Inequality, Bioethics and Human Rights

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Abstract

The aim of this article is to demonstrate that the *Universal Declaration on Bioethics and Human Rights* (UDBHR) constitutes an appropriate theoretical-normative tool for proposing reflexive and prescriptive contributions on the current context of inequality, particularly in health. The study involves bibliographical and documentary review concerning inequality and how it unfolds in the health area, as well as the UDBHR. It has been found that the UDBHR provides tools that make possible reflection and prescription regarding inequality, notably through the principles of justice and of international cooperation. The principle of justice convokes the States and international institutions to adopt policies aimed at reconfiguring the current system of distribution of resources in the world; and the principle of international cooperation lends impulse to the shaping of models of cooperation that give priority to inequality among the countries and population groups, and that contribute to growing solidarity among the peoples.

Keywords: Health inequalities. Social inequity. Equity in health. Social justice. Human rights. Bioethics. International cooperation.

Resumo

Desigualdade, bioética e Direitos Humanos

Este artigo tem como objetivo salientar o papel da *Declaração Universal sobre Bioética e Direitos Humanos* (DUBDH) como a recomendação teórico-normativa mais adequada na proposição de aportes reflexivos e prescritivos sobre o atual contexto de desigualdade, particularmente em saúde. O estudo envolveu revisão bibliográfica e documental acerca da desigualdade e seu desdobramento na esfera da saúde, bem como sobre a DUBDH. Verifica-se que a DUBDH fornece ferramentas que permitem a reflexão e a prescrição acerca da desigualdade, notadamente por meio do princípio da justiça e da cooperação internacional. O princípio da justiça clama aos Estados e instituições internacionais a adoção de políticas destinadas a reconfigurar a atual distribuição de recursos no mundo, e, na mesma linha, a cooperação internacional impele à conformação de modelos cooperativos que tomem em conta, prioritariamente, a desigualdade entre os países e grupos populacionais e, dessa forma, contribuam para o incremento da solidariedade entre os povos.

Palavras-chave: Desigualdade em saúde. Iniquidade social. Equidade em saúde. Justiça social. Direitos humanos. Bioética. Cooperação internacional.

Resumen

Desigualdad, bioética y Derechos Humanos

Este artículo tiene como objetivo destacar el papel de la *Declaración Universal sobre Bioética y Derechos Humanos* (DUBDH) como la recomendación teórico-normativa más adecuada para proponer planteamientos reflexivos y prescriptivos en el actual contexto de la desigualdad, especialmente en la salud. Este estudio involucró revisión bibliográfica y documental sobre la desigualdad y su impacto en el sector de la salud; así como la DUBDH. Constatase que la DUBDH proporciona herramientas que permiten la reflexión y la prescripción sobre la desigualdad, especialmente a través del principio de la justicia y la cooperación internacional. El principio de justicia clama los estados y las instituciones internacionales para que adopten políticas destinadas a la reconfiguración de la actual distribución de los recursos en el mundo y la cooperación internacional impulsa la conformación de modelos de cooperación que tengan en cuenta principalmente la desigualdad entre países y grupos poblacionales y contribuyan para mayor solidaridad entre los pueblos.

Palabras-clave: Desigualdad en la salud. Inequidad social. Equidad en salud. Justicia social. Derechos humanos. Bioética. Cooperación internacional.

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Inequality of income and wealth is recognized as one of the largest social threats of our times [1]. According to Piketty, *the issue of inequality and redistribution is at the heart of the political conflicts* [2]. Indeed, it is one of the most serious problems of contemporary times, and it reaches countries of high , middle and low income, as well as reflects in various areas of people's lives such as health, nutrition, education, violence and mortality [3]. Inequality refers to inequitable access to resources, which causes unfair differences between individuals and groups of people at the national and international level. In the present scenario, inequality is a global issue, closely connected with neoliberalism and economic globalization. The neoliberal movement and the globalization of the economy, expanded to different continents from the 1980s, also brought new settings in communications, geopolitical borders and global issues concerning health, education and bioethics [1].

According to Piketty [2] and Medeiros and collaborators [3], Dreifuss, at defining the concept of inequality, notes different phenomena that are grouped under the name of "globalization", as well as a set of processes within the scope of the economy, such as research, funding, production, management, marketing, which spreads in societies, is expressed in the culture and influences policy, conditioning global governance. Economic globalization also triggered other phenomena that affected forms of human interaction through different social processes [4], as the mobility of goods and people and the expansion of the Internet [5]. Thus, on the one hand, the world is becoming ever more diverse, plural and complex, and on the other, presents an *economic one-dimensionality* [6], characterized by financial concentration.

For over a decade the global economy is in crisis, which began in high-income countries and developments for others, and deepened from 2008, due to budgetary imbalances and lack of regulation of financial markets. This crisis has had repercussions in the fulfillment of social rights by states, since it involves the gradual elimination of social spending as a cost-cutting measure and investment reduction. Another significant effect of the crisis impacting social rights is increasing financial concentration between states and between people, creating a scenario of social inequality and concentration of wealth and power in the hands of 1% of the population at the expense of the remaining 99%. In countries like the US and the UK, after the initial shock of the 2008 crisis, the rich have become super-rich [1].

A series of protests has been going around the world, in face of this inequality scenario [4,5]. From the global perspective, most of these events that occurred from January 2006, focused on the issues of economic justice. In 2006 59 large protests were held in various parts of the globe, and only the first half of 2013, 113 similar sized events were recorded. Such protests are prevalent in high-income countries, since their populations have organized themselves to address the effects of inequalities [1].

It is observed from the economic crisis, that even rich countries are losing their governance capacity for the implementation of public policies to better distribute the wealth internally and to promote human development. This inequality scenario becomes even greater when analyzed on the basis of different contexts and categories, such as high-income countries and low-income population groups different in gender, age, color, ethnicity, etc.

Dealing with inequality has always been challenging, in that it happens both in the public space, in States using democratic or concentrator system models, as in private spaces, as seen, for example, in relation to women, the elderly, the population discriminated by color and ethnicity. There is, however, a tendency, especially in the Western world to support the idea of equality as an ethical-legal principle, which has become widespread especially after the adoption of the Universal Declaration of Human Rights by the United Nations (UN) 1948 [7]. This understanding was reaffirmed in the sphere of bioethics, though not without controversy [8], and deepened in discussions on equity, as appropriate principle to reflection about the contemporary inequality in the Universal Declaration on Bioethics and Human Rights (UDBHR), adopted by the United Nations Educational, Scientific and Cultural Organization (UNESCO) in 2005 [9]. Cortina, in the introduction of his book "Ethics without moral" ("Ética sem moral", 2010) asks if the moral order is fact or fiction, pointing out: *Fictions, all fictions to sort through necessary laws, a chaotic world in which reign chance and contingency, a world in which inequality is the largest anthropological evidence* [10].

Considering the inequality, particularly in health, the way bioethics has contributed to the reflection and prescription on this subject must be understood. However, it is not appropriate to treat bioethics as a field of homogeneous regulatory knowledge, especially when you consider the diversity of bioethical currents. So in this article, we chose to employ the normative dimension of bio-

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ethics, particularly UDBHR, as a theoretical basis for analyzing inequality from the global perspective.

The choice of the UDBHR as the theoretical and normative framework took place by virtue of it being a document that, despite having raised initial discussions and controversies about its necessity and recommendations, managed to advance in concepts such as health as well as enable universal consensus about bioethical issues. Thus, this article aims to highlight the importance of the UDBHR as propitiator of appropriate theoretical and regulatory tools, in that it presents reflective and prescriptive contributions on the current context of inequality, especially in health. Therefore, the methodological steps taken in this study involved bibliographical and documentary review on the theme of inequality, notably the report of the Oxford Committee for Famine Relief (Oxfam) of 2015 [11], and on its unfolding in the health sector, in which the theoretical framework of reference consists of studies by Daniels [12] and Labonté and Schrecker [13]. As for the UDBHR, research used as the basis focus on the principle of justice and international cooperation, as well as the works of other authors [14-16] who have dedicated themselves to these principles from data on economic and social dimensions today [17-19].

Inequality in general - and, notably, in income and wealth - impacts bioethical issues, so that in the examination of moral issues, bioethicists should contemplate them from their various facets. Similarly, instrumental bioethics can contribute to the debate on inequality, particularly in the health sector. Therefore, this article is structured in three parts, with the aim of addressing issues of inequality, as well as its specificity in health and its connection with bioethics.

The first part presents the overall picture of economic and social inequality in order to present the contemporary picture of the distribution of wealth and power. The second part deals with inequality in the health sector, demonstrating its impact on public health, in economic, social and power terms and, finally the the UDBHR is taken as subject and, in particular, the employment of principles alluded as a tool for reflection and the prescription about the current inequality, prioritizing the health approach.

The global overview if inequalities

Available data on economic and social issues show that the contemporary world remains extremely uneven. In the economic dimension, the study of Oxfam [11] shows that the concentration of wealth has reached alarming numbers, especially after the economic crisis installed in the past decade. As proof of this, in 2010 the world's 388 richest people now hold an equity amount equivalent to 3.5 billion people (48% of world population). The 80 richest people in the world had at that time, equity equal to half of the poorest people on the planet. Even more serious is the prediction that such a scenario is expected to worsen; these 80 richest, who have had their wealth increased between the years 2010 and 2014, they will concentrate 50% of the world's wealth in 2016.

For Dorling [20], when referring to considerations of Shiller about the harmful effects of the greed of the super rich, those are higher than the crisis of 2008. The super-rich contribute to the increase of inequality not only increasingly appropriating the world's wealth, but also promoting the idea that greed is acceptable, since they have their own media such as newspapers and television channels that serve them uncritically [1]. Note that of the list of billionaires, those working in pharmaceutical and health care areas had the largest increase in their wealth between 2013 and 2014.

However, the debate on inequality is not new, as Piketty shows [21]. According to the author, the concentration of wealth and inequality have changed little since the early historical records in France and England from the nineteenth century and, even though there was decline in the concentration of wealth at the end of that century and early twentieth century, this concentration has grown again with the financial globalization, from the 1970s to 1980. We call attention to the trend seen in the UK, but which can be extended to other countries, that although there is greater equality between the 99% least wealthy of the population, the same can not be said when compared to the richest 1%, whose wealth is increasing, while that 99% have been impoverished [1].

Despite the efforts of the international community to formulate policies aimed at promoting economic development and global social, as demonstrated by the Millennium Development Goals (MDGs) adopted by the UN General Assembly in 2000, it turns out that before the economic crisis started in that same decade, some sectors failed to advance towards the fulfillment of the objectives, due to various factors, including the resumption of growth of economic and financial inequality [11,17-19,21]. It should be noted that the debate occurred in the

preparation of the MDGs on application of the principle of justice with a view to human development of the population has not been considered in the discussion of measures to cope with the economic crisis, which are summarized in the restraining of social spending and financial balance of countries. Such measures actually have been implemented as the same old formulas, subtracting redistributive policies and actions and reversing the goal of achieving a more equitable environment [22].

The most immediate impact of the economic crisis is revealed in rising unemployment and the loss of family income. However, there are also impacts on social policies, to the extent that states have adopted measures such as cost containment and reduction of investments, of which effects are felt in the maintenance of universal systems of health and education, enshrined as equitable policies addressing inequalities [23]. An example of this impact is the UK, where health services are universal, and the series of cuts in social spending, with the consequent reduction of social workers visits to the elderly, culminated in increasing mortality among individuals in this age group [1].

By analyzing the variables of inequality in several countries, broken down by race, gender, age, among other indicators, it is demonstrated that in addition to the concentration of wealth by the few, there is also discrimination as a result of a pattern related to the attributes of the white man and of working age, which generally has better indicators [24,25]. As for Latin America in particular, it must be observed that it is the most unequal region in the world where the distribution of wealth is linked to a strongly hierarchical social structure, product not only of its history, but also of the global economic dynamics [26].

In Brazil, Medeiros and collaborators show that inequality presents high levels, nearly half of all income in the country is concentrated in the 5% richest and a quarter of the income, in the 1% richest: *The richest thousandth accumulate more income than all the poorest half of the population* [3]. Therefore, Brazil shows a trend similar to that in the United Kingdom; that is, although there has been change in the basis of the distribution among the 99% poorest, the concentration remains among the 1% richest. Similarly, although the income in Brazil has grown, the distribution of growth was uneven, *only about one tenth of all the growth went to the poorest population of the country. Half of the growth went to the top 5%, and 28% to the 1% richest* [3].

It is worth mentioning the recognition of important initiatives for universal access to health services and basic education. However, even in such spheres significant inequalities persist, such as the existence of a greater number of years of education in the age group from 15 years in higher income families, among the white, female, living in urban areas of more developed regions of the country; as browns, blacks and others had the worst indicators in any geographic region of the country, both in urban and rural areas [27].

The economic dimension is central in the debate on the interface between bioethics and inequality because it is linked to the survival of human beings, living in societies of a globalized economic system and concentrated wealth, although advocates of equality as a human right [7,9]. During the last century and the beginning of this, with the preparation and dissemination of the UDBHR and socially engaged bioethical currents, the debate on the principle of justice and measures related to the principle of international cooperation gains momentum. Its focus is on the urgency of greater investment of resources by societies, to the needy, in order to achieve a more egalitarian horizon in the world [9,14].

With respect to other types of inequality, gender still reveals a serious global problem. Brazil seems to accompany a phenomenon that also occurs in developed countries, where women have shown a better health condition and a larger number of years of education, including higher education, which has not been reflected in the labor market, as revealed by Craide [28], in mentioning the statements submitted in the Global World Social Forum 2014 by Gender Report 2014. Despite the significant improvement made by some countries, most understood in this report, women still occupy fewer management and / or executive positions and earn lower wages than men, even in management positions.

Similarly, inequality concerning the race in Brazil, particularly the black and indigenous populations, is a fact on which light must be shed, as they are the groups - and in urban strata, especially blacks - that still have the worst indicators of illiteracy, health and income, among others, showing that, despite the occurrence of improvements resulting from public policies, such advances have not been sufficient to reverse the inequality in relation to the white population [29].

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The scenario of inequality in health in contemporary times

Disparities in the health status of individuals and populations are largely connected with the unequal distribution globally the necessary resources for health [13]. Daniels [30], referring to studies by Pogge, emphasizes that 18 million preventable and premature deaths are linked to global poverty. The correlations between income inequality, wealth and other types, and the health status of individuals and populations have been exposed both in literature and in documents produced by international organizations. To give an example of the second approach, the Pan American Health Organization (PAHO), with intense participation of the Brazilian delegation, drew up in 2014 a document on health for discussions on sustainable development based on the United Nations Conference in the Rio de Janeiro in 2012, in which it was recognized that *health is a precondition, a result and an indicator of the three dimensions of sustainable development: economic, social and environmental* [31]. As for literature, its scope is the presentation of interconnection models between inequality and health, which will initially be approached from the global perspective and then some data from national scenarios will be brought.

First, Dorling [1] highlights the strong connection between wealth inequality and life expectancy. For example, life expectancy in Swaziland is half of that in Japan [12]. Life expectancy at birth has made significant progress, but that progress has variation, as in the comparison between Canadians, who at birth can expect to live 80 years, and the populations of low-income countries, whose life expectancy at birth is estimated at 59 years on average. In Zambia, one of the countries most affected by the AIDS epidemic, life expectancy at birth fell from 50 years in 1980 to 45 years in 2009 [13].

In the sphere of global inequality related to child health, a child born in Angola is 73 times more likely to die before age 5 than one born in Norway [12]. Still, the mortality of children under five years, those between the poorest 20% of five developing countries have at least twice as much chance of dying before age 5 and, in some cases, up to three times more, when the comparison is made with children from the richest 20% [13]. In Latin America, malnutrition affects 16% of children [32].

As for maternal mortality, inequality is significant. Complications related to pregnancy and childbirth kill more than 500,000 women each year, a situation almost nonexistent in high-income countries. For example, the risk of a woman in Canada to die from complications of pregnancy is 1 in 11,000; for a woman in Nigeria, one of the poorest countries in the world, it is 1 in 7 [12]. A pregnant woman in sub-Saharan Africa is 100 times more likely to die during childbirth, compared with industrialized countries [13].

Inequalities pertaining to disease prevalence are dramatic. Sub-Saharan Africa, for example, has about two-thirds of the world's population infected with HIV, and it is estimated that of the 2 million deaths from AIDS, 1.4 million occurred in this region of the globe. Malaria and tuberculosis were virtually extinct in high-income countries, while in this region they still kill almost one million and 1.7 million, respectively.

Also there are other inequalities in health between population groups in high, middle and low income countries. Among the 49.4 million deaths occurred in middle and low income countries in 2002, 21% occurred among children under 5 years of age while in high-income countries, among the 7.9 million deaths, only 1% It occurred in this age group [13].

Inequality of wealth and power in health care involves the activities of pharmaceutical companies and health care, they spend millions of dollars every year to create favorable ambience in the countries in which they operate, which obviously leads to tax relief and passing laws that benefit them. During 2013, pharmaceutical and health care industry spent over 487 million dollars on lobbying in the United States, part of this amount was used in marketing to influence prescribers and over 260 million in financing election campaigns.

Of the 90 billionaires in the pharmaceutical and health care sectors, 22 are Americans and 20 Europeans. The industry spends at least $ 50 million annually on lobbying in Europe. Millions spent on this practice consist of calculated investments, before which the expectation of the companies is that these amounts are reversed in policies and laws that benefit them, even indirectly, thus compensating the investment. The tax relief, the greater goal of companies, impacts on the budget of countries, resulting in fewer resources to public health [11].

The impact of inequality in the health sector is not only in middle and low income countries. In the UK, for example, men who die in the cities of

Kensington and Chelsea are on average older than 14 years older than those who die in Glasgow. For women, this interval is 12 years. If the richer are compared with the poorer, the gap is increased. Also in England after the 2008 crisis, the diet of the poorer adults and children was radically changed: cheaper, energy-rich and potentially addictive food, containing saturated fat and sugar, have become more consumed at the expense of fresh vegetables and fruits. The decrease in household income detrimentally impacts the health of diets [1].

In the United States, socioeconomic and racial inequality are the most important issue in terms of public health. The evidence of the correlation between socioeconomic status and health indicators are expanding. Despite the increase in health expenditure per capita by the US government, its indicators show no improvement, it will be necessary to invest seriously and heavily in reducing social inequality, so that the health condition of the poorer population and that of black people may improve . Regarding gender inequality, the expectation of life for women in the United States have declined or stagnated in most states since 1985; in some counties, women are dying younger than their mothers [1].

In the Americas, there are abysmal disparities between the richest countries and the poorest countries concerning maternal mortality. For example, in Canada, the maternal mortality ratio is 4.8 (in 100 000 inhab.) In Brazil it is 61.6 and in Haiti, it is 157.0; the rate of infant mortality in Canada is 4.8 (in 100,000 inhab.) in Brazil it is 14.6 and in Haiti it is 59.0 [33]. In the Latin American region, inequality in health reflects the inequalities of various orders that are manifested in the region. According to Kliksberg [32], all Latin American countries surpass the international average of Gini coefficients, which measure the inequality of income distribution. By the health perspective, inequality is a matter of *great proportions and high gravity, a sort of almost irreducible problem* [34].

In order to illustrate the health inequality in Brazil, there is the issue of children's health. Although progress has been made in this field, *mortality of children under five years is still seven times higher than in countries with the lowest coefficients and the prevalence of height deficit is three times higher than that found in well-nourished populations* [35]. Particularly with regard to inequality between regions in the North the mortality rate in childhood, the highest in the country, is of 25.0 (in 100,000 inhab.); in the South, the lowest in the country, it is 13.5. Finally, note the racial inequality, expressed by the death rate for assault: 28.2 (. in 100 000 inhabitants) between whites and 72.1 among blacks, considering adolescents and young people [36].

Because it is a serious contemporary problem that spreads by various parts of the globe, health inequalities will be examined then by the look of UDBHR particularly considering the bioethical principle of justice and the importance of international cooperation.

The Universal Declaration on Bioethics and Human Rights and global inequality

When discussing about the emergence of the global right knowledge of health, Gostin and Taylor [37] outline the current context of globalization of public health. The globalization of the contemporary world brings profound impact on the health of populations everywhere in the world, with repercussions never seen before in global public health. Indeed, economic globalization undermines the capacity of countries, particularly the poorest, to sustain their health systems since the international trade and intellectual property rules affect its power to ensure access to essential medicines and vaccines. In addition, unfair competition from the private market causes the displacement of health professionals from poor areas of the planet to the rich countries. Given this situation the protection of the health of the population escapes from unilateral actions by States, imposing, thus the empowerment of the international community, state and non-state actors, in order to establish suitable mechanisms to achieve this protection.

The draft of *The Universal Declaration on Bioethics and Human Rights* was presented after two years of intense debate, the UNESCO General Assembly in October 2005, which was finally approved by acclamation [38]. As to the UDBHR text, The version adopted is structured in six parts: "Preamble", "General Provisions", "Principles", "Application of the principles ", "Promotion of the Declaration" and "Final Provisions", containing a total of 28 articles [9].

The content of UDBHR is based on fifteen substantive principles. Thus, UNESCO, when producing an instrument whose provisions configure principles, maintain a form of construction that provides both the maturation of ethical and legal concepts permeating the norm concerning negotiation, without imposing mandatory rules [39]. Considering the principle-based content of the document, it can be

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said that his company was most have established a framework of principles and criteria on which states may legislate on bioethical issues [40]. Indeed, the UDBHR has as nodal goal in setting general principles of ethical character in an "open" text , which is positive because it enables interpretation and application combined with national and international norms part of the bioethical rules and international law on human rights [40].

Being considered as a normative expression of global bioethics, in that it provides ethical instruments for public policy development, the the UDBHR is valuable in addressing issues related to global inequality. The phenomenon of globalization,besides having led to changes in the modes of economic circulation of people and information, also reflected on the sphere of bioethics, because *globalization is not only an economic problem but also a legal and ethical issue* [41]. The perception that there are indeed issues such as inequality, that cross borders - that is, they do not concern just one country - coupled with the consequent realization that the way to deal with them also implies international measures, leads to building a global bioethics notion, ie, a comprehensive approach to bioethics [38].

The world, ever more interdependent, requires the search for harmonious solutions among the States; thus, Espiell concludes [42], a universal approach is needed and the the UDBHR proves helpful in that sense, because complies a series of principles that cross national borders. Thus, the document, such as externalization of globalization of bioethics, proves to be important to highlight the interconnectedness of global issues, as in the case where populations with the worst health indices have reduced their opportunities, while poverty increases the chances of illness, thereby setting a vicious circle [43].

The UDBHR - notably through the principles of justice, in its Article 10, and international cooperation under Article 13 - also constitutes a global governance tool to compete to boost the actors of the international community towards public policies addressed to combat inequality as a complex and comprehensive phenomenon, transmitted from generation to generation. In this sense, inequality requires addressing a number of issues, such as prejudice regarding color, gender and ethnicity, among others, which are intertwined with poverty and income distribution [44].

With regard to the principle of justice and of its connection with inequality at the global level, one can argue that the UDBHR sustains moral distributive obligations of the States, which are anchored on the concept that the primary value of international society is the flourishing of individual lives [45]. Thus, the principle of constant justice of the UDBHR can be understood, according to the denomination of Vita, as a principle of international distributive justice, whose object are the inequalities produced by the global institutional framework. Indeed, the principle of justice established in the UDBHR prescribes obligations to the desideratum to correct inequalities brought about by the *distributive inequity of institutional arrangements of which rich people are the biggest beneficiaries* [46].

Consequently, those who hold power in the international community and modulate the international distributive arrangements should consider inequality as a moral issue and make distribution more suitable to the demands of justice. Thus, the principle of justice contained in the UDBHR proclaims that *a just international society should prioritize the welfare of the underprivileged on the global scale* [47]. The UDBHR, through the principle of justice, supports the idea that any disadvantage among people that is independent of their choices is unfair.

An example of this proposition is the notion that if no one chooses where born, so it is unfair that a child born in Swaziland has half the life expectancy of a child born in Japan [12]. From the point of view of UDBHR, the current global distribution of resources, particularly in health, is unfair [43], imposing therefore an ethical recognition of the States which should rally means to promote the fair distribution of resources.

From the perspective of the principle of international cooperation between states, the UDBHR expresses a recommendation that there be cooperation among them, especially among high-income and low-income countries. The global facing the problems concerning the inequality without the scientific, economic, social or political cooperation of high income countries proves to be ethically inconceivable today [37]. *As pointed out by Santana and Bottle on the entry of international cooperation in the UDBHR, this theme was included in various provisions that apply to government policies and plans involving the health sectors of two or more countries, either in the preamble or in the body of the Declaration* [48].

International cooperation can be of various kinds: humanitarian, military, scientific, technological and technical [49]. However, regardless of type, the essence of this cooperation is the idea of interdependence between States and solidarity of international relations. Thus, the principle of inter-

national cooperation contained in the UDBHR is to be interpreted as a command that advocates human development, specific attention to vulnerable groups, the achievement of sustainable development [50] and the reduction of global inequality.

In this sense, such principle expressed in the the UDBHR stipulates that States and international institutions, have obligations focused on measures to reduce inequalities, since this is essential to achieve a degree of fairer distribution. One way to reduce inequality is on the decline of liens on income derived from work and wages and rising encumbrances against the property, as suggested in an interview of Piketty by Skoknic [51], generated not by the imposition of a global tax on equity, but by the increase and qualification of international cooperation on tax administration.

To the dilemmas and bioethical questions posed globally, the answer must be through the adoption of international ethical standards. The phenomenon of globalization, cross-border problems, the weakness of the normative instruments of states to deal with them as well as the urgency to carry out international cooperation, impel the recognition that a universal evaluative agenda for global bioethics is essential when the objective protection of the individual. It is here that the UDBHR fits because, consisting in a set of ethical content norms accepted in the international community, it is revealed as the best universal axiological parameter to be adopted in global bioethics. The the UDBHR is the universal rules of example rooted in a cosmopolitan outlook. That is, every human person has a universal dimension; and, in the world's citizen condition, it is the rights holder as a member of the international community.

It is the task of the occupied bioethicists of global inequality that plagues contemporary societies to engage not only in theoretical debates about the moral obligations of countries and international institutions concerning the redistribution of resources and the reduction of inequality, but also in the debate and proposition of concrete policies and measures for this purpose, correlating inequalities that permeate disputes on color, gender, ethnicity, religion, among others. The UDBHR aggregates theoretical-normative consistency to the discourse of the existence of a moral obligation to reduce global inequality, marginalization and social exclusion.

Final Considerations

Bioethics, be it Brazilian or global, should not evade one of today's biggest problems: inequality, which spreads by countries and contaminates societies and interpersonal relationships. It is the primary task of the bioethicist who is uneasy with transnational social issues and takes into account inequalities in income, wealth, gender, color, among others, that directly affect not only the conditions of life, but also their health. In short, inequality is, above all, an ethical issue. In this sense, The UDBHR – which in 2015 celebrates ten years since its approval by the Assembly of UNESCO 2005 - provides theoretical and normative tools that allow reflection and the prescription about inequality, notably by applying the principle of justice and international cooperation. The principle of justice calls upon States and international institutions to adopt policies to reconfigure the current distribution of resources in the world, and converging, the principle of international cooperation impels the conformation models that take into account primarily the inequality countries and population groups and thus contribute to increased solidarity among peoples.

Referências

1. Dorling D. Inequality and the 1%. London: Verso; 2014.
2. Piketty T. A economia da desigualdade. Rio de Janeiro: Intrínseca; 2014. p. 9.
3. Medeiros M, Souza PHGF, Castro FA. A estabilidade da desigualdade de renda no Brasil, 2006 a 2012: estimativa com dados do imposto de renda e pesquisas domiciliares. Ciênc Saúde Coletiva. [Internet]. 2015 [acesso 21 jan 2015];20(4):971-86. DOI: http://dx.doi.org/10.1590/1413-81232015204.00362014
4. Lee K. Globalization and health policy: A conceptual framework and research and policy agenda. In: Bambas A, Casas JA, Drayton H, Valdés A, editors. Health and human development in the new global economy: The contributions and perspectives of civil society in the Americas. Washington, DC: PAHO; 2000. p. 15-41.
5. Buss P. Globalização, pobreza e saúde. Ciênc Saúde Coletiva. 2007;12(6):1575- 89.
6. Beck B ¿Qué es la globalización? Falacias del globalismo, respuestas a la globalización. Barcelona: Paidós; 1998.

7. Organização das Nações Unidas. Declaração Universal dos Direitos Humanos. Adotada e proclamada pela Resolução 217 A (III) da Assembleia Geral das Nações Unidas em 10 de dezembro de 1948. [Internet]. 1948 [acesso 18 jun 2015]. Disponível: http://www.direito.mppr.mp.br/arquivos/File/declaracaouniversal.pdf
8. Oliveira AAS. Bioética e direitos humanos. São Paulo: Loyola; 2011.
9. Organização das Nações Unidas para a Educação, Ciência e Cultura. Declaração Universal sobre Bioética e Direitos Humanos. [Internet]. Paris/Lisboa: Unesco; 2006 [acesso 18 jun 2015]. Disponível: http://unesdoc.unesco.org/images/0014/001461/146180por.pdf
10. Cortina A. Ética sem moral. São Paulo: Martins Fontes; 2010. p. 11.
11. Oxford Committee for Famine Relief. Wealth: Having it all and wanting more. [Internet]. 2015 [acesso 22 jan 2015]. Disponível: http://www.oxfam.org/sites/www.oxfam.org/files/file_attachments/ib-wealth-having-all-wanting-more-190115-en.pdf
12. Daniels N. Just health: Meeting health needs fairly. New York: Cambridge University Press; 2008.
13. Labonté R, Schrecker T. The state of global health in a radically unequal world: Patterns and prospects. In: Benatar S, Brock G. Global health and global health ethics, editors. Cambridge, UK/New York: Cambridge University Press; 2012. p. 24-36.
14. Garrafa V, Porto D. Intervention bioethics: A proposal for peripheral countries in a context of power and injustice. Bioethics. 2003;17(5-6):399-416.
15. Schramm RF. Bioética da proteção: ferramenta válida para enfrentar problemas morais na era da globalização. Rev. bioét. (Impr.). 2008;16(1):11-23.
16. Fortes PAC. A equidade no sistema de saúde na visão de bioeticistas brasileiros. Rev Assoc Med Bras. 2010;56(1):47-50.
17. Instituto de Pesquisa Econômica Aplicada. Objetivos de desenvolvimento do milênio: Relatório Nacional de Acompanhamento. Brasília: Ipea; 2010 [acesso 21 jan 2015]. Disponível: http://www.pnud.org.br/Docs/5_RelatorioNacionalAcompanhamentoODM.pdf
18. Carin B, Bates-Eamer N. Poast 2015 Goals, Targets and Indicators: Conference report; 10-11 abr 2012; Paris. [Internet]. Ontario, Canada: Centre for International Governance Innovation; 2012 [acesso 21 jan 2015]. Disponível: http://www.cigionline.org/publications/2012/10/post-2015-development-agenda-goalstargets- and-indicators
19. The World We Want. Health in the post-2015 agenda: Report of the Global Thematic Consultation on Health; apr 2013; Gaborone, Botswana. [Internet]. 2013 [acesso 21 jan 2015]. Disponível: http://www.worldwewant2015.org/file/337378/download/366802
20. Dorling, D. Op.cit. p. 1.
21. Piketty T. O capital no século XXI. Rio de Janeiro: Intrínseca; 2014.
22. España. Real Decreto-ley 16, de 20 de abril de 2012. De medidas urgentes para garantizar la sostenibilidad del Sistema Nacional de Salud y mejorar la calidad y seguridad de sus prestaciones. Boletín Oficial del Estado. [Internet]. 24 abr 2012 [acesso jan 2015];(98):31278-312. Disponível: http://www.boe.es/buscar/pdf/2012/BOE-A-2012-5403-consolidado.pdf
23. Abellãn Perpiñám JM, editor. El sistema público en España y sus comunidades autónomas: sostenibilidad y reformas. Bilbao: Fundación BBVA; 2013.
24. Instituto de Pesquisa Econômica Aplicada. Diretoria de Estudos e Políticas Sociais. Políticas sociais: acompanhamento e análise: anexo estatístico. [Internet]. 2014 [acesso 21 jan 2015];(22). Disponível: http://www.ipea.gov.br/portal/images/stories/PDFs/politicas_sociais/140930_bps22_anexo.pdf
25. São Paulo (Estado). Fundação Sistema Estadual de Análise de Dados (Sead). Portal de Estatísticas do Estado de São Paulo. Indicadores de desigualdade Racial – IDR. [Internet]. [acesso 28 jan 2015]. Disponível: http://produtos.seade.gov.br/produtos/idr
26. Delgadillo Ramírez D. Pobreza y desigualdad en la cooperación internacional. Observatorio de Cooperación Internacional para el Desarrollo en México. [Internet]. 2009 [acesso 26 abr 2015]. Disponível: http://www.academia.edu/1854174/Pobreza_y_desigualdad_en_la_Cooperaci%C3%B3n_Internacional
27. Castro JA. Evolução e desigualdade na educação brasileira. Educ Soc. [Internet]. 2009 [acesso 29 jan 2015];30(108). Disponível: http://www.scielo.br/scielo.php?pid=S0101-73302009000300003&script=sci_arttext
28. Craide S. Brasil piora em ranking mundial de desigualdade de gênero. Agência Brasil. [Internet]. 28 out 2014 [acesso 29 jan 2015]. Disponível: http://agenciabrasil.ebc.com.br/direitos-humanos/noticia/2014-10/brasil-cai-em-ranking-que-analisa-diferencas-entre-homens-e
29. Instituto de Pesquisa Econômica Aplicada. Situação social da população negra. [Internet]. Brasília: Ipea; 2014 [acesso 10 fev 2015]. Disponível: http://www.ipea.gov.br/portal/images/stories/PDFs/livros/livros/livro_situacao-social-populacao-negra.pdf
30. Daniels N. Op.cit. p. 334.
31. Organização Pan-Americana de Saúde. Desenvolvimento sustentável e saúde: tendências dos indicadores e desigualdades no Brasil. Brasília: Opas/OMS; 2014 [acesso 6 fev 2015]. (Série Desenvolvimento Sustentável e Saúde 1). Disponível: http://www.paho.org/bra/images/stories/Documentos2/perfil%20do%20brasil_desenvolvimento%20sustentavel.pdf?ua=1
32. Kliksberg B, Sen A. As pessoas em primeiro lugar: a ética do desenvolvimento e os problemas do mundo globalizado. São Paulo: Companhia das Letras; 2007.

33. Pan American Health Organization. Health situation in the Americas: 20 years basic health indicators. [Internet]. Washington, DC: PAHO/WHO; 2014 [acesso 20 abr 2015]. Disponível: http://www.paho.org/hq/index.php?option=com_docman&task=doc_view&gid=27299&Itemid=270&lang=en
34. Kliksberg B, Sen A. Op. cit. p. 156.
35. Victora CG, Aquino EML, Leal MC, Monteiro CA, Barros FC, Szwarcwald CL. Saúde de mães e crianças no Brasil: progressos e desafios. The Lancet. [Internet]. 2011 [acesso jan 2015];377(9780):1863-76. p. 1864. DOI: 10.1016/S0140- 6736(11)60138-4
36. Instituto Brasileiro de Geografia e Estatística (IBGE). Síntese de indicadores sociais: uma análise das condições de vida da população brasileira 2013. [Internet]. Rio de Janeiro: IBGE; 2013 [acesso 20 mar 2015]. Tabela 6.1 - Taxa de mortalidade na infância e taxa de mortalidade infantil, segundo as grandes regiões e as unidades da federação – 2010. Disponível: ftp://ftp.ibge.gov.br/Indicadores_Sociais/Sintese_de_Indicadores_Sociais_2013/pdf/saude_pdf.pdf
37. Gostin LG, Taylor AL. Global health law: A definition and grand challenges. Public Health Ethics. 2008;1(1):53-63.
38. Ten Have HAMJ. Introduction. In: Ten Have HAMJ, Jean MS, editors. The Unesco Universal Declaration in Bioethics and Human Rights: Background, principles and application. Paris: Unesco; 2009. p. 17-55.
39. Stefani PD. La Dichiarazione Universale sulla Bioetica e i Diritti Umani. In: Turoldo F, a cura di. La globalizzazione della bioetica. Padova: Lanza; 2007. p. 105-40.
40. Jean MS. Le CIB et le processus d'élaboration de la Déclaration universelle sur la bioéthique et les droits de l'homme. In: Byk C, directeur. Bioéthique et droit international. Paris: NexisLexis; 2007. p. 15-21.
41. Sánchez YG. Los principios de autonomía, igualdad y no discriminación en la Declaración Universal sobre Bioética y Derechos Humanos. In: Espiell HG, Sanchez YG, coordinadores. La Declaración Universal sobre Bioética y Derechos Humanos de la Unesco. Granada: Comares; 2006. p. 271-308. p.272.
42. Espiell HG. Ética, bioética y derecho. Bogotá: Themis; 2005.
43. Widdows H. Global ethics: An introduction. Durham: Acumen; 2011.
44. Vita A. O liberalismo igualitário: sociedade democrática e justiça internacional. São Paulo: Martins Fontes; 2008. p. 232.
45. Vita A. Op. cit. p. 233.
46. Vita A. Op. cit. p. 242.
47. Vita A. Op. cit. p. 250.
48. Santana JP, Garrafa V. Cooperação em saúde na perspectiva bioética. Ciênc Saúde Coletiva. 2013;18(1):129-37. p. 135.
49. Brasil. Ministério das Relações Exteriores. Agência Brasileira de Cooperação. Sistema de Informações Gerenciais de Acompanhamento de Projetos. [Internet]. [acesso 26 abr 2015]. Disponível: http://www.abc.gov.br/sigap/ct.aspx
50. Sánchez YG. Cooperación internacional y bioética. Biblioteca Jurídica Virtual del Instituto de Investigaciones Jurídicas de la UNAM. [Internet]. [acesso 24 abr 2015]. Disponível: http://biblio.juridicas.unam.mx/libros/6/2673/20.pdf
51. Skoknic F. Piketty: "La desigualdad pude llevar a la captura de las instituciones políticas" [entrevista]. Ciper. Actualidad y Entrevistas. [Internet]. 14 jan 2015 [acesso 24 abr 2015]. Disponível: http://ciperchile.cl/2015/01/14/piketty-la-desigualdad-puede-llevar-a-la-captura-de-las-instituciones-politicas

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