Protecting the right to health through inclusive and resilient health care for all

Issue paper

COMMISSIONER FOR HUMAN RIGHTS

COMMISSAIRE AUX DROITS DE L'HOMME

COUNCIL OF EUROPE

CONSEIL DE L'EUROPE

Protecting the right to health
through inclusive and resilient health care for all

Issue paper published
by the Council of Europe
Commissioner for Human Rights

Council of Europe

French edition:

Protéger le droit à la santé grâce à des systèmes de santé inclusifs et résilients accessibles à tous

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Acknowledgements:

This issue paper was prepared by Dr Rachel HAMMONDS, J.D., Ph.D. in Medical Sciences, Law and Development Research Group, University of Antwerp Law Faculty.

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Introduction

The COVID-19[1] pandemic is the greatest public health crisis in generations, placing an unprecedented strain on health care systems globally. At the end of January 2021, one year after the World Health Organisation (WHO) declared a public health emergency, almost three quarters of a million persons across Europe had died of or with the Coronavirus.[2] As the longer-term repercussions of the pandemic continue to unfold, the health crisis has developed into a rights crisis, resulting in violations not only of the right to life and the right to health, but of all human rights. Since the onset of the crisis, the Commissioner for Human Rights has released numerous statements highlighting emerging COVID-19-related human rights challenges.[3] This issue paper focuses on the often overlooked or "taken for granted" right to the highest attainable standard of physical and mental health for all. Without it, we cannot live in dignity, and our ability to vote or enjoy other civil and political freedoms, and to work, learn or create is significantly restricted.

Council of Europe member states are home to some of the world's best performing health and social care systems. Yet, health equity gaps have revealed persistent challenges to health systems' inclusiveness across the region and these have been shown to incur significant social, human and economic costs to individuals and societies.[4] Even before the pandemic struck, health data demonstrated that disparities in access to preventive health care and treatment, based on gender, minority or socio-economic background, were common.[5] In addition, insufficient regional progress on important social determinants of health, such as education and socio-economic status, due often to underlying and deeply embedded structural inequalities, has increased the risk that those who are less advantaged in society experience worse health outcomes and have shorter lives than average.

Combined barriers to access to health care have proven lethal during the COVID-19 pandemic.[6] This shows that the right to health cannot be protected at an individual level only. It requires effective systems that provide for inclusive prevention, treatment and rehabilitation for all, leaving no one behind and ensuring that structural inequalities are not magnified over time but pre-empted and addressed.

Austerity measures over the past decade have atrophied health and social systems in some states and the COVID-19 pandemic has exposed their resulting weaknesses and lack of resilience.[7] Hospitals, laboratories and public health agencies have been operating beyond capacity, diagnostic capacity has been lacking in many countries, the supply of personal protective equipment has often been insufficient and front-line health and social care workers have faced increased risks of disease and death. These factors have contributed to often preventable excess mortality and suffering throughout Europe.

The dramatic toll on vulnerable and/or marginalised groups living in long-term care facilities, and especially amongst older persons, is deeply alarming. The Commissioner for Human Rights has repeatedly underlined how important it is for member states to move away from the practice of institutionalising older persons, persons with physical or mental health issues or disabilities and children.[8] The COVID-19 crisis demonstrates how urgent it is to implement the international human rights commitment to deinstitutionalisation contained in Article 19 of the Convention on the Rights of Persons with Disabilities (CRPD).[9]

The protection and promotion of the right to health is not an easy task. Health care is a complex sector with many public and private actors working interdependently. Given the dramatic situation in Europe in the wake of COVID-19, concerted efforts must be made in many Council of Europe member states to evaluate the state of their health systems and improve them where necessary so as to guarantee free access to high-quality health care that is "guided by the needs of patients rather than profit and regardless of gender, nationality, religion or socio-economic status".[10]

As we collectively learn lessons from the different country responses to COVID-19, Council of Europe member states must co-operate and act in solidarity across borders and organisations to ensure that health care systems are both inclusive and resilient. To chart a path forward for a human rights-based approach to health, including in the post-COVID recovery period, this Issue Paper is preceded by the Commissioner's twelve recommendations to all Council of Europe member states on how to build inclusive and resilient health care systems for all.

The first chapter of the issue paper reviews member states' universal and European health-related commitments, clarifying standards and principles that should underpin and guide related policies and processes.

The second chapter presents key health governance partners that can advance co-operation and solidarity to tackle the health gaps exposed and magnified by COVID-19.

The third chapter explores the six key components required to deliver inclusive and resilient health care systems.[11]

The final chapter lays out how good-quality, accessible health care is reinforced by the broader social determinants of health: income security and social protection; adequate living conditions; education; and decent labour and employment conditions.[12]

The Commissioner's recommendations

To ensure that human rights form the basis for developing inclusive and resilient health care systems and the social policy responses needed to safeguard the right to the highest attainable standard of physical and mental health for all, including in the context of a pandemic, and to combat health inequalities for current and future generations, the Commissioner for Human Rights calls on Council of Europe member states to:

Enhance ratification and implementation of relevant universal and European instruments in the area of social and health rights

- ratify the revised European Social Charter and agree to be bound by the Collective Complaints Procedure, and ratify the European Code of Social Security;
- make progress on the broader social rights commitments enshrined in the European Social Charter and the European Code of Social Security that are necessary to narrow the health equity gap and move forward on the Sustainable Development Goals commitment of leaving no one behind;
- ratify the Aarhus Convention on Access to Information, Public Participation in Decision-Making and Access to Justice in Environmental Matters and participate in the UN Framework Convention on Climate Change process.

Make progress on measures to promote universal health coverage (UHC) with primary health care as its foundation

- develop and maintain well-funded health systems that deliver high-quality preventive, promotive and curative care to all throughout people's lives, without exposing them to financial hardship;

- ensure that mental health services, an essential component of UHC, are accessible to all when needed, of appropriate quality and affordable;
- ensure that all people have access to the full range of high-quality sexual and reproductive health services, including age-appropriate, comprehensive sexuality education for children in school;
- support strong emergency health preparedness and response systems and strengthen capacities at national, regional and international levels, with a view among other things to mitigating the impacts of the climate emergency on health.

Ensure that health and social systems respect the autonomy and dignity of all people

- take immediate steps to ensure that health and social systems are designed to be people-centred and life-cycle sensitive, including offering older persons diverse living options with a view to minimising long-term institutional care;
- progressively transition to a living-in-the-community model and move away from long-term residential care institutions for persons with disabilities or mental health issues;
- enact measures and fund diverse programmes that enable persons with disabilities or long-term or chronic illnesses to attain and maintain maximum independence and full physical, mental, social and vocational ability;
- eliminate coercive practices in all sectors of health, including in gynaecology, psychiatry, mental health care services and services for persons with psychosocial disabilities.

Ensure non-discriminatory access to health services and the underlying determinants of health for all

- proactively remove existing barriers to inclusive and non-discriminatory access to health with a view to safeguarding effectively the health rights of all persons, including those belonging to marginalised or disadvantaged groups;
- ensure that health services are gender sensitive and respond to the broad range of factors that affect women's and men's health;
- extend protections against age discrimination to the health sector;
- provide initial and ongoing human rights and non-discrimination training to all medical, care and administrative staff and incorporate mandatory courses into relevant university and other professional curricula;

- ensure that monitoring and evaluation processes collect disaggregated data with multiple stratifiers (including age, gender, sexual orientation, gender identity and sex characteristics, disability, geographic location and socio-economic background) in line with European data protection safeguards, and conduct qualitative surveys to identify and understand health service coverage gaps.

Ensure that decision-making processes prioritise broad participation and empowerment

- strengthen broad participation in health and social policy related decision-making processes to ensure that all relevant stakeholders at local, regional and national level are effectively consulted, including in particular national human rights structures (NHRSs) and relevant civil society representatives;
- develop systematic processes and outreach channels to engage with representatives of marginalised communities with a view to ensuring that their specific views, concerns and interests are effectively considered in decisions affecting them and to redressing existing structural inequalities in their access to health care;
- take immediate steps to implement fully the participation rights of persons with disabilities, as enshrined in the Convention on the Rights of Persons with Disabilities.

Institutionalise transparency and accountability processes throughout the policy cycle

- strengthen and protect space for civil society organisations and NHRSs such as ombudspersons, equality bodies, and human rights commissions, to enable them to provide effective oversight over government decision-making and monitor policy implementation;
- ensure that NHRSs are endowed with sufficiently broad mandates and the expertise and stable funding needed to cover social and economic rights effectively;
- implement robust monitoring and accountability processes that strengthen the rule of law, deliver redress for human rights violations and ensure timely, necessary policy adjustments;
- ensure effective evaluation and monitoring of progress on human rights commitments by funding adequate systems for the collection of disaggregated data and ensuring that transparency is secured at all levels of governance and throughout the health system.

Enhance commitments to respect and protect the rights of the health and social care workforce

- take immediate measures, including through education and training, to guarantee the safety of health and social care workers in the workplace and create adequate working conditions;
- take all necessary measures to ensure that all members of the health and social care workforce are treated with appropriate levels of dignity and respect, including in terms of their contractual situation, income security and fair compensation;
- implement measures to increase diversity across the health and social care workforce and ensure that gender disparities are eliminated.

Promote access to essential medicines for all

- invest in bio-medical and pharmaceutical research that is gender inclusive and evidence-based and adequately addresses the health needs of the whole population throughout their lives;
- engage with all relevant stakeholders, including pharmaceutical companies, to increase transparency around the process of developing and bringing to the market new medicines and vaccines that are cost-efficient and based on the needs of patients rather than profit;
- engage in collaborative forums and processes, including within the Council of Europe Committee on Bioethics, to facilitate the exchange of information and jointly promote effective responses to global health challenges, including anti-microbial resistance and equitable global distribution of medical products and vaccines;
- take effective steps to protect secure supply chains for the production of essential medicines and medical products to ensure that they are available to the population at all times.

Ensure access to accurate, up-to-date health information for all

- strengthen information transparency and trust by engaging in open, evidence-based communication and dialogue, including with respect to remaining data gaps and ongoing research;
- promote health literacy through initiatives in formal and non-formal education settings, providing a plurality of independent, evidence-based information related to health promotion, including preventive campaigns, information on healthy lifestyles and nutrition, and comprehensive sexuality education;

- ensure that health information is readily available to the whole population and presented in a variety of accessible formats and languages;
- provide regulatory oversight of health information to ensure that it is accurate, impartial and communicated in neutral language.

Ensure adequate levels of public financing to deliver the right to health for all

- commit to safeguarding appropriate financial support for the health and social care sectors as austerity impacts on the resilience and inclusiveness of health care undermining access to health rights for all and leading to higher costs in the long term;
- ensure that public funding of health care systems promotes universal access to primary health care by responding to population level data on existing affordability obstacles to access to preventive, curative and promotive physical and mental health care services;
- engage in participatory, rights-based budgeting that covers a broad cross-section of society.

Ensure a comprehensive, coherent approach to health and social policy making

- implement measures to promote national, regional and international health commitments to reducing health inequality by adopting a Health in All Policies approach to systematically ensuring that public policies across sectors are coherent;
- integrate the economic, social, environmental and governance dimensions of health at all stages of policy making to avoid harmful health effects and align with broader social protection efforts;
- address fragmented social protection systems and build consensus between health and other social programmes by engaging in inter-sectoral dialogue with diverse partners on issues including the reduction of unemployment, supporting renewable, clean energy schemes and increasing access to affordable housing;
- adopt a "One Health" approach in public health preparedness and global health security, accepting the interactions between animals, humans and the environment as integral factors in disease prevention, detection and response, and strengthen national and international efforts to protect the ecosystems that underpin human, animal and environmental health.

Lead efforts to promote international solidarity and multilateral approaches to health governance

- pursue solidarity and international co-operation, including in generation of scientific knowledge of benefit to humankind, to strengthen health systems' resilience;
- commit to and strengthen multilateral leadership to address global health challenges by supporting an empowered and accountable World Health Organisation;
- provide continued support for ongoing efforts to reform and strengthen the International Health Regulations with a view to ensuring their responsiveness to future health emergencies;
- participate in and contribute to international co-operation and development assistance programmes that promote human rights for all.

Chapter 1
Standards and principles on the right to health

The COVID-19 pandemic has challenged European and international commitments on human rights including the right to health with unprecedented speed and intensity, testing the resilience of health systems in all Council of Europe member states. Most member states have responded with emergency measures restricting freedom of movement, such as hard and soft "lock-downs" or stay-at-home requirements.[13] Such measures may be necessary to prevent health care systems from becoming overwhelmed and slow down virus transmission, but they also have a significant impact on access to essential services, including health care, education and social services, and on the economy.[14] COVID-19 has highlighted the interconnected nature of rights and showcased the fundamental nature of the right to health as a precondition for accessing and enjoying other human rights.

Resilient health systems contribute to the right to health and individual and collective health security by reducing the vulnerability of societies to health threats that spread across national borders.[15] They are robust and adaptable, able to adjust to shocks, respond and reorganise, and to ensure that they maintain their ability to protect human life and produce good health outcomes for all, even during a public health crisis.[16] International and European frameworks related to building resilient health systems focus on enhancing preparedness and response capacity prior to an emergency and on strengthening health systems after an emergency. Health system resilience requires co-operation, communication and solidarity across countries and international organisations,[17] as provided for in European and international human rights treaties, the International Health Regulations (IHR) and the Sustainable Development Goals (SDGs).

This Chapter presents the most relevant standards and principles for inclusive and resilient health care systems, as set out in universal and European human rights and health security treaties.

1.1 The international legal framework for the right to health and health security

1.1.1 Universal human rights instruments

The 1946 WHO proclaims that "the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition."[18] Health is defined expansively as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity." Article 25 of the 1948 Universal Declaration of Human Rights (UDHR),[19] which asserts universal values and lists the human rights that all people are entitled to, establishes a universal commitment to health rights.

The International Covenant on Economic Social and Cultural Rights

In 1966, two legally binding Covenants were adopted, the International Covenant on Economic, Social and Cultural Rights (ICESCR) and the International Covenant on Civil and Political Rights (ICCPR). All Council of Europe member states are parties to these two universal human rights treaties and committed to promoting the rights listed in them. Echoing the WHO Constitution, Article 12 of the ICESCR asserts a right "to the enjoyment of the highest attainable standard of physical and mental health" (the right to health). Article 12-2(c) contains a clear obligation for states to take measures to prepare for and address epidemic diseases, like COVID-19.[20]

General Comment 14 on the right to health

General Comment 14, adopted by the United Nations Committee on Economic, Social and Cultural Rights (UN Committee), clarifies that states' commitments include the obligations to respect, to protect and to fulfil the right to health.[21] It specifies that the right to health is an inclusive right that contains two key components: health care and the underlying social, environmental, economic and commercial determinants of health.[22] States commit to taking steps to ensure non-discriminatory access to quality health care systems and the full range of the underlying determinants or preconditions of health. Progress is measured by assessing the extent to which they move forward on those overlapping commitments. The UN Committee further specified that states have "minimum core obligations" to ensure satisfaction of minimum essential levels of social and economic rights for all, which are non-derogable.[23] The concept of minimum core obligations is especially important during a crisis like the COVID-19 pandemic as it establishes a minimum standard below which no government should fall, even when resources are scarce.[24] Inquiries have been launched

in several European states as to the extent to which these standards have been adhered to and what improvements should be made.[25]

Specialised United Nations human rights conventions

Specialised UN human rights treaties have subsequently emphasised and elaborated on the unique and often overlooked health needs of women, children and persons with disabilities.[26] Women should be provided with health services equal to those of men and meeting their unique health needs. As a result, Universal Health Coverage (UHC) packages include accessible and affordable sexual, reproductive, maternal, new-born, child and adolescent health services. States have also committed themselves to actively consulting and involving persons with disabilities and their representative organisations in planning and monitoring the implementation of measures that affect them.

1.1.2 International health security

The 2005 International Health Regulation is an international health treaty that serves as a legal foundation for international health security measures.[27] All WHO members are bound by the IHR and its provisions governing emergency preparation and responses to the declaration of a Public Health Emergency of International Concern, such as COVID-19.[28]

The excess mortality experienced globally and in many Council of Europe member states over recent months as a result of the pandemic raises important concerns about the health security measures taken by states.

1.2 The European legal framework for the right to health and health security

1.2.1 European human rights instruments

The European human rights framework guarantees a broad range of civil, political, social and economic rights, including the right to health. While the European Convention on Human Rights does not specifically guarantee a right to health, health-related cases have been brought before the European Court of Human Rights and have most frequently been argued under Article 2 (right to life), Article 3 (right to freedom from cruel, inhuman or degrading treatment), and Article 8 (right to respect for private life).[29]

For European Union member states, the Charter of Fundamental Rights establishes the right of access to preventive health care and medical treatment under the conditions established by national laws and practices.[30] The European Pillar of Social Rights adopted in 2017 by the European

Commission enshrines 20 principles on interconnected determinants of health, including equal opportunities and access to the labour market, fair working conditions, and social protection and inclusion.[31]

The European Social Charter (the Charter) and the Revised Charter, the key regional instruments for the advancement of social and economic rights, enshrine the right to protection of health (Article 11), the right to social security (Article 12) and the right to social and medical assistance (Article 13). In addition, they safeguard broad protection of other social rights, including protection against poverty and exclusion (Article 30) and the right to housing (Article 31).[32] Implementation of the Charter is overseen by the European Committee of Social Rights (ECSR), which is made up of 15 independent and impartial members and has issued important conclusions and decisions on member states' obligations with respect to the rights enshrined in the Charter, including on the right to health.[33] In April 2020, the ECSR issued a statement of interpretation on the protection of the right to health in times of pandemic.[34]

The introduction of a collective complaints procedure by the Additional Protocol adopted in 1995 (entry into force in 1998) enhances the effectiveness, speed and impact of the implementation of the Charter by enabling social partners and non-governmental organisations to apply directly to the ECSR for rulings on possible non-implementation of the Charter by States Parties.[35] A number of collective complaints regarding access to the right to health and social and medical assistance are currently pending, often in conjunction with Article E (non-discrimination).[36]

The Charter echoes the WHO Constitution, broadly defining the right to health as the "state of complete physical, mental and social well-being and not merely the absence of disease or disability". The Charter recognises that all rights are interrelated and that progress on the right to health requires advances on a wide range of factors that contribute to a healthy life, including healthy working and environmental conditions and gender equality.

The protection of the human rights of persons deprived of their liberty is monitored by the Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT). The CPT, established under the European Convention against Torture, which guarantees protection from ill treatment,[37] has the broad remit to monitor conditions in all places where people are deprived of their liberty including prisons, immigration detention centres, psychiatric hospitals, social care homes and quarantine zones. It has outlined ten principles to ensure that the health and safety

standards of all persons deprived of their liberty, and those that work with them, are respected and protected during the COVID-19 pandemic.[38]

In recognition of the importance of the social determinants of health (explored in Chapter 4) the Council of Europe has long advocated for enhanced social security protection. In addition to Article 13 of the European Social Charter, which extends the right to urgent social and medical assistance to all present on a member state territory, documented or not,[39] the European Code of Social Security establishes a higher level of social security protection for Council of Europe member states.[40] Creating a social security model based on social justice, it deems the state responsible for establishing and maintaining a stable and financially sound social security system, which guarantees a decent standard of living for those who cannot earn their own living because of sickness, unemployment, old age, employment injury, occupational disease, maternity, invalidity, or death of the breadwinner, going far beyond the model advocated by the International Labour Organisation.

The 1997 Oviedo Convention, the only international legally binding instrument on the protection of human rights in the field of biology and medicine including biomedical research,[41] establishes fundamental principles applicable to daily medical practice and is often viewed as a European treaty on patient's rights. It is especially important in the light of the intense biomedical research required to respond to the COVID-19 pandemic, and the ethical issues related to equity of access to health care raised by its impact on available resources.

1.2.2 European health security commitments

Article 11(3) of the European Social Charter echoes the IHR approach to health security, providing that States Parties must demonstrate their ability to cope with infectious diseases by means of arrangements for reporting and notifying diseases and by taking all the necessary emergency measures in the event of epidemics.[42]

Co-operation on research and exchanging information and health data enhance health systems' resilience and health security.[43] This means that states should engage in collaborative forums and processes, such as the ECSR and the Committee on Bioethics, to facilitate the exchange of information and jointly promote effective pandemic responses along with other collaborative efforts regarding global health challenges, including anti-microbial resistance.

1.3 General human rights principles

International and European human rights instruments enshrine four key human rights principles that fundamentally underpin access to social and economic rights, including the right to health.

1.3.1 Non-discrimination

Non-discrimination is a cross-cutting human rights principle that applies to all human rights and is an obligation of immediate application. The right to health does not invoke a judicially enforceable "right to be healthy" but an obligation of member states to provide access to the highest attainable standard for health. This must of course be provided for all persons under a state's jurisdiction, irrespective of their age, gender, sexual orientation, gender identity and sex characteristics, disability, geographic location or socio-economic background.

Gender can have a major impact on health equality. The different health statuses and needs of women and men are not related solely to biological differences but to the impact of societal gender norms and stereotypes. All health efforts must therefore be gender-responsive, taking gender norms and inequalities into account and acting to reduce their harmful effects. Progress towards gender equality can have a positive impact on the health of both women and men, ultimately helping to transform norms and structures that act as barriers to achieving healthy lives and well-being for everybody.[44]

It is well-documented that discrimination, whether direct or indirect, can act as a significant barrier to health equity. It can lead to specific groups of people being systematically disadvantaged in accessing their health rights owing to factors such as their religion, economic status, ethnic origin, migration status, age, gender, sexual orientation, gender identity, sex characteristics, health status or other similar grounds.[45] Studies from Sweden and France also show that perceived discrimination is separately associated with a tendency to refrain from seeking medical treatment.[46] Moreover, discrimination and racism are also known to have a powerful impact on victims' mental health.

In many member states, Roma women face long-standing discrimination in accessing quality reproductive health care services.[47] Throughout Europe, discriminatory barriers to health care facilities, goods and related services are a contributing factor to the lower life expectancy of Roma and Traveller groups.[48] Lesbian, gay, bisexual, transgender and intersex (LGBTI) people experience multiple, diverse barriers to accessing health care throughout Europe, which exacerbate inequalities and discrimination,

ultimately impacting negatively on both their physical and mental health.[49] In relation to mental health, research suggests that, in comparison to the general population, LGBTI people are at higher risk of poor mental health including higher rates of suicidal thoughts, anxiety and deliberate self-harm stemming from intersecting vulnerabilities and discrimination.[50]

Disaggregated data on the impact of COVID-19 show that people with African, Asian and other minority backgrounds are at increased risk of contracting and dying of COVID-19 due in part to housing deprivation and high rates of employment in essential public-facing jobs.[51] Continued reports of racially discriminatory attitudes amongst some health care staff resulting in denial of access to essential services are deeply alarming.[52] In some countries, minority groups, including LGBTI people, undocumented migrants and Roma, have even been scapegoated by politicians and members of authorities as sources of the virus.

Data also show that persons with disabilities as a whole had significantly worse health outcomes during the pandemic.[53] There are also studies placing long-term unemployed people at an 84% higher risk of developing complications following a Coronavirus infection.[54] Over 95% of COVID-19 deaths in the WHO Europe region occurred among people over 60 years of age. When resources including intensive care beds and ventilators were scarce, some countries limited access based on age.[55]

The promotion of inclusive and non-discriminatory access to health care for all must therefore be an absolute priority for Council of Europe member states and special efforts must be made to be proactive in ensuring that the rights of persons belonging to particular groups that face access barriers, including women, Roma, persons with disabilities, older persons, LGBTI persons, prisoners, persons with migrant backgrounds or migrants, are effectively safeguarded.

1.3.2 Participation and empowerment

Participation is another cross-cutting human rights principle that affects the quality and effectiveness of health policies and programmes and is a vital means of addressing any structural problems that impede inclusive access to health.[56] Participatory priority setting, policy design and decision making helps ensure that national public health strategies and plans of action are based on input from a wide range of citizens, researchers and patients, not just on epidemiology, disease patterns, or arguments of cost-effectiveness.[57]

Where a health problem disproportionately affects members of a vulnerable or marginalised population, it is vital for them to take part fully in decision making to ensure that adequate and sustainable solutions are found.

Meaningful participation by members of the LGBTI community, for instance, in health policy discussions and implementation plans will help ensure that a health system is inclusive and respectful of difference, including during crisis situations.[58]

Patient groups have so far been excluded from European decision making on COVID-19.[59] The COVID-19 response also highlights the importance of broad-based gender inclusive participation in health governance, including during a public health crisis. Despite numerous global and national commitments, women's input has been largely absent from COVID-19 decision making. A survey of 115 COVID-19 decision-making and expert task forces found that a mere 3.5% had gender parity in their membership while 85.2% had a majority of men.[60] Emergency public health measures, like lockdowns, have had unattended human rights consequences, including an increase in gender based violence (GBV).[61] Widespread measures taken to "shield" and protect older persons, persons with disabilities and others deemed to be at higher risk of death from COVID-19 have led to their increased social isolation, which is strongly associated with anxiety, depression, self-harm and suicide throughout the course of people's lives.[62]

These examples highlight the importance of ensuring that relevant decision-making processes provide effective and systematic opportunities for the participation of those that are most affected by resulting policies and measures, as prescribed by the CRPD and required by the Committee of Ministers Recommendation on the promotion of human rights of older persons.[63]

1.3.3 Progressive realisation and non-retrogression

Not all countries have the means to provide access to the highest-quality health care, and the right to health does not provide an immediate, universal entitlement to the best available health care system in the world.[64] Instead, states have committed themselves to realising the right to health for all in a progressive manner, including through the development of an effective health care system. As a result, economic constraints will affect the scope of the health and related social services that are offered by any given country, but there is a reasonable expectation that access to care and services will gradually become better and more inclusive, rather than the opposite. During a pandemic, states must therefore be particularly mindful of the impact that their choices will have on groups with heightened vulnerabilities and on other persons, including their families in particular, who shoulder the heaviest burden in the event of institutional shortcomings.[65]

1.3.4 Accountability and transparency

Accountability, as an ongoing process that is broader than judicial accountability, is a core human rights principle that underpins progress on inclusive and resilient health systems. Accountability mechanisms can play a key role in addressing discrimination and help drive forward the protection and implementation of the policy measures required to advance the right to health. As part of European efforts to advance right to health commitments, the 53 member states of the WHO European Region launched the European Health Equity Status Report (HESR) Initiative in 2019. It works to collect and analyse disaggregated data on health and the underlying determinants of health, which help to expose shortcomings and inform health and social policy processes.[66]

Unfortunately, health care systems have been and continue to be spaces where serious and irreversible human rights violations take place, including forced sterilisations or coercive practices in psychiatry, which must be eliminated.[67] It is crucial to establish full accountability in these cases in order to foster trust in the system and ensure that such practices are not repeated. European monitoring mechanisms, including the CPT, play an important role in drawing attention to human rights violations and offering ways to address them. In many countries, prisoners and refugees, asylum seekers and migrants continue to live in poor detention conditions in cramped, overcrowded cells with poor access to quality health services and high rates of infectious and chronic diseases, including tuberculosis, diabetes and HIV, highlighting the urgent need for increased attention to the health and human rights of detainees and relevant staff.[68]

Corruption is a substantial barrier to health care access. According to OECD estimates, 45 percent of global citizens believe that the health sector in their country is corrupt or very corrupt.[69] Corruption can take various forms, including unofficial payments to a health professional to avoid being placed on a long waiting list for an operation or simply a consultation. Low salaries for health professionals, combined with a lack of ethics training, non-transparent systems of financing by the national health system and underfunded clinics, can create fertile ground for bribery,[70] contributing to inequality in access to health care adversely affecting those who lack sufficient means and potentially having a different impact on men and women.[71] Research suggests that countries with high levels of corruption are less able to provide health care for their citizens and are least equipped to handle crises.[72] The COVID-19 crisis has particularly increased corruption risks in the health sector, owing to surges in the immediate need for medical supplies and the simplification of procurement rules, overcrowded medical facilities and overburdened medical staff. The Council of Europe's Group of States against Corruption (GRECO) has published guidelines addressed to

its 50 member states to help prevent corruption in the context of the health emergency.[73]

Overall, COVID-19 has highlighted the importance of transparent decision making and accountability in numerous areas that have impacted on health and society, from lockdown measures to public spending. Older people have suffered disproportionately during the COVID-19 crisis and accountability for the consequences of the failure to fulfil the positive obligations related to protecting the right to health and life of older persons and care facility workers is being pursued through legal action in several countries including France, Italy and Spain.[74]

In addition, public procurement failings in numerous countries have underscored the importance of exercising oversight to ensure that legally mandated processes are followed.[75] While emergency-related adaptations to procurement processes may be necessary in some circumstances, they require close scrutiny to ensure lawfulness.[76]

Chapter 2
Key partners for co-operation

In their effort to ensure and promote access to the highest attainable standard of health for all, health authorities depend on close co-operation with important human rights bodies who raise awareness and trust in society, advise national authorities, ensure that measures are proportionate vis-à-vis their impact on other rights and provide low-threshold complaints avenues for individuals.

2.1 Civil Society

Civil society organisations (CSOs) play multiple key roles in ensuring that individuals and communities understand their rights and seek redress for human rights violations occurring within health systems.

CSOs advocate on behalf of individuals and help ensure that the interests of all affected groups are considered when health policies are being devised. Involving women's rights organisations which represent the views of survivors of gender-based violence, for instance, will help ensure that effective protective and preventive contingency measures are put in place and communicated widely ahead of further lockdown processes.[77] During the COVID-19 crisis, CSOs have continued to advocate for the rights of those whose voices often go unheard, like undocumented migrants.[78]

CSOs also assist individuals and groups, including those who are marginalised or disadvantaged, to ensure that their rights are respected, protected and fulfilled through judicial and other accountability processes. As representatives of directly affected groups who see the impacts of diverse rules and measures on the ground, members of civil society can also be drivers for inter-disciplinary research and outreach that can enhance the effectiveness and sustainability of health strategies.

In the United Kingdom, for example, CSOs have highlighted the disproportionate impact of COVID-19 on certain groups, including the government's handling of the situation of older persons in care homes.[79] Concerns from civil society also provided impetus for a parliamentary

inquiry into the impact of COVID-19 on the access of, among others, persons with disabilities to health care services.[80] As regards the latter group, it was revealed later that two thirds of COVID-19 deaths in the first half of March 2020 were persons with disabilities.

2.2 National Human Rights Structures (NHRSs)

NHRSs such as ombudsmen institutions, national human rights institutions, human rights commissions and equality bodies are essential in the protection and promotion of the right to health. As statutory and independent advocates of human rights and equality, they are key in ensuring human rights-compliant responses to health matters, including public health crises, and help ensure that comprehensive approaches towards human rights commitments drive the development of inclusive health care policies.

NHRSs can take an active role in assessing policies and budgets according to human rights standards, such as by engaging in human rights impact assessments and monitoring the implementation of health-related measures. As accessible, low-threshold human rights complaints bodies, they also help individuals in making their concerns heard and facilitate constructive dialogue between civil society and the relevant authorities working towards the attainment of better health outcomes for all. NHRSs also embed participation and accountability into the health policy process, including through formal co-operation with regional mechanisms , including ENHRI (European Network of European Human Rights Institutions).

NHRSs have denounced the discriminatory impacts of COVID-19 response measures and have called on governments to address structural inequalities and respect their human rights commitments towards all.[81] In the midst of the crisis, NHRSs in Europe have continued their important monitoring work and publicised the impacts on people's rights to health, housing, education, labour and social protection, giving advice to policymakers and informing the public about their rights.[82] The UK Equality and Human Rights Commission was explicitly acknowledged as a major contributor to the above-mentioned parliamentary inquiry into the unequal impact of the COVID-19 pandemic on certain groups.

Equality bodies have called for a continued focus on the human rights principles of equality and non-discrimination and the importance of protecting the human rights of disadvantaged and marginalised groups of people who have often been hit hardest by the crisis.[83] This work demonstrates that NHRSs can inform national and regional responses to COVID-19, building a bridge between national, regional and international

human rights protection systems. Member states should strengthen the effectiveness and independence of NHRSs in line with the European Commission against Racism and Intolerance (ECRI) General Policy Recommendation No. 2 on Equality Bodies, the updated Recommendation of the Committee of Ministers on the development of the Ombudsman institution, and the upcoming Recommendation on National Human Rights Institutions, so that they are empowered to perform their critical role in safeguarding a comprehensive approach to the right to health, including in times of crisis.[84] It is particularly important that national authorities consult NHRSs on policy and legislative developments related to the right to health and that they implement their recommendations promptly and thoroughly.

2.3 Parliaments

National parliaments enable the right to health through their legislative work and their provision of democratic oversight over government action. The European Parliament has not only issued reports and recommendations on diverse health-related topics but has also conducted several surveys on European citizens' opinions regarding measures taken in response to the health crisis.[85]

National parliaments work with CSOs and NHRSs to ensure that policy and programme development take rights commitments forward. Additionally, as part of their obligations under international and European human rights treaties, they are required to engage in periodic reporting on their progress. At European level the Parliamentary Assembly of the Council of Europe (PACE) plays an important and multi-faceted role in promoting rights by engaging in dialogue with international organisations, governments, national parliaments and civil society. Its wide-ranging powers include conducting investigations into human rights violations and drafting recommendations that help to set priorities across the Council of Europe region and beyond.[86]

Already in 2016, PACE adopted a Resolution on the handling of public health crises, calling on all stakeholders to co-operate closely to strengthen international emergency preparedness, with an empowered, well-governed and accountable WHO at its apex and efficient, equitable and resilient national health systems at its foundation.[87] PACE has been particularly active during the COVID-19 pandemic, highlighting the impact of the pandemic on a wide range of human rights and engaging with WHO to ensure that parliamentarians bring their skills and influence to the COVID-19 response.[88]

2.4 The Sustainable Development Goals (SDGs)

The SDG commitments link the Council of Europe and national parliaments to the broad range of global goals enshrined in the UN's 2030 Agenda on international co-operation and the realisation of social and economic rights for all.[89] The SDG Framework includes extensive multi-annual monitoring and accountability processes that transcend national frameworks and encourage international co-operation on cross-border challenges.

The third SDG, which is to ensure healthy lives and promote well-being for all at all ages, includes universal health coverage (UHC), considering it to be one of a number of inter-related and necessary components. The SDG monitoring framework, which all Council of Europe member states report on, helps to drive accountability for UHC by setting targets and indicators and establishing regular monitoring, evaluation and reporting.

Council of Europe member states reiterated their commitment towards achieving UHC in the 2019 UHC Declaration. This asserts that mental health and well-being are essential components of UHC and stresses the importance of strong and resilient health care systems as a prerequisite to reach all people and ensure pandemic preparedness.[90]

Chapter 3
Building inclusive and resilient health care systems for all

Realising the right to health for all requires the development of inclusive and resilient health care systems. Health care systems consist of "all public and private organisations, institutions and resources mandated to improve, restore or maintain health."[91] The essential components of good quality public health and health care systems are long defined, and comprise: high-quality health service delivery; a skilled health workforce; health financing; access to essential medicines and vaccines; health research and information systems; and leadership and good governance.[92] These six inter-connected constituent parts must function together within the political and institutional framework of a country to deliver a health care system that is effective, inclusive and resilient.

3.1 High-quality health service delivery

A health system should deliver affordable, accessible, high-quality health services to all, where and when needed.

Access to care is a key aspect of the fundamental right to health. Yet, inequalities in access to health care are growing in the Council of Europe member states due to financial, geographical and language barriers, corruption, socio-economic inequalities, certain migration and security policies, and the economic crisis of 2008 and ensuing austerity measures, which had repercussions on health systems.[93] Despite extensive efforts to promote universal health coverage, health inequities among groups of people remain either the same or have worsened over the past ten to fifteen years in many of the 53 countries in the WHO EURO region.[94]

3.1.1 Affordability

Universal health coverage signifies that the entire population is covered for a comprehensive range of health care benefits.

Gaps in public health care coverage or differences in benefits lead to

out-of-pocket payments and result in affordability problems for some. These inequalities lead to a phenomenon of non-recourse or delayed recourse to care which can have disastrous implications for both individual and public health and lead in the long term to an increase in health expenditure. In many states, mental health care, family-planning services or dental care are excluded from universal health packages. Out-of-pocket payments also have a gendered impact on men's prevention and treatment-seeking behaviours as evidence shows a strong correlation between a higher level of payments for health services and men's premature mortality from cardio-vascular diseases.[95] In countries where financial protection is relatively weak, unforeseen health spending is mainly driven by out-of-pocket payments for outpatient medicines. This undermines equity because the health financing structure shifts costs to poor people and regular users of health care, including people with chronic health conditions.[96] User fees also encourage inefficient use of health services as people delay preventive and promotive care.

States should therefore strive to ensure that the range of services offered by various health providers is comparable for all people, including a mix of hospital care, outpatient primary and specialist care, and pharmaceutical products. As the European population ages and chronic diseases have increased, new and more expensive treatments have become necessary. Expanding primary health care ensures that care is delivered in the community and at an early stage, helping to provide affordable, comprehensive and continuous care to all individuals throughout their lives, from prevention and treatment to rehabilitation and palliative care.[97]

3.1.2 Accessibility

The geographic isolation of many regions and the spatial and housing segregation affecting some groups, including the Roma population, can undermine the accessibility of physical and mental health care services. For persons with reduced mobility, health centres and hospitals must have functioning elevators or ramps to allow for equal access.

In meeting their obligations under the CRPD, Council of Europe member states must take steps to ensure that people with disabilities have access to a full range of community support services.[98] Across Europe, too many states continue to rely on long-term residential care institutions to house persons with disabilities. The lack of access to a range of appropriate care options, including care in the community, is unacceptable and a long-standing violation of human rights and international law as enshrined in Article 19 of the CRPD, including the obligation to provide for "the equal right of all persons with disabilities to live in the community, with choices equal to others."

The COVID-19 pandemic has exposed and magnified the existing biases that act as health care access barriers for persons with disabilities who are placed in institutions.[99] For example, persons with disabilities in Romania who contracted COVID-19 in institutional settings were quarantined instead of being hospitalised, which was not the case for those without disabilities.[100] Human rights violations like these have highlighted the importance of ending long-term institutional care and increasing investment in community-based services.[101]

Many persons with disabilities enjoy healthy lives and having a disability does not by itself put someone at higher risk of contracting or dying from COVID-19. But many have specific underlying conditions that increase the risk of COVID-19 being more dangerous for them. During the COVID-19 crisis, legal, social, economic and environmental constraints have undermined the dignity and human rights of persons with disabilities and have prevented them from accessing high-quality preventive services and curative care. These obstacles expose them to a greater risk of contracting COVID-19, resulting in direct discrimination and a violation of the right to health and potentially the right to life.[102] The COVID-19 pandemic should be a lesson to all of us that these standards are not just aspirational ideals: failure to implement them leads to suffering and loss of life, which could and should have been avoided or alleviated.[103]

Undue waiting times for preventive health services also present barriers to accessibility of health care and contribute to health inequity in Europe.[104] COVID-19 has further exacerbated the situation of premature and increased mortality and morbidity due to foregone, delayed or interrupted treatment for diseases such as cancer and diabetes, as well as disruption to preventive screening services.[105]

The ECSR has underlined that it is contrary to the Charter for any "legislation or practice" to deny entitlement to medical assistance to foreign nationals within the territory of a State Party, "even if they are there illegally".[106] Non-nationals, especially if undocumented, are at greater risk of contracting infectious diseases due to multiple intersecting risk factors, including lack of access to housing and preventive health care and poor nutrition.[107] During the COVID-19 crisis some states have taken positive measures to guarantee human rights, including health rights, to all.[108]

3.1.3 High-quality care

A 2018 WHO review of adults with psychosocial and intellectual disabilities living in institutions in the European region found regular deficiencies with regard to human rights commitments at national, regional and global levels.[109] For example, the individual autonomy of residents in some

institutions was not respected and deficiencies in other key health-system building blocks, including health information, essential medicines and staffing, also undermined the accessibility, availability and quality of health care.[110] Residents were poorly informed of their treatment options and were not able to challenge decisions. The study also found that essential psychotropic medication had run out in numerous facilities and that shortages of staff, including mental health professionals, were affecting quality of care. A CPT report of December 2020 found that the persistent lack of adequately trained staff in psychiatric and social care institutions in a member state had led to regular ill-treatment of patients and the misuse of restraint mechanisms.[111]

The dangerous increase in long-term care for older persons in Europe must also be addressed as a priority.[112] It runs counter to the quality requirement of devising health and social systems that are people-centred and life-cycle sensitive. In April 2020, WHO Europe reported on the large number of deaths in long-term care facilities, in particular those for older persons.[113] The continued neglect of the situation and a lack of preparedness within the long-term care sector has contributed to older persons suffering more deaths during the COVID-19 pandemic than any other group.[114]

Adequate access to pain relief treatment is crucial to high-quality health care. Despite the existence of inexpensive and effective pain relief medicines, tens of millions of people in the world continue to suffer from moderate to severe pain each year without treatment owing to a variety of reasons, including failure to set up functioning drug supply systems or policies on pain treatment and palliative care, poor training of healthcare workers, unnecessarily restrictive drug control regulations and practices, and the inflated cost of pain treatment.[115]

The COVID-19 pandemic has had a marked impact on respect for and access to sexual and reproductive health rights (SRHR) and services, which are an essential component of women's human rights and help to foster gender equality.[116] Several states have prevented women from having a companion of their choice attend childbirth, thus denying women their rights at this time, while other states have been able to develop new approaches that respect women's rights while maintaining COVID-19 safety protocols, demonstrating that the pandemic can provide opportunities for innovation that improve access to health services, thereby enhancing resilience.[117]

3.2 Skilled health workforce

Council of Europe member states have committed themselves to ensuring the availability of a well-financed skilled workforce, including health service providers and health management and support workers in both the public and private sector. Health workers are key to strengthening people-centred health systems, increasing public health capacity and ensuring emergency preparedness, surveillance and response.[118]

Despite these workforce-related commitments, continued under-investment and undervaluing of the health workforce have undermined the capacity of health service delivery, leaving some countries ill-equipped to deal with the spike in demand for health care driven by COVID-19 because of factors including the resulting "brain-drain" of qualified staff in some Council of Europe member states and an over-reliance on migrant workers in others. Respect for the rights of every worker to a safe and healthy working environment applies to the public and private sector and remains a fundamental right also during a health emergency. The COVID-19 pandemic has exposed health and social workers to diverse work safety challenges including shortages in the personal protective equipment (PPE) that is vital to prevent the virus from spreading to and from health and social care workers. Especially during the first months of the pandemic, people living in psychiatric institutions and their care-givers were exposed to major shortages of PPE and masks, increasing their health risks.[119] These PPE shortages also exposed persons with disabilities and their personal assistants to increased health risks.

Attention to and investment in salaries and training to ensure the necessary skills-mix and supply of health workers is crucial. While there is no standard for the optimal composition of a health workforce, employment in the health and care workforce has become unattractive in many Council of Europe member states due to disproportionately low wages, long working hours and insufficient efforts to reduce stress and improve work-life balance. Health workforce shortages have threatened workplace safety as the necessary quarantining of health workers exposed to COVID-19 has placed even more pressure on qualified health staff. Responding to the extreme demands of the COVID-19 crisis within the context of existing shortages of staff and resources or routinely operating at maximum capacity will exacerbate existing gaps in access to care and undermine the quality of the response.[120]

The extra workload and high death toll from COVID-19 has placed an enormous strain on the physical and mental health of health and social workers. Some states have provided emotional, financial and practical support to protect health workers' mental health and wellbeing and

enable them to do their job during the crisis.[121] For example, Armenia, Latvia and North Macedonia have paid bonuses to health care workers and many countries have expanded child care options. The recognition of their vital role highlights the need for ongoing respect for their important contribution through commensurate pay and continued investment to ensure robust staffing levels. The issue of labour segregation and the over-representation of women in low-paid care jobs must also be addressed.[122]

The challenges posed by COVID-19 provide an opportunity for innovation and the transformation of medical, health and social care curricula. Improvements and reforms should be pursued in consultation with a broad range of health workforce representatives. An increase in the use of innovative digital or telehealth solutions could help to address some of the health systems' capacity issues, such as workforce shortages, which have affected the availability of quality primary and preventive care, including antenatal care. Germany and Italy have adjusted their maternal health care provision, including scaling up the use of telehealth where possible, and increasing the quantity and scope of co-ordination meetings to share information.[123]

Across Europe, persons belonging to minority groups, including LGBTI persons, persons with disabilities, Roma, migrants and sex workers have reported discriminatory, negative attitudes when accessing health services, resulting in significantly diminished health outcomes.[124] This may be due to social stigma based on bias and prejudice among health care workers and is often due to insufficient training and knowledge among health staff. Human rights and non-discrimination education should be included in medical and health care curricula, as should discussion of LGBTI issues. Such material should be developed in consultation with workforce representatives and those from concerned groups. Changes to medical curricula and health workforce training and awareness raising can help health workers to be sensitive to and respectful of difference. It is essential that LGBTI identities are not pathologised or their bodies medicalised by members of the health workforce.[125]

3.3 Health financing

Without proper and accountable fund allocation, health systems will not meet individual and collective health needs. Council of Europe member states finance and organise their public health care systems in different ways. No matter the system, all states have committed to advancing UHC through a health financing system that funds quality health care for all.[126] This commitment requires that sufficient public funding, drawn from general taxation and/or compulsory health insurance contributions, is

allocated to the health system to meet the health needs of the population.

The right to health applies regardless as to whether a health care system is publicly or privately financed.[127] Most states have a mix of publicly funded statutory health insurance schemes and private health insurance. Yet, private provision of health services does not change the state's role as the ultimate guarantor of the right to health for all. While private health insurance schemes play a different role in each country's system and have been shown to expand individual choice, they have also been shown to contribute to unequal access and fail to contain costs or increase efficiency.[128] States must adopt solid regulatory frameworks and effective monitoring of private insurance schemes to detect and eliminate exclusionary practices such as only enrolling wealthy, low-risk individuals, which may lead to health equality gaps. To protect the right to health, states must ensure through appropriate regulatory and enforcement measures that both private and public health care and insurance providers facilitate access to quality health care on a non-discriminatory basis.

Following the 2008 financial crisis, many European states enacted austerity measures, reducing public health financing, which contributed to gaps in health service coverage.[129] Clear evidence exists that budget reductions in primary care and public health spending adversely affect health outcomes, including life expectancy.[130]

Austerity-related measures, like the introduction of user payments for basic services, have undermined primary health care in many member states, and weakened the foundations of health care systems.[131] In Spain, for instance, austerity measures which had been widely opposed by health professionals were reported to have led to increases in malnutrition and mental health issues, and in a perceived deterioration in the quality of care and outcomes.[132] Austerity strongly affects inclusivity, hitting the marginalised and vulnerable hardest, with those on lower or fixed incomes, including older persons, children and persons with disabilities, suffering the most. In Sweden, austerity measures, including reductions in government services and tax cuts, are associated with the high percentage (45%) of COVID-19 related deaths of older persons in residential facilities and the lack of intensive care units during the first half of 2020.[133] Short-term cost savings such as reducing the number of staff or stock of medicines and PPE may have important long-term consequences on health systems' resilience. Sustained and long-term public investment in the various components of the health system, including the work force, is crucial for health systems' inclusivity.[134]

Collecting disaggregated data on the impact of health financing will allow countries to identify how and where funding and investment decisions

can be used to lessen gaps in health service accessibility. Health ministries need to work with health economists to identify the investment needs for inclusive, efficient and effective health systems to close health equity gaps and increase the resilience of health care systems in the mid- to long-term. In the aftermath of the pandemic we should not repeat the mistakes of the previous economic crisis by reducing health system capacity.

3.4 Access to essential medicines and vaccines

Providing access to essential medicines for all is a core obligation under the right to health and should form part of national UHC packages. The pharmaceutical industry has played an indisputable role in this context by investing massively in research and development for new medicines. While it remains a key player in the health field, concerns have been expressed in recent years as to the significant upsurge in the price of medicines, resulting in particularly exorbitant prices for cancer and hepatitis C treatments.[135] As a result, public health systems are faced with constant cost increases in this area, jeopardising their ability to fulfil their role. In order to ensure the viability of health systems and the accessibility of affordable and innovative medicines in the long term, member states should strengthen their co-operation with and support for WHO in its efforts to increase transparency in terms of the real costs of pharmaceutical research and development, and to put forward alternatives to the patent-based pharmaceutical innovation and production models.

To provide access to quality medicines for all, medical research should also be gender inclusive. In the past, women were excluded from most clinical pharmaceutical trials because of the perception of potential risks related to childbearing. Consequently, most drugs currently in use were approved based on clinical trials conducted on men.[136] The European Institute for Gender Equality is pushing for greater investment in medical research and health services that address the impact of both sex and gender on differences in the health of women and men.[137] Some member states still set a minimum age for entitlement to certain medicines, including hormone therapy for transgender people.[138]

The COVID-19 crisis has revealed the importance of protecting supply chains for essential medical goods, including medicines and equipment. In the early months of the pandemic, shortages of key health supplies, including diagnostic tests and ventilators, contributed to unnecessary deaths in many countries. As viral pandemics take hold in a population, variants occur as part of the virus' evolution creating further strain on the health system. Stopping transmission, through testing and vaccines, blocks the opportunity for viral mutation.[139] Disruptions in supply chains have

also resulted in shortages of other essential medicines and treatments and prevented women from accessing sexual and reproductive health rights, including emergency contraception.[140] Interruptions in healthcare for transgender and intersex people have also been reported.[141]

The roll-out of the COVID-19 vaccine across Europe raises ethical and logistical issues that will test the inclusivity and resilience of health systems. Ethical discussions about which groups of people are prioritised for the vaccine must be transparent and inclusive.[142] Strategies should be put in place to avoid inequalities in access due to logistical and administrative barriers, such as fees for vaccinations and risks of manipulations of the system. These strategies should further be adapted to the needs of persons who are systematically disadvantaged in accessing healthcare. Effective distribution planning also requires engagement with numerous non-health sector partners and cross-border co-operation to ensure fair and equitable vaccine distribution at global level, which is an essential prerequisite for recovery. Reports of "vaccine nationalism", in which wealthier states secure the available vaccine stock, leaving others unable to vaccinate even their most vulnerable populations, are deeply alarming.[143] Initiatives aimed at the creation of global risk-sharing mechanisms for pooled procurement and equitable distribution of COVID-19 vaccines should be supported as they ensure fair access for all countries, rich or poor, to effective immunisation.[144]

3.5 Health research, information and communication

A well-functioning health research and information system is vital to ensuring that health authorities and other stakeholders have up-to-date information with which to assess their policies and improve the performance of the health care system. Systems for monitoring and collection of disaggregated data on health should be designed to be forward-looking and help identify emerging gaps or relevant shifts in demography. The impact of ageing on demand and access to health care services, for instance, will be an increasingly important challenge across Europe requiring excellent, inter-disciplinary health research and data.[145]

Monitoring the availability of different health services is also vital where it comes to identifying access and coverage problems. It should cover data such as the percentage of the population facing limits on access to health care due to distance and transportation issues or the availability of education materials in culturally diverse and accessible formats. It should also include tracking of waiting times for preventive, promotive or curative services.[146] States should collect data, in line with European data protection safeguards, relating to multiple stratifiers, including age, gender, sexual orientation, gender identity and sex characteristics, disability, geographic

location and socio-economic background, and conduct qualitative surveys to understand coverage gaps and health workforce shortages. Health research and information systems also play a vital role in emergency preparedness planning. Sustained investments in health research and information should help to ensure that Council of Europe member states are better prepared for future health emergencies. It is also necessary to widely share the benefits of scientific research to ensure that emerging treatment options to non-communicable diseases become globally accessible.

COVID-19 has highlighted the importance of building trust in scientific research and public policy through well-conceived, adaptable health communication policies that ensure that new scientific knowledge is communicated rapidly, transparently and accurately in accessible formats.[147] Especially in crisis situations, when public outreach is vital, restrictions on free access to information or a tendency to dwell on past mistakes or remaining uncertainties or issue broad and unsubstantiated warnings instead of allaying public concerns are more likely to erode trust and solidarity, thus undermining the efficiency of crisis-response measures. The COVID-19 “infodemic” has demonstrated that transparent communication is crucial for the public to understand the situation, make informed decisions, recognise disinformation and limit rumours. In a joint statement, UN institutions have called on "member states to engage and listen to their communities" as they develop their national action plans and to "empower communities to" develop solutions and resilience against mis- and disinformation.[148]

In the same vein, the impact of preventive public health programmes such as mass cancer screening or childhood vaccination campaigns is undermined if health communication and education are not prioritised.[149] Teaching health literacy in schools, through accessible and age-appropriate formats, also helps to raise public awareness about the importance of health promotion activities, leading to empowerment in health decision making from an early age on.

Accessing life-saving information on COVID-19 has been a challenge for some persons with disabilities.[150] States need to ensure that information is developed rapidly for all, including in sign language, braille and easy-to-read versions. Countries should also ensure that health information is made readily available in regional and minority languages so that the entire population is informed promptly and helped to adopt the appropriate promotive and preventive measures.[151]

3.6 Leadership and good governance

The COVID-19 pandemic has demonstrated powerfully the importance of effective governance. In their analysis of the most important lessons to be learnt for health system resilience from the pandemic, experts have pointed out that leadership and good governance are central.[152] Local and regional authorities in particular have been on the front line in containing the spread of COVID-19 and mitigating the impact of the pandemic on society.

Good governance and leadership are integral to all the other building blocks of health systems, including the wide-ranging processes by which states deliver on their legal and policy commitments. While the strategic use of health information and research is a core element of the leadership and governance function, effective governance also involves engagement with and regulation of private sector stakeholders, both profit and non-profit. In most countries, the Ministry of Health has the regulatory and leadership role for health sector governance, which may be shared with other national ministries and local government at decentralised levels.

An inclusive and resilient health care system, which builds on universal coverage and reaches disadvantaged people, is ready to respond effectively to public health emergencies. Emergency preparedness requires inbuilt governance mechanisms that support a continuous process of planning, implementing, monitoring and revising national and sub-national pandemic preparedness and response plans. Systems that are prepared can cope better with sudden upsurges in demand, thus saving lives and potentially lessening the collateral impact on society.[153]

Strong leadership is also required to withstand the pressure to cut emergency preparedness funding during economic crises. In the 2019 UHC Declaration, political leaders undertook to "enhance emergency health preparedness and response systems, as well as strengthen capacities at national, regional and international levels, including to mitigate the impacts of climate change and natural disasters on health".[154]

Solidarity and co-operation are key features of good governance. Global solidarity has been driving research efforts for a COVID-19 vaccine and it will be especially important to ensure continued funding and distribution throughout the world. The support of Council of Europe member states for efforts to manufacture, purchase and distribute vaccines globally will be a good indicator of European commitment towards global solidarity and a recognition of the fact that the vaccine must be available everywhere for everyone to be safe.[155]

Lastly, good governance requires a "Health in All Polices" approach to public policy, grounded in holistic, rights-based approaches. While restrictive

measures have affected everyone's enjoyment of human rights, the rights of some groups of people, including persons with disabilities, older persons, children and migrants, have proven to be much more vulnerable to the impact of COVID-19-related lock-down measures.[156] The accumulation of the social, economic and health consequences of lockdown measures have compelled governments to think carefully about more targeted responses, through which some restrictions can be relaxed without allowing infections to grow exponentially. The prolonged closure of schools, for instance, has been shown to lead to undue social and economic costs in the short-, mid- and long-term.[157] In addition to learning from the past, good governance requires us to look forward and do more to address the currently known health risks. This includes identifying and fighting climate change as a driver of emerging health threats, enhancing international co-ordination at regional and international level in support of a "One Health" approach, and strengthening multilateral leadership.[158]

Chapter 4

The essential social determinants of health

In addition to the presence of inclusive and resilient health care systems, extensive research has identified four social determinants that are essential for creating and sustaining suitable conditions for the right to health for all: income security and social protection; adequate living conditions; education; and decent labour and employment conditions. These underlying conditions are interdependent and must be addressed comprehensively to contribute to inclusive and resilient health care systems and good individual and population-level health outcomes. The social determinants discussed below are often exacerbated by existing stigmatisation and discrimination, making certain groups particularly vulnerable, including Roma, LGBTI people, older persons, migrants and others.

4.1 Income security and social protection

Income security and social protection gaps are the main problem most associated with health equity gaps in the WHO EURO region. 35-46% of self-reported health inequities in health, mental health and life satisfaction relate back to them.[159] The correlation between low income levels and poor health has been long established, with evidence making it clear that concerted efforts in the social security sphere are required to improve health outcomes for all.[160] The 1990 revised European Code of Social Security commits states to making progress in many aspects of social protection, including pensions, unemployment and invalidity benefits.[161]

Insecurity and lack of control over income have powerful effects on health. The lower people are in the social hierarchy of industrialised nations, the more common are continued anxiety and stress, which can lead to poor health and premature death.[162] While average life expectancy across the WHO European region of 52 countries has increased overall, significant health inequities remain between social groups, with women's life

expectancy reduced by 7 years and men's by up to 15 years if they find themselves among the most socio-economically disadvantaged groups. It is also deeply worrying that health gaps between socio-economic groups increase with age.[163] Alarmingly, the COVID-19 pandemic has demonstrated a direct link between poverty and increased mortality as a result of the infection.[164]

Over the past two decades, many workers have seen their employment conditions deteriorate, often with insufficient social protection guarantees. The increase in insecure contracts, such as zero hour contracts, and employment policies that encourage the replacement of employee contracts with bogus self-employment contracts are two developments that have increased economic insecurity, contrary to the objectives of the European Social Charter and the European Code of Social Security.[165] The COVID-19 crisis has highlighted the consequences of these measures in many countries and serves as a wake-up call for Council of Europe member states to ratify European instruments in the fields of social rights and social security, such as the revised Charter, its collective complaints procedure and the European Code of Social Security.

It is also vital to understand and address the gendered dimension of income security and social protection to improve health outcomes for all, throughout people's lives. Both the gender pay-gap and the fact that women are more likely to work part-time and in less-economically valued sectors like primary education and care professions, contribute to a gender pension gap and income insecurity and poverty in later life. The ECSR has found violations of the right to equal pay and the right to equal opportunities in the workplace in 14 out of 15 countries applying the European Social Charter's collective complaints procedure, demonstrating the potential of this mechanism where it comes to promoting social rights, including the right to health.[166]

4.2 Living conditions

Living conditions, which include housing provision, fuel deprivation, environmental conditions, such as water and air quality or access to green spaces, and unsafe neighbourhoods, are associated with between 22 and 30% of health inequities identified in self-reported health, mental health and life satisfaction data.[167] The Commissioner for Human Rights has highlighted the importance of housing, including the need for long-term solutions for homeless people, as a key means of promoting the right to health.[168]

Research shows that poor housing and indoor environments cause or contribute to many preventable diseases and injuries, such as respiratory, nervous system and cardiovascular diseases and cancer. A degraded urban environment, with air and noise pollution and lack of mobility options, also poses health risks. A French study showed that disproportionately high coronavirus infection rates in certain neighbourhoods were mainly the result of crowded and substandard housing situations, where it is often impossible to implement sanitary measures properly due to a lack of clean water and sanitation.[169] The impact of the COVID-19 crisis on incomes has further exacerbated the affordable housing problem in many countries, thus highlighting the need for fresh thinking in this area and further efforts to honour commitments under Article 31 of the European Social Charter guaranteeing the right to housing, which is integral to delivering the right to health. WHO's health equity status report of 2019 argued that the most cost-effective means of closing the health divide is increased investment in housing and community amenities.[170]

Across Europe, feeling unsafe in one's neighbourhood and fear of crime or violence contribute to mental health problems, especially among women.[171] There is also growing evidence that hazardous environments have a direct detrimental effect on human health, with some estimates finding that the environment accounts for almost 20% of all deaths in the WHO European Region.[172] More than 9 out of 10 people worldwide breathe polluted air, which contributes to a third of all deaths by stroke, cardiovascular and respiratory diseases. The European Environment Agency estimates that polluted air causes almost half a million premature deaths each year in the European Union alone, and WHO says it decreases every European's life expectancy by almost an entire year.[173]

Human health is therefore intimately linked to the state of the natural environment. The sustainable and urgent protection of the ecosystems which underpin human, animal and environmental health is a key worldwide challenge, which Europe should play a leading role in addressing, through steps including support for UN efforts to advance formal recognition of the human right to a healthy environment,[174] participation in the UN Framework Convention on Climate Change process, and ratification of the Aarhus Convention on Access to Information, Public Participation in Decision-Making and Access to Justice in Environmental Matters, which is the first international treaty to recognise "the right of every person of present and future generations to live in an environment adequate to his or her health and being". Within Europe and beyond, the human rights and health rights of the marginalised are disproportionately affected by environmental degradation and the climate emergency. Addressing these problems requires European and global co-operation.

4.3 Education

Even in places where health care is guaranteed, people with limited education tend to be sicker. Higher education is more likely to lead to health-promoting benefits such as higher wages, paid leave and early retirement options, while people with less education are more likely to work in high-risk occupations with fewer benefits. This means that building genuinely inclusive education systems to guarantee the right of all children to education without discrimination is also an important health-enhancing measure. The Commissioner for Human Rights has called for urgent steps to end school segregation in all its forms, which continues to particularly affect Roma children, children with disabilities, children with a migrant background and other children encountering problems because of their social or personal circumstances (such as children living in institutions and children in the juvenile justice system).[175]

Research shows that building social and human capital through education, social cohesion and trust empowers individuals and communities to increase control over life and health.[176] Education in particular has been shown to offer positive lifelong health effects, not only through increased employment opportunities and income but also through better living conditions, confidence levels and literacy, including health literacy.[177] Life-long learning is also of great value, with research showing that adult learning can have positive effects on life satisfaction, mental health and changes in health-supporting behaviour such as giving up smoking, adopting active lifestyles and healthy eating. The Commissioner for Human Rights has highlighted the importance of comprehensive sexuality education for all children, especially girls.[178]

A health-related programme in Greece focusing on the improvement of Roma social inclusion offers an example of how otherwise marginalised communities can be empowered by using education as an innovative approach to improving health.[179] It included Roma mediators who had expert knowledge of Romani language and culture and who worked closely with Roma communities, alerting them to the significance of health promotion, preventive care and vaccination.

Recent research suggests that the COVID-19 pandemic is having particularly adverse implications for the mental health of children and adolescents, due chiefly to the experience of disruption from their daily routine and social support structures as a result of school closures.[180]

4.4 Employment and working conditions

Employment has clear social, psychological and financial benefits which improve health. Beyond the material and status-related rewards, paid work also influences individuals' social integration, prestige and sense of meaning. For men, long-term unemployment is a predictor of more frequent heavy drinking. This gendered impact of unemployment also contributes to men having an increased risk of cardio-vascular disease and engaging in behaviours which contribute to health risks, such as accidents, crime, and violence. Overall, persons with disabilities have much lower levels of employment than the general population across Europe owing to multiple obstacles to participation in the labour market, including lack of accessibility, prejudice regarding their competence, discrimination and the unwillingness of employers to make reasonable accommodation in the workplace.[181]

An important issue from the health perspective is not only whether a person is employed or unemployed and what their contractual circumstances are, but also the working conditions themselves. Workers may be exposed to potentially health-harming physical and psychosocial stressors, including exploitative or dangerous conditions, the key factor being excessive working hours.[182] These can cause occupational diseases or exacerbate other health problems.

Health and social care workers, cleaners, agricultural workers, those employed in food production factories and many others have been providing essential services during the COVID-19 pandemic and been exposed to significant risks to themselves and their families. Implementing adequate health and safety measures in these sectors and promoting supportive working environments is key to ensuring the health and well-being of workers and to helping them cope in these challenging times.

Sex workers face significant risks of physical and sexual violence and crime along with extortion and coercive police measures. Despite their increased health care needs, they are confronted with important obstacles to securing their right to health due to stigma and marginalisation.[183] Protecting workers is particularly challenging with respect to non-standard forms of employment and in the informal economy, where adequate labour and social protection are often missing. In addition, many of these precarious workers are young or come from groups facing multiple layers of discrimination and stigma at work and in society, such as migrants.[184]

The COVID-19 crisis has disproportionately affected women's employment and working conditions. Not only do women make up the majority of health and social care professionals and vendors, but women and girls have

also taken on extra, unpaid work at home, including care for school-age children and older and sick family members. It is vitally important that the possible longer-term effects of the pandemic on women's working lives is addressed in post-COVID-19 planning.

Endnotes

1. The official name of the virus as agreed by the International Committee on Taxonomy of Virus is severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2).
2. As per the statistics provided by the Johns Hopkins Corona Research Centre.
3. See the thematic page of the Office of the Commissioner for Human Rights, particularly the Human Rights Comment "Learning from the pandemic to better fulfil the right to health".
4. The World Health Organisation (WHO) defines health inequities as systematic inequalities in the health status of different population groups which can be addressed through the right mix of government policies. See 10 Facts on Health Inequities and Their Causes, February 2017.
5. WHO "Healthy, Prosperous lives for all: the European Health Equity Status Report", 2019.
6. Abrams, E., and Szeflerhe, S. "COVID-19 and the impact of social determinants of health", May 2020.
7. Abimbola S, Topp SM. "Adaptation with robustness: the case for clarity on the use of "resilience" in health systems and global health", February 2018.
8. See Commissioner for Human Rights, Statement "Lessons to be drawn from the ravages of the COVID-19 pandemic in long-term care facilities", May 2020.
9. See Article 19 of the CRPD adopted by the United Nations General Assembly on 24 January, 2006.
10. See Resolution 2329 (2020) of the Parliamentary Assembly of the Council of Europe (PACE), "Lessons for the future for an effective and rights-based response to the COVID-19 pandemic", June 2020.
11. WHO developed the six building blocks of a health care system which serve as a useful framework for their evaluation and assessment, January 2007.
12. Hanefeld, J., Reeves, A., Brown, C., Östlin, P. "Achieving health equity: democracy matters", November 2019.
13. Several Council of Europe member states submitted notifications of derogation from the European Convention on Human Rights.
14. The European Centre for Economic and Policy Analysis and Affairs. "The Impact of Covid-19 on Schools in Europe", June 2020
15. WHO Bulletin, Kutzin, J. and Sparkes, S., "Health systems strengthening, universal health coverage, health security and resilience", 2016.
16. See Endnote 7.
17. See Council of Europe, Statement by the Secretary General and "A Council of contribution to support member states in addressing health care issues in the context of the present public health crisis and beyond", 17 September 2020.
18. See WHO Constitution. All Council of Europe member states are members of the WHO, 1946.

19. See Universal Declaration of Human Rights, 1948.
20. Article 12-2(c) of the ICESCR stipulates that states should take steps necessary for "the prevention, treatment and control of epidemic, endemic, occupational and other diseases".
21. UN Committee on Economic, Social and Cultural Rights, "General Comment No. 14: The Right to the Highest Attainable Standard of Health", August 2000.
22. WHO and Office of the United Nations High Commissioner for Human Rights (OHCHR). Factsheet on the right to health, June 2008.
23. General Comment 14 states that "core obligations" under the right to health include at least: 1. Ensuring non-discriminatory access to health facilities, goods and services, especially for vulnerable or marginalised people, 2. Ensuring access to food, basic shelter, housing, sanitation and water, 3. Providing essential drugs as defined by WHO, 4. Ensuring equitable distribution of all health facilities, goods and services, 5. Adopting a national public health strategy and plan of action on the basis of epidemiological evidence addressing the health concerns of the whole population. See Endnote 21.
24. According to the General Comment, "a State party cannot, under any circumstances whatsoever, justify its non-compliance with the core obligations". See Endnote 21.
25. See, for instance, the Fourth Special Report on the public inquiry into the Government's response to the Covid-19 pandemic launched in the UK, November 2020, and the first investigative COVID-19 Commission being launched in the Lombardy region of Italy, October 2020. A Parliamentary Commission of inquiry into the coronavirus crisis was also established in France in June 2020.
26. See Article 12 of the 1979 Convention on the Elimination of all Forms of Discrimination against Women (CEDAW), Article 24 of the 1989 Convention on the Rights of the Child (CRC), and Articles 25, 26 and 4.3 of the 2007 Convention on the Right of Persons with Disabilities (CRPD).
27. Global public health security is defined "as the activities required, both proactive and reactive, to minimise the danger and impact of acute public health events that endanger people's health across geographical regions and international boundaries." See WHO, July 2007.
28. On 30 January 2020, WHO declared the novel coronavirus outbreak a public health emergency of international concern (PHEIC), WHO's highest level of alarm, requiring all states to respond in eight core capacities: 1. National legislation, policy and financing. 2. Coordination and national focal point communications. 3. Surveillance. 4. Response. 5. Preparedness 6. Risk communication 7. Human resources 8. Laboratory.
29. European Court of Human Rights. Factsheet on health, October 2020.
30. Article 35 of the Charter of Fundamental Rights establishes: "Everyone has the right of access to preventive health care and the right to benefit from medical treatment under the conditions established by national laws and practices. A high level of human health protection shall be ensured in the definition and implementation of all Union policies and activities".
31. See Communication establishing a European Pillar of Social Rights of 26 April 2017. Domain 16 on health proclaims that "Everyone has the right to timely access to affordable, preventative and curative health care of good quality".
32. See Council of Europe European Social Charter (ETS 035) and Council of Europe European Social Charter (Revised) (ETS 163).
33. See the Digest of Conclusions and Decisions of the ECSR, December 2018.
34. See the Statement of interpretation on the protection of the right to health in times of pandemic, adopted by the ECSR on 22 April 2020.

35. See Additional Protocol to the European Social Charter Providing for a System of Collective Complaints (ETS 158).
36. See Complaints Nos. 173/2018 (International Commission of Jurists (ICJ) and European Council for Refugees and Exiles (ECRE) v. Greece), 185/2019 (European Roma Rights Centre (ERRC) v. Belgium) and 195/2020 (European Roma Rights Centre (ERRC) v. Belgium).
37. Council of Europe European Convention for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (ETS 126).
38. The Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment, Statement of Principles relating to the treatment of persons deprived of their liberty in the context of the coronavirus disease (COVID-19) pandemic, 2020.
39. ECSR Press briefing elements conclusions 2013/xx-2 Statement of Interpretation of Article 13, 2013.
40. See Council of Europe European Code of Social Security, ETS No. 139, 1990.
41. See Council of Europe Convention on Human Rights and Biomedicine, ETS No. 164, 1997.
42. Council of Europe, European Social Charter (Revised), ETS 163, 1996.
43. See ECSR Statement of interpretation on the right to protection of health in times of pandemic, April 2020.
44. See Human Rights Comment "Learning from the pandemic to better fulfil the right to health", 23 April 2020.
45. See European Union Agency for Fundamental Rights and the Council of Europe, Handbook on European non-discrimination law, 2018.
46. Perceived discrimination is when respondents report that they were treated in a way that made them feel humiliated, due to ethnicity/race, religion, gender, sexual orientation, age or disability. See Rivenbark, J.G., Ichou, M. "Discrimination in health care as a barrier to care: experiences of socially disadvantaged populations in France from a nationally representative survey", 2020, and Wamala S, Merlo J, Boström G, et al. "Perceived Discrimination, socioeconomic disadvantage and refraining from seeking medical treatment in Sweden", 2007.
47. In April 2019, the ESCR held Bulgaria responsible for Roma women's inferior access to reproductive healthcare in public hospitals, specifically during pregnancy and childbirth, finding a violation of Article E in conjunction with Article 11§1 of the Charter with regard to access to health insurance and health care for Roma women in respect of maternity. See also European Roma Rights Centre, 2020. Cause of Action. Reproductive Rights of Romani Women in Hungary; and Center for Reproductive Rights, Poradňa pre občianske a ľudské práva. Vakeras Zorales – Speaking Out, Roma Women's Experiences in Reproductive Health Care in Slovakia, 2017.
48. European Roma Rights Centre "Hidden Health Crisis: A report by the European Roma Rights Centre", 2013.
49. See the baseline report on access to health for LGBTI people included in the European Commission project Health4LGBTI: Reducing health inequalities experienced by LGBTI, 2018.
50. Sherriff, N, Zeeman, L, McGlynn, N, et al. "Co-producing knowledge of lesbian, gay, bisexual, trans and intersex (LGBTI) health-care inequalities via rapid reviews of grey literature in 27 EU Member States", 2019.
51. See Human Rights Council "COVID-19, systemic racism and global protests", 2020. Report of the Working Group of Experts on People of African Descent. See also Public Health England "Disparities in the risk and outcomes of COVID-19", 2020.

52. See ENAR Report "COVID-19 impacts on racialised communities", May 2020.
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54. See Study on the social dimension of the pandemic, Düsseldorf University, June 2020.
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60. See van Daalen KR, Bajnoczki C, Chowdhury M, et al. "Symptoms of a broken system: the gender gaps in COVID-19 decision-making", 2020.
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62. Hao Yao et al., "Patients with mental health disorders in the COVID-19 epidemic", The Lancet Psychiatry, April 2020.
63. Council of Europe. Recommendation CM/Rec(2014)2 of the Committee of Ministers to member states on the promotion of human rights of older persons. Article 33 (3) of the UNCRPD provides "Civil society, in particular persons with disabilities and their representative organisations, shall be involved and participate fully in the monitoring process."
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65. See Endnote 43.
66. See Endnote 5.
67. PACE Resolution 2291 (2019) "Ending coercion in mental health: the need for a human rights-based approach". See also Commissioner for Human Rights Issue Paper on Women's Sexual and Reproductive Health and Rights in Europe, 2017; and European Roma Rights Center "Coercive and Cruel", 2016.
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72. See "Why fighting corruption matters in times of COVID-19", Transparency International Corruption Perception Index 2020, Research Analysis, 28 January 2021.
73. See GRECO guidelines, 15 April 2020.

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75. Europol. Press release "Corona crimes: suspect behind €6 million face masks and hand sanitisers scam arrested thanks to international police cooperation", 6 April 2020.
76. British Medical Journal, McKee, M. "England's PPE procurement failures must never happen again", July 2020.
77. Council of Europe Gender Equality website "Women's rights and the COVID-19 pandemic" provides extensive information about the Council of Europe institutional response (such as official documents and statements) as well as on the initiatives by other international organisations and NGOs.
78. The Platform for Undocumented Migrants gathers statements and resources about the COVID-19 pandemic and its impact on migrant communities, and on civil society organisations working with migrants.
79. See Amnesty International Care Homes Report, 4 October 2020.
80. House of Commons Women and Equalities Committee, UK Impact, "Unequal impact? Coronavirus, disability and access to services", December 2020.
81. See the European Network of National Human Rights Institutions on COVID-19 and Human Rights.
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83. See EQUINET's reaction to the equality challenges posed by the COVID-19 pandemic, 5 February 2021.
84. ECRI General Policy Recommendation Nr 2 on Equality Bodies to combat racism and intolerance at the national level (2018); Recommendation CM/Rec(2019)6 of the Committee of Ministers to member states on the development of the Ombudsman Institution. The Council of Europe Steering Committee on Human Rights (CDDH) is preparing a new recommendation on the development and strengthening of effective, pluralist and independent national human rights institutions.
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86. See the powers of the Council of Europe Parliamentary Assembly.
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88. See remarks of the Director of WHO at the PACE Standing Committee, 26 June 2020.
89. UN, "Transforming Our World: The 2030 Agenda for Sustainable Development", 2015.
90. UN General Assembly Political declaration of the high-level meeting on universal health coverage: moving together to build a healthier world , 2019.
91. WHO, "The Tallinn Charter: health systems for health and wealth", Copenhagen, Regional Office for Europe, 2008.
92. See Endnote 11 on the WHO six building blocks of health care systems, 2007.
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95. WHO Regional Office for Europe, "The health and well-being of men in the WHO European Region: better health through a gender approach", 2018.

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109. See WHO Assessment of the quality of institutional care for adults with psychosocial and intellectual disabilities in the WHO European Region, pages 19-21.
110. See Commissioner for Human Rights Country Report on Slovakia, 2015.
111. See CPT Report on Bulgaria, 2 December 2020.
112. See also the Commissioner for Human Rights' statement on the International Day of Older Persons, 1 October 2020.
113. See Statement to the press by the WHO Regional Director for Europe.
114. See Endnote 8.
115. See BMC Medicine, Lohman, D, Schleifer, R & Amons J, "Access to Pain Treatment as a Human Right", 2010.
116. Commissioner for Human Rights statement "Covid-19. Ensure women's access to sexual and reproductive health and rights", 7 May 2020.
117. Equinet, Konowrocka, J. "Let's talk about sexual and reproductive health and rights: Not fully implemented before COVID-19 & suspended during the pandemic", 14 September 2020.
118. WHO: "Health 2020. A European policy framework and strategy for the 21st century", Copenhagen: WHO Regional Office for Europe, 2013.
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143. UN Secretary General António Guterres has repeatedly called for COVID vaccines to be treated as a "global public good," available to everyone, everywhere on the planet. Yet, by September 2020, OXFAM International reported that wealthy nations representing just 13 percent of the world's population were reported to have secured 51% of the promised doses of leading COVID-19 vaccine candidates. In January 2021, the Director General of the WHO warned of "catastrophic moral failure" because of "me-first" approaches to COVID-19 vaccine policies that "will only prolong the pandemic, the restrictions needed to contain it, and human and economic suffering".

144. COVAX, which was launched in April 2020, brings together governments, global health organisations, manufacturers, scientists, private sector, civil society and philanthropy, with the aim of providing innovative and equitable access to COVID-19 vaccines. See also Covid-19 vaccines: ethical, legal and practical considerations, PACE Resolution 2361 (2021) (Provisional version) of 27 January 2021.

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156. See Council of Europe "Protecting and empowering children during the Covid-19

pandemic", 2020. See also Fundamental Rights Agency, "Coronavirus pandemic in the EU – Fundamental rights implications: with a focus on older people", 2020.

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166. See ECSR News "Right to equal pay: European Committee of Social Rights finds violations in 14 countries", 29 June 2020.
167. See Endnote 5.
168. See Endnote 44.
169. See Study by the French National Institute of Health and Medical Research, 9 October 2020.
170. See Endnote 5. In January 2020, the Commissioner for Human Rights highlighted multiple challenges where it came to guaranteeing the right to affordable housing, including the high rates of housing costs in Bulgaria, Denmark, Germany and Greece. Housing cost overburden arises when more than 40% of a person's disposable income is spent on housing. See Commissioner for Human Rights Comment "The right to affordable housing: Europe's neglected duty", 23 January 2020.
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174. See "Right to a healthy and sustainable environment report, prepared jointly by the former Special Rapporteur Mr. John Knox (2012-2018) and the current Special Rapporteur Mr. David Boyd (2018 – present), OHCHR, July 2018.
175. See Commissioner for Human Rights Position Paper "Fighting School Segregation in Europe through Inclusive Education", 2017.
176. Rocco L, Suhrcke M., "Is social capital good for health? A European perspective", Copenhagen: WHO Regional Office for Europe, 2012.
177. WHO Regional Office for Europe, "Health 2020: Education and health through the life-course", 2015.
178. See Commissioner for Human Rights, Human Rights Comment "Comprehensive sexuality education protects children and helps build a safer, inclusive society", 21 July 2020.

179. This ROMED related project was jointly organised by the Greek Government, Council of Europe and the European Commission.
180. National Centre for Biotechnology Information, "School closures and mental health concerns for children and adolescents during the COVID-19 pandemic", 4 September 2020.
181. See for an overview "For a disability-inclusive workforce", PACE Report 14665, November 2018.
182. See statement of Group of Experts on Action against Trafficking in Human Beings (GRETA) on the special needs and exploitation risks of victims of human trafficking as a result of COVID, 16 October 2020.
183. See Amnesty International "Research on human rights abuses against sex workers", May 2016.
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The Commissioner for Human Rights is an independent and impartial non-judicial institution established in 1999 by the Council of Europe to promote awareness of and respect for human rights in the member states.

The activities of this institution focus on three major, closely related areas :

- country visits and dialogue with national authorities and civil society,
- thematic studies and advice on systematic human rights work, and
- awareness-raising activities.

The current Commissioner, Dunja Mijatović, took up her functions in April 2018. She succeeded Nils Muižnieks (2012-2018), Thomas Hammarberg (2006-2012) and Álvaro Gil-Robles (1999-2006).

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COMMISSIONER FOR HUMAN RIGHTS

COMMISSAIRE AUX DROITS DE L'HOMME