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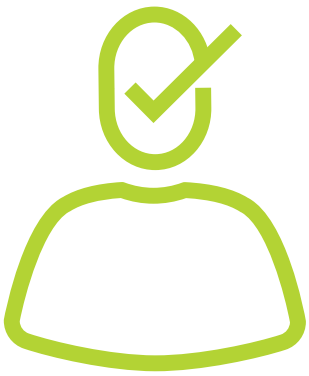

Accountability as a driver of health equity

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Rachel Hammonds, Johanna Hanefeld and Gorik Ooms

ABSTRACT

This paper highlights how accountability mechanisms and processes can play a vital role in driving progress on the Health 2020 and Sustainable Development Goals health equity commitments. Using concrete examples, it identifies how accountability mechanisms and processes assist countries in advancing on health equity and demonstrates how progress stalls when they are absent. It highlights how advancing on accountability requires engaging with multiple diverse actors at different levels in dynamic accountability processes, the importance of collecting and employing disaggregated data to underpin accountability processes and the potential of new accountability tools to address health equity. It demonstrates that progress on accountability requires state engagement with its health-related commitments, both within and beyond the health sector. The examples highlight that when such commitment is weak or absent, accountability suffers and progress on health equity is undermined.

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Executive summary

Accountability mechanisms and processes can play an important role in driving health equity. The diverse examples in this paper demonstrate the multiple ways in which accountability mechanisms can assist countries in advancing health equity obligations. They also highlight that when accountability is weak or absent, progress on health equity falters.

It is important to acknowledge that each Member State of the WHO European Region faces unique challenges that reflect the specifics of their history, structure of their health system, available economic resources and social challenges. This means they face diverse barriers to enhancing health equity, and each will benefit from different accountability processes and mechanisms. With this contextual caveat in mind, the key messages of this paper are summarized below.

How accountability helps advance health equity

Engaging multiple diverse actors at different levels in a dynamic accountability process

The state (national, regional and local) is the key actor in the accountability process. It needs to engage with diverse actors, including civil society, professional bodies and corporate actors, to advance its health equity commitments. Accountability mechanisms and processes need to adapt to reflect continually evolving political, environmental, economic and social challenges. The increasing importance of the commercial determinants of health on health equity emphasizes the need for openness and flexibility when thinking about accountability.

Engaging with accountability mechanisms that address issues beyond the health sector (such as poverty reduction, increasing access to affordable nutritious food, and regulating advertising and marketing of alcohol) can help drive progress on health equity. Health ministries need strong allies and evidence to ensure that legislation and regulations that advance public health are enacted and implemented.

Israel enacted new nutrition policy and regulations in 2017, in keeping with its Health 2020 commitments to ensure that healthy food is affordable and unhealthy food is clearly labelled *(1)*. The Ministry of Health sought wide-ranging public input into this policy process. It employed evidence provided by nutrition experts and public health researchers on the financial and economic cost of a poor diet to counter food-industry financial arguments and the concerns of the ministries of finance and the economy about the cost of making food healthier *(2)*. The regulations that emerged from this multisectoral collaboration help Israel to be accountable for its Health 2020 commitments to advancing health equity.

Collecting and employing disaggregated data to underpin accountability

Disaggregated national data are fundamental to accountability for health equity. Countries should prioritize data collection and use in policy-making, as they allow a light to be shone on the health needs of people whose lives typically are hidden or invisible in national statistics. Monitoring health outcomes and identifying gaps due to direct or indirect discrimination requires that monitoring and evaluation systems be researched, designed, funded and implemented. These systems should specifically be designed (with broad-based input) to identify gaps in coverage that arise from multiple discrimination,

many of which may stem from factors outside the health system. Such monitoring and evaluation allows countries to develop policies and programmes that take account of hidden health issues and conditions that foster ill health and suffering. In the absence of disaggregated data, countries can believe they have made progress on health equity indicators while ignoring pockets of health inequity.

A visit by the United Nations Special Rapporteur on the Right to Health[1] to Sweden in 2006 triggered a debate on access to health care for undocumented migrants *(3,4)*. Public debate about this coverage gap led to political engagement and a change in the law that contributed to greater equity in access to health care in Sweden. Public health bodies clearly have an oversight role in ensuring that programmes do no harm by collecting, monitoring and publishing disaggregated data and pushing for governments to redress obstacles and barriers to health equity in future policy.

Creating tools to advance accountability

Accountability is about more than judicial accountability. Understanding accountability as an ongoing process helps to identify multiple entry points and levels for different actors and diverse processes that play a role in enhancing accountability, enabling it to help to remove new, and address emerging, barriers to health equity.

Officials in Ukraine worked with the private sector to develop a public procurement transparency mechanism to help address the corrosive effect of corruption on the national budget. By July 2016, public agencies, including defence, police, customs, health, infrastructure and energy, had awarded more than 85 000 tenders through the Pro-Zorro system, saving the country tens of millions of dollars that could then be used to fund programmes that advance health equity *(5)*.

The Swiss Federal Office for Gender Equality introduced an online tool that contributes to advancing accountability for gender equity. The free downloadable software allows companies to check whether they are implementing equal pay for equal work between men and women, which can contribute to health equity *(6)*. The Icelandic parliament enacted a law mandating all companies and employers (including state entities) with 25 or more employees to undergo certification to prove they pay men and women equally. The certification process uses an equal-pay management system developed by diverse stakeholders, including trade unions, the employers' confederation and state officials *(7)*.

How weak or absent accountability undermines health equity

Accountability requires the state's engagement with its obligations

Advancing health equity requires state engagement with accountability processes within and beyond the health sector.

The financial crisis of 2008 led to many European countries implementing austerity programmes that cut housing, education and health budgets. This affected their ability to comply with their national, regional and global human rights obligations to respect, protect and fulfil the right to health. Efforts to hold them accountable for policies that negatively affect health equity have exposed the weakness of some accountability mechanisms, and the consequences thereof for health equity.

[1] The official title is the United Nations Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health; it has been shortened in this paper for convenience.

In 2012, the European Social Committee found that Greece's austerity budget violated the European Social Charter, as it had made insufficient efforts to maintain adequate levels of protection for the most vulnerable people *(8)*. Despite this decision, Greece did not take remedial action, which highlights the importance of increasing compliance with existing accountability mechanisms that can help advance health equity.

Accountability requires that all sectors work together to ensure the state is accountable for its obligations

Efforts in the WHO European Region to administer public sector control over the private sector in the interests of health promotion have met with resistance and resulted in mixed outcomes for public health. Countries need to work together to reclaim the policy space to assert their regulatory authority. New challenges, including trade and investment policies and free-trade agreements, have the potential to diminish the policy space within which countries can exert control over tackling noncommunicable diseases. Efforts to curb marketing and advertising of alcohol to adolescents and unhealthy diets to children require regional cooperation, as exemplified in the WHO European Action Network code on reducing marketing pressure on children *(9).*

WHO is mandated to assist states to harmonize and improve their accountability processes to deliver on their Sustainable Development Goals pledge to leave no one behind and deliver health equity for all.

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Introduction

In 2012, the 53 Member States of the WHO European Region adopted Health 2020 as the European policy framework for health, thereby committing to reducing health inequities and improving governance for health and health equity *(1)*. Health equity is broadly defined as the absence of inequities, which is the absence of differences in health that are not merely differences, but also unnecessary, avoidable, unfair and unjust *(2)*. As Whitehead *(2)* explains:

> *The term inequity has a moral and ethical dimension. It refers to differences which are unnecessary and avoidable but, in addition, are also considered unfair and unjust. So, in order to describe a certain situation as inequitable, the cause has to be examined and judged to be unfair in the context of what is going on in the rest of society.*

Accountability can play an important role in helping drive progress on the health equity commitments in Health 2020, but requires other common goods[3] – policy coherence, participation and empowerment – to deliver. This paper highlights why an ongoing dialogue among states, populations and the multiple actors within and outside the health sector is vital to the accountability process and, consequently, advancing health equity. It focuses on the opportunities for diverse accountability mechanisms and processes to act as drivers of health equity, highlighting their multifaceted role and linkages with other common goods.

The mechanisms and processes highlighted in this paper were chosen because they address health equity, help generate state accountability and have the potential positively to influence the health status of the people or communities affected by the issue.[4] The paper highlights the importance of state action to advancing health equity by showing how states can act on their Sustainable Development Goals (SDGs) political commitment to "leave no one behind" by actively engaging with the potential of the diverse accountability mechanisms and processes described.

[3] Section 3 of the upcoming European health equity status report identifies common goods that drive health equity as, "the measures that are known to be important in driving forward policy action and combatting discrimination and exclusion for the health and well-being for all in society".

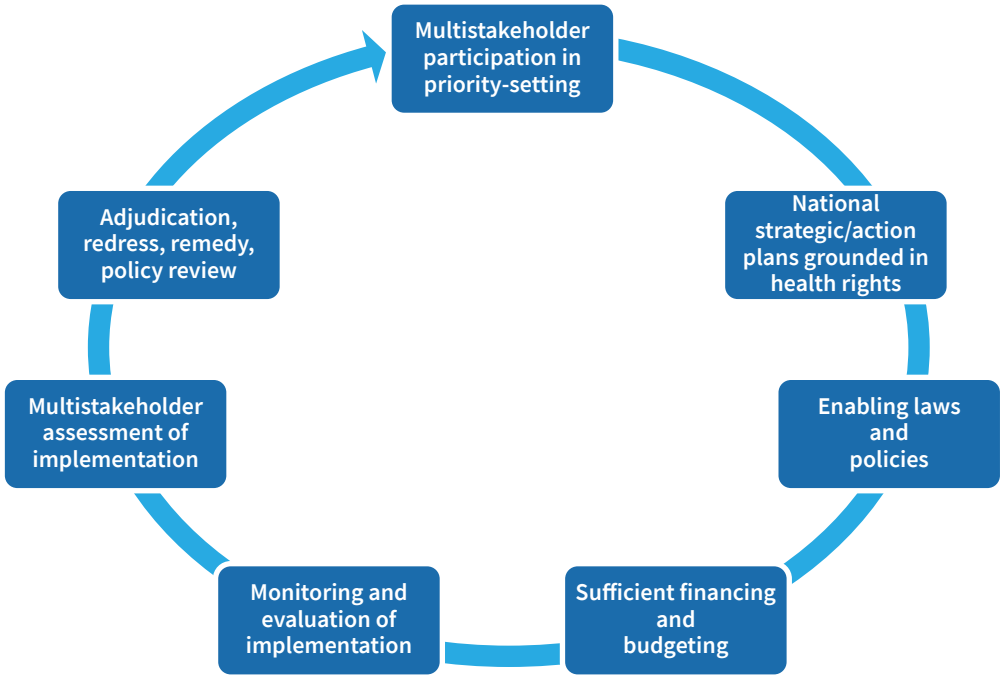
[4] It is beyond the scope of this paper to verify that the impact of the mechanisms highlighted are the cause of a positive, long-term impact on health equity (see the discussion on page 46 in Stronks et al. *(3)*).

Defining accountability

Accountability and health equity

Improved accountability is presented frequently as a panacea for addressing wrongs in multiple arenas, including the health and social sectors, yet it often remains ill-defined and poorly understood *(4)*. This paper defines accountability as answerability or legal responsibility for identifying and removing obstacles and barriers to health equity, through a complex ongoing process that engages multiple actors at different points on the circle of accountability (Fig. 1) *(5)*.

Fig. 1. The circle of accountability to drive health equity



Source: Yamin and Lander *(5)*.
Figure reproduced by kind permission of Taylor & Francis Ltd from the Journal of Human Rights (www.tandfonline.com). Alicia Ely Yamin & Fiona Lander (2015). Implementing a Circle of Accountability: A Proposed Framework for Judiciaries and Other Actors in Enforcing Health-Related Rights. Journal of Human Rights, 14 (3): 312-331. DOI: 10.1080/14754835.2015.1056874.

This process also guarantees access to effective remedies (including, but not limited to, judicial remedies) and robust mechanisms for incorporating evidence (such as epidemiological evidence) or judicial findings in the policy process. Accountability is therefore fundamental to good governance and the rule of law, as it underpins the legal commitment that *(6)*:

> *all persons, institutions and entities, public and private, including the State itself, are accountable to laws that are publicly promulgated, equally enforced and independently adjudicated, and which are consistent with international human rights norms and standards. It requires, as well, measures to ensure adherence to the principles of supremacy of law, equality before the law, accountability to the law, fairness in the application of the law, separation of powers, participation in decision-making, legal certainty, avoidance of arbitrariness and procedural and legal transparency.*

These multifaceted features of the accountability process contribute to its impact in advancing health equity.

In committing to advancing health equity through Health 2020, Member States of the European Region acknowledged that progress requires efforts by both the whole of government and the whole of society to reduce unnecessary, avoidable and unjust disparities in health. The SDG pledge to "leave no one behind" and the focus on the interconnectedness of all SDGs are further examples of the commitments made by global leaders to engage with all of society to advance equity, including health equity. The political commitments in Health 2020 and the SDGs echo the legal commitments made by Member States when they ratified international and regional human rights treaties and the right to health *(7–14)*, embedded in the WHO Constitution *(15)*.

Human rights and rights-based accountability

Human rights provide principles, standards and processes that are grounded in international and national legal commitments. They have legal weight, which means they are tied to accountability mechanisms (not just judicial) and can therefore act as drivers of change. It is for these reasons that this paper draws heavily on human rights principles and thinking as it explores how accountability can drive health equity.

A state's legal commitments to health-related rights and relevant standards and processes are enshrined in the international and regional human rights treaties it ratifies and, in over 70% of states, the national constitution *(16)*. The right to health is a universal right of people defined broadly in Article 12 of the United Nations International Covenant on Economic, Social and Cultural Rights, which "recognize[s] the right of everyone to the enjoyment of the highest attainable standard of physical and mental health" *(7).* Importantly, it does not guarantee the right to be healthy. As noted above, all Member States have made legally binding commitments to advance the right to health and other rights enshrined in the key regional and international treaties: key health rights elements are embedded in, for example, the Convention on the Elimination of All Forms of Discrimination Against Women *(10)*, the Convention on the Rights of the Child *(11)* and the Convention on the Rights of Persons with Disabilities *(12)*.

The United Nations Committee on Economic, Social and Cultural Rights (the UN Committee) provided authoritative guidance on the obligations underpinning the right to health in 2000, emphasizing that the right to health is not limited to health care, services and goods, but also includes the right to the underlying determinants of health *(17)*.

Much work on understanding and advancing accountability in health is rooted in the human rights-based approach to health, which has helped to clarify the parameters of different obligations. Like other human rights, health-related rights are grounded in the human rights principles of participation, accountability, transparency, nondiscrimination, empowerment and equity. Under a human rights-based approach to health, both policy-making and programmes that affect health should be guided by human rights principles. They should aim to empower rights holders to claim their rights and the duty bearer – the state (national, regional and local) – to meet its human rights obligations.

The UN Committee has also provided authoritative guidance on a typology of the state's right to health obligations (to respect, to protect and to fulfil) (Table 1) and the availability, accessibility, acceptability and quality (AAAQ) framework for assessing essential health-related services *(17)*. The human rights-based approach incorporates both frameworks; together, they are useful for driving accountability as they provide guidance on what is required of a state to be compliant with a particular obligation and,

consequently, aim to build the capacity of the state at all levels (national, regional and local) to respect, protect and fulfil rights.

Table 1. Three types of state obligations with respect to economic, social and cultural rights

Obligation	Requirement	Example
Respect	Non-interference (direct or indirect) with, inter alia, the right to health	The state must refrain from introducing policies or programmes that discriminate against specific groups; for example, legislation governing access to health services must not discriminate on the basis of migration status
Protect	Prevent third parties from interfering with the right to health	The state must enact regulations/laws and monitor and ensure compliance by non-state actors (business and nongovernmental organizations (NGOs)) by, for example, adopting legislation regulating promotional activities by the soft-drinks industry in education settings
Fulfil	The state must adopt the necessary legislative, regulatory, financial and judicial measures	The state must ensure that health and social sector budgets are fully funded by, for example, adopting: legislation and providing funding for an adequate programme to make social housing accessible to all; progressive taxation policies; and legislation and funding to enable access to legal remedy for all

The AAAQ framework focuses on the interrelated and key elements of the right to health. Availability requires that health facilities, goods and services be available in sufficient quantities. Accessibility examines whether they are geographically, physically and economically accessible and free from discrimination (in relation to economic accessibility, this means that services must be equitable and affordable for all, including socially disadvantaged groups). The acceptability and quality requirements look at whether health facilities, services and goods are medically, ethically and culturally appropriate, and reviews whether they are of good quality. As this paper demonstrates, the definition of accessibility is particularly relevant to health equity as it includes nondiscriminatory access, requiring inclusion of the most vulnerable and marginalized sections of the population.

Accountability requires continuous monitoring and assessment of the health equity effects of national policies and laws. It is not possible to identify obstacles and barriers to advancing health equity without reliable disaggregated data; disaggregated data require that choices be made on which categories need to be considered to identify inequities, and there is often no consensus within and among states as to which categories need to be considered.

From a health equity perspective, it would be useful to have data disaggregated on the basis of, for example, economic status, educational level, geography, gender, migration status, sexual orientation, ethnicity and other factors that may increase vulnerability and marginalization. Even when a system of categories exists, not all social groups can participate. Religion, for instance, can be used as a system to identify social groups, but perhaps not all religious groups are recognized (Bahaism, for example), and some groups can be outside the system of categories (atheists). In brief, some social groups have the power to create systems of categories and to define the categories to be used, while others do not.

Accountability's role in driving health equity requires engagement from the state and ensures those responsible for implementing policies and laws are answerable to the rights-holders – the population. It then requires engagement with a process of adjudication leading to redress, remedy and policy review to address individual wrongs and demand necessary policy changes.

As human rights are universal entitlements, human rights commitments require that states pay particular attention to the needs of society's most vulnerable and marginalized people. Implementation is measured by the degree to which the health and other status of those who have been disadvantaged and marginalized is brought close to the mainstream standard *(18)*. This requires recognition that when choices are made regarding the allocation of resources, the most cost-effective intervention may not be in line with human rights requirements, or those of health equity.

The international human rights regime has a well established accountability process. The standards and principles enshrined in treaties and authoritative guidance form the basis for assessing a state's compliance with its human rights obligations under the Universal Periodic Review by the United Nations Human Rights Council and the periodic review of compliance with Covenant obligations by the UN Committee *(19)*.

The United Nations human rights system presents one way in which legal accountability can help to drive political accountability for health equity. For example, following his 2006 visit to Sweden, the United Nations Special Rapporteur on the Right to Health publicly addressed the issue of access to health-care services for undocumented migrants at a press conference, noting *(20)*:

> *Sweden's present law and practice places health professionals in a very difficult – if not impossible – position. Does a doctor turn away a sick, pregnant, undocumented woman who cannot afford to pay for the medical treatment she – and her unborn baby – needs? If so, what has become of the doctor's professional ethical duty to provide health care to the sick without discrimination?*

His official report sparked a public debate in Sweden, reinforcing civil society action to ensure access to health care by undocumented migrants *(21)*. This contributed to the Swedish parliament adopting legislation increasing access to health-care services for undocumented migrants and, in particular, children.

Human rights accountability tools allow state representatives to explain policy decisions and priorities and United Nations institutions and civil society groups to raise problematic issues. As such, they provide an important arena for encouraging dialogue and play a key part in the accountability process. They allow assessment of the extent to which a state is complying with, and making efforts to comply with, its obligation arising from the right. They also require a commitment to remedies, and the revision of policies and programmes to comply with rights obligations.

This paper draws on the commitments and learning from human rights-based approaches to explore how these rich veins of experience can be useful for driving accountability for health equity.

Unpacking accountability as a driver of health equity

Types of accountability

Health sector actors are familiar with multiple types and levels of accountability that often overlap and feed into one another. Drawing on the work of Potts *(22)* and others, Table 2 shows six key types of accountability that often overlap and which can be harnessed to advance health equity obligations.

Table 2. A typology of accountability

Type of accountability	Mechanisms	Key characteristics	Pros	Drawbacks
Judicial	Litigation before an international or national court	Legal process with binding outcome	Legally binding decision, sets precedent, may have wide application	Ex-post facto, costly, lengthy, may be limited to plaintiff
Quasi-judicial	International or national human rights body	In-depth review with advisory opinion	Expert review of case	Ex-post facto, non-binding
Financial	Financial audit	Tracks allocation and utilization of funds	Identifies where and how funds dispersed	Ex-post facto, limited to funding
Performance	Expert assessment of international and national data	Tracks progress on indicators towards targets	Focus on service, output and results	Not legally binding, targets and indicators may be inappropriate
Political or democratic	International or national laws or conventions	Involves policy-making, the political process and elections	Multiple opportunities to review, forward-looking	Not legally binding
Social	Civil society engagement, media	Representative of all members of society, media	Inclusive, diverse, forward-looking	Not legally binding/ advisory

Governance levels driving accountability

States make local, national, regional and international commitments to binding and non-binding goals. Different forms of accountability are integral to these levels of governance. Ideally, the goals should complement and reinforce one another, but in reality, they can prove burdensome if monitoring and reporting obligations are not streamlined. Mechanisms need to be available and accessible at the lowest possible level, meaning a person should be able to seek redress close to home and not have to travel to a national capital or bring a case to an international body. Table 3 outlines governance levels, highlighting those that are legally binding and which therefore potentially involve judiciary engagement.

Table 3. Governance levels for health equity

Level	Instruments (legally binding in bold)	Example of monitoring mechanisms/bodies	Accountability mechanisms
Global	**International human rights treaties** **WHO Framework Convention on Tobacco Control** SDG commitments	**United Nations human rights bodies** WHO, national governments Organisation for Economic Co-operation and Development, European Union, Council of Europe, national governments, international and national NGOs and civil society	**United Nations human rights bodies**
Regional	**European Social Charter** **European Convention on Human Rights** **Charter of Fundamental Rights of the European Union** Health 2020	**European Committee of Social Rights** European Union Fundamental Rights Agency Regional and national civil society and NGOs	**European Committee of Social Rights** **European Court of Human Rights** **European Court of Justice**
National	**National constitution** SDG commitments	International and national statistics offices, civil society and NGOs	**National courts** International and national SDG monitoring mechanism
Local	City charter	Various local bodies	Various local methods[a]

[a] Examples of accountability mechanisms include: in Barcelona, Spain, the Committee on Social Inclusion, Participatory Democracy and Human Rights of the United Cities and Local Governments, a local ombudsman focused on human rights and a non-discrimination office; and in the United Kingdom, York, Sheffield and Leeds are so-called Cities of Sanctuary, which commits them to respecting specific norms in relation to the treatment of migrants *(23)*.

Key actors and obligations

From health equity and human rights perspectives, the state is the key actor, engaged with, and accountable for, advancing health equity in its territory. Importantly, non-state actors have a key role to play in advancing, or undermining, health equity. As discussed above, the state has the ultimate responsibility for protecting health rights, which includes ensuring that non-state actors (including those beyond the health sector) comply with regulations that impact on health (see Table 3).

The state must also ensure that civil society can fulfil a monitoring or watchdog function by establishing a transparent regulatory framework through which civil society organizations can flourish. This allows for initiatives such as the Bloomberg Philanthropies' Stopping Tobacco Organizations and Products (STOP) global watchdog *(24)*, which complements existing country and global efforts to identify evidence of so-called industry deception and, importantly, fully align with Article 5.3 of the WHO Framework Convention on Tobacco Control (FCTC) *(25)*. Article 5.3 of the FCTC provides that:

> *In setting and implementing their public health policies with respect to tobacco control, Parties shall act to protect these policies from commercial and other vested interests of the tobacco industry in accordance with national law.*

From the accountability perspective, the state has the legitimacy, financial power and tools of state (legislature, judiciary) to support it to achieve the health equity commitments made in Health 2020. In human rights language, the state has the primary obligation to realize the health rights of those in its territory by regulating non-state actors, including corporations and civil society actors. The state has the legitimacy and power to establish policy, pass legislation and, when necessary, hold other actors accountable for undermining health equity goals.

For example, in relation to advancing the target of reducing premature mortality, the state, following consultation with stakeholders, may choose to legislate to ban alcohol marketing to underage drinkers.[5] The state will then need to create accountability mechanisms to monitor compliance with the law and ensure entities that do not comply are held responsible to enable this measure to advance health equity. Participatory processes and legislative initiatives alone will not advance health equity goals.

Coupling population participation in all health-related decision-making at community, national and international levels with a robust accountability process will help to drive lasting progress towards health equity. The accountability process may engage with the judiciary, but the role of, and obstacles to access to, judicial bodies need to be addressed at the beginning of the policy process and be built into monitoring and review *(5)*.

[5] The state would be seeking to reduce, "Total (recorded and unrecorded) per capita alcohol consumption among people aged 15 years and over within a calendar year (litres of pure alcohol), reporting recorded and unrecorded consumption separately, if possible" *(26).*

The preventive, promotional and transformative role of accountability

The preventive role of accountability

Accountability can play a role in ensuring that discriminatory legislative and policy proposals are identified before they are implemented. It can drive efforts to combat discrimination if review mechanisms, such as health impact assessments, are a legal requirement of the planning process *(27)*. If such consultations are made mandatory, state authorities can be held accountable for any failure to consult by the judiciary; in their absence, the legislative process could be halted by the judiciary. This approach can also be applied outside the health sector – for example, the state can require a health impact assessment before a new motorway is constructed.

It is well documented that discrimination can act as a barrier to health equity, as it can lead to groups of people being systematically disadvantaged in accessing their health rights due to their religion, economic status, ethnic origin, age, sex, sexual orientation, health status and other analogous grounds *(28)*. Discrimination can be either direct or indirect *(29)*. Direct discrimination describes when an individual or group is treated less favourably than someone else has or would be treated in a comparable situation due to a specific attribute, such as sexual orientation. Indirect discrimination is when a practice, policy or law applies to everyone in the same way, but it has a worse effect on some people; health promotion material, for instance, is provided mainly in written form, so is not accessible to people who are illiterate or non-sighted *(30)*. Accountability mechanisms, particularly the judiciary, can play a key role in addressing both types of discrimination and help drive forward the protection and realization of rights for health equity and policy measures.

Most European constitutions contain provisions prohibiting discrimination *(14)*. People experiencing discrimination in the WHO European Region should have access to diverse national, regional and international mechanisms to seek justice. Access to justice is a key element of the rule of law and is both a process and a goal in its own right. It underpins access to substantive and procedural rights.

It is worth emphasizing that nondiscrimination is a key human rights principle to which all WHO Member States have committed as States Parties to international covenants and conventions, and as Parties to regional instruments such as the Council of Europe's Convention on Human Rights and the European Union's (EU) Charter of Fundamental Rights *(31)*. As nondiscrimination has a legal basis, people who experience discrimination should be able to access national-level justice mechanisms to protect themselves against infringements of their rights, hold executive powers accountable and claim remedy for wrongs. Such mechanisms include judicial (courts and tribunals) and non-judicial bodies, such as national human rights institutions, equities bodies, data protection authorities, alternative dispute procedures (mediation or arbitration, for instance) and ombudsperson institutions.

Importantly, these non-judicial bodies do not override a person's right of access to a court and should be subject to judicial review. The Italian National Office Against Racial Discrimination provides an example of how decentralizing accountability may improve effectiveness. By working with national NGOs and labour inspectors, the Office helps to provide a range of accountability procedures to identify and address racial discrimination in the workplace *(32)*.

The state is the key entity responsible for advancement in relation to health equity. If a person holds a well-founded belief that a state policy or programme discriminates against them, they should have access to the courts and/or other avenues in the country's legal system to claim their rights. This requires, however, that the legal system is accessible to all. Finances, education, socioeconomic status and geography can all serve as barriers to access and present obstacles to judicial accountability driving health equity.

Blatantly discriminatory laws and policies that undermine health equity and violate a state's human rights commitments are rare. Many examples of policies and laws that have unintended discriminatory effects (such as austerity policies that cut public services), or which are applied in a discriminatory manner, nevertheless exist. Identifying the impact of these laws and redressing their effects requires that states ensure residents are well informed of their rights (through diverse channels) regarding the availability of accountability mechanisms, and that these mechanisms are accessible (including financially, geographically and linguistically). This requires that accountability mechanisms are well funded and that efforts to publicize them reach all possible audiences.

In relation to access to health-care goods, services and facilities, for example, age and disability can act as a barrier to accessing care. Patients with disabilities, particularly those with learning disabilities, may be excluded from access to sexual and reproductive health care and adequate and targeted information may be lacking. In some cases, older people may be excluded from accessing treatment, including kidney dialysis, rehabilitation and clinical trials *(33)*. Information and transparency are vital to the accountability processes and can help to challenge discrimination, offer redress and push for policy change, consequently driving health equity.

Advancing accountability through transparency

Adequate and sustained public funding of the social sector is a necessary, but not sufficient, element of advancing health equity in the European Region. Inadequate funding can stem from multiple causes, including political choices (such as austerity budgets), the disappearance of allocated funds (corruption) or insufficient funds in the budget (taxation policy or a small or weak economy). Many sectors compete for public financing, so ensuring that the maximum of what is allocated to health is spent on improving health equity is important.

The consequences of inadequate public funding on the equity of health systems and services are well documented. Research on the impact of austerity measures adopted by many European countries following the financial crisis, for example, demonstrates that limits on, or cuts to, social spending have greatest effects on people who are marginalized and vulnerable (those with precarious employment or housing, or with existing health issues) *(34)*. A recent European Parliament study found that corruption costs the EU between €179 billion and €990 billion annually in gross domestic product terms *(35)*. The toll of corruption on all WHO European Region social budgets goes beyond financing; it also *(36)*:

> *weakens the rule of law, leads to vulnerable public institutions, inefficient use of resources and suboptimal quality of public services. Most of all, corruption erodes citizens' trust in their leaders and institutions.*

Improved transparency, oversight and accountability in public procurement helps ensure that public funds are not eroded by corruption and, given the appropriate policies, can contribute to reducing health inequities.

Ideally, states should put in place accessible judicial mechanisms that provide the opportunity to challenge proposed policies and legislation, including those that perpetuate structural inequity (the social, economic and political structures, policies and mechanisms that shape the unfair and inequitable distribution of, and access to, power, wealth and other resources). The judiciary can help to advance health equity by, for example, engaging with structural discrimination in circumstances where the health system and other key drivers of health, such as education, fail to meet the needs of marginalized people or groups, including those with physical or mental disabilities

A promotional role for accountability in advancing health equity

Accountability can play a promotional role in driving health equity by prioritizing state action on the determinants of health and intersectoral work *(37)*. Political, social and democratic accountability mechanisms can help to advance intersectoral health promotion work through playing a part in designing, implementing, assessing and funding polices that address multiple social and commercial determinants of health and therefore drive health equity. Other cross-sectoral health equity promotion activities include WHO recommendations to adopt regulations to reduce the extent and impact of commercial promotion of energy-dense foods and beverages, particularly to children, substantially *(38,39)*. Governments cannot be held accountable in a court of law for failing to implement these recommendations but can choose to fund (or not) public health information campaigns and to regulate advertising.

Work on determinants also highlights the impact of the social gradient in health outcomes: the lower an individual's social and economic status, the worse their expected health. Evidence from numerous European countries demonstrates that obesity and overweight follow a socioeconomic gradient *(40–42)*. In the 2013 Vienna Declaration on Nutrition and Noncommunicable Diseases in the context of Health 2020 *(43)*, ministers of health in the European Region built on their Health 2020 commitment to reduce health inequities by committing to take action on nutrition and noncommunicable diseases, including tackling obesity and its associated inequities. The Vienna Declaration commitments are not legally binding but can be considered practical expressions of legally binding commitments to realize the right to health. They also have the potential to generate forms of accountability that go beyond judicial processes, including social, performance and democratic accountability.

A transformative role for accountability in advancing health equity

The accountability process can play a transformative role in driving health equity in society by ensuring that governance is inclusive and participatory, and by supporting the development of such practices. Civil society actors and public health bodies have an important role to play in ensuring commitments are monitored and that evidence of what does and does not work leads to changes in laws and policies. Civil society actors and public health bodies have to hold governments accountable for failings to ensure accountability is transformative. This approach to accountability can be constructive as, in theory, all parties have the same goal – advancing health equity. The state can be shown where barriers and obstacles exist through engagement in multiple accountability processes, and the relevant government ministry can be pushed to comply with its obligations to respect, protect and fulfil economic and social rights, such as the rights to food and health.

For accountability to act as a transformative driver of health equity, it needs to begin with a broad-based, inclusive, participatory approach to identifying health and other inequities, as examined in detail in the WHO paper, *Participation as a key driver of health equity (44).* One key way of identifying health and other inequities is through collecting disaggregated data on the entire population, which requires difficult choices on which categories to use. Once data are available, they can serve as evidence for advancing and establishing consensus among diverse actors on key societal issues that can address health inequities. The process continues with the adoption and implementation of diverse policies to improve, and advance monitoring of progress on, health equity, and finally to holding people and institutions accountable for that progress, or lack thereof. Including a neglected community's voices in priority-setting, decision-making and monitoring provides a unique opportunity to gain genuine input from the whole community, enhancing legitimacy in the legislative process.

To be effective, the accountability process requires the meaningful participation of all stakeholders in priority-setting for tackling health inequity through policies, monitoring mechanisms, accessible accountability mechanisms and accessible, appropriate remedies (including compensation, restitution or rehabilitation) in the event of failed policy or flawed implementation.

The accountability process does not stop with identifying positive or negative outcomes that require redress. It continues with identifying opportunities for expanded efforts (such as exploring how to widen the geographical reach of a successful programme) if results are positive. If results are negative, redress and analysis of where problems occurred and refocusing efforts to improve processes and outcomes may be required.

Importantly, accountability, including access to justice, should be built into the policy cycle *(5)*. Ideally, this process is continuous, so that small problems are identified before they become big. The whole process needs to be reiterated on a continuous basis and sufficiently rooted in the state's human rights commitments so that policies that advance health-related rights and equity do not disappear when the government changes.

It is worth highlighting that states' right-to-health obligations require engagement in a broad-based consultation (including populations that are marginalized) prior to enacting a new national health strategy to jointly set health priorities and strategies for their advancement. No robust international accountability mechanism for ensuring that state parties comply with this obligation exists, but the UN Committee can request a state to explain why it failed to consult broadly.

Other key human rights-related considerations tied to consultation include access to information; the process should therefore ensure that information related to the consultation is freely provided in a manner that is accessible for all (see the Charter of Fundamental Rights of the European Union, Article 11 on freedom of expression and information *(14)*, and the European Convention on Human Rights, Article 10 *(13)*).

Advancing health equity by addressing commercial determinants

The often-limited impact of corporate social responsibility commitments and voluntary codes of conduct on reducing marketing pressure on children suggests that binding legislation, and the concomitant engagement of judicial accountability, may be necessary in this area *(45)*. The former United Nations Special Rapporteur on the Right to Health called on states to "regulate unhealthy food

advertising and the promotion strategies of food companies" *(46)*, and the former Special Rapporteur on the Right to Food for strict regulation of food advertising because of its "strong impact on children" *(47)*. States are the sole entity with the power to regulate companies and they have the obligation to protect rights-holders (the population) by doing so *(48–50)*. As the legal scholar Amandine Garde suggests, "It is time to shift the paradigm – not only using fundamental rights as a 'shield' to oppose industry challenges, but also as a 'sword' to regulate food industry operators" *(50)*.

Recent litigation on reducing toxic emissions from cars is an example of intersectoral action to address the commercial determinants of health *(51,52)*. This suggests how different communities can work together to assist states in realizing their commitments to advancing on Health 2020 headline target 1.1 of reducing premature mortality in the European Region by 2020 through addressing the burden of disease and risk factors, and SDG target 3.4, to reduce by one third premature mortality from noncommunicable diseases through prevention and treatment and promote mental health and well-being, by 2030.

On 27 February 2018, a German court upheld a claim by environmentalists to ban diesel cars from the city centres of Dusseldorf and Stuttgart *(53)*. This example demonstrates how national regulators, national courts and local environmental groups can work together to drive accountability processes, with the potential to improve health equity.

Progress on a binding treaty on business and human rights

The above example highlights the increased reach and impact of corporate actors on health equity and raises questions on how best to hold them accountable. The success of the WHO FCTC suggests the potential of the legal route. This raises the question of whether a treaty on business and human rights *(54)* may be an effective route to address the impact of business actors on health equity.

From a health perspective, it is clear that some corporate actors engage in activities that create barriers to health equity, including promoting and selling tobacco and alcohol, producing and marketing high-fat and sugar-processed food, and selling polluting vehicles. There is disagreement among scholars, politicians and business actors about the best approaches to regulating, preventing and responding to these abuses and the feasibility and desirability of adopting an associated treaty *(55)*. Debate on the roles and responsibilities of corporate actors regarding human rights within the human rights community has seen the business and human rights discussion climb up the United Nations agenda.[6]

[6] The UN Committee also guides the work of the Forum on Business and Human Rights, an annual gathering on business and human rights *(56)*.

Engaging the public health community

This section focuses on the role different actors in the public health community can play in enhancing accountability for health equity.

The role of the public health community in delivering accountability for health equity

Public health research – generating evidence for policies that drive health equity

Committing to the SDGs and ratifying human rights treaties means that the progress of WHO European Region Member States in achieving the related goals, including health equity, will be monitored. For progress to be made in improving health equity, health policy needs to be based on up-to-date, robust and disaggregated data. Public health research has a vital role to play in generating the evidence that identifies health inequities. Public health researchers have the professional expertise to know what knowledge is needed and are well placed to push for funding for research and policies that address health equity. They can call for the state to be held accountable for its commitments and provide adequate funding.

Public health scholars and practitioners – engaging with diverse monitoring mechanisms and processes that are integral to accountability

The public health community plays a fundamental part in the accountability circle by collecting, analysing and disseminating evidence of policies and programmes that work. This requires engagement in accountability, which can include providing evidence in judicial hearings and parliamentary proceedings, and engaging with the media.

Public health bodies and civil society – ensuring programmes are evidence-based, funded, implemented and monitored

Public health policies that aim to address health equity need to be evidence-based, funded, implemented and monitored. The public health community and civil society have important roles to play in ensuring these objectives are met. Public health researchers need to engage with policy-makers to help ensure their research is fed into policy. Civil society can contribute to ensuring that policy priorities are established through a participatory process that has equity as an objective.

Accountability mechanisms can play a health promotion role by ensuring, for example, that governments develop and fund healthy eating in school programmes. Enacting and implementing legislation that addresses poor nutrition through the provision of subsidized nutritious school meals is one way of tackling obesity and overweight in children that may have an impact on health equity *(57–59)*. The public health community can help to make the evidence-based public health case explaining why the design and roll-out of such programmes need to take the social gradient into account to ensure that policies do no exacerbate inequities.

Public health bodies have an oversight role in ensuring that programmes do no harm by monitoring and publishing disaggregated data and pushing for government to redress obstacles and barriers to health equity in future policy. Civil society, public health bodies and politicians all have a role to play in

engaging with budgetary processes that allow for the government to be held accountable for failures to fund health promotion programmes or participate in monitoring initiatives like the WHO European Childhood Obesity Surveillance Initiative *(60)*.

The ministry of health and/or public health – ensuring programmes that advance health equity are adopted and funded

The ministries responsible for advancing health equity need to work with finance ministers to ensure adequate funding and may look beyond national borders for other funding sources. The EU has sought to address child health and increasing childhood obesity in multiple ways, including through subsidizing the provision of milk, fruit and vegetables (healthy foods) in schools. The EU school fruit, vegetables and milk scheme (EU Scheme) shows how the engagement of diverse actors in implementation and accountability processes can contribute to improving programmes that aim to increase health equity.

The EU operated separate milk (1977) and fruit and vegetable (2007) schemes that had public health, educational and economic objectives for several years, funded under the Common Agricultural Policy. A 2013 impact assessment that engaged in targeted stakeholder consultation recommended merging the two schemes to increase effectiveness and efficiency and give Member States the opportunity to apply for different levels of co-funding for national programmes. The assessment *(61)* noted that:

> *Without the EU aid, the majority of Member States would either be forced to scale down (in terms of the scope and/or effectiveness) or discontinue their programs. Without the EU aid, the access to the schemes would be available only to children from richest regions, possibly leading to territorial and social imbalances.*

The EU aid is provided through the regional Common Agricultural Policy and the EU Scheme has a mix of public health, educational and economic objectives. The wide-ranging impact assessment of merging the two schemes (public health impact, financial assessment, equity considerations) shows how engaging diverse actors in the circle of accountability can help to drive health equity in areas beyond the health sector. This example demonstrates how monitoring, review and adjustment of a regional policy can help national governments to advance health equity objectives by engaging in, and encouraging multiple stakeholders to participate in, accountability processes.

The importance of access to information – the Aarhus Convention

Accountability can also provide an important element in driving health equity through the sharing of accurate information. Action on the social and commercial determinants of health requires public health scholars and practitioners to be ready to engage in accountability processes beyond the health sphere. The SDGs have brought the social, economic and environmental communities under one umbrella, and the public health community can play a leading role in making the case for a whole-of-society approach to advancing health that includes environmental considerations.

This task is made easier in the WHO European Region through the legal obligation for states to share information on environmental matters established by the 1998 United Nations Economic Commission for Europe Convention on Access to Information, Public Participation in Decision-making and Access to Justice in Environmental Matters (known as the Aarhus Convention) *(62)*, a rights-based multilateral treaty that enshrines the public's (present and future generations') right to know and to live in a healthy environment.

The Aarhus Convention is a particularly interesting legal instrument for driving accountability for health equity. It is actively engaged with the SDGs and, through the Task Force on Access to Justice, it is striving to *(63)*:

> *facilitate removing the existing barriers and to enable effective access to justice for all, which is critical for the successful implementation of Sustainable Development Goals, in particular, Goal 16 (peace, justice and strong institutions).*

The importance of monitoring and evaluation for accountability

This section provides an overview of current leading health-related targets, indicators and data sets that measure inequities and can be useful for improving accountability in health. It focuses first on identifying those in the SDGs *(64)* and then assesses how they can help drive accountability for health equity.

The SDG framework

Achieving the targets in SDG 3, "Ensure healthy lives and promote well-being for all at all ages", clearly requires that Member States of the WHO European Region focus on equity and cross-sectoral thinking and action. This includes collecting health data disaggregated on the basis of, for example, educational attainment, economic status, geography, gender, migration status, ethnicity and other factors that can contribute to the vulnerability and marginalization of people and communities. Monitoring also needs to extend beyond the health sector to address other issues that impact on health *(65)*. For example, public health specialists concur that addressing tuberculosis requires action on poverty and the associated social and structural factors that contribute to inequities in diagnosis and treatment *(66–68)*; progress on reducing tuberculosis (SDG target 3.3 includes ending the tuberculosis epidemic by 2030) requires that progress be made on the goals and targets related to poverty reduction (SDG 1) and action on discrimination (SDGs 5 and 10).

Progress on SDG 5, "Achieve gender equality and empower all women and girls", requires the ending of discrimination against women and girls everywhere (target 5.1). Understanding gender as a determinant of health recognizes that women and men often have different socially determined roles and responsibilities, and different social realities. Women and men also have different opportunities to access and control resources, in part due to the gender pay gap, which means women in the European Region still, on average, earn less than men *(69)*. From a human rights perspective, this represents a violation of the obligation of nondiscrimination. The impact of this discrimination on women's mental health is apparent in studies that show heightened anxiety and depression related to work *(70–72)*.

Work–life balance policies, if well designed, can contribute to reducing the gender pay gap. Availability and affordability of child-care services are known to be associated with a smaller gender pay gap, while longer parental leave can lead to a reduction in women's relative wages. Understanding which actions work and which do not is a key part of accountability for reducing the gender pay gap.

New data collection tools and commitments to adjust policy on the basis of findings can help to drive gender pay equity. In Switzerland, the principle of equal pay for women and men is enshrined in the Federal Constitution and in the Federal Act on Gender Equality (1995), but despite these legal commitments, progress was slow until the Swiss Federal Office for Gender Equality developed and required the use of an innovative tool to collect data on the gender pay gap. It received a Public Service Award in 2018 for its innovative approach, noting it as a significant contribution to Switzerland advancing toward the SDG targets in this area *(73)*.

SDG 10 also requires action on discrimination, a barrier to advancing health equity. It commits countries to reducing inequity within and among countries by tackling multiple forms of discrimination and requires states to collect data to better understand patterns of discrimination and prevent

discrimination. It includes indicator 10.2, empowering and promoting the social, economic and political inclusion of all, irrespective of age, sex, disability, race, ethnicity, origin, religion or economic or other status, and 10.3, ensuring equal opportunity and reducing inequities of outcome, including by eliminating discriminatory laws, policies and practices and promoting appropriate legislation, policies and action in this regard. The SDG framework provides through SDGs 5 and 10 an opportunity for monitoring and reporting on intersectoral issues and therefore has the potential to contribute to removing barriers to advancing health equity. It requires states to shine a light into darkness and illuminate and remedy the problems that generally are hidden or ignored, like the social and health needs of undocumented migrants or homeless people.

The 53 Member States of the WHO European Region collect vast amounts of health data. Under the SDG framework, they commit to collecting disaggregated data to identify pockets of discrimination, including hidden discrimination. It is important that efforts are made to align reporting and monitoring efforts so that states and other actors are not overburdened by such processes. The key question is – how can these data be used to hold states accountable for their health equity goals, going beyond identifying obstacles to health equity and actually removing barriers? Accountability commitments under the SDGs are now discussed briefly to assess whether they provide a way for states to be held accountable for their health equity commitments.

The Agenda 2030 monitoring and accountability framework – advancing the SDGs?

The 2030 Agenda created the High-level Political Forum on Sustainable Development (HLPF) to act as a follow-up and review mechanism for the SDGs, but the HLPF does not provide accountability *(64,74)*. Paragraph 84 of the 2030 Agenda provides that HLPF reviews are to be voluntary, state-led, and undertaken by developed and developing countries, and shall provide a platform for partnerships, including the participation of major groups and other relevant stakeholders.

Although the HLPF is more of a political than an accountability body, the SDGs include commitments to wider-ranging accountability mechanisms that have the potential to drive health equity. SDG 16 commits all states to advancing the rule of law and strengthening current institutions and mechanisms. Specifically, it commits countries to "Promote peaceful and inclusive societies for sustainable development, provide access to justice for all and build effective, accountable and inclusive institutions at all levels." To achieve this, target 16.7 requires states to "Ensure responsive, inclusive, participatory and representative decision-making at all levels".

States are expected to track progress with two indicators: 16.7.1, the proportions of positions (by sex, age, persons with disabilities and population groups) in public institutions (national and local legislatures, public service and judiciary) compared to national distributions; and 16.7.2, the proportion of the population who believe decision-making is inclusive and responsive, by sex, age, disability and population group. Additionally, states commit to strengthening national human rights institutions under target 16.a. Under 16.b, they commit to promoting and enforcing nondiscriminatory laws and policies that will be tracked by measuring:

> *the proportion of population reporting having personally felt discriminated against or harassed in the previous 12 months on the basis of a ground of discrimination prohibited under international human rights law.*

The precise means by which such commitments to inclusion and accountability will be assessed is left to each state to decide. Estonia, for example, has taken steps to assess patient satisfaction and has developed service quality measurements for different areas of the health sector, including measuring satisfaction with acute care hospitals, visits to the family doctor and outpatient specialists *(75,76)*.

Linking human rights-based processes with the SDGs

Accountability mechanisms under the numerous international human rights treaties are long-standing and well developed. They can provide a way for infusing more accountability into the SDG equity commitments, and the SDGs can infuse new energy into the human rights mechanisms.

Periodic reporting to the UN Committee

All WHO European Region Member States are required to report on a periodic basis to the UN Committee on their progress on advancing rights, including their obligation to realize the right to health for all (Article 12). United Nations institutions (such as WHO) provide input to these proceedings, including data and analysis, and national and regional civil society organizations are entitled to provide information through a shadow, or parallel, report *(77)*. This process launches a dialogue that is intended to assist the state in making progress on its obligations. It is not adversarial in nature, as it is understood that all participants have the same goal – improving the realization of rights for all.

The process does not provide for sanctions for failure to act, but forms part of an ongoing review process that seeks input from a variety of actors and then engages the state and its institutions in finding solutions. If both states and civil society align their reports with the SDG monitoring framework, they will use disaggregated data that help to identify where the barriers and obstacles lie. The engagement of civil society organizations in this process (through shadow reports) suggests that they believe it plays a useful role in advancing accountability and action.

The United Nations Special Rapporteur mechanism

Engagement with the United Nations Special Rapporteur procedures can also drive accountability. United Nations Special Rapporteurs have a specific mandate (examples include the right to food and the right to housing) from the United Nations Human Rights Council under the Special Procedures mechanisms. National political accountability for international human rights obligations can be triggered through scrutiny by a Special Rapporteur, as happened in Sweden with respect to migrants' rights.

Mass migration is one of the biggest political and social challenges facing the world. Becoming or staying healthy through accessing health and other social services is increasingly difficult for migrants to the European Region, as elsewhere *(78–80)*. Health evidence from several European countries shows that migrants suffer from higher maternal morbidity and mortality, experience poorer pregnancy outcomes, have less access to sexual and reproductive services, including family planning and safe abortion services *(81,82)*, and are more likely to become victims of sexual and other types of interpersonal violence and harmful cultural practices, including female genital mutilation *(83–85)*. The risks are even greater for those without documents or whose asylum claims are rejected. Restrictions placed on migrant access to health and social services can violate the human rights obligations of WHO European Region Member States.

Migrants' health is to a large extent determined by the availability, accessibility, acceptability and quality of services in the receiving country. The legal status of a person within WHO European Region

Member States determines the social services to which they have access. A recent WHO study analysed how variations in the definitions used for different groups of migrants affected health system policies and access to health care *(86)*. This variation, and its consequences for health, is problematic, given WHO policies promoting universal health coverage for all migrants in the Region.

Diverse actors can play a role in driving accountability for health equity. International media attention can focus attention on the issue, as it has done with the detention and separation of children from their families at the United States border. In the case of Sweden, the Special Rapporteur helped to push the Swedish government to assume its international human rights obligations regarding access to health care for undocumented migrants.

Conclusions

The accountability mechanisms examined throughout this paper largely focus on the efforts of the state. Human rights-based accountability mechanisms go beyond the statistical measures in the SDGs, focusing on the importance of process and broad-based consultation. Applying an OPERA framework analysis[7] *(87)* would help to expose how change is achieved. This important type of assessment uses process indicators that connect policy measures, goods and services with human rights assessments of acceptability, accessibility (financial, geographic), availability and quality.

For accountability to be truly transformational, it would need to expose the structural barriers (the social, economic and political structures, policies and mechanisms that shape the unfair and inequitable distribution of, and access to, power, wealth and other resources) and commercial determinants that are barriers to health equity. Further research is needed to better understand the role that corporate actors can play in both advancing and blocking progress on health equity, and what forms of accountability can address this effectively. Engagement in the processes and mechanisms outlined in this paper will be important steps towards transforming the political processes and institutional responses needed to overcome structural and commercial obstacles to advancing health equity *(88)*.

[7] The OPERA framework is designed to be dynamic and adaptable to different contexts, serving as a guiding resource for human rights practitioners and advocates. It consists of four elements: **Outcomes** – assessing the level of realization of the right; **Policy efforts** – assessing the commitment and efforts of the state to realize the right; **Resources** – assessing whether the state is devoting adequate resources to the right; and **Assessment** – understanding constraints, before making an overall assessment.

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