

# Social Determinants of Health from a Rights-Based Approach

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## Introduction

The right to the highest attainable standard of health is a fundamental human right. It is indispensable to the exercise of other human rights and especially to the right to life. It is closely related to, and dependent upon, the realization of the rights to food, housing, work, education, non-discrimination, equality and the prohibition of ill-treatment, and respect of human dignity. It is also linked to the rights to privacy and family life, access to information and the freedoms of association, assembly and movement.<sup>1</sup>

A multitude of factors, either intrinsic or extrinsic, may hinder or even prevent the full enjoyment of the right to health, as guaranteed by Article 12, paragraph 1, of the International Covenant on Economic, Social and Cultural Rights.<sup>2</sup> Ill health is caused by, and the result of, poor living conditions. It is a direct consequence of an unhealthy and polluted environment, unsafe drinking water, and undernourishment. Dangerous working conditions also contribute to poor health.

Certain categories of the population are more at risk than others: prisoners and detainees, ethnic minorities and indigenous populations, disabled persons, older persons, asylum-seekers, refugees and migrant workers are all in danger of suffering from ill health. Due to gender inequality, inadequate access to health services and goods affects, in particular, women and girls.

Lack of enjoyment of the right to health also results from insufficient financial resources, either of individuals or of the state, but most frequently of both. The right to health will suffer from the general economic climate and the degree of economic development of a state. It will also be affected by disparities between different regions within a state, in particular, between urban and rural areas. The level of health enjoyed will vary according to the national origin and social status of different categories of the population, the most vulnerable generally being the worst hit by insufficient public spending on health care.

The right to health may also be affected by natural or man-made disasters. In addition, trade or financial agreements may adversely impact upon the right to health. In this respect, not only states but also third parties have a responsibility to eliminate factors and obstacles which may impede or block the full enjoyment of the right to health. The “brain drain” of qualified medical personnel to the private sector, or to foreign countries, can reduce the effectiveness of public health care systems particularly in developing countries.

Even though many factors of a national and international nature may interfere with the right of everyone to enjoy the best possible level of health, the greatest hindrance to the full enjoyment of this right is poverty. More than 2.8 billion people in the world are living in conditions of abject poverty, with little or no hope of accessing adequate health facilities, goods and services.<sup>3</sup> Poverty erodes or nullifies economic and social rights, such as the right to health, adequate housing, clothing, food and safe water. It also promotes unhealthy lifestyles, such as prostitution, drug addiction, alcoholism and begging.

Poverty is not a phenomenon confined to developing countries. It is a global condition and is experienced by all states in varying degrees. Many developed states have categories of the population who experience poverty: people belonging to ethnic minorities, indigenous populations and migrant workers often live in appalling conditions, such as slums and temporary settlements without proper infrastructure. Women are more likely to live in poverty than men, and frequently have the sole responsibility for the care of children.<sup>4</sup> Furthermore, children who grow up in poverty are severely, and often permanently, disadvantaged.<sup>5</sup>

The aim of this chapter is to pinpoint and analyse, as far as possible, the principal social factors or determinants which may impair or prevent the

full enjoyment, without discrimination, of the right to the highest standard of health possible.<sup>6</sup>

### **Discrimination**

Health facilities, goods and services must be accessible to everyone without discrimination.<sup>7</sup> The various prohibited grounds of discrimination are laid down in many international human rights instruments and, notably, in Article 2, paragraph 2, of the Covenant on Economic, Social and Cultural Rights. Despite this legally binding guarantee which is immediately applicable,<sup>8</sup> access to health facilities, goods and services is, in practice, not always guaranteed to everyone on an equal footing. Vulnerable and marginalized groups, such as ethnic or religious minorities, women and children, older persons and the disabled, are often victims of limited or even lack of access to health care and the underlying determinants of health. This is largely due to the disproportionately high cost of health services and goods in relation to the financial means of these people.

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### **Income and property**

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Everyone should have access to hospitals, clinics and other health care facilities, as well as to trained medical personnel and essential drugs<sup>9</sup> without discrimination.<sup>10</sup> Equally, health facilities, services and goods must be affordable for all. Payment for such goods and services must therefore be based on the principle of equity.<sup>11</sup> Whatever measures have been taken to ensure social security benefits,<sup>12</sup> and whether health care insurance be provided by a public, private or mixed system, the state is obliged to ensure that adequate health care is economically accessible to everyone, including socially disadvantaged groups.<sup>13</sup>

Inevitably, the health of the poorest and most vulnerable persons in society will suffer if the cost of health care is prohibitive. In this respect, the right to health is directly linked to the right to social security,<sup>14</sup> as well as the right of everyone to work, and to earn a decent living for themselves and their families, as guaranteed by Articles 6 and 7 of the Covenant on Economic, Social and Cultural Rights.<sup>15</sup>

Lack of universal coverage of health care schemes, privatization of medical facilities and services and the departure of trained medical personnel to the private sector all constitute significant obstacles to the right of every-

one to receive adequate health care without discrimination. Large-scale privatization in a number of countries has been shown to affect not only the cost but also the quality and availability of health services and goods. This impacts, in particular, on the poorest categories of the population.<sup>16</sup>

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#### Racial or ethnic origin

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Persons belonging to racial or ethnic minorities must have safe physical and economic access to health facilities, services and goods without discrimination.<sup>17</sup> Unfortunately, due to their ethnicity or the colour of their skin, these persons are often victims of de facto and even multiple discrimination in relation to health care. In some cases, for example, Roma are reportedly denied access to health services, including emergency aid services; they are segregated in hospitals, and discriminated against by medical practitioners, who allegedly provide medical services of lower quality to them, or extort from them unjustified amounts of money.<sup>18</sup>

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#### Indigenous peoples

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In indigenous communities, the health of the individual is closely linked to the society as a whole<sup>19</sup> and the organization of health care takes on an autonomous aspect. Indigenous communities often develop and practise their own traditional health care system, using their own particular healing techniques and medicines. In this context, indigenous peoples should benefit from “specific measures” which enable them to have access to appropriate health services and goods that are culturally acceptable. If they are deprived of the necessary resources, or even access to their ancestral lands, which allow them to carry out traditional preventive care, healing practices and cultivate vital medicinal plants, their health may be seriously impaired. The means to provide the medicinal plants, animals and minerals necessary to the health of these peoples depends largely on freedom of access to their lands. Moreover, any break with the “symbiotic relationship” which they have with their traditional territories may have an adverse effect on their physical and mental health.<sup>20</sup> In addition, indigenous peoples are often victims of discrimination in access to public health services.<sup>21</sup>

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### Gender and sexual orientation

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Despite the economic growth achieved by a state, lack of expenditure on health care sometimes means that significant proportions of the population, in particular, women and girls, have limited or no access to basic health care services and goods. This situation results, in some cases, in high rates of maternal and infant mortality, as well as a high incidence of tuberculosis and other communicable diseases.<sup>22</sup>

Even in states where comprehensive legislation on equality between men and women may have been adopted, widespread gender inequalities and cultural stereotypes often continue to prevail, negatively affecting the equal enjoyment of economic, social and cultural rights for women and especially for those belonging to disadvantaged and marginalized groups.<sup>23</sup> Single mothers, in particular, experience multiple forms of discrimination and often encounter difficulties in access to health facilities, services and goods.<sup>24</sup> They also are at risk from a lack of adequate reproductive health services,<sup>25</sup> especially in rural areas.<sup>26</sup>

Discrimination on the basis of sexual orientation is still widespread in certain states and affects the enjoyment of economic, social and cultural rights by many people. Homosexuals experience discrimination in access to employment, housing and, in particular, health services. In some cases, the lack of access to essential health care and goods can seriously affect the health of these persons, especially those suffering from HIV/AIDS.<sup>27</sup>

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### National or social origin

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This prohibited ground of discrimination overlaps to a large extent with ethnicity. It does however encompass a wider segment of the population to include refugees, asylum-seekers, migrant workers and all other non-nationals under the state's jurisdiction. It also protects persons considered as belonging to "socially inferior" groups.

In spite of constitutional and legislative provisions prohibiting caste-based discrimination, *de facto* discrimination persists with impunity in some states.<sup>28</sup> Persons belonging to these groups are often victims of discrimination in relation to many of the rights guaranteed by the Covenant and, in particular, with regard to coverage from universal healthcare schemes.<sup>29</sup> Refugees, asylum-seekers, migrant workers and other non-nationals may also be victims of discrimination in access to basic health care<sup>30</sup> and, as a result, are more likely to suffer from poor health than the rest of the population.

The Committee on Economic, Social and Cultural Rights is particularly concerned about the wide disparities in the quality of health care between rural and urban areas.<sup>31</sup> Persons living in rural or remote areas, especially refugees and indigenous peoples, may also experience discrimination in access to primary health care,<sup>32</sup> increased susceptibility to disease and reduced life expectancy.<sup>33</sup>

### **Food and nutrition**

Food, along with water, is essential not only to good health but also to life. In spite of the fact that there is enough food in the world today to feed everyone sufficiently, at least 854 million people are currently suffering from food insecurity and two billion people are suffering from malnutrition.<sup>34</sup> The consequences of this chronic crisis on the state of health of those affected is self-evident: vitamin deficiency leads to increased susceptibility to all kinds of diseases, malformation of babies and growing children, blindness, brain damage and mental retardation. Even death will result from severe undernourishment. The enjoyment of the right to adequate food and the right to be free from hunger, as guaranteed by Article 11 of the Covenant on Economic, Social and Cultural Rights, is therefore of paramount importance.

The right to adequate food is not only essential to health but it is “indivisibly linked to the inherent dignity of the human person” and is “indispensable for the fulfilment of other human rights enshrined in the International Bill of Human Rights.”<sup>35</sup> Furthermore, the right to food which is nutritionally adequate and safe, and the right to be free from hunger, are considered to be part of the core obligations of state parties.<sup>36</sup>

There are many causes of lack of adequate food and nutrition: climate change, the use of agrofuels, imbalances of power in the food production and distribution chain, speculation on the agricultural commodity markets, and soaring food prices are but a few.<sup>37</sup> Poverty – not only of the individual but also of the state – is however the principal cause of the lack of enjoyment of the right to adequate food. In theory, all categories of the population may be affected but, in practice, it is the most vulnerable groups who are the worst hit by lack of food, malnutrition and hunger.<sup>38</sup> Access to food may be hampered by inefficiency, corruption and discrimination in the distribution of food. Once again, it is the disadvantaged and marginalized groups of society who are excluded.<sup>39</sup>

In all circumstances, states have a core obligation to take the necessary action in order to ensure the availability and the accessibility of sufficient food, in ways which do not interfere with the enjoyment of the right to health.<sup>40</sup>

### **Housing and living conditions**

Safe physical and economic access to health care and goods implies that medical services and the underlying determinants to health, such as safe and potable water and adequate sanitation facilities, are accessible to all categories of the population, including those who reside in rural areas.<sup>41</sup>

A large number of individuals and families on low incomes live in sub-standard housing and thus in unsafe, unhygienic and unhealthy conditions.<sup>42</sup> Persons belonging to racial, ethnic and national minorities, especially migrant workers and persons of foreign origin, are especially affected.<sup>43</sup> In addition, they also have inadequate access to health care facilities.<sup>44</sup> For example, many Roma live in informal settlements or slums which lack basic infrastructure and services, such as safe water, electricity, gas, heating and adequate sewage and garbage disposal.<sup>45</sup> They are frequently denied access to social housing and are increasingly victims of forced evictions, often without any provision of adequate alternative housing.<sup>46</sup> Women and, in particular, migrant women or those belonging to ethnic minorities, older persons, and persons with disabilities are subject to lack of security of tenure and forced evictions.<sup>47</sup> Indigenous peoples are often deprived of access to their ancestral lands.<sup>48</sup> All these negative living conditions will take their toll on the health of the people concerned.

In many states, prisoners and detainees live in appalling circumstances. Overcrowded and unhygienic conditions in prisons, as well as lack of appropriate health care, have all given rise to a high rate of tuberculosis and other serious health problems, such as HIV/AIDS, among the prison population.<sup>49</sup>

Homelessness affects more than 100 million people in the world. It is the cause of much ill-health,<sup>50</sup> affects marginalized and vulnerable groups<sup>51</sup> and may even lead to suicide.<sup>52</sup> Although there is no sole and easily identifiable cause of homelessness, a certain number of risk factors have been pinpointed by states: lack of affordable housing, speculation in housing and land for investment purposes, urban migration, unemployment, poverty,

domestic violence, drug addiction and mental illness are but a few reasons which make people vulnerable to homelessness.<sup>53</sup>

### **Forced displacement**

Persons may be displaced within the territory of a state for various reasons: internal armed conflict often makes people flee their homes, seeking refuge in safer regions. Violence, armed conflict and natural disasters have one tragic common denominator: they all lead to the forced displacement of large numbers of people which, in turn, can cause serious damage to mental and physical health.<sup>54</sup>

Urban development projects, real estate speculation, or the preparation for mega-events, such as the Olympic Games, lead to forced evictions of city dwellers.<sup>55</sup> Equally, land acquisition by private and state actors, for the purposes of constructing dams and mines, may result in the displacement of indigenous peoples, against their will, from their traditional territories and environment, thus depriving them of their essential sources of nutrition and the means for preparing their own traditional medicines.<sup>56</sup>

Lack of employment sometimes forces the rural population to move to urban areas in search of work.<sup>57</sup> Many of these immigrants end up living in squalid and unsafe settlements, deprived of the most basic services such as clean water, sufficient space and health care.<sup>58</sup>

Displacement is also caused by natural disasters, such as earthquakes, tsunamis and cyclones. Those persons affected not only become vulnerable to serious communicable diseases requiring urgent medical attention, they also find themselves cut off from their regular sources of health care and goods. Even when special, emergency measures have been taken to alleviate suffering, delays and inadequacies in the distribution of health care and vital medicines may occur leading to an increased risk to health.<sup>59</sup>

### **Natural disasters and armed conflict**

Natural disasters always leave a trail of devastation in terms of human life and sickness. States have a joint and individual responsibility to provide disaster relief and humanitarian assistance in times of emergency. Priority should be given to supplying medical aid, food and water to the victims and to ensuring that any financial assistance given, actually reaches the most



vulnerable or marginalized groups of the population.<sup>60</sup> Psychiatric help is frequently required by victims and especially by those who not only are displaced, but have also lost members of their families.<sup>61</sup>

Whether it be internal or international, armed conflict always causes violence, hardship, suffering and disease. At a time when urgent medical help is vital to health and even to life, access to the usual health services and goods may break down irreparably. It is then important that humanitarian aid be brought to victims of the conflict.<sup>62</sup>

Persons belonging to vulnerable categories of the population, such as women, children, ethnic minorities, older persons, handicapped persons and non-nationals of a state, always suffer most from the disastrous consequences of armed conflict. Their health, although fragile in peace-time, will often deteriorate even further and require emergency aid. All too often, the most needy will not receive the urgent medical help they so desperately require.

As in the case of natural disasters, states have immediate obligations to allow humanitarian aid to reach the victims of armed conflict and to do all in their power to facilitate this type of assistance.<sup>63</sup> In the aftermath of armed conflict, severely damaged infrastructures may hinder the mobility of persons and access to goods and essential public services, namely health care facilities.<sup>64</sup> In such cases, the Committee on Economic, Social and Cultural Rights urges state parties to provide adequate and immediate assistance, in order to alleviate the adverse impact of the conflict on all members of the population.<sup>65</sup> In particular, persons belonging to vulnerable and marginalized groups should benefit from special temporary measures.<sup>66</sup>

### **Harmful lifestyles and physical and mental violence**

It should be underlined that good health cannot be ensured by the state, nor can a state provide protection against all causes of ill-health.<sup>67</sup> Nevertheless, preventive measures, such as awareness campaigns and public information schemes, should be introduced in order to alert the population to the potential risks engendered by unhealthy living. In this respect, the Committee on Economic, Social and Cultural Rights encourages state parties to adopt measures aimed at informing the public of the dangers linked to drug or alcohol abuse,<sup>68</sup> both active and passive smoking<sup>69</sup> and unsafe sex.<sup>70</sup> Furthermore, the Committee recommends that state parties analyse the motives for committing suicide, “with a view to developing effective

measures aimed at the prevention of suicide among vulnerable groups”, such as young people, homosexuals, persons addicted to drugs and/or alcohol, detainees and older persons.<sup>71</sup> The promotion of a healthy lifestyle, especially amongst young people, is paramount.<sup>72</sup>

Harmful traditional medical or cultural practices which are discriminatory towards women and girls, such as female genital mutilation, child marriages, witch-hunting, honour killings, and the preferential nourishment and care of male children are strictly condemned as being serious violations of the right to health and physical integrity.<sup>73</sup>

Physical or mental violence takes many different forms and concerns a wide spectrum of victims. However, women and children belonging to disadvantaged or marginalized groups are usually the most affected. Domestic violence is unfortunately widespread in many states and frequently goes unreported and therefore unpunished.<sup>74</sup> It is not only confined to developing states but is often prevalent in economically developed states.<sup>75</sup> Spousal rape and sexual abuse of children have tragically become common-place.<sup>76</sup> In many cases, domestic violence will have disastrous effects on physical and mental health and can even lead to death.<sup>77</sup> The Committee has reiterated on many occasions the necessity to criminalize such acts and to provide shelter and medical assistance to the victims.<sup>78</sup>

In a broader context, women and children are vulnerable to exploitation, whether it be economic,<sup>79</sup> or sexual,<sup>80</sup> or both.<sup>81</sup> In particular, trafficking in persons remains a serious problem in many states causing considerable physical and mental suffering.<sup>82</sup> The victims of such practices require specific protection and medical attention which are all too often sadly lacking.<sup>83</sup> Children are often victims of forced labour or hazardous working conditions.<sup>84</sup> This type of exploitation is in direct contradiction with Articles 6 and 7 of the Covenant and the International Labour Organization's Convention No. 182 on the Worst Forms of Child Labour.<sup>85</sup> It is also contrary to the right of every child to receive a basic education.<sup>86</sup> In addition, millions of children live in the streets and are amongst the most vulnerable to sexual exploitation and forced labour,<sup>87</sup> as well as to health risks, such as alcohol or drug addiction and HIV/AIDS.<sup>88</sup>

There is also a strong prevalence of HIV/AIDS among high-risk groups such as sex workers, drug users and incarcerated persons. These people are also frequently victims of discrimination by health care institutions.<sup>89</sup> Trade in human organs, particularly in kidneys, is prevalent in some states and is on the increase.<sup>90</sup> Such practices are an affront to human dignity and

constitute a serious violation of the right to physical integrity. They affect primarily the poorest and most vulnerable categories of the population.

### **Safe and healthy working conditions and a healthy environment**

As guaranteed by Article 7(b) of the Covenant on Economic, Social and Cultural Rights, state parties must recognize the right of everyone to the enjoyment of just and favourable conditions of work, which include safe and healthy working conditions.<sup>91</sup>

Despite the obligation to ensure industrial safety and hygiene, occupational accidents and diseases are on the increase,<sup>92</sup> affecting greatly the enjoyment of the right to health of the active population.

Occupational accidents and illnesses often have irreparable consequences. Unsafe or unhygienic working conditions can lead to serious accidents and industrial diseases, such as lead poisoning and asbestos-related illnesses. Article 12(2)(b) of the Covenant urges state parties to take preventive measures and to minimize, as far as is reasonably practicable, the causes of health hazards inherent in the working environment.<sup>93</sup>

Despite legal guarantees, many serious accidents occur in coalmining,<sup>94</sup> in the construction sector<sup>95</sup> and in the transportation industry.<sup>96</sup> It must be pointed out that not only state authorities, but also non-state actors, such as private employers, have the responsibility to create a healthy and safe working environment.<sup>97</sup>

In addition, generally poor conditions of work, such as excessive working hours, lack of sufficient rest breaks and lack of periodic holidays with pay, are not only contrary to Article 7(d) of the Covenant, they are also dangerous to health.<sup>98</sup>

More generally, environmental degradation has a strong negative impact on the health of the whole population.<sup>99</sup> Exposure to a dangerous, or polluted environment, can have serious consequences on the enjoyment of the right to health.<sup>100</sup> Pollution of water, air and soil, radiation and exposure to harmful chemicals or heavy metals can all seriously impair the health of an entire community. For instance, survivors of the 1984 gas leak in a pesticide plant in Bhopal are continuing to suffer serious long-term effects on health from exposure to gas.<sup>101</sup> Reported incidents and lack of security in nuclear plants, as well as an absence of information about the risks to the health of those persons living in close proximity to nuclear installations are constant reminders that transparency is all important.<sup>102</sup> In such

cases, state parties are strongly advised to adopt measures for preventing nuclear accidents and for ensuring rapid intervention should a serious incident occur.<sup>103</sup> In this context, states have a general obligation to inform the population of any dangers to the environment which could harm the health or life of the community.<sup>104</sup>

### **Access to information, education and effective remedies**

Access to health-related education and information, including information on sexual and reproductive health, is an important determinant of the right to health.<sup>105</sup> This means that the right to seek, receive and to communicate health issues must be respected.<sup>106</sup> In addition, the population should be associated with, and participate in, all health-related decision-making in the community at local, national and international levels.<sup>107</sup> However, access to health information does not mean that personal health data, which should be treated with confidentiality, may be divulged.<sup>108</sup>

The prevention, treatment and control of epidemic, endemic and occupational and other diseases require states to draw up and adopt prevention and education programmes.<sup>109</sup> Information on health should also be made available throughout the state territory, including remote rural or mountainous areas.<sup>110</sup>

More generally, lack of education and illiteracy present serious obstacles to the full enjoyment of the right to health. The phenomenon of early marriages, the high rate of maternal mortality, and the rapid spread of HIV/AIDS and other sexually transmitted diseases, can largely be attributed to the lack of sex and reproductive education which is still viewed by some states as taboo.<sup>111</sup> Children and girls in particular are often deprived of access to education, thus barring them from obtaining basic schooling and hence valuable knowledge on health issues. Equally, adults who have never had the possibility to receive a basic education are severely handicapped when accessing health goods and services. Due to their lack of understanding of the written word, at best they are likely to experience difficulties and bureaucratic problems when dealing with health personnel and, at worst, they may be victims of discrimination and lack of access to health care,<sup>112</sup> without any hope of redress.

Access to effective judicial or other remedies without discrimination constitutes an essential determinant of the right to health:<sup>113</sup> Without the possibility to claim health entitlements within the legal order of a state, the most

vulnerable and needy may find themselves deprived of the means to exercise their right to receive basic health care.

The Committee on Economic, Social and Cultural Rights recommends that state parties ensure redress for victims of violations of the right to equal access to health care services, facilities and goods.<sup>114</sup> States should also provide information on the number and nature of cases brought before the courts in relation to violations of the right to health and physical integrity.<sup>115</sup>

### **National and international trade and financial agreements**

Trade and financial agreements may have negative effects on the cost of health services and especially that of essential drugs.<sup>116</sup> They may even have an impact on access to health care, social security and the intellectual property regimes protecting, inter alia, access to generic medicines, biodiversity, water and the right of indigenous communities to these resources.<sup>117</sup>

The Committee on Economic, Social and Cultural Rights strongly recommends that state parties assess ex ante the potential adverse impact of trade or financial agreements and development policies on the right to health of their populations and, in particular, on the health of the most vulnerable groups.<sup>118</sup> In order to ensure that the rights to health, adequate food and a decent standard of living are not adversely affected, states should also eliminate dependency of small-scale farmers on multinational corporations.<sup>119</sup>

The failure of a state to respect its legal obligations regarding the right to health when entering into bilateral or multilateral agreements with other states, international organizations and multinational corporations constitutes a violation of the standards laid down in Article 12 of the Covenant,<sup>120</sup> which can result in serious damage to physical and mental health.

### **Concluding remarks**

Although many factors in society today may lead to ill-health, there are two main root causes: poverty and hunger.

Despite rapid economic development in recent years, poverty persists in many states, disproportionately affecting persons belonging to marginalized and vulnerable groups, such as ethnic minorities, immigrants, indigenous peoples, women and the rural population. Disparities in income,

and in the enjoyment of an adequate standard of living, continue to widen between the rich and the poor.<sup>121</sup> In some states, the number of people living in extreme poverty has even increased.<sup>122</sup> The absence of a poverty line which would enable states to define the extent of poverty and to monitor and evaluate progress in alleviating poverty, is deeply regrettable.<sup>123</sup> Poverty is also one of the main social determinants of health.

In addition to being poor, 100 million people will go to bed hungry tonight. Although the causes of the current food crisis are numerous and hotly debated in the international community, one hard fact stands out: food prices are too high for the poorest nations and peoples in the world to afford adequate nourishment. As a result, food insecurity and hunger are on the increase, leading inevitably to ill-health and, in many cases, to death.

Unless these two important obstacles to health and well-being can be tackled and overcome with success in the short, medium, and long-term, the health of millions of people will suffer irreparably. This is an intolerable situation, because it is a preventable one.<sup>124</sup>

The realization of the right to health, like other human rights, requires states to pursue international cooperation in order to identify and eliminate the obstacles to the full enjoyment of this right by everyone.<sup>125</sup> This obligation implies that states must protect effectively the right to health by regulating and monitoring the activities, not only of national authorities, but also of private actors in order to ensure that the right to health is respected and promoted.

Although the health of all sectors of the population is affected by poor living conditions, an unhealthy and unsafe environment, together with increasing violence, the most vulnerable and marginalized groups will always suffer the most from poverty and hunger. As a matter of priority, states must address the root causes which undermine the enjoyment of the right to health in order to promote the well-being and safety of the entire population.

- \* This article reflects the personal opinions of the author in her capacity as Professor of Human Rights Law and not as member of the Committee on Economic, Social and Cultural Rights.
- 1 See Committee on Economic, Social and Cultural Rights (CESCR), General Comment No. 14 on the right to the highest attainable standard of health, 11 August 2000, UN Doc. E/C.12/2000/4, at para. 1 and para. 3; unless otherwise stated, all General Comments referred to are those of the Committee on Economic, Social and Cultural Rights.
  - 2 Hereinafter referred to as the 'Covenant' or the 'Covenant on Economic, Social and Cultural Rights'.
  - 3 General Comment No. 14, *supra* note 1, para. 5; see also, Statement on Poverty and the International Covenant on Economic, Social and Cultural Rights, adopted by the Committee on Economic, Social and Cultural Rights, 4 May 2001, E/C.12/2001/10, para. 4.
  - 4 General Comment No. 19 (2007) on the right to social security (art. 9), para. 32.
  - 5 Statement on Poverty, *supra* note 3, para. 5.
  - 6 In August 2008, a report on the topic of social determinants of the right to health was published by the Commission on the Social Determinants of Health at the World Health Organization. This chapter does not address this report and was written before this report was issued. However, for those interested in this topic, it is recommended that readers consult the Commission on Social Determinants of Health, *Closing the Gap in a Generation: Health Equity Through Action on the Social Determinants of Health* (Geneva: WHO, 2008), available at [http://www.who.int/social\\_determinants/final\\_report/en/index.html](http://www.who.int/social_determinants/final_report/en/index.html).
  - 7 General Comment No. 14, *supra* note 1, para. 12(b) and para. 18.
  - 8 General Comment No. 3 (1990) on the nature of states parties' obligations (art. 2 para. 1), para. 1.
  - 9 For a list of essential drugs, see, WHO Model List of Essential Medicines, revised in March 2007 (for adults); WHO Model List of Essential Medicines for Children, revised in October 2007.
  - 10 General Comment No. 14, *supra* note 1, para. 12(a) and (b).
  - 11 Ibid., para. 12(b)(III); see also, Concluding Observations on the second periodic report of Ireland, E/C.12/1/Add.77, para. 22.
  - 12 General Comment No. 19, *supra* note 4, para. 4(a) and (b): the schemes instituted may be contributory or insurance-based (such as social insurance) or non-contributory (such as universal schemes) or targeted social assistance (for those in need) or other forms of social security (such as self-help, community-based or mutual schemes).
  - 13 Ibid., para. 2 and para. 23; General Comment No. 14, *supra* note 1, para. 36; Concluding Observations on the initial report of Switzerland E/C.12/1/Add.30, para. 24 and para. 36.
  - 14 General Comment No. 19, *supra* note 4, para. 12(a) and (b), para. 22 and para. 23.
  - 15 See also, General Comment No. 18 (2005) on the right to work (art. 6), para. 1, para. 2 and para. 7.
  - 16 Concluding Observations on the second to fifth periodic report of India, E/C.12/IND/CO/5, para. 38.
  - 17 General Comment No. 14, *supra* note 1, para. 12(b) (II).
  - 18 Concluding Observations on the third periodic report of Hungary, E/C.12/HUN/CO/3, para. 25.
  - 19 General Comment No. 14, *supra* note 1, para. 27.
  - 20 Ibid., para. 27; see also, Concluding Observations on the second periodic report of Bolivia, E/C.12/BOL/CO/2, para. 24.
  - 21 Concluding Observations on the second periodic report of Bolivia, *supra* note 20, para. 15.
  - 22 Concluding Observations on the second to fifth periodic report of India, *supra* note 16, para. 33; Concluding Observations on the second periodic report of Algeria, E/C.12/1/Add.71, para. 21.
  - 23 Concluding Observations on the second to fifth periodic report of India, *supra* note 16, para. 16 and para. 33; Concluding Observations on the initial report of Zambia, E/C.12/1/Add.106, para. 30.
  - 24 Concluding Observations on the third periodic report of France, E/C.12/FRA/CO/3, para. 13.
  - 25 Concluding Observations on the second periodic report of Nepal, E/C.12/NPL/CO/2, para. 26.

- 26 Concluding Observations on the second periodic report of Benin, E/C.12/BEN/CO/2, para. 25.
- 27 Concluding Observations on the second to fifth periodic report of India, *supra* note 16, para. 13, para. 52 and para. 73.
- 28 Concluding Observations on the second periodic report of Nepal, *supra* note 25, para. 13; Concluding Observations on the second to fifth periodic report of India, *supra* note 16, para. 13 and para. 14.
- 29 Concluding Observations on the second to fifth periodic report of India, *supra* note 16, para. 38.
- 30 Concluding Observations on the second periodic report of Senegal, E/C.12/1/Add.62, para. 33; Concluding Observations on the third periodic report of France, *supra* note 24, para. 26 and para. 46; Concluding Observations on the third periodic report of Belgium, E/C.12/BEL/CO/3, para. 21 and para. 35; see also, Committee on the Elimination of Racial Discrimination, General Recommendation XXX on discrimination against non-citizens (2005), para. 3, para. 29 and para. 36.
- 31 Concluding Observations on the fifth periodic report of Ukraine, E/C.12/UKR/CO/5, para. 27.
- 32 Concluding Observations on the initial report of Serbia and Montenegro, E/C.12/1/Add.108, para. 33.
- 33 Concluding Observations on the fourth periodic report of the Russian Federation, E/C.12/1/Add.94, para. 31 and para. 33.
- 34 Statement on the World Food Crisis of the Committee on Economic, Social and Cultural Rights, 19 May 2008, E/C.12/2008/1, para. 2; see also, Olivier de Schutter, Background Note: Analysis of the World Food Crisis by the Special Rapporteur to the United Nations on the Right to Food, 2 May 2008, para. 2, available at [www2.ohchr.org/english/issues/food/docs/SRRTFnotefoodcrisis.pdf](http://www2.ohchr.org/english/issues/food/docs/SRRTFnotefoodcrisis.pdf).
- 35 Statement on the World Food Crisis, *supra* note 34, para. 6; General Comment No. 12 (1999) on the right to food, para. 4; see also, Human Rights Council, 7<sup>th</sup> Special Session, Resolution S-7/1: the negative impact of the worsening of the world food crisis on the realization of the right to food for all, adopted by consensus, 22 May 2008.
- 36 General Comment No. 14, *supra* note 1, para. 43(b).
- 37 Address by the UN Special Rapporteur on the Right to Food, Olivier de Schutter, at the High-Level Conference on World Food Security: The Challenges of Climate Change and Bioenergy, Rome, 3–5 June 2008.
- 38 Concluding Observations of the second periodic report of Benin, *supra* note 26, para. 22: 43% of the population suffer from chronic malnutrition; *ibid.*, para. 23: prisoners and detainees suffer from severe undernourishment; Concluding Observations on the second periodic report of Nepal, *supra* note 25, para. 22: almost a quarter of the population is undernourished, rural communities and persons belonging to the lower castes are particularly vulnerable to food insecurity; Concluding Observations on the initial report of Uzbekistan, E/C.12/UZB/CO/1, para. 27 and para. 31: 28% of the population (approx. 6.7 million people, two thirds of whom reside in rural areas) live below the poverty line and do not have enough food for their basic needs. Consequently, there is a high incidence of malnutrition in the state party.
- 39 Concluding Observations on the second to fifth periodic report of India, *supra* note 16, para. 28.
- 40 General Comment No. 12, *supra* note 35, para. 8.
- 41 General Comment No. 14, *supra* note 1, para. 12(b) (II).
- 42 Concluding Observations on the third periodic report of France, *supra* note 24, para. 22 and para. 23.
- 43 Concluding Observations on the third periodic report of Belgium, *supra* note 30, para. 14.
- 44 *Ibid.*, para. 21; Concluding Observations on the third periodic report of France, *supra* note 24, para. 21.
- 45 Concluding Observations on the fifth periodic report of Ukraine, *supra* note 31, para. 25; Concluding Observations on the third periodic report of Hungary, *supra* note 18, para. 22; Concluding Observations on the initial report of Greece, E/C.12/1/Add.97, para. 22.



- 46 Concluding Observations on the third periodic report of Hungary, *supra* note 18, para. 22.
- 47 Miloon Kothari, Statement by the Special Rapporteur on Adequate Housing on World Habitat Day, 1 October 2007, available at <http://www.unhchr.ch/hurricane/hurricane.nsf/view01/E23B1F14F3D942FBC125736700705408?opendocument>.
- 48 Concluding Observations on the second periodic report of Bolivia, *supra* note 20, para. 23: whilst indigenous peoples make up 62% of the population, almost 70% of the land is controlled by only 7% of the population.
- 49 Concluding Observations on the fifth periodic report of Ukraine, *supra* note 31, para. 29; Concluding Observations on the second to fifth periodic report of India, *supra* note 16, para. 35; Concluding Observations on the initial report of Uzbekistan, *supra* note 38, para. 34. See also, 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: Summary of communications sent to and replies received from Governments and other sectors, 4 March 2008, A/HRC/7/11/Add.1.
- 50 Concluding Observations on the fourth periodic reports of the United Kingdom of Great Britain and Northern Ireland, the Crown Dependencies and the Overseas Dependent Territories, E/C.12/1/Add.79, para. 19: the homeless often suffer from alcoholism or mental illness.
- 51 Concluding Observations on the fifth periodic report of Ukraine, *supra* note 31, para. 22 and para. 45: children leaving state-run school orphanages are particularly vulnerable to becoming homeless.
- 52 Concluding Observations on the third periodic report of France, *supra* note 24, para. 25 and para. 27.
- 53 See, for example, Third periodic report of France, E/C.12/FRA/3, para. 193–199; Miloon Kothari, Report of the Special Rapporteur on adequate housing as a component of the right to an adequate standard of living, E/CN.4/2005/48.
- 54 Concluding Observations on the implementation of the Covenant in the Republic of the Congo (in the absence of a written report), E/C.12/1/Add.45, para. 22: as a result of the violence and the ensuing massive displacements, epidemics of diseases and diarrhoea occurred.
- 55 Concluding Observations on the initial report of China E/C.12/1/Add.107, para. 31; Concluding Observations on the initial report of Greece, *supra* note 45, para. 21.
- 56 General Comment No. 14, *supra* note 1, para. 27; Concluding Observations on the second to fifth periodic report of India, *supra* note 16, para. 31.
- 57 Concluding Observations on the combined second, third and fourth periodic report of Costa Rica, E/C.12/CRI/CO/4, para. 19.
- 58 Miloon Kothari, Statement by the Special Rapporteur on Adequate Housing, *supra* note 47.
- 59 Concluding Observations on the second to fifth periodic report of India, *supra* note 16, para. 32.
- 60 General Comment No. 14, *supra* note 1, para. 40; see also, Concluding Observations on the second to fifth periodic report of India, *supra* note 16, para. 32 and para. 72.
- 61 Concluding Observations on the second periodic report of Japan, E/C.12/1/Add.67, para. 27.
- 62 General Comment No. 14, *supra* note 1, para. 10.
- 63 *Ibid.*, para. 16; see, also: Concluding Observations on the implementation of the Covenant by the Republic of the Congo, *supra* note 54, para. 22 and para. 28.
- 64 Concluding Observations on the second periodic report of Nepal, *supra* note 25, para. 10; Concluding Observations on the fourth periodic report of the Russian Federation, *supra* note 33, para. 10 and para. 38.
- 65 Concluding Observations on the initial report of Bosnia and Herzegovina, E/C.12/BIH/CO/1, para. 39.
- 66 Concluding Observations on the second periodic report of Nepal, *supra* note 25, para. 36.
- 67 General Comment No. 14, *supra* note 1, para. 9.
- 68 Concluding Observations on the third periodic report of Austria, E/C.12/AUT/CO/3, para. 16; Concluding Observations on the fourth periodic report of Spain, E/C.12/1/Add.99, para. 23.
- 69 The Committee commends states which have enacted legislation banning smoking in public places: Concluding Observations of the third

- periodic report of France, *supra* note 24, para. 9; public awareness campaigns should be conducted to reduce tobacco use and alcohol consumption: Concluding Observations on the initial report of Latvia, E/C.12/LVA/CO/1, para. 52.
- 70** Concluding Observations on the initial report of China, *supra* note 55, para. 60.
- 71** Concluding Observations on the third periodic report of France, *supra* note 24, para. 47.
- 72** Concluding Observations on the fifth periodic report of Finland, E/C.12/CO/FIN/5, para. 27.
- 73** General Comment No. 14, *supra* note 1, para. 21, 37 and 51: See for example: Concluding Observations on the second to fifth periodic report of India, *supra* note 16, para. 25; Concluding Observations on the second periodic report of Benin, *supra* note 26, para. 19 and para. 26.
- 74** Concluding Observations on the initial report of Latvia, *supra* note 69, para. 21.
- 75** See, for example: Concluding Observations on the fourth periodic report of Norway, E/C.12/1/Add.109, para. 15; Concluding Observations on the third periodic report of France, *supra* note 24, para. 19.
- 76** See, for example: Concluding Observations on the initial report of Greece, *supra* note 45, para. 16 and para. 17; Concluding Observations on the second periodic report of Benin, *supra* note 24, para. 17; Concluding Observations on the second to fifth periodic report of India, *supra* note 16, para. 26.
- 77** Concluding Observations on the fourth periodic report of Spain, *supra* note 68, para. 17.
- 78** See, for example: Concluding Observations on the third periodic report of France, *supra* note 22, para. 39; Concluding Observations on the third periodic report of Belgium, *supra* note 30, para. 32; Concluding Observations on the fifth periodic report of Ukraine, *supra* note 31, para. 42.
- 79** Concluding Observations on the second periodic report of Benin, *supra* note 26, para. 20; Concluding Observations on the fourth periodic report of Mexico, E/C.12/MEX/CO/4, para. 22.
- 80** Concluding Observations on the second periodic report of Benin, *supra* note 26, para. 18.
- 81** Concluding Observations on the second and third periodic reports of Paraguay, E/C.12/PRY/CO/3, para. 12(h).
- 82** Concluding Observations on the initial report of Greece, *supra* note 45, para. 18.
- 83** Concluding Observations on the second to fifth periodic report of India, *supra* note 16, para. 27; Concluding Observations on the fifth periodic report of Ukraine, *supra* note 31, para. 20 and para. 43.
- 84** Concluding Observations on the initial report of China, *supra* note 55, para. 23: hazardous occupations include mining; Concluding Observations on the second periodic report of Nepal, *supra* note 25, para. 19: some children continue to work in conditions of bonded labour; Concluding Observations on the second periodic report of Bolivia, *supra* note 20, para. 14(d): indigenous children, in particular, are exploited and frequently victims of the harmful practice of 'criaditos' which constitutes forced domestic labour of children.
- 85** On the need to protect children from all forms of work which are likely to interfere with their development or physical or mental health, see, General Comment No. 18, *supra* note 15, para. 15.
- 86** As guaranteed by art. 13 of the Covenant; see also, General Comment No. 13 (1999) on the right to education (art. 13), para. 1.
- 87** Concluding Observations on the second periodic report of Georgia, E/C.12/1/Add.83, para. 20.
- 88** Concluding Observations on the fifth periodic report of Ukraine, *supra* note 31, para. 22; Concluding Observations on the initial report of Latvia, *supra* note 69, para. 23; Concluding Observations on the initial report of the Former Yugoslav Republic of Macedonia, E/C.12/MKD/CO/1, para. 21: hundreds of children in cities, primarily Roma, live on the streets and do not attend school or benefit from adequate health care.
- 89** Concluding Observations on the fifth periodic report of Ukraine, *supra* note 31, para. 28.
- 90** Concluding Observations on the second to fifth periodic report of India, *supra* note 16, para. 39.
- 91** See also, General Comment No. 18, *supra* note 15, para. 2.

- 92** Concluding Observations on the fourth periodic report of Spain, *supra* note 68, para. 14; Concluding Observations on the initial report of Latvia, *supra* note 69, para. 18.
- 93** See also, General Comment No. 14, *supra* note 1, para. 15; ILO Convention No. 155, Occupational Safety and Health Convention (1981), art. 4 para. 2.
- 94** Concluding Observations on the fifth periodic report of Ukraine, *supra* note 31, para. 16; Concluding Observations on the initial report of China, *supra* note 55, para. 24.
- 95** Concluding Observations on the fourth periodic report of Spain, *supra* note 68, para. 14.
- 96** Concluding Observations on the third periodic report of Hungary, *supra* note 18, para. 15.
- 97** Concluding Observations on the fourth periodic report of the Russian Federation, *supra* note 33, para. 47; Concluding Observations on the initial report of Latvia, *supra* note 69, para. 42: the Committee urges state parties to sanction employers who fail to observe safety regulations in the work-place; see, also: General Comment No. 14, *supra* note 1, para. 35; Andrew Clapham, *Human Rights Obligations of Non-State Actors* (Oxford: Oxford University Press, 2006) 326.
- 98** Concluding Observations on the initial report on China, *supra* note 55, para. 24 and para. 53; Concluding Observations on the second periodic report of Japan, *supra* note 61, para. 19; Concluding Observations on the combined second, third and fourth periodic report of Costa Rica, *supra* note 57, para. 18.
- 99** Concluding Observations on the initial report of Uzbekistan, *supra* note 38, para. 28.
- 100** General Comment No. 14, *supra* note 1, para. 15; Concluding Observations on the second and third periodic reports of Paraguay, *supra* note 81, para. 16: the expansion of soybean cultivation has fostered the indiscriminate use of toxic agro-chemicals, leading to illness and even death among children and adults, contamination of the water supply and the disappearance of ecosystems.
- 101** Concluding Observations on the second to fifth periodic report of India, *supra* note 16, para. 36 and para. 76.
- 102** Concluding Observations on the second periodic report of Japan, *supra* note 61, para. 22.
- 103** *Ibid.*, para. 49.
- 104** See, at a regional level: European Court of Human Rights, *Guerra v. Italy*, judgment of the Grand Chamber of 19 February 1998, Reports of Judgments and Decisions 1998-I, para. 60; *Oneryildiz v. Turkey*, judgment of the Grand Chamber of 30 November 2004, Reports of Judgments and Decisions 2004-XII, para. 90.
- 105** General Comment No. 14, *supra* note 1, para. 11.
- 106** See, in this context, art. 19(2) of the International Covenant on Civil and Political Rights.
- 107** General Comment No. 14, *supra* note 1, para. 11; see also, Statement on Poverty, *supra* note 3, para. 12.
- 108** General Comment No. 14, *supra* note 1, para. 12(b) (IV).
- 109** *Ibid.*, para. 16.
- 110** *Ibid.*, para. 36; see, for example: Concluding Observations on the second to fifth periodic report of India, *supra* note 16, para. 77; Concluding Observations on the second periodic report of Benin, *supra* note 26, para. 46.
- 111** Concluding Observations on the second to fifth periodic report of India, *supra* note 16, para. 37.
- 112** Concluding Observations on the second periodic report of Bolivia, *supra* note 20, para. 14(g) and para. 15; Concluding Observations on the second to fifth periodic report of India, *supra* note 16, para. 42: adult illiteracy rates continue to remain high, especially amongst women and disadvantaged and marginalized groups.
- 113** General Comment No. 3, *supra* note 8, para. 5.
- 114** Concluding Observations on the second to fifth periodic report of India, *supra* note 16, para. 52; see, also: Concluding Observations on the fourth periodic report of the Russian Federation, *supra* note 33, para. 32 and para. 60: legislation on the rights of patients concerning, inter alia, professional ethics and redress for medical errors is necessary.

- 115** Concluding Observations on the second periodic report of Benin, *supra* note 26, para. 47: on cases related to female genital mutilation; Concluding Observations on the third periodic report of Hungary, *supra* note 18, para. 42: concerning victims of domestic violence.
- 116** Concluding Observations on the third periodic report of Morocco, E/C.12/MAR/CO/2, para. 29.
- 117** Concluding Observations on the combined second, third and fourth periodic report of Costa Rica, *supra* note 57, para. 27.
- 118** Concluding Observations on the third periodic report of Morocco, *supra* note 116, para. 56; Concluding Observations on the combined second, third and fourth periodic report of Costa Rica, *supra* note 57, para. 48; see, also: Statement on the World Food Crisis, *supra* note 34, para. 13.
- 119** Concluding Observations on the second to fifth periodic report of India, *supra* note 16, para. 69.
- 120** General Comment No. 14, *supra* note 1, para. 50.
- 121** Concluding Observations on the fourth periodic report of Mexico, *supra* note 79, para. 23.
- 122** Concluding Observations on the second and third periodic reports of Paraguay, *supra* note 81, para. 12 a).
- 123** Concluding Observations on the fifth periodic report of Finland, *supra* note 72, para. 17; Concluding Observations on the initial report of China, *supra* note 55, para. 30; see also, Concluding Observations on the second to fifth periodic report of India, *supra* note 16, para. 28: in its pursuit of economic growth, the state party defined the poverty threshold exclusively in terms of consumption. In addition, economic, social and cultural rights have yet to be fully integrated into poverty-reduction strategies.
- 124** Olivier de Schutter, Background Note: Analysis of the World Food Crisis, *supra* note 34, para. 2.
- 125** See, UN Charter, art. 56; Covenant on Economic, Social and Cultural Rights, art. 2, para. 1, and art. 23; Vienna Declaration and Programme of Action, adopted at the Vienna World Conference on Human Rights, 14–25 June 1993, A/CONF.157/23, 12 July 1993.

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