishing or wellbeing (Figure 6), by combining the concepts of capabilities and functionings.

Figure 6 **Representation of the capability approach spaces for evaluation.**



Capabilities are the opportunities or 'substantive freedoms' a person 'enjoys to lead the kind of life he or she has reason to value'.[767] Capabilities thus provide a means to convert the resources available to a person into functionings. These are real concrete

International Publishing 2022) <https://link.springer.com/10.1007/978-3-030-78063-0> accessed 21 October 2022.

[765] Sen, *Development as Freedom* (n 203).

[766] *Interview with Amartya Sen on the Quality of Life (Part 1) by Ingrid Robeyns (24th January 2013)* (Directed by 64 Minutes, 2013) <https://www.youtube.com/watch?v=12r13whU4Rw> accessed 18 March 2017.

[767] Sen, *Development as Freedom* (n 203) 85.

options as opposed to notional options and could encompass a whole range of possibilities.[768] 'The combination of a person's functionings reflects their actual *achievements,* the capability set represents the *freedom* to achieve: the alternative functioning combinations from which this person can choose'.[769] This Sen refers to as a 'capability set' which 'represents the freedoms to achieve: the alternative functioning combinations from which this person can choose.'[770]

3. An incomplete theory

The capability approach has an internal pluralism which comes from Sen's innovation of the opportunity to realise functionings in ways which fit with different moral concepts of a good life of value.[771] Nussbaum invokes the concept of dignity, resonant with human rights principles, to provide the normative foundation to the capability approach.[772] Jay Drydyk believes this insufficient and instead advocates a 'responsible pluralism'.[773] Not to try and identify overlapping consensus grounded in human dignity where certain beliefs and values may be marginalised, but instead to recognise that we all have a common shared enterprise, from whatever moral standpoint, to live a life of value. The responsibility then arises to attend to those things that cause neglect, suffering and harm and to exclude these from selected capabilities.

Whilst it is essential to attempt a justification of the capability approach for a global understanding of health needs. Ruger is strongly critical of what she sees as under-

[768] For example, Nussbaum's list of 10 central capabilities include life, bodily health, bodily integrity, senses imagination and thought, emotions, practical reason, affiliation, other species, play and control over ones' environment. Nussbaum (n 739) 33–34.
[769] Sen, *Development as Freedom* (n 203) 75.
[770] ibid.
[771] Clark (n 765).
[772] Nussbaum (n 739) 29–33.
[773] Jay Drydyk, 'Responsible Pluralism, Capabilities, and Human Rights' in Diane Elson, Sakiko Fukuda-Parr and Polly Vizard (eds), *Human Rights and the Capabilities Approach: An Interdisciplinary Dialogue* (Routledge 2012).

specification of the capability approach as a theory of social justice and as a guide to policy development and yet she continues to utilise the strengths of this very different evaluative space and the normative implications of the capability approach to advance a means towards a more just social policy.[774] To do so she invokes Cass Sunstein's theory of Incompletely Theorized Agreements.[775] Sunstein identified a strategy used in law to bridge the pluralistic beliefs about what justifies a law and the need to apply that law and come to a decision. This he termed an Incompletely Theorized Agreement such that where people disagree upon fundamental principles, they move to a lower level of particularities upon which they can agree. This, he argues, also occurs in society more broadly thus enabling a social consensus and maintaining social stability. Ruger uses Sunstein's theory as a 'normative and prescriptive analytical framework for public policy'.[776] Thus she argues that it is an indispensable additional element to the capability approach with its inherent pluralism and its usefulness towards specifying capabilities in order to operationalise the approach for public policy development.

B. The Social Gradient and Concepts of Causation

As discussed, the SRRH mission and thematic reports address social determinants of health as a central feature fundamental to the right to health, so the social gradient as a social determinant of health which determines the unfair distribution of health inequalities should be incorporated into the right to health. To incorporate the social gradient in the right to health requires that public health and right to health academics and practitioners need to collaborate upon a shared understanding of causation. However, how do you prove the pathway from policy to heart attack? We need to be

[774] Jennifer Prah Ruger, *Health and Social Justice* (Oxford University Press 2010).
[775] Cass R Sunstein, 'Incompletely Theorized Agreements' (1995) 108 Harvard Law Review 1733.
[776] Ruger, *Health and Social Justice* (n 778) 73.

mindful of the public health mantra ‘correlation is not causation’ and recognise that the social gradient articulates correlation between a range of health determinants and health (or social) outcomes for which there is robust evidence.

The important underlying principle for the explanatory mechanisms for the social gradient presented in chapter one is the understanding that there is no direct linear pathway of causation between a social determinant and a health outcome. There are various explanatory mechanisms for the social gradient including psycho-social theory, intersectionality, the life-course approach, social determinants of health and the capability approach. These explanatory mechanisms are not mutually exclusive and can overlap or complement each other. For example, Marmot expands the psycho-social theory around stress responses, to include the life-course approach and notions of the ‘good conditions of daily life.’[777] Marmot demonstrates, in the 1970’s Whitehall studies, that the control one has over one’s own life and the decisions one can make is an important determinant of health and quality of life.[778] Each determinant is mediated or exacerbated by many others, involves bi-directional processes, and has differential impacts upon people living in diverse circumstances. Also, when discussing social determinants of health, we must recognise that the term references the harms and risks to health. It does not represent the ‘good conditions of daily life’ that Marmot speaks of.

Similarly with the capability approach, a direct causal pathway cannot be demonstrated; however, a more fine-grained examination of the alternative space for evaluation provided by the capability approach reveals the significance of conversion factors and constraining factors. Conversion factors influence the relationship between resources and capabilities and constraining factors between capabilities and functionings.

[777] Venkatapuram, ‘Social Gradient in Capabilities’ (n 12) 556.
[778] See Marmot, *The Health Gap* (n 197) ch 5.

Robeyns has developed a schematic that places the capability set, the opportunity set for achievable functionings, at the centre of the analysis rather than resources available or health outcomes (Appendix 14).[779] In her modular framework she explains the central importance of conversion factors and constraining factors to the capability approach.

1. Conversion factors and causation

Conversion factors are a core idea of the capability approach. They can be categorised into personal, social, and environmental factors.[780] Personal conversion factors relate to the individual: physiological, genetic, cognitive, emotional, and behavioural dispositions. With the example of nutrition above, this may include whether someone has a physiological reason to avoid certain foods, or whether they are a child needing specific nutrients to grow or a labourer requiring additional calories. The social conversion factors relate to social norms, policies, laws, social hierarchies and power structures, family structures, and social characteristics (class, gender, race, etc.). Certain social mores for example may mean the foods available are not permitted and those that are permitted are unavailable, or family structures may preference the males when apportioning meals. Environmental conversion factors are those of the geographic, built and natural environments in which people learn, work, and live. Perhaps foods are available but there is no means to prepare and cook them. If all these factors are favourable that person will have the capability to be nourished and a range of options available: eating a balanced diet, managing diet to reduce obesity, preparing for a marathon, celebrating events with family and friends, and so on.

[779] Robeyns, *Wellbeing, Freedom and Social Justice* (n 742) 80–84.
[780] ibid 46–47, 83.

Conversion factors align to social determinants of health, which influence many steps in causal processes. Social determinants influence resources available to us as individuals, groups and to the population. They also determine exposure to risks and vulnerabilities. Social determinants define each person's conversion factors, the set of capabilities or realistic opportunities people may have to 'live a life we value and have reason to value' and constrain the choices people may make. Focusing upon these many processes between resource and outcome helps to explain the social gradient.

Structural factors, in Robeyns' framework, refer to the institutions, policies, social norms, cultural expectations, governance and laws that can influence people's conversion factors. These may shape access to material resources, but more importantly also determine whether those material resources can be converted to achieve capabilities. The impact of structural constraints is highly dependent upon contextual factors.[781] Robeyns provides the examples of laws criminalising same-sex relationships, people of colour facing labour market discrimination, or those stigmatised by mental ill health. All affected may have material resources but are unable to convert those resources into capabilities to have a family life, career advancement or social relationships for example.

2. Constraining factors and agency

The next layer in the causative chain are factors that may constrain a person's choosing of the actual options available. This may not mean a formal deliberation of the pros and cons but something as simple as feeling hungry or tired, or the influence of people present at that moment in time. Constraining factors also include larger societal, environmental, and cultural factors which determine the choices people may make.

[781] ibid 65–66.

Having an account of the influence of constraining factors and how they contribute to causation is fundamental to the capability approach.[782] It is also central to understanding the social gradient.

The ability to control one's environment and make one's own choices is an important causative factor in ill health. Identified by Marmot in the Whitehall Studies of the 1970s, this theory has been researched and developed extensively over the last four decades and has gained much traction in public health.[783] For example, biomedical research has identified physiological mechanisms to explain the pathway between control and health in individuals,[784] and sociological research has evidenced the relationship between control and societal health.[785]

The notion of control or agency is a necessary feature of the capability approach, but one which, according to Robeyns' modular understanding of the capability approach, can accommodate many interpretations.[786] Sen's definition of an agent is 'someone who acts and brings about change, and whose achievements can be judged in terms of her own values and objectives, whether or not we assess them in terms of some external criteria as well'.[787] Many of the capabilities included in Nussbaum's list of ten central capabilities include the notion of control: control over one's own body, being able to move freely from place to place, being able to play, having political and material control over one's environment, and the ability to sense, think and reason.[788] Venkatapuram

[782] ibid 66 & 202–210.
[783] Marmot and others, 'Health Inequalities among British Civil Servants' (n 8).
[784] Brunner and Marmot (n 197).
[785] Wilkinson and Pickett (n 150).
[786] Robeyns, *Wellbeing, Freedom and Social Justice* (n 742) 59–64.
[787] Sen, *Development as Freedom* (n 203) 19.
[788] Nussbaum (n 739) 33 & 34.

argues that the 'capability to control one's daily environment through the life-course must be identified as a basic human capability'.[789]

The notion of control and agency is open to multiple interpretations and challenges. Not least concerning adaptive preferences. Sen's notion of control or agency relies on reflection and reasoning to convert capabilities into functionings. [790] This does not necessarily mean, however, that a person making unhealthy choices is unable to reflect or lacks critical ability. Adaptation of preferences to the context in which people live can undermine such critical ability and self-reflection. People can internalise the harshness of their circumstances so that they do not desire what they can never expect to achieve. [791] People may become accepting or inured to their circumstances and not perceive any injustice when they have assumed such situations to be normal, deserved, or unchangeable. Adaptation is an important notion when considering what is valued as wellbeing and has many dimensions.[792] People can adjust their aspirations to fit what realistic options are available to them.[793]

Reasoning and public debate are essential for raising awareness of the real contexts of people's lives and can influence change in the values and choices people may have. In her discussion of health agency, Ruger notes that agency in health terms requires a conceptualisation of what constitutes good health and the pursuit of valuable health goals.[794] This in turn is influenced by social norms including social expectations, lifestyle factors, and even misconceptions. The agent therefore requires critical ability and self-

[789] Venkatapuram, 'Social Gradient in Capabilities' (n 12) 556.
[790] Sen, *Development as Freedom* (n 203) 17.
[791] ibid 62–63.
[792] Miriam Teschl and Flavio Comim, 'Adaptive Preferences and Capabilities: Some Preliminary Conceptual Explorations' (2005) 63 Review of Social Economy 229, 244.
[793] Jon Elster, *Sour Grapes: Studies in the Subversion of Rationality* (Cambridge University Press 2016) 110 <https://www.cambridge.org/core/books/sour-grapes/F2076EE5F87E99C6A47C708D7D99509A> accessed 27 October 2022.
[794] Ruger, *Health and Social Justice* (n 778) 146–150.

reflection to make choices that result in positive health functionings. However, what if the context in which we live is not conducive to such reflection? Where such a context exists, the opportunity set and achievable functionings are significantly diminished.

Care must be taken to not reduce an understanding of causation to simply focus upon individual behaviours and individual lifestyle choices. Some authors including Nussbaum see adaptive preferences as a deficit to reasoning and a threat to autonomy.[795] Alistair Wardrope argues that an equal threat to autonomy can occur when measures to redress adaptive preferences can 'invite worrying, coercive remedies for perceived deficits of autonomy'.[796] Manipulation of preference formation, through for example provision or restriction of information, failing to address false information, proliferation of certain information through social media echo chambers, and processes of socialisation into society, is particularly important and speaks to such 'coercive remedies'.[797] Paternalistic public health interventions such as applying a sugar tax or warnings on tobacco product labelling seek to influence health behaviours and improve outcomes by manipulating peoples' autonomy to choose. Wardrope argues that such paternalistic interventions undermine peoples' sense of their ability to make reasoned choices and exacerbates adaptive preferences.[798] This can result in victim blaming and stigmatisation further undermining people's ability to make healthy choices. It is a reductionist view that focuses upon risk factors and a very limited concept of holism.[799]

It is a false dichotomy to present action on autonomy and choice in causation as either non-interference or paternalism, but rather a more complex ecological understanding is

[795] Nussbaum (n 739) 81–84.
[796] Alistair Wardrope, 'Relational Autonomy and the Ethics of Health Promotion' (2015) 8 Public Health Ethics 50, 60.
[797] Elster (n 797) 116–118.
[798] ibid 56.
[799] Krieger, *Epidemiology* (n 38) 202.

needed that perceives causation as a varied interaction of multiple individual, institutional and social factors, occurring at different social levels, through generations, across the life-course, and in time and space.[800]

The place of power and its relationship to autonomy and control is one central construct in understanding causation in epidemiologic ecological models and is a growing concern for human rights. Krieger draws upon a political economy of health framework to explain how political and economic systems both drive and constrain individual, institutional and social action at all levels thus determining the distribution of disease and health inequalities.[801] The CSDH 2008 report places action on the inequitable distribution of power, money and resources as central to addressing the social gradient in health inequalities.[802] This perspective from epidemiology and public health is becoming influential in the right to health.[803] Empowerment and active participation have long been fundamental principles of the right to health. However, in recent decades the tentative acknowledgement of political and economic systems' influence on health has been extended and deepened with growing debates concerning the relationship of power to poverty, and neoliberal political and economic systems and inequality.[804]

The understanding of power in the capability approach is less clear. Peter Evans criticises the lack of consideration of power in Sen's capability approach: 'he does not explore the ways in which influences on 'mental conditioning' might systematically

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[800] ibid 7; Wardrope (n 800) 55.
[801] Krieger, *Epidemiology* (n 38) 225–235.
[802] Commission on Social Determinants of Health (n 10) pt 4.
[803] See for example Nancy Krieger and others, 'Who, and What, Causes Health Inequities? Reflections on Emerging Debates from an Exploratory Latin American/North American Workshop' (2010) 64 Journal of Epidemiology and Community Health 747.
[804] Alston, '2015 Thematic A/HRC/29/31' (n 127); Chapman, *Global Health, Human Rights, and the Challenge of Neoliberal Policies* (n 405); See for example, Moyn (n 375).

reflect the interests of those with greater economic clout and political power'.[805] Stewart and Deneulin perceive limitations in Sen's view of reasoning and public debate: 'Sen's concept of democracy seems an idealistic one where political power, political economy, and struggle are absent'.[806] Alexander points out that it can be argued that aligning one's theory with positive liberty can in Berlin's view, risk progression to paternalism or authoritarianism, the question for Berlin being who or what has control over an individuals' life and to what extent, and that in response Sen is very much mindful of the issue of authoritarianism and is not in any way advocating for paternalism.[807] Evans, Alexander, and Stewart and Deneulin offer no easy solutions to the issue of power from within the capability approach but return us to broader considerations such as the 'capabilities of states' and the place and form of 'struggle'. This from Stuart Corbridge:

> The pursuit of intrinsic freedoms is sometimes encouraged by a restriction on some individual freedoms or identities, however much we wish this was not so. Sen is surely right to insist that development is, finally, about freedom. But to become 'developed' is not simply a matter of maximizing individual freedoms. Development also involves concerted struggles against the powers of vested interests, at all spatial scales.[808]

Making choices and control are central to the capability approach and to public health explanations of the social gradient. This is important to an understanding of causation as not just concerning factors that determine the distribution of vulnerabilities and risk, or that determine the ability of people to enjoy specified capabilities, but as factors that constrain the availability of choices and constrain people's ability to choose. The notion of control or agency is an important aspect of causation that cannot be unmoored from

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[805] Peter Evans, 'Collective Capabilities, Culture and Amartya Sen's Development as Freedom' (2002) 37 Studies in Comparative International Development 54, 58.
[806] Frances Stewart and Séverine Deneulin, 'Amartya Sen's Contribution to Development Thinking' (2002) 37 Studies in Comparative International Development 61.
[807] John M Alexander, *Capabilities and Social Justice: The Political Philosophy of Amartya Sen and Martha Nussbaum* (Ashgate Pub Ltd 2008) ch 7.
[808] Stuart Corbridge, 'Development as Freedom: The Spaces of Amartya Sen' (2002) 2 Progress in Development Studies 183, 209.

social, political, and economic contexts. There are, however, multiple conceptualisations of autonomy. Public health, human rights and the capability approach are yet to grapple with such issues in a way that unites them all conceptually and in terms of action upon the 'causes of the causes of the causes' of diminished wellbeing, morbidity, and mortality.

3. The informational basis of policy making.

The informational basis of public health policy making and monitoring of the right to health is clearly recognised as important in SRRH reports which frequently call for the collection of disaggregated data. Early in the mandate the SRRH stressed the importance of indicators to identify different population groups who may disproportionately experience poorer health outcomes and to develop human rights-based monitoring of principles such as participation, accountability, and progressive realisation.[809] Hunt and MacNaughton emphasise that indicators should correspond to human rights norms and incorporate monitoring interrelated factors such as a public health national strategy and plan of action that includes the right to health.[810] In policy making, indicators determine the dimensions included or excluded, shape the agenda, influence the analysis, include or exclude participation of certain groups in society, and provide impetus for action.[811]

The evaluative framework of the capability approach expands the informational basis for the right to health and for public health and facilitates capability-promoting policies. For

[809] Hunt, '2003 Thematic A/58/427' (n 717); Paul Hunt, 'The Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health' (UN General Assembly Fifty-ninth session 2004) A/59/422; Hunt, '2006 Thematic E/CN.4/2006/48' (n 470).
[810] Paul Hunt and Gillian MacNaughton, 'A Human Rights-Based Approach to Health Indicators' in Mashood Baderin and Robert McCorquodale (eds), *Economic, Social, and Cultural Rights in Action* (Oxford University Press 2007) 313–314.
[811] Hans-Uwe Otto, Melanie Walker and Holger Ziegler, *Capability-Promoting Policies: Enhancing Individual and Social Development* (Policy Press 2018) 7–10.

example, The Equality Measurement Framework (EMF), developed by Alkire and colleagues for the *Equality and Human Rights Commission* in the UK, drew upon Sen's capability approach and the international human rights framework to identify indicators that would provide a baseline of evidence for evaluating progress and deciding priorities.[812] The framework addresses inequality of outcome, process and autonomy, across ten domains[813] for eight protected characteristics.[814] An equivalent framework was developed for children.[815] Such a framework is not without its difficulties.[816]

The issue is deciding which capabilities and functionings constitute health, wellbeing, or flourishing and which ones should comprise the evaluative space and should be measured. Sen declines to stipulate specific capabilities because of the plurality of differing views of what constitutes a good life and the centrality of the notion that each individual themselves chooses a life of value.[817] Nussbaum argues that the specification of capabilities is dependent upon what you wish to achieve with them.[818] However, she proposes ten central capabilities as a core set of fundamental entitlements in order to create political principles, constitutional law and a society grounded in social justice.[819] Other capability approach theorists have taken different routes to specifying capabilities,

[812] Sabina Alkire and others, 'Developing the Equality Measurement Framework: Selecting the Indicators' (Equality and Human Rights Commission 2009) 31.
[813] Life; health; physical security; legal security; education and learning; standard of living; productive and valued activities; individual, family and social life; identity; expression and self-respect; participation influence and voice.
[814] Age, disability, ethnicity, gender, religion or belief, sexual orientation, transgender, social class.
[815] Holly Holder, Tiffany Tsang and Polly Vizard, 'Developing the Children's Measurement Framework:' 347.
[816] Sylvia Walby and Jo Armstrong, 'Developing Key Indicators of "Fairness": Competing Frameworks, Multiple Strands and Ten Domains – an Array of Statistics' (2011) 10 Social Policy and Society 205; See for example Mark Priestley and Stefanos Grammenos, 'How Useful Are Equality Indicators? The Expressive Function of "Stat Imperfecta" in Disability Rights Advocacy' (2021) 17 Evidence & Policy 209.
[817] Alkire (n 203) 29.
[818] Nussbaum (n 739).
[819] In *Creating Capabilities* p33–34 Nussbaum lists the 10 fundamental capabilities as being: life, bodily health, bodily integrity, senses, imagination and thought, emotions, practical reason, affiliation, other species, play, and control over ones political and material environment.

depending upon what they wish to achieve with them.[820] Ruger closely follows Nussbaum's idea of central capabilities and thresholds, drawing particular attention to avoidable mortality and morbidity (as opposed to non-central capabilities) to create a framework for health policy financing, prioritisation and planning.[821] Alkire offers a practical means for small or poor communities to debate the capabilities that are of particular value to themselves.[822] Deneulin chooses the ambiguities of the language of the capability approach to propose a transformative space where social actors in relationship with others can seek to act justly and create freedom of opportunity for living well, shaping our own and others' lives and protecting the environment in which we live together.[823] Venkatapuram advocates the CH as a cluster of capabilities and functionings to define health justice.[824]

It is therefore not clear as to what should be measured and selecting specified capabilities poses certain risks. Alkire identifies three key risks in specifying capabilities: prescriptivity, epistemology and power.[825] The issue of prescriptivity is concerned with the potential for the imposition of norms upon communities for which the norms may not have the same significance or meaning. Alkire acknowledges that Nussbaum has worked transparently to develop a high-level generalisation of universal norms that can be adapted and adopted in a variety of ways to suit specific contexts and circumstances, but questions how this could be achieved in practice when its purpose is to make comparisons across nations, societies and communities which

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[820] Each theorist employing different theoretical approaches, for example Ruger draws upon an iterative process of dominance partial ordering combined with concepts drawn from social choice theory and incompletely theorised agreements; Alkire suggests John Finnis's 'dimensions of well-being' separating the practical from the normative to articulate the valuable human dimensions important to a particular group.
[821] Ruger, *Health and Social Justice* (n 778).
[822] Alkire (n 203) ch 2.
[823] Séverine Deneulin, *Wellbeing, Justice and Development Ethics* (Routledge 2014).
[824] Venkatapuram, *Health Justice* (n 761).
[825] Alkire (n 203) 35–43.

differ. Epistemologically the question is how we know what people would or should prefer. Here Alkire raises the issue of socially conditioned consciousness, or what Sen terms adaptive preferences, and who decides that a preference is false and should be changed. This brings her to the issue of power and political voice: whose voices are heard in the process of selecting capabilities? A clarification of such a process is required.

The process of selecting capabilities to avoid the attendant risks then becomes more important than having an immutable list. Hunt and MacNaughton also identify process as important when they recommend structural, process and outcome indicators, as process measures towards achieving the right to health, for example, the number of training programmes and campaigns promoting sexual and reproductive health rights.[826] The EMF demonstrates that a synthesis of indicators can be achieved for both human rights and a range of social determinants of health that does not just focus upon functionings and outcomes, but also upon processes, capturing the conversion factors-capabilities-constraining factors aspect of the evaluative space.[827] Yet these notions do not capture the process as understood in the capability approach. Sen recognises that capabilities do need to be specified and ordered, particularly for poverty measurement and analysis, but advocates a process of evaluation, public debate, dialogue and reasoning to do so.[828] Alkire argues that if there is a locally agreed understanding based upon reasoned debate, which the capability approach favours, then what is required is a process rather than a list.[829] Whilst Alkire details methodologies for identifying valued beings and doings at a local community level she also draws upon theories such as Len

[826] Hunt and MacNaughton (n 814) 316–317.
[827] Alkire and others (n 816).
[828] Alkire (n 203) 28–29.
[829] ibid 2 section 3.

Doyal and Ian Gough's intermediate and basic needs influential in public health and Rawls' basic needs influential in human rights, for the purposes of poverty reduction.[830] It seems hard to avoid the compulsion to specify capabilities or dimensions to be measured and applied.

The capability approach maintains that equal respect for the moral worth of every human being compels society to ensure that all individuals have an adequate and equitable capability to conceive of and pursue their life plans. Different understandings of causation permit alternative points of entry for policy action.[831] The evaluative space offered by the capability approach would provide points of entry to address conversion and constraining factors. Supporting capabilities and functionings should be the final ends of ethical policy making.[832] This suggests that policy action should occur along the whole of the gradient rather than targeted at poverty or wealth at each end of the gradient.

C. Equality and Justice

Taking the social gradient seriously means taking relative as well as absolute deprivation seriously. It is not a matter of simply bringing the absolute poor above a threshold to become relatively poor. Both relative and absolute deprivation are important. Following Yamin's argument, as the general level of income rises and people are lifted over the poverty line, we should be more concerned about relative poverty; a rich nation can afford to address such inequality.[833] Not doing so undermines all

[830] ibid section 4.
[831] DS Goldberg, 'In Support of a Broad Model of Public Health: Disparities, Social Epidemiology and Public Health Causation' (2009) 2 Public Health Ethics 70.
[832] Otto, Walker and Ziegler (n 815).
[833] Yamin, *Struggle for Dignity* (n 1) 195–197.

elements of the human rights framework, including participation and accountability. Not doing so becomes an issue of social justice.

Social justice and public health

It has long been asserted that social justice is the foundation of public health.[834] Yet, it is only in recent decades that the debates about what social justice is in public health have really come to the fore.[835] Resorting to Whitehead's definition of health inequity as being health inequalities that are 'unnecessary, avoidable, unfair and unjust' requires an additional judgement to ascertain whether an inequality is inequitable. [836] However, it is not clear using Whitehead's formula how this could be made.[837] If an injustice is identified then it requires remediation and this in terms of public health policy and practice. The CSDH 2008 report concludes with the words:

> Reducing health inequities is, for the Commission on the Social Determinants of Health, an ethical imperative. Social injustice is killing people on a grand scale.[838]

We have already noted that '[t]here is no single prime mover that explains all forms of inequality. A key characteristic of inequality is therefore its complexity.'[839] Such complexity persists when trying to establish whether an inequality is an injustice. As Maxwell Smith goes on to argue, philosophical debates and normative theorising fail to address the messy context of public health policy and practice. It is not helpful in telling

[834] Levy and Sidel (n 43).
[835] See for example the concise review by Maxwell J Smith, 'Social Justice and Public Health' in Sridhar Venkatapuram and Alex Broadbent (eds), *The Routledge Handbook of Philosophy of Public Health* (1st edn, Routledge 2022) <https://www.routledge.com/The-Routledge-Handbook-of-Philosophy-of-Public-Health/Venkatapuram-Broadbent/p/book/9781138938823> accessed 14 February 2023.
[836] Whitehead (n 58).
[837] ibid; Wilson (n 62).
[838] Commission on Social Determinants of Health (n 10) 256.
[839] Holton (n 49) 71.

us what we ought to do in the complex myriad of changing contextual factors faced by public health.[840]

When considering justice in public health and in relation to the social gradient two points seem salient. Firstly, a shift in paradigm away from utilitarianism is required as notions such as cost-effectiveness, efficiency, QUALYs and DALYs have not been enough to alleviate injustice.[841] Such a view leads us to Sen who has articulated a cogent challenge to utilitarianism and offered an alternative view in the capability approach as described above. Secondly, viewing social justice as being distributive, procedural, and relational is valuable in helping us to consider approaches to the social gradient. Smith's succinct description is helpful here: distributive justice concerns itself with how goods and services and health outcomes are distributed across society; procedural justice involves the application of criteria or principles to decision making and public health policy; and relational justice focuses upon social relations and issues of power and privilege.[842] The social gradient articulates a distribution of health outcomes as a hierarchy with fine gradations across society. This might suggest a policy application of proportionate universalism applying certain principles to provide services and facilities in different ways to meet different needs as a co-ordinated whole system approach to redress the unjust health outcomes distributed across the gradient.[843] However, the CSDH report describes the social gradient as a social determinant of health, placing the causes of inequity at the door of 'power, money, and resources.' [844] It suggests actions should include health equity in all policies, fair financing, market responsibility, gender equity, political empowerment, and good global governance. This presupposes the

[840] Smith, 'Social Justice and Public Health' (n 839) 341–342.
[841] Venkatapuram, *Health Justice* (n 761) 26.
[842] Smith, 'Social Justice and Public Health' (n 839) 334–336.
[843] Francis-Oliviero and others (n 139).
[844] Commission on Social Determinants of Health (n 10) pt 4.

relational nature of social injustice. So, a relational understanding of the philosophical underpinning of public health is required. The capability approach offers this.

Social justice and the capability approach

Sen's capability approach explicitly recognises the social and structural factors that prevent the conversion of commodities into functionings, as his analysis of famines and entrenched hunger clearly demonstrates.[845] Although it has been criticised by some authors for an individualistic focus.[846] Sen recognises that the freedom and agency an individual enjoys is 'inescapably qualified and constrained by the social, political and economic opportunities that are available to us.'[847] He fully accepts that 'our opportunities and prospects depend crucially on what institutions exist and how they function.'[848] The relationship between individuals and social structures is identified as 'a two way relation between (1) social arrangements [such as economic, social and political opportunities] to expand individual freedoms and (2) the use of individual freedoms…to make the social arrangements more effective.'[849] He also acknowledges the central role of, for example, women's movements in advocating for greater freedoms for women to make their own choices.[850] His detailed analysis of women within the family introduces notions of cooperative conflict as a means to negotiate between the

[845] Sen, *Development as Freedom* (n 203) ch 7.
[846] Charles Gore, 'Irreducibly Social Goods and the Informational Basis of Amartya Sen's Capability Approach' (1997) 9 Journal of International Development 235; Des Gasper, 'Is Sen's Capability Approach an Adequate Basis for Considering Human Development?' (2002) 14 Review of Political Economy 435; Evans (n 809); Frances Stewart, 'Groups and Capabilities' (2005) 6 Journal of Human Development 185; Solava S Ibrahim, 'From Individual to Collective Capabilities: The Capability Approach as a Conceptual Framework for Self-help' (2006) 7 Journal of Human Development 397; Pinar Uyan-Semerci, 'A Relational Account of Nussbaum's List of Capabilities' (2007) 8 Journal of Human Development 203; Kia MQ Hall, 'Introducing Joint Capabilities: Findings from a Study of Development in Honduras' Garifuna Ancestral Villages' (2017) 18 Journal of Human Development and Capabilities 60; Rachel Godfrey-Wood and Graciela Mamani-Vargas, 'The Coercive Side of Collective Capabilities: Evidence from the Bolivian Altiplano' (2017) 18 Journal of Human Development and Capabilities 75.
[847] Sen, *Development as Freedom* (n 203) xii.
[848] ibid 142.
[849] ibid 31.
[850] ibid 190.

disparate needs of individuals within the family unit.[851] Thus, Sen's capability approach does account for social relations but requires further development for a truly relational approach.

Various authors have developed the relational aspect of Sens's capability approach. Robeyns eschews criticisms of an individualistic bias to the capability approach. [852] Sen's capability approach, she argues, incorporates elements of group influences and social structures. Matthew Smith and Carolina Seward agree with Robeyns that Sen's works contain an 'ontology of a relational society', which for the most part they argue, is implicit in what Sen has already written.[853] Deneulin recognises the need for further development of the capability approach and draws upon Paul Ricoeur to develop the concept of 'structures of living together.'[854] She states: 'individuals are living together and this fact constitutes the very condition under which individual human lives may flourish.'[855] Séverine Deneulin and J. Allister McGregor assert that the capability approach needs to be expanded from a notion of 'living well' to one of 'living well together' to be able to consider the ways power is embedded in our social structures and institutions and therefor how policy is made.[856]

[851] ibid 192.
[852] Ingrid Robeyns, 'The Capability Approach: A Theoretical Survey' (2005) 6 Journal of Human Development 93.
[853] Matthew Longshore Smith and Carolina Seward, 'The Relational Ontology of Amartya Sen's Capability Approach: Incorporating Social and Individual Causes' (2009) 10 Journal of Human Development and Capabilities 213.
[854] Séverine Deneulin, 'Beyond Individual Freedom and Agency: Structures of Living Together in the Capability Approach' in Flavio Comim, Mozaffar Qizilbash and Sabina Alkire (eds), *The Capability Approach: Concepts, Measures and Applications* (Cambridge University Press 2008).
[855] ibid 112.
[856] Deneulin and McGregor (n 740).

The capability approach and human rights

A theory of equality and justice requires challenging the dominant biases in both public health and human rights, whilst also addressing conceptual gaps between health and rights to provide an ethical response to ill health and inequalities.[857] Sen's capability approach starts from the point of moral reasoning with his recognition that people often do not have the capabilities and functionings to be able 'to be and do' as they would wish in order to live a life they would choose and value. His critique of both utilitarianism and Rawlsian 'primary goods' as evaluative spaces for wellbeing challenges predominant theories of public health. The social ontology he develops in his account of freedom provides a significant argument against the libertarian bias in human rights. He provides a substantively normative account of agency which aligns with a more positive understanding of freedom when he places individual agents within a social context of mutual interdependency.

The capability approach as health justice

The capability approach maintains that equal respect for the equal moral worth of every human being compels society to ensure that *all* individuals have an adequate and equitable capability to conceive of and pursue their life plans.[858] This inherent moral worth is intrinsic to Sen's notion of capabilities in that freedom to choose one's own life of value should be available to all.

The capability approach starts from an ethical standpoint in contrast to the legal positivist account which holds that human rights are inherently legal. It provides a sufficient conceptual framework in terms of the right to health in that it addresses values

[857] Venkatapuram, *Health Justice* (n 761) 28 and 181–184.
[858] ibid 128.

and moral concerns, provides clarity in ‘scope’ or ‘object’, and creates an entitlement that is legally principled, coherent, practical and context sensitive that can be protected, respected, and fulfilled.[859]

The right to health is fundamental to being able to realise other human rights.[860] In much the same way health is a central capability and is required to be able to achieve other capabilities.[861] Venkatapuram developed the capability to be healthy (CH) as a meta-capability and a cluster right.[862] Building upon Lennart Nordenfelt’s definition of health as an ability to achieve vital goals, the meta-capability or the CH combines Nussbaum’s ten basic capabilities.[863] Each capability itself reflecting a combination of personal traits and external conversion and constraining factors. Venkatapuram advances the conceptual foundations of Sen’s capability approach to challenge and bridge the ethical dimensions of public health and the right to health. He presents social determinants of health, a theory of causation, and the distribution of health capability along the gradient as external evidence for the CH.[864] Rather than being reductionist, this approach aligns with both public health understandings of the inseparable nature of social determinants of health and human rights principles that all ‘human rights are universal, indivisible, interdependent and interrelated’.[865]

An individual’s right to the capability to be healthy requires obligations to implement social policies that limit conversion factors that impact capabilities and remove constraining factors to people’s choices. How might the capability approach be

[859] Drydyk (n 777) 43; Tobin, *The Right to Health in International Law* (n 334) ch 3.
[860] Zahara Nampewo, Jennifer Heaven Mike and Jonathan Wolff, ‘Respecting, Protecting and Fulfilling the Human Right to Health’ (2022) 21 International Journal for Equity in Health 36.
[861] Sridhar Venkatapuram, ‘Health, Vital Goals, and Central Human Capabilities’ (2013) 27 Bioethics 271.
[862] Venkatapuram, *Health Justice* (n 761) 43–44 and 56–60.
[863] ibid 134–137.
[864] ibid 235.
[865] World Conference on Human Rights (n 358) para 5.

implemented and advance the right to health? Ruger offers a normative and practical foundation to public health and to human rights by extending the concept of health capabilities and operationalising them.[866] Building upon a health capability paradigm Ruger calls for an alternative health governance framework beyond national constitutions and supra-state organisations which brings together a collaborative architecture of a wide range of organisations, communities and individuals with a common aim of ensuring human flourishing.[867] Recognising the limitations of the state-centric nature of human rights and the influence of the vested interests of state and non-state actors upon global health institutions such as the WHO, she argues that the right to health has failed to achieve its full potential.[868] Her approach also places public health within a global health framework where states cannot just be concerned with the risks of imported disease and bioterror but have to recognise their responsibility and accountability for the promotion of global public health and health as a global good.[869]

Concluding Comments

The capability approach provides sufficient normative foundations and evaluative dimensions to enhance the collaboration between public health and the right to health. It appeals to public health with understandings of causation and the place of agency in considering social determinants of health. It aligns with human rights through its emphasis upon the fundamental moral worth of human beings and the importance of freedoms and social justice. Moreover, it offers a vision of health justice and global

[866] Jennifer Prah Ruger, *Global Health Justice and Governance* (Oxford University Press 2018); University of Pennsylvania, 'Health Equity & Policy Lab' (*Health Equity & Policy Lab*, n.d.) <https://www.healthequityandpolicylab.com> accessed 18 February 2023.
[867] Ruger, *Global Health Justice and Governance* (n 872) s Preface.
[868] ibid 149–151.
[869] ibid 157.

health justice founded upon the purposes of human flourishing and principles of collaboration, participation and social relations, and responsibility.

As one of a number of explanatory mechanisms for the social gradient the capability approach has the space to integrate other theories. It provides a broad conceptual framework for assessing individual wellbeing, evaluating social arrangements, and determining social policy across the whole social gradient.[870] It need not be confined to an examination of inequalities in terms of income and wealth or in terms of ethnicity and gender, but can encompass a broad range of other theories and concepts.[871] Following Robeyn's modular understanding of the capability approach it can elaborate different conceptions of agency, dimensions of capabilities, and human diversity, for different purposes as long as the core elements remain. It is pluralistic, adaptable, and it is gaining traction in both public health and the right to health.

[870] Robeyns, 'The Capability Approach' (n 204).
[871] Robeyns, *Wellbeing, Freedom and Social Justice* (n 742) 84–87.

Chapter 7. Conclusion

This chapter will conclude the study by summarising the key findings in relation to the research aim, objectives and questions. The conclusion is presented in three sections. The first answering to what extent the SRRH reports address the social gradient, the second integrating key themes to address the question of implications of the social gradient for the right to health, and finally some closing reflections on health inequalities.

The right to health contends that human flourishing and the capability to be healthy is a morally central aim shared by all persons by virtue of their common humanity and dignity. Public health believes health to be a morally salient human characteristic that warrants respect and requires protection.

I commenced with Yamin's exhortation to the human rights community:

> It is essential for the human rights community to grapple with what is normatively acceptable in terms of a social gradient and with the trade-offs to be made in moving in that direction.[872]

In this thesis I have responded to Yamin by contributing to that process of engaging with what the social gradient means for the right to health. In doing so this thesis makes three important contributions to knowledge. The scoping review (chapter two) of academic literature at the intersection of public health and the right to health reveals the limited understanding of the significance of the social gradient in health in both public health and right to health literature. The lack of a clear conceptual framework for the social gradient and any broad theoretical explanation for the social gradient adds to the difficulty in communication between the two disciplines. The thesis is to my knowledge the only study that assesses the Special Rapporteur reports on the right to health as a

[872] Yamin, *Struggle for Dignity* (n 1) 195.

whole body of work. The analysis of the conceptualisation of the engagement with and action on the social gradient has incorporated two methodological frameworks: Framework Analysis to guide the process and Grahams policy matrix for the analysis of action. Building upon Venkatapuram's *Health Justice* (and other work) the capability approach is offered as a means to conceptualise the social gradient in health in a way that resonates with public health and right to health approaches.

A. Conceptualisations, Engagement, and Action for the Social Gradient

The study asked the question 'To what extent does the right to health conceptualise, engage with, and act upon the social gradient in health inequalities?'

The social gradient tells us that health inequalities are experienced by all in society and that the highest attainable standard of health is achieved by those at the top of the gradient. It also tells us that health inequalities are reduced through action on the 'causes of the causes of the causes' and that health inequalities reflect broader social, political, economic, and environmental conditions in which people live. The social gradient articulates the unequal distribution of the social determinants of health themselves.

Academic literature presents vague conceptions of the social gradient as simply representing health inequalities without any clear definition of what those health inequalities are. There is an assumption that the social gradient represents socio-economic inequalities, even though gradients in health inequalities can be demonstrated for other factors. It is not surprising that human rights authors do not necessarily understand the significance of the social gradient if public health cannot present a clear conceptual framework that could be adopted and applied to the right to

health. There is a growing number of authors who are exploring this concept more diligently and acknowledging that it is in some way significant even if they are unclear in what way. Conceptual models for the social gradient are being developed for specific topics, with the model presented by Bezo and colleagues the only one directly addressing human rights.[873] Other authors such as Yamin and Venkatapuram are considering the implications of the social gradient more directly: quotations from their work have initiated my exploration of this concept in this study.

This thesis adds to their explorations by closely examining right to health treaties and general comments to ascertain to what extent they engage with the concept of the social gradient in health inequalities. The social gradient has only recently become a broadly accepted concept, so it is not surprising that it is not a feature of right to health treaties and general comments. The right to health demonstrates a clear engagement with the social determinants of health within a holistic understanding of physical and mental health. A distinct category of social determinants as being structural or root causes has developed over the last two decades, particularly following the CSDH report with its own delineation of intermediary and structural determinants. However, the social gradient is absent as a social determinant of health. The centrality of the principles of equality and non-discrimination have skewed attention towards horizontal inequalities to the detriment of action on socio-economic or vertical inequalities and the type of health inequalities articulated by the social gradient are entirely missed.

This study's use of 'Framework Method' to structure the coding of SRRH reports contributes to a novel approach to the analysis of UN human rights monitoring documents. As Meier and Kim observe, in their qualitative analytic coding of CESCR

[873] Bezo, Maggi and Roberts (n 11).

reports, previous analysis has adopted largely linguistic documentary approaches.[874] Empirical studies such as this, provide an evidence base to operationalise human rights.[875] Using framework analysis with a social determinants of health framework applied to SRRH mission and thematic reports, this thesis demonstrates that the Special Rapporteurs did not conceptualise the social gradient in any way. They engaged only briefly with the notion of vertical socio-economic inequalities. They did, however, make recommendations for action on structural determinants of health implicated in the social gradient such as laws and policies, societal violence, and poor governance as applies across the whole population. The SRRH reports also employed certain explanatory mechanisms and perspectives related to the social gradient such as social determinants of health, psycho-social perspectives and the life-course approach.

Furthermore, this thesis highlights the value of systematic analysis of UN human rights monitoring documents. The analysis of SRRH reports demonstrates that they provide a thoughtful engagement with and a nuanced consideration of global health issues, although at times constrained by mandate expectations and required format. The Special Procedures system offers a wealth of untapped information concerning a range of public health issues. Recently I discovered that global health students in my class had never heard of the SRRH and were astonished at the range and depth of their reports. Not surprising, given that whilst SRRH reports are frequently referenced in human rights literature, they are rarely discussed in public health literature despite the obvious linkages of social determinants of health to all civil, political, economic, social, and cultural rights.[876]

[874] Meier and Kim (n 480) 171.
[875] ibid 230.
[876] The scoping review found for example that only 6% (n=13) of public health journal articles referenced special procedures compared with 32% (n=14) of right to health literature.

Analysis of SRRH reports introduces additional voices into the debates around the right to health to facilitate cross- and inter- disciplinary collaboration. The processes involved in creating both thematic and mission reports capture the voices of public health practitioners and communities. The collaborative discussion observed for the preparation of Pũras' report on social determinants of mental health brought together experts in the field of social determinants with mental health advocates and others. As Murphey and Müller note, selecting SRRH reports as the missing population in the public health right to health discourse reveals the hidden populations of health experts and organisations that have helped to develop the scope and content of the right to health over time.[877]

The transferability of the findings from the SRRH reports to jurisprudence, human rights monitoring, and right to health advocacy is unclear. SRRH reports make the distinction between judicial and policy-oriented processes with SRRH reports supporting the operationalisation of the right to health in policy processes.[878] In terms of policy-oriented processes there is a lack of attention to the concept of the social gradient in the right to health. For some authors the social gradient encompasses only vertical health inequalities and not the social gradient as a whole, and to other authors the social gradient extends beyond socio-economic inequalities.[879] It must be remembered that the SRRH reports are envisaged to be normative documents not evidenced-based public health documents.[880] They aim to document human rights abuses and gather evidence to that effect.[881] They are not meant to provide empirical public health

[877] Murphy and Müller (n 439).
[878] Hunt and Leader (n 295).
[879] See Chapter 2 Authors in the scoping review of literature.
[880] Marc Limon and Ted Piccone, 'Human Rights Special Procedures Determinants of Influence. Understanding and Strengthening the Effectiveness of the UN's Independent Human Rights Experts' (Universal Rights Group 2014) 26–27.
[881] Subedi (n 442) 1.

evidence and do not conduct methodologically sound surveys but simply listen to representatives and communities.[882] Whilst they do rely on epidemiological data and public health evidence a review of their content is, as such, a selective review of evidence for the social gradient in the right to health.

B. Implications of a Social Gradient Approach

The second question posed was: 'What are the implications for the integration of the social gradient in the right to health?'

The lack of attention to social gradient inequalities means that those who are positioned in the middle of the gradient experience inequalities in health that are not sufficiently recognised and are failing to achieve the highest attainable standard of health. The social gradient tells us that we are all subject to health inequalities to some degree. Those in the middle who were comfortable, even if not well off, are falling into poverty as the gap between rich and poor widens. Indeed, in some SRRH reports the term 'near poor' is used to indicate those vulnerable to falling into poverty. Failure to attend to the middle of the gradient risks negative health impacts for those individuals and communities and the broader societal consequences of a 'squeezed middle'.[883] The right to health is the right of *everyone* to the enjoyment of the highest attainable standard of physical and mental health. Moreover, the highest attainable standard of health in any nation or society is that achieved by those at the top of the gradient, even if states do not necessarily have the resources to realise that highest attainable standard of health for all, they mostly have capacity to improve the health status of those in the middle of the gradient as well as the poor.

[882] Interview #2
[883] Organisation for Economic Co-operation and Development (n 151) 17–19.

However, caution is required to not relativise the health achievements of those at the top of the gradient compared to those lower down the gradient. Firstly, viewing the social gradient in such a way assumes that those at the top of the gradient are as healthy as they can be. They too are worthy of consideration in terms of health rights and their situation cannot be abstracted from that of those in the middle. Secondly, this thesis has not taken a global perspective on the social gradient as indeed the gradient can be demonstrated across countries as well as within. The highest attainable standard of health of those in poorer countries may fall below that of those in wealthier countries, so again we need to consider the context of health achievements for those at the top of the gradient.

This leads us into considering how we might respond to Yamin's question about what is normatively acceptable in terms of a social gradient. Recognising that we might never eliminate the gradient, how steep should the social gradient be allowed to become? The steeper the gradient the worse the inequalities. It must be remembered that the number of people in poverty in a country can decrease but the gradient may only shift upwards. If inequalities continue to deepen the gradient becomes steeper.[884] Moreover, if there are problems inherent in using a threshold approach than are we not just replacing a poverty line with a social gradient line? To do so belies the complexities in the mechanisms by which the gradient is created. How do we address the needs of those at the top of the gradient who do not have the highest level of health that they could achieve? What are we to understand of the shifts and changes in health gradients? Do we consider the social gradient in terms of a global gradient or a local gradient? How indeed do we monitor gradients for right to health purposes given the lack of

[884] Graham, 'Tackling Inequalities in Health in England' (n 29).

epidemiological data in many contexts or the difficulty in selecting indicators by which to measure and compare gradients?

This raises the question: 'How therefore might the right to health strengthen its engagement with the social gradient in health inequalities?' In response four main themes are addressed: the social gradient should be included in the right to health as any other social determinant of health and issues of causality considered; notions of health inequalities need to be reframed; a clear conceptual framework for the social gradient is required; and the right to health needs to attend to wealth, the middle of the gradient, thresholds, and the minimum core. In order to facilitate this the capability approach is offered as a sufficient normative and evaluative framework for collaboration between public health and the right to health.

Firstly, the social gradient is a social determinant associated with the unequal distribution of ill health across a population but is not included in the diverse range of social determinants addressed in the SRRH reports. The SRRH reports unequivocally integrate the social determinants of health in theory and practice making frequent recommendations to reduce the negative impacts of a wide number of intermediate and structural social determinants. Therefore, the social gradient should also be included. However, the lack of a clear conceptual framework, as indicated above, and the complexities around understanding how the gradient causes health inequalities make this a difficult prospect. If the concept cannot be explained within a singular conceptual framework in public health, it is difficult to imagine how the concept can be effectively communicated across disciplines. References are made to some explanatory mechanisms for the social gradient, such as psycho-social and life-course approaches, and there are strong assertions of the health consequences of poverty and discrimination, but the reports draw minimally on theoretical understandings of

causation. There is an intimation of fundamental cause theory in the term 'underlying determinants' but this is not clear. Causality is such an important issue that the right to health cannot simply ignore it so has to have some way of incorporating causation into its own lexicon.[885] However, in public health the notion of causality is contested and uncertain.[886] Ruger warns that '[t]he onerously high burden of proof of causation renders attribution of responsibilities troublesome'.[887] Furthermore including notions of causality in human rights is also deeply problematic.[888] Recognising that human rights monitoring is looking for the causes of human rights violations and is therefore different to the public health process of identifying the causes of ill health, which may or may not be human rights violations, further complicates notions of causality.

Secondly, the right to health attends largely to poverty and discrimination as causes of health inequalities. Using Graham's policy analysis matrix this study shows that the SRRH reports make numerous recommendations to ameliorate poverty at the lower end of the social gradient and to reduce inequalities between groups or for specific vulnerable groups. It is recognised that human rights generally fail to attend to vertical inequalities of socio-economic status. However, the few population level recommendations made do not address the inequalities articulated by the social gradient. Horizontal and vertical inequalities do not exist in isolation and the social gradient expresses overlapping issues and common themes between them.[889] Moreover, I have argued that the social gradient articulates inequalities beyond socio-

[885] Marks (n 374).
[886] Arnaud Chiolero, 'Causality in Public Health: One Word Is Not Enough' (2019) 109 American Journal of Public Health 1319.
[887] Jennifer Prah Ruger, 'Global Health Justice and Governance' (2012) 12 The American Journal of Bioethics 35, 36.
[888] David McGrogan, 'The Problem of Causality in International Human Rights Law' (2016) 65 International and Comparative Law Quarterly 615.
[889] David A Leon, 'Common Threads: Underlying Components of Inequalities in Mortality between and within Countries' in David A Leon and Gill Walt (eds), *Poverty, Inequality, and Health: An International Perspective* (Oxford University Press 2000).

economic status as it demonstrates gradients for health outcomes correlated with a broad range of factors other than socio-economic status. This tells us that gradient is not solely tied to socio-economic status. This would suggest that the framing of health inequalities as horizontal, vertical, and global, as described at the beginning of the thesis, belies the complexities of health inequalities and is somewhat inaccurate.

A more nuanced understanding of health inequalities is required that combines horizontal, vertical, and social gradient inequalities between and within countries. I have suggested that the capability approach is a sufficient conceptual foundation for integrating horizontal and vertical inequalities. It offers both normative and evaluative dimensions, with the understanding that it is an evolving theory. This task requires collaboration as described above to develop a conceptual foundation for health inequalities that serves the purposes of both public health and the right to health.

Thirdly, a lack of any singular agreed theoretical framework for an understanding of causation in the social gradient allows a plethora of explanatory mechanisms to be employed including materialist and biomedical explanations. This may result in a shift in the way inequalities are framed that pressures action towards ameliorating the health outcomes experienced by those living in poverty and preventing discrimination from impacting the health of various marginalised groups. How inequalities are framed determines how issues reach the policy agenda and the actions proposed in response. This study confirms Graham and Vallgårda's observations of a drift towards focusing upon poverty and gaps in policy development even if policy makers are cognisant of social gradient inequalities.[890] This is understandable when national governments and

[890] Graham, 'Social Determinants and Their Unequal Distribution: Clarifying Policy Understandings' (n 29); Graham, 'Health Inequalities, Social Determinants and Public Health Policy' (n 29); Vallgårda, 'Health Inequalities' (n 492); Vallgårda, 'Social Inequality in Health' (n 215).

international agencies must prioritise limited funds. The Special Rapporteurs and their researchers lament the fact that their reporting in both mission and to a lesser extent thematic reports is constrained such that they experience pushback when trying to articulate certain perspectives or challenge perceived notions around health inequalities. Recognising that there are a huge number of factors internal to the UN system of Special Procedures, and well-documented limitations in Special Rapporteurs being able to influence national and internal policy directions, these findings must be treated with caution as the absence of social gradient actions in the SRRH reports may largely be due to external pressures.

Fourthly, a social gradient approach requires attention to wealth and thresholds. Wealth is important because it determines the steepness of the social gradient and therefore the degree to which that society is experiencing health inequalities. An understanding of the role wealth plays in creating the social gradient is required. Authors of much note have exhorted the human rights community to examine issues of wealth more closely. The SRRH reports rarely mention wealth, or socio-economic status beyond poverty. The social gradient does not demonstrate a particular threshold below which people can be considered to be living in poverty. Whilst poverty is a specific focus of attention in the SRRH reports, action does not always make it clear who the poor are, and minimal reference is made to thresholds to facilitate any definition. This would suggest that thresholds are not helpful in this regard and where the SRRHs do employ them it is to make a general assertion about needing to identify those who are living in poverty.

Allied to the notion of thresholds is the minimum core. Although the minimum core is clearly established in General Comments 14 and 22 for the ICESCR,[891] the SRRH

[891] UN Committee on Economic, Social and Cultural Rights, 'General Comment 14 ICESCR' (n 18); UN Committee on Economic, Social and Cultural Rights, 'General Comment 22 ICESCR' (n 18).

reports rarely draw upon it explicitly when making recommendations. Much debate over the minimum core remains inconclusive. Whilst this study does not seek to define the minimum core or enter this debate it does highlight how, when operationalising the right to health as evidenced in SRRH reports, it seems to have limited value.

The capability approach

In this thesis I have explored the value of the capability approach to the process of developing, adopting, and integrating social gradient approaches in the right to health. The capability approach provides a sufficient normative and evaluative framework for this task. A conceptual understanding of the social gradient is required that can bridge both public health and the right to health. The capability approach offers a useful bridging framework and is also one of the explanatory mechanisms for the social gradient. In particular, the CH delineates an alternative evaluative space as opposed to resource distribution and provides an alternative paradigm to utilitarian approaches common to public health. This gives an opportune starting point to begin to better understand the social gradient.

There does need to be some common understanding of the complexities of causation and how these may impact policy recommendations made and how responsibilities for action are apportioned. Further empirical work could use the concept of the capability approach outlined here to understand causation that incorporates a relational ontology and an account of agency that recognises the place of the individual in societal structures for public health and the right to health as a collective right. Understanding the social gradient through the lens of the capability approach offers a means to commence and structure debates around causation.

The way inequalities are framed determines what reaches the policy agenda and how policy recommendations may be formulated. There is much evidence for the value of the capability approach for policy making.[892] [893] The capability approach is considered incompletely theorised, but this lends it to the collaborative development of new theories, paradigms, and concepts.[894] [895]

C. Synergies and Divergencies

This study found that there is much synergy between the right to health and public health. Whilst existing literatures have highlighted the discordance between public health and human rights, this study confirms that there is a *'*catalytic synergy of health and human rights', an interrelationship which is essential to both the development of public health and to the achievement of the right to health.[896] A human rights approach to public health has long been advocated to counter the narrative of disjuncture.[897] Much of the argument demonstrates a human rights shift from legalistic argument to moral principles to better enable public health to accommodate a human rights-based approach. Kristen Hessler contends that the synergistic vision of public health and human rights rests upon an expanded version of both disciplines.[898]

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[892] Otto, Walker and Ziegler (n 815).
[893] Michael Marmot, 'Capabilities, Human Flourishing, and the Health Gap' in Sridhar Venkatapuram and Alex Broadbent (eds), *The Routledge Handbook of Philosophy of Public Health* (1st edn, Routledge 2022) <https://www.routledge.com/The-Routledge-Handbook-of-Philosophy-of-Public-Health/Venkatapuram-Broadbent/p/book/9781138938823> accessed 14 February 2023.
[894] Venkatapuram, *Health Justice* (n 761).
[895] Ruger, *Global Health Justice and Governance* (n 872).
[896] Laura Turiano and Lanny Smith, 'The Catalytic Synergy of Health and Human Rights: The People's Health Movement and the Right to Health and Health Care Campaign' [2008] Health and Human Rights 137, 137.
[897] *Symposium: Human Rights and the Social Determinants of Health 5th May 2017* (Directed by Media Production, 2017) <https://www.youtube.com/watch?v=IqIMab-sdro> accessed 22 July 2017; Benjamin Mason Meier and others, 'Human Rights in Public Health: Deepening Engagement at a Critical Time' (2018) 20 Health and Human Rights 85; Kristen Hessler, 'Public Health, Human Rights, and Philosophy' in Sridhar Venkatapuram and Alex Broadbent (eds), *The Routledge Handbook of Philosophy of Public Health* (1st edn, Routledge 2022) <https://www.routledge.com/The-Routledge-Handbook-of-Philosophy-of-Public-Health/Venkatapuram-Broadbent/p/book/9781138938823> accessed 14 February 2023.
[898] Hessler (n 905) 407–411.

Whilst important initiatives have been undertaken to develop the right to health to facilitate its adoption by public health, more work needs to be done to integrate public health concepts more concretely within the right to health. This study shows that the SRRH reports do adopt public health concepts in the right to health. From the start, Hunt attempted to integrate some social determinants of health into the right to health, challenging the narrower focus on health care provision. In more recent reports we can see Pũras adopting public health research on psycho-social explanations for health inequalities, challenging individualistic biomedical perspectives, and adopting the life-course approach. Human rights could further expand to adopt public health concepts.

However, public health also needs to unpack the language and concepts of social epidemiology and public health to make it understandable to human rights. The scoping review of academic literature in peer-reviewed journal articles shows that the concept of the social gradient is poorly articulated and often misunderstood (with few notable exceptions) even in public health. The review did not identify any clear conceptual framework for the social gradient that could be used for the framework analysis of this study or help to effectively communicate the concept to both public health and right to health audiences.

Adopting the perspective of learning from public health, demonstrated by the SRRH, further collaboration and research on a unified understanding and a conceptual framework of the social gradient across both disciplines is required. Interdisciplinary research would facilitate a collaborative understanding of the social gradient for public health and the right to health to develop such a conceptual framework. The CESCR provision of General Discussion Days could bring together public health and right to health experts to develop a joint understanding of the concepts of the social gradient

and its implications for the right to health,[899] additionally a SRRH thematic report and attendant discussions and inputs could explore this issue. A body of experts is available to the right to health to undertake such a task.

Right to health and public health scholars and practitioners are now working together to reduce the divergencies between public health and human rights.[900] What a social determinants of health approach offers the right to health is often under-represented at, to use Foreman's words, this 'discursive intersection'.[901] Foreman goes on to say that public health social determinants of health approaches help to establish causality processes driven by inequitable social norms, gender and race (etc.) which is a fundamental component for establishing accountability for human rights. The social determinants of health framework offers an understanding of macro social and economic determinants, beyond laws and policies that are responsible for unequal distribution of health among and within populations in ways which human rights is not yet equipped to do.[902] Social determinants of health can offer a better understanding of collective dimensions to the right to health, which human rights considers only as having a marginal impact upon individuals.[903] A social determinants of health approach focuses attention on prevention rather than health care. Social determinants of health can offer an analysis of systemic and structural causes of health inequalities which could

[899] Office of the High Commissioner for Human Rights, 'General Discussion Days' (2015) <http://www.ohchr.org/EN/HRBodies/CESCR/Pages/DiscussionDays.aspx> accessed 28 February 2015.
[900] Dalla Lana School of Public Health University of Toronto, 'Human Rights and the Social Determinants of Health (Video)', *Conference by Comparative Program on Health and Society 6th May 2017* (Media Productions 2017) <https://www.youtube.com/watch?v=IqIMab-sdro> accessed 22 July 2017.
[901] *Symposium: Human Rights and the Social Determinants of Health. Introductory Remarks Lisa Foreman (5th May 2017)* (Directed by Media Production, 2017) s 11:50-29:40 <https://www.youtube.com/watch?v=IqIMab-sdro> accessed 22 July 2017.
[902] *Symposium: Human Rights and the Social Determinants of Health. Health and Human Rights: Concepts, History and Potential Contributions to Conversations on the Social Determinants of Health Sofia Gruskin (5th May 2017)* (n 724).
[903] *Symposium: Human Rights and the Social Determinants of Health. The Potential for Mutual Strengthening. Audrey R. Chapman (5th May 2017)* (n 723).

encourage human rights to identify and seek to rectify inequitable distribution of power, money, and resources in the way society is organised. In this way human rights could be encouraged to develop a more expansive and substantive conception of equality: not just equality of status or equality of dignity.[904]

Human rights approaches would also benefit public health. Human rights could offer social epidemiology a broader legal and policy context in which interventions can take place e.g. non-discrimination, marginalised peoples, privacy and confidentiality, monitoring and feedback, participation, and accountability.[905] A human rights lens ensures individuals are able to participate in policy and programme formulation and relevant accountability schemes affecting health, and to ensure existence of mechanisms that support accountability and redress for rights violations.[906]

Human rights provide a normative framework and legal mechanisms which link health to human dignity, freedom, wellbeing and development.[907] This includes duties to: respect the physical and mental integrity of the individual, respect individual autonomy including personal and group self-determination, guarantee the material conditions of existence necessary to lead a healthy productive and fulfilling life, and equality and non-discrimination. Human rights can offer justice claims so that social determinants of health can rest upon human rights norms instead of the power of ethical reasoning, as some determinants of health are internationally recognised human rights.[908]

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[904] ibid.
[905] Chapman, 'Missed Opportunities' (n 239).
[906] Hunt, 'Missed Opportunities' (n 293).
[907] *Symposium: Human Rights and the Social Determinants of Health. Health and Human Rights: Concepts, History and Potential Contributions to Conversations on the Social Determinants of Health Sofia Gruskin (5th May 2017)* (n 724).
[908] *Symposium: Human Rights and the Social Determinants of Health. The Potential for Mutual Strengthening. Audrey R. Chapman (5th May 2017)* (n 723).

Additionally, there is great variability over time, as population needs change within countries and differ between countries. Jonathan Wolff then employs Joseph Raz's concept of 'synchronic universality' to help validate this variability: meaning that if one person has a right then all people who are currently alive have that human right.[909] Thus, Wolff argues that as long as the right to health is very general in its content as a means to protect against common serious threats that differ from place to place, it can be applied globally within very differing local and national contexts.[910] The very generality or indeterminacy of the right to health may indeed be a useful feature that permits integration of social determinants of health, as relevant to specific local or national contexts.

The right to health has evolved through activism and advocacy campaigns, and through individual and collective action. Laura Turiano and Lanny Smith discuss, for example, the achievements of the People's Health Movement and its Right to Health and Health Care Campaign in promoting preventive health services, health promotion, and health protection (e.g. water and sanitation) in the right to health.[911] Civil society rarely mobilises around public health and social determinants of health but they do use human rights as a focal point and rallying opportunity and so can utilise human rights to mobilise groups towards the realisation of certain social determinants, and build a global movement to challenge entrenched power structures.[912] Incorporation of social

[909] Jonathan Wolff, 'The Content of the Human Right to Health' in Rowan Cruft, S Matthew Liao and Massimo Renzo (eds), *Philosophical Foundations of Human Rights* (Oxford University Press 2015) 495–496 employing Raz and synchronic universality in; Joseph Raz, 'Human Rights in the Emerging World Order' in Rowan Cruft, S Matthew Liao and Massimo Renzo (eds), *Philosophical Foundations of Human Rights* (Oxford University Press 2015).
[910] Wolff, 'RTH Content' (n 917) 496.
[911] Turiano and Smith (n 904).
[912] *Symposium: Human Rights and the Social Determinants of Health. The Potential for Mutual Strengthening. Audrey R. Chapman (5th May 2017)* (n 723).

determinants of health in the right to health would provide a rallying point for activism around such determinants.

As movements rally around various aspects of the right to health, the right itself evolves, the right to water and sanitation being an example. Stephen Marks traces the evolution of the right to water and sanitation from a derivative element of the right to an adequate standard of living in ICESCR and the *Convention on the Elimination of all Forms of Discrimination Against Women* (CEDAW), of prevention of disease and malnutrition in the *Convention on the Rights of the Child* (CRC), and of health in General Comment 14, to the adoption of General Comment 15 on the right to water in 2002.[913] Marks postulates that the normative expansion of rights occurs through an interplay of methods which has allowed the right to water and sanitation to become first what he terms a 'soft norm' (following Christine Chinkin[914]) whereby a political consensus as the importance of the right is reached, leading to a 'hard law' or customary rule in international law.[915] Water and sanitation was pushed forward on the global political agenda through civil society action and through for example the UN Development Programme 2006 Human Development Report on the global water crisis.[916] In this way it came to be extended into a new right. Water and sanitation gathered momentum as a broader social interest, key to which was the level of moral agreement and perceived injustice. Drawing upon social interest theory, John Tobin proposes that the identification of interests that ground a human right is the result of negotiation and

[913] UN Committee on Economic, Social and Cultural Rights, 'General Comment 15 ICESCR' (n 346).
[914] Quoting from Christine Chinkin, 'Sources', in International Human Rights Law 92 (Daniel Moeckli, Sangeeta Shah & Sandesh Sivakumaran eds., 2d ed., 2014)
[915] Stephen P Marks, 'Normative Expansion of the Right to Health and the Proliferation of Human Rights' (2016) 49 George Washington International Law Review 97, 109; follwing Christine Chinkin, 'Sources' in Daniel Moeckli and others (eds), *International Human Rights Law* (Second edition, Oxford University Press 2014).
[916] UN Development Programme (ed), *Beyond Scarcity: Power, Poverty and the Global Water Crisis* (UNDP 2006).

compromise and none of the interests that ground or inform the nature and scope of the duties attendant upon the right will ever be fixed or determined by reference to a particular theory – they will always remain contested historically contingent and will be constantly evolving.[917] Elevating health to the status of a human right is a deliberative and collaborative process. For example, lobbying and advocacy from civil society and institutional bodies influences states' adoption and implementation of the right to health. Moreover, it is not only the interest of the beneficiary that ground right but also the interests of the duty bearer that determine the scope and content of the right. The recognition of the right to health and its attendant duties is not simply to benefit individuals but is intended to benefit the interests of the broader community. This idea is foundational to public health and underpins the Constitution of WHO.

There is a bidirectionality between various concepts in the two domains.[918] Public health epidemiology assesses risks and threats to health as its starting point to developing a public health response and supports the inclusion of social determinants of health. Wolff's concept of 'standard threats' has resonance with public health.[919] Wolff develops Henry Shue's typology of common, serious and remedial threats to determine the content of the right to health in *Basic Rights*.[920] A threat is common if it is an ordinary commonplace threat. It is serious if its neglect is a matter of concern for the international community. It is remedial if it can be practically addressed. Introducing the concept of remedial ensures that the right to health does not generate impossible duties. This

[917] John Tobin, 'The Right to Health - Its Conceptual Foundations', *The Right to Health in International Law* (Oxford University Press 2012) 54–59.
[918] *Symposium: Human Rights and the Social Determinants of Health. Health and Human Rights: Concepts, History and Potential Contributions to Conversations on the Social Determinants of Health Sofia Gruskin (5th May 2017)* (n 724).
[919] see Jonathan Wolff, 'The Demands of the Human Right to Health' (2012) 86 Aristotelian Society Supplementary Volume 217, 5–6.
[920] Shue (n 669).

echoes Whitehead's argument that inequalities become inequities if they are 'unnecessary, avoidable, unfair and unjust'.[921] Though Wolff argues that an issue does not necessarily need to be remediable to claim a violation of a human right, as when the threat is common and serious some form of remedial action should be sought.

This thesis highlights the need for a global movement to take forward the collaboration between social determinants of health epidemiology, human rights generally and the right to health specifically.[922] A movement that has the political teeth to challenge those who maintain the status quo and hold the power to limit action upon, in Birn's words, the 'causes of the causes of the causes'. [923] The social gradient has the power to capture the imagination and attention to secure a champion for health equity, as it affects everyone, not just those in poverty.[924] Local human rights and civil society health organisations have played a primary role in galvanising action and achieving important milestones for the right to health.[925] The social gradient in health could provide a useful focus for human rights activism to secure the right of *everyone* to the enjoyment of the *highest* attainable standard of physical and mental health.

D. Reflections on Health Inequalities and the Social Gradient

I sit down to write this final chapter with the first signs of spring becoming more established and the days at last getting longer and I pause to reflect. It is uncomfortable to use the old 'journey' trope, but thinking back nine years to the beginning of this PhD it seems relevant. The landscape has much changed over time: both internal and external. The world seemed a different place when I started. The Covid-19 pandemic

[921] Whitehead (n 58).
[922] Chapman, 'Missed Opportunities' (n 239).
[923] Birn (n 78) 172.
[924] Herbert Zollner, 'National Policies for Reducing Social Inequalities in Health in Europe' (2002) 30 Scandinavian Journal of Public Health 6, 9.
[925] Chapman, 'Missed Opportunities' (n 239) 146.

has killed an estimated 6,844,267 people worldwide[926] and of 500 million cases has left unknown numbers with life limiting 'long Covid-19'.[927] The war in Ukraine seems unbelievable, propelling thousands of people into cold, hunger, grief, and fear. COP27 has been and gone with little movement on what feels like the impending doom of climate change. Türkiye and Syria have been utterly devastated by an earthquake with one reporter recording an observation from the ground that 'earthquakes don't kill, bad buildings do'.[928] Here in the UK the cost-of-living crisis is putting the simple heating of a home out of the reach of many. Food costs and inflation are spiralling and food banks proliferating. Poverty is becoming more entrenched despite Alston's warnings about the travesty of a decade of unnecessary austerity following his visit in early winter 2018.[929] Reporting on a plethora of strikes lights up our TV screens on each evening news. War, poverty and discrimination are deepening and widening social and health inequalities like never before. How can the nuances of the social gradient still be relevant when poverty and discrimination are such potent intractable forces? Is it not right to prioritise these as more urgent?

Such events have galvanised a response. A 2022 Oxfam Report *Inequality Kills* has highlighted the impacts of the rise in billionaire wealth, economic violence, gender-

[926] World Health Organisation, 'WHO Coronavirus (COVID-19) Dashboard' <https://covid19.who.int> accessed 19 February 2023.
[927] Lauren L O'Mahoney and others, 'The Prevalence and Long-Term Health Effects of Long Covid among Hospitalised and Non-Hospitalised Populations: A Systematic Review and Meta-Analysis' (2023) 55 eClinicalMedicine <https://www.thelancet.com/journals/eclinm/article/PIIS2589-5370(22)00491-6/fulltext> accessed 19 February 2023.
[928] Cameron Sinclair, 'Earthquakes Don't Kill People, Bad Buildings Do' [2023] *Dezeen* <https://www.dezeen.com/2023/02/08/turkey-earthquake-cameron-architecture-sinclair-opinion/> accessed 19 February 2023.
[929] Philip Alston, 'Statement on Visit to the United Kingdom, by Professor Philip Alston, United Nations Special Rapporteur on Extreme Poverty and Human Rights' (United Nations Special Rapporteur 2018) EOM_GB_16 Nov2018.pdf <https://www.ohchr.org/Documents/Issues/Poverty/EOM_GB_16Nov2018.pdf> accessed 13 January 2019.

based violence, climate catastrophe, and the Covid-19 pandemic.[930] The report has spearheaded a public campaign to raise awareness and promote civil society activism to address inequalities in the UK.[931] Many of their recommendations echo calls for redistribution of wealth and tax justice found in the World Inequality Report 2022.[932] Civil society activism and Island Nations globally have fought and won a first at COP27 with rich countries agreeing to pay climate damages to poor nations, though how this might be implemented is still to be seen.[933] Carbon inequalities across the globe, within regions, between countries and between individuals are being monitored, measured and discussed with calls for action.[934] Human rights are increasingly engaged with environmental and climate change issues.[935] The WHO has begun negotiations on a global pandemic treaty to prevent future pandemics, ensure global pandemic preparedness, and develop responses to pandemics, underpinned by global equity.[936] Related discussions are ongoing to agree amendments to the International Health Regulations to be presented to the World Health Assembly 2024.[937] Health sectors across the globe face challenges with ageing populations, economic crises, slow growth, work force shortages, and the impact of Covid-19. In the UK, we face questions about whether we can still have a functioning public national health service for all. Much

[930] Ahmed and others (n 2).
[931] Oxfam GB, 'Oxfam GB | Fight Inequality' (*Oxfam GB*) <https://www.oxfam.org.uk/get-involved/campaign-with-oxfam/bridging-inequality-gap-making-things-fair/> accessed 10 April 2023.
[932] Chancel and others (n 4).
[933] UN Climate Change, 'Establishing a Dedicated Fund for Loss and Damage | UNFCCC' (*United Nations Climate Change*, 2022) <https://unfccc.int/establishing-a-dedicated-fund-for-loss-and-damage> accessed 10 April 2023.
[934] Chancel and others (n 4) ch 6.
[935] 'Journal of Human Rights and the Environment' (*Elgar Online: The online content platform for Edward Elgar Publishing*, n. d.) <https://www.elgaronline.com/view/journals/jhre/jhre-overview.xml> accessed 10 April 2023.
[936] Alexandra L Phelan, 'The World Health Organization's Pandemic Treaty' (2023) 380 BMJ p463.
[937] World Health Organisation, 'Second Meeting of the Working Group on Amendments to the International Health Regulations (2005)' (*World Health Organisation*, 2023) <https://www.who.int/news-room/events/detail/2023/02/20/default-calendar/second-meeting-of-the-working-group-on-amendments-to-the-international-health-regulations-(2005)> accessed 10 April 2023.

of the discussion has focused upon health sector problems and reforms.[938] All these challenges sit within the bigger picture which reinforces the need to focus on social determinants of health and address health inequalities.

Despite the change in landscape the social gradient is still relevant, perhaps even more so. But here I present only a small window upon the social gradient, public health, and the right to health: one person, one view, many potential directions, and implications. There are still many gaps. Not least that the social gradient is frequently misunderstood, misrepresented, or missed altogether by both public health and the right to health. It is a concept in need of clarification, which this study does not offer. The Special Rapporteurs are only one aspect of the right to health and there are many more facets, not least the implications for human rights law and right to health litigation. The social gradient tells us that no matter how much health care or new medical technological magic is provided, gradient inequalities persist. It tells us that decades of pro-poor and anti-discrimination policies have not resolved issues of inequality. The social gradient tells us that if we do not develop new approaches to health inequalities, do not collaborate to create a foundational philosophical approach to inequalities, and if we do not address the causes of the causes of the causes, that is power and wealth, then we do indeed put the 'entire world at risk'.[939]

[938] Hugh Alderwick and others, 'Will a New NHS Structure in England Help Recovery from the Pandemic?' (2021) 372 BMJ n248.
[939] Venkatapuram, 'Social Gradient in Capabilities' (n 12) 555.

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APPENDICES

Appendix 1. Public Health Paradigms

The **biomedical model** focuses attention upon individual determinants of health with the result that health impacts are simply aggregated across the population and inequalities measured as differences between identified groups (horizontal inequalities). It has an underlying set of assumptions about causal mechanisms of disease that focuses epidemiology upon the biological, physical, pathological, and biochemical determinants of disease and their risk factors. This results in action for technological interventions to ameliorate the risks, provision of for example vaccination and screening programmes and the predominance of Randomised Control Trials (RCT) as public health evidence.[940] The biomedical model sees the body as the sum of its parts with innate characteristics vulnerable to malfunctioning. [941] This encourages a population level view of health as an aggregate of individual health functionings, with demarcations within populations due to particular innate individual characteristics (gender, age, and ethnicity).[942] Population rates of disease are therefore a consequence of individual events within a specified population.[943] Health is measured as relative to other groups in society and the choice of comparison groups may determine how inequality is understood. [944] Moreover, identifying and detailing inequalities between groups is not enough without an understanding of the policy processes required to reduce those inequalities.[945]

[940] Rayner and Lang (n 39) 87.
[941] ibid 83–88.
[942] Krieger, *Epidemiology* (n 38) 138.
[943] ibid 136.
[944] Graham, 'Tackling Inequalities in Health in England' (n 996) 120–123.
[945] Carey and Crammond (n 214).

The **materialist approach** argues that income levels influence access to goods and services, which in turn determines health, so attention is directed towards ameliorating poverty, and a focus upon vertical health inequalities. High-income levels provide access to health benefitting educational opportunities, health care services, social support networks, transport, and other resources and confer higher prestige and power in society.[946] Whereas a low income exposes people to health risks such as poor housing, inadequate diet, unhealthy work situations, and environmental hazards, and is characterised by insecurity and poverty. [947] Action from a materialist perspective would target resources to the poor with the aim of raising those at the bottom of the gradient above the poverty threshold. Materialist explanations also fail to clarify how the same goods and services might not meet different individual's particular needs.[948] Moreover, the discussion above has highlighted issues inherent in this approach.

The **lifestyle model** attends to behavioural choices as social determinants of health and gives limited attention to the material conditions in which people live and the realistic choices available to them. The lifestyle model represented an important shift in paradigms supplanting the biomedical model in the 1974 Canadian Lalonde report.[949] Yet, the concept of lifestyle, which was drawn into public health from the social sciences, has a similarly reductionist approach, and has Krieger argues, negatively influenced epidemiology.[950] The lifestyle model is underpinned by a methodological individualism that has doubly emphasised the focus upon the individual as the unit of analysis and action.[951] Methodological individualism theorises that social phenomena

[946] Clare Bambra, *Health Divides: Where You Live Can Kill You* (Policy Press 2016) 110–111.
[947] Solar and Irwin (n 356) 10.
[948] Graham, 'Health Inequalities, Social Determinants and Public Health Policy' (n 29) 468.
[949] Lalonde (n 82).
[950] Krieger, *Epidemiology* (n 38) 146–148.
[951] ibid 140.

are simply an aggregate of characteristics of individuals and can be wholly explained by individual behaviours.[952] This has translated into an epidemiologic definition of lifestyle as: '[t]he set of habits and customs that is influenced by the lifelong process of socialization; examples include the use of alcohol and tobacco, dietary habits, or exercise.'[953] This has come to be operationalised as lifestyle meaning individual choice as expressed through health behaviour in response to behavioural risk factors as related to key targets around alcohol and drugs, and diet and exercise. The predominant public health interventions are therefore through information giving and education to shape beliefs and influence public norms of behaviour.[954]

Fundamental Cause Theory is more aligned to a social determinant of health perspective and incorporates an understanding of the social gradient. Fundamental Cause Theory proposes certain fundamental causes of ill health or social determinants, that impact upon how ill health and the causes of and risk factors for ill health are distributed. [955] It has gained much traction in public health as it appeals to a sense of there being primary, underlying causes of morbidity and mortality. [956] Bruce Link and Jo Phelan observed that when various environmental and behavioural risk factors are removed or as diseases become treatable the socio-economic gradient in health remains, thus indicating something beyond those risk factors at work.[957] Their concerns are with the public health emphasis upon individual risk factors for disease such as diet and exercise, and they argue instead for a shift in focus to that of the social conditions

[952] For a more detailed discussion see: Geoffrey M Hodgson, 'Meanings of Methodological Individualism' (2007) 14 Journal of Economic Methodology 211.
[953] Porta and others (n 181) 168.
[954] Rayner and Lang (n 39) 79.
[955] Link and Phelan (n 94).
[956] And echoes of this theory can be found in the right to health, with the concept of 'underlying determinants'
[957] Bruce G Link and Jo C Phelan, 'McKeown and the Idea That Social Conditions Are Fundamental Causes of Disease' (2002) 92 American Journal of Public Health 730.

influencing people's vulnerabilities to risk. Social factors such as economic status and social support can be considered 'fundamental causes' of disease because 'they embody access to important resources, affect multiple disease outcomes through multiple mechanisms, and consequently maintain an association with disease even when intervening mechanisms change.'[958]

However, Fundamental Cause Theory, as with biomedical, materialist and lifestyle explanations for health inequalities, does not elaborate the mechanisms by which individuals become distributed into the different levels evidenced by the social gradient. [959] [960] The Solar and Irwin conceptual framework for social determinants incorporates Diderichsen, Evans and Whitehead's model of social stratification.[961] This elaborates the mechanisms by which people are distributed along the social gradient. Social contexts determine the distribution of people within a social hierarchical which then determines the differential experience of risks, vulnerabilities, and health consequences in terms of resources and health outcomes. Power and wealth are important drivers of social stratification and is reflected in the CSDH reports emphasis upon power money and resources.[962]

Psycho-social theory offers partial insights not only into the social gradient effect upon individuals but also upon society. Key proponents of psycho-social theory, including Michael Marmot and Richard Wilkinson, argue that it is the individuals' perceptions of their social conditions and how they respond psychologically, behaviourally and

[958] Link and Phelan (n 94) 80.
[959] Mel Bartley, *Health Inequality: An Introduction to Theories, Concepts and Methods* (2nd ed, Polity Press 2017) ch 6.
[960] Solar and Irwin (n 85) 64.
[961] Solar and Irwin (n 356) 19–20.
[962] Commission on Social Determinants of Health (n 10) pt 4.

biologically that impacts their health.[963] The psycho-social approach recognises the impact of social issues such as relative rank in the social gradient, position in social hierarchies, low status, lack of opportunity and choice, work stress etc. but understands the mechanisms causing ill health as being physiological through altered neuro-endocrine function and brain-mediated allostatic overload.[964] Michael Marmot entitled this phenomenon *The Status Syndrome*.[965] Wilkinson and Picket in *The Spirit Level: Why Equality is Better for Everyone* presented data to demonstrate that this phenomenon is not limited to individuals but impacts the whole of society.[966] They termed this phenomenon 'the sick society'.[967] Greater economic inequality reduces trust, public participation, collaboration, and social cohesion and increases segregation, division, and social instability. This can result in higher levels of violent crime and homicide rates, greater prevalence of depressive disorders, increasing discrimination and racism, growing numbers of teen pregnancies and a larger prison population disproportionate to population size.[968] This affects everyone in society – all of us on the social gradient - not just the poor.

The **life-course approach** incorporates the dose-response relationship explanation of the social gradient effect and is complementary to psycho-social theory. The life-course approach is concerned with how the differential exposures to health risks and specific forms of vulnerability at different stages in a person's life, from foetus to old age, are linked to a person's social orientation and status and health outcomes in later age.[969]

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[963] Marmot, *The Health Gap* (n 197); Brunner and Marmot (n 197); Pickett and Wilkinson (n 155); Wilkinson and Pickett (n 150).
[964] Krieger, *Epidemiology* (n 38) 191–201.
[965] Marmot, *The Status Syndrome* (n 153).
[966] Pickett and Wilkinson (n 153).
[967] Wilkinson (n 201).
[968] Pickett and Wilkinson (n 153); Pickett and Wilkinson (n 155); Wilkinson and Pickett (n 150).
[969] Ben-Shlomo and Kuh (n 195).

Five life-course explanatory mechanisms are offered: accumulation of risk over time through all life stages, particular sensitivities at particular life stages such as early childhood, a synergy of clustered risks each interacting with the other, chain reactions of risk with one leading to increased risk of another, and the latency of effect whereby negative health impacts at an early age are expressed at a later life stage.[970] These risks not only include biological or behavioural risks but also encompass the impacts of education, socio-economic status and contextual factors. Moreover, an intergenerational view of life-course with the incorporation of genetic explanations is becoming increasingly influential in public health to encompass historical contexts and the intractable persistence of health inequalities across generations.[971]

However, psycho-social and life-course explanations are at risk of drifting into biological and behaviour change action. Actions following a psycho-social approach might highlight adverse factors and promote protective factors amongst the population by providing psychologically informed support services to families to create resilient family relationships, improving psycho-social working conditions, create a greater sense of belonging in communities and improve social cohesions, and supporting people to reduce factors adversely affecting their health.[972] However, this approach still emphasises the individual mind, and can channel action towards an individual's response to social stress factors.[973] Recommendations in *Closing the Gap* strongly evidence a life-course approach with the first principle requiring improvement in people's daily living conditions. Action here embeds equality in early childhood

[970] Diana Kuh and others, 'Life Course Epidemiology' (2003) 57 Journal of Epidemiology & Community Health 778.
[971] Shanahan and Boardman (n 196).
[972] Ruth Bell, 'Psychosocial Pathways and Health Outcomes: Informing Action on Health Inequalities' (Public Health England (PHE) 2017) 2017209.
[973] Krieger, *Epidemiology* (n 38) 198.

development as part of a life-course approach to health inequities and requires investment in nutrition, education, health, support, and maternal health for early years of childhood.[974] Fair employment and decent work and social protection across the life-course are recommended to reduce health inequalities. This needs to be a whole society approach but can become reduced to targeted action on specific groups without addressing whole society determinants.

Intersectionality redirects attention from simply thinking about horizontal as compared to vertical health inequalities towards consideration in the interrelationship between the two but is at risk of losing its explanatory power. The concept of intersectionality, which arose out of a feminist discourse, describes the dynamics of multiple systems of inequality interacting to influence power structures and systems in society.[975] A number of different expressions of this concept have since been developed, and have seen increasing application to public health.[976] Intersectionality offers a different perspective for understanding the interrelationship of social determinants such as ethnicity and gender in relation to income and wealth that moves beyond the often unidirectional view presented by horizontal and vertical inequalities.[977] It provides a means to articulate a more political analysis of power relations and their influence upon inequalities in health.[978] However, care is needed to not reduce the concept to simply reflect a multiplicity of determinants of health on both a horizontal and vertical axis and to maintain its explanatory power in terms of the impact of power relationships as

[974] Commission on Social Determinants of Health (n 10).
[975] Crenshaw (n 143).
[976] Kapilashrami, Hill and Meer (n 144).
[977] Lopez and Gadsden (n 142); Hernández-Yumar and others (n 142); See for example Webb and others (n 142).
[978] Hill (n 144); Kapilashrami, Hill and Meer (n 144).

determinants of health.[979] Moreover, the concept has at times become an addition to traditional race and gender analysis, losing the broader texture of inequalities and centrality of the influence of power relationships across all hierarchical positions in society.[980]

[979] Josée Lapalme, Rebecca Haines-Saah and Katherine L Frohlich, 'More than a Buzzword: How Intersectionality Can Advance Social Inequalities in Health Research' (2020) 30 Critical Public Health 494.
[980] Corinne L Mason, 'Buzzwords and Fuzzwords: Flattening Intersectionality in Canadian Aid' (2019) 25 Canadian Foreign Policy Journal 203.

Appendix 2. Steps in Conducting a Scoping Review

Steps 1 and 2: Aligning aims, objectives and research question, and inclusion and exclusion criteria

The aim of this scoping review of academic literature is to map available literature referring to the social gradient and allied concepts in relation to discussion of the right to health. The two specific objectives are to 1) describe the manner in which the social gradient is portrayed, and 2) explore the relationship between the social gradient and the right to health.

The alignment of aim, objectives and question was conducted using the Participant, Concept, Concept framework advocated by Peters and colleagues.

Step 3: Study protocol

An *a priori* protocol delineating the steps to be taken in conducting the review should be developed to ensure transparency of the process, to provide a plan for the review and to limit reporting bias.[981] Registration of systematic review protocols has long been considered good practice and some organisations are now considering protocol registrations for scoping reviews. A protocol for this review was registered with the Open Science Framework.[982] The review was structured and evaluated using the PRISMA-ScR statement (see Appendix 3).[983]

Step 4: Searching for evidence

A search of academic literature was conducted in eleven databases (CINAHL, MEDLINE, APA PsycInfo, APA PsycArticles, OpenDissertations, E-Journals– through

[981] Peters and others (n 222) s 11.2.
[982] Registration number https://osf.io/2kwvu DOI: 10.17605/OSF.IO/YU9BR
[983] Tricco and others (n 224).

EBSCOHost, HeinOnline, JSTOR, SCOPUS, IBSS and Web of Science) cataloguing both human rights and public health resources. Phrase searches using Boolean operators were applied to full text rather than abstracts or keywords only, in order to capture every mention of the social gradient and the right to health where it might not be of substantive concern in the article. Date limitations were not applied in order to be able to trace the development of the concept. Articles were limited to English only. An Excel spreadsheet was used to catalogue all articles and identify duplicates. The search strategy was developed and refined based upon returns on search strategies tested in EBSCOHost. The scoping review was initially conducted in December 2017 and then repeated in April / May 2021 to update findings. A further process of selection identified articles where both the social gradient and the right to health were discussed more substantively. These texts were appraised first and additional texts searched for by reference and citation tracking. 656 articles were found through database searching and 118 through hand searches. 314 articles were included in the mapping and 18 in the core literature. See Figure 3 for the PRISMA flow diagram summarising the search results (see also Appendix 4).

Step 5: Screening and selecting evidence

After removing duplicates, the titles and abstracts of the articles were reviewed. Items such as annotated bibliographies, book reviews and conference abstracts were excluded. News items, editorials, letters, conference presentations, and opinion pieces were included alongside peer reviewed articles and research reports in order to capture the nature of the discussion about the relevant concepts. Articles had to include both the social gradient and the right to health. Articles were included in the scoping review even if they mentioned the social gradient or right to health only in passing or in references and footnotes.

Step 6: Extracting the evidence

As each article was reviewed data were extracted for particular characteristics: year, type of article (public health / human rights / right to health) based on their substantive content and author affiliations, document type (e.g. research paper, commentary etc.), the level of inclusion of the social gradient (footnotes and references / in passing / discussed / substantive) and similarly for the right to health (see Appendix 5). Articles were then reviewed for explanatory mechanisms for the social gradient, the interrelationship between the social gradient and the right to health and for how health inequalities were portrayed.

Step 7: Analysis of the evidence

A framework synthesis approach was adopted to structure the analysis of such a large body of articles and ensure rigour.[984] Coding strategies were applied in NVivo-12 software.[985] The framework matrices in NVivo facilitate framework synthesis. Data analysis adopted an iterative process as recommended by Levac and colleagues, moving from the small group of 31 articles for detailed appraisal to the larger body of literature and back again.[986] The smaller body of literature was created from those articles that substantively discussed the social gradient and the right to health (see Appendix 7).

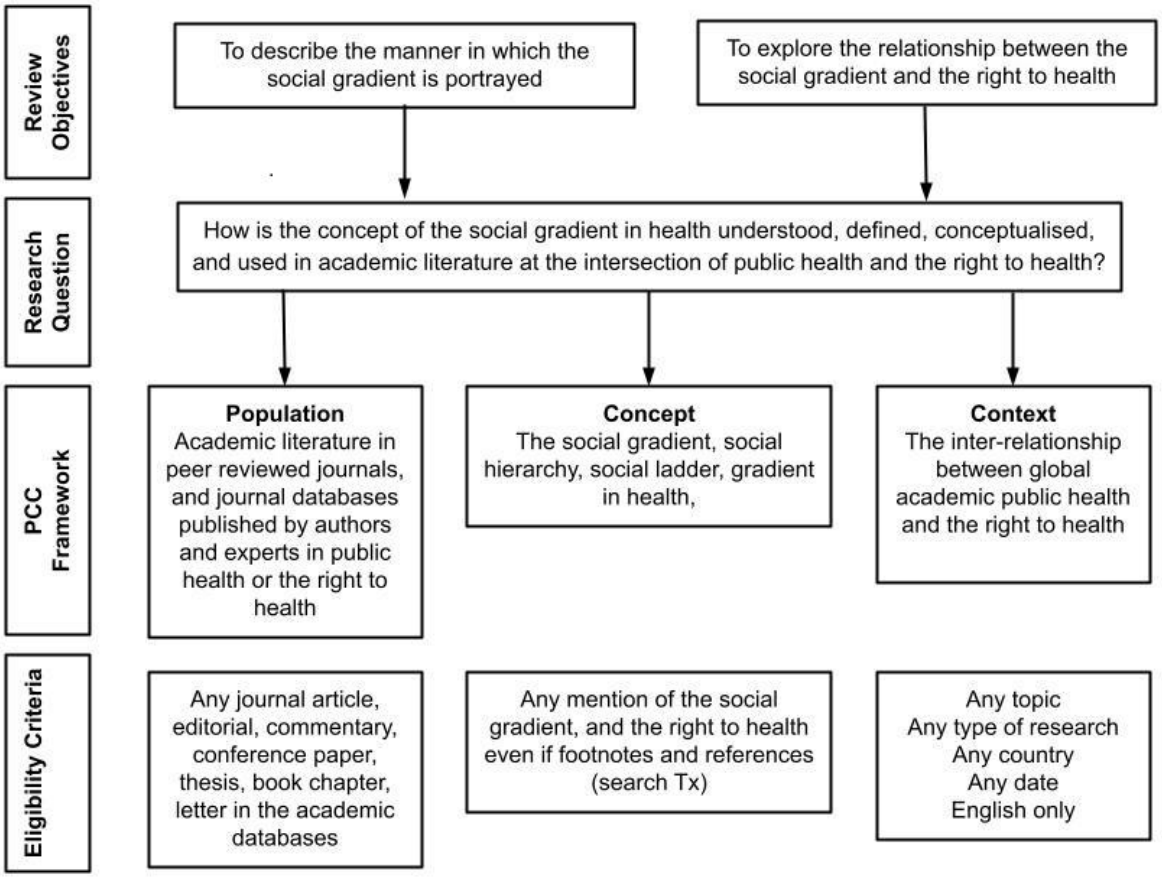
Step 8: Presenting evidence in tabular form

[984] Spencer and others (n 227); Parkinson and others (n 227); Hackett and Strickland (n 227).
[985] QSR International (n 228).
[986] Levac, Colquhoun and O'Brien (n 221).

Step 9: Interpreting the implications of the findings in relation to the purpose of the review.

Appendix 3. Developing and Aligning Eligibility Criteria

The participant, concept, context framework was used as described by Peters and colleagues to align research questions with eligibility criteria.[987]



Participants

The participants in this review are the papers themselves. The strength of the scoping review methodology is its ability to cover a breadth of material in an emerging field where there is a paucity of evidence and permits inclusion of a range of study designs in academic and grey literature.[988] The literature was situated at the intersection of public health and the right to health where health topics are addressed, and the social gradient and human rights are included. Papers rather than specific authors celebrated for their

[987] Peters and others (n 222) s 11.3.6.
[988] Andrew Booth, Diana Papaioannou and Anthea Sutton, *Systematic Approaches to a Successful Literature Review* (Sage Publications 2012) 28 and 83.

work in public health and right to health, were selected to highlight occasions where each field recognises the social gradient and the right to health, even in some small way.

Concepts

Studies considered for inclusion had to address both the social gradient AND the right to health specifically or human rights generally. Papers were then searched for related concepts which were included in the data extraction sheet.

Context

This scoping review sought studies on any health topic in any country, and of any research type (quantitative, qualitative research, mixed methods or reviews), and included theses, opinion pieces, commentary, and conference papers published in peer reviewed journals. Academic literature was sought as it represented the forefront of debate and the development of concepts. The scoping review did not include grey literature such as reports as these are huge in number and sourced from a wide range of global organisations or include books and book reviews as these are too complex to screen. Some are included elsewhere in the thesis, such as the WHO Commission report and most specifically the Special Rapporteur reports for the right to health and represent that intersection of public health and right to health policy and practice. Articles in languages other than English were excluded, (recognising the inherent bias in not accessing potentially valuable literature in other languages not spoken by the author).

Appendix 4. Preferred Reporting Items for Systematic reviews and Meta-Analyses extension for Scoping Reviews (PRISMA-ScR) Checklist

SECTION	ITEM	PRISMA-ScR CHECKLIST ITEM	REPORTED ON PAGE #
TITLE			
Title	1	Identify the report as a scoping review.	Title
ABSTRACT			
Structured summary	2	Provide a structured summary that includes (as applicable): background, objectives, eligibility criteria, sources of evidence, charting methods, results, and conclusions that relate to the review questions and objectives.	56-61
INTRODUCTION			
Rationale	3	Describe the rationale for the review in the context of what is already known. Explain why the review questions/objectives lend themselves to a scoping review approach.	56
Objectives	4	Provide an explicit statement of the questions and objectives being addressed with reference to their key elements (e.g. population or	56 and Appendix 3

SECTION	ITEM	PRISMA-ScR CHECKLIST ITEM	REPORTED ON PAGE #
		participants, concepts, and context) or other relevant key elements used to conceptualize the review questions and/or objectives.	
METHODS			
Protocol and registration	5	Indicate whether a review protocol exists; state if and where it can be accessed (e.g. a Web address); and if available, provide registration information, including the registration number.	Open Science Framework Registration number https://osf.io/2kwvu DOI: 10.17605/OSF.IO/YU9BR
Eligibility criteria	6	Specify characteristics of the sources of evidence used as eligibility criteria (e.g. years considered, language, and publication status), and provide a rationale.	56-58 and Appendix 3
Information sources*	7	Describe all information sources in the search (e.g. databases with dates of coverage and contact with authors to identify additional sources), as well as the date the most recent search was executed.	57 and Appendix 5
Search	8	Present the full electronic search strategy for at least 1 database,	Appendix 5

SECTION	ITEM	PRISMA-ScR CHECKLIST ITEM	REPORTED ON PAGE #
		including any limits used, such that it could be repeated.	
Selection of sources of evidence†	9	State the process for selecting sources of evidence (i.e., screening and eligibility) included in the scoping review.	57 and Appendix 5
Data charting process‡	10	Describe the methods of charting data from the included sources of evidence (e.g. calibrated forms or forms that have been tested by the team before their use, and whether data charting was done independently or in duplicate) and any processes for obtaining and confirming data from investigators.	61-4 And Appendix 2
Data items	11	List and define all variables for which data were sought and any assumptions and simplifications made.	61-66
Critical appraisal of individual sources of evidence§	12	If done, provide a rationale for conducting a critical appraisal of included sources of evidence; describe the methods used and how this information was used in any data synthesis (if appropriate).	Not included

SECTION	ITEM	PRISMA-ScR CHECKLIST ITEM	REPORTED ON PAGE #
Synthesis of results	13	Describe the methods of handling and summarizing the data that were charted.	61-66 And Appendix 3
RESULTS			
Selection of sources of evidence	14	Give numbers of sources of evidence screened, assessed for eligibility, and included in the review, with reasons for exclusions at each stage, ideally using a flow diagram.	58
Characteristics of sources of evidence	15	For each source of evidence, present characteristics for which data were charted and provide the citations.	66-75
Critical appraisal within sources of evidence	16	If done, present data on critical appraisal of included sources of evidence (see item 12).	Not included
Results of individual sources of evidence	17	For each included source of evidence, present the relevant data that were charted that relate to the review questions and objectives.	Not included
Synthesis of results	18	Summarize and/or present the charting results as they relate to the review questions and objectives.	66-75

SECTION	ITEM	PRISMA-ScR CHECKLIST ITEM	REPORTED ON PAGE #
DISCUSSION			
Summary of evidence	19	Summarize the main results (including an overview of concepts, themes, and types of evidence available), link to the review questions and objectives, and consider the relevance to key groups.	66075
Limitations	20	Discuss the limitations of the scoping review process.	59-60
Conclusions	21	Provide a general interpretation of the results with respect to the review questions and objectives, as well as potential implications and/or next steps.	76-84
FUNDING			
Funding	22	Describe sources of funding for the included sources of evidence, as well as sources of funding for the scoping review. Describe the role of the funders of the scoping review.	1

JBI = Joanna Briggs Institute; PRISMA-ScR = Preferred Reporting Items for Systematic reviews and Meta-Analyses extension for Scoping Reviews.

* Where *sources of evidence* (see second footnote) are compiled from, such as bibliographic databases, social media platforms, and Web sites.

† A more inclusive/heterogeneous term used to account for the different types of evidence or data sources (e.g. quantitative and/or qualitative research, expert opinion, and policy documents) that may be

eligible in a scoping review as opposed to only studies. This is not to be confused with *information sources* (see first footnote).

‡ The frameworks by Arksey and O'Malley (6) and Levac and colleagues (7) and the JBI guidance (4, 5) refer to the process of data extraction in a scoping review as data charting.

§ The process of systematically examining research evidence to assess its validity, results, and relevance before using it to inform a decision. This term is used for items 12 and 19 instead of "risk of bias" (which is more applicable to systematic reviews of interventions) to include and acknowledge the various sources of evidence that may be used in a scoping review (e.g. quantitative and/or qualitative research, expert opinion, and policy document).

From: Tricco AC, Lillie E, Zarin W, O'Brien KK, Colquhoun H, Levac D, et al. PRISMA Extension for Scoping Reviews (PRISMA-ScR): Checklist and Explanation. Ann Intern Med. ;169:467–473. doi: 10.7326/M18-0850

Appendix 5. Search Terms and Database Searches

Full text searching was essential to be able to capture every mention of the 'right to health' and of the social gradient as required to create a picture of how these concepts are used and understood. Only thirty of the 314 articles in this scoping review contained the words 'social gradient' in the title, key words, or abstract. Only two of those also contained 'right to health' or 'health and human rights' in title, keywords or abstract.[989] Emphasising the need to search 'All text'.

There are a number of terms used in place of the social gradient. In their scoping review of social determinants of health literature, Lucyk and McLaren identified that the term 'social gradient' was used in 37% of their articles, but that other terms were interchangeable with 'social hierarchy' (29.6%), 'social position' (56.5%) and 'social ladder' (9.3%) prominent among them.[990] Searches using these alternative terms were tested in EBSCO Host but generated far too many irrelevant results to be manageable For example, the search TX ((“social hierarchy”) NOT (“social gradient” OR “socio-economic gradient” OR “socio-economic gradient” OR “gradient in health”) AND (“right to health” OR “health rights” OR “rights-based” OR “rights based” OR “human rights”)) generated an additional 294 articles, only one of which was relevant but was already included in the previous search. This was replicated with the terms “social stratification”, “social position” and “social ladder” which accessed a wide range of sociological and psycho-social literature irrelevant to this study.

[989] Dennis Raphael, Toba Bryant and Zsofia Mendly-Zambo, 'Canada Considers a Basic Income Guarantee: Can It Achieve Health for All?' (2019) 34 Health Promotion International 1025; Bezo, Maggi and Roberts (n 11).
[990] Lucyk and McLaren (n 82) 13–14.

Searches using the overarching concept of ‘health inequity’ and relevant synonyms again generated far too many results to be manageable. The review therefore remains focused upon the concept of the social gradient in health, as articulated by Marmot and colleagues in the CSDH, as it is a much more specific concept than that of social stratification or social hierarchy used in a broader range of sociological and psychological literature. Additionally, the term social gradient expresses a nuanced understanding of health inequity that moves debate beyond a focus upon poverty and the most vulnerable and marginalised groups. It is this more nuanced understanding that is important to this review, which aims to seek out a means to understand those small gradations of health inequality and the implications for the right to health.

The search string (“social gradient” OR “socio-economic gradient” OR “socio-economic gradient” OR “gradient in health”) AND (“right health” OR “health rights” OR “rights-based” OR “rights based” OR “human rights”) was applied with the truncation and wild cards appropriate to each database.

Database	Results	Duplicates	Screened	Eligibility	Mapping	Review
EBSCOHost	370	67	16	120	167	10
HeinOnline	65	9	5	8	43	1
JSTOR	64	16	9	9	30	1
SCOPUS	41	4	1	3	33	3
IBSS	111	32	11	31	37	2
Web of Science	5	4	1	0	0	0
Other	118	18	7	89	4	1
TOTAL	774	150	49	261	314	19

EBSCOHost [CINAHL Complete, MEDLINE. PsycINFO, PsycARTICLES, E-Journals, OpenDissertations]

7th December 2017 – 123 included in mapping with 9 for detailed analysis

Search updated 18th February 2021 - 44 results added to mapping with 1 for detailed analysis

Search mode – Find all my search terms, Apply equivalent subjects

S1 TX("social gradient" OR "socio-economic gradient" OR "socio-economic gradient" OR "health gradient" OR "gradient in health") – 7,792 results

S2 TX("right health" OR "health right*" OR "human right*" OR "right*-based") – 151,861 results

S3 S1 AND S2 – 278 results

S4 Subject headings social gradient AND right to health – 98 results

S6 S4 OR S5 – 372 results

S7 *Limiter applied –English only (2) – 370 results*

Duplicates (67) – 303 results remaining

Screening Title and Abstract Exclusion – Conference abstracts (14), Listed Bulletins (2) – 287 results remaining

Full Text Review Exclusion – no reference to either social gradient / right to health or allied terms (120) - **167 results**

HeinOnline

9th December 2017 - 37 included in mapping with 1 for detailed analysis

Search updated 23rd April 2021 – 6 results added to mapping

Search mode – Find all my search terms, Apply equivalent subjects

S1 TX("social gradient" OR "socio-economic gradient" OR "socio-economic gradient" OR "health gradient" OR "gradient in health") – 196 results

S2 TX("right health" OR "health right*" OR "human right*" OR "right*-based") – 51,071 results

S3 TX("social gradient" OR "socio-economic gradient" OR "socio-economic gradient" OR "health gradient" OR "gradient in health") AND TX("right health" OR "health right*" OR "human right*" OR "right*-based") –65 results

Duplicates removed (9) – 56 results remaining

Screening Title and Abstract Exclusion –Conference abstracts (2), Irrelevant (2), Embargoed (1) – 51 results remaining

Full Text Review Exclusion – no reference to either social gradient / right to health or allied terms (8) - **43 results**

JSTOR

11th December 2017 – 28 results added to mapping with 1 for detailed analysis

Search updated 14th May 2021 – 2 results added to mapping

Search mode – Search within results

S1 TX("social gradient" OR "socio-economic gradient" OR "socio-economic gradient" OR "health gradient" OR "gradient in health") – 2,820 results

S2 TX("right health" OR "health right*" OR "human right*" OR "right*-based") – 278,523 results

S3 TX("social gradient" OR "socio-economic gradient" OR "socio-economic gradient" OR "health gradient" OR "gradient in health") AND (TX("right to health" OR "health rights" OR "rights-based") *(Maximum of 200 characters in search string so human rights missed off as a search term)* - 64 results

Duplicates removed (16) - 48 remaining

Screening Title and Abstract Exclusion –Programme and abstracts (2), Irrelevant (2), Posters (1), Annex (1), Unobtainable (1), Book Review (2) – 39 results remaining

Full Text Review Exclusion – no reference to either social gradient / right to health or allied terms (9) - **30 results**

SCOPUS

15th December 2017 – 33 results added to mapping with 3 for detailed analysis

Search updated 17th May 2021 – 0 additional results

Search mode – Search within Title, Abstract, Keywords

S1 ("social gradient" OR "socio-economic gradient" OR "socio-economic gradient" OR "health gradient" OR "gradient in health") – 4,489 results

S2 ("right health" OR "health right*" OR "human right*" OR "right*-based") – 109,170 results

S3 ("social gradient" OR "socio-economic gradient" OR "socio-economic gradient" OR "health gradient" OR "gradient in health") AND (TX("right to health" OR "health rights" OR "rights-based") - 41 results

Duplicates removed (4) - 37 results remaining

*Screening Title and Abstract Exclusion – Chinese (1) – 3*6 results remaining

Full Text Review Exclusion – no reference to either social gradient / right to health or allied terms (3) - ***33* results**

IBSS

18th December 2017 – 30 results added to mapping with 2 for detailed analysis

Search updated 17th May 2021 – 7 additional results

S1 ("social gradient" OR "socio-economic gradient" OR "socio-economic gradient" OR "health gradient" OR "gradient in health") – 1,077 results

S2 ("right health" OR "health right*" OR "human right*" OR "right*-based") – 132,085 results

S3 ("social gradient" OR "socio-economic gradient" OR “socio-economic gradient” OR "health gradient" OR "gradient in health") AND (TX("right to health" OR "health rights" OR "rights-based") - 111 results

Duplicates removed (32) - 79 results remaining

Screening Title and Abstract Exclusion – unobtainable (5), Lists of books (4) Government round up (1), Book review (1) – 68 results remaining

Full Text Review Exclusion – no reference to either social gradient / right to health or allied terms (31) - **37 results**

Web of Science

20th December 2017 – 0 results added to mapping

Search updated 17th May 2021 – 1 additional result

Search mode – Core collection, all years

S1 ALL=("social gradient" OR "socio-economic gradient" OR “socio-economic gradient” OR

"health gradient" OR "gradient in health") – 1,664 results

S2 ("right health" OR "health right*" OR "human right*" OR "right*-based") – 59,095 results

S3 S1 AND S2 - 5 results

Duplicates removed (4), unobtainable (1) - **0 result**

Other

Search updated 26 May 2021 - 4 results added to mapping with 1 for detailed review

Search mode - Snowballing, Zotero

118 resources found, excluded 18 duplicates, excluded 7 videos and webpages on screening titles and text, excluded 79 on review – **4 results**

Appendix 6. Scoping Review Core Articles

Author(s)	Type / Topic	Main argument	Social gradient in health	Social gradient as related to the right to health
Malbon E, Carey G and Melyzer A, (2019) Personalisation schemes in social care: are they growing social and health inequalities	Public Health Review Australia Personalisation schemes for health care	Personalisation schemes to access health care can deepen inequalities - personalisation schemes in Australia demonstrate that the better off – those in the middle and the top of the gradient – are able to benefit more from personalisation schemes than those lower down the gradient.	The social gradient in health articulates a particular type of inequalities, although many just focus on the lower end of the gradient. Those at the middle of the gradient are better able to exert navigate health systems to improve their health. Explanatory mechanism – social capital, psycho-social theory	Human rights principle of autonomy and participation mean that people should be able to exert choice and control over their health and be able to advocate for their needs and their rights. Even with UHC, which exemplifies important human rights principles, people cannot exert choice and control so those at the lower end of the gradient benefit less.
Sridharan S, Maplazi J, Shirodkar A, Richardson E and Nakaima A, (2016) Incorporating gender, equity, and human rights into the action planning process	Public Health Policy analysis General / global Implementation of WHO gender, equity and human rights action plans	Using a theory of change framework, the authors make nine recommendations to WHO to better support the implementation of gender, equity and rights action plans	Socioeconomic status and the social gradient are social determinants of health. Poverty is the focus of the analysis with identification of groups at the lowest end of the gradient, examining barriers to access and how to communicate effectively with these groups. Explanatory mechanisms – multiple definitions of disadvantage	Human rights standards and treaties are an important foundation for gender equity and can help identify and develop plans and communication to aid those at the lowest end of the social gradient.
Farrer L, Marinetti C, Cavaco YK and Costongs C, (2015) Advocacy for health equity: A synthesis review	Public health Literature Review Europe	Advocacy organisations could be central to sharing of evidence from research with the public, civil society organisations and the media thus influencing both the private sector and public policy decisions in favour of health equity.	Evidence for the social gradient supports a social justice argument. Actions to reduce the gradient require a long-term vision, however most health policy judgements are short term. Explanatory mechanism – social determinants of health	Human rights have the power to support participation for vulnerable groups to be able to advocate for improved social determinants of health which contribute to the social gradient in health. The indivisibility of rights can help address a range of social determinants.

Author(s)	Type / Topic	Main argument	Social gradient in health	Social gradient as related to the right to health
	The role of advocacy in health.			
Yamin AE and Norheim OF, (2014) Taking equality seriously: Applying human rights frameworks to priority setting in health	Right to health Opinion and analysis paper Global / General Mechanisms for priority setting	This paper builds upon Yamin's earlier paper argues that a human rights-based approach can contribute to priority setting mechanisms through advocating and supporting greater public participation and deliberation.	The social gradient is evidence of social inequality and is a key determinant of health in *Closing the Gap*. The implications of this social hierarchy being the unequal power relations in societies, which need to be addressed in order to achieve the *Closing the Gap* aim to flatten the social gradient. Explanatory mechanism – socio-political and human rights	Human rights traditionally focus at the lower end of the gradient. A human rights-based approach is required to address issues of power money and resources at the root of the social inequalities articulated by the gradient.
Vega J and Frenz P (2013) Integrating social determinants of health in the universal health coverage monitoring framework	Public Health Opinion and analysis Global / general UHC monitoring framework	UHC should include SDH otherwise UHC will be limited to health care and financial support. A gradient approach is necessary to not just focus on the poorest and most disadvantaged	The social gradient demonstrates multidimensional social stratification not just socio-economic status. Focusing on the 40% at the lower end of the gradient as currently proposed does not reach the remaining 60% Explanatory mechanism – multi dimensional stratification	UHC is the means by which to address the social gradient and is the means to encompass human rights with the health system. But to do so it must include social determinants of health and must address the full implications of the gradient.
Khoo S, (2013) Health governance and 'Wicked Problems': facing complex developmental transitions using a rights-based approach	Public health Commentary Low- and Middle-Income Countries	The article discusses the promises and shortfalls of the 'shared health governance' approach in Africa and suggests that a rights-based approach provides an alternative capable of addressing the 'wicked problems' of governance.	Factors that contribute to the social gradient include the global economic system and labour market policies and fragmentation in health and welfare systems. The ineffectual public health focus on behaviour change fails to understand how behaviour impacts the social gradient.	A human rights-based approach provides a legal and normative core to address the CSDH concern with poor and unfair policies and economics and political power imbalances, which the CSDH say contribute to the social gradient in health inequalities.

Author(s)	Type / Topic	Main argument	Social gradient in health	Social gradient as related to the right to health
	Health governance		Explanatory mechanism – structural determinants	
Bezo B, Maggi S and Roberts WL, (2012) The rights and freedoms gradient of health: evidence from a cross national study	Human rights Secondary data analysis Global / general Human Rights Gradient	Models of a "rights and freedoms gradient of health" whereby increasing levels of rights and freedoms improved physical and mental health outcomes in a gradient	Correlation pathways were described to model how impacts of social capital and socio-economic status on physical or mental health were completely or partially mediated via rights and freedoms. Explanatory mechanism – human rights	A physical and mental health gradient is evidenced against measures of political rights, civil liberties, perception of corruption, indicators of democracy, electoral processes, freedom for political participation, transparency, freedom of expression and belief, freedom of association, rule of law, autonomy, and individual rights.
Chapman AR, (2011) Missed opportunities: The human rights gap in the reports of the CSDH	Right to health Commentary Global / general Critique of the process and report from the 2008 WHO CSDH	The CSDH failed to incorporate sufficient explicit consideration of human rights which has weakened its impact.	The social gradient is introduced demonstrates that health inequalities are structurally determined. Explanatory mechanism – structural determinants	Human rights are required to act upon the structural determinants of health, that help to create the social gradient if they are to address the 'toxic combination of poor social policies and programmes, unfair economic arrangements, and bad politics' (p133).
Venkatapuram S., Bell R. and Marmot M. (2010) Social epidemiology, human rights and social justice.	Public health Opinion and analysis Global / General Social epidemiology and the RTH	This paper explores the intersections of social epidemiology, social medicine and the right to health. It examines *Closing the Gap* and contrasts human rights and social justice approaches to health equity to conclude with four potential areas of collaboration.	There is extensive evidence for the social gradient but gradients within and between countries vary considerably and change over time. The social gradient is indicative of social justice issues and results from the ways in which societies are organised. Explanatory mechanism – structural determinants, human rights, capability approach	Human rights have much to contribute to addressing social justice issues. However, it is not immediately clear as to how human rights can relate to social epidemiology and address the social gradient.

Author(s)	Type / Topic	Main argument	Social gradient in health	Social gradient as related to the right to health
Braveman P, (2010) Social Conditions, Health Equity, and Human Rights	Public health Critical Concepts Essay Global / General Relationship between health equity and human rights	The fields of health equity and human rights each have frameworks, concepts and tools that could strengthen the other. However, differences in language, and means to action can create divergences between the two.	The social gradient demonstrates the importance of various explanatory mechanisms to the creation of health inequalities. It requires action for 'levelling up' the lower end of the gradient rather than reducing the upper end of the gradient. Explanatory mechanisms – structural and political determinants, psycho-social, life-course, social stratification, capability approach.	The complex interrelationship of determinants articulated by the social gradient reflects the indivisibility of rights. The highest attainable standard of health is that at the top of the gradient. Human rights principles of non-discrimination and equality can strengthen the concept of health equity by identifying those with a lack of health equity and strengthening action with law. Health equity can contribute to human rights by providing empirical evidence and providing means to measure equity for accountability purposes.
Chapman AR (2010) Social determinants of health, health equity, and human rights.	Right to health Commentary Global / General CSDH report and public health and human rights approaches to health equity.	The right to health needs to address both power dynamics and health inequities to provide a fuller understanding of the underlying determinants of health.	The social gradient in health perpetuates health inequalities and the slope of this gradient needs to be reduced. Explanatory mechanism – structural determinants	The social gradient articulates issues of structures and power in health. A rights-based approach to health includes the social determinants of health, including the social gradient. The right to health needs to give greater attention to social determinants and to the issue of power
Bell R, Taylor S and Marmot M, (2010)	Public health Colloquium paper Global / General CSDH	CSDH report demonstrates inequalities within and between countries that require determined action at global and national levels.	Society is subject to an unequal distribution of health outcomes on a gradient which is responsive to political and socio-economic policy choices. The social gradient provides a social justice imperative to act. Social gradients exist across society and within groups so need to not only address gaps between	The gradient affects everyone, and everyone has a right to health. Participation and civil society action necessary for material, psycho-social and political empowerment. People's Charter calling for action on social determinants based on protecting the right to health. Need human rights to protect macro-economic factors.

Author(s)	Type / Topic	Main argument	Social gradient in health	Social gradient as related to the right to health
			richest and poorest but also reduce the slope of the gradient. Explanatory mechanism – structural determinants, psycho-social, life-course, social stratification	
Yamin AE. (2009) Shades of dignity: Exploring the demands of equality in applying human rights frameworks to health	Right to health Critical concepts paper Global / General Public health and human rights-based approaches	This paper considers the concepts of equality and non-discrimination in international law and in public health arguing that human rights offer a means to redefine what is meant by inequalities in public health, particularly through a consideration of power relationships and by advocating for meaningful participation.	The social gradient is evidence of social inequality and is a key determinant of health in *Closing the Gap*. The implications of this social hierarchy being the unequal power relations in societies, which need to be addressed in order to achieve *Closing the Gap* aim to flatten the social gradient. Explanatory mechanism – structural determinants, discrimination	Human rights need to focus on relative deprivation, as depicted in the social gradient, not just absolute poverty. Attention to ensuring everyone has the same rights fails to acknowledge what is required for people in different circumstances to have equal rights.
Baum F. (2007) Cracking the nut of health equity: top down and bottom-up pressure for action on the social determinants of health	Right to health Theoretical essay General with high-income case study Action on social determinants of health	Successful action requires both top-down public health strategies in terms of population level action across the social gradient accompanied by bottom-up civil society advocacy and participation.	The social gradient demonstrates that inequalities are not just a consequence of discrimination and disadvantage, and requires action across the whole social gradient with universalist policies Explanatory mechanisms – social capital, psycho-social,	Human rights can strengthen civil society action and advocacy to develop networks and social exchanges across less advantaged populations and improve social capital through exhorting fair and transparent public policy, commitment to redistribution, interaction between different groups to reduce the negative psycho-social impacts
Marmot M, (2006) Health in an unequal world	Public health Lecture Global / General	We need to address SDH for the whole population in order to reduce the social gradient, not just improve conditions for the poor.	Social gradients in health are evidence of the 'causes of the causes' – the ways society is organised that cause an unequal distribution of the SDH.	Freedom, choice and control are important to the social gradient in health. Power is important. Human rights can help to address power

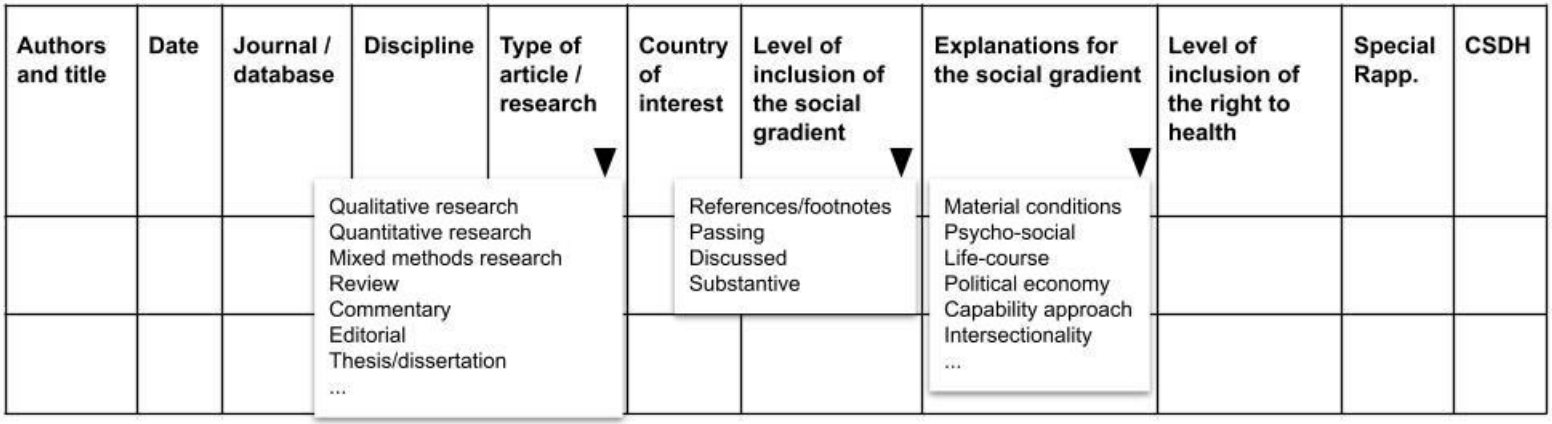
Author(s)	Type / Topic	Main argument	Social gradient in health	Social gradient as related to the right to health
	Health Inequalities		Explanatory mechanism – structural determinants, psycho-social	imbalances and support people's freedoms.
Danis M and Sepinwall A, (2002) Regulation of the global market place for the sake of health	Public health / human rights Presentation Global / General Multinational corporations	Corporations have ethical obligations with regard to the RTH, because they significantly affect health through their impact upon wealth distribution.	Multinational corporations have an important impact on socio-economic status they are therefore obliged to avoid creating negative health outcomes within populations. Explanatory mechanism – structural determinants, marketplace economics	Deprivation of health is a rights violation. Health is determined by socio-economic factors. Multinational corporations' impact upon socio-economic status and the social gradient in health. Human rights require that their actions do not deprive people of good health or impact negatively upon good health.
Feldman E. A and Bayer R, (2011) The triumph and tragedy of tobacco control: A tale of nine nations	Public health Commentary Upper Income Countries Tobacco control	Overall decreases in tobacco consumption following law and policy to limit tobacco consumption has been unequally distributed across populations	Social gradient striking and steep in Brazil but absent or reversed in South Africa. Once a disease can be controlled the benefits accrue to those with greater access to knowledge, money, power and prestige.	Discussion as to whether limiting peoples ability / access to smoking contravenes their rights
Raphael D.et al (2019) Canada considers a basic income guarantee: can it achieve health for all?	Right to Health Commentary Canada Basic income and right to health	Simply moving people up the social gradient towards the poverty line does not assure improved health or access to positive determinants of health without additional supportive programmes.	Simply moving people up the social gradient towards the poverty line does not assure improved health or access to positive determinants of health without additional supportive programmes.	Welfare rights need to be supported along with greater access to a full range of human rights

Appendix 7. Data Extraction Sheet

There is much debate as to the value of using software. Detractors point to the way the software can lead a researcher to 'see' only the aspects they are researching, and the tendency towards more descriptive than analytical processes.[991] However, the benefits outweighed the limitations: the ability to manage large amounts of data, integration with a framework analysis process, ease of storage and retrieval, and the facilities to develop images, matrices and charts to facilitate data analysis. Notes on observations and reflections were kept in NVivo to document the thinking and analysis process. Documents were linked where they had both similarities and differences in ideas. Annotations were made and formed part of the note taking process. The explore facility was used to visualise the data in tree maps and cluster diagrams. Classification sheets were used to aid the development of an analytical framework. The data extraction sheet (see below) grew through the project as other variables of interest were added: such as various explanatory mechanisms for the social gradient.

[991] Clive Seale, 'Using Computers to Analyse Qualitative Data' in David Silverman (ed), *Doing Qualitative Research* (Fourth edition, SAGE 2013).

Sample data extraction sheet



Authors and title	**Date**	**Journal / database**	**Discipline**	**Type of article / research**	**Country of Interest**	**Level of inclusion of the social gradient**	**Explanations for the social gradient**	**Level of inclusion of the right to health**	**Special Rapp.**	**CSDH**
Acacio-Claro PJ, Koivusilta LK, Borja JR, Rimpelä AH.	2013-2017	BMC Public Health	Public health	Quantitative research	High income	Passing	SES Psycho-social	Passing	No	No

Adolescent reserve capacity, socio-economic status and school achievement as predictors of mortality in Finland		EBSCOHost					Life-course			
Acharya SS. Socio-economic correlates of bereavement among women - Examining the differentials on social axes	2018-2021	The Indian Journal of Medical Research EBSCOHost	Public health	Literature review	Middle income	Passing	SES Psycho-social Poverty Discrimination	Passing	No	No

Appendix 8. Social Determinants of Health in General Comment 14

Although the right to health does not assert a right to be healthy it does recognise that preventing ill health is important and that the right extends beyond the right to health care.[992] Analysis, using NVivo qualitative data analysis software, demonstrates that *General Comment No. 14* does encompass both specified social determinants of health and more general and emergent understandings of underlying determinants.

Paragraphs of General Comment No. 14 relating to the social determinants of health

Para.	Expression	Content relating to SDH[993]	
		Intermediary	Structural
3	Right to health is closely related to and dependent upon the realisation of other human rights	Food, housing,	work, education, human dignity, life, non-discrimination, equality, torture, privacy, access to information, freedoms of association, assembly and movement
4	Right to health embraces a wide range of socio-economic factors…and extends to the **underlying determinants** of health	food and nutrition, housing, access to safe and potable water and adequate sanitation, safe and healthy working conditions, healthy environment	
9	The notion of the highest attainable standard of health…takes into account	the individual's biological ….right to enjoyment of a variety of facilities, goods, services and conditions	the individual's socio-economic preconditions
10	The world health situation has changed…**more determinants of health** are being taken into consideration		Resource distribution, gender differences, socially related concerns such as violence and armed conflict

[992] Jonathan Wolff, *The Human Right to Health* (WW Norton & Co 2012) 10.

[993] UN Committee on Economic, Social and Cultural Rights, 'General Comment 14 ICESCR' (n 18).

11	Not only to health care but also to **underlying determinants** of health	Access to safe and potable water, adequate sanitation, adequate supply of safe food, nutrition, housing, healthy occupational and environmental conditions, health-related education and information including sexual and reproductive health	
12(a)	Availability of goods and services including **underlying determinants** of health	Safe and potable drinking water, adequate sanitation, hospitals, clinics and other health-related buildings, trained medical personnel, essential drugs	
12(b)ii	Accessibility also implies that **underlying determinants**…are within safe physical reach	Safe and potable water, adequate sanitation facilities, access to buildings for persons with disabilities	
12(b)iii	Payment for health care services as well as services related to the **underlying determinants** of health	…affordable for all	…has to be based on the principle of equity
12(b)iv	Information accessibility	Right to seek, receive and impart information and ideas concerning health issues	
14	The right to maternal, child and reproductive health	Including sexual and reproductive services, access to family planning, pre and post-natal care, emergency obstetric services and information	
15	The right to healthy natural and workplace environments	Preventive measures in respect of occupational accidents and diseases, safe potable water,	

		sanitation, prevention and reduction of the population's exposure to harmful substances such as radiation and harmful chemicals or other detrimental environmental conditions, minimisation of causes of health hazards inherent in the working environment, adequate housing, safe and hygienic working conditions, food nutrition, discourage abuse of alcohol, tobacco, drugs and other harmful substances	
16	Prevention and control of epidemic, endemic, occupational and other diseases and promotion of **social determinants** of good health	Environmental safety, urgent medical care, disaster relief, relevant technologies, immunisation programmes	education, economic development and gender equity
18	Non-discrimination and equal treatment in…access to **underlying determinants** of health		Eliminate health-related discrimination
20	A gender-based approach recognises	That socio-cultural factors play a significant role in influencing the health of men and women	That socio-cultural factors play a significant role in influencing the health of men and women
21	Reducing women's health risks	Maternal mortality,	domestic violence, impact of harmful traditional cultural practices
22	Children and adolescents – ensuring access to	Child-friendly information about preventive and health promoting	

		behaviours and support to families and communities	
23	Adolescents	Safe and supportive environment	
25	Older persons	Integrated preventive services	
35	Obligation to protect		Ensure harmful and social or traditional practices do not interfere with access to pre- and post-natal care, measures to protect all vulnerable or marginalised groups, ensure third parties do not limit people's access to health-related information
36	Obligation to fulfil -ensuring equal access for to all to the **underlying determinants** of health.	Immunisation programmes, nutritiously safe food, potable drinking water, basic sanitation, adequate housing a living conditions, sexual and reproductive health services, safe motherhood, sufficient number of health facilities, health education, policies to reduce pollution, occupational health and safety	Insurance system affordable for all
	Obligation to fulfil – providing health education and information campaigns for	HIV/AIDS, sexual and reproductive health, abuse of alcohol and the use of cigarettes and drugs.	traditional practices, domestic violence,
36	Obligation to fulfil – adopt measures and policies	against environmental and occupational health hazards and against any other threat as demonstrated by	

		epidemiological data. To reduce and eliminate pollution of air water or soil including pollution by heavy metals such as lead from gasoline. To minimise the risk from occupational accidents and diseases	
43	Core obligations	Food, basic shelter, housing, sanitation, safe potable drinking water, essential drugs, epidemiological evidence	public health strategy,
44	Obligations of comparable priority	Pre-natal care, immunisations, prevent epidemic and endemic diseases,	provide education and access to information concerning the main health problems in the community, including methods of preventing and controlling them

Appendix 9. SRRH Thematic and Mission Reports

Tables below are adapted from Paul Hunt in *Health and Human Rights*[994]

PAUL HUNT 2002-2008 Thematic Reports	
The right to health: sources, contours and content. The mandate holder's key objectives, themes and specific issues.	Report to the Commission on Human Rights, February 13,2003 (E/CN.4/2003/5)
Right-to-health indicators. Good practices. HIV/AIDS. Neglected diseases (and leprosy). Optional Protocol to the Covenant on Economic, Social, and Cultural Rights.	Report to the General Assembly, October 10,2003 (A/58/427)
Sexual and reproductive health. Poverty (and Niger's Poverty Reduction Strategy). Neglected diseases. Violence prevention.	Report to the Commission on Human Rights, February 16,2004 (E/CN.4/2004/49)
Millennium Development Goals. Indigenous peoples. Child survival indicators.	Report to the General Assembly, October 8, 2004 (A/59/422)
Mental disability	Report to the Commission on Human Rights, February 11, 2005 (E/CN.4/2005/51)
Commission on Social Determinants of Health. Health professionals and human rights education. The skills drain: migration of health professionals.	Report to the General Assembly, September 12, 2005 (A/60/348)

[994] Paul Hunt, 'Thematic and Mission Reports Prepared by UN Special Rapporteurs on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health' (2016) 18 Health and Human Rights Appendix.

Right to an effective, integrated health system accessible for all. Human rights-based approach to health indicators.	Report to the Commission on Human Rights, March 3, 2006 (E/CN.4/2006/48)
Maternal mortality. Access to medicines (responsibilities of states and pharmaceutical companies.	Report to the General Assembly, September 13, 2006 (A/61/338)
Health and human rights movement. Cases on the right to health and other health-related rights.	Report to the Human Rights Council, January 17, 2007 (A/HRC/4/28)
Prioritization. Impact assessments. Water and sanitation.	Report to the General Assembly, August 8, 2007 (A/62/214)
Health systems and the right to health.	Report to the Human Rights Council, January 31, 2008 (A/HRC/7/11)
Accountability. Human Rights Guidelines for Pharmaceutical Companies in relation to Access to Medicines.	Report to the General Assembly, August 11, 2008 (A/63/263)

PAUL HUNT 2002-2008 Mission Reports	
Intellectual property and access to medicines. Trade in services and the General Agreement on Trade in services. Impact assessments. Gender and trade. Technical assistance. Trade Policy Review Mechanism Acceding countries to World Trade Organisation.	Report to the Commission on Human Rights on Mission to World Trade Organisation, March 1,2004 (E/CN.4/2005/51/Add.1)

Poverty. Prevention, treatment, and control of diseases. Women's and children's health. Health-related policy frameworks (poverty reduction and non-discrimination). Availability, accessibility, and acceptability of health care. Health professionals. Water and sanitation. Availability of resources.	Report to the Commission on Human Rights on Mission to Mozambique, January 4, 2005 (E/CN.4/2005/51/Add.2)
Poverty, discrimination, inequality, and the right to health. Role of international community, civil society, and health professionals. Trade agreements. Environment. Mental health. Sexual and reproductive health. Ethnicity and culture (indigenous peoples).	Report to the Commission on Human Rights on Mission to Peru, February 4, 2005 (E/CN.4/2005/51/Add.3)
Participation, access to information, accountability, and health professionals. Health system financing. Corruption. Sexual and reproductive health. HIV/AIDS. Tuberculosis. Mental health. Environment. Roma.	Report to the Commission on Human Rights on Mission to Romania, February 21,2005 (E/CN.4/2005/51/Add.4)
Neglected diseases.	Report to the Commission on Human Rights on Mission to Uganda, January 19,2006 (E/CN.4/2006/48/Add.2)
Detention. Mental health. Ethical obligations of health professionals. Force-feeding.	Report to the Commission on Human Rights on Mission on the situation of detainees in Guantanamo Bay, February 27, 2006 (E/CN.4/2006/120)

Protection of civilians during and after the conflict of 2006, and the right to health.	Report to the Human Rights Council on Mission on the Lebanon/Israel conflict of August 2006, October 2, 2006 (A/HRC/2/7)
Integration of the right to health into domestic laws and policies. Access to appropriate health care. Mental health. The Sami. Harm reduction for drug users. Human rights education and health professionals. Asylum seekers and undocumented foreign nationals. International obligations in relation to the right to health and development, Health indicators. Disaggregation of data. Impact assessment.	Report to the Human Rights Council on Mission to Sweden, February 28, 2007 (A/HRC/4/28/Add.2)
Sweden's obligations of international assistance and cooperation in relation to the right to health. Sweden's role in Uganda, the World Bank, and International Monetary Fund.	Report to the Human Rights Council on Mission to Uganda, the World Bank, and the International Monetary Fund, March 5, 2008 (A/HRC/7/11/Add.2)
The government of Ecuador invited the rapporteur to appraise Columbia's aerial spraying of glyphosate along the Columbia-Ecuador border. The rapporteur visited Ecuador (May 2007) and Columbia (September 2007).	The Rapporteur publicly presented his preliminary conclusions and recommendations at the end of both visits. Subsequently, Ecuador issued proceedings against Columbia before the International Court of Justice. In these circumstances, the Rapporteur did not submit a full report to the Human Rights Council
Access to medicines. Human rights responsibilities of pharmaceutical companies. Affordability of medicines. Effects of patents and licensing on access to medicines.	Report to the Human Rights Council on Mission to GlaxoSmithKline, May 5, 2009 (A/HRC/11/12/Add.2)

Research and development: neglected diseases and paediatric formulations.	
Maternal mortality.	Report to the Human Rights Council on Mission to India, April 15, 2010 (A/HRC/14/20/Add.2)

ANAND GROVER 2008 - 2014 Thematic Reports	
Access to medicines. Impact of intellectual property rights on access to medicines.	Report to the Human Rights Council, March 31, 2009 (A/HRC/11/12)
Informed consent.	Report to the General Assembly, August 10, 2009 (A/64/272)
Same-sex conduct, sexual orientation and gender identity. Sex work. HIV transmission. Effects of criminalisation on the right to health.	Report to the Human Rights Council, April 27, 2010 (A/HRC/14/20)
Impact of drug control on the right to health. Compulsory treatment for drug dependence. Access to controlled medicines. Human rights-based approach to drug control.	Report to the General Assembly, August 6, 2010 (A/65/255)
Access to medicines.	Report to the Human Rights Council, March 16, 2011 (A/HRC/17/43)
Development. Convergence of development, human rights, and the right to health. Human rights-based approach to development.	Report to the Human Rights Council, April 12, 2011 (A/HRC/17/2)
Right to health of older persons.	Report to the Human Rights Council, July 4, 2011 (A/HRC/18/37)

Impact of criminalisation on sexual and reproductive health. Family planning. Education and information.	Report to the General Assembly, August 3, 2011 (A/66/254/)
Occupational health.	Report to the Human Rights Council, April 10, 2012 (A/HRC/20/15)
Health financing and the right to health.	Report to the General Assembly, August 13, 2012 (A/67/302)
Access to medicines.	Report to the Human Rights Council, May 1, 2013 (A/HRC/23/42)
Right to health of migrant workers.	Report to the Human Rights Council, May 15, 2013 (A/HRC/23/41)
States and non-state actors' obligations toward persons affected by or involved in conflict situations.	Report to the General Assembly, August 9, 2013 (A/68/297)
Unhealthy foods and diet-related non communicable diseases.	Report to the Human Rights Council, April 1, 2014 (A/HRC/26/31)
Effective and full implementation of the right to health framework. Justiciability. Progressive realisation and the enforcement of the right to health. Transnational corporations. International investment agreements. Investor state dispute settlement.	Report to the General Assembly, August 11, 2014 (A/69/299)

ANAND GROVER 2008 - 2014 Mission Reports	
Sexual and reproductive health. Harm reduction policies for drug users. Harm reduction policies and HIV/AIDS.	Report to the Human Rights Council on Mission to Poland, May 20, 2010 (A/HRC/14/20/Add.3)
Right to health of indigenous peoples. Detention.	Report to the Human Rights Council on Mission to Australia, June 3, 2010 (A/HRC/14/20/Add.4)
Inequalities and discrimination. Indigenous peoples. Women's right to health. Sexual and reproductive health. Violence against women. Access to medicines.	Report to the Human Rights Council on Mission to Guatemala, March 16,2011 (A/HRC/17/25/Add.2)
Women's and children's health. Gender-based and family violence. Right to health of stateless persons and refugees. Detention.	Report to the Human Rights Council on Mission to Syrian Arab Republic, March 21, 2011 (A/HRC/17/25/Add.3)
Mental health. Maternal health. Malaria. Environment. Occupational health.	Report to the Human Rights Council on Mission to Ghana, April 10, 2012 (A/HRC/20/15/Add.1)
Access to medicines. HIV/AIDS. Criminalisation of sex work and the use of drugs. Detention.	Report to the Human Rights Council on Mission to Vietnam, June 4, 2012 (A/HRC/20/15/Add.2)
Tuberculosis. Mental health. Domestic violence.	Report to the Human Rights Council on Mission to Tajikistan, May 2, 2013 (A/HRC/23/41/Add.2)
Tuberculosis. Detention.	Report to the Human Rights Council on Mission to Azerbaijan, May 3, 2013 (A/HRC/23/41/Add.1)
Right to health and nuclear disaster management.	Report to the Human Rights Council on Mission to Japan, July 31, 2013 (A/HRC/23/41/Add.3)

DAINIUS PŪRAS 2014-CURRENT Thematic Reports	
Overview of the mandate. Priorities in future work.	Report to the Human Rights Council, April 2, 2015 (A/HRC/29/33)
Child survival. Early childhood development.	Report to the General Assembly, July 30, 2015 (A/70/213)
Right to health of adolescents.	Report to the Human Rights Council, April 4, 2016 (A/HRC/32/32)
Sports and healthy lifestyles. Non-state actors' obligations. Good practice approaches	Report to the Human Rights Council, April 4, 2016 (A/HRC/32/33)
Sustainable development goals.	Report to the General Assembly, August 5, 2016 (A/71/304)
Right to health of indigenous peoples with a focus on children and youth	Report to the Human Rights Council, August 10, 2016 (A/HRC/33/57)
Mental health, right to health framework, dominance of the biomedical model, shifting the paradigm	Report to the Human Rights Council, March 28, 2017 (A/HRC/35/21)
Corruption and medical ethics and the right to mental health	Report to the General Assembly, July 14, 2017 (A/72/137)
Confinement and deprivation of liberty including mental health, children, women, public health detention	Report to the Human Rights Council, April 5, 2018 (A HRC/38/36)
Mental health and migration, especially children and families and detention	Report to the General Assembly, July 27, 2018 (A/73/216)

Social and underlying determinants of mental health	Report to the Human Rights Council, April 12, 2019 (A/HRC/41/34)
Mental health – setting a rights-based global agenda	Report to the Human Rights Council, April 15, 2020 (A/HRC/44/48)

DAINIUS PŪRAS 2014-2020 Mission Reports	
Health system financing. Vulnerable groups.	Report to the Human Rights Council on Mission to Malaysia, May 1,2015 (A/HRC/29/33/Add.1)
Poverty and the right to health. Unsafe abortions. Sexual and reproductive health. Children deprived of liberty. Persons with disabilities. LGBT. People living with HIV/AIDS. Mental health policy. National health care system.	Report to the Human Rights Council on Mission to Paraguay, May 24, 2016 (A/HRC/32/32/Add.1)
Rehabilitation and reintegration of women and children liberated from Boko Haram captivity.	Report to the Human Rights Council on Mission to Nigeria, June 15, 2016 (A/HRC/32/32/Add.2
Right to health of women, adolescents and youth, HIV/AIDS, people who use drugs, mental health framework	Report to the Human Rights Council on Mission to Algeria, April 20, 2017 (A/HRC/35/21/Add.1)
Health care institutions, sexual and reproductive rights, right to health of children, migrants, Roma, people who use drugs	Report to the Human Rights Council on Mission to Croatia, April 28, 2017 (A/HRC/35/21/Add.2)
Mental health, Right to health of women and girls, HIV/AIDS, people who use drugs	Report to the Human Rights Council on Mission to Indonesia, April 10, 2018 (A HRC/38/36/Add.1)

Mental health, Communicable diseases, Drug policy and controlled medicines	Report to the Human Rights Council on Mission to Armenia, April 26, 2018 (A HRC/38/36/Add.2)
Mental health, health in detention – tuberculosis and drug use, sexual and reproductive rights	Report to Human Rights Council on Mission to Kyrgyzstan, May 2019 (A/HRC/41/34/Add.1)
Mental health, Indigenous peoples, other groups in vulnerable situations, sexual and reproductive rights	Report to Human Rights Council on Mission to Canada, June 2019 (A/HRC/41/34/Add.2)
Mental health, Key populations and groups: women and girls, children and adolescents, lesbian gay, bisexual and transgender persons, people living with HIV/AIDS, persons with psycho-social, intellectual and cognitive disabilities, People on the move, Environment	Report to Human Rights Council on Mission to Ecuador, May 2020 (A/HRC/44/48/Add.1)
	End of mission statement Fiji Mission Dec 2019

Appendix 10. Framework Analysis Process

Step 1 - Familiarisation with the reports

The first step in the Framework Method, in common with qualitative data analysis generally, is the process termed familiarisation which aims to obtain a broad overview of the data to be analysed, and to ensure categories and themes developed later remain grounded and supported in the data.[995] Some critics of the use of qualitative data analysis software claim that it can form a barrier to immersion in the transcripts being analysed.[996] In text search features might encourage a researcher to take shortcuts and leave out this step to speed up the research process. Yet the process of familiarisation, whilst time consuming, provided a sense of chronology to the reports and a flavour of the different approaches adopted by each of the Special Rapporteurs. For example, it was clear to see the efforts to establish a means to ground and operationalise the right to health by Paul Hunt, the focus on the legal aspects of the right to health by Anand Grover, and the adoption of newer public health concepts by Dainius Pũras. The reports were annotated with such initial impressions using NVivo 12.

Step 2 - Initial data coding

The next step in the Ritchie and Spencer framework approach is indexing or coding the data. This is where segments of the documents were labelled with an aspect relevant to the coding framework described above. A number of coding strategies were adopted using what Saldaňa describes as ‘Elemental Methods’, which are commonly used primary strategies in qualitative data analysis. Descriptive coding for topics and issues, in vivo coding to identify conceptualisations of the social gradient, structural coding for

[995] Ritchie and Spencer (n 27); Spencer and others (n 451); Spencer and others (n 227).
[996] Spencer and others (n 451) 289–290.

engagement with the social gradient and allied explanatory mechanisms, and holistic coding to bring together actions relative to the social gradient in each paragraph of recommendations.[997] They provided a foundation for the framework approach stages of sorting and categorising before interpretation of the data.

The documents are presented in numbered paragraphs which were coded as a block rather than coding single words or phrases. This required simultaneous coding whereby the same piece of data is coded more than once.[998] This coding method is used where the data is complex and recognises that the data is both descriptively and inferentially meaningful.[999] This type of coding can 'help you to see both "the bigger picture" and "the trees in the forest"' and can help to investigate the interrelationship between different aspects of the data.[1000] Special Rapporteur reports are constrained by format and word count and each paragraph has to compress a chosen topic, with descriptive evidence substantiating the issues, explanations as to the impact or the reasons why the current situation needs to be addressed, recognition of action already taken and recommendations for further action. There is also a chronological aspect to the data with three different Special Rapporteurs reporting over two decades, necessitating a recognition in changes of salient issues, the developing evidence base, growth in experience and practice over time. The process of coding does require separating different aspects of the data from its context in order to capture emergent ideas and concepts.[1001] Each paragraph was systematically scrutinised and assigned one or more

[997] Johnny Saldaña, *The Coding Manual for Qualitative Researchers* (Sage Publications Ltd 2009) 45–51 and 66–85.
[998] ibid 62–65.
[999] Matthew B Miles and A Michael Huberman, *Qualitative Data Analysis: An Expanded Sourcebook* (SAGE 1994) 66.
[1000] Saldaña (n 1005) 64.
[1001] Spencer and others (n 451) 279–283.

codes, labelling these codes in NVivo 12 Plus from Hunt's 2005 Mozambique Mission report paragraph 39.

Step 3 - Indexing and sorting the data

Following initial coding, Ritchie and Spencer's process of sorting and categorising data was applied to re-group split coded fragments of data to generate new perceptions, interpretations, concepts or theories.[1002] A single category is discussed in numerous places across all the reports and so it is necessary to re-group split coded fragments of data to identify unexpected connections.[1003] This also requires close examination of data that was not coded. This aligns to Saldaňa' s second cycle coding: using focused coding to identify the most frequent or significant initial codes and pattern coding for explanatory or inferential codes.[1004] The focused coding was made easier by using the software NVivo 12 Plus and proved useful in identifying that the mission report recommendations were overwhelmingly concerned with a wide variety of structural determinants of health, including almost a third of these addressing structural determinants of health care provision. Few recommendations addressed intermediary determinants such as food, water and sanitation, and housing. However, the value of focused coding was limited by adhering to an a priori framework and was less useful in understanding what was happening in the data in relation to context. Pattern coding was more useful in this regard.

Step 4 - Constructing framework matrices and summarising the data

Developing a framework matrix for each of the categories identified, in this case those aligned specifically to the conceptual framework, is a critical and time-consuming step in

[1002] ibid 282–283 and 300–309.
[1003] ibid 303.
[1004] Saldaňa (n 1005) 150–159.

the Ritchie and Spencer framework process which demands close engagement with the data.[1005] With the use of NVivo 12 Plus a matrix was created with each report assigned a row and each code a column. The cells were then populated automatically with the coded data. Summaries of the data in each cell were then created by finely balancing key terms and phrases used by the writer with a condensed synopsis of the information, without interpretation.[1006] The use of software makes this process much easier as each document is also to hand to ensure the data is grounded in the context of the actual report.[1007] It is important that the data remain grounded in contextual factors as each report reflects the particular issues of the country mission, changes in the right to health and public health over two decades, and the shifting priorities of the three SRRH.

Analytic memos were created alongside the summaries to record personal impressions, preliminary interpretations, comments upon the analytic process, emergent patterns, linkages across reports, relevance to study questions and future directions for the study.[1008]

The first analytic memos for the mission reports included observations about the huge amount of data in each cell generated by the automatic population of data by the software. This was in part caused by coding of whole report paragraphs, such that many of the paragraphs were repeated in many cells. A different approach was adopted to the coding of the thematic reports where only particular words or phrases were coded. Creating the summaries became a much easier process and the software permitted direct access to the report sections alongside the framework matrix that allowed the

[1005] Spencer and others (n 451) 305–309.
[1006] ibid 309.
[1007] ibid.
[1008] Saldaňa (n 1005) ch 2.

summary to remain grounded in the report. However, using the code view in NVivo was less detailed and not as useful as a chronological read through of report sections.

Step 5 - Abstraction and interpretation of the coded data

The framework matrices were essential to facilitating the next step in Ritchie and Spencer's framework process whereby categories from the conceptual framework were reviewed one by one in order to detect key elements and dimensions of the data and map linkages across the data to develop the thematic analysis.[1009] Reviewing the categories revealed the range of comments the SRRH would make on aspects of an issue or topic. Similarities and differences in these characterisations would provide what Ritchie and Spencer refer to as elements and dimensions.

Linkages between dimensions were then sought. These are critical in that they provide greater abstraction of the data for explanation and interpretation. This stage also offered the opportunity to return to the conceptual framework and understand the data in light of the concepts and theories underpinning the framework.[1010] This was also the point where the findings and themes were located within the wider context in the field and any original contribution to the field identified. This is captured by the discussion sections of the following chapters.

Step 6 - Triangulating the data with general comments and interviews.

Locating the findings within the field also requires a process of triangulation to ensure rigour and validity. Short, informal, unstructured interviews were undertaken with the Special Rapporteurs for the right to health and some of their researchers and support staff. These were conducted in a manner of 'In discussion with…' and were wide

[1009] Spencer and others (n 451) 318–340.
[1010] Spencer and others (n 227) 318–331.

ranging and free flowing reflecting the principal concerns of the individual being interviewed and the mandate, rather than any formal stance of the UN Special Procedures or the Office of the High Commissioner for Human Rights (OHCHR).

Appendix 11. Example of Coding a Paragraph using Different Types of Coding

The SRRH mission reports were first reviewed and coded using descriptive coding as defined by Saldaňa, to identify the right to health topics addressed.[1011] The mission reports were then reviewed and coded for conceptualisations of the social gradient and the inclusion of allied concepts as described in chapter two using *in vivo* coding to capture hints and vague nuances relating to the concept.[1012] The mission reports were then reviewed and coded, using Saldaňa's *structural* coding for engagement with significant features of the social gradient such as socio-economic status, explanatory mechanisms for the social gradient, and social determinants of health.[1013] The mission reports were then reviewed and coded for action on the social gradient using a holistic approach to the coding whereby whole paragraphs and recommendations were evaluated for their broad meaning rather than split down into words or phrases.[1014]

Initially recommendations were coded using the actions exampled in *Closing the Gap*, but some reports embedded recommendations within the main text and others listed recommendations at the end. Some reports implied recommendations. For example, coding for living conditions went beyond the specific areas for action in *Closing the Gap*. Coding for 'power relations' required several decisions to be made in order to allocate codes consistently but each time a decision was made with a different result, as a process of developing themes rather than direct coding. It was difficult therefore to ensure that all actions were identified. Coding against *Closing the Gap*

[1011] Saldaňa (n 1005) 70–73.
[1012] ibid 74–77.
[1013] ibid 66–70.
[1014] ibid 118–120.

recommendations was abandoned in favour of using the Solar and Irwin conceptual framework.

Previous coding was retained and permitted a more in-depth perspective when developing themes. However, other elements beyond recommendations were required and so the coding process was applied to all the text in the reports to capture the population focus of the recommendations, identify public health approaches such as the life-course approach, and to tease out issues of power relationships.

34. These objectives are consistent with right-to-health norms such as ensuring universal access to primary health care; the prevention, treatment and control of HIV/AIDS, malaria and tuberculosis; reducing child and maternal mortality; enhancing access to safe and effective methods of contraception; ensuring access to potable water; and eliminating gender inequity in access to health care. Nevertheless, PARPA does not, at present, seem to adequately address some human rights concerns relating to poverty in Mozambique, including the situation of some particularly marginalized groups, such as children affected by HIV/AIDS. The Special Rapporteur recommends that greater attention be given to integrating human rights, in particular the human rights of vulnerable groups, into PARPA during the review process. Particular attention should be paid to addressing inequalities between men and women, as well as the impact of poverty on vulnerable groups, such as children affected by HIV/AIDS.[1015]			
Type of coding	**Purpose**	**Examples of coded text**	**Categorised as**
Structural coding - content based label or conceptual phrase	To code data for the conceptual framework	universal access primary health care prevention, treatment and control child and maternal mortality access to potable water gender inequity	Minimum core obligations
Descriptive coding - a noun / phrase describing the topic of a section	To capture the context, aspects of health, issues to be addressed, in which the conceptual framework is embedded	PARPA poverty marginalized groups children affected by HIV/AIDS vulnerable groups inequalities impact of poverty	Policy Poverty Horizontal inequality Action for vulnerable groups
Process coding – to capture types of action	To identify the types of recommendations for action made by the SRRH	not adequately address attention to integrating human rights review process particular attention to addressing	Action by state

[1015] Hunt, '2005 Mozambique E/CN.4/2005/51/Add.2' (n 506) para 34.

In Vivo coding	To identify concepts, issues, ideas that were not included in the conceptual framework	vulnerability marginalisation epidemics people living in poverty	Processes by which people are made vulnerable and marginalised

Appendix 12. Example of Theme Development

THEME: Minimum Core Obligations **Sub-theme:** Minimum essential health care package		
Data summary in the framework matrix	Detected elements	Key dimensions
Hunt 2006 Uganda discusses the States commitment to achieve the MDGs and national commitments (ICESCR etc.) with the Uganda national Minimum Health Care package as one of a number of pro-poor and health policies. This concept is mentioned in other reports in relation to pro-poor policies and MDGs and reflects one aspect of the minimum core - having a national health policy and plan of action but not specifically in terms of the content of a minimum package. Grover picks up the idea of a basic benefits package when discussing fees for service and out-o- pocket expenditures in Tajikistan - advocating free access to primary health care for all and free hospital services for some groups (17-19) In Armenia Pũras recommends a basic benefits package for the poorest and most vulnerable and includes primary health care, emergency care, treatment of certain infectious diseases, obstetric care certificates for socially vulnerable groups in the context of the country moving to a mandatory health insurance scheme (31-34 and 42 54). Pũras relates this to a universal health care insurance system. In Indonesia 2018 we see Pũras' growing support of a universal health care system not only providing a package of primary care for the poorest but also winning the trust of more affluent members of society (32, 37, 47) but then in Ecuador he comments that free and universal health care has not guaranteed the right to health 19	as part of a pro-poor policy to meet MDGs targets included in a national plan of action included as a part of a benefits package free care related to issues of out-of-pocket payments (corruption) vulnerable groups minimum provision includes primary health care and some hospital care but not all aspects of the minimum core as universal health care but does not always meet right to health requirements	Poverty and vulnerability Associated with moves to requiring health insurance, pro-poor policies, MDG targets, moves for UHC not necessarily able to meet right to health needs

Appendix 13. Ethical Authorisation Processes

The Right to Health, Public Health, and the Social Gradient

23rd March 2022

Invitation to this study

I would like to invite you to participate in this research project on *The Right to Health, public health and the Social Gradient*. You should only participate if you want to; choosing not to take part will not disadvantage you in any way. Before agreeing to take part, it is important for you to read the following information carefully. Please ask if there is anything that is not clear, or you would like more information.

What is the purpose of the research?

My research explores the extent to which the right to health has incorporated the social gradient in health. The public health concept of the social gradient in health is important to the right to health because it raises questions concerning the nature of health inequalities, it demands a re-evaluation of the socio-political frameworks that are no longer predominant in public health, and it suggests particular actions to address health inequalities. Whilst much has been made with regard to incorporation of the right to health or human rights-based approaches within public health, little has been written that addresses how the right to health can integrate concepts from public health such as the social gradient.

My starting point is the Commission on Social Determinants of Health 2008 report *Closing the Gap in a Generation: Health Equity through Action on the Social Determinants of Health,* which identifies the social gradient as one of a number of social determinants of health. I scrutinise three aspects of the right to health to assess whether and in what ways understandings of the social gradient are implicitly or explicitly

incorporated into the continued development of the contours, content and scope of the right to health. I examine the international right to health as expressed in the International Bill of Rights and in general comments; I review the intersection of public health and right to health academic literature and explore the practical application of the right to health in the work of the Special Rapporteurs for the right to health. I reflect upon the disjuncture between the philosophical underpinnings of public health and the right to health, the lack of conceptual clarity around social determinants of health and the social gradient, and the implications for action on health inequalities for the right to health. I also explore the potential for the capability approach, as first articulated by Amartya Sen and further developed by Sridhar Venkatapuram, to bridge the divide between public health and the right to health. My aim is to contribute to a deepening of the ongoing debate around health inequalities in public health and right to health, and to highlight the valuable achievements and huge potential of the role of Special Rapporteur on the Right to Health (SRRH).

What is involved in participating?

Participation in the project will involve a single, semi-structured interview with the principal investigator, Susan. The interview can be conducted on Zoom virtual meeting platform, will be recorded on Zoom and later transcribed. The interview will last half an hour to an hour. Participants will decide whether they wish their data to be anonymised or if they are happy to be named.

What are the benefits and risks of participating?

Participants in this research will make a valued and important contribution to an original piece of research that contributes to knowledge about the right to health and its engagement with public health social determinants of health.

Participants could potentially expose their affiliated organization (UN Special Procedures) to reputational risks or themselves face legal risks if they disclose confidential information relating to their organization. I will prevent any harm to participants by anonymising such data if they so wish and by omitting any information from my thesis that will clearly put an identifiable interviewee at risk. I will also ensure I ask questions that encourage participants to respond in a professional capacity.

How will you confirm your consent to participate?

Consent forms and participant information sheets will be sent to participants on first contact when booking the Zoom audio-visual meeting. You are kindly requested to sign (DocuSign) the form and return a copy by email. I will provide a reminder if necessary two weeks prior to the meeting in order to give you further time and will check to ensure that the consent form has been signed before the meeting commences.

How can you withdraw from the research?

If participants wish to withdraw at any stage in the research, they should email me at spstal@essex.ac.uk All participant data will be destroyed.

What happens to the data gathered?

Interview recordings and transcripts will be stored securely on my computer in password protected NVivo software throughout the research and backed up on a University of Essex secure cloud drive. All recordings and transcripts will be coded so they are non-identifiable. Participants can choose to be named in the research or to have their data anonymised.

What is the legal basis for processing your data?

The General Data Protection Regulation requires the consent of research participants that is 'freely-given, specific, informed and unambiguous' – 'given by a statement or a clear affirmative action'. The Data Controller is the University of Essex.

What should you do if you have any concerns or complaints?

If you have any concerns about any aspect of the study or you have a complaint, please contact the principal investigator on the project (see below). If you are still concerned or you think your complaint has not been addressed to your satisfaction, please contact the Director of the Human Rights Centre (Dr Andrew Fagan). If you are still not satisfied, please contact the University's Research Governance and Planning Manager (Sarah Manning-Press).

How is the research funded?

The research is partly self-funded as an individual PhD student project with fees funded as a University of Essex member of staff.

Contact Details

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Participant Consent Form

Project Title: The Right to Health, Public Health and the Social Gradient

Researchers: Susan Stallabrass (PhD researcher),

Dr Andrew Fagan & Judith Bueno De Mesquita (PhD Supervisors)

	Taking part	Please initial box
1.	I have read and understood the participant information sheet, sent to me at least 24 hours prior to interview	
2.	I understand that my taking part is voluntary	
3.	I have had the opportunity to ask any questions I have about the project	
4.	I agree to take part in the project. Taking part in the project will include being interviewed and audio recorded	
5.	I understand that I am free to withdraw from the project at any time without giving any reason and without penalty	

Use of the information I provide for this project only

6.	I understand my personal details such as phone number and address will not be revealed to people outside the project	
7.	I understand that my words may be quoted and analysed in publications, reports, web pages, and other research outputs	
8.	I understand that all research data I provide will be anonymised unless I agree otherwise (please refer to question below)	

Please choose one of the following options:

9.	I would like my real name used in the above	
	I am happy for my real name to be used in the above but would like to check over the use of any quotes before publication	
	I would not like my real name used in the above	
	I would not like any identifying details (e.g. position, organisational affiliation) to be used in the above	

Use of the information I provide beyond this project

10.	I understand that no other researchers are involved in the project but that the completed PhD Thesis, once passed, will be deposited in the University of Essex research repository and the British Library ETHOS Database for student and academic access.	

So we can use the information you provide legally

11.	I agree to assign the copyright I hold in any materials generated by this project to Susan Stallabrass	

Please return a signed copy by email to spstal@essex.ac.uk

Name of ParticipantSignature of Participant

.....

Name of ResearcherSignature of Researcher

Susan Stallabrass.....

Researcher Contact Details

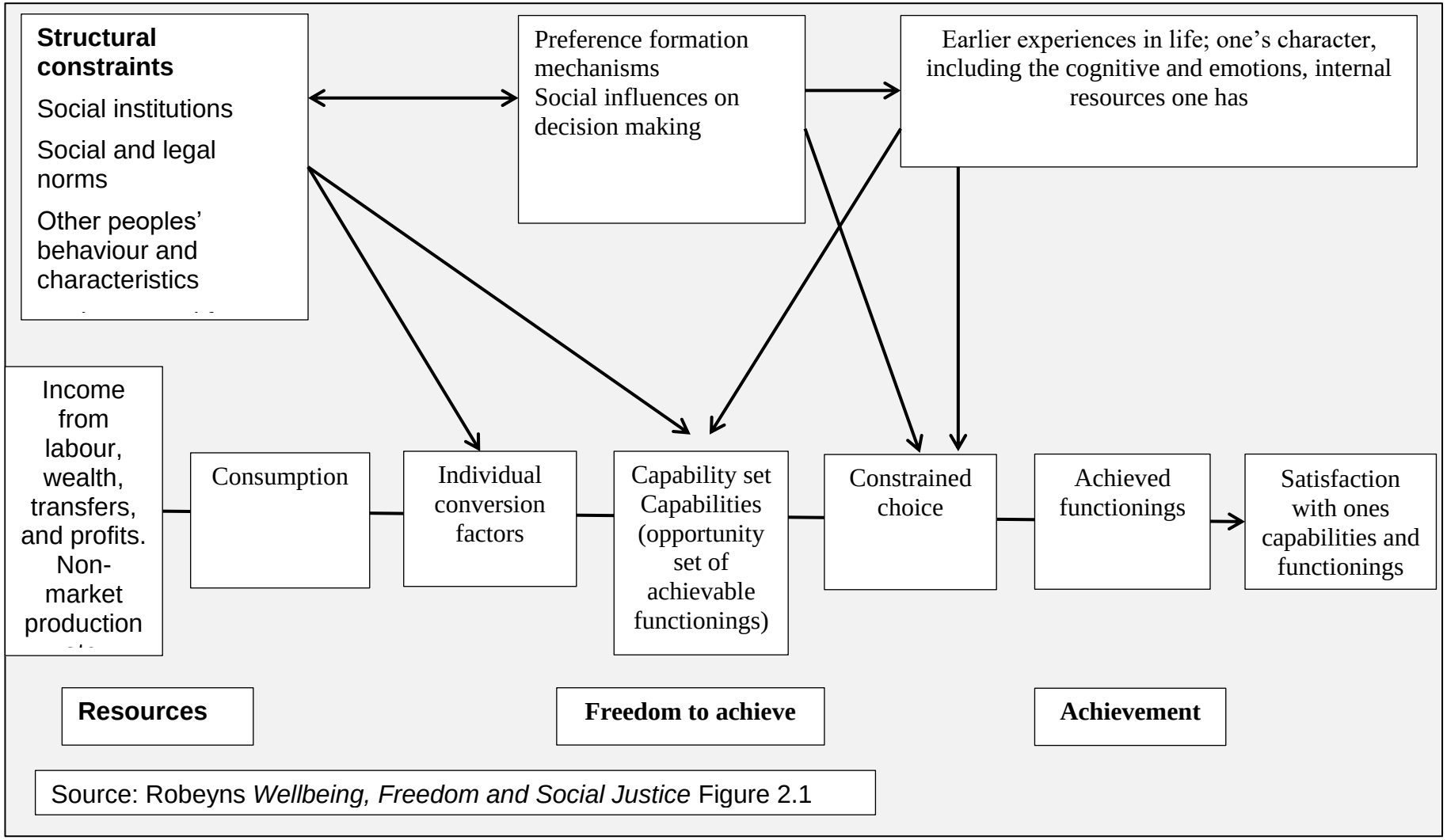
Name: Susan Stallabrass

Email address: spstal@essex.ac.uk

Phone number: +44 (0) 7506871130

Appendix 14. Robeyn's Modular Framework for Capability Approach Elements

<table>
<tr><td colspan="2">Table from Robeyns I (2017) Wellbeing, Freedom and Social Justice. The Capability Approach Re=examined. Cambridge, UK: OpenBook Publishers p74</td></tr>
<tr><td rowspan="2">The A module: the non-optional core
Key elements that define the capability approach
A1: Functionings and capabilities as core concepts
A2: Functionings and capabilities as value-neutral categories
A3: Conversion factors
A4: The distinction between means and ends
A5: Functionings and/or capabilities form the evaluative space
A6: Other dimensions of ultimate value
A7: Value pluralism
A8: Valuing each person as an end</td><td>The B modules: non-optional modules with optional content
The way each of these concepts is understood by be different as long as some element of the concept is present
B1: The purpose of the capability theory
B2: The selection of dimensions
B3: An account of human diversity
B4: An account of agency
B5 An account of structural constraints
B6: The choice between functionings, capabilities or both
B7: Meta-theoretical commitments</td></tr>
<tr><td>The C modules – contingent modules
Dependent upon purpose of study
C1: Additional ontological and explanatory theories
C2: Weighing dimensions
C3: Methods for empirical analysis
C4: Additional normative principles and concerns</td></tr>
</table>



Source: Robeyns *Wellbeing, Freedom and Social Justice* Figure 2.1