EDITORIALS

Health for all in an unequal world: Obligations of global bioethics

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Introduction

The theme of the joint 14th World Congress of Bioethics and 7th National Bioethics Conference Congress "Health for all in an unequal world: Obligations of global bioethics" is of critical relevance in the present global context. Although the world is better off in terms of improved health status of people by many measures than before, there exist colossal gaps across and within populations. Much needs to be done to respond to the lack of access to healthcare, poor quality of living and working conditions, and deteriorating quality of overall environment which affects more adversely the already deprived. We take this opportunity to make a few observations about the current status of affairs on this front, and offer brief analytical insights into the complex origins of the global health scenario characterised by disparities. We revisit the original conception of bioethics and suggest that it is well placed to respond to the current global crisis of inexorably widening disparities in health and wealth, and that global bioethics has an obligation to engage with this crisis.

The significance of the World Congress theme in the year 2018

The Congress theme holds a special significance in the year 2018 which marks the decadal anniversaries of a number of landmark documents which either conceptualised the notion of "Health for all" or contributed to such a conception. 2018 marks the 70th anniversary of the Universal Declaration of Human Rights (UDHR), of 1948 (1), which laid the foundation for seeking the highest attainable standards of health. The year also marks 40 years since the Declaration of Alma Ata (DAA) of 1978 (2), in which the world pledged "Health for all by 2000 AD". During this year of the 40th anniversary of DAA, the World Health Organisation (WHO) steered a series of consultations to review the progress made on the DAA commitments. It culminated in the signing by countries around the globe of yet another document namely, Declaration of Astana (DoA) in October 2018 (3) which reaffirms DAA commitments in pursuit of health for all.

While the aspirations behind these declarations remain commendable, the failure to meet the targets set by them is remarkably common.

We will also briefly touch upon some of the foundational constraints of meeting such targets in a sustained manner.

Scale of health inequity

Despite several gains in health research and healthcare, and spectacular technological advances, the global community has not been able to achieve equitable healthcare eco-systems. For example, at least half of the global population lacks access to essential health services (4). About a quarter of children under five are malnourished, more than 260 million children and youth are not in school, and 60 percent of primary school children in developing countries are still failing to achieve minimum proficiency in learning. In too many places, governments are failing to invest in their populations (5)

The statistics on six parameters which are globally accepted to know the status of disparities – maternal mortality, death rate under 5, life expectancy at birth, per capita income, annual per capita health care expenditure, and number of physicians per 100,000 people – continue to be of an inexorable scale within and between populations (6).

Emerging challenges to the aspiration of "Health for all"

Wars and conflicts, displacement – inter and intra, disasters – natural and manmade, epidemics, shrinking natural resources and

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their over-exploitation, increasing risk to biodiversity, increasing corporatisation, growth of the unorganised sector, breakdown in the ecological balance, air and water pollution, occupational health hazards, an unaccountable industry sector, migration – inter and intra national, and deforestation are the problems that we face, regardless of where we are located, across the globe. Climate change, unprecedented corporatisation, nexus between the political class and corporate entities on matters that are directly or indirectly linked to health and health care, and overall the manner in which the neo-liberal conception of development continues to have its stronghold are deeply connected to each other in complex ways. They continue to adversely contribute to structural injustices.

The public health crisis and emergencies due to Ebola and later Zika that emerged and prevailed for longer than expected, along with many other ethical challenges, have foregrounded global inequities and the plight of vulnerable populations due to inadequately developed and organised national health systems of the affected countries. This can be attributed to state players and multi-lateral agencies ignoring their obligation to invest in making health systems robust and comprehensive; focusing instead on single disease interventions and over emphasis on health technologies as "magic bullets" to address all problems.

What explains the challenges and threats to achieving "Health for all"

We consider the DAA as a reference point for this conversation since it was for the first time "Health for all" was globally talked about. The DAA continues to be a bold and explicit recognition of health as a fundamental human right, and universally accessible primary healthcare as essential. It was a call for action by governments to protect and promote health for all as it believed to be the responsibility of governments to ensure the health of their people. It did not make any reference to the private sector or partnerships with business entities. Over the past few decades as neo-liberal ideologies shaped the development discourse including the one on health and healthcare, the commitments of governments to their peoples' health in the DAA have been extensively watered down. Here are some of the examples:

First, the World Development Report (WDR) of 1993 entitled "Investing in Health" (7) is considered one among the landmark and influential documents by the World Bank. Interestingly however, it was critiqued by a diverse community of scholars identified with different schools of political ideologies and development. Amongst others, some critiqued the report for its approach to health sector reform being regressive and damaging for it was characterised by privatisation, decentralisation, structural adjustment policies, and imposition of user fees.

Secondly, both the Sustainable Development Goals document of 2015 (8), and now the DoA, 2018 (3) emphasise the role of private entities in meeting the goal of universal health coverage (and *not healthcare*, the commitment in the DAA). By doing this, these documents underplay the responsibility of governments in achieving primary health care for all. By doing so they also dismiss the state's obligation of honouring the people's right to health as a human right.

The DoA emphasises the role of health technologies in achieving the goal of affordable healthcare for all. However, there is little evidence to support such a claim, especially when the health technology industry is largely a private sector affair driven by economic growth in line with the principles of business.

Today, the critique of documents such as WDR 1993 (7) stands vindicated both by empirical research findings and the substantive discourse in this area. We note an example from the Indian context. Chakravarthy and colleagues (2017) (9) demonstrate that in India it is the withdrawal of the state from healthcare, the transformation of healthcare into a commodity, and promotion of the private healthcare sector by the state. This has led to an unregulated health industry trans-national pharma, equipment, insurance, and other health corporations that is aggressively seeking expansion and profits from the provision of healthcare, and attracting investments by global finance capital. The authors further note that the overall healthcare market in India was estimated to be $100 billion in 2015, and expected to grow to $280 billion by 2020, an unprecedented annual growth rate of 22.9 per cent.

The rising commodification and corporatisation of healthcare, the international pro-industry regime of intellectual property and the collapse of public health systems in many parts of the world, are manifestations of the inability of the current neoliberal order to address the ever accentuating crisis in health and other arenas. Accompanying these trends is a global order where governance for health is being held captive by private foundations and corporations.

In a neoliberal order where health and wealth are closely connected, private entities have grown to be dominant players in healthcare provision, with the wealth of the corporate sector having become comparable to and even surpassing that of governments. Johnson (2018) (10) notes a finding by Global Justice Now, a UK based campaign group: "When it comes to the top 200 entities, the gap between corporations and governments gets even more pronounced: 157 are corporations… Walmart, Apple, and Shell all accrued more wealth than even fairly rich countries like Russia, Belgium, Sweden.". He further notes that such a concentration of wealth with a small number of corporate entities lends them power to influence policy in their favour and skirt accountability.

Generally speaking, it would not be an overstatement to say that the root causes of disparities are often side tracked in an effort to find quick fixes. It is noteworthy that a rich scholarship has evolved in the development discourse over the past few decades and critiques by wide-based people's movements from around the world have persistently questioned the development model motivated by economic and consumption growth which makes "sustainable development" an untenable notion by any standards regardless of how we may approach it. There is a small constituency from within bioethics or global health ethics which has contributed to this discourse over the past two decades. For example, Benatar and Bensimon (2006) (11) had proposed a "… paradigm shift toward a new metaphor that develops sustainability, rather than sustains development." (p:59). This provides a base for global bioethics to build on and pursue this discourse.

The original conception of bioethics in the context of "Health for all"

Against this backdrop, the question we ask is: as part of the bioethics peer community, are enough of us engaging adequately with the pursuit of "Health for all", especially in the context of changing eco-systems and emerging challenges which have implications for the inclusive and comprehensive wellbeing of human society? Do we need to further expand the scope of the bioethics discourse? Should we not remind ourselves of the "all-encompassing" conceptual framework and notion of bioethics conceived by scholars like Fritz Jahr (1927), (12) the German theologian, and Van Rensselaer Potter (1970), (13) the American biochemist and oncologist, much earlier? And our response to all these questions is affirmative.

Contemporary mainstream bioethics witnessed a more restricted remit by limiting itself to responding to ethical dilemmas affecting human beings in medicalised settings. Within this remit, over time, the discipline of bioethics, like any other discipline, has grown in scope in response to the fast-paced changing contexts of health, healthcare, and healthcare technologies. It has largely been able to maintain its pace of engagement with the changing contexts and emerging issues in this domain. It has embraced within its traditional framework wide-ranging topics such as abortion, reproductive ethics, end of life care, research ethics, the doctor-patient relationship, genetic manipulation, allocation of resources, and global health ethics. Besides this, peoples' movements on wide ranging issues centred around social justice have shaped the bioethics discourse outside academic settings. Such activism, in varied global contexts, has informed advocacy initiatives aimed at legal and policy reforms founded on the principles of equity and justice.

However, in the face of the emerging issues that we have listed earlier, it is the original conception of bioethics that would be more helpful, as it acknowledges the interconnectedness of and interdependence of various elements of the larger eco-system. In the contemporary complex context, the discourse on "Health for all" as an ethical imperative, and needs to be expanded, going beyond the traditional approach.

A revitalised original conception of bioethics allows further strengthening and expanding of discourse in the areas of equity, justice and solidarity to raise and deliberate on challenging philosophical and political questions relating to all-pervasive injustices and inequities. We believe that such a conception enables us to respond to this crisis via multidisciplinary engagement, taking into account macro, meso and micro level contexts. This is because this conception appreciates interdependence and interconnectedness across populations and countries; and beyond human health to planetary health. This, we hope, would help connect the dots with the larger eco-system – social, environmental, developmental, and structural determinants of health.

Obligations of global bioethics

Given the problem at hand, the analysis of the problem and its causes, and the broader conception of bioethics as a field of enquiry, the global bioethics community ought to squarely engage with this foundational crisis of the 21st century and its incongruity against the backdrop of the strides the field of health sciences has been credited with, especially in high end health technologies which are either not affordable to all, or are relevant only to the health concerns of a few around the world. The contemporary crisis sans any robust response runs the risk of adversely impacting existing human capital and poses serious threats to our future generations and our planet. The need to locate the discourse on health inequities in the broader context of the conception of development (mis) guided by economic and consumption growth models demands attention now, more than ever before.

"Fostering the ethics of greater cooperation, mutual respect, deeper democracy, solidarity and enhanced social justice could facilitate the development of sustainability as a maxim of wisdom and praxis. Ultimately however, such progress requires the transformation of political power, as well as policies that are grounded in new ethical commitments." in the words of Benatar, Upshur and Gill (6).

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Ways of dying

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How do we die? Is it an event or a process? Does everyone die in the same way or are there different ways of dying? Even with humankind's claims to gigantic strides in knowledge, death still remains one of the great mysteries for the living. And that makes it the subject of profound and perennial philosophical and religious enquiry. Modern medical science, however, had no option but to engage with it in its bodily form and try to define the precise nature of the process of death. Things were rather easy when death was equal to stoppage of the heart. But inevitably, the world of medicine with its keen sense of observation and constant yearning for scientific reasoning, recognised, somewhere in the middle of the last century, that the brains of a set of individuals hooked onto support systems in intensive care units were dying first, inevitably followed by the heart after some time. The tremendous progress in the science of resuscitation, organ support and intensive care while saving many lives resulted in an increasing number of such individuals, who were soon termed "brain dead" but whose hearts were still beating. The damage to the brain was irreversible and complete and inevitably, the heart had to follow within hours, or sometimes days.

More than fifty years after it was recognised and then legalised, the concept of "brain" death as distinct from traditional "cardiac" death remains enigmatic, complicated and still lends itself to doubts. From questions around its scientific validity, to the accuracy of the diagnosis, to its application in the context of organ donation, brain death has been subjected to intense technical, ethical and philosophical analysis. Naturally, it has appeared with regularity in the pages of this journal, often in the context of deceased organ donation (1) but sometimes in other settings, including the recent bizarre and ludicrous attempt by an Indian researcher to conduct a clinical trial to "reverse" it (2).

By now, in many countries across the globe, brain death (or "brain stem" death, considered a more precise term, though the two are used interchangeably) is legally accepted as death, though the criteria for declaring it differ marginally from country to country. Donation of organs in the state of brain death, when the organs are perfused with blood, contributes to a larger proportion of organs available for transplants. In addition, once brain death is declared, if organ donation is not possible, either for medical reasons or lack of consent from the family, the medical supports which include a ventilator (brain-dead individuals have no respiratory drive) are actively withdrawn. It is intuitive that it is futile to keep a dead person hooked indefinitely onto multiple supports including a ventilator.

Shroff and Navin, pioneers in the field of deceased donation in India, in a paper in this issue (3) highlight a serious continuing dilemma concerning the implementation of brain death in India. As they point out, historically, the awareness and recognition of the concept of "brain death" preceded the idea of removal of organs in this state for transplantation. Thus, while the condition was not recognised only for organ donation, it must be acknowledged that countries legislated and popularised this concept

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