Bioethics, health care and social justice

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Abstract

Brazilian´s Unified Health System (SUS) ensures universal access to comprehensive health services. However, in practice SUS has not allowed citizens to enjoy a health care with equity, increasing the difficulty of achieving social justice in a society as unequal and unfair as the Brazilian. Ethics proposes equity as a basis for resolving the distortions in the distribution of health, enabling universal access. This article aims to discuss how bioethics can help for greater equity in health care in our country.

Keywords: Bioethics. Social Justice. Health care.

Resumo

Bioética, assistência médica e justiça social

O Sistema Único de Saúde (SUS) brasileiro garante o acesso universal e integral aos serviços de saúde. Entretanto, na prática, o SUS não tem permitido que os cidadãos desfrutem de uma assistência com equidade, reforçando a dificuldade de se atingir a justiça social em uma sociedade tão desigual e injusta como a brasileira. A ética propõe a equidade como base para resolver as distorções na distribuição da saúde, possibilitando o acesso universal. Este artigo tem como objetivo precípuo discutir como a bioética pode auxiliar para que haja maior equidade na assistência médica em nosso país.

Palavras-chave: Bioética. Justiça social. Assistência à saúde.

Resumen

Bioética, atención médica y la justicia social

El Sistema Único de Salud (SUS) de Brasil garantiza el acceso universal e integral a servicios de salud. Sin embargo, en la práctica, el SUS no ha permitido a los ciudadanos a disfrutar de una asistencia con equidad, lo que aumenta la dificultad de lograr la justicia social en una sociedad tan desigual e injusta como la brasileña. La ética propone la equidad como base para resolver las distorsiones en la distribución de la salud, permitiendo el acceso universal. Este artículo tiene como principal objetivo discutir cómo la bioética puede ayudar a lograr una mayor equidad en la atención médica en Brasil.

Palabras-clave: Bioética. Justicia social. Prestación de atención a la salud.

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In legal terms, in Brazil the universal, comprehensive and equal access to health care and services is granted by the Unified Health System (SUS). However, since its implementation it has been difficult to achieve social justice in a society as unequal and unjust as the Brazilian[1]. This difficulty is not faced only by our society; there are outstanding inequalities in health care between countries and inside a same country. For example, the life expectancy varies from 34 years in Sierra Leone to 82 years in Japan. Moreover, there are differences of 20 years in the life expectancy between rich and poor populations in the United States of America (USA)[2].

An important starting point for the discussion about the social determinants of health is the application of the John Rawls' theory. In *A theory of justice* this author argued that justice requires the fair distribution of the main goods. Primary goods are allocated to individuals on the basis of *fair equality of opportunity*, due to the disadvantages that they have gathered through the *natural lottery of life*[3]. In the application of Rawls' theory for the social determinants of health, Norman Daniels and cols. argue that justice requires a reduction *of the socioeconomics inequalities in a robust form, guaranteeing much more than minimum of dignity*[4].

Considering that justice constitutes a basic principle of bioethics, the present article has the primary purpose of discussing how bioethics can contribute to make the medical assistance in Brazil fairer.

Dimensions of the inequality in health

The dimensions of the inequality in health are explained by the differences in the distribution, organization and use of the resources in health. Moreover, several factors linked to the health and illness conditions can contribute for a bigger inequality[2,5].

Despite the statement in the Brazilian constitution and code of ethics that every citizen has a right to health care without distinction of any kind, whether of race, sex, age, social status, nationality, political opinion, religious or otherwise, or to be carrying any disease, infectious or not, the persistent inequality in the access to and use of health services in our country has worried managers, academics and legislators, fostering discussions and research with the aim of promoting greater equity[2,3,5]. Such discussions are not limited only to explain inequality by differences between social groups, but seek to incorporate the conceptual dimension of social justice into the analysis. So, it has been possible to characterize different types of inequality and propose, in the political field, the inclusion of ethical and moral values that make the society more egalitarian.

Accordingly, more developed and poorer countries, with different models of health systems, turn their attention to inequalities in health. It is a fact that there are differences between these countries, as some have a fairer health care. Despite this, the concern of all in reducing inequality must be exalted, because it can involve the formulation of policies that provide greater equity[2,3,5].

Inequalities in health are directly related to social inequality. Therefore, effective actions that promote more equitable access to health services are important to diminish the differences between social groups, related to illness and death. Finally, to implement equitable policies it is necessary to contemplate three important fields in health: distribution of resources, opportunities for access and use of services.

Equity in health care

Equity is the ethical basis that should guide the decision-making process of resources allocation. The association of this principle with individual and public responsibility and justice allows enforcing the right to health. Recognizing the different needs of different subjects in order to achieve equal rights is the way of practical ethics that can lead to a greater access to health care[6].

It's necessary, therefore, to establish priorities in health care. However, when we choose to hierarchize health needs in order to make the allocation of resources fairer; we should not make mistakes like those that occurred in Oregon and Seattle (USA), where, from highly questionable criteria, alcoholics were placed at the end of the waiting list for liver transplantation. In this case, there was a preference for transplant candidates who did not consume alcohol, because in this case they considered it more important to focus on the other, making prejudice and unfairly selection clear.

In Brazil and in many countries, for economic reasons only, depriving a portion of the population the access to technological advances in medicine has been fundamental to the balance of the health system. There are known, for example, guidelines of many countries which impede hemodialysis and organ transplants of persons of advanced age or carriers of some degenerative diseases[7]. So, what is the ethical conduct in front of the scarcity of resources

in health care? This seems to be a question that has no single and satisfactory answer[7].

Another ethical and common dilemma in daily medical practice is how to establish fair criteria for deciding which patient to choose, facing limited resources and the inability to offer assistance to all. Utilitarian thinkers like John Mill[8] defend that patients with better economic conditions, and thus with more chance to survive, should be chosen if there is only one kidney transplant. In contrast to the utilitarianism, Childress[9] defends the randomization in the choice. What method of choice should be adopted and who should have the authority to do so? Nowadays, in most countries, that decision lies with doctors and many of them, though trained to prioritize life instead of death, suffer by being forced by an unequal system to choose without being sure if the adopted choice is the fairest[7].

Every ethical procedure involves choices, which define that people will primarily benefit or not. The ethical reflection forces us to choose with balance, weighing costs and benefits, efficiency and effectiveness, but never forgetting the principles of morality, fairness and priority[6].

Is there health care equity in Brazil?

Latin America and the Caribbean passed through sectorial reforms in the decade of 90, sponsored and directed by international organisms as the World Bank. Such reforms have some points in common such as changes in funding rules, participation of public and private actors and separation of provision, regulation and funding.

Brazil was not entirely immune to such influences. However, the SUS was structuralized before these sectorial reforms. The SUS represented an ample proposal recognized as the Health Care Reform. The Brazilian Health Care Reform can be considered nonpartisan and independent, because it is linked to ideas of human rights, democratization of health and citizenship. Before long, these international organisms met some resistance and even opposition in Brazil, since the health reform always advocated universal health policies. However, there was an acceptance of some points proposed by sectorial reforms such as the decentralization of health actions and the segmentation of the health system.

The country has managed to maintain the legal instruments that guarantee the right to health, particularly with regard to universal health care, despite the constraints imposed on the development of health policies. The Brazilian health policy maintained its scope, but restrictions on public spending and contradictions deepened the segmentation of the health system in the country. The distribution of health facilities is uneven between regions and states, with more registered establishments concentrated in the Southeast and in more populated municipalities[14]. This segmentation, illustrated by the Brazilian supplementary healthcare, accentuates inequalities in the use of health services[13]. Currently, more than 40 million Brazilians seek solutions to their health problems in the supplementary healthcare. This fact constitutes the great paradox of the Brazilian health system, which in this way excludes most citizens of a system designed to be universal. In addition, the supplementary health care system is exclusionary by creating rules as pre-existing disease and waiting period, obligating often its users to use the services of SUS.

The private healthcare, when implying higher quality, agility and comfort to patients, in comparison with the public service, accentuated inequalities in health. This system with a highly specialized and focused attention to the disease impairs the establishment of equity in health care, given that people can't pay for it. Additionally, unplanned contracting of private services by SUS and the disorderly offer of outpatient medical care hamper the local planning and programming in health and favor the concentration of some assisted individuals at the expense of others[16].

Bioethics, health care and social justice

In matters of health care, the next few years shall bring a constant questioning. Probably, new medical techniques will no longer be universally adopted before a cost-benefit evaluation. The search will, increasingly, be for a process of rationalization. However, there are difficulties between providers in order to understand what is rational for a health service. If rationalization is perceived as rationing, there is the risk of providing inefficient health services that accentuate inequalities[17].

To solve the dilemma of costs rationalization it is necessary to overcome two obstacles. The first refers to the medical profession, which has responsibility for decision and the power to decide - in addition, the physician often has a conflicting role between patient advisor and services vendor. The second is the difficulty to answer about the necessity or not of additional tests for the elucidation of

the diagnosis and of the best treatment. If we want to limit the resources for the provision of appropriate services, we must define the levels of health care that will be practiced. However there are multiple opinions regarding this subject, even the most authorized ones. In many cases, physicians differ on the nature of the best treatment. There is also the influence of the doctor-patient relationship; that often goes from the individual to the collective[18].

Decision-making in medicine is complex and depends on various factors such as ethical and scientific considerations, respect for patient autonomy, physician preferences and the influence of family and society. Nowadays, medical practice undergoes a crisis when referring to decision-making. On one side, there is the pressure of the economic growth and technological development by creating a consumer relationship between physicians and patients, on the other, the patient, a human being who seeks health care as a fundamental right that should be provided by the state. In the middle of them is the physician, unprepared to manage such conflict. Only reflections promoted by multidisciplinary groups, proposed by bioethics, will be able to resolve these conflicts, or at least provide criteria for decision-making[7,19,20].

An interesting proposal to assist health professionals is that of moral deliberation created by Diego Gracia[21]. According to this author, the decision arises from the recognition and acceptance of the incommensurability of reality, which indicate the need to enrich the understanding of things and facts starting with the inclusion of different views and perspectives. The resolution considers it impossible to apply mathematical reasoning to practical life issues, such as ethics.

The moral deliberation is the consideration of values and duties involved in a concrete fact, in order to handle the situation in a reasonable, wise and possible way. Without going into relativism, the deliberation does not seek to find the optimal or right decision, or the one that maximizes the results, once it is not guided by idealistic, pragmatic or utilitarian ideas, quite usual in theories and methods of decision-making[21].

Regarding autonomy, rights of citizens, physicians and health institutions, which need to be met before any decision, Gutierrez[22] considers that the achievement of respect for autonomy is a fairly recent historical phenomenon in our country, which slowly displaces the principles of beneficence, and not of maleficence, as prevalent in the actions of health care. However, he claims that the medical code of ethics limits autonomy, which, like the rights of the citizen, cannot be absolutely considered, but according to the situations in which it is exercised.

The respect for the individual autonomy is coupled with the principle of the human nature's dignity, accepting that the human being is an end in itself, not just a means of satisfying interests of third parties, or commercial and industrial interests, or interests of the professionals themselves or of health services. To respect the autonomous person presupposes the acceptance of the social-ethical pluralism that is characteristic of our time. But for Gutierrez, *the respect for autonomy does not mean being indifferent to the circumstances, but considering them as objectively as possible*[22].

Finally, it is stressed that for the effective achievement of more equitable societies it is necessary to have public policies that go beyond the sectorial scope and are able, together, to reduce currently existing inequalities, such as, investments in early childhood development, nutrition programs and health promotion, improvements in the quality of the work environment and reductions in income inequality, being allied to this the efficiency, effectiveness and the fundamental principles of bioethics.

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