

Reflecting on ethical values of Global Health

Refletindo sobre valores éticos da Saúde Global

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Abstract

The field of Global Health has been under construction since the last decades of the past century. It focuses on health issues that extrapolate national borders, as well as their determinants and possible solutions. Global health conceptions carry ethical values. This essay aims to reflect on values involved in global health: social justice, equity and solidarity. To this end, we reviewed scientific papers and multilateral agencies' documents. We identified the defense of global health as a universal public good, and we analyzed justice and equity values with a focus on the allocation and distribution of resources, within a tendency to prioritize the most disadvantaged ones. Solidarity concepts are presented in an attempt to explain whether there is a moral responsibility for being supportive of people from other countries, which would justify international cooperation in health.

Keywords: Solidarity; Equity; Institutional Ethics; Social Justice; Global Health.

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Resumo

Desde as últimas décadas do século passado vem sendo construído o campo da saúde global, enfocando questões de saúde supraterritoriais, que extrapolam as fronteiras nacionais, assim como seus determinantes e suas possíveis soluções. Este ensaio objetiva refletir sobre os valores éticos envolvidos na saúde global: justiça social, equidade e solidariedade. Procedeu-se à revisão de artigos científicos e documentos de agências multilaterais. Identificou-se a defesa da saúde global como um bem universal público, analisando os valores da justiça e da equidade com enfoque na alocação e distribuição de recursos, com tendência a priorizar os mais desfavorecidos. São apresentados conceitos de solidariedade, buscando compreender se há a responsabilidade moral de ser solidário com pessoas de outros países, o que justificaria a cooperação internacional na saúde.

Palavras-chave: Solidariedade; Equidade; Ética Institucional; Justiça Social; Saúde Global.

Building the field of Global Health

We are part of a new world order. With the current means of communication, information and planetary transport, national borders have become permeable, as they can be crossed continually. Globalization integrates and connects communities and organizations in “new space-time combinations” (Hall, 2011, p. 67).

Furthermore, globalization brings new spatial, temporal and cognitive dimensions. It modifies our perception of distances and barriers to global contacts. It alters our temporal perception when it connects daily life with events that occur in other parts of the planet. And it modifies our cognitive perception - how we see and understand ourselves and the world that surrounds us (Alarcos, 2005; Bozorgmehr, 2010).

Health issues can affect many countries and/or regions of the planet. They can affect people only in some regions, but with the potential and probability of spreading across many regions in a reduced period of time, like the onset of the H1N1 pandemic - influenza pandemic. They can occur at specific places, but the solution requires action from other countries, as they are transnational or determinant - for example, climate changes, migration of health professionals, nutrition patterns not adapted to national cultures. In addition, health problems can be limited to certain regions, even though research and the search for solutions are useful to others, like the control of infectious diseases through immunization or other sanitary measures, such as the health surveillance of ports, airports and borders (Manciaux; Flidner, 2005).

There is also evidence that the increase in trade exchanges among nations is related to the increase in chronic diseases, like diabetes and obesity, in countries of low or medium economic power, due to the dissemination of unhealthy lifestyles and habits and of products that are harmful to health (Monteiro, Cannon, 2012; Labonté, Mohindra; Lencucha, 2011).

Thus, the field of Global Health has been under construction since the last decades of the 20th century, with a multi-professional and interdisciplinary character that involves knowledge, teaching, research and practice. Global Health focuses on

health issues and problems that extrapolate national borders, as well as their determinants and possible solutions. Intervention and agreements are needed among diverse social actors, including countries and governments, international agencies and institutions, both public and private (Fortes et al., 2012; Kickbusch; Berger, 2010; Koplan et al., 2009).

The emerging discipline of Global Health has, as important precedents, public health and international health. With public health, it shares the focus on the collectivity, interdisciplinarity, and actions for the promotion, prevention and recovery of human health. As for international health (the term was coined in 1913 by the Rockefeller Foundation, in the United States), it is characterized mainly by actions developed to prevent and control infectious diseases, to combat malnutrition, maternal and child mortality, and to provide technical assistance activities, mainly to the so-called less developed nations (Koplan et al. 2009). According to Franco-Giraldo and Álvarez-Dardet (2009), the classic international health was grounded on medical and biological bases and on assistentialist relations originated in developed countries and targeted at less developed countries.

These conceptions are gradually replaced, in the final decades of the 20th century, by the “consolidation” of Global Health, a complex and polysemic term and concept. Diverse social phenomena contributed to the transition from international health to Global Health, such as the increasing role of perceiving the importance of health in economic development agendas, world security, peace and democracy; the growing international transfer of health-related risks and opportunities caused by globalization; the pluralism of public and private social actors working in partnerships; the loss of the World Health Organization’s (WHO) predominance in decisions concerning the collectivity’s health and the World Bank’s predominance in the area of investments to the sector; the quick advance in medical technologies; activism for conditions of access to health and rights; and the community sectors’ struggle for a greater participation in decision-making processes (Frenk, Gomez-Dantés, 2007).

Global Health has been developing simultaneously with the global forces that connect people’s

daily life to facts that occur in other parts of the planet. This notion guides stances such as those shown by many countries’ ministers during a meeting in Oslo, Norway, in 2007, when they expressed that global action is fundamental because many contemporary health problems - like influenza, SARS, drug-resistant tuberculosis, malaria, poliomyelitis and dengue - do not respect national borders and, therefore, the solution needs nations’ joint work and action (WHO, 2007).

In addition, Global Health has been concerned about the transnational impacts of globalization on social determinants and health problems that are beyond the individual control of national states and affect diverse dimensions of human life, that is, persistent, emerging and reemerging problems. Some examples are the access to health care and essential medicines, the emergence of new pandemic diseases, the reemergence or resurgence of infectious diseases like dengue and yellow fever, violence and its consequences, the issue of mental health, and the consequences of socio-environmental disasters. Global Health also deals with forms of international trade and investment and their repercussions on health, problems related to the migration of people and health professionals, international medical tourism, and the marketing of products that are harmful to health, like alcoholic beverages, unhealthy foods and tobacco (Franco-Giraldo; Alvarez-Dardet, 2009; Kawachi; Wamala, 2007; Frenk; Gomez-Dantes, 2007).

Ethical values of Global health

Conceptions and problems related to Global Health, as well as measures to solve them because they affect people and/or collectivities, are fundamentally ethical, and we must reflect on the values that are involved. Values are components of the daily life of human beings and collectivities, and it is “impossible to imagine life without them”. Therefore, we must respect and protect them so that we can have a good and fair social interaction (Cortina, 2007).

They are central in political life and support policies, programs, actions and behaviors, both in neoliberal approaches, which focus on safety, individual freedom, efficiency and cost-effectiveness,

and in approaches grounded on social justice, equity and solidarity (Steward; Keusch; Kleinman, 2010).

We can evoke diverse values when we reflect on Global Health issues. However, this article will approach the values that prevail in the discourses of authors in the field of Global Health: social justice, equity and solidarity - values that involve collective action, a characteristic of the Global Health field.

Global Health, social justice and equity

To reflect on social justice and equity, our presupposition is that the orientations provided for Global Health actions by national states, multilateral agencies, non-governmental or private organizations present important differences if health is or is not understood as a global public good (Rowson et al., 2012).

We believe that being a global public good - a notion that is still marked by theoretical and ideological clashes - means that no person or no collectivity can be excluded from its possession or consumption, and that such possession or utilization by a person or group cannot prevent other individuals or collectivities from enjoying it. In other words, there must be no rivalry in the possession or consumption of the good. Thus, it is accepted that no person, country, region or population group should be excluded and that all can benefit from this global public good - health (ALASAG, 2013; Stewart; Keusch; Kleinman, 2010; Buss; Ferreira, 2010; Smith, 2003).

We can argue that health is a global public good in the perspective of social justice, equity and ethics. Justice is a secular principle of interaction among human beings that brings the interface between individual ethics and collective ethics. According to the French philosopher Paul Ricoeur (1995), if good is intuitive, fair is constructed within human relations.

The Spanish philosopher Adela Cortina (2005) teaches us that we should consider justice as the grounds for interaction among people, the basis for an ethics of minimal things, necessary in each morally pluralistic society so that people can reach their individual and autonomous project of happiness. Justice brings the notion of mutual obligation

among people, and relates individuals to the collective dimension.

The term social justice is relatively recent. It dates back to the 19th century and is confounded with distributive justice. Mainly during the 20th century, there is a separation from the notion of meritorious justice and the contemporary concept of distributive justice is built. This notion demands intervention on the economic and social fields and aims to guarantee an equitable distribution and the supply of a certain level of interests and material resources to all people (Fleischacker, 2006).

The theme of social justice, approached in Global Health, is extremely relevant because of the contribution, allocation and distribution of human, technical and economic resources across countries and regions. It belongs to the field of distributive justice, as it relates individuals to the collectivity and political authorities. In many international declarations and documents on Global Health, the sense of justice is closely related to the value of equity.

As Amartya Sen (2011) argues, it is important not only to consider institutions as fair; they should also act to promote justice. We can cite some renowned authors who deal with the theme, like Koplan et al. (2009), who defend Global Health as a field of study, research and practice that prioritizes health improvement and the search for equity to all peoples in the world. Kickbusch (2013), an author who is strongly identified with the WHO, states that the main objective of Global Health is the equitable access to health in all regions of the world.

Furthermore, other authors argue that the aim of Global Health is to reduce the social and health inequalities and inequities found in the world, and to propose to the field an orientation based on the value of equity (Fried, 2010; Macfarlane; Jacobs; Kaaya, 2008; McMichael; Beaglehole, 2003; Brundtland, 2001).

It is known that equity is a polysemic term. However, as Almeida (2002) emphasizes, the option for a definition to be operationalized reflects the values and choices of a society. Unlike the principle of equality, equity deals with differences, like, for example, the avoidable and unnecessary social and health inequalities, in the search for what is fair.

Equity can be understood as the effort of treating the unequal unequally according to their needs. This interpretation has diversified bases and defends that the treatment given to people should be different when it is grounded on each person's needs. Egalitarian theories founded on meeting people's needs accept that the State, through public policies, should guarantee, with justice, the distribution of goods and services to minimize the effects of the biological and social lotteries.

An example are the Brazilian government's equity promotion policies, which state that their objective is to reduce persistent inequalities, the vulnerabilities to which certain population groups are exposed, which result from social determinants of health (Brasil, 2013).

Without aiming to make value judgements about the different concepts of equity, we can say that the discourses of authors in the Global Health field show a strong trend towards the presupposition of "justice as equity", formulated by John Rawls (2003,1997) in the 1970s. This presupposition defends that equity is a priority in the development of a theory of justice that, treating the unequal unequally, considers that fair actions must be conducted to prioritize society's less favored individuals, those who are in social disadvantage. The philosopher's thought defends a contractarian procedure in which the action that has different and unequal consequences to the diverse social actors involved in a certain situation is fair only when it results in compensatory benefits to each one and, particularly, to society's less favored members, that is, those who are in social disadvantage.

This would lead, within the Global Health field, to the prioritization of countries, regions or social groups that are considered less favored, with larger social, economic and health disadvantages. That is why, for example, the region of Sub-Saharan Africa, which has the worst sanitary levels of the planet, received in 2010 the largest part of the international financial resources allocated to health care development, corresponding to 28.7% of all the resources spent in the planet (IHME, 2012).

Following Rawls's thought, we can see that it is not the population's magnitude that should guide the actions, but the needs of the less favored. Thus,

Global Health guided by equity should be developed in order to eliminate, or at least reduce, as much as possible, the unnecessary, avoidable and unfair inequalities that exist among human groups with different social levels. According to the Commission on Social Determinants of Health, created by the WHO in 2005, reducing health inequalities is an ethical imperative for peoples and governments (WHO, 2010).

Equity can confront the maximalist principle of social utility, defending more benefits to the largest number of people. The principle of social utility, formulated by the English philosophers Jeremy Bentham and John Stuart Mill in the 19th century, establishes that we should search for the greatest happiness of all those whose interests are at stake, and this would be the fair and adequate purpose of human action. Its paradigm is "the greatest amount of good for the greatest number", that is, the maximization of wellbeing and/or the minimization of the pain, displeasure and suffering of the majority (Bentham, 1974; Mill, 2000; Goodin, 2000).

If we accept that the objective is to protect the needs of the collectivity, that is, maximalist needs, even at the expense of minority individual interests, criteria like magnitude, productive force, transcendence and cost-benefit would be validated, and not equity. This would be against the investment of resources in expensive activities with low population coverage, which is not explicitly present in the Global Health discourse.

However, a few authors disagree with the view mentioned above, as they believe that equity is a notion significantly loaded with ideological content, and this can exclude from the field of Global Health those who do not share this value (Rowson et al., 2012).

Solidarity and technical cooperation in Global Health

One of the most important and frequent areas of action in Global Health is related to international solidarity actions - assistance or cooperation. However, solidarity is also a complex and polysemic term influenced by theoretical lines from diverse orientations. Its etymological root is the reference to a

behavior *in solidum*, that is, the “reciprocal bond of independent people or things; moral meaning that bonds the individual to life, to the interests of a social group, a nation, or humankind” (Ferreira, 2004).

We do not have the intention, here, to exhaust the theme, nor to list all the theoretical lines that deal with solidarity. When it is evoked in the field of Global Health, we understand it as social solidarity, with a collective reach and a concern that extrapolates borders. We believe it is a value grounded on the bond of reciprocal recognition among people, that is, on people’s need, as social beings, of co-existing socially, having interdependent relations.

However, we can question whether there is a moral obligation, a requirement, which would lead people to do or to prevent themselves from doing something - in this case, of being supportive in an autonomous way. What would make a State, or a multilateral institution, either public or private, be ethically supportive? Why should public or private international organizations be supportive towards the poor, the vulnerable, the disadvantaged? How can we justify and explain solidarity and, for example, the South-South cooperation among developing countries? Another example: why should Brazil invest in establishing an antiretroviral drug factory in Mozambique?

The answers given by some authors are based on the notion that solidarity can profit from an ethics of closeness. This means that we worry and care for those who are close to us, with whom we interact, for affective and family reasons, or because we belong to the same social or religious group, or to the same community (Wilkinson, 2010; Furrow, 2007; Cortina, 2007).

Along this line of thought, Sandel (2012) argues that, in the liberal conception, although we must not commit injustice (considering the various possible meanings of the term), we are not morally obliged to do good. However, the author defends the thesis that solidarity is the moral obligation of acting in relation to people with whom we share a certain history.

Other authors, whose conceptions differ from the liberal model, although they are also based on the ethics of closeness, argue that solidarity would be the willingness to help others in whom we recognize similarity and identity, at least in a biological or so-

cial aspect, and to whom financial, social, emotional and other costs would be allocated. This can be easily noticed in self-help groups and organizations of patients defending resources and health care to specific problems or pathologies, such as AIDS (Illingworth; Parmett, 2012; Prainsack, Buyz, 2012).

However, what about the distant and unknown individual, the stranger with whom we do not have a direct relationship and we do not recognize a possibility of immediate reciprocity? Is there a moral obligation to be responsible for their health? How do we justify the obligation to assist them? An ethics of closeness would not apply to this case.

In a line of thought that is closer to the Kantian conceptions, we might argue that the fact that we belong to humankind, transcending national borders, is what makes us equal and close. Belonging to humankind induces us to solidarity with those who are distant, those we do not know and have only heard of their misfortunes - for example, through the global means of communication, like what happened recently in Haiti, the poorest country in the Caribbean region.

Our human identity cannot be reduced to national borders, as it can be related to religion, gender, race, profession or political convictions. This notion would help us explain the efforts of public and private international agencies, like the organizations Doctors Without Borders and Doctors of the World, to act in situations of socio-environmental catastrophes, as well as in the prevention, diagnosis and treatment of diseases that are called neglected, in which the pharmaceutical companies do not have any commercial interest, such as malaria, dengue and tuberculosis.

Regarding this matter, Sen (2011) tells us that human identity is, perhaps, our “most basic” identity. The author states that “the imperatives that can be associated with our humanity may not be mediated by our condition as specific peoples and nations”, but fundamentally as human beings.

We can add that our interdependence as human beings to live in society, be it economic, political, social, ethical or religious, has been growing, mainly in this globalized world, which reduces distances. Furthermore, our human condition and our condition of ecological subjects that share one single

world impel us to decide, in order to maintain social cohesion, to be concerned about and protect the other, due to a bond that is not personal; it emerges due to our belonging to humankind (Eckenwiler; Straehle; Chung, 2012).

In addition, it is understood that the basis of solidarity is human dignity, one of the few common values in our world of philosophic pluralism, which expresses that all human beings have a unique and unconditional value, and creates a moral obligation to protect it. Human dignity would involve the notions of vulnerability and fragility, which would correlate with the principle of equity, in the protection of the most vulnerable, while solidarity is the point of view that complements the principle of egalitarian treatment (Conill; Cortina, 2012; Andorno, 2009; Cortina, 2007).

Moreover, it is important to reflect on Furrow's (2007) argument: if someone is confronted with real situations in which their interests are at risk, why would it be rational for them to limit such interests in behalf of the interests of others, mainly in a historic moment of a global economic crisis that has been affecting mainly the developed nations? In addition, one can argue that the needs of a national State lead it forcibly to act through strategic obligations, maximizing the interests of its citizens, its national and sanitary security, based mainly on ethical references of a utilitarian nature.

We cannot deny the reality that shows international solidarity in health being affected by the economic crisis of rich countries, which has caused a slowdown, compared to the first decade of the 21st century, in the financial support provided by these countries. Recent studies have shown that, since 2010, the governments of Germany, France, USA and Canada have reduced the resources allocated to Global Health funds. This hampers them from achieving the goal established in the Doha Declaration on Financing for Development, when the richer nations committed to allocate 0.7% of their respective GDPs to the poorer countries until 2015 (IHME, 2012; Buss; Ferreira, 2010).

Last but not least, one can argue that solidarity actions related to technical cooperation in health that are performed among countries, organizations and institutions must occur in a horizontal way,

without the prevalence of dominant relations. The agents must be observed in order to avoid vertical relations to control power, resources or knowledge, respecting the culture of all the involved parties. Buss and Ferreira (2010) warn us that supportive cooperation moved by good intentions towards the other cannot be converted into the imposition of one's own view, that is, doing good to the other according to one's own notion of what good is, without promoting the autonomy and empowerment of the subjects involved in the actions. By treating the other as being of equal value, we differentiate the solidarity action from the charitable action, which considers the other in an asymmetric relation (Prainsack; Buyz, 2012; Caponi 2000).

The historical shift from the concept of health assistance to that of cooperation in health tries to attenuate the paternalistic orientation that had dominated the relations between developed and developing countries, central and peripheral nations, as Almeida et al. (2010) have argued. Now, the orientation is to promote more symmetric relations shared between cooperators and recipients of the cooperation, donors and beneficiaries, those who provide assistance and those who receive it, based on local and national realities and priorities, and aiming at the autonomy and empowerment of the involved parties. Partnerships are constructed and the participants are recognized as subjects, not as objects of exogenous practices and prescriptions. This results in a joint learning and sharing of responsibilities and results.

Some authors understand that technical cooperation in Global Health should be guided towards the empowerment of the cooperant parties, according to the orientation provided by Andrade and Vaitsman (2002), "in a process of social action in which individuals become the owners of their lives through the interaction with other individuals, generating critical thought in relation to reality, favoring the construction of social and personal capacity, and enabling the transformation of power relations".

For this to occur, a deep cultural change must take place, so that, in processes involving groups and countries with different social and economic conditions, relations marked by dialog can happen,

in which all the social actors are accepted as valid interlocutors that can reach consensus for a cooperative action (Stewart; Keusch; Kleinman, 2010; Cortina, 2005).

Finalizing

We considered that health, as a global public good, has social justice, equity and solidarity as its guiding ethical values. Such values raise questions to be further investigated by ethical reflection. For example, in a world in which moral pluralism is one of the characteristics and there is little tolerance of it, in which we perceive an attempt to obtain moral consensus by force, and we doubt that it is possible to make a complete evaluation of justice, we should ask whether we should support solidarity actions to those guided by racist, antidemocratic, segregating, or sexist ideals (Illingworth; Parmett; Sen, 2011; Engelhardt Jr, 2009; Wickler; Cash, 2003).

Therefore, diverse ethical questions and problems can derive from Global Health policies, measures and practices. Due to this, Cortina (2005) warns us that the members of post-industrial societies must establish a type of identity in which they recognize themselves, so that they feel they belong to it. In addition, they must be concerned about each person, social group, region and country, so that the conviction that it is worth maintaining and improving them can be formed. This is one of the challenges to Global Health in the current political and social context of the broad inequalities experienced by countries, regions and social groups spread across the planet.

If we are guided by justice and equity, we should, once more, pay attention to Amartya Sen (2011), who states that: “asking how things are going and whether they can be improved is a constant and fundamental element in the search for justice”. And, without wanting to evidence supposed neutralities, we can agree with Feito (2012) when this author argues that, when human beings and institutions make ethical decisions and choose one among possible alternatives, they adopt a stance on the society in which they want to live and interact. Thus, they build the moral responsibility of contributing to the construction of a pacific, fair and equitable global society.

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