

Interview: inequality the key concept when discussing health internationally

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Abstract *Economic, scientific and technological development, and innovation have influence in the inequalities between countries, especially in terms of the differences between their populations' level of health and wellbeing. The phenomenon is seen not only between countries, but also within them. How these inequalities can be reduced and how to examine health in the international context are the themes of this interview with Gastão Wagner, President of the Brazilian Collective Health Association (Associação Brasileira de Saúde Coletiva, or Abrasco).*

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What's your analytical view of health in the international context?

The key analytical category is inequality. There is a very great heterogeneity in health conditions in the world both in terms of the epidemiological profile of a population (morbidity, mortality, etc.), and also instruments of policies and programs to confront these problems. This inequality is seen between the regions of a country, between countries, and between continents.

There have been, for instance, important advances in access to technologies, vaccines, control of the environment, and control of the use of foods, pesticides and pharmaceutical drugs in European countries. Even so, at the same time, we live with certain situations as if we were in the First World War, or in the 19th century. Examples that we see in some populations, are: refugees, the high rate of mortality from avoidable causes, malnutrition, infectious diseases, death in childbirth, and child mortality.

Another theme is violence, right?! Syria, principally, is going through a very serious social regression. Africa, with interventions by large companies and groups; the presence of mercenaries. A very bad health situation, depending on the interference of Doctors without Borders, important focal programs, but...

But?

In spite of the efforts of the UN, the inequalities in the right of access to the defense of health prevail. What exists are those emergency acts of help by the UN itself, the organizations of each continent, the NGOs, and joint support by philanthropic entities.

Even here in Latin America there is a disparity between rights, which is reflected in the health indicators. If we compare life expectancy in Brazil and Paraguay, to give an example of a neighboring country, we find an enormous difference in life expectancy and survival for people who live with chronic diseases in general. This is the result of the singular political, social and economic development of each country.

Another central point for this analysis is the existence, or not, of a national public health system. Countries that have public systems with an average, reasonable degree of effectiveness compensate their economic and social inequalities. They compensate with access, with inter-secto-

rial actions, with promotion of health and with other public policies, like the *Bolsa Família*: the countries that succeed in building and implementing these public policies and especially the public health systems, even if only partially, such as the case of Brazil, succeed in ensuring a protection of social rights.

The international organizations, as well as those help programs, need to argue in favor public health systems, don't you agree? Something beyond the slogans "health for everyone by the year X – but we are not quite sure of the value of X...".

You have pointed to some ethical problems that are present in the discussion about health at the international level. What are the main ones?

I think there's an ethical dilemma, or better, there are various ethical dilemmas. In his book *Piketty* (Thomas Piketty, author of *Capital in the 21st Century*) raises the unbalanced relationship between concentration of wealth and public policies, including the right to health, the needs for health and health as a business. The latter refers to the medical-industrial complex – which in most countries the public systems do not nationalize or socialize, but try to make increasingly appropriate negotiations with. Health supervision tries to place limits on distribution and sale of the products of the medical-industrial complex. Policies try to prevent the use of medical tests that are complementary to hospitalization. That is to say, it's a very complex relationship, because the logic and the rationality of the public system are those of the needs for health. The basic rationality of the medical-industrial complex, which is private, is that of the market: those who have money buy, those who don't have it don't buy.

On the drugs for HIV/Aids, for example, this becomes very clear. Brazil is one of the few countries of the world that assumed complete, full-scale treatment as a public policy, both in prevention and in promotion. A decision in which we struggled to find funds, negotiate, deal with generics, break patents. This is not simple.

There is a very large ethical-political dilemma that explains a large part of these inequalities, and also the economic dominance of one part of the world. We need to see what needs to be done with this ethical-political conflict between these two rationalities.

And is there a way of resolving this? What would be the possible routes?

If one thinks of it as an “all or nothing” issue, there is nothing that can be done. But if one thinks in terms of a coefficient, then there is an approach to solving the problem. Many countries face this dilemma. The United States, because it is rich, faces it through the side of business, and through the liberal and traditional market culture. And it’s clear that it’s not only a question of the intellectual degree of achievement and qualification of the population, or the politicians, or the level of schooling. I think that, in South America, Brazil has faced up to this by approaching the issue more in terms of health needs. With the policy on HIV/Aids and in the case of vaccines, for example, Brazil has its own manufacturing, and negotiates strongly with the private sector, in spite of all the money-related power, and this concubinate between the market and the State. In spite of these, we have succeeded reasonably better than other countries.

Nethis (Nethis is the Portuguese acronym of the Center for Studies on Bioethics and Diplomacy in Health – *Núcleo de Estudos sobre Bioética e Diplomacia em Saúde*) has been working, over the years, with the correlation of three concepts: development, inequality and international cooperation. The central analysis is of what impact scientific and technological development, and innovation, have on the inequalities between the countries. In what way could cooperation reduce these inequalities? What’s your opinion?

The universities and public research, like public policy, have to have autonomy. The university was created to have autonomy in relation to the Catholic Church in Europe. And later, the university developed to the point of having autonomy in relation to the State. Today, we are expanding the university’s autonomy in relation to the market. One has to say though, that autonomy is always relative, because academia studies the church, relates to the State, trains people for the State, runs a School of Government, etc.

I argue that the public budget for research has to be divided: one part for free initiative of the scientists, and the academic dynamics; and the other part for public policies, with a focus on the needs of health. We need to achieve this combination.

And what should we do when science serves only a minority and moves in the opposite direction to the interests of society?

World scientific and technological development, and innovation, do not guarantee health and wellbeing if all these movements are appropriated by the market and the access becomes something that depends on cost.

I am not making the scientists responsible for thinking applied science. I think that the UN, the World Health Organization and Abrasco have to think of the application and the impact of this science and technology.

And cooperation between countries?

It’s fundamental. Ten countries have more negotiating power than one against the monopolies on vaccines, medications and equipment. Brazil, by negotiating vaccines with other countries that have greater capacity for production and research, could do this jointly with Africa, for example. Clearly we can’t allow this to make a loss – i.e. that we have to finance the budget –but we can have this cooperation between public policies. So, I think that this is the way forward, cooperation is fundamental. The problem is that our governments speak of the State as if it were something neutral, but every government presents a certain composition of forces, and this conglomeration has a capacity to enter into these political blocks with a very large power, don’t you agree? In the media, in public opinion... often cooperation is impeded and is a hostage to the position of each government.

What repercussion does involvement of the population with health issues have on a State’s political decisions on strengthening health systems?

If there is not a very strong social movement, we tend to lose the contest to this dynamic of the increasingly concentrated market and of the medical-industrial complex, its organically-integrated intellectuals and the journalists that repeat the discourses of these interests. The WHO and the UN provide sounding-boxes for negotiating these various pressures. We need to keep up the pressure that is usually made by health academics and professionals, by users’ movements, and by popular movements that sway public opinion, and occupy spaces in the media. If the social

movement is strong, then we have a chance to get more appropriate laws, systems and policies passed, to legitimate the UN and the WHO and to have a firmer policy, a policy with capital P and not a policy of smaller-scale interests. This rationality of the market in all the spaces tends to be something denaturalized. This is what the conservative, liberal and radical discourse tends to naturalize. They naturalize a product that is social, which is health. The use of pesticides, for example, is typical of this – if it was up to the medical-industrial complex, and the chemical industry, we would live in a chemical world.

Up to what point are the interests of society represented in the actions of the States in the international sphere, in the case of health?

The political pressure and force of the market and of economic interests are always present and strong, but they don't always prevail. I will give you an international example: The boycott of apartheid in South Africa lasted between 15 and 20 years, and 98% of the countries did not break it. And another example, which did not prevail 100%, but which did grow a lot, was the United States' boycott of Cuba – it was only the communist countries that traded with Cuba, and then with the democratization of Latin America, some countries began to trade and invest. So, this, too is down to cooperation. That is to say, the spaces for mediation need to be created and the result is not a given, one has to try, make efforts, that's what politics is for – and that's what Abrasco is for!

How do you interpret the change of concept, which some writers have been working, from international health to global health?

It indicates an attribution of joint responsibility, that is to say, the health is the planet's, it's the health of all the people and all the nations. It's an important declaration of intent from the conceptual and ethical point of view. Now, what concrete implications will this change have? It depends on battle, struggle, conflict. This thing of changing the name so as not to change the reality is something that we use a lot. There is a certain movement that is demagoguery – not in this case, but in general.

If you have a crisis situation, another name is given to it and it is pretended that the prob-

lem was solved, or one does not face up to the concrete results of that problem. Brazil's Constitution of 1988 has an interesting viewpoint on the rights of indigenous peoples, when compared with other peoples of Latin America. It happens that, in practice, they are the victims of aggression by agribusiness and by the mining companies. Is it good to have that law? The answer is obvious, but how are we going to guarantee the outcomes and results of that law?

In this present case, the global concept indicates a concern: the problem in the health of refugees is also our problem; the problem of health in Ethiopia is ours, too.

And who is this 'ours'? In this discussion on global health, some writers think that it relates only to the States, while other writers believe it's possible to give a voice to other actors, such as, for example, industrial companies and other conglomerates, with differing commercial interests in health.

When I said 'ours', I spoke of humanity in general. It happens that humanity is heterogeneous, stratified, and to talk about humanity is also an abstract concept, isn't it? We have indigenous peoples, descendants of Africa, Brazilians, entrepreneurs, workers, unemployed people, Africans, refugees, Latin Americans, Europeans, etc. The idea that only the State... it's not like that. It's the State *and* society: when one talks about a State all of these people come into it. This idea of the minimal State, that the non-state actors will produce public policies, is a misunderstanding. And also the idea that the State alone, while waiting in hope for real socialism, will produce wellbeing by nationalizing everything, has also been shown to be mistaken.

I think that we have to learn from the 20th century, from the past. This strengthening of the market and of liberal ideology, ethics and policy – what is called neoliberalism – arises in part from the major defeats in the area of universal social rights. The communist States failed from a democratic point of view, from the point of view of liberty, wellbeing, growth and respect for nature.

So, the discussion that one should be having is a different one: one has to rethink the systems without the logic of the market, because if we don't, then they are not public policies, they become once again market policies.

The root of the very words “public policy” mean that all the planning of management is not carried out in the name of the most able. Social policies have created a logic that the most vulnerable will be defended – the elderly, the disabled, those without private insurance, those who have chemical dependency, etc.

Public policies are for everyone, and each country has to develop its techniques and its coefficients. There are two rationalities that we have to consider. I don’t see any proposal today to have zero market, I don’t see the sense of it.

About this Resolution [The Resolution for the Framework of Engagement with Non-state actors (FENSA) of the WHO was approved in May 2016], approved by the WHO, that aims to create limits for the relationship with foundations, NGOs, private companies and the academic world. Does this directly affect Abrasco, what do you think?

We have an international challenge in the third millennium in relation to the non-state actors that reflects in the discussion of the WHO. Non-state actors is a generic name that covers up, more than explains. If you look at the pharmaceutical industry and Doctors without Borders, they are non-state actors; Abrasco, a public health association, is also a non-state actor. So there is a heterogeneity in this that is difficult to deal with, but it’s better to recognize this heterogeneity and move on to work with different rules of relationship.

I think it needs to be done provided that these differences and the conflict of interests are recognized. I don’t see, on humanity’s horizon, the possibility of our living in a state-controlled world, we don’t want that anymore, it didn’t work.

Now, how does society exercise control, outside the spheres of election, and lobbies? The people who do this are the companies which have much more funds, and have many more employees that are economists and advertising people. So, returning to Piketty, he ends his book elucidating this thing of concentration of income in a small percentage of the population. This concentration of capital reduces the production of culture, of production of explanations for the world, of narratives, of control of the executive power, of parliament. That is to say, democracy in favor of these interests, this minority, is a democracy between quotation marks.

You pointed to the role of Abrasco in these spaces of mediation. How does the Association participate in international forums?

Abrasco participates in the associations with its analog organizations, and is also always present and in contact with the General Assembly of the WHO. We participate in the General Assemblies of the WHO, of the PAHO and of the Directors’ Councils as an invited party, without the right to vote, but seeking to have influence on the agenda, and we have subjects that we judge to be important for global health. We speak, distribute documents, articulate with other associative entities of the world and NGOs.

Abrasco still has only a very limited structure for its operation, but it is what we manage to do – it’s very expensive to do this. Each international meeting costs one-third of Abrasco’s budget, which is very difficult, because it is we who pay. If we enter as part of the delegation of the Health Ministry, we cannot pursue and express our own independent arguments autonomously.

