Bioethics and Global Health: Basic Health Care as Instrument for Social Justice

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Abstract

Bioethics and global health: basic health care as an instrument of social jusice

This article provides reflection on health inequities in global scale. Therefore, it describes bioethics path from outbreak to become a field of knowledge, presenting the multiple challenges met, and it focus in health inequities as flagrant example of social injustice within global health realm. Utilitarianism model is considered as reflection basis that aims highest wellbeing for the largest number (global population) as it is the closest to World Health Organization (WHO) objectives. Moreover, it discusses the *Declaration of Alma-Ata* strategy, under utilitarianism, to implement universal basic health care, which is considered as valid response that will contribute to minimize global social injustice. It concludes by considering as urgent the bioethical reflection on this threat to human dignity and taking quick needed intervention in order to halt the growing gap between nations with different development levels.

Key words: Bioethics. World health. Social justice. Primary health care.

Resumo

Este artigo reflete acerca das desigualdades em saúde em escala global. Para tanto, descreve o percurso da bioética desde seu surgimento até constituir-se como campo do saber, apresenta os múltiplos desafios encontrados e enfoca as iniquidades em saúde como exemplo flagrante de injustiça social no domínio da saúde global. É considerado como base de reflexão o modelo utilitarista, que visa o máximo bem para o maior numerosa população em escala global), pois é o que mais se aproxima dos objetivos da Organização Mundial da Saúde (OMS). A luz do utilitarismo é também discutida a estratégia da *Declaração de Alma-Ata* para a implementação universal de cuidados primários de saúde, considerada resposta bioética válida que poderá contribuir para minimizar a injustiça social global. Conclui considerando ser urgente a reflexão bioética sobre esta ameaça a dignidade humana, tornando necessárias rápidas intervenções para travar o crescente abismo entre os povos com diferentes níveis de desenvolvimento.

Palavras-chave: Bioética. Saúde mundial. Justiça social. Cuidados primarios.

Resumen

Bioética y salud mundial: la atención primaria como un instrumento de justicia social

Este articulo discute las desigualdades en salud en escala mundial. Para ello, describe el recorrido de la bioética desde su surgimiento hasta constituirse como campo de la sabiduría, presenta los múltiples desafíos encontrados y muestra énfasis en las inequidades en salud como ejemplo flagrante de injusticia social en el dominio de la salud mundial. Es considerado como base de la reflexión el modelo utilitarista, que objetiva el mayor bien al mayor número (la población en escala mundial), pues es lo que más se acerca a los objetivos de la Organización Mundial de la Salud (OMS). Asimismo, a la luz del utilitarismo se discute la estrategia de la *Declaración de Alma-Ata* para la implementación universal de cuidados primarios de salud, considerada una respuesta bioética válida que podrá contribuir para minimizar la injusticia social mundial. Concluye considerando ser urgente la reflexión bioética sobre esta amenaza a la dignidad humana haciendo necesarias rápidas intervenciones para frenar el creciente hueco entre los pueblos con distintos niveles de desarrollo.

Palabras-clave: Bioética. Salud mundial. Justicia social. Atención primaria de salud.

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They declare that there is not any conflict of interest.

Outbreak and Development of Bioethics

Bioethics, a discipline that results from ethics enforcement in life sciences, has arisen in the second half of the 20th century[1]. From a perspective of Patrao Neves, quoted by Garrafa, the period since then can be divided in four sequential stages: a) foundation and basis; b) expansion and dissemination; c) consolidation and critical review; d) conceptual enlargement [2].

Foundation and Basis stage covers Bioethics outbreak and the establishment of its initial conceptual basis[1,2]. In 1970, Porter (North-American researcher of Oncology) has presented Bioethics as the *survival science*. Such dissertation was reaffirmed in 1971 through his work *Bioethics: bridge to the future* [1,3]. The term coined by Porter integrated the essence of everything it desired to express regarding problem and solution: *bios* (life) and *ethos* (ethics) [1,3].

Indeed, Porter intended to warn about the picture that emerged in the 20th century, in which the knowledge acquired by the human being has led to technology, comfort and power over nature, which would also set it against humanity, causing damages to present, as well as to future generations, and seriously threatening of mass extinction all forms of life[1,3]. Hence, Bioethics neologism uses an utopia of happy overcoming for mankind and the planet, in which the bridge to such ideal future would be an integration of knowledge about life sciences (cellular and molecular biology, genetics, biochemistry, physiology, ecology, amongst others) with human sciences, disseminators of thinking, ethical values and spirituality [3,4].

The stage of expansion and dissemination of Bioethics corresponds to the eighties, a period in which this field emerged from North America and was spread to other countries. However, the Bioethics that Porter designed and proposed was not exactly the one developed in the United States (USA) and disseminated to the five continents. Indeed, Porter purpose did not largely impact the North-American intellectuality, being damaged by the fact that the word bioethics was inserted in the medical area as a synonym of *medical ethics* or *health care ethics* [3], *reducing its action field and redirecting it to a different sense from the one firstly designed by the father of this applied ethics.* As decisive factors for this Bioethics orientation, there were scientific, political and social heritages and circumstances of the first half of the twentieth century, particularly the experiments in human beings aiming to develop biomedical research. The appeal complaint was done to groups of unprotected, institutionalized or regarded as inferior people (orphans, prisoners, elderly, Jewish and other ethnic minorities) in projects of North-American, German, Japanese and others for achieving scientific and military objectives of their governments. From such complaint, international agreements resulted, especially the 1978 Belmont Report [5-7].

From this context has emerged the theoretical structuring that so far would determine the course of bioethics history. For achieving this level, the contributions of the North-Americans Beauchamp and Childress (from the Chicago School) were severely significant when designing the principialist model, presented in the book *Principles of Biomedical Ethics,* 1979. This model is ethically based in four main principles: *autonomy, beneficence, non-maleficence and justice,* being especially recognized the applicability in clinic and research domains [1,2,8].

In the nineties, stages of *consolidation* and *critical review* were assigned, when Bioethics has strengthened its presence and relevance as ethics applied to the field of life sciences. However, and notwithstanding the international success, first critics to the principialist model, prevalent and so far assumed as universal emerged: 1) maximization of the individual and his autonomy, which led to a real industry of *informed consent terms*, incorporated on a linear basis and uncritical to human being researches and hospital treatments without verifying if all people were truly capable (whether they had literacy or not) and independent in the decision-making process; 2) inability to achieve historical objectives of protecting the most vulnerable in a practical way,

revealing insufficiency for advocacy and intervention in deep socioeconomic inequalities and iniquities regarding public health; 3) severe insufficiencies with regards to levels of flexibility and suitability in various cultural contexts throughout the world, that would compromise the usefulness and validation of the universal principles in societies with beliefs and values so different, among other limitations [1,2,5].

The *conceptual enlargement* stage happens in the transition of century and millennium. This new stage of Bioethics life brought a change in perspective, with the homologation of *The Universal Declaration on Bioethics and Human Rights* as a notable example, promulgated under Unesco (Paris) in 2005 [2,9]. This political document that gathers 191 signatory countries (significant parties of the international community) consists of 28 articles that, besides traditional biomedical and biotechnological issues, incorporate new social topics about health and environment, as well as ethical concepts and references for human dignity, individual and collective responsibility, vulnerability, integrity, privacy, confidentiality, equality, equity, non-discrimination and non-stigmatization, solidarity, tolerance (among others) [1,10], some of them are traditional in UN declarations since its foundation. Thus, in the ideological framework of all documents developed at UN, the link of Bioethics to the *public thing* is restated regarding the definition of its priorities for reflection and intervention, as well as for enhancing issues of global scale [2].

Bioethics has come to the new millennium with a professedly *global* nature. Nevertheless, the variations of acceptation assigned to the term and its global attribute, indeed Bioethics emphasizes that: 1) It embraces all dimensions of life, from individual to collective scales in planetary terms; 2) more than multi or inter-disciplinary, it is a trans-disciplinary field of knowledge, overcoming borders that limit disciplines involved in the study of the object in question, in a close dialogue that leads to new knowledge, mutual enrichment by all agents in which the whole is greater than its parts; 3) it is disseminated through the whole planet and internationalized as an institution, with its agents working in a global network, in the permanent conflict of universality of principles *versus* ethical relativism [1,2,11].

In a certain sense, the *globalization age* has contributed to the *Global Bioethics Globalization*, whose epistemological structuring, working tools development (conceptual basis, principles and theoretical-practical models), definitions of categories and study objects (as an answer to emerging bioethical dilemmas), recruitment of resources and agents are being permanently questioned and challenged about reconstruction, suitability and expansion[2].

Undoubtedly, one of the greatest challenges is to gather *capability* that allows the coverage of the complex reality that implies globalization [12], in a concrete entirety that registers various paces, interactions, dependencies, consequences. As it is by common sense, some of the bioethical problems found in developed countries are different from the ones faced in emerging countries and, as such, require diverse solutions, specific for each situation. Classically, two great groups of situations are considered, distinguished according to the type of questions and topics brought for Bioethics reflection: 1) *emerging situations* – features of industrialized countries, which are questions predominantly related to new reproductive technologies, genomics, organs and tissues transplants, amongst others; 2) *predominant situations* – related to less developed countries that highlight social exclusion, poverty, violence, barriers for accessing health care, among others [2]. Such differences are not linear and challenges of both situations may coexist in the same country. At the same time, the process of economic globalization, far from being reduced, has further deepen inequalities verified between "rich" and "poor" nations [1,2,5,12-14].

Global Bioethics and Health Inequities

Among all challenges that global Bioethics face, the relevant ones are inequities regarding health access (between countries and within themselves). Such disparities have always existed. However, and in spite of efforts undertaken at national and international levels, such differences

remain exposed and, in certain health fields, they are even more pronounced [2,15]. In this article, health disparities will be particularly emphasized among the great groups of countries that belong to different concepts of economic development.

According to information from *World Health Statistics 2009,* a publication of the World Health Organization (WHO), and without neglecting encouraging signs, especially at the level of child health or the absence of losses verified in relation to HIV/AIDS, tuberculosis and malaria, in some areas there have been little or no gain in health, as well as maternal and neonatal health. In parallel, even in fields with better results in terms of trend, the real magnitude would keep being overwhelming and would need heavy investments[15]. In order to document it, it is necessary to present a few health indicators in some public health areas, officially adopted by WHO in that report.

In terms of *children's health*, it was verified that the ratio of children under five years that suffered of malnutrition has decreased from 27% in 1990 to 20% in 2005. Yet, the progress would be irregular, with the estimation of 112 million of children under the weight recommended to their age. Malnutrition is pointed as a basic death cause in more than one third of childish deaths. The reduction of global childish mortality would also increasingly depend on fighting against neonatal death. Around 37% of under-five deaths occur in the first month of life, with majority of cases happening in the first week. This epidemiological scenario was more serious in emerging countries, where civil and military conflicts coexisted, as well as economic difficulties and high predominance of infectious diseases such as HIV/AIDS' [15].

Concerning *maternal health*, it is possible to state that up to the report publication date around 536.000 women have died on an annual basis (between 1990 and 2005) due to complications during pregnancy or at the delivery time, of which 99% were citizens of emerging countries. Most of maternal deaths have occurred in the African region, where the mortality rate was of 900 per 100.000 born alive, with no measurable improvements between 1990 and 2005 [15].

In the field of *infectious-contagious diseases*, not only pandemics can be stressed, but also neglected diseases of minority natures. In 2007, around 2,7millions of people were infected by HIV, increasing the total number of infected ones to 33 million people. The use of antiretroviral therapy has increased, although from around 9,7million of people in the emerging countries that needed the treatment, only 3 million were given the medication. By the end of 2007, only 33% of women infected by HIV were given antiretroviral drugs to reduce the risk of mother-to-child transmission. Regarding neglected tropical diseases, it was estimated that around one billion of people would be affected by these disabling chronic infections that specifically develop in poor living conditions and where health care systems are deficient [15].

In terms of respect to *affordability of drugs*, and although almost all emerging countries are given drugs called essential from foreign parties (from namely non-governmental organization [NGO], and WHO itself, as well as private institutions, such as Gates Foundation), the availability would be often deficient, mainly in remote areas, far from political centers of such countries. This was verified, *in loco*, by one of the authors, during three months of voluntary work at a NGO as a public health physician, in the countryside of Guinea-Bissau Republic. Surveys performed in around 30 countries of this disadvantaged group indicated that the availability of essential drugs at health units of those countries were of only 35% in the public sector and 63% in the private sector [15].

At last but not the least, it is fair to note *hygiene* and *environmental health* determinants, such as drinking water and sanitation, as important risk factors for mortality and morbidity. Worldwide, the rate of populations with drinking water access has increased from 76% to 86% between 1990 and 2006.

However, in 2006 54 countries declared that less than a half of its population had sanitation [15,16].

Due to this scenario presented by WHO, it is possible to observe deep health iniquities among peoples. In view of this *scream of reality*, how does one answer ethically? How does this challenge of global public health fit into Bioethics reflection and action? In order to elaborate action purposes for this and other challenges, Bioethics appeals to a variety of authors or moral philosophies (virtues and duty virtues, utilitarianism, relativism, discursive ethics, etc.), whereof principles of bioethics have emerged. The most significant are: beneficence, non-maleficence, autonomy and justice. It also shall be considered vulnerability, dignity, integrity, solicitude, responsibility and solidarity, besides some theoretical-practical models, such as principialism (most predominant), contractualism, libertarian, the one of the virtues, casuistry, foundational, European) [1].

By discussing health inequities, we automatically place us in the theoretical reflection plan regarding the models of social justice to be implemented in the field of resources for health care[1]. Justice is a central matter in Bioethics, either in individual side (e.g. when selecting individuals for research or for therapy application) or in the collective plan (e.g. with protection of vulnerable groups and universal access to health care).

In the sense of obtaining answers for such challenges, a deep research of various ethical theories has been done, as well as the respective transposition for principles and models of bioethics, as per field of specific usage. Alone, none is almighty for solving dilemmas. The four philosophic theories or ethical justice models that have emphasized the most over time are the *libertarian, utilitarian, egalitarian* and the *communitarian*. Each one also has a vocational area in which may be more pertinent in terms of equity achievement and justice: the *libertarian* model strongly advocates individual rights and freedom in order to avoid possible abuses; the *utilitarian* model values actions with greater usefulness, setting priorities to the ones that enable effective benefits for the greatest possible number of people

the *egalitarian* model consists of inter-individual differences, yet aiming its overcoming through equal opportunities. The *communitarian* model does not separate justice from the socio-cultural context and the current moral principles, without which is impossible and unreal to act fairly [1].

In this article, in which the reflection focus are inequalities in health care on a global scale, (the) reflection shall be based on the *utilitarian* model, from which potentials will be explored, as well as limitations, by tracking it as the basis for a Bioethics answer to this challenge of social justice nature.

Utilitarianism: a brief presentation of the theory

Utilitarianism is an ethics current of thought that encompasses a variety of principles, almost exclusively of Anglo-Saxon authors. They have in common the fact that the evaluation of moral actions is exclusively based in the consequences of these actions and their advantageous and disadvantageous nature, the reason why the designation of consequentialism is often given. Therefore, *utilitarianism* fits the action objective (theological ethics) and not its origin or the intention of its moral agent, as well as it does not consider the process and means used for achieving such goal, the way it would happen in an ethics code. As a result from this matrix, the *cornerstone of utilitarianism* is the *usefulness principle*, according to which the action will be morally correct if the *greater happiness of the number* is achieved. However, the comprehension of this principle done in the past and nowadays by utilitarianism is not regular. After all, there were many variants that emerged from this utilitarian core over time [1,17-19].

The expression *the greatest good* or, more precisely, *the greatest happiness,* has first appeared as a formula for moral rule in 1670, in *De legibus natura*, by Richard Cumberland. However, it was Jeremy Bentham (1789) who created the term *utilitarianism* and the inherent theory known and influential. Bentham has started from this theory. Its criteria for distinguishing good from bad laws and its use have been more practical and political than theoretical.

He advocated that the only goal sought by the human being is happiness, that is to say, pleasure and the absence of pain. From this philosophic position, a *hedonistic utilitarianism* (individualist) has resulted, by prospecting happiness as a positive balance of pleasure over pain, and the good action would be the one that could maximize this happiness on an individual perspective. However, in order to explain how one should fight for happiness, Bentham calls certain "penalties": if one does not consider pleasures and pains of the others, one must be arrested (political sanction), or marginalized (moral or social sanction) or even punished (theological sanction). In this aspect, Stuart Mill (1863) has proposed an Eudaimonist Utilitarianism (universalistic) that included new distinct elements of hedonistic basis or pleasure, in particular the defense that some pleasures are higher and nobler than others. These ones aims, more than pleasure and for its own good, virtue and knowledge. By multiple underlined constraints, these forms of utilitarian individualism were practically set apart [17-19].

Moore, in *Principia ethica (*1903), rejected happiness as the only final objective to be achieved. Knowledge, affection and enjoyment are elements that contribute to the intrinsic appreciation and they also may assume the role of *supreme good*. In *Ethic (*1912) Moore defended the principle that an act will be correct if it reaches the *greatest good for the greatest number*. Sometimes this version is called *Utilitarianism Act*, for distinguishing it from the Hedonistic and Eudaimonist principles. Moore has also recognized that in the judgment of actions, whether good or bad and according the utilitarian criteria, their reasons and laudable or objectionable intentions should be met, (differently from his predecessors, to whom intentions and means were not important in relation to the objective) [17-19].

As a counterpart to the Utilitarianism Act, there is the Rule Utilitarianism. Maybe Richard Brandt was the most prominent defender of this principle, by postulating that we should firstly ask for what is the best set of rules according to the utilitarian perspective - greatest good to the greatest number. What rules in force would we prefer having in our society so that people could thrive? Individual acts would be therefore considered correct or wrong whether accepted or not in the light of such rules [17-19].

In addition to these doctrinal versions of utilitarianism, others have emerged based on the attempts of improvement or suitability to certain realities or reflection objects. However, when searching for new utilitarian versions, it was dedicated a discussion about the defense and consolidation about the best of its theory. Although the recognized constraints, utilitarianism has enjoyed wide dissemination and acceptance, undoubtedly revealing its pertinence and usefulness. Special emphasis must be given to John Rawls' reflexive work, already in the 20th century. Rawls was one of the philosophers that criticized the exposed utilitarian models, presenting a *justice principle* that intended to rely social equity regarding access to essential assets, such as health[18,19].

Nevertheless, utilitarianism that comes to the twenty-first century may be summarized in three essential ratios: 1) actions are morally right or wrong only due to their consequences; 2) when evaluating consequences, the only thing that matters is the amount of created happiness or unhappiness; 3) the happiness of each person counts in the same way [18]. This theory has greatly been attractive to the decision process theorization. Its central concepts are solid and, for anti-utilitarian arguments, the current utilitarian attitudes have been the reformulation for increasingly satisfactory ways.

Utilitarianism and inequalities in global health

The answer to the question *what is good?* is essential for utilitarianists, because the evaluation in terms of moral correction and actions justification depend on that, as well as the means to achieve such goal. This stated, an action shall be right if it generates such good to the greatest number of individuals. Thus, and in the first place, the question to be wondered is: Is health a good or a conductor of happiness? Beyond doubts and relativisms regarding value, the WHO Constitution states that:

THE STATES Parties to this Constitution declare, in conformity with the Charter of the United Nations,

that the following principles are basic to the happiness, harmonious relations and security of all peoples. Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity. 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. The health of all peoples is fundamental to the attainment of peace and security and is dependent upon the fullest co-operation of individuals and States. The achievement of any State in the promotion and protection of health is of value to all. Unequal development in different countries in the promotion of health and control of disease, especially communicable disease, is a common danger. (...) Governments have a responsibility for the health of their peoples which can be fulfilled only by the provision of adequate health and social measures (...) [20].

Facing such inalienable value, the existence of WHO as a coordinator author of international works in health care aims to support *the attainment by all peoples of the highest possible level of health*, as per first article of the same Constitution[20].

This sovereign will of WHO Member States has been repeated over history, noteworthy to say the Declaration of Alma-Ata, as a result of the International Conference on Primary Health Care, held in Alma-Ata in 1978, USSR at the time, from September 6 to 12: (…) a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, is a fundamental human right and that the attainment of the highest possible level of health is a most important world-wide social goal whose realization requires the action of many other social and economic sectors in addition to the health sector [21]. Nevertheless the usual undertaken controversy regarding universally assuming health as a fundamental human right, this content has always been in all editions of the Universal Declaration of Human Rights [10,22].

In view of the above, health care is worldwide agreed and undertaken as integral part of a happy life; in addition to be a good in itself for every human being, it is also a determinant for the greatest good for nations and the world, as an element of peace, safety and prosperity. All human beings from all peoples shall have access to it in an equal way, fighting for its highest level. In conclusion, utilitarian criteria of the central idea of good to be generated by actions are accomplished. Therefore, actions that produce or improve *physical, mental and social well-being* of the largest possible number of people, to actually generate gains for health care in an equal and distributive way to communities of all countries will be morally right, legitimate and commendable from the ethical-utilitarian point of view.

Under this symmetrical reasoning, health care inequalities and all actions that worse them are morally reprehensible. At this level there is also the substrate of ideological agreements in the documents of WHO. As previously stated, In WHO Constitution, health care inequality represents a common danger an all governments share the responsibility [20]. Again, in the Declaration of Alma-Ata, all signatory countries reaffirm that: (...) *the existing gross inequality in the health status of the people, particularly between developed and developing countries, as well as within countries, is politically, socially and economically unacceptable and is, therefore, of common concern to all countries*[20].

What actions would WHO discuss and what interventions does it propose in order to maximize this good at a global level? For this purpose, the document with the greatest historical value was the *Global Strategy for Health for All by the Year 2000*. Its development and publication (1981) were a result of a long journey of a joint work of the Member States and it constituted in the crucial idea that (*translated by authors*): the strategy is based on the concept of national health systems based on primary health care as stated in the Alma-Ata Declaration (1978). That proposal is equally valid for both developed and developing countries, and it targets each country's specific needs [23].

To recap Alma-Ata, primary health care is the key for achieving such goal, as part of the development, in the spirit of social justice [20]. As the new millennium has come, the ideals of health for all by the Year 2000 are still valid and urgent

in terms of minimizing inequalities that afflicts human kind. Indeed, the Millennium Declaration, as a result of the Millennium Summit in 2000, from September 6 to 8, restated the faith of the UN Member States and their fundamental role for a more peaceable, prosperous and fair world, with effectiveness being a shared concern. They desire action and, above all, results. Leaders have set concrete targets, such as reducing by half the rate of people living in extreme poverty, providing drinking water and education for all, reversing the spread of HIV/AIDS, among other objectives in the field of health care and development [24].

Consequently, the utilitarian matrix of aiming factual results at the common good level, as a figure of a greater social justice in a larger scale, keeps being an utopia that guides actions and responsibilities. Health inequity as a social injustice once again is accepted by Margaret Chan, Director of WHO, adjusting it in the globalization era that we live in. We think that the only challenge to be taken nowadays is to make globalization a positive force for all peoples worldwide, once considering that it offers great possibilities, currently its benefits and costs are unevenly distributed [25]. This perverse circumstance was retaken at the Millennium Conference under the aegis of solidarity among nations. Global problems must be faced so that costs and responsibilities be fairly distributed, in accordance with fundamental principles of equity and social justice. Those who suffer, or that have benefited least, deserve help from those who benefit the most [24].

Considering as true that the most urgent deficiency focal points are in the African continent, the Millennium Declaration recorded the commitment of strengthen *the struggle for lasting peace, poverty eradication and sustainable development, thereby bringing Africa into the mainstream of the world economy*. However, in the concrete fields of morbidity and mortality, the commitment directly supports the *enhancement of capability in order to deal with the scourge* of *HIV/AIDS and other infectious diseases* [24].

And in the new millennium, which is the strategy to be adopted? After thirty years, is the Declaration of Alma-Ata still contemporary? The desired targets were not achieved. Would primary cares continue to play their key-roles in the execution of the millennium goals? WHO and Member States jointly restate affirmatively. WHO (Europe area) is emphatic: *primary cares, more than ever*! Global leaders have increasingly got more knowledge about how health care systems can become more equitable, inclusive and fair [25].

Values underlying WHO Constitution and the ones in the *Declaration of Alma-Ata* have been tested and they remain true. The main issue is the suitability to new challenges in health care, the huge progress in global terms, aiming to overcome collective failures in providing care as per these values and that according to Margaret Chan, *are painfully obvious and deserve our greatest attentionn*[25]. Essentially, this position does not vary in relation to the health area of WHO, with the strategy of developing access to more social justice among countries and within them at the most possible universal level [25-27]. WHO now needs to speed up the attainment of its ideals and to create minimum mechanisms for effective fulfillment by governmental entities regarding documents they are signatory.

From the exposition made, there is a demonstration of the compatibility of the utilitarianism philosophy with the structural ideals for theory and practice by the superior supporter entities at the level of global health. Health is a good to be generalized in order to get well-being and happiness, while all human beings deserve this equally, and actions, particularly of primary care implementation (proven carriers of results and positive impacts in health promotion and fight against disease) are legitimate and morally right from the utilitarian point of view. However, this utilitarian position against the bioethical challenge of inequalities in global health, such as the genesis theory, is full of argumentative constraints that need further investigation.

Utilitarianism and its limitations

In the utilitarian approach, one of the central purposes is the idea that we have to treat the well-being of each person as equally important. According to Mill, we shall be *as strictly impartial as an unconcerned and benevolent spectator*[19].Such proposition seems plausible when presumably stated or registered in global political documents, such as the above mentioned. However, it may contain troubling implications.

From the very beginning, the requirement of *equal consideration* places us in a position of excessive demand. In the faithful adherence to utilitarian standards, it would imply the most fortunate people or countries to abandon their resources and well-being in order to match the level of the neediest ones. In terms of global health, it would require a global government so that all peoples could be placed in a *common denominator*. However, UN is not such centralized government of power, but an organized aggregation of individual and sovereign nations instead. As States, equality is in the recognition of the identical self-determination, whose leaders shall equally struggle for the compliance with the universal resolutions of which they are signatory, with the final goal of setting them at the highest reachable good. The globalized world has borders and it is a mosaic of sovereign States. Documents of UN/WHO are recommendations or intentions and not legal obligations. There is no way for *invading* a country and determining its health care system.

On the other hand, literal equality of peoples is impracticable due to its own anthropology underlying the notion of good and happiness, being concrete in the health care concept. Specificities of each culture, population group, individuals and the concepts of good and health care shall be met. The notion of health is impregnated of interpersonal and cultural heterogeneity (especially the psychosocial extent, with the physical aspect strictly associated with it). A *quantitative estimation* would be necessary in order to evaluate it in utilitarian terms, in a correct way and with a moral nature. The definition of "good" would depend on that and, as a consequence, the reference for demanding equality and social justice as well.

However, and assuming the constraints for *measuring health care and well-being*, developed and permanently in development assessment methods are available, at the individual and collective levels (clinical and population-based, respectively), that generate health care indicators and establish epidemiological scenarios. Even when weaknesses are admitted, such as objects hard to be measured, computer systems of partial coverage, deficit in data processing, voluntary and involuntary handling, amongst others, they are perfectly valid and suitable for a demonstration of health inequities at a global level. However, those who use such tools for struggling against these health scourges ensure their effectiveness.

Realistically, if this equality does not allow putting this common denominator to the whole planet population, in parallel, it would generate more injustice, and at least damage to the majority. Putting countries on the same level means creating barriers for engaging the most developed, losing the possibility of high progress that pulls the squad and even benefiting the least wealthy.

Real examples of benefits for developing peoples are investigation of malaria vaccine with funds from cybernetics (Melissa Gates Foundation), technologies for renewable energy production in African countries, with great natural resources that may feed them (sun, wind, water) essential to electricity supply for health care infrastructure, advances in information technologies (telemedicine), so that medicine experts support distance and care provision, improving practices, training professional and fighting problems of scarcity, investments on research of methods regarding portable, simple and economical diagnosis (laboratory and imaging), so that they can be supported by economically weak health care systems, among others.

The impartial observer position (utilitarian) still has the angularity of destroying human relations, clearly based and conducive to preferences. Regarding preferences depreciated by (utilitarians) utilitarianissts, it must be said that, in practice, no one is willing to treat all people as equal, because it would require that we would abandon our special relations with friends and families. It is known that the biggest mistake of utilitarianism that lose all contact with reality.

Treating children as *strangers* is a moral aberration. The same way, the State that would not choose for supporting and protecting its people would be morally unacceptable. Under sovereignty, there is the maximum of responsibility by each government to firstly and primarily defend its people, putting into practice constitutional ideals. Conversely, such governments must also report to fellow citizens in case they do not fight for social justice in their own territory. In this aspect, over the years two schools of Bioethics have been developed (*prevention bioethics*[16] and *intervention bioethics*[28]), strongly implied for the defense of concrete health care situations of specific groups, with special emphasis in Latin American countries.

Indeed, preferences may be beneficial, in order to obtain more positive results and, overall, more well-being and happiness. In some sense, it is as if we would say: "better well help few than badly many others". Such preferences of international cooperation may have several origins, such as historical, political, cultural and religious, but, essentially, they almost usually point anthropological compatibility among peoples and governments. This fluidity aspect of diplomatic relations, of an easily understanding nature and close negotiating relationship, is essential to the effective success of global health interventions.

As a familiar example, there is the Portuguese cooperation with the *Portuguese-speaking African countries* (Palop). Indeed, Portugal has a strategic position for mediation and direct cooperation with these countries, or former colonies. Abdicating the status of preferential channels that Palop countries have with Portuguese-speaking countries, also historically related, would be a loss of opportunity, under the penalty of wasting favorable conditions for developing morally right actions as per the utilitarian point of view.

The only considerations that the utilitarian theory defends as significant for determining correction of actions are related to the future. Due to the exclusive concern regarding consequences, utilitarianism takes us to directly pay attention to what will happen as a result of our actions. However, considerations with the past are of equal importance[19]. Meeting national and international scales, and at the limits of the achievable legitimate, States have to be responsible for not protecting their citizens health. It is not fair that bad leaders, due to mismanagement, corruption, lack of transparency and strategy, benefit from efforts of abdication and concession of resources that resulted from the good performance of others.

In this line of reasoning, States must be publicly identified and punished by UN when they allow valuable assets for health care (such as water[16]) to be unruly explored by economic foreign powers, as well as when political, financial and economic interests prevent wide access to essential medicines for rehabilitation of population groups by a country, such as retroviral and antidepressant, among other situations.

Nonetheless, utilitarian theory can be applied if it focuses on requirements of proactive actions that aim to reach greater good in the future and perform evaluation of results. Indeed, evaluation is essential because reconsideration of actions as good or bad will depend on that. As an example, there are empirical evidences obtained through evaluation of the gains in health that derive from the implementation of primary cares, in addition to the evidence that at a higher health level, progress and prosperity of peoples are associated (as documented).

Continuing to explore the utilitarian model weaknesses, it is possible to recap that its crucial point is to look to actions consequences, focusing on something considered as good, without contemplating the origin or principle of such actions, neither resources nor procedures required to their performance. This way, utilitarianism is

not interested in the intentions of the moral agent. It would not disapprove a cooperative organization developing health care programs in an underprivileged country aiming to build a local structure that could enable the practice of clinical trials and experiments in humans without control, under the veil of targets officially defended.

Similarly, in terms of process, there is a risk of sacrificial logic in the search for this individual or collective *good*. Speaking of struggling for the good of the majority, the lack of acting reasonableness may appear and threaten *what* or *who* it may encounter. From economically or militarily dominant countries, the iatrogenic intervention is exemplified by the elimination of practices and habits in intervention places, without the presence of acculturation, anthropological suitability or real and effective empowerment on partnership work, not by simple subjugation. Hence, it is possible to infer that utilitarianism conflicts with the idea that peoples have rights and cannot be despised only because someone anticipates good results. Sometimes, it may occur that good targets are served by the infringement of such rights.

However, Declaration of Alma-Ata safeguards that *primary health care is essential health care based on practical, scientifically sound and socially acceptable methods* [21]. Utilitarians themselves also recognize that the rights of citizens, cultural heritage, community identity and peoples sovereign shall not be lightly set aside. On the contrary, it should be a notion that sets limits to actions. If this were not the case, this theory, so progressive and close to the common sense in principle, would be indefensible, especially due to the conflict with fundamental moral notions, such as individual rights.

Regarding consequences, those that at the same time may be caused by intervention benefits for health care and social justice must not be forgotten. From the very beginning, health care sustainability (a problem for most of the developed countries with public health systems). Indeed, the Declaration of Alma-Ata advise that the provision of primary care shall be *universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development* [20]. It does not mean that it is necessary to step back regarding its implementation, but rather to provide ways of solving secondary effects and using benefits in order to face these collateral damages. A healthier and more prosperous society may work and better contribute to the production of internal richness that will face up public expenses.

Utilitarianism, when evaluating good and bad, as well as not invading rights that individuals and communities consider as basic rights, must meet and respect the common sense. Therefore, what could be more incomprehensible than the idea that people have about rights, dissociated from any benefits derived from the recognition of such rights? Utilitarianism is not incompatible with common sense. On the contrary, it is rooted in it. To the common sense, belongs the idea that being healthy is better than sick. Such thinking sets cohesion and strength to the cause, and the more universal, the better. With regards to global health, it is universally accepted that health care is essential for prosperity, well-being of peoples and world peace. That is why States have united in 1948 to establish WHO and currently still validate and subscribe it in its constitutional target of reaching the highest possible level of health care for all peoples. The same way, worldwide leaders agree about the plausibility and relevance of *primary cares*.

However, it must be advised that common sense is not right all the time and keeping it would lead to the prevalence of morally bad actions. Our moral common sense is not necessarily reliable. It may consist of various irrational elements, namely prejudices originally from a countries, religions and cultures. This situation of countering bad actions and false preconceived factors may be considered even as utilitarianism most important contribution. As an example, the common practice of certain African peoples that behave in a fundamentalist way regarding genital mutilation (female and male) in their children, sexual behaviors that cause

HIV/AIDS proliferation perpetuation of poor habits regarding hygiene at home, amongst.

The problem is essentially attached to conflicting beliefs. But why should such peoples accept a *foreign* theory that conflicts with deep-rooted feelings and beliefs? Instead of theory, feelings should be excluded for the greater good of health care, also implying an integration between these beliefs and irrationalities of the human beings, so difficult to be countered that individuals with schooling, technical training in health care, access to information and scientific evidence do not consider AIDS as a viral disease, but rather as a bewitchment or *evil eye*. Not to mention genital mutilation they keep doing in their children, aiming to ensure familiar and community acceptance, as well as dignity within the society and to the eyes of divine entities.

Final considerations

Global bioethics faces severe and urgent challenges permanently originated by worldwide daily life. It is appropriate to state through the several quarters (social, political, scientific and religious) that one of the biggest problems of human kind still and increasingly is the difficulty of setting up the *Universal Declaration of Human Rights*. Concerning the right to health care, the view is that inequities are even more apparent in this globalized world. It is urgently necessary to think about social justice in global terms and to find ethical answers that guide the repairing actions of nations.

Many aspects weaken the utilitarian model as a purpose for fighting against inequities in global health. Todavia, paira sobre esses aspectos o fato de o However, over these aspects is the fact that the *utility principle* is essentially, a guide when choosing for rules and practical interventions aimed to create results morally right and at a great scale. Normally, we should accept rules that when followed, allow us to regularly promote general wellbeing and to suppress the need of once again invoking the principle, in order to determine the correction of actions developed at the scope of such rules validation.

To a certain extent, this reflection corresponded to the questioning about the *rule*-established decades ago by the highest entities in charge of health care policies. In the current scenario, it is necessary that such rules and strategies (are) be revisited. Rules cannot be kept if they do not show effects, are not consciously applied and defended where they effectively generate *utilitarian* results or not discussed and agreed to be renewed. Ultimately, the lack of revaluation and methodical questioning would correspond to reducing scientific, technical, legal, political, ethical and moral progresses.

Hence, utilitarianism as bolder model for obtaining positive results in global health care reveals conciliation with worldwide documents that are more significant for the matter, subscribing primary care as instruments for excellence when fighting against sanitary inequities. It is therefore possible to state that primary cares are points for the application of a joint among bioethics, biorights and biopolitics of rare agreement at a global level, keeping their consistency and strategic solidity over time without ever having lost the future sense.

May *Alma-Ata be enforced:* The Conference calls on all the aforementioned to collaborate in introducing, developing and maintaining primary health care in accordance with the spirit and content of this Declaration [21].

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Received: 4. 13.10
Reviewed: 9. 26.11
Approved:: 11. 10.11

Authors' participation in this article

- Authors have participated equally in all parts of this article.