Poverty, equity, human rights and health

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Abstract Those concerned with poverty and health have sometimes viewed equity and human rights as abstract concepts with little practical application, and links between health, equity and human rights have not been examined systematically. Examination of the concepts of poverty, equity, and human rights in relation to health and to each other demonstrates that they are closely linked conceptually and operationally and that each provides valuable, unique guidance for health institutions' work. Equity and human rights perspectives can contribute concretely to health institutions' efforts to tackle poverty and health, and focusing on poverty is essential to operationalizing those commitments. Both equity and human rights principles dictate the necessity to strive for equal opportunity for health for groups of people who have suffered marginalization or discrimination. Health institutions can deal with poverty and health within a framework encompassing equity and human rights concerns in five general ways: (1) institutionalizing the systematic and routine application of equity and human rights perspectives to all health sector actions; (2) strengthening and extending the public health functions, other than health care, that create the conditions necessary for health; (3) implementing equitable health care financing, which should help reduce poverty while increasing access for the poor; (4) ensuring that health services respond effectively to the major causes of preventable ill-health among the poor and disadvantaged; and (5) monitoring, advocating and taking action to address the potential health equity and human rights implications of policies in all sectors affecting health, not only the health sector.

Keywords Health status; Poverty; Social justice; Human rights; Health services accessibility/ethics; Health care sector/organization and administration; Public policy; Intersectoral cooperation (*source: MeSH, NLM*).

Mots clés Etat sanitaire; Pauvreté; Justice sociale; Droits homme; Accessibilité service santé/éthique; Secteur soins/ organisation et administration; Politique gouvernementale; Coopération intersectorielle (*source: MeSH, INSERM*).

Palabras clave Estado de salud; Pobreza; Justicia social; Derechos humanos; Accesibilidad a los servicios de salud/ética; Sector de atención de salud/organización y administración; Política social; Cooperación intersectorial (*fuente: DeCS, BIREME*).

الكلمات المفتاحية: الوضع الصحي، العدالة الاجتماعية، حقوق الإنسان، إتاحة الخدمات الصحية، أخلاقيات إتاحة الخدمات الصحية، قطاع الرعاية الصحية، منظمة الرعاية الصحية وتقديمها، السياسات العمومية، التعاون بين القطاعات (*المصدر: رؤوس الموضوعات الطبية، المكتب الإقليمي لشرق المتوسط*).

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Voir page 543 le résumé en français. En la página 543 figura un resumen en español. يمكن الاطلاع على الملخص بالعربية على الصفحة ٥٤٤ .

Introduction

Approaches focusing on poverty, equity, or human rights in relation to health have sometimes been viewed as conflicting or competing, and champions of the poverty–health relationship have sometimes viewed equity and human rights concerns as too abstract or insufficiently relevant. In addition, links between health, equity and human rights have not previously been examined rigorously. We explore the concepts of poverty, equity, and human rights in relation to health and to each other, suggesting operational implications and opportunities for effective action by health institutions.

Poverty and health

Given the strong and pervasive links between poverty and health, a commitment to health necessarily implies a commitment to reducing poverty (i.e., material deprivation and the multiple social disadvantages associated with it). For centuries, powerful associations have been noted between health and an absolute lack of economic resources (*1, 2*); recent evidence also suggests adverse health correlates of relative deprivation (*3, 4*) which could reflect diverse mechanisms (*5–8*). For many poor people, the health-damaging effects of economic poverty are compounded by inequality related to sex, racial or ethnic group, disability, HIV infection, or other factors associated with social position (*9*). Thus, efforts that focus exclusively on economic poverty may have limited effectiveness for promoting health.

Globally, ill-health also can lead to, exacerbate and perpetuate poverty (*10–12*). Because the health sector generally has little or no control over many of the most powerful influences on health, such as education, food supply, housing, environmental hazards, and work conditions (*2, 13*), it faces the practical challenge of identifying how, alone and in coordination with other sectors, it can most effectively work to interrupt the vicious cycle of poverty–ill-health–poverty (*12*).

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Equity and health

Equity is an ethical concept (*14*) grounded in the principle of distributive justice. Equity in health reflects a concern to reduce unequal opportunities to be healthy associated with membership in less privileged social groups, such as poor people; disenfranchised racial, ethnic or religious groups; women; and rural residents. In operational terms, pursuing equity in health means eliminating health disparities that are systematically associated with underlying social disadvantage or marginalization (*15*). An equity framework systematically focuses attention on socially disadvantaged, marginalized, or disenfranchised groups within and between countries, including but not limited to the poor (*16*).

Practical experience suggests that eliminating systematic health disparities between social groups requires correcting their fundamental causes, at least to some extent, as well as cushioning their health-damaging effects (*17, 18*). Furthermore, a commitment to equalizing opportunities to be healthy inherently requires identification of the determinants as well as manifestations of health disparities (*15*). Concern for health equity thus implies a values-based commitment to tackle poverty and health, with or without conclusive evidence of aggregate utilitarian gains.

Human rights and health

As used here, human rights refers to internationally recognized norms applying equally to all people everywhere in the world. International human rights law is a set of legal standards to which governments have agreed with the purpose of promoting and protecting these rights. International treaties not only prohibit direct violations of human rights but also hold governments responsible for progressively ensuring conditions enabling individuals to realize their rights as fully as possible. Every country is now party to at least one treaty encompassing health-related rights and is therefore responsible for reporting periodically to an international monitoring body on its compliance (*19, 20*).

The right to health, i.e. the right to the highest attainable standard of health (*21–23*), makes governments responsible for prevention, treatment and control of diseases and the creation of conditions to ensure access to health facilities, goods and services required to be healthy (*24, 25*). Because all human rights — economic, social, cultural, civil and political — are considered interdependent and indivisible (*26*), governments are accountable for progressively correcting conditions that may impede the realization of the "right to health", as well as related rights to education, information, privacy, decent living and working conditions, participation, and freedom from discrimination (*27*). Systematic attention to this range of rights by the health sector can provide a coherent framework for a focus on conditions that may limit people's ability to achieve optimal health and to receive health services (*28*).

Poverty, equity, human rights and health: the links

The links between the concepts of poverty, equity, and human rights in relation to health are many and profound. Both equity and human rights principles dictate striving for equal opportunity for health for groups of people who have historically suffered discrimination or social marginalization. Achieving equal opportunity for health entails not only buffering the health-damaging effects of poverty and marginalization: it requires reducing disparities between populations in the underlying conditions — such as education, living standards, and environmental exposures — necessary to be healthy. Thus, both human rights and equity perspectives require that health institutions deal with poverty and health not only by providing care to improve the health of the poor but also by helping to alter the conditions that create, exacerbate, and perpetuate poverty and marginalization. Governments are accountable, as parties to human rights treaties, for setting benchmarks and targets towards progressive achievement of full realization of human rights: "progressive realization" requires that they should show movement in good faith towards full realization of all rights.

Poverty is not, in itself, a violation of human rights. However, government action or inaction leading to poverty, or government failure to respond adequately to the conditions that create, exacerbate, and perpetuate poverty and marginalization, often reflect — or are closely connected with — violations or denials of human rights (*29*). For example, lack of access to education, especially primary education, is increasingly recognized both as the denial of a right and as inextricably connected with poverty and ill-health. Education fosters empowerment and participation in informed decisions about health-related behaviours (*30*) and is therefore key to breaking the poverty–ill-health cycle.

Strategies that narrowly focus on poverty and health without the broader perspectives offered by equity and human rights may fail because they do not take into consideration the key factors that often influence the relationship between poverty and ill-health. Without a systematic focus on how marginalization and discrimination can cause, exacerbate, and perpetuate poverty, efforts to reduce the effects of poverty on health may be relatively ineffective. For example, improving the geographical and financial accessibility of preventive health services may not alleviate disparities in their use, without active outreach and support for the groups most likely to be underutilizers despite equal or greater need (*31, 32*). Both equity and human rights principles require that health institutions systematically consider how the design or implementation of policies and programmes may directly or indirectly affect social marginalization, disadvantage, vulnerability or discrimination. Equity and human rights principles require identifying and overcoming the obstacles — such as language, cultural beliefs, racism, gender discrimination, and homophobia — that keep disadvantaged groups from receiving the full benefits of health initiatives. While many policies and programmes to reduce poverty and improve the health of the poor routinely consider and incorporate these concerns, unfortunately many do not (*33*). Explicit adoption of equity and human rights approaches can ensure systematic attention to social disadvantage, vulnerability and discrimination in health policies and programmes.

A human rights perspective can provide a universal frame of reference for identifying inequitable conditions, which may be a matter of dispute. For example, human rights norms assert rights to the living standards that are prerequisites for optimal health, and they prohibit discrimination on the basis of gender, racial or ethnic group, national origin, religion or disability. Particularly where certain groups are systematically excluded from decision-making, human rights stan-

dards can play a crucial role in agenda-setting by strengthening consensus about the existence of inequitable health disparities and the need to reduce them.

A human rights perspective removes actions to relieve poverty and ensure equity from the voluntary realms of charity, ethics and solidarity to the domain of law. Furthermore, the internationally recognized human rights mechanisms for legal accountability could be used by the health sector to provide processes and forums for engagement and to suggest concrete approaches to reducing poverty and health inequity. International human rights instruments thus provide not only a framework but also a legal obligation for policies towards achieving equal opportunity to be healthy, an obligation that necessarily requires consideration of poverty and social disadvantage.

Just as the equity and human rights frameworks can strengthen work focused on poverty, efforts to reduce poverty are essential aspects of fulfilling commitments to equity and human rights. Throughout most of the world, material poverty and its associated disadvantages play a central role in creating, exacerbating, and perpetuating ill-health (*34*). Equity and human rights perspectives can highlight the responsibility of wealthier countries to seek out the causes and consequences of poverty within and beyond their borders. A commitment to equity or to human rights calls for major action on poverty and health, as an ethical and legal imperative.

How have health institutions traditionally considered these concepts?

Prior to the 1970s, global-level efforts to improve health among the poor focused mainly on vertical programmes to control the major tropical diseases and increase health care facilities and personnel in poor countries. From the mid-1970s to the mid-1990s, many relevant efforts focused on primary health care, meaning low-technology, low-cost, community-based, multisectoral solutions to the most common and important health problems experienced by the poor (*29*). Through its concerns with universal coverage and the determinants of ill-health associated with poverty, this vision implicitly invoked equity and human rights principles.

The 1990s saw increasing efforts to clarify the operational implications of a commitment to equity in health (*16, 35*) and more explicit attempts to focus on poverty reduction (*12, 36, 37*). In addition, spurred in part by the 1997 call for integration of human rights throughout the United Nations' work, efforts began systematically to include human rights in the work of national and international health institutions (*38, 39*). Too often, however, health sector efforts to move beyond rhetoric towards operationalizing equity, human rights and poverty concerns have been marginalized, and champions of these issues have found themselves competing for limited funds and attention rather than joining forces in coordinated, focused and mutually reinforcing efforts.

Operational implications: what can the health sector do?

In light of these concepts and considerations, how can health institutions have maximal impact on poverty, equity, and human rights in relation to health? We recommend five general areas of focus that are by no means comprehensive. These recommendations represent an attempt to provide a framework for focusing actions within the health sector and with other sectors in a limited number of areas where substantial contributions could be made under current conditions.

(1) Institutionalize the systematic and routine application of equity and human rights perspectives to all health sector actions

While most public health efforts are intended to benefit the poor and vulnerable, experience has shown that a strategic approach is necessary to overcome the tendency for the poor or marginalized to benefit too little from even the best-intentioned efforts (*31, 40*). At a minimum, this requires ongoing monitoring of social inequalities in health, receipt of health care, health care financing, and allocation of health care resources, with built-in mechanisms for translating findings into actions that fill the gaps. Equity and human rights perspectives systematically call attention to factors that traditionally are beyond the purview of the health sector, including gender-based, racial/ethnic and other forms of discrimination, as well as perceived poor quality of available health services, and lack of infrastructure or adequately trained and compensated medical personnel in areas where the poor and disadvantaged live.

Work on poverty, equity, and human rights must be integrated as an ongoing priority — rather than an afterthought or token concern — across health institutions' programmes. This requires adoption of simple and practical tools that personnel perceive to be helpful in their work. Effective use of tools requires training and ongoing support at all professional levels, along with curricula for students. To promote and sustain health workers' attention to the importance of poverty, equity, and human rights, findings from continuing monitoring of social inequalities in health should routinely be discussed within a framework of equity principles and human rights norms.

(2) Strengthen and extend public health functions, other than health care, that create the basic conditions needed to achieve health and escape poverty

The health sector could make a major contribution through such functions as setting and enforcing standards for major health determinants, including: clean water and sanitation; food and drug safety; tobacco control; access to health-related education and information; and standards for safe working, housing, transport, and environmental conditions. These actions benefit society as a whole but particularly the poor and disadvantaged; like police and fire services, they represent essential public goods that should not be determined by market forces.

The health sector itself has little or no direct control over most of the underlying conditions required for health; thus, traditional public health functions should be expanded through collaboration with other sectors to develop strategic plans that target those conditions in light of both equity and human rights concerns. Reflecting human rights norms (*41*), such conditions include: an adequate food supply; universal education to levels that permit full economic, social, and political participation; housing and neighbourhood environments that promote health; and dignified, safe employment. Activities in these directions require collaboration with sectors that have not commonly been health partners, for example in economic,

social, political, educational, environmental and general development.

(3) Implement equitable financing of health care

Equitable financing means that those with the least resources pay the least, not only in absolute terms but also as a proportion of their resources. It means that lack of personal resources does not restrict an individual's receipt of services that are recommended based on prevailing norms and scientific knowledge. Equitable financing would increase access to health care for the poor and near-poor, which — if health care services are effective — should improve people's health and thus their ability to earn a living, thereby indirectly reducing poverty. More directly, equitable financing of health care could reduce the prevalence and depth of poverty by protecting those who are most vulnerable from impoverishment resulting from health care expenses. Equitable financing is likely to be sustainable only if resources are pooled for those members of society who are healthy and those less healthy, and for the affluent and the poor (*42*); implementing this strategy requires building public consensus around commitments to equity and human rights.

(4) Ensure that health care services respond effectively to the major causes of preventable ill-health and associated impoverishment among the poor and disadvantaged

Health institutions will need to make systematic and sustained efforts to build infrastructure, to overcome the complex barriers to receiving health care that often accompany poverty and social disadvantage, and to achieve comprehensive and high-quality universal services. Access and quality must be considered together; perceived low quality is a widespread barrier to use of available health services by the poor and disadvantaged (*43*). To assess whether services are received by those who need them and are effective, systems must be in place for the routine monitoring of poor and disadvantaged groups (in relation to those that are more advantaged) with respect to health status, receipt of care, and health care financing and resource allocation.

Highly visible and specifically targeted global campaigns have recently been launched, focusing on a limited number of infectious diseases; there has been considerable controversy over the advisability of such vertical campaigns and the need to build up sustainable infrastructure that can cope with more than a few conditions (*44, 45*). Where resources are severely constrained, it seems reasonable and equitable to place highest priority on handling a limited number of devastating but highly preventable common conditions — such as malaria, HIV/AIDS, tuberculosis, selected childhood diseases, and maternal morbidity and mortality — that disproportionately afflict the poor and exacerbate and perpetuate poverty. However, from equity and human rights perspectives, targeted short-term campaigns that fail to consider broader issues fundamentally linked with poverty and ill-health (such as disempowerment) may be politically expedient but less likely to achieve sustained health improvements for the poor and disadvantaged. Specific disease campaigns may further marginalize the health concerns of the poor and vulnerable from the political agenda, and may undermine long-term efforts that are crucial to achieving sustained gains. From a practical standpoint, health agencies must systematically assess which services are most essential to the health and livelihoods of the poor and disadvantaged and give priority to their effective provision. However, consistent with a human rights commitment to "progressive realization" of all rights, this narrowed focus must be seen as temporary. Benchmarks and targets must be set as part of a strategic long-range plan to build infrastructure and ensure, progressively, more comprehensive, high-quality services for the entire population (*46*).

(5) Monitor, advocate and take action to address the health equity and human rights implications of development policies in all sectors that affect health

The health sector must strengthen its capacity for active, ongoing monitoring and become an effective advocate to raise awareness of the potential implications of development policies for health equity and human rights and to call for appropriate action. This must be done at international, national and local levels, in both public and private sectors, and with respect to policies in all sectors affecting health, not only the health sector. The fact that most societies have far less tolerance for social disparities in health than in wealth or other social privileges (G. Dahlgren & F. Diderichsen, personal communication, 1997) provides the health sector with a powerful tool for mobilizing public opinion.

Routine assessment of potential health implications for different social groups should become standard practice in the design, implementation and evaluation of all development policies. Equity and human rights principles require that routinely collected data on health, health care and other health determinants that are monitored overall should also be disaggregated into more and less socially advantaged groups by factors such as wealth, gender and race/ethnicity that reflect poverty and social disadvantage (*16, 20, 35, 47*). If not, it will be difficult to hold any sector accountable for the differential impact of policies on vulnerable groups.

Quantitative data should routinely be supplemented by qualitative information from the poor and disadvantaged and their advocates describing unmet need, perceptions of service quality, and obstacles to receiving recommended services in any sector influencing health. While the precise impact of any single given policy cannot be determined, either retrospectively or prospectively, the likely consequences for health equity and human rights should none the less be considered in the design and evaluation of policies in all sectors.

National and international capacity must be developed to set benchmarks and targets reflecting equity and human rights concerns. More practical, affordable, sustainable and scientifically sound methods and data sources are needed for ongoing monitoring of health equity and human rights over time; however, in virtually every country more could be done now with existing data and relatively simple methods (*35*). Accountability for equity as well as human rights may be further improved by more formally involving the health sector in governments' routine reporting to human rights monitoring bodies about their compliance on a range of rights relevant to poverty and health equity.

National and international health agencies should provide global leadership to mobilize coordinated action to reduce poverty and achieve health equity and human rights. Meaningful participation of those who represent the poor or disadvantaged and other civil society groups, of political leaders, and of policy-makers from all relevant sectors is

essential. WHO and health institutions at all levels should consider convening periodic high-visibility interagency and intersectoral forums to examine the evidence on poverty, equity, human rights and health; to discuss multisectoral policy implications; to set priorities for joint and separate action to tackle highlighted problems; to ensure ongoing and coordinated monitoring by health and human rights institutions; and to determine issues for further study.

Final remarks

Based on the considerations discussed in this paper, we have concluded that poverty, equity, and human rights are closely linked, conceptually and operationally, with health and with each other. Each construct — focusing on poverty and health, doing so within a broader commitment to achieving greater equity in health, and using a human rights framework to consider both poverty and equity — can provide unique, valuable and concrete guidance for actions of national and international organizations of health and development. The authors hope that discussions based on this document will lead to greater awareness of opportunities to strengthen work on the interaction of poverty, equity, human rights, and health, both globally and within countries. ■

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Résumé

Pauvreté, justice sociale, droits de l'homme et santé

Les liens entre la santé, la justice sociale et les droits de l'homme n'ont pas été étudiés de manière systématique, et ceux qui s'intéressent à la pauvreté et à la santé ont parfois considéré la justice sociale et les droits de l'homme comme des concepts abstraits ayant peu d'application pratique. L'examen des concepts de la pauvreté, de la justice sociale et des droits de l'homme, et de leurs liens entre eux et la santé, démontre qu'ils sont étroitement liés en théorie et en pratique et que chacun de ces concepts est une aide précieuse et unique pour le travail des institutions s'occupant de santé. Travailler dans le sens de la justice sociale et des droits de l'homme peut contribuer concrètement à l'action des institutions s'occupant de santé pour lutter contre la pauvreté, et il est indispensable de se concentrer sur la pauvreté pour concrétiser ces engagements. Les principes de justice sociale et des droits de l'homme imposent de lutter pour que les groupes de personnes victimes de marginalisation ou de discrimination aient le même droit à la santé que les autres. Les institutions s'occupant de santé peuvent agir dans un cadre intégrant la justice sociale et les droits de l'homme selon cinq grands axes : 1) institutionaliser l'application systématique et régulière des considérations de justice sociale et de droits de l'homme à toutes les actions du secteur de la santé ; 2) renforcer et élargir les fonctions de santé publique, autres que les soins de santé, créant les conditions propices à la santé ; 3) instaurer un système de financement équitable des soins de santé, qui devrait contribuer à réduire la pauvreté tout en favorisant l'accès des pauvres à ces soins ; 4) veiller à ce que les services de santé répondent efficacement aux principales causes des maladies évitables chez les pauvres et les démunis ; et 5) surveiller, promouvoir et prendre les mesures nécessaires pour traiter les répercussions que pourraient avoir les politiques de tous les secteurs concernant la santé, – et non pas seulement celles du secteur de la santé – sur la justice sociale et les droits de l'homme.

Resumen

Pobreza, equidad, derechos humanos y salud

Los vínculos entre la salud, la equidad y los derechos humanos no han sido examinados de forma sistemática, y quienes se interesan por la pobreza y la salud han considerado a veces que la equidad y los derechos humanos son conceptos abstractos con escasa aplicación práctica. El análisis de los conceptos de pobreza, equidad y derechos humanos y de las relaciones entre ellos y con la salud demuestra que están estrechamente relacionados desde el punto de vista conceptual y operacional y que cada uno de ellos proporciona valiosas orientaciones singulares para el trabajo de las instituciones sanitarias. Las perspectivas de la equidad y de los derechos humanos pueden contribuir de forma concreta a los esfuerzos de las instituciones sanitarias para abordar la pobreza y la salud, y para operacionalizar estos compromisos es esencial centrarse en la pobreza. Los principios de la equidad y de los derechos humanos determinan la necesidad de luchar por la igualdad de oportunidades de salud para los grupos de personas que han sufrido marginación o discriminación. Hay cinco formas generales en que las instituciones sanitarias pueden abordar el problema de la pobreza y la salud en un marco que integre los temas de la equidad y de los derechos humanos: 1) institucionalizar la aplicación sistemática y rutinaria de las perspectivas de la equidad y de los derechos humanos a todas las acciones del sector de la salud; 2) fortalecer y ampliar las funciones de salud pública distintas de la asistencia sanitaria para crear las condiciones necesarias para la salud; 3) poner en práctica una financiación equitativa de la asistencia sanitaria, lo cual ayudaría a reducir la pobreza e incrementaría el acceso de los pobres; 4) asegurar que los servicios de salud respondan eficazmente a las principales causas de enfermedades prevenibles entre los pobres y los desfavorecidos, y 5) vigilar, sensibilizar y actuar para que se aborden las repercusiones que sobre la equidad y los derechos humanos puedan tener las políticas de todos los sectores que afectan a la salud, y no sólo las del sector de la salud.

ملخص

الفقر والعدالة وحقوق الإنسان والصحة

ينظر المعنيون بقضايا الفقر والصحة أحياناً إلى العدالة وحقوق الإنسان كمفاهيم مجرَّدة ذات تطبيقات عملية محدودة، وكروابط بين الصحة والعدالة وحقوق الإنسان لم تفحص بعد فحصاً منهجياً. إن دراسة مفاهيم الفقر والعدالة وحقوق الإنسان وعلاقتها المتبادلة بالصحة توضح أن هذه الأمور مترابطة فيما بينها من حيث المفاهيم ومن حيث التطبيقات العملية، ويقدم كلٌّ من هذه المفاهيم إرشادات قيمة وفريدة لعمل المؤسسات الصحية. ويمكن لآفاق العدالة وحقوق الإنسان أن تساهم مساهمة وثيقة في تفعيل جهود المؤسسات الصحية لمكافحة الفقر وتأثيره على الصحة، وللتركيز على الصحة كأحد الالتزامات العملية الميدانية الأساسية. وتملي مبادئ كل من العدالة وحقوق الإنسان ضرورة النضال من أجل إتاحة فرص متساوية للتمتع بالصحة لمجموعات الناس الذين يعانون من التهميش والتمييز. ويمكن للمؤسسات الصحية أن تتعامل مع الفقر ضمن إطار يتضمن قضايا العدالة وحقوق الإنسان في خمس طرق رئيسية؛ الطريق الأولى: إضفاء الصفة المؤسسية على التطبيقات الروتينية والمنهجية لآفاق العدالة وحقوق الإنسان في جميع الأنشطة في القطاع الصحي، الطريقة الثانية: تعزيز وظائف الصحة العمومية وتوسيعها لما هو أبعد من الرعاية الصحية، وترسيخ الظروف الضرورية للصحة. الطريقة الثالثة: اتباع العدالة في تمويل الرعاية الصحية، وبالشكل الذي ينبغي معه تخفيف وطأة الفقر مع زيادة إتاحة الخدمات الصحية للفقراء. الطريقة الرابعة: ضمان استجابة الخدمات الصحية بشكل فعَّال للأسباب الرئيسية التي يمكن توقِّيها للأمراض بين الفقراء والمستضعفين والمحرومين، والطريقة الخامسة: المراقبة والدعوة واتِّخاذ الخطوات العملية لتحقيق العدالة الممكنة والاستجابة للتبعات والمقتضيات التي تتطلبها سياسات حقوق الإنسان في جميع القطاعات التي تؤثِّر على الصحة، وعدم الاقتصار على القطاعات الصحية.

References

1. Chapin CV. Deaths among taxpayers and non-taxpayers, income tax, Providence, 1865. Originally published in *American Journal of Public Health* 1924;14:647-51; reprinted in *Journal of Public Health Policy* 1999;20:227-34.
2. Berkman L, Kawachi I, editors. *Social epidemiology.* New York: Oxford University Press; 2000.
3. Marmot MG, Smith GD, Stansfeld S, Patel C, North F, Head J, et al. Health inequalities among British civil servants: the Whitehall II study. *Lancet* 1991;337:1387-93.
4. Kawachi, I, Kennedy BP, Lochner K, Prothrow-Stith D. Social capital, income inequality, and mortality. *American Journal of Public Health* 1997;87:1491-8.
5. Bosma H, Marmot MG, Hemingway H, Nicholson AC, Brunner E, Stansfield SA. Low job control and risk of coronary heart disease in Whitehall II (prospective cohort) study. *BMJ* 1997;314:558-65.
6. Lynch JW, Kaplan GA. Understanding how inequality in the distribution of income affects health. *Journal of Health Psychology* 1997;2:297-314.
7. Wilkinson RG. Socioeconomic determinants of health. Health inequalities: relative or absolute material standards? *BMJ* 1997;314:591-5.
8. Wilkinson RG. *Unhealthy societies: the afflictions of inequality.* New York: Rutledge; 1996.
9. Evans T, Whitehead M, Diderichsen F, Bhuyia A, Wirth M, editors. *Challenging inequities in health: from ethics to action.* New York: Oxford University Press; 2001.
10. *Macroeconomics and health: investing in health for economic development.* Report of the Commission on Macroeconomics and Health. Geneva: World Health Organization; 2001.
11. *Health: a precious asset. Accelerating follow-up to the World Summit for Social Development.* Geneva: World Health Organization; 2000. WHO document WHO/HSD/HID/00.1.
12. Haines A, Heath I, Smith R. Joining together to combat poverty: everybody welcome and needed. *BMJ* 2000;320:1-2.
13. Benzeval M, Judge K, Whitehead M, editors. *Tackling inequalities in health: an agenda for action.* London: King's Fund;1995.
14. Whitehead M. The concepts and principles of equity in health. *International Journal of Health Services* 1992;22:429-45. First published under same title from: Copenhagen: World Health Organization Regional Office for Europe; 1990, document EUR/ICP/RPD 414.
15. Braveman P, Gruskin S. Defining equity in health. *Journal of Epidemiology and Community Health* 2003;57:254-8.
16. Braveman P, Tarimo E, Creese A. *Equity in health and health care: a WHO initiative.* Geneva: World Health Organization; 1996.
17. Whitehead M. *The health divide.* In: *Inequalities in health.* London: Penguin; 1988.
18. Acheson D. *Independent Inquiry into Inequalities in Health.* London: Stationery Office; 1998.
19. Tomasevski, K. Health rights. In: Eide A, Krause C, Rosas A, editors. *Economic, social and cultural rights: a textbook.* Dordrecht: Martinus Nijhoff; 1995.
20. *Manual on human rights reporting.* Geneva: United Nations Centre for Human Rights; 1996. UN document HR/PUB/96/1.
21. Constitution of the World Health Organization as adopted by the International Health Conference, New York, 19–22 June 1946; signed on 22 July 1946 by the representatives of 61 States. Geneva: World Health Organization; 1946. *Official Records of the World Health Organization* No. 2. p. 100.
22. International Covenant on Economic, Social and Cultural Rights (ICESCR). New York, United Nations, 1966. United Nations General Assembly resolution 2200 (XXI), UN GAOR, 21st Session, Supp. No. 16, at 49, UN Doc. A/6316, entered into force 3 January 1976.
23. United Nations World Conference on Human Rights, Vienna 1993. United Nations General Assembly Resolution 48/121.
24. Kirby M. The right to health fifty years on: still skeptical? *Health and Human Rights* 1999;4:7-24.
25. Leary V. The right to health in international human rights law. *Health and Human Rights* 1994;1:24-56.
26. United Nations. Universal Declaration of Human Rights. *JAMA* 1998;297: 469-70. United Nations General Assembly resolution 217 A (III); 10 December 1948. United Nations document A/810 at 71 (1948).
27. Eide A. Economic, social and cultural rights as human rights. In: Eide A, Krause C, Rosas A, editors. *Economic, social and cultural rights: a textbook.* Dordrecht: Martinus Nijhoff; 1995.
28. Gruskin S**,** Tarantola D. Health and Human Rights. In: Detels R, Beaglehole R, editors. *Oxford textbook on public health.* New York: Oxford University Press; 2002.
29. *Primary health care. Report of the International Conference on Primary Health Care, Alma-Ata, USSR, 6–12 September 1978.* Geneva: World Health Organization; 1978.
30. Backlund E, Sorlie PD, Johnson NJ. A comparison of the relationships of education and income with mortality: the national longitudinal mortality study. *Social Science and Medicine* 1999;49:1373-84.
31. Hart JT. The inverse care law. *Lancet* 1971;1:405-12.
32. Aday LA, Andersen RM. Equity of access to medical care: a conceptual and empirical overview. *Medical Care* 1981;19:4-27.
33. Feinstein O, Picciotto R, editors. *Evaluation and poverty reduction. Proceedings from a World Bank conference.* Washington, DC: The World Bank; 2000.
34. Wong MD, Shapiro MF, Boscardin WJ, Ettner SL. Contribution of major diseases to disparities in mortality. *New England Journal of Medicine* 2002;347: 1585-92.
35. Braveman P. *Monitoring equity in health and health care: a policy-oriented approach in low- and middle-income countries.* Geneva: World Health Organization, 1998. Equity Initiative Document No. 3. WHO document WHO/CHS/HSS/98.1.
36. United Nations Development Programme (UNDP). *Human development report 1996.* New York: Oxford University Press; 1996.

37. World Bank. *World development report 2000/2001. Attacking poverty*. New York: Oxford University Press; 2001.
38. *Report by the Secretary General on programme for reform*. New York: United Nations; 1997. UN document A/51/950.
39. *Renewing the United Nations: a programme for reform*. New York: United Nations; 1997. United Nations General Assembly, 14 July 1997. UN document A/RE/52/12.
40. Braveman P, Tarimo E. *Screening in primary health care*. Geneva: World Health Organization; 1994.
41. United Nations Committee on Economic, Social and Cultural Rights. *The right to the highest attainable standard of health*. Geneva: United Nations; 2000. CESCR General Comment 14, document E/C.12/2000/4.
42. Davies P, Carrin G. Risk-pooling — necessary but not sufficient. *Bulletin of the World Health Organization* 2001;79:587.
43. Haddad S, Fournier P, Machouf N, Fassinet Y. What does quality mean to lay people? Community perceptions of primary health care services in Guinea. *Social Science and Medicine* 1998;47:381-94.
44. Raviglione AC, Pio A. Evolution of WHO policies for tuberculosis control, 1948–2001. *Lancet* 2002;359:775-80l.
45. Bluestone K. Strengthening WHO's position should be a priority for the new Director-General. *Lancet* 2003;361:2.
46. Gruskin S, Loff B. Do human rights have a role in public health work? *Lancet* 2002;360:1880.
47. Joint United Nations Programme on HIV/AIDS. *The UNAIDS guide to the United Nations human rights machinery*. Geneva: UNAIDS; 1997.