Original Article

EQUITY IN THE HEALTH SYSTEM ACCORDING TO BRAZILIAN BIOETHICISTS

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ABSTRACT
Objective. To understand the meaning attributed to equity in health system by Brazilian bioethicists.
Methods. Qualitative and exploratory research. Between July 2007 and July 2008, 20 bioethicists, directors and former directors of the Sociedade Brasileira de Bioética (Brazilian Bioethics Society) and their regional administrations (2005-2008) were interviewed. To analyze data discourse analysis was used.
Results. Discourse analysis led to establishing these main ideas: treat unequal people unequally according to their needs; compensated equity and inequalities; equity and benefits maximization; equity and social merit; equity and rights.
Conclusion. Research results evidence the existence of a diversity of interpretations, in bioethicists researched, on equity in health system, reinforcing the notion that it is difficult, in contemporary world, to deliberate upon what would be a just and equanimous system.

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Introduction

North-American philosopher John Rawls[1] (1921-2002), an important historical milestone in the reflection on principles of justice and equity, understands that justice is the primary virtues for social institutions, an offspring of human cooperation that must seek the realization of mutual benefits. For him, 'justice is the main virtue of social institutions, just like truth is the main virtue of systems of thought.'

According to Spanish philosopher Adela Cortina,[2] justice is the basis for civic ethics, necessary for people to attain their projects of contentment in a morally pluralistic society, that is, it constitutes the ethical capital shared by the members of human society.

Justice may be divided in commutative justice (corrective or retributive) and distributive justice. By distributive justice it is understood the distribution of honors, social incumbencies and goods, relating individuals to collectiveness and political authority. However, there are various concepts that refer to conditions of scarcity and competition for resources in the health field. As Campos affirms[3] concepts are not innocuous, for they 'reflect a commitment of the one who invents them or uses them with a certain world outlook or a certain set of values.'

It can be said, thus, that only from the 18th Century on, and mainly in the 20th Century, the modern concept of distributive justice is constructed. This concept demands of politically and juridically organized society, the State, to intervene in the social and economic field in order to guarantee the distribution of goods, providing people with a certain level of interests and material resources.[4]

There is, among the various ethical theories of distributive justice, a seeming agreement that a just distribution must be achieved. Yet, in actualizing the principle, the diversity of interpretations is evidenced, involving the principle of equity, in addition to the principles of liberty, social usefulness and efficiency, which, in concrete situations, may confirm contrasting alternatives.[5]

In relation to the concept of equity, some consider it the most important concept in orienting health policies, being it evidenced at Alma Ata Declaration.[6]

However, it is important to have in mind that this concept is polysemic, and, as Almeida points out,[7] the chosen definition of equity to be operationalized comes to reflect society's values and choices in certain historical moments.

Thereby, as part of the research on bioethics analysis on distributive justice in the health system, knowing and analyzing the meaning of equity in the health system for a group of Brazilian bioethicists was aimed at, because Brazilian bioethics, since the 1990s, is directing its attention to issues related to collectivity, sanitary policies, and health systems.[8,9,10]

Objective

To know and analyze the attributions of meaning on equity in health system by Brazilian bioethicists.

Methods

It is a qualitative and exploratory research, with an analytic and descriptive orientation. The choice of the qualitative approach

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was due to the possibility of understanding cultural values. Twenty semi-structured interviews were conducted in the period of July 2007 to July 2008, with Bioethics professors, acting in public and private schools in the field of health sciences. Interviews, conducted by the researcher, were recorded in a magnetic recorder and, afterwards, transcribed in whole. The answers of three researchers were obtained in written form after the formulary was sent via internet, due to personal difficulties in scheduling the interview.

To all the researchers the following open question was posed: 'What would be a health system founded on the principle of equity?'

A convenience sample was constructed, composed of directors and former directors of the Sociedade Brasileira de Bioética' (Brazilian Bioethics Society) and some of its regional directorships (2005-2008): Rio de Janeiro, Pernambuco, and São Paulo, all of them with scientific productions in the field of bioethics present in CNPq's Curriculum Lattes. This society, created in 1995, currently congregates most of Brazilian bioethicists and has as its finality to assemble people from different academic backgrounds interested in advancing the discussion and diffusion of Bioethics. There was a diversification of professional categories involved by incorporating to the sample professionals from the fields of medicine, dentistry, nursing, anthropology, and theology.

In the interviewees' discourses central ideas were sought, which would be descriptors of the meanings existing in the discourses,[11] presenting similar or complementary meaning.

In the text some key-expressions for each of the central ideas discovered will be presented. These expressions are 'literal transcriptions of part of the testimonies, which permit resuming the essence of the discursive content of the segments in which the testimony is divided.'[12]

According to the guidelines and norms of the CNS/MS 196/96 Resolution that regulates the ethics of research involving human beings in Brazil, an informed consent term was demanded from each of the researched subjects to participate in the study, with their signature. Initially the interviewees were informed by e-mail of the character of the research, its objectives, procedures to be observed and refusal possibility. Anonymity and confidentiality of data were assured, because the results are presented with no possibility of nominal identification. Interviewees were numbered in sequence (E1, E2 ... E20).

The research project, as well as the informed consent term, was submitted to the Research Ethics Committee of the Public Health School of the Universidade de São Paulo.

It is important to mention, yet, that the results presented in this article constitute part of those obtained in the study: *O princípio ético da justiça distributiva e sua aplicação no sistema público de saúde na visão dos bioeticistas brasileiros* (The ethical principle of distributive justice and its application in the public health system in Brazilian bioethicists' vision), financed by CNPq (PQ - CA 10/2005).

Results

Five central ideas were identified in the interviewees' discourses: 'treat unequal people unequally according to their needs'; 'compensated equity and inequalities'; 'equity and benefits maximization'; 'equity and social merit'; 'equity and rights.'

Treat unequal people unequally according to their needs

A considerable number of interviewees correlated equity as principle of unequal attention to individual needs in situations considered also unequal (E2, E4, E5, E6, E10, E12, E15, E 17, E18).

Treating unequal people unequally according to their needs is an interpretation of the principle of justice, and derives from diverse bases – from Christian thought to the foundations of various socialist lines of thought -, and is marked by the principle of equality among all the people. However, a differentiated treatment among people when it is based on individual needs is accepted, in order to attain the ideal of maximum possible equality. The ethical orientation is: 'To each person, according to their needs.'

Some examples of this representation:

"The health system, based on the principle of equity, would be a health system concerned with attending the needs of every individual, regardless of color, race, creed, ultimately, purchasing power or not.' (E15)

"Equity would be giving different things to different people, that is, we can think about the individual, the need of the individual and not generalize the whole society.' (E2)

Compensated equity and inequalities

A significant part of the interviewees' discourses manifested favorable opinions to prioritizing resources to disadvantaged people, or 'more vulnerable' ones. (E7, E8, E9, E16, E17, E20)

This notion of equity is close to that suggested by Rawls,[1] who advocated as just the action that has unequal consequences to the various individuals involved only when they result in compensatory benefits to each and every one, and particularly to the 'less advantaged' 'less fortunate' society members

Examples of this interpretation of equity:

"I think equity means, actually, that you discriminate in a positive way, that is, in a very heterogeneous, very unequal, society, you cannot treat equally, for one has elementary needs, and the other has a different need.' (E7)

"It would be a health system very close to the population's more vulnerable layers, focusing primarily on this part of the population, in terms of resources investment.' (E9)

Equity and benefits maximization

Some discourses defending orientations related to ethical thinking of benefits maximization, on a utilitarian basis, were also found. (E1, E11, E16)

Utilitarianism has, while ethical orientation, as its exponents, Anglo-Saxon thinkers Jeremy Bentham and John Stuart Mill. It is a theory whose foundation is the principle of social utility and whose paradigm is the 'greatest good for the greatest possible number of people,' that is, the maximization of well-being and/or the minimization of pain, discomfort or suffering for the majority.[13]

Quotations defending this line of thought:

"I consider as just a health system that has conditions to provide health care to the greatest possible number of people. We will have to seek diseases that affect the greatest number of people (...).' (E11)

"I think that resources should be prioritized, respecting a

right of the majority, which means that that affects most of the population (...).' (E16)

Equity and social merit

The notion of equity as social merit was evoked by only one of the interviewees (E3).

The relation between equity and merit originates in Aristotelian thought, which understands that goods and rights must be distributed according to the extent of social merit of the person, assessed regarding the collectivity's interest.[14]

"To be just there must be equity, respect to each one's right; if one makes ones duties better, has a more complex function, makes more effort, one has to accomplish many more things to do what was put as ones duty (...)' (E3)

Equity and rights

The discourses of some bioethicists link the equity discussion to the language of rights (E3, E10).

The language of rights is one of the elements in our vocabulary. International declarations, such as that of the World Health Organization, claim rights, but even those not associated to juridical sphere of the countries have an important moral effect on the conscience of individuals and of the collectivity.[15]

"Equity would be faith in justice. I would define justice as respect to right, to each one's right, respect to people's right.' (E3)

"I understand that equity puts us inside society as people who have equal rights and, therefore, equal respectability. That is, the way, in this organization, the system reflects this respectability for all the people with equal rights, which means overcoming discrimination.' (E10)

Discussion

According to Campos,[3] from the 1990s on, the term 'equity' gains political visibility in documents related to health policies and systems, first due to the influence of international organs such as the World Bank, of neoliberal orientation, pointing to one interpretation of the polysemic principle, favorable to prioritizing and/or focusing resources to less assisted populations or groups, and contrarily to the notions of universality of integral attention to health needs. However, afterwards, the term passes to the discussion agenda of those interested in the Brazilian public health system concretization, associated to the principle of universality. But it is only in the Norma Operacional de Assistência à Saúde (Operational Norm to Health Care), 2002, that the term is found expressed, with no specification.

Equalitarian theories based on the attention to people's needs understand that the organized society and the State, by means of implementing public policies, should intervene to assure distributive justice and minimize the lottery effects – both the biological lottery and the social one.[16]

For Durant,[17] using the conception of needs has the advantage of accepting, at the same time, formal equality among people and inequality of their needs. Nevertheless, despite the importance of the discussion on what would be sanitary needs and which should be prioritized in the health system, this was not the objective of this work. Cookson and Dolan[18] remind us that the resources distribution according to needs is particularly popular in the medical activity – clinical needs, mainly referred to death risk.

It is certain that the theoretical and practical difficulty of differentiating needs from desires is put forth, and in the health field the demand for care from the demand for comfort.[19]

Brazil, in the 1988 Federal Constitution, followed this ethical orientation, contemplating health as a social right and a duty of the State of attending the citizens' health needs, structuring the public health area under the Unified Health System (Sistema Único de Saúde – SUS), under the principles of universal access and integrality.

There seems to be an agreement between part of the bioethicists' discourses and the one proposed by Rawls,[1,20] accepting as just the orientation, by the democratic State, of resources distribution to result in unequal consequences to the various individuals involved, but benefiting the 'less favored' ones in the society, 'the poorer,' 'the more vulnerable,' those with no conditions of affording care to their health needs in the ways available in liberal market models, the adequacy of a 'positive discrimination."

The Latin-American bioethical line known as 'Protection Bioethics,' in our opinion, is in accordance with the preferential orientation 'to affected individuals and populations, vulnerable and excluded from the globalization process in course.' The Brazilian bioethics line, known as 'Intervention Bioethics', also defends that bioethics in peripheral countries must be oriented towards the diminution of existing inequities, protecting those who present more needs.[21,22]

The maximizing utilitarian thought, on its turn, invites us to reflect on if resources should be oriented to the satisfaction of collective needs or individual needs, maximizing the beneficial results to those directly or indirectly involved in the action. In the health field, the use of the notion of social usefulness, even if not directly expressed, is common, by means of using criteria of cost/benefit, cost-effectiveness or local effectiveness.[23]

It is important to remember that utilitarianism is highly influential in bioethics analysis models. For example, the theory of the four principles, the so-called principlist model in bioethics, proposed by Beauchamp e Childress[24] is essentially utilitarianist.

Intervention Bioethics, mentioned before, also adopts a line oriented by utilitarianism in declaring that 'in the public and collective field: prioritizing policies and decision making that privilege the biggest number of people, in the broadest span of time resulting in the best consequences, even if leaving aside certain individual situations, with punctual exceptions to be discussed."[22]

As for accepting the ethical validity of the social merit criterion for considering equity, Macintyre[25] warns us that it would be necessary to exist one only orienting vision for evaluating personal contributions for the project of society and for classification of rewards, which is not an easy task in a society like ours, characterized by moral pluralism.

In the field of health care, it can be reminded that, in a country of fundamental liberal orientation, such as the United States of America, merit criterion is recognized in the case of war veterans, who have health care systems organized and financed by the public power. This is due to the comprehension of the merit they had in fighting in times of war, in having volunteered to sacrifice themselves for the collectivity, or yet, because they were drafted by the State to defend the collectivity.

From 1988 on, with the Brazilian constitutional norm, 'health is a right of everyone and a duty of the State,' the language of 'rights' in the area of health starts to have a constant and remarkable presence.

However, we agree with Gracia[26] when he affirms that the justification of rights is fundamentally ethic, in spite of the legal apparatus that is progressively broadened in an international level, since the United Nations' Universal Declaration of Human Rights, in 1945, till the recent Universal Declaration on Bioethics and Human Rights, by the UNESCO.

In the case of health as a right, it means that health is a value that has priority in face of the concretization of other values. Nevertheless, the notion of right to health may be observed in various manners. Summing up the discussion, Kottow[27] differentiates 'right to health,' 'right to health care,' and 'right to medical attention,' each with its own specificities.

Daniels[28] still mentions the conception of negative right, related to preventing actions that may affect the health of individuals. Negative rights presuppose that the State and the society must not interfere with the individual's liberties to consent, complain, think freely, acquire and maintain properties etc.

However, in an opposite way, it can also be accepted, as in the Brazilian case, as a duty of the society and of the State to act and provide proper conditions for people to promote, protect, prevent or regain their health.

Conclusion

It must be highlighted that it is a qualitative research, with convenience sample, that does not intend to be representative of the whole of Brazilian bioethics, but, with its exploratory character, intended to present tendencies among bioethicists associated to well-known academic institutions. We consider the results as significant, for the bioethical reflection intends to favor the conscience of ethical values and not only the construction of norms, being able to influence, direct or indirectly, by means of academic training processes, research and assistance to institutions responsible for the formulation of health policies.

Yet, the research results evidence the existence, among researched bioethicists, of a diversity of interpretations on equity, reinforcing the notion that it is difficult, in the morally pluralistic contemporary world, to decide upon what would be a just and equanimous health system, an exhaustive dialogue among all the interested parts being necessary to arrive at possible consensuses for the organization and functioning of the health system, remembering that, in Brazil, the Pact for Health, firmed among the three governmental spheres (Union, State, and Municipalities), redefines the responsibilities of each managing instance in accordance to the population's health needs and the search for social equity.

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