

## HEALTH ETHICS, EQUITY AND HUMAN DIGNITY

**Mamdouh Gabr**

*Professor of Pediatrics, Faculty of Medicine, Cairo University, Egypt*

**Keywords:** equity, health ethics, global health, health determinates, human rights, human dignity, futures

### Contents

1. Introduction.
  2. Definitions and Concept
    - 2.1. Ethics
    - 2.2. Equity
    - 2.3. Human Rights and Human Dignity
  3. Ethics and Major Determinants of Health
    - 3.1. Political system
    - 3.2. Economic factors
    - 3.3. Demographic Changes
    - 3.4. Cultural Diversity
    - 3.5. Global Ecosystem Sustainability
    - 3.6. Technological advances
    - 3.7. Changing pattern of disease
  4. Future Oriented Approach
- Bibliography  
Biographical Sketch

### Summary

Ethics in health evolved through several phases during the last few decades; traditional ethics, bioethics, health policy ethics and ethics in relation to human rights. Equity which has to do with a fair distribution of benefits from health and social development is defined in various ways. There are two views on achieving equity, the solidarity approach and the individual right approach. The last can only be achieved in wealthy politically stable communities. A balance has to be established between the two approaches. With the promotion of human rights gaining momentum in recent years; there is a need to review ethical principles in health to ensure that human rights and dignity are fully respected. The health sector has the obligation of considering the ethical dimensions of the major determinants of health. These include the political system, economic situation, demographic changes, cultural diversity, role of women, global ecosystem sustainability, technological advances and the changing pattern of disease. As we start the third millennium, social mobilization in support of health ethics, equity and human dignity is a responsibility of the academic and advocacy groups involved in ethics and human rights. An ethical culture should be developed at the national level.

Institutionalization of health ethics is required. New, sensitive, reliable indicators and a vigilance system to monitor inequalities in health care, and abuse or neglect of human

rights are to be developed. This can be achieved through innovative research and fostering international cooperation. It is hoped that the twenty-first century will be characterized by wisdom with which acquired knowledge will be applied with equity.

## **1. Introduction**

Health ethics evolved into four phases during the last few decades. Traditional ethics, which mainly prevailed until the sixties, involved the relationship between the health care provider and the patient, and was dominated by the Hippocratic culture which had provided it with a core of values for more than 2000 years.

Advances in bio-sciences and biotechnology, such as organ transplantation, genetics, and molecular biology, introduced an additional ethical dimension usually referred to as bioethics.

The democratization and market liberalization which swept the world resulted in an increasing cost of health services. A new ethical dilemma developed because of the growing gap between health needs and available health resources. The concept of health ethics was broadened to what is sometimes referred to as “health policy ethics”. This would cover such issues as health policy priorities, cost effectiveness, coverage, quality, delivery and research. Ethics moved from being a personal matter limited to the satisfaction or dissatisfaction of the individual to a social matter dealing with the mental and social well being of the people.

As we move into the twenty-first century, the promotion and protection of human rights is gaining greater momentum. “The enjoyment of the highest standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition,” stated the WHO constitution in 1946. It is relatively recent that the implications of this statement on ethics and equity in health care have been receiving more support.

The dual relationship between human rights and the right to health will impose a fourth dimension on our interpretation of health ethics.

## **2. Definitions and Concepts**

While the definition of health is well established in the WHO constitution as “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity,” the definitions of ethics, equity and human dignity tend to be more complex.

### **2.2. Ethics**

Ethics is grounded on socio-cultural, philosophical or religious convictions of what is good or evil. Ethics is considered as the effort to find justifiable grounds for distinguishing what is right or wrong in human actions and ways of life. Ethics incorporates social dimensions; it is concerned with justice, rights, respect of human dignity, autonomy of the individual and respect of the community. Health policy ethics is concerned with organization financing and delivering health care.

In this respect, ethics is a bridge between health policy and values, where values are recognized as guides and justifications people use for choosing goals, priorities and measures. Ethics examines the moral validity of the choice.

## 2.2. Equity

Equity is frequently defined as an expression of social justice. It has to do fundamentally with a fair distribution of benefits from health and social development. It goes beyond equality of access to health care. It calls for responses that are in accord with the needs of the individual in relation to the needs for all. From the point of view of health, equity can be defined in various ways:

- a.) equal resources expended for each individual (supply equity);
- b.) equal resources expended for each case of a particular condition;
- c.) equal access to health services;
- d.) equal quality of health care;
- e.) equal status of health for all (which is eutopic);
- f.) equal healthy life gained per dollar expended;
- g.) care according to needs (demand equity).

Equity involves both process and outcome. An operational approach would be to assess the impact of specific health decisions on equity and to ensure that decisions taken do enhance equity.

One view of equity focuses on the health of the most vulnerable. However, the definition of the vulnerables is not clear. Are they the most sick, the most socially deprived or a group in a certain population such as women, children or the elderly? A distinction is usually made between those who are inherently vulnerable (such as those with a congenital disability) or those whose vulnerability is a result of social construct (such as the poor, women in certain cultures, etc.). An overlap might exist. As an example, the deaf, whose inherent vulnerability renders them powerless, are excluded through the social construct from being involved in decisions or resource allocations even if related to their disability, such as cochlear implantation. Ideally, health inequities contingent on factors such as gender, age, residence, education, income, ethnic group, family size, etc. are unacceptable.

It is difficult to judge equity by its impact on national health indicators per se or on cost effectiveness of a certain health intervention on the community. Equity might not have a direct relation to aggregate health indicators. Improvement on national health statistics can be achieved without improving equity, and dramatic gains in equity can occur without having an impact on aggregate national health statistics. Because of the various determinants affecting health outside the health sector, a cost-effective approach to health ethics may be biased. The cost of supplying basic infra-structure such as housing, clean water, sanitation or transportation to deprived remote areas cannot be included in the cost-effectiveness of a specific health intervention.

There are two views on achieving equity. One is the “solidarity approach”, which focuses on the society as a whole but may ignore or subjugate the needs of some members or groups. The opposite extreme to this approach is “the individual right

approach” according to which each individual should have equal access to health care and equal outcome. It is obvious that this can only be achieved in a wealthy, politically stable community. Most third-world countries, which suffer the greatest burdens of disease, cannot fulfill these criteria. Sometimes the right of the individual to attain the highest state of health in a poor country would lead to inequities through exhausting the limited resources available for health in highly expensive health interventions. A balance has to be established where priority is given to support the basic health needs for the community. If the language of human rights were to be strictly adhered to in developing countries, it would set the good of the individual against the good of the whole community. The tension even exists in one of the richest countries, USA, where Lawrence Gostin notes that: “although public health authorities assuredly are empowered to constrain the freedoms and rights of individuals if necessary to achieve a collective good, they must do so consistent with constitutional constraints on government action. Achieving a just balance between the powers and duties of the state to defend and advance the public health and legally protected rights of human beings represents an enduring interest of those immersed in the discipline of public health law”.

### **2.3. Human Rights and Human Dignity**

Promotion of human rights was identified as a core principle of the UN charter. The Universal Declaration of Human Rights adopted in 1948 states that all people are “free and equal in dignity and rights”. Several international treaties, declarations and conventions followed; the convention against racial discrimination (1969); the convention for elimination of all forms of discrimination against women (1981); the convention on the rights of the child (1989), etc.

The promotion and protection of human rights and of health care are fundamentally linked. The right of the individual to receive correct information facilitated legalizing the compulsory information labels on cigarettes resulting in a positive health and economic impact. There has been a growing tendency in recent years to minimize the burden of public health care on individual human rights. In the past, notification, quarantine, isolation, mandatory, testing, etc. were justified on the grounds of limiting the rights of the few for the good of the many. This is no longer ethically acceptable in many cases. The AIDS epidemic is an example where UN policy supports and prevents discrimination against HIV infected people.

Human dignity is considered along with human rights to be inherent, inalienable and universal. While important dignity-related health impacts may include such problems as the poor health status of indigenous peoples, a coherent framework of human dignity violations in the field of health is lacking. A taxonomy and an epidemiology of dignity may uncover an enormous field of previously suspected yet thus far unnamed and therefore undocumented damage to physical, mental and social well-being. The relationship between scientific advances, ethics and human dignity will continue to be a focus for discussion and recommendations throughout the next few decades. As far back as 1993, the World Conference on Human Rights in Vienna noted that certain advances, notably in the biomedical and life sciences as well as in information technology, may have potentially adverse consequences for the integrity, dignity and human rights of the individual, and called for international cooperation to ensure that human rights and

dignity are fully respected in this area of universal concern.

### **3. Ethics and Major Determinants of Health**

The health sector has an obligation to consider the ethical implications of the major determinants of health, since causes for inequity or violation of human dignity may originate from outside the health sector. Major determinants include the political system, economic factors, demographic changes, cultural diversity including the role of women, global ecosystem sustainability, technological advances and as a consequence the changing pattern of disease.

#### **3.1. Political system**

Democratization is a prerequisite to ensure the respect of human rights, social justice and equity. As we enter the third millennium the process of democratization is spreading to more and more countries. The progress, however, is relatively slow. Progress in health ethics to achieve equity and respect human dignity should not wait. Attempts to achieve equity in health care are usually welcomed even by the most authoritative regimes. Decision makers play a decisive role in adopting ethical principles in health care that ensure equity, justice and respect for human beings. It is the responsibility of professionals, academicians, as well as ethical, human rights and consumer protection groups to supply decision makers with valid, reliable data on the merits of adopting an ethical code of health care that ensures equity and justice. It is not comprehensible that environmental groups (green parties) could be successful, even in third world countries, in mobilizing public opinion and in getting political support; while health ethics groups still lack a strong political lobby to support their humanitarian goals.

Political instability is a great impediment in achieving health for all in certain third world countries. It is estimated that more than 10 million lives were lost as a result of armed conflicts during the last decade of the twentieth century, mostly those of civilians, and mainly children. There are more than 50 million refugees worldwide in need of an equitable share in health care. If the human burden of natural disasters is added to these figures, the challenge of delivering proper health care to those people is staggering.

-  
-  
-

TO ACCESS ALL THE 12 PAGES OF THIS CHAPTER,  
Visit: <http://www.eolss.net/Eolss-sampleAllChapter.aspx>

#### **Bibliography**

Bankowski, Z., Bryant J.H, (1994), *Poverty, vulnerability and the value of human life, a global agenda*

for bioethics, CIOMS, WHO, Geneva; Switzerland. [The effect of poverty on vulnerability to disease and its ethical dimension].

Bankowski, Z., (1996), Ethics and human values in health policy, *World Health Forum*, Vol. 17, pp. 146-149. [Standard reference text on health policy ethics].

Bankowski, Z. Bryant J. H and Gallagher J, (1997), *Ethics, equity and health for all*, Publisher, CIOMS, WHO, Geneva, Switzerland. [Highlights the key role of equity in health ethics].

Bryant J, H, Kauser S. K., Hyder A.A, (1997), Ethics, equity and renewal of WHO's health for all strategy, *World Health Forum*, Vol. 18, pp. 107- 148. [An update of health for all strategy taking ethics into consideration].

Gostin, Lawrence, O., (1996), Public health law, a review, *Current Issues in Public Health* Vol. 2, no 6, Oct. - Dec. 1996. pp. 205-314. [An analysis of law and regulations concerning public health and their ethical implications].

Mann, J.M., Gostin L, Gruskin S, Brennan T, Lazzarini.Z, Finberg H.V., (1994), Health and Human Rights, Vol, No1, pp. 6-24. [Right to health as an ethical issue].

Pompidou, A., (1997), Geoethics and equity, *World Health Forum*, Vol 18 pp. 146-149. [Equity in relation to geopolitics].

Sen G, Germain A, Chen L, (1994), *Population policies reconsidered, health, empowerment and rights*, published by Harvard University Press, Boston, U.S.A. [How do population dynamics affect health and human rights? -- an ethical concern].

### **Biographical Sketch**

**Prof. Mamdouh Gabr**, born in Cairo, Egypt (1925). Graduated from Faculty of medicine, Cairo University, December 1947, MD Pediatrics, Cairo, November 1951, FRCP London 1981.

At the national level, Prof. Mamdouh Gabr was the Minister of Health of Egypt from 1978 until 1982, the Chairman of the population Council from 1978 until 1981, and the Chairman of the Pediatric Department of Cairo University from 1982 until 1986. He is a member of the High Ministerial Council of Childhood and Motherhood.

At the international level, Prof. M. Gabr was the president of the International Union of Nutrition Sciences from 1985 until 1989, the president of the International Pediatric Association from 1992 to 1995, and he was the President of the Global Advisory Committee on Health Research, WHO, Geneva from 1991 until 1994.

He was awarded the National Prize of Science in Egypt 1961. He is the Bearer of the Order of Science, first degree, 1962, Egypt, and the high Order of the Sacred Treasure, Japan, 1986. He was awarded the WHO Shousha prize in 1997.

He has published four monographs and more than 150 publications on nutrition, child health and development.