

Indigenous health: bioethics as instrument of respect for differences

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Abstract

Since 1999, indigenous health is organized based on a different model of health care U the Subsystem for Indigenous Health, which is currently undergoing through changes in its management, jeopardizing the specificity of its actions. From the analysis of legislation and brief historical background, this paper argues in favor of policy attention specific to the natives by the perspective of bioethics. The concepts that support the arguments relate to the *Universal Declaration on Bioethics and Human Rights*, as well as different authors working with social and pluralistic bioethics, and seek dialogue in order to obtain democratic resolution of conflicts.

Key words: Bioethics. Indigenous health. Public health. Health policy. Human rights.

Resumo

Saúde indígena: a bioética como instrumento de respeito às diferenças

A atenção a saúde indígena, desde 1999, é organizada em um modelo de atenção diferenciado, o Subistema de Saúde Indígena, que passa por alterações de gestão que vêm colocando em risco a especificidade dessas ações. A partir da análise da legislação e breve contextualização histórica, este trabalho apresenta, a partir da bioética, argumentos em defesa da política de atenção diferenciada aos indígenas. Os conceitos que embasaram a argumentação reportam-se a *Declaração Universal sobre Bioética e Direitos Humanos*, bem como a diferentes autores que trabalham com a perspectiva social e pluralista em bioética, buscando no diálogo a resolução democrática dos conflitos.

Palavras-chave: bioética. Saúde de populações indígenas. Saúde coletiva. Política de saúde. Direitos humanos.

Resumen

Salud indígena: la bioética como instrumento de respeto a las diferencias

La atención a la salud indígena, desde 1999, está organizada en un modelo diferenciado de atención: el Subistema de Salud Indígena, el cual sufre alteraciones de gestión que han puesto en riesgo la especificidad de esas acciones. A partir del análisis de la legislación y de un breve contexto histórico, este trabajo presenta, a partir de la bioética, argumentos defendiendo la política de atención diferenciada a los indígenas. Los conceptos que sirvieron de base a los argumentos hacen referencia a la *Declaración Universal sobre Bioética y Derechos Humanos*, así como a diferentes autores que trabajan con la perspectiva social y pluralista en bioética, buscando en el diálogo la resolución democrática de los conflictos.

Palabras-clave: Bioética. Salud indígena. Salud pública. Política de salud. Derechos humanos.

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The social perspective adopted by Latin American bioethics and, mainly, the lines developed in Brazil provide its actual work, in health sector, contributing to deepen discussion on care, specifically considering that targeted to special segments and groups, such as indigenous people. Historically, these people have been exterminated and expropriated and, in all senses, suffer in view of the negligence of the State in its policies. The health care provided to these people reflects this chronic illness, characterized by indifference, discrimination, and disrespect to their cultural idiosyncrasies that mark comprehension of the involved society.

This statement mirrors the fact that only in 1978 Law 6,001/78 was published – the Indian Statutes, which sets forth on indigenous people's collective rights. This document has been often remodeled in the past four decades in order to adapt to current notions of citizenship, attempting to respond to these people's needs as well. The first and crucial change regarding health, concomitantly to the establishment of the Single Health System (SUS), which proposed a differentiate way of health care through the Arouca's Bill ².

This Bill, derived from Sanitary Reform and popular movements, still remains in discussion, subsidizing the agenda that intends to guide the reorganization of the system according to the needs and priorities of served groups. This reorganization touches in neuralgic bioethical features related to the right to difference, which is the core of this paper.

Method

This is a survey, from the methodological stand point, of the qualitative type, particularly appropriated to work with beliefs, habits, attitudes, representations and opinions, privileging the point of view of subjects involved in certain process. Thus, the qualitative survey is capable to clarify particular meaning that subjects give to the social phenomenon.

The paper was developed based in technique denominated as "case study". Our premise is that documents are part of a case, in the understanding of Yin ^{3, 4}, who suggests that in situations in which we are unable to differentiate the phenomenon as matter of its content, this type of approach is suited ideally to the method of searching a knowledge regarding the topic.

For the author, the wealth and complexity of the situation under study goes back to the large number of variables, the use of several sources of data, and the different strategies to be used both for designing the survey and for analysis. Thus, our method, in addition to being qualitative, includes the case study. Therefore, using the historical unfolding of indigenous health care and its organization format as a case, in which we apply the knowledge provided by bioethics, aiming at ensuring differentiated care to indigenous people.

These developments were "captured" by means of emblematic documents related to the Indigenous Health Subsystem (Sasi). Our approach was based in the hermeneutic perspective, taking as core text the documents produced at the institution – such as internal reports, ordinances, decrees, action manuals, institutional publications, resolutions from conferences, analyses and diagnoses produced by internal and independent auditors, and scientific articles. Our approach will also be, in a certain way, of historical type, retaking the main milestones of the Brazilian society and indigenous population relationship, integral part of the former that ended crystallizing in formal documents.

It may also be stated that we were, during the survey's designing and implementation process, participant observers, since we worked directly connected to the institution that, until recently, was responsible for indigenous health care – the National Health Foundation (Funasa). Thus, directly or indirectly, we were involved with the actors of the designing process of proposals that we describe and, consequently, we also followed up its practical unfolding in operationalization of the subsystem.

In this period, we participated in debates, talks, and Exchange of electronic mails with the diverse segments involved with indigenous health. Thus, among the possible choices coherent to the undertaken survey and listed objectives, two techniques were privileged: the *participant observation* and the *documental analysis*. The first intends to obtain and capture the *imponderable of real life* as proposed by Malinowski, directly and without intermediation of speech or by a hermeneutics of the subject. We define this methodology, in accordance with the definition by Morris Schwartz and Charlotte Schwartz, quoted by Haguette ⁵, as:

(...) *A process in which the presence of the observer in a social situation is kept for scientific investigation goal. The observer is in a face to face relationship with the observed and participating with them in their natural life environment, he collects the data. Thus, the observer is part of the context, been observed, in which he modifies and is modified at the same time by this context.*

The documental analysis is a fundamental technique for the qualitative survey, since the entire research works starts with written or image sources, a method that owes much to the advances in the discipline of History. As pointed by Pimentel, *studies based in documents as primary material, either bibliographic reviews or historiographical research, extract from them the whole analysis, organizing them and interpreting them according to proposed investigation objectives* ⁶.

The documental analysis requires, in order to achieve intended outcomes, the use of different sources to get information beyond the analysis of formal texts, such as, for example, information collected in wide circulation newspapers, official institutions' websites, and from the internet. Thus, we proceeded, since many events and reports took place concomitantly to the development of this paper and had as exclusive sources these information means.

Initially, a bibliographic review on the topic was carried out, by reading selected texts and critical analysis of the producing sources for this material, in addition to their contextualization. Publications with interdisciplinary features, as proposed by the research, were valued and it can be verified the scarce production in the area that we delimited for the work, mostly concerning the relation between bioethics and indigenous health, as well as bioethics and public policies.

The rationale that demanded the research in conceptual texts, whether philosophical, ethical, or bioethical, we sought in the authors' original sources or acknowledged reviewers. When an opinion became necessary, we sought basically in previously explicit data and concepts, seeking, therefore, to avoid presentation of ideas without justified background.

It was also sought also, in the presentation of the paper, to follow a historical-political line that would provide similar understanding of the events that culminated in the preparation of differentiated health policy for the indigenous people. Pursuant to this format of exposure, we attempted to show, throughout this work, how indigenous health policy and bioethics got close, recently, by different but synchronic historical reasons, enabling to consider that it may be a guarantee instrument of pluralism inside the health system.

The discussion of concepts, arguments, and other topics of the research was, in many occasions, submitted to critical evaluation. This occurred through debate and presentations in seminars in the progressing of attended disciplines and, also, of communications and articles in domestic and international congresses.

The information obtained by these means were analyzed critically in accordance with the contextualization criterion for the sources producing the material. It is necessary to stress that, although targeted toward bioethical reflection, the outcome may be characterized as historical type, retaking the major milestones of the Brazilian society and indigenous population relationship, which should integrate it, but ends up socially circumscribed by a type of institutional exclusion, crystallized in formal documents.

Indigenous health management

Indigenous people health was one of the most delicate topics of the Brazilian health policy, and our indigenous population was always assisted, in some way, in their health needs – from medicine men's rituals, in the pre-Colombian America, until caring by missionaries during the colonial period.

Assistance would undergo significant changes with the emergence of the Republic when the State, now with layman features, takes on this responsibility. Thus, since the former Indian Protection Service (SPI), conceived by Rondon, passing by the Villas-Boas brothers and Noel Nutels' Roncador-Xingu Expedition, there were many state initiatives that dealt with indigenous people health care. These were consolidated in the National Indian Foundation (Funai), after the extinction of the former SPI, a specific health sector was then established, where it would be institutionalized the caregiving model based in visiting health teams based in the old Air Force Sanitary Units Service (Susa), designed by Nutels in the 1950s⁷.

The institution responsible for indigenous health care was, until recently, Funasa, which took up this function in July 1999, previously undertaken by Funai – it is highlighted that this activity was turned to the scope of Funasa practically at the same time that Law 9,836/99 was approved, which is known as Arouca's Bill¹, giving legal support to Sasi as institution.

After the approval of the Arouca's Bill, indigenous health care began to be organized within a caregiving model on its own that differs from SUS in aspects such as, for example, the structuring of sanitary districts. It was the implementation of Sasi, by Funasa that enabled improving health conditions of the indigenous population, in addition to providing greater visibility to health policies by creating proper social control mechanisms – such as the health district councils.

There is discrepancy in the number of indigenous people living in the Brazilian territory, while the Brazilian Institute of Geography and

Statistics (IBGE) includes in its census people who declare themselves as indigenous, a self-referencing mechanism, Funasa accounts the population living in the indigenous special sanitary districts (Dsei).

Currently, the indigenous population is estimated in approximately 800 thousand individuals and, more exactly in 817,963, that is, 0.4% of the total Brazilian population, according to IBGE's 2010 Census⁸. They are distributed in 683 indigenous lands and in some urban areas. There are also references to existence of 82 of non-contacted indigenous groups, of which 32 have been confirmed. There are, still, groups requesting recognition of their indigenous condition in the Federal indigenous agency⁹.

Funasa's figures for 2010, in its page in the National Network of Health Studies and Research of Indigenous People (Renisi), with data from the Indigenous Health Care Information System (Siasi), showing total of 620,972 people, divided in 294 ethnic groups, with 4,830 registered villages.

Since its establishment, Sasi provided significant improvement in health indicators of the indigenous population, with a drop in child mortality of 74.6 per thousand, in 2000, to 41.9 per thousand in 2009¹⁰. This progress can be verified in issuance of the *Arouca Bill: Funasa in 10 years of Indigenous health*, launched in 2009 at time of celebrating ten years of its approval¹¹. Several indicators on indigenous population are found in it, among those which mirror the conditions of life, like child mortality, classic in Epidemiology. Pursuant to presented data, in eight years, the coefficient passed from 74.61 deaths per thousand live births in 2000, to 44.35 in 2008, recording a drop of 40.55%.

Another major parameter is the indigenous health financing. Generally, budgetary issue is not much discussed by bioethics, although it constitutes basic and sensible aspect in rendering health. For Garrafa, Meneghel, and Selli, in Brazil, with maintenance of multi-century of social inequality, *bioethical reflection* [will have to] give priority] *increasingly in allocation of funds to health*.

¹². Concerning resources targeted to Indigenous health, a noticeable increment can be seen, as noticed in Table that follows. It is possible to suggest that the substantive increase of applied funds reflects the priority level conferred to indigenous people health by sectorial administration during the years of subsystem management by Funasa.

Table 1. Funds applied in indigenous health between 2000 and 2008, in millions of Brazilian Reals

Institutions	2000	2008	% of increase
MS	29,6	72.8	145
Funasa	66.2	378.9	472
Total	95.8	451.7	371.5

Source: Arouca's Bill and Funasa in the 10 years of indigenous health ².

As it can be inferred, the positive evolution of indicators follows the increase of applied funds. This data refers to the period of 2000-2008, a relatively short interval to set up a historical series of epidemiological trend. Nevertheless, it can be verified the qualitative and quantitative changes in indigenous people care, even if specific studies are needed to better understand them. In spite of still being far from the acceptable, these expressive outcomes justify the advocacy of the subsystem organization as an alternative for differentiated care services rendered to indigenous people.

The Government, induced by pressure from diverse sectors, sent to the Congress in August 2010 the Provisional Measure 483 ¹³, changed into Law 12,314 ¹⁴, which enabled the reorganization of the Health Ministry (MS) structure, establishing the Indigenous Health Care Special Secretariat (Sesai). Thus, indigenous health ceased to be managed by Funasa, becoming directly managed by the MS.

What would be theoretically only an administrative measure ended by turning into a bigger problem. When changing management, indigenous health care model underwent the risk of been diluted in SUS structures, ceasing to be a differentiated organization. To this adverse possibility is added the questioning about legitimacy of this change since the 4th National Indigenous Health Conference (CNSI) ¹⁵, the last to be undertaken, approved the maintaining of Funasa as the subsystem manager.

Contradictions of the indigenous health policy

Although celebrated with consistent figures, presented in 2009, the last years were marked by serious moments for the indigenous people healthcare policy. Such events initiated during the 4th CNSI. Undertaken in 2006, this conference had as motto *Indigenous Special Sanitary District: territory for health production, life protection, and valuation of traditions* ¹⁵. The jump in organization since the preceding conference may be quantified by the effort of 206 previous conferences in villages and in the sanitary districts, with twelve thousand and five thousand participants, respectively.

The national phase had 1,228 individuals among them users, indigenous and non-indigenous workers, managers, service renderers, members of working commissions, national and international guests. Altogether, 800 delegates were present ensuring legitimacy to the meeting. In the discussion about right to health, subtheme "Evaluation of Indigenous Health Subsystem", the greatest discussions in the 4th CNSI took place. The presentation of this polemic is important to set the context of events that followed the conference and their implications in ethical and bioethical issues, pointed in this paper.

Centered in the discussion about which institution should manage indigenous health, this debate polarized the final plenary that decided favorably for the continuity of actions under the responsibility of Funasa. However, the polemics around this deliberation would start after the end of the conference. In one note signed by some entities that were present, it was stated:

The most troubled voting at the final plenary was certainly that on the National Indigenous Health Policy management issue when, in the morning of March 31, not only due to the strategic importance of the matter, but, once again, due to lack of clarity in guidance of the board: several indigenous delegates who voted for the winning proposal (to keep Funasa as managing agency) protested publicly, in the morning of April 1, against the confuse coordination of that voting, which would have induced them to vote against the proposal that actually they advocated ¹⁶.

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Although the 4th CNSI had stood favorably on the continuity of Funasa's responsibility for the indigenous health actions, the debate on management would go on in the years that followed. Teixeira points to this polarity, expressing and bring to surface the background issue that permeated it:

*The tension between particularism and universalism present in the indigenous health subsystem has experienced a pendulum movement, tending generally for singularity at rhetoric level, for homogeneity in practice and for invisibility in the institutional memory of public health government agencies*¹⁷.

Political-administrative problems in the institution, in the indigenous sector and in others, boosted sectors of the MS, of the indigenous movement, of non-government organizations, and some civil servants to retake the discussion on the permanence of indigenous health within Funasa. Continuity and lack of consensus in such discussions led MS to take a stand on the issue. Based in this, the Ministry sent to Congress the Exposition of Interministerial Rationale (EMI) 228, later changed into Bill 3,958¹⁸. This EMI proposed the establishment of the Primary Care and Health Promotion Secretariat, which in its item 5, specifies:

The proposal aims also the transfer of competences and attributions carried out by the National Health Foundation – Funasa, concerning the management of health services supplied to indigenous people.

After the EMI had been sent to the Congress, the Ministry would start its policy of withdrawing Funasa's actions. This objective will be sought after with the publication of the MS Ordinance 1,922¹⁹, of September 2008, which in its Article 12 proposes to create a Work Group (WG) with the objective of discussing and presenting a proposal of action and measures to be implemented within the scope of Ministry of Health relating to indigenous people health care, targeting incorporation of competences and attributions derived from the National Health Foundation in this area.

These actions undertaken by the MS will unleash a political-administrative crisis with

national repercussions, as the Ministry's initiative displeased Funasa's managing board, as well as indigenous movement speakers. The dispute among managers got on newspaper headlines and would turn into a national political crisis. The situation was solved only with a political agreement involving partisan leaders in Congress, since both the Minister of Health and Funasa's Chairman belonged to the same political party.

The agreements signed for easing spirits of involved managers in the dispute were expressed in administrative acts. Ordinances 3,034²⁰ and 3.035²¹ published in December 2008, expressing the political moment. It is observed, in those Ordinances, a substantive change in relation to the September Ordinance. The proposal creating the Primary Care and Health Promotion Secretariat disappeared, replaced by the pre-project creating the Indigenous Health Subsystem. The enlargement of institutions represented in the Work Group stands out, which included indigenous participation that previously were not even mentioned.

This sequence of political and administrative events affecting the institutions and their managers would be determining in the indigenous health implementation. Conditions had been given from then in order to redirect actions and implementation of the most significant changes since the establishment of the subsystem in 1999.

The administrative changes process would achieve its pinnacle with the sending of the Provisional Measure (PM) 483/10 to the Congress, which dealt, among other topics, with the establishment of the Indigenous Health Care Special Secretariat, within the Ministry of Health. After the PM signature, in March 25, the *Amazon Indigenous Organizations Coordination* (Coiab) website would describe the event:

*The struggle of the Indigenous Movement in favor of the Special Secretariat began in 2008 when indigenous leaderships were able to bar government's decision to create, through a Bill, a Primary Care and Health Promotion Secretariat, where the indigenous health issue would have been diluted in many other topics, with the risk of not respecting the specificities of the different Brazilian indigenous people*²².

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The MS announced, in April 2011, the postponement of the deadline for transferring indigenous health responsibilities from Funasa to Sesai. The initial deadline of 180 days for transferring the attribution, foreseen in the published Decree, which would end in October 2010 was extended to December 2011. Decree 7.530²³, of July 2011, rectified this change of deadline, but it maintained the substance of the previous document.

Thus, one of the most debated concerns in the 4th CNSI was materialized, which referred to a possible management paralysis deriving from these changes, as well as the inevitable delay of years until normality of management would be reestablished. By putting off major decisions in health management and postponing urgent determinations in policies implementation, it would be putting off again attending the claims from the 4th CNSI and indigenous people health itself. Such postponements in case of health usually have serious consequences.

The suspicions and fears expressed in the 4th CNSI, previously described, that Sasi action could be diluted or incorporated by instances in the MS, even with the establishment of the Sesai, did not take long to appear.

Questioning of political decisions

The aforementioned events have as core axis the transfer of responsibilities through execution of indigenous health actions by Funasa to the Ministry of Health. This topic polarized attention from all segments involved with indigenous health, since the 4th CNSI, when the proposal to maintain actions at Funasa won. Thus, it is fit to question the reason for the MS to forward to the Congress the EMI proposing the establishment of the Primary Care and Health Promotion Secretariat that would absorb indigenous health actions, until then developed by Funasa.

In view of this initiative by the Ministry, the first discussion hereto raised regards the role or function that health conferences perform in health policies. The legislation²⁴ ensures as functions of conferences *to propose guidelines for designing health policy. Additionally, social control, at national level, will be undertaken by the National Health Council, ensured by the Indigenous Health Intersectorial Commission - Cisi, existing already and in operation.*

Therefore, the function of conferences is defined by legislation, which ensures that their deliberations

contribute in the design of policies guidelines. Indigenous health conferences have the authority *to propose guidelines for designing health policies* for these people. Such prerogative is ensured not by specific legislation, but indirectly by the National Health Council (CNS), collegiate instance of SUS. In the case of the 4th CNSI, legitimacy rituals were fulfilled in order for approved deliberations to serve as *guidelines for designing health policies* - what was verified not having been enforced by the Ministry.

The MS, as seen above, did not ensure that deliberations by the 4th CNSI were to be actually forwarded and did not consider even the political legitimacy rationale. In spite of the elected delegates' representative participation in the conference, this was still not enough to ensure implementation of deliberations, markedly about the subsystem management. Thus, it became indispensable to question the proposals from the Ministry. When legal conditions and political legitimacy are not sufficient to enforce the collegiate decisions, as in the conference's case, how to ensure decisions? Or, still, how does one prevent initiatives opposing those deliberated by highest instances of social control?

The case of sending the EMI-MP/MS 228 to Congress proposing the transfer of the indigenous health from Funasa to the Primary Care and Health Promotion Secretariat, is an example of subtraction of the legal and political functions of collegiate, which counteracts deliberations of the 4th CNSI. In face of this undeniable disrespect to what is foreseen by the norm, as well as deliberated in the conference, we should question ourselves if bioethics would not be the suitable instrument to indicate the resolution of these conflicts.

Bioethical reflection

In order to ensure maintenance of Sasi and, consequently, implementation of policies that meet the specificities in the indigenous people care, it is necessary that legal dispositions ensuring them be enforced. However, as noticed, if such dispositions are not always met, would it not be the case to look for rationale in the premises of bioethical instrumentation? In order to consolidate an indigenous health policy based in bioethical content, could it be the way to ensure a differentiated care, as well as to improve health and life conditions of

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this population?

In this regard, Alves, Cordon, and Gonçalves²⁵ put their stakes in the Brazilian social bioethics as alternate path to deal with these issues:

(...) bioethics presents itself as essential discipline in dealing with economic and social conflicts in the health sector. However, it is observed, in its practice, centralization of reflection and of referrals in issues related to research with humans and its use in medical treatment, suggesting an uncoupling of ethical prescriptions to the desirable behavior for operating of SUS, in its totality, and at same time indicating a gap in policy execution and bioethical development in the country.

Support for the criticism of decisions opposing deliberations by the conference in the content of different Brazilian bioethical trends also can be found, as pointed by Porto and Garrafa: *the Brazilian bioethics is built in articulation with social movements, targets the interest of real people, the social agents who produce and reproduce society's dynamics in the dimension of their bodies and lives (...)* [this] implies admitting that tools outlined for each of these perspectives of Brazilian bioethics are potentially capable of responding to the ethical conflicts in public health²⁶.

If bioethics, as seen, has tools to discuss those issues, which would be these instruments? In our understanding, the main is Unesco *Universal Declaration on Bioethics and Human Rights*²⁷, which can contribute decisively in the solution of these dilemmas, since it predicts *respect for cultural diversity and for pluralism*. Although it does not have a binding feature, that is, it cannot be taken as Law, the Declaration outlines recommendations reiterated by the member States, which should be assimilated and transformed into legislation within the internal scope of countries.

Article 18 of the Declaration referring to decision making and treatment of bioethical issues, recommends: *b) Involved individuals, professionals and the society at large should be included regularly in a common dialogue process; c) It should be promoted opportunities for plural public debate, seeking for manifestation of all relevant opinions*²⁷. It is possible to realize that, Just as CNS proposes, the Declaration also reinforces the importance of social participation in deliberation mechanisms, recommendations that, as seen, were not followed by the MS.

Incorporation of indigenous health actions by Ministry instances, the so-called *inclusion in the SUS*, has happened already and it may have unforeseeable consequences for differentiated care. Even if MS action may be understood as well intentioned, targeted to consolidate SUS, it does not meet the indispensable prerequisites for caring groups with different characteristics, such as the indigenous population. It is fit, therefore, to search for new rationale in order to avoid that this risk situation becomes real, causing more losses to these people's health. In this sense, Olivé's reflection²⁸ on risks that should be perceived in accordance with the different stands from which individuals understand the generating phenomenon of danger or risk situation is fit. The author argues:

There is not just one correct and universally objective way to identify and evaluate risk (...) and neither is possible one single view on risk management that is the sole correct and ethically acceptable way. In risks identification and evaluation there may be different legitimate points of view (...) one is not dealing with a relativist view sustaining that any point of view is as good as any other. It is rather a pluralist view sustaining that - there is not a single view that it is the only correct one.

Olivé suggest that different paths should be investigated in order to evaluate and manage risks, such as those occurring in Sasi. He proposes the practice of dialogue to approach processes when dealing with situations in which plurality, in this case, differentiated care, faces problems with identification, evaluation, and management of risks: *decision making should be the outcome of a broad dialogue process (...) seeking to achieve acceptable agreements for the different parties*²⁸. In the same line, Lorenzo states: *We are speaking here precisely of contemporary trends in ethics, which, acknowledging the impossibility of applying universally acceptable confirmation methods to determine of what is right or wrong, consider that making an ethical decision necessarily implies in setting up spaces for free dialogue*²⁹.

Could Olivé and Lorenzo's suggestions support a proposal of intervention in a risk management environment, here, the dilution of Sasi in the macro structures of SUS? In principle, yes, as long as these

instances or spaces are consolidated where this needed dialogue process could take place. As Feitosa and Garrafa advocate, *the capacity of dialoguing with the other, [with] different groups, is the premise enabling bioethical action*³⁰. As seen here, such spaces exist in the institutional dimension, but in order to produce expected effects, the effective respect for interlocution dialogue must still be built.

To follow the dialogue proposal, ensuring authentic spaces for its undertaking would bring hope that differentiated care of indigenous people's health can be maintained. Legislation itself makes references to the indigenous population specificities and to *the need of differentiated regulations of access*. Ensuring that the subsystem is the differentiated instance responding to this specificity depends on political decisions, which must be implemented in accordance to State's and its managers' responsibility.

The materialization of a plural dialoguing space ensures the exercise of freedom, encompassing different views on the topics under discussion also may be fostered or stimulated by establishing a bioethical committee targeted to act as the promoting instance for reflection, sensitiveness, and mediation. Such committee would be a space for reflection to stimulate sensitiveness to differences, avoiding hegemony of the identical, allowing for a *broad dialoguing a process among all stakeholders in the indigenous people health*.

Final considerations

In the *Universal Declaration on Bioethics and Human Rights* one finds the rationale that guides the problematization presented in this paper, although, in several points it refers to the indigenous topic, it is on Articles 12 and 18 that is stressed the respect for cultural differences, plurality, and dialogue. Added to Olivé, Lorenzo and Garrafa's proposals, which emphasizes the importance of symmetric and plural dialogue, these articles show how bioethics can subsidize the discussion on indigenous health in

Brazil, guiding the rationale advocating major proposals for these people, such as the maintenance of Sasi.

If advocating the plural debate and respect for differences is in consonance with the *Universal Declaration on Bioethics and Human Rights*, as well as with mentioned authors who attest dialogue as value for bioethics, it should be reminded that such proposal extends, in this case, well beyond the mere proposition. Firstly, because it responds to the commitment assumed when Brazil signed this document. Secondly, because it strengthens domestic legislation and norms that also advocate the recognition these people's specificities. And last but not the least, because to advocate indigenous health care specificities, as shown, has consequences in the improvement of these people's health.

In order to be in consonance with bioethics processes, indigenous health policy needs to advocate and affirm the differentiated care system. The Presidential Decree 7,508³¹, of June 2011, which enacted after 20 years the regulation of Law 8,080/90 (Health Organic Bill), goes toward this path ensuring that the *indigenous population will count on different regulation of access compatible with their specificities and needs of integral health care*.

It is expected, under the support of this document, to revert some problems emerged with the incorporation of care for these people within the scope of the Single Health System (SUS). Finally, it is fit to reiterate the importance of establishing a bioethics committee to follow public practices within the scope of the Ministry of Health. Such committee could favor pluralism of sectorial-policies, especially indigenous health. We believe that this solution would avoid reproduction of integrationist policies for the indigenous population already obliterated by the 1988 Constitution.

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Authors' participation

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