



United Nations
Educational, Scientific and
Cultural Organization



**International Bioethics
Committee (IBC)**

Distribution: limited

SHS/EST/CIB-15/08/CONF.502/3
Paris, 16 October 2008
Original: English only

Draft Report on Social Responsibility and Health

This draft report has been drawn up on the basis of work carried out by IBC in 2006-2007, the deliberations of the IBC Working Group on social responsibility and health at its first meeting (2-4 July 2008), and the written contributions received from members of the working group.

Division of Ethics of Science and Technology

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I. INTRODUCTION

Adopted by acclamation on 19 October 2005 by the 33rd General Conference of UNESCO, the **Universal Declaration on Bioethics and Human Rights** (hereafter 'the Declaration') right from the Preamble expresses the desirability of 'developing new approaches to social responsibility to ensure, whenever possible, that progress in science and technology contributes to justice, equity and to the interest of humanity' and devotes an entire article - Article 14 - to the issue of social responsibility and health⁽¹⁾.

By including Article 14, the Declaration opens up perspectives for action that reach further than just medical ethics and reiterates the need to place bioethics and scientific progress within the context of reflection open to the political and social world. Article 14 is designed to draw the attention of policy makers in the field of medicine and life sciences to the practical concerns of bioethics contributing to re-orienting bioethical decision-making towards issues that are urgent for many countries. Even though the list is not exhaustive, five specific elements are singled out as priority and universal areas of decision to be taken into assessment: access to quality health care and essential medicines, especially health of women and children; access to adequate nutrition and water; improvement of living conditions and the environment; the elimination of the marginalization and exclusion of persons on the basis of whatever grounds, and the reduction of poverty and illiteracy. Article 14 therefore significantly widens the agenda of bioethics, so that the social and basic issues related to the provision of health care will be taken into account. The bioethical debate can thus escape from its focus on sophisticated technologies that give rise to many ethical discussions while at the same time relevant for only a limited number of people.

Article 14 formulates important directions for policy making in health care. There is no doubt that Article 14 of the Declaration sums up many of the most important issues faced by our societies at this time to address the problem of global inequities in health. All these issues have ethical, economical, cultural, political, technical, and philosophical implications, and any discussion about them requires a multidisciplinary approach. Bioethical exploration of Article 14 should thus take into account the global perspective of health care problems that are confronted by all people similarly, though in different conditions, and analyse the implications of the Article within different cultures and traditions.

Article 14 is relatively new in the discussions in bioethics and it is essential that its possible interpretations and applications be elaborated. This is why the International Bioethics Committee of UNESCO (IBC) decided to focus on the principle of social responsibility and health, as set forth in Article 14 of the Declaration. In considering bioethical issues IBC, the only bioethics committee with a really global scope and mandate, is in a position to take into account the perspectives of all Member States of UNESCO. It also has a role in assisting UNESCO in disseminating and promoting the principles set forth in the Declaration.

II. SOCIAL DETERMINANTS OF HEALTH AND CONSTRAINTS TO HEALTHCARE ACCESS

At the beginning of the new century, global health conditions are marked by growing inequities due mostly to poverty and lack of access to health-care services. Health policy was once thought to be about little more than the provision and funding of medical care. This

1. *'1. The promotion of health and social development for their people is a central purpose of governments that all sectors of society share.*

2. *Taking into account that the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition, progress in science and technology should advance:*

- (a) *access to quality health care and essential medicines, especially for the health of women and children, because health is essential to life itself and must be considered to be a social and human good;*
- (b) *access to adequate nutrition and water;*
- (c) *improvement of living conditions and the environment;*
- (d) *elimination of the marginalization and the exclusion of persons on the basis of any grounds;*
- (e) *reduction of poverty and illiteracy'.*

is now changing and health policy has been considered recently to be more than the provision and funding of medical care, by taking into consideration that for the health of the population as a whole, the social and economic conditions making people ill and in need of medical care are clearly of utmost importance. These include, among others, the lifelong importance of health determinants in early childhood, and the effects of poverty, unemployment, malnutrition, working conditions, drugs, social support, adequate food and position in the social ladder. In contrast, the influence of biological and physical factors on health has been estimated as less than 15% and 10%, respectively.

Throughout the world, people who are vulnerable and socially disadvantaged have less access to health resources, get sicker and die earlier than people in more privileged social positions. The greatest share of health problems is attributable to the social conditions in which people live and work, referred to as the social determinants of health. Good medical care is vital to the well being of populations, but improved clinical care is not enough to meet today's major health challenges and overcome health inequities.

Without action on social determinants, those countries in greatest need will neither meet the health-related MDG nor achieve global targets for reducing chronic diseases such as cardiovascular diseases, cancer and diabetes. Problems are especially urgent in developing countries where the burden of chronic illnesses is growing rapidly on top of the burden of unresolved infectious epidemics.

III. THE ETHICAL AND LEGAL DIMENSIONS OF SOCIAL RESPONSIBILITY AND HEALTH

a. *The emergence of the notion of responsibility*

Social responsibility is a quite new expression. The word 'responsibility' is in fact new in all languages. In English it appeared for the first time in the eighteenth century. And when it appeared, it was in the legal context, as amongst others, criminal responsibility and civil responsibility. Only very recently, a century ago more or less, the word 'responsibility' acquired moral sense.

The expression 'social responsibility' is even more recent. It appeared in the context of the ethics of private companies and institutions, as the way of defining the moral duties these companies have with the societies in which they are rooted, beyond the constraints and obligations determined by law. 'Corporate social responsibility' means that corporations have moral obligations, apart from these determined by law. These are, between others, the so-called 'duties of good citizenship'.

From the moral point of view, this means that these duties should be understood as been part of what traditionally has been called in ethics *imperfect duties*. These duties, also called 'duties of beneficence', are morally binding for individuals, but cannot be demanded, requested or imposed by others or by the State. The word 'imperfect' does not mean that these are duties of less importance than those called *perfect duties* or 'duties of justice'. These duties are not different in importance but in the way in which they can be managed. The perfect duties are public; their fulfillment can be demanded by the State, in contradistinction to the imperfect duties. Paying taxes is a typical example of a perfect duty, and solidarity another of an imperfect duty. This difference is important, because perfect duties are correlative to the rights of others. Therefore, if I have a perfect duty, someone or even everybody has the correlative right to this duty. For instance, if I have the duty not to kill others, then the other persons have the right to life. At this level, therefore, duties are correlative to rights. And when there is a universal agreement about these perfect duties, then it is possible to define a set of universal rights, corresponding to these duties. This is the origin of human rights. These rights have been defined in order to determine the duties that all human beings have in relation to each other.

But there are duties which are irrespective of rights. One typical example is the imperfect duty of 'solidarity'. It is evident that all human beings have a specific moral duty, that of being supportive of others when they are in need, or of practicing solidarity at the familial,

communal, social, national and international levels. All human beings are morally obliged to assist each other in times of need but this obligation cannot be required by law. The imperfect duties are typical moral duties, but irrespective of some kind of human rights. There is not a right to solidarity in any definition of human rights. Solidarity is a moral duty, but without any legal constraint. This is the moral origin of many social institutions of solidarity, as, for instance, illustrated in the case of non-governmental organizations. They are called non-governmental organizations due to this reason, because they are private institutions, organized freely by social agents, without any legal obligation of doing it.

The expression 'social responsibility' has come into use only recently. It implies that the notion of responsibility is extended from individuals to groups, communities, institutions and corporations, public and private (as also indicated in the scope of the Declaration). Institutions and corporations, like individuals, have moral duties that go beyond what is legally required. In other words, institutions and corporations do not only have a legal personality, but also a moral one, and they should assume duties which are exclusively moral, without any kind of legal requirement.

Responsibility and social responsibility in particular are therefore connected to the moral vocabulary of imperfect duties. Individuals as well as institutions and corporations have moral duties that cannot be demanded by others or by States, and that are thus not legally required.

b. The moral task of social responsibility

This is the context of the ethical analysis of Article 14 of the Declaration. The novelty and the importance of this article is that it widens the concept of social responsibility, applying it not only to the private sector but also to the public domain. The spirit of this article is that States have also duties of social responsibility. These duties, therefore, are now applicable not only to individual or private bodies, but also to public institutions and corporations.

This is an important novelty, which at the same time put on the table new and important problems. The first query is whether State duties are always perfect, or whether States have also duties of the type called imperfect. The traditional answer is that States have not only perfect duties or duties of justice, but also imperfect duties or duties of beneficence. But today the most usual view is that in the field of the so-called 'social primary goods' all State duties are necessarily perfect, because in this field duties are always of justice, and not of beneficence. Providing and guaranteeing health care for example is no longer, as in the past, depending on charity and solidarity, as imperfect duties of citizens towards each other, but has become a right of citizens to be warranted by the State which has therefore the perfect duty to make sure that health as a primary good will be attainable by all.

Reasoning this way, we could say that, when dealing with social primary goods, State duties of social responsibility are perfect, and therefore correlative to rights. Therefore, there are some human rights related with the perfect duties of social responsibility. In fact, the second point of Article 14 says that 'the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being'. This is the transcription of Article 12 of the International Covenant on Economic, Social and Cultural Rights (1966), which in its first point says: 'The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health'. But in order to understand correctly the content of this paragraph, it is necessary to know that these economic, social and cultural rights of people are correlative to duties of States only within the limits established by the own State. This is the difference with the other human rights, the so-called civil and political rights, which are justiciable by everyone, in every circumstance and everywhere.

Promotion of social responsibility is therefore primarily a moral task, not a legal requirement. When social primary goods are at stake, social responsibility is correlative to specific human rights, such as the right to the highest attainable standard of health. But these human rights are justiciable only within the limits established by the positive state law. And due to the fact

that these limits are determined also by the State, we will return to the same point where we were in the beginning: the application and execution of social responsibility is a moral task. The aim of the Declaration is to promote the reflection on these important duties, in order to sharpen the moral conscience of people, social institutions and States, and to reach a more human, just and friendly society.

c. Wide scope of article 14

Article 14.1 is of crucial importance to a proper understanding of the wide ranging scope of the Article as a whole. It states that 'the promotion of health and social development for their people is a central purpose of governments that all sectors of society share'.

There are three important items to note in this succinct phrasing: 1) the obligation that is described is related to the promotion of health **and** the promotion of social development, 2) this is identified as a **central** purpose of government and 3) it is stated that it is a purpose that **all sectors** of society share.

This sub-section of the Article clearly entails that the promotion of health and social development must be given special importance. It is not only 'a purpose of government' but 'a **central** purpose of government'. This entails by implication that there are other more peripheral purposes of government that must yield if there is a conflict between them and the promotion of health and social development. Article 14 is silent on what these more peripheral purposes might be and it would be inappropriate to try to develop a list, partly because such a list is likely to be context dependent.

How can the centrality of promotion of health and social development as a government purpose be justified? One perhaps surprising line of argument finds justification in a neo-Hobbesian analysis of the obligations of the sovereign. Hobbes famously held in the *Leviathan* that life outside the State was 'solitary, nasty, brutish and short' and that the only obligation of the sovereign to his subjects was to ensure their security against external and internal threats of violence. But in modern welfare States and even in many resource poor countries the threat of war or violence is no longer the main threat facing citizens and the legitimation of sovereignty must therefore be located elsewhere in the ability to protect citizens from current threats. Among these threats is the risk of death due to (untreated) disease and this gives the modern State a reason to make the promotion of health, and the protection against health threats a central purpose of government. Similarly States have neo-Hobbesian obligations to protect citizens from social threats like poverty or severe environmental degradation.

Other more familiar lines of argument would justify the centrality of these purposes in the importance of health as a general precondition for successful agency and participation in society. Health is thus a basic good because it contributes significantly to welfare or preference satisfaction. Similarly it is obvious that individual wellbeing and welfare is intimately connected with social development.

The other important issue that Article 14 makes clear is that **all sectors of society** share in the purpose of promotion of health and social development. This is a normative and not a descriptive statement, and is perhaps the normatively most important statement of the whole Article. Why is the statement so important?

It is clearly possible for a sector in society not to feel any responsibility for health and social development and not to act in a way that promotes health and social development. Furthermore it is possible to mount arguments based on some strands of moral and political philosophy (e.g. libertarianism) that certain sectors in society are justified in ignoring such a responsibility, or perhaps even that it would be wrong for them to try to pursue such a responsibility. But Article 14 clearly denies the legitimacy of these arguments. No sector in society can legitimately isolate itself from responsibility for the promotion of health and social development. A corollary to this is that it is a valid criticism of a sector in society if it does not take this responsibility seriously, whether this is a criticism mounted by government or by civil

society organizations. The exact addressee of such a criticism can, however, be difficult to fix because even if we have an intuitive grasp of what 'a sector of society' is, there is rarely any natural or elected representative of such a sector we can address. We may, for instance believe that parts of the food industry does not take its responsibility for preventing childhood obesity seriously or seriously enough but there may not be one easily identifiable representative of that industry to whom we can address our criticism or who would be able to act on it.

The focus in Article 14 is clearly on the promotion of health and social development, and these concepts need philosophical and ethical analysis.

d. Health and social development

Both the concept of 'health' and the concept of 'social development' are contested. In the philosophical literature on the concept of health there is only agreement on two things: 1) health is not the opposite of disease, and 2) the WHO definition of health as 'complete physical, psychological and social well being' may define some human state, but it does not define health.

Accepting the WHO definition as a definition of health would also entail that all areas of societal policy became areas of health policy since all areas of policy influence psychological and social well being.

The two leading contenders for a philosophical conception of health are:

- health as a state of species typical functioning;
- health as an ability to pursue your chosen goals.

The bio-statistical conception of health sees health as an objective biological state that can be defined in terms of species typical functioning in relation to an age and gender matched reference class. A healthy organ is thus an organ with species typical functioning, and a healthy organism is an organism where all parts are functioning at their species typical level. The attraction of this conception of health is that it is seemingly objective, value free and linked to biology only. This conception has been criticized for hiding the value judgments in the choice of reference class, and for having difficulty in dealing with mental illness and any subjective elements of illness and disease.

The action theoretic conception of health sees health as the set of biological and mental properties that enables an agent to pursue his or her reasonable goals. The healthy agent is thus the agent who is not restricted by biology in pursuing his or her reasonable goals. This conception is avowedly value-laden in the sense that what counts as health for you may not count as health for me if we have different reasonable life goals. Values also enter in discussing what counts as 'reasonable goals'. The attraction of this conception of health is that it inherently links health with the main reasons why we value health. It has been criticized for on the one hand allowing too many States to be classed as healthy (for persons who have limited life goals) and on the other hand allowing too many States to be classed as unhealthy (for persons who have expansive and ambitious life goals).

It is plausible that the action theoretic conception is closer to the conception of health and the value of health embodied in the Declaration in Article 14.2a '... health is essential to life itself and must be considered to be a social and human good' which is clearly not a purely biological conception.

In many policy decisions (e.g. in relation to public health interventions) it will not matter what conception of health the policy maker adopts. There is a large overlap between the States classed as healthy (or unhealthy) by the two conceptions, and most people who are affected by the policy decision will be unhealthy and in need of health promotion according to both.

Fixing the content of the concept of 'social development' is more complicated partly because the reference of 'social' is vague, partly because the concept of 'development' is itself contested.

It should be uncontroversial that a change in material social conditions within a given society that is actually Pareto optimal, i.e. it benefits some and harms no one is an instance of social development, at least if the number benefited is sufficiently large. But actually Pareto optimal social changes are few and far between. Most social changes are only potentially Pareto optimal, i.e. there are winners and losers and the situation can be converted to an actually Pareto optimal situation if the winners compensate the losers. But potentially Pareto optimal changes are only ethically uncontroversial if the compensation happens. In assessing whether a change is a truly beneficial social change we therefore need to guard against any rhetoric that hides the fact that there are losers or relies solely on an unspecified future 'trickle down' effect from those who gain to those who lose.

Positive social changes can occur across the whole range of societal sectors and activities but they are not all equally important social developments and it would, for instance be strange to define an improved ability of teenagers to sing in tune and keep rhythm as a social development that government should promote as a central purpose even though it would undoubtedly be a beneficial social change.

We therefore need to ask what kind of social developments that are covered by the obligations outlined in Article 14. A help in this task is the partial explication provided by article 14.2a-e:

- '(a) access to quality health care and essential medicines, especially for the health of women and children, because health is essential to life itself and must be considered to be a social and human good;
- (b) access to adequate nutrition and water;
- (c) improvement of living conditions and the environment;
- (d) elimination of the marginalization and the exclusion of persons on the basis of any grounds;
- (e) reduction of poverty and illiteracy'.

Any social change that improves one of the areas mentioned here is *eo ipse* a social development that should be promoted by government and all sectors in society. This is so whether or not it can be shown to improve health since the obligations relating to health and social development in Article 14 are separable. This must be so despite the interpretive problem that arises because the first part of Article 14.2 is phrased solely in terms of health.

It is important that the social developments that should be promoted are both developments in material conditions (e.g. access to water), in formal and cultural structures (e.g. elimination of marginalization and exclusion) and in education (e.g. reduction in illiteracy). This indicates that the scope of promotion of social development is quite wide and must involve most sectors in society.

There is nothing in the Article suggesting that 14.2a-e is intended to provide a definitive and exhaustive list of important areas of social development and there may well be a number of other areas that ought to be promoted by States and other societal actors. It would, however be natural to see the areas mentioned in 14.2a-e as areas of primary interest for social development.

The promotion of social development and the promotion of health are contingently linked since the areas of social development are at the same time the social determinants of health. By achieving social development we therefore in most cases also achieve a positive change in the determinants of health and health promotion.

e. *The status of health as 'a good'*

Article 14.2a states that '... health is essential to life itself and must be considered to be a social and human good'. But exactly what kind of good is health?

As mentioned above many philosophical and ethical theories acknowledge health as a basic good, either on its own or because of the strong links between health and welfare and health and social participation. These arguments are not affected by the observation that there may be individuals who do not value health or for whom health is not important.

There is also little doubt that having healthy citizens is a benefit to society and that health is a social or public good in that sense. The health of individuals contributes positively to general social conditions.

There is, however another economic sense of 'public good' in which it more doubtful whether health qualifies as a public good. Economists distinguish between private goods that are characterized by being 'rival and excludable' and public goods that are 'non-rivalrous and non-excludable'. A non-rivalrous good is a good where my consumption does not affect your consumption of the same good and a non-excludable good is a good where it is impossible effectively to exclude some but not others from consumption (e.g. exclude non-payers but still allow payers to consume). Classic examples of economic public goods are clean air, effective national defense and street lighting. Economic theory predicts that there will be undersupply of public goods because their non-excludable nature means that it will be impossible to extract market value payment from all consumers of the goods. This entails that there is an economic argument for State intervention in the market and possible State provision of the good or taxation to make up for the market failure. If health was an economic public good there would thus be a purely economic argument for providing health (in reality, providing health promotion and care since health cannot be provided directly). This would be a desirable outcome because it would reduce the need for appeal to moral or even prudential obligations to secure health care for those who cannot pay for themselves.

The 'health is a public good' argument does, however, face significant obstacles. It is clearly not the case that most forms of health care are non-rivalrous or non-excludable. Physical and manpower resources are finite leading to rivalry between consumers and it is very easy to exclude people from health care or the benefits of health care. Health care knowledge is non-rivalrous, but it is not non-excludable and therefore still falls outside of the definition of an economic public good. The increasing tendency to patent university based inventions in the health care area clearly indicates that exclusion is possible in the area of health care knowledge, and that it is seen as economically desirable by some.

There are areas where it is more plausible to see health as an economic public good, especially in relation to the prevention of infectious disease and in relation to treatment of infectious disease which significantly reduces the spread of the disease. I am benefited by the fact that other people have immunizations and this general benefit of 'herd immunity' is non-rivalrous and non-excludable. But similar arguments cannot be made for health care in general. My appendectomy does not in any appreciable way benefit you. In an economic sense health (care) is a private good.

But acknowledging that health is a private good in an economic sense does not negate the fact that health is a public good in the much more straightforward sense outlined above that a society with healthy citizens is a better society than one with much illness. This can still be an excellent reason to promote health.

Certain areas of social development more clearly involve economic public goods than the health area. Many improvements of living conditions and the environment are of the nature of an economic public good and there are thus good reasons drawn from economic theory for involving States in ensuring that these public goods are efficiently produced at the appropriate level.

Other social development goods are like health contested. There is for instance an economic public good aspect to basic education in modern complex societies, because I benefit from everyone having a generally adequate level of education. But more than adequate education is in an economic sense a clearly private good.

f. Social responsibility, justice, solidarity and equality

Current discussions about justice, solidarity and equality are relevant for a proper understanding of the justification for and scope of the obligations imposed by Article 14, especially because all of these concepts are mentioned in the preceding articles of the Declaration.

The concept of solidarity is probably the most contested of the three concepts. There is a common shared understanding of what justice and equality is, although there is profound disagreement concerning what justice requires of us and whether equality is a goal that should be pursued. But for solidarity both the content and the normative importance of the concept is contested.

It is not the aim here to give a full analysis of solidarity in its manifold possible forms but to provide a brief outline of a fairly common understanding of social solidarity where solidarity is seen essentially as a group concept. This will show how considerations of solidarity may differ from considerations of justice. According to the group conception of social solidarity it is the case that without existence of a definable group of which one can feel a member, solidarity has no meaning.

In most groups there will be some tendency to prefer or be benevolent towards other members of the group, but solidarity requires more than that. It requires an idea of shared life or destiny. It also requires a sense of belonging, integration or rootedness of each individual member within the group.

This sense of belonging is the underlying motivation which changes the passive understanding of a common destiny to active work for common goals. Because solidarity is essentially a group concept, it restricts the scope of our usual notions of justice. Within the group justice may be a fully operative concept, but in comparing treatment of persons in the group and persons outside of the group justice concepts may not be applicable. Even though the formal principles of justice tell us to treat similar cases similarly, the cases are just not similar. One of these persons is someone with whom we share a common goal, a common destiny and perhaps even a common idea of the good life, the other is an outsider who just happens to be in my neighborhood, so to speak. We may have compassion with the outsider, or show mercy towards him, but neither of these reactions is likely to lead to the kind of assistance we (the group) would offer to a person within the group.

If solidarity can be harnessed to goals such as the promotion of health and social development it can be a powerful motivating force.

Article 10 of the Declaration re-affirms that 'the fundamental equality of all human beings in dignity and rights', but a plausible interpretation of Article 14 supports the view that with regard to the promotion of health and social development the needs of those who have the greatest need, or are most vulnerable should be given priority. Article 14.2a mentions 'women and children' and 14.2e 'poverty and illiteracy'. What philosophical accounts of social justice can support such an 'option for the poor'?

The perhaps most obvious candidate is Rawls' so-called 'Difference Principle' as expounded in *A Theory of Justice*. According to Rawls social and economic inequalities are to be arranged so that they are of the greatest benefit to the least-advantaged members of society. It is plausible that the poor and the illiterate, as well as women and children will count as the least-advantaged or the worst off in many of the decisions a government has to make which have distributive implications. However, there is a potential problem in that someone who is worst off in respect to one parameter may not be worst off in respect to other parameters. Someone who is rich and powerful may be very ill and worst off on the health scale, while still

being very advantaged in relation to resources and power. This means that it becomes unclear what the implications of the difference principle are in situations where someone or a group is worst off on one relevant parameter, but not worst off on another.

A significant amount of philosophical work on issues of relevance to social justice has also taken place within the consequentialist or utilitarian school of moral philosophy. It is a well known problem for the classical account of consequentialism that it does not contain and cannot accommodate any substantial account of distributive justice. Pursuing consequentialist maximization can lead to end states with very large disparities between persons in welfare and resources, and even introducing the idea of a decreasing marginal return of utility does not remove the underlying problem. It was however only when Derek Parfit showed that standard consequentialism was open to the so-called 'repugnant conclusion' that consequentialists became seriously interested in distributive issues. One current strand of consequentialist theory, usually called 'prioritarianism' or 'the priority view' argues for the proposition that benefits to the worse off count for more, in terms of overall utility, than comparable benefits to the better off. Here the best and the worse off are defined in terms of their prior levels of utility, levels that at least in theory can be explained as a single number and the approach is thus immune against the criticism often raised against Rawlsian approaches that it is impossible to define who is worst off.

Prioritarianism can also justify giving priority to the poor and the illiterate, although it has greater difficulty in justifying prioritizing women and/or children as distinct groups, since at least some women and children already possess high levels of utility.

Neither the Rawlsian nor the prioritarian approach implies strict equality, but many people clearly have strong egalitarian intuitions in relation to basic goods or more generally in relation to the distribution of resources globally and in specific societies. The pursuit of strict distributive equality is, however fraught with theoretical and practical difficulties. At a theoretical level most egalitarian approaches are vulnerable to the so-called 'levelling down objection'. The point of the objection is that one way of achieving equality (or just reducing differentials) is not by making the disadvantaged better off, but by making the better off worse off. We can make the distribution of health more equal by making the healthy ill. And levelling down will sometimes be the only way of achieving strict equality in situation where it is impossible to improve the status of the worst off to the level of the best off (e.g. if some have such severe health problems that they cannot be made healthy).

Other difficulties arise for the egalitarian because there is no non-arbitrary way to perform trade-offs between equality and welfare. There are many situations where the welfare of the worst off can be improved, but only if the welfare of the better off is improved as well. In some of these situations this will lead to greater equality, but in some it will lead to greater inequality. Egalitarianism has a clear answer to give with regard to the first set of situations where inequality is reduced, but no clear answer with regard to the second set of situations.

All of this leads to the tentative conclusion that whereas Article 14 in conjunction with Article 10 and Article 13 leads to an obligation to pay special attention to the interests of those who are worst off with regard to social status and health or otherwise vulnerable (e.g. children) when contemplating activities to promote health and social development, it is more difficult to argue that these Articles imply an obligation to seek strict distributive equality.

g. Health care: from respect to love

Article 14 makes clear two crucial and apparently contradictory points, intertwined in the very basic statement that 'the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being'. The first point is that the lack of health care directly infringes upon the right which is simply the keystone of all the others: the right to life, as it is obvious that health is essential to life itself. Whatever contents the concept of human dignity may include in different cultures and traditions, it seems that a fundamental right cannot be conceived but in terms of *equality*. That means, following the Universal Declaration of Human Rights (1948), that neither distinctions stemming from 'race, colour,

sex, language, religion, political or other opinion, national or social origin, property, birth or other status', nor those made on the grounds 'of the political, jurisdictional or international status of the country or territory to which a person belongs', should operate as factors of restriction and constraint. On the other side, - and this is the second point -, it is not simply the pursuit of the highest, but rather that of the highest *attainable* standard that can be claimed as such a right. The idea of attainability implies the acknowledgment of some limits. Does it imply, by the same token, the acceptability of inequalities? Huge, growing inequalities are indeed what we see both at domestic and especially at international level. Is that a real dilemma or rather the expression of an unavoidable shift in the kind of responsibility involved, which requires a complex strategy and combination of legal rules and moral principles?

Immanuel Kant, in the *Metaphysics of Morals*, distinguishes between the duty to respect and the duty to love. The former implies an obligation to refrain: from intruding on one other's freedom, from doing harm to somebody else, from treating them as mere instruments. In this sense, the duty to respect keeps a distance between individuals, each of them free to pursue their own goals. The duty to love, on the contrary, brings the same individuals nearer to each other, looks for the good of one's neighbour and implies a commitment to actively doing something. This is the duty to enhance everyone's capabilities, as well as to help them in their needs in order to promote their happiness. But only the duty to respect is a strict one: it is a perfect duty that is correlative to legal rights, secured by the coercive force of law. The duty to love remains an imperfect duty, both in relation to its content and its context and in the sense that it implies just a moral obligation, for which one ought to feel responsible in conscience and not before a court. This distinction clarifies the idea and the difficulties of social responsibility. By recognizing a right to health care (a right to health as such, of course, does not exist) as a fundamental right, we assume not only an obligation to respect, to refrain from doing something. Although that may be the case in some specific circumstances (typically the refusal of a medical treatment on the basis of the principle of free, informed consent), it is exactly a kind of care we are focusing on. In the Kantian language, we need to move from the sphere of respect to that of love. This is not a hypothetical discourse but the expression of the very concrete concept of solidarity referred to in article 13 of the Declaration. In the language of the traditional tripartition of political obligations, we need to move from exactly that obligation to respect to those to protect and to fulfil. Both duties (i.e. the duty to respect and the duty to love) need to be implemented and both contribute to determining a justice-based approach to the issue of attainability.

What is attainable depends not only on the conditions *imposed* to the individual by the social and cultural environment, but also on those factors that come from everyone's unique genetic endowment or that are *chosen* as goals, styles of life, kind of education. That means that there is an individual level of responsibility, which is fundamental and unavoidable. Everyone takes or does not take care of himself or herself, as well as or even before somebody else takes care of him or her. Health is a private good, also in the specific economic sense that it does not correspond in principle to the classical criteria of being non-rivalrous and non-excludable: although a widespread prevention of infectious disease may probably be conceived in this way, producing the greatest benefit for everyone as far as the greatest number is benefited, it remains true that my appendectomy does not benefit another person and could even make it impossible for this person to receive the treatment he needs. All the same, health is a private good of public interest. As argued above, there is a quite obvious link between health and social development, as a society with healthy citizens is a better and more efficient, dynamic society than one which is tormented by diseases. Either in a neo-hobbesian or in a liberal and democratic view of power and sovereignty, legitimacy is first of all rooted in the effective capacity to protect citizens from violence and whatever risk of death, hence poverty, environmental degradation and, of course, diseases. Because of these reasons, States and governments are the addressees of a *strict* obligation not only to use the force of law to secure respect (that is prohibiting as far as possible all factors of harm and threat to human health), but also to protect and fulfil. To protect: for instance, controlling the market of medical equipment and medicines. To fulfil: for instance, providing a national health policy or

promoting health education. Even when expressed in the programme-type manner which is often used to distinguish economic, social and cultural rights from civil and political rights, these provisions are essential instruments to further the cause of social responsibility.

The explicit denial of the legitimacy of any economic discrimination in particular places on governments a clear responsibility to make the necessary resources available, as well as to guarantee that no other distinction could infringe upon the right of *every individual* to receive adequate health care: not on the basis of philanthropy and moral solidarity, but of legal obligations, every time it becomes necessary; not on the basis of charities, but of taxes. Health care has growing costs, especially in those countries with ageing populations. Priority and allocation decisions are to be made. Within a rights-based approach, respectful of the dignity of every human being, they should meet two kinds of requirements. On the one hand, there are requirements connected with the specific conditions of the individual, within the general scope of technical and medical knowledge and without stretching the duty to care beyond its limits. On the other hand, at the level of political choice, there are requirements connected with *publicity* (the reasons for decisions are made accessible to the wider public and always open for scrutiny), *relevance* (an assessment of reasonableness in terms of shared values and justification), *appeals* (an institutional mechanism that provides patients with viable opportunities to challenge decisions against what they consider their own interest), and *enforcement* (public or voluntary regulation of the decision-making process to ensure that the three other components are maintained).

Solidarity plays a relevant role at two levels. The first is exactly that of enforcement. The other provides the most important, if not the only conceivable complement for the lack of legally binding rules. Governments and parliaments pass laws and make them effective to secure the maximum of equality in the access to quality health care and then in the enjoyment of the highest attainable standard of health. Solidarity may of course boost this effectiveness, as the purpose is shared by 'all sectors of society'. It is evident, for instance, that corporations are called upon to implement their standards as to environmental protection and working conditions, while the State remains the addressee of the specific obligation to prevent harmful action, as far as possible, by the means of legal coercion. Institutions and groups within civil society can do and actually do a lot for the worst-off, although governments cannot use it as a pretext for shifting their responsibility to the noble, but discretionary commitment of morals. Things are completely different at the international level. The extent of coercion is very weak in the case of international law. It is true that the right to quality health care is not justiciable as such in many developed countries, but what about the idea of considering their citizens and governments *legally* responsible for people starving in the poorest areas of the world, often without seeing a doctor for the whole length of their life? As a matter of fact, individuals are far from being equal in enjoying their fundamental rights. And solidarity itself appears to be a weak instrument to tackle this evident source of injustice. It is essentially a group concept and the sense of belonging is the underlying motivation which changes the passive understanding of a common destiny of finitude to active engagement for common goals. It is much easier to feel solidarity towards men and women who live in our own country, who speak our language, who share our culture and especially towards those who belong to our *community* of belief or of interest. Is it possible to foster and broaden this attitude?

Some instructive examples are available and strengthen a bottom up push. It is meaningful to find out that all actors are able to share this responsibility: individuals practicing fair trade; multinational companies ready to apply the most strict standards beyond the weak legal obligations of some developing countries; governments that look for a joint effort and innovative financial mechanisms to provide resources to confront the most terrible epidemics (for instance, Unitaid). Jürgen Habermas has proposed the idea of a concrete cosmopolitan solidarity, to which all cultural traditions and religions rooted in the fundamental idea of universal brotherhood, could contribute as well. The maximum of equality, as far as everyone's right to life is concerned, remains the ultimate goal. The maximum of solidarity can help provide at least the minimum to support human dignity: safe water, food and freedom from hunger; basic shelter and housing; essential drugs; access to health care of adequate level, when the highest is not attainable.

h. Relationship of Article 14 with other articles of the Declaration

Article 14 the Article cannot be interpreted as an isolated text fragment. In accordance with Article 26 of the Declaration, any interpretation must take account of the whole of the Declaration, in particular the other principles. These provide both constraints on the possible interpretations and guidance concerning the fundamental values underlying the Declaration.

Article 14 should be read in the light of Article 13 on solidarity and co-operation ('Solidarity among human beings and international cooperation towards that end are to be encouraged. '), which reflects the commitment that the Declaration is based not only on the individualist concept of *rights* but that it also recognizes the importance of *solidarity* between individuals and across communities. The idea of collective social protection and fair opportunity should be a governing principle in policy decisions and it is an essential element of a bioethics that provides guidance to decisions or practices, not only of individuals, but of groups, communities, institutions and corporations.

Cooperation between and among individuals, families, groups and communities, with special regard for those rendered vulnerable (also expressed in Article 8), should be of special concern in the relevant decision-making and the establishment of appropriate practices within the scope of the Declaration. The international dimensions of health care today are more significant than ever before. Rare diseases that are sometimes neglected by health care systems at the national level may be very dangerous in other parts of the world, and this requires international cooperation. In the case of HIV/AIDS-prevention, for example, the ethical dimensions of health care frequently go beyond national frontiers.

Also, Article 15⁽²⁾ in dealing with the benefits resulting from scientific research and its applications and the need to share them with society and the international community, echoes Article 14. It identifies as concrete areas of implementation of such sharing, access to quality health care, provision of new diagnostic facilities for new treatment or medical products stemming from the research and support for health services.

In the first paragraph of article 14 it is stated that promotion of health and social development is a 'central purpose of governments' and Article 1.2 emphasizes that this 'Declaration is addressed to States'. Articles 21, 22, 23 and 24 are explicitly addressing the responsibilities of governments and States.

The relevance of Article 21 (Transnational practices) to Article 14 relates to the crucial role attributed to 'progress in science and technology' to promote health and social development. Article 21.3 states that transnational health research 'should be responsive to the needs of host countries'. This implies that promotion of health and social development is not the sole responsibility of the government of a country hosting transnational research; also States sponsoring transnational research have a responsibility in safeguarding that the transnational research undertaken in a host country contributes to the research needs of that particular country.

In the first paragraph of article 14 it is also stated that promotion of health and social development is a responsibility not confined to governments; it is shared by all sectors of society. And while Article 2.1 states that the Declaration is also providing guidance to public

2. ¹ *Benefits resulting from any scientific research and its applications should be shared with society as a whole and within the international community, in particular with developing countries. In giving effect to this principle, benefits may take any of the following forms:*

- (a) *special and sustainable assistance to, and acknowledgement of, the persons and groups that have taken part in the research;*
- (b) *access to quality health care;*
- (c) *provision of new diagnostic and therapeutic modalities or products stemming from research;*
- (d) *support for health services;*
- (e) *access to scientific and technological knowledge;*
- (f) *capacity-building facilities for research purposes;*
- (g) *other forms of benefit consistent with the principles set out in this Declaration.*

2. *Benefits should not constitute improper inducements to participate in research'.*

and private institutions and corporations, Article 21 is not only addressing States and governments involved in transnational practices but also public and private institutions from initiating countries involved in such practices. This implies that promotion of health and social development in a country hosting transnational research is a shared responsibility of such institutions involved as well.

Article 22.2 emphasizes the role of States in establishing independent, multidisciplinary and pluralistic ethics committees, as set out in Article 19. The relevance of such institutions in relation to Article 14 relates to the role they could play in developing sustainable research priority policies within the domain of health and social development in the countries concerned. More specifically these national bodies could contribute to the promotion of health and social development by:

- identifying the most pertinent research for health and social development needs in the country concerned,
- formulating recommendations about sustainable research priority policies within the domain of health and social development, and
- fostering debate and public awareness about the ethical dimensions of promoting health and social development.

The relevance of Article 23 (Bioethics education, training and information) to Article 14 also relates to the crucial role attributed to 'progress in science and technology' to promote health and social development, but in a different sense and meaning than the one stated in 3a). 'Progress' in science and technology does not only mean progress in terms of the generation of new and context sensitive *products* of scientific and technological knowledge; 'progress in science and technology' also relates to the *process* of doing and implementing science and technology. Article 14 states that 'progress in science and technology' is crucial for health and social development. This implies that such development is dependent on:

- the production, implementation and application of context sensitive scientific and technological *products*, but also on
- raising awareness and sensitizing researchers, policymakers and the public about the ethical implications and possibilities of scientific and technological progress.

Article 14.2.e) states that reduction of illiteracy is important in order to promote health and social development. Bioethics education, training and information represent important ways of reducing *moral illiteracy* with regard to scientific and technological development.

As progress in science and technology is viewed as crucial for health and social development, it becomes clear that also Articles 15 and 24 are highly relevant for the promotion of such development. Furthermore, these articles state that high income, industrialized countries have a special responsibility with regard to the promotion of benefit sharing, solidarity and international cooperation in the field of science and technology, by assisting developing countries in building up their capacity, thus enabling them to make use of the fruits of scientific and technological progress and to develop their own research policies and scientific and technological know-how.

IV. SPECIAL AREAS OF FOCUS

a. Education

[to be drafted]

b. Research

Improving health is not only an outcome of development but also a prerequisite for development. Consequently, investment in health yields one of the highest rates of return that a country can achieve. Improving health requires the effective application of existing research. It also, crucially, requires research aimed at creating new knowledge and new technologies. This includes the whole spectrum of research: biomedical sciences (creating affordable and accessible new drugs, vaccines, diagnostics and appliances) health systems and policy research, social sciences, political sciences, health economics, behavioural and operational research, research into the relationship between health and the cultural, physical, political and social environments. Research for health can make a major contribution both to health and to more general development. In many countries, however, the benefits of health research are not optimized due to low investments, absence of a culture of evidence-based decision-making or lack of capacity. Countries that have invested consistently in health research and general science and technology research are now advancing rapidly in health and in economic development. International aid needs to ensure that research for health is part of its total package and is fitted in a manner that enhances national health research systems.

Few of the world's resources for health research are directed to solving the health problems of developing countries. In 1990, the Commission on Health Research for Development estimated that less than 10% of the global health research resources (totalling US\$30 billion/year in 1986) were being applied to the health problems of developing countries, which accounted for over 90% of the world's health problems – an imbalance subsequently captured in the term the '10/90 gap'. In 1996, the WHO Ad Hoc Committee on Health Research Relating to Future Intervention Options estimated that US\$55.8 billion was expended globally on health research in 1992 but noted that the '10/90 gap' persisted. The world now spends considerably more on health research: the latest estimate puts the figure at US\$105.9 billion for 2001, of which 44% by the public sector, 48% by the private for-profit sector and 8% by the private not-for-profit sector. Despite these positive increases, there is still a massive under-investment in health research relevant to the needs of low-and middle-income countries – the imbalance of the '10/90 gap'. More research is needed to address the lack of appropriate drugs and technologies to treat the multiple burdens of communicable and chronic diseases that many developing countries now face, and more research is needed to provide knowledge and evidence about what policies, systems and services work in different places and settings, about what is failing, and about what is needed to improve them.

A specific recommendation on research funding was made at the end of Forum 8, in Mexico City stating:

'To provide the resources necessary for essential research within developing countries, we urge governments of these countries to spend at least 2% of their national health budgets on health research, as recommended by the 1990 Commission on Health Research for Development. These funds should be used locally for health research and research capacity strengthening. Also in line with the Commission's recommendation, donors are urged to allocate 5% of their funding for the health sector to health research and research capacity strengthening in developing countries. Monitoring the use of funds for capacity development is a vital complementary activity'.

The point here is how governments perceive research. If they see research as an expenditure and not as an investment, the amount of funds will be scarce, mainly when the funds in poor countries have to be distributed among greater needs, relegating health research as an expenditure and one activity that is not a priority, falling with this into a vicious cycle that will not make it possible to improve social determinants of health. But also, we come to a basic question: is there a greater need than health, as a key determinant to development?

c. Industry

Development agencies have challenged the pharmaceutical industry to improve its efforts to tackle the health crisis affecting developing countries. They consider that a socially responsible company should have policies on access to treatment for developing countries

which include the five priorities of pricing, patent, joint public private initiatives, research and development and the appropriate use of drugs. They comment, in addition, that the industry currently defines its policy on access largely in terms of philanthropic ventures and that critical challenges remain, particularly the issue of pricing.

The generalized lack of interest on the part of industry in research geared to the development of new vaccines and drugs to treat tropical diseases and ailments typical of the poor sections of the community is explained by the extremely high cost of research and the small, not to say negative, profit margins to be expected. Furthermore, since the establishment of the World Trade Organization (WTO) and the signing of the Agreements on Trade-Related Aspects of Intellectual Property Rights (TRIPS), developing countries have been faced with an increase in the cost of basic medicines, whose protective patents enable the pharmaceutical industry to impose their price. Consequently, some basic medicines cannot be made available to poor population groups at affordable prices. The industrial and commercial rationale of the pharmaceutical industry often runs counter, however, to the public health objectives of developing countries that are confronted by epidemics of diseases such as AIDS, malaria and tuberculosis, and no doubt also conflicts with the terms of the Declaration, since the excessively high price of medicines puts them virtually beyond the reach of the world's poorest communities.

One solution to such prohibitive prices, which are indeed a huge stumbling block, would be to reach agreements with the pharmaceutical industry on a voluntary price differentiation between rich and poor countries, allowing the latter to pay only production costs and not research and development costs. WHO and UNAIDS have had some success in this regard. This system presupposes, however, that poor countries agree not to re-export the medicines to rich countries and that they are careful to ensure that the products are properly used to reduce to the minimum any possibility of resistance. The TRIPS Agreement (Trade-Related Aspects of Intellectual Property Rights) has also been revised in favour of the poorest countries. Those that do not have the capacity to produce medicines, may now request an extension of compulsory licenses for generic products that are still protected by patent so that they may be imported from other countries. The number of generic medicines is quite large at present, but it is likely to rise in the years ahead because of the number of medicines whose patents are due to expire. This situation will lead to a sharp fall in the profits of the pharmaceutical industry.

Recently, new projects have a distinctly charitable aspect and will not generate profits. Examples include the new Institute for Tropical Diseases in Singapore for the discovery of drugs for tuberculosis and dengue, and a considerable number of projects aimed at new treatments for malaria, elephantiasis, river blindness, HIV/AIDS, leprosy, dengue and sleeping sickness.

d. Health care

Despite the important biomedical and biotechnological advances which have had positive results in reducing morbidity and mortality, access to health care is far from satisfactory. Millions of people have no access to proper health care. Even in developed countries, many well established preventive treatments are not used, having as a consequence future complications and sometimes, the need of using more expensive treatments when the illness that could have been prevented occurs. Many treatments which have been proven to have favourable outcome are frequently underuse. Few examples can illustrate the magnitude of this problem: according to the Joint United Nations Program on HIV/AIDS (UNAIDS) 2008 report, by the end of 2007, an estimated of 33.2 million people were living with HIV, of whom 2.1 million were children, and 2.1 million died from AIDS. As many as 6800 people are newly infected with HIV every day because of poor access to affordable, proven interventions to prevent HIV transmission, only about 2700 additional people receive antiretroviral therapy per day. Despite progress, antiretroviral therapy coverage remains low: only 31% of people in need were receiving antiretroviral therapy in 2007. That same year, an estimated 2.5 million people were newly infected with HIV. Although mother-to-child transmission has been

almost entirely preventable for years, only a third of infected pregnant women receive antiretroviral drugs to prevent transmission, and even fewer receive medications for their own health. In other hands, 27 million children have not been vaccinated to prevent different illness. Many patients do not receive treatments based on evidence: About 30% of patients with myocardial infarction do not receive Aspirin to prevent new events. 50% of patients with coronary disease do not receive beta blockers, only 37% receive statins and less than 40% have LDL cholesterol less than 100, all factors which prevent new coronary events. 79 % of eligible, elderly patients with acute myocardial infarct did not receive b-blockers and their subsequent mortality at 2 years was 75% greater than those who had received b-blockers. It has been published that failure to use effective treatments (eg, thrombolytics, b-blockers, aspirin, and angiotensin-converting enzyme inhibitors) for acute myocardial infarction in all patients who could benefit from these interventions may lead to as many as 18,000 preventable deaths each year in the United States. The failure in using proved treatments as a primary or secondary prevention produces future complications which need to be treated using more expensive methods. Undetected and untreated hypertension, depression and failures in prenatal care are examples of underuse medical services.

Despite of the important scientific advances, there is a significant gap between medical knowledge and medical practice. Underuse of proven effective interventions leads to mayor forgone opportunities to improve health and function, as well as it increase the health care cost. The current investments in health protection are far overshadowed by expenditures to restore health once it is lost.

Other times, patients undergo to health services under circumstances in which its potential for harm might exceed the benefits; in this regard: some patients are exposed to expensive treatments simply because the technology exists without there being any reasonable expectation of receiving a benefit; a variety of new treatments, with scientifically known benefits compete with treatments used every day without evidence of effectiveness or even with negative results; treatments which have scientific evidence for a specific clinical situation are also used in other clinical settings in which no evidence has been obtained. The literature has shown that antibiotics are frequently overused, which increases the adverse reactions and increases the antibiotic resistance. Coronary angiographies, carotid endarterectomies, gastrointestinal endoscopies, pacemakers have been also reported in the literature as examples of overuse.

At the end of life, we have resources that allow us to treat health problems that would have been impossible to treat a few years ago. These techniques have made it possible to improve the quality of many patients lives, but sometimes, the same techniques rather than saving lives might just contribute to prolonging the process of dying, increasing suffering and costs. Serious doubts exist regarding how life-sustaining interventions should be applied and when they should be withheld or withdrawn from patients with vegetative states, advanced forms of cancer, advanced AIDS or from any other patient with low possibilities of surviving, or from patients with some chance of surviving, but with a limited quality of life. As a consequence many patients are over treated. How should they be treated to be just and equitable? How can the dignity and rights of those patients be respected appropriately?

Besides that, despite all technological advances many people have medical complications or die due to errors. Many hospital admissions of elderly patients for drug toxicity occur after administration of a drug known to cause drug-interaction and many of them could have been avoided. It has been reported that more than 10.000 might have die due to steroids in patients with brain injury. The American Medical Association reported in the year 2000 that 44,000 to 96,000 patients died in United States as a consequence of medical errors. Variables figures have also been reported in Europe. A new paradox has appeared: as development increases morbidity, mortality, inequalities and inequities also increase.

An important percentage of patients do not receive adequate information about treatment or diagnostic methods which they will be submitted to, or the information they receive is not understandable to them. Sometimes, they are not consulted, whereas other times their wills are not fully respected.

In addition to the significant problems described before, health care systems are faced with one of the most difficult challenges they have ever faced: the costs of medical care have driven up expenses far beyond the limits of any realistic budget, even in the richest countries. The increase in health care costs reduces the opportunities of many patients to receive the treatment they might need. Every day, we have more and more technologies which are used for less people because of the increase in costs.

Even if it is accepted that full equality for the best possible care will not be achievable, nowadays each member of society, irrespective of his or her economic position, should have equal access to an adequate, although not maximal, level of health care. In order for a health-care system to be just and equitable, it needs, first of all, to be efficient in terms of cost-benefit. This means that there must be an efficient management of the limited budget in order to cover the basic needs as a minimum. Beyond the management decisions to reach this goal it is necessary to address important ethical questions: Should all new technologies be used in every patient? Should all patients be treated? Are the new medical technologies being used for saving people with good chances of having an acceptable quality of life or, instead of that, are these new treatments being used on individuals with bad prognosis, in terms of life expectancy and quality of life?

Today, it is accepted that some rationing in health care is needed. A decent minimum has to be defined. In such a case, what criteria should be followed? Will it be possible to accept a trade off? In practical terms, is it possible to guarantee the highest attainable standard of health care? What does the highest attainable standard mean? What are the real goals of medicine in the twenty-first century? What must be considered just when all these new technologies are applied? None of these questions has an answer yet and answering them will require, first of all, an intense educational program which should include all members of society, followed by a wide deliberation process which should be addressed to: re-define the concepts of health and illness, to understand the technology's limits, to set forth strategies for defining the health necessities in health care, as well as the criteria for establishing a decent minimum in health care; discuss acceptable criteria for rationing; clarify the limits of the patients' rights regarding the use of new technologies. But above all, the deliberation process must be addressed to redefine new reasonable goals of medicine.

Access to health care should be understood as established in article 14, as access to 'quality health care', which has been defined as: 'The degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge'. (Chassin M, 1998)

Quality health care requires the following steps: 1) Adequate prevention and/or treatment, based on evidences, should be applied at the right time; 2) primary or secondary harm avoided or reduced; 3) patient's wishes respected; 4) the cost-benefit relationship preserved.

Our moral responsibility increases in the same proportion as our knowledge does. When a person gets sick or dies due to an illness with unknown preventive or effective treatment, there is no moral responsibility but when this illness is preventable or has an effective treatment, an enormous moral responsibility exists which has to be assumed by societies. Members of society as well as patients bear a great burden of harm because a lack of an adequate quality health care system, a burden that produces lost lives, reduced functioning and wasted resources. Improving the quality of our health care systems requires the cooperation of all institutions and members of our society, each of them has to know and accept it own responsibility.

d. Other

[to be drafted]

V. RECOMMENDATIONS

a. Decision-making procedures

It is evident that pursuing the goals of promoting health and social development is not without cost and that few societies, if any have the resources to actively pursue all the goals mentioned in Article 14 to a sufficient degree and concurrently. This entails that societies will have to prioritize between and within goals. Recent work on priority setting in health care and on societal priority setting more generally has shown that there is no uncontroversial algorithm that can provide definite answers to how such priorities should be set. Drawing on ideas from discussion in political philosophy on the characteristics of deliberative democracy, and the use of deliberative processes to confer legitimacy on decisions various deliberative accounts of priority setting have been developed.

Procedures for priority setting emphasize the application of a fair process that allows us to agree on what is legitimate and fair. Key elements of fair process will involve transparency about the grounds for decisions; appeals to rationales that all can accept as relevant to meeting health needs fairly; and procedures for revising decisions in light of challenges to them. The basic notion behind the process is that it will increase the likelihood of priority decisions being based on reasons that reflect a commitment to fairness.

It could be argued that any societal priority setting within and between goals outlined in Article 14 would have to follow a legitimate process and that legitimate decision-making procedures e deliberative component of deliberative democracy would be a good candidate for specifying the necessary elements of that process. This is not a line of argument that will be pursued further here, except in the context of the reasons that can be given for a given priority decision.

Within a framework where decisions receive part of their normative force through the process by which they have been made and part of their force from the reasonableness of the reasons that have featured in the process Article 14 is relevant because it establishes the *prima facie* reasonableness of a set of reasons related to the goals enumerated in sub-section 2 of the article. The mere fact that an activity, for instance aims at relieving poverty is a reasonable, though not sufficient reason to pursue the activity. And conversely, the mere fact that an activity would increase poverty is a reasonable, though not sufficient reason not to pursue the activity.

More generally a decision maker who is contemplating a decision with implications for the promotion of health and/or social development ought to ensure that the effect of the contemplated activity on all the goals mentioned in Article 14 are considered. Otherwise there is a significant possibility that reasonable and important reasons have not featured in the decision making process. Article 14 can thus be the basis for a rough checklist for the reasonableness of reasons given by policy makers to justify decisions in the areas covered by the Article.

b. Transnational scope

Does Article 14 have transnational scope, i.e. do the obligations it allocates to governments and other societal actors go beyond the borders of any particular nation State? The following article, Article 15 on benefit sharing clearly has transnational scope, but Article 14 may initially seem not to carry any transnational implications and the use of the term 'for their people' might even indicate an explicit restriction to the people in the particular State. Furthermore, all the actions Article 14 describes are within the scope of normal governmental activities. In this context it is, however important to remember that all articles in the Declaration have to be interpreted so as to comply with Article 21.1. Article 21.1 is not restricted to research activities, as Article 15 and the following sub-sections of Article 21 but covers all transnational activities.

In so far as the governmental activities or activities of other social actors are pursued in different States the full set of obligations imposed by Article 14 must therefore also be observed in the other States that are affected by the activities. One example of this would be that a firm that is engaged in activities in a different country than the country in which it is incorporated cannot absolve itself from its obligations by the argument that it only has these obligations in 'its own country'.

Another possible transnational aspect of Article 14 is in relation to establishing rules for intellectual property. Establishing rules for the legal recognition and exploitation of intellectual property in all its different forms is one of the ways in which a State can try to ensure that '...progress in science and technology ...' (Article 14.2) advances health and social development in the areas mentioned in 14.2a-e but modern intellectual property regimes reach far beyond the borders of individual States. In so far as the intellectual property regime of one State has implications elsewhere or in relation to negotiations concerning international intellectual property rules State and societal actors have a plausible obligation to consider what the effects of the rules will be in other States, especially whether health and social development will be promoted.

c. National Bioethics Committees

According to article 19 (c) of the Declaration, national bioethics committees (NBC) should be established in order to 'assess scientific and technological developments, formulate recommendations and contribute to the preparation of guidelines on issues within the scope of this Declaration'.

One way NBCs could contribute to this endeavour is to address the particular research and development needs of the country concerned and provide ethically justifiable recommendations with regard to how different forms of research for health and social development should be ranked with regard to priority setting. This would represent a way of linking Article 14 on the promotion of health and social responsibility to the need for developing sustainable research priority policies within the domain of health and social development in the countries concerned.

In a Report of a Commission on Macroeconomics and Health set up by WHO four research needs for health development are identified⁽³⁾:

- 'operational research at the local level' to learn 'what actually works, and why or why not';
- 'a significant scaling up of financing for global R&D on the heavy disease burdens of the poor', such as HIV/AIDS, malaria, tuberculosis, childhood infectious diseases and micronutrient deficiencies;
- 'reproductive health', including research to block perinatal transmission of HIV; and
- epidemiological research.

In the Report it is also suggested that *national commissions on macroeconomics and health* with the tasks of assessing 'national health priorities' and proposing strategies for the 'coverage of essential health services' should be established⁽⁴⁾.

Article 14 of the Declaration makes clear that promotion of health is also dependent on a whole range of non-medical factors such as access to adequate nutrition and water, improvement of living conditions and the environment and reduction of poverty and illiteracy. For these reasons there is a need to widen the research-needs-perspective proposed by the Commission on Macroeconomic and Health to include non-medical forms of research for health needs as well.

3. Ibid., p. 8-9.

4. WHO, *Macroeconomics and Health: Investing in Health for Economic Development*, Geneva 2001, p. 10.

National Bioethics Committees are independent, multidisciplinary and pluralistic bodies with an ethics mandate that not only covers medical research; they have been established in order to assess scientific and technological developments within *all* the bio-, life- and health sciences. Besides they have been established to formulate recommendations and foster debate, education and public awareness in bioethics. These national bodies should therefore be encouraged to take on the responsibility of:

- identifying the most pertinent research for health and social development needs in the country concerned,
- formulate recommendations about sustainable research priority policies within the domain of health and social development, and
- fostering debate and public awareness about the ethical dimensions of promoting health and social development.

d. Other

[to be drafted]

VI. CONCLUSIONS

[to be drafted]

**HISTORICAL OVERVIEW OF INTERNATIONAL INITIATIVES
IN PROMOTING THE PRINCIPLE OF SOCIAL RESPONSIBILITY AND HEALTH**

INITIATIVES UNDERTAKEN WITHIN THE UN SYSTEM

The international context regarding health and social responsibility can be traced back to many existing international instruments declarations, international covenants or statements, as well as initiatives, which explicitly refer to health and welfare of human beings.

Constitution of the World Health Organization (WHO)

The well-known Constitution of WHO defines health as *'a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity'* and affirms that *'the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition'*.

Universal Declaration of Human Rights

The Universal Declaration of Human Rights (1948) refers to health and welfare of human beings in article 25, which states that: *'Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services...'* and follow:

'(2) Motherhood and childhood are entitled to special care and assistance. All children, whether born in or out of wedlock, shall enjoy the same social protection'.

International Covenant on Economic, Social and Cultural Rights

Article 15 of the International Covenant on Economic, Social and Cultural Rights (1966), states that *'everyone has the right to enjoy the benefits of scientific progress and its applications'* and Article 12 states:

'1. The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.

2. The steps to be taken by the States Parties to the present Covenant to achieve the full realization of this right shall include those necessary for:

(a) The provision for the reduction of the stillbirth-rate and of infant mortality and for the healthy development of the child;

(b) The improvement of all aspects of environmental and industrial hygiene;

(c) The prevention, treatment and control of epidemic, endemic, occupational and other diseases;

(d) The creation of conditions which would assure to all medical service and medical attention in the event of sickness'.

Health-for-All by the Year 2000

In 1977 the Thirtieth World Health Assembly decided that the main social goal of governments and WHO in the coming decades should be the attainment by all people of the world by the year 2000 of a level of health that would permit them to lead a socially and

economically productive life. This goal is commonly known as Health-for-All by the Year 2000 (Resolution WHA30.43).

The commitment to global improvements in health, especially for the most disadvantaged populations, was reviewed in 1998 by the World Health Assembly. This led to the development of 'Health-for-All for the Twenty-First Century' policy and programme, within which the commitment to primary health care is restated.

In the report of the 51st World Health Assembly on this issue, it is indicated: *'Over the past two decades primary health care as a cornerstone of Health-for-All. Despite gains, however, progress has been hampered for several reasons, including insufficient political commitment to the implementation of Health-for-All, slow socioeconomic development, difficulty in achieving intersectoral action for health, insufficient funding for health, rapid demographic and epidemiological changes, and natural and man-made disasters. Further, poverty has increased worldwide. Health has suffered most where countries have been unable to secure adequate income levels for all'*. The report also indicated that primary health-care policy approaches should reinforce the following points:

- make health central to development and enhance prospects for intersectoral action;
- combat poverty as a reflection of primary health care's concern for social justice;
- promote equity in access to health care;
- build partnerships to include families, communities and organizations;
- reorient health systems towards promotion of health and prevention of disease.

The 'Health-for-All' WHO commitment and programme were marked by a series of Global Conferences on Health Promotion which began in Ottawa in 1986 and produced the Ottawa Charter on Health Promotion. This benchmark conference was followed by conferences in Adelaide (1988), Sundsvall (1991), Jakarta (1997) Mexico City (2000) and Bangkok (2005).

Alma Ata Declaration

The International Conference on Primary Health Care (PHC), held in Alma-Ata, Kazakhstan, in 1978, realized that improving health called for a comprehensive approach whereby primary health care was seen as 'the key to achieving an acceptable level of health throughout the world in the foreseeable future as a part of social development and in the spirit of social justice'. The Conference adopted 'The Alma-Ata Declaration' which reaffirmed that *'health... is a fundamental human right and that the attainment of the highest possible level of health is a most important world-wide social goal whose realization requires the action of many other social and economic sectors in addition to the health sector'*. The Conference called for a transformation of conventional health-care systems and for broad intersectoral collaboration and community organizing.

Ljubljana Charter

The Ljubljana Charter, adopted by the Ministers of Health or their representatives from the European Member States of WHO at the WHO Conference on European Health Care Reforms in Ljubljana, Slovenia in June 1996, addresses health-care reforms in the specific context of Europe. The purpose of this Charter is to articulate a set of principles which are an integral part of current health-care systems or which could improve health care in all the Member States of WHO in the European Region. These principles emerge from the experience of countries implementing health-care reforms and from the European health-for-all targets, especially those related to health-care systems.

Jakarta Declaration

The promotion of social responsibility for health was first established as a priority at the WHO Fourth International Conference on Health Promotion: New Players for a New Era – Leading Health Promotion into the 21st Century, held in Jakarta, Indonesia in July 1997.

In the final Declaration, the Conference, the first to be held in a developing country, and the first to involve the private sector in supporting health promotion, recommended that decision makers must be *'firmly committed to social responsibility'* and both public and private sectors *'should promote health by pursuing policies and practices that:*

- *avoid harming the health of individuals,*
- *protect the environment and ensure sustainable use of resources,*
- *restrict production of, and trade in, inherently harmful goods and substances such as tobacco and armaments, as well as discourage unhealthy marketing prices,*
- *safeguard both the citizen in the marketplace and the individual in the workplace,*
- *include equity-focused health impact assessments as an integral part of policy development'.*

Bangkok Charter

More recently, the Bangkok Charter, adopted at the WHO Sixth Conference on Global Health Promotion held in Thailand in August 2005, identifies actions, commitments and pledges required to address the determinants of health in a globalized world through health promotion. Thus, it is recommended that *'governments at all levels must tackle poor health and inequalities as a matter of urgency because health is a major determinant of socioeconomic and political development'*. Its four key commitments are to make promotion of health:

- central to the global development agenda: strong intergovernment agreements that improve health and collective health security and effective mechanisms for global governance for health are needed;
- a core responsibility for government as a whole: the determinants of health need to be addressed by all ministries at all levels of government;
- a key focus of communities and civil society: well-organized and empowered communities are highly effective in determining their own health, and are capable of encouraging governments and the private sector to be accountable for the health consequences of their policies and practices;
- a requirement for good corporate practice: the private sector has a responsibility to ensure health and safety in the workplace and to promote the health and well-being of employees, their families and communities, and to contribute to lessening wider impacts on global health.

UN Millennium Development Goals

Further international efforts to meet the needs of the poorest, including better health, have been included in the eight UN Millennium Development Goals (MDG) (United Nations Millennium Declaration adopted by the General Assembly in September 2000). The UN Millennium Development Goals address health in a global and social perspective. Indeed, among the development goals, reduction of child mortality (Goal 4), improvement of maternal health (Goal 5) and combat HIV/AIDS, malaria and other diseases (Goal 7) can be found. Moreover, one of the seven modalities set out to achieve Goal 8 'Develop a global partnership for development' is to provide access to affordable essential drugs in developing countries in cooperation with pharmaceutical companies.

INITIATIVES UNDERTAKEN BY OTHER ORGANIZATIONS

Outside the United Nations systems, a number of alliances between public, private, nongovernmental and international organizations and civil society have been organized with the aim to address the determinants of health in a globalized world through health promotion. Recent initiatives are described below as examples.

Global Forum for Health Research. At recent parallel meetings of the Forum 8 organized by the Global Forum for Health Research and the Ministerial Summit on Health Research, held in Mexico City in November, 2004, over 1,400 policy makers, health ministers, researchers and representatives of governments, development agencies and research institutions examined the issue on how research could improve strategies and help to attain the MDG. One of the conclusions of both the Forum and the Summit was that achieving the Goals will require addressing health and its determinants in a comprehensive way and will necessitate further health research, of high quality, focused on the needs of developing countries and vulnerable populations. It must give systematic attention to cross-cutting issues of poverty and equity, taking account of inequities based on gender, ability, ethnicity and social class, among others; the needs of both the aged and the largest generation ever of young people 0-19 years, and the needs of other specifically disadvantaged groups such as migrants, refugees and those exposed to violent conflict. It was concluded that all the participants must commit themselves to the shared responsibility of advancing the volume and pace of health research that is focused on improving the lifespan and health of people everywhere. Special consideration was given to increase funding for health systems research, as this activity of research is the one that may have the largest impact on improving health.

Grand Challenges in Global Health. This initiative is a partnership dedicated to supporting scientific and technical research to solve critical health problems in the developing world. The initiative's partners are the Bill & Melinda Gates Foundation, the Canadian Institutes of Health Research, the Foundation for the National Institutes of Health, and the Wellcome Trust. A grand challenge is meant to direct investigators to a specific scientific or technical breakthrough that would be expected to overcome one or more bottlenecks in an imagined path towards a solution to one or preferably several significant health problems. Therefore a grand challenge is envisioned as distinct from a simple statement of one of the major problems in global health, such as malnutrition or the lack of access to medical care. The initiative has identified and supported seven long-term goals to improve health in the developing world:

- to improve childhood vaccines,
- to create new vaccines,
- to control insects that transmit agents of disease,
- to improve nutrition to promote health,
- to improve drug treatment of infectious diseases,
- to cure latent and chronic infection,
- to measure health status accurately and economically.

Reaching the Poor Programme (RPP). This is an effort to begin finding better ways of ensuring that the benefits of health, nutrition, and population (HNP) programmes flow to disadvantaged population groups. It has been undertaken by the World Bank, in cooperation with the Gates Foundation, and the Dutch and Swedish Governments. In order to help improve how well HNP programmes reach poor people, the RPP seeks to:

- determine which HNP programmes do or do not reach disadvantaged groups effectively. The resulting information, produced through application of recently-developed quantitative techniques for assessing programmes' distributional

performance, is intended to provide guidance to policy makers about which approaches to adopt and to avoid in developing pro-poor initiatives;

- encourage others to undertake similar determinations of HNP programme effectiveness in reaching the poor. More widespread application of the techniques just mentioned, derived from the 'benefit incidence' approach used to determine who benefits most from government expenditures, would allow policy makers to assess and then improve their performance in reaching the poor on an ongoing basis.

The programme considers that health policies do not have to be inequitable: 'While most health, nutrition, and population services exacerbate poor-rich inequalities by achieving much lower coverage among the disadvantaged than among the better-off, many significant and instructive exceptions exist. This demonstrates the feasibility of reaching the poor much more effectively than at present, and point to promising strategies for doing so'.

GLOBAL HEALTH CONDITIONS – AN OVERVIEW

Global health conditions at present have been summarized in 2006 by WHO: 'In this first decade of the 21st century, immense advances in human well-being coexist with extreme deprivation. In global health we are witnessing the benefits of new medicines and technologies. But there are unprecedented reversals. Life expectancies have collapsed in some of the poorest countries to half the level of the richest – attributable to the ravages of HIV/AIDS in parts of sub-Saharan Africa and to more than a dozen 'failed States'. These setbacks have been accompanied by growing fears, in rich and poor countries alike, of new infectious threats such as SARS and avian influenza and 'hidden' behavioural conditions such as mental disorders and domestic violence. The world community has sufficient financial resources and technologies to tackle most of these health challenges; yet today many national health systems are weak, unresponsive, inequitable – even unsafe. What is needed now is the political will to implement national plans, together with international cooperation to align resources, harness knowledge and build robust health systems for treating and preventing disease and promoting population health'.

MAJOR PUBLIC HEALTH PROBLEMS

Despite progress in the medical and health field, major public health problems and inequalities of health care between North and South still remain. Today 800 million individuals suffer from hunger and malnutrition, and more than a billion people do not have access to safe drinking water, basic education and health care. In this information age where future development is supposed to be based on knowledge, two billion are not connected to an electricity supply and more than 4.5 billion or 80% of the world's population is deprived of basic telecommunication technology.

Maternal mortality

Notwithstanding all the advances of science and technology in medical and health fields witnessed in the 20th century, maternal deaths continue unabated – the annual total now stands at 529,000 often sudden, unpredicted deaths which occur during pregnancy itself (some 68,000 as a consequence of unsafe abortion), during childbirth, or after the baby has been born – leaving behind devastated families, often pushed into poverty because of the cost of health care that came too late or was ineffective. These deaths are even more unevenly spread than newborn or child deaths: only 1% occur in rich countries, every day more than 1,600 women die in developing countries of causes related to child birth. Every 45 seconds a woman dies from pregnancy related causes, and every seven and a half minutes, a woman dies from an unsafe, often self-induced abortion. Over 300 million women suffer from short-term or long-term illness brought about by pregnancy and childbirth.

Child mortality

Globally, mortality rates in children under five years of age fell throughout the latter part of the 20th century: from 146 per 1000 live births in 1970 to 79 in 2003. Towards the turn of the millennium, however, the overall downward trend started to falter in some parts of the world. In 93 countries, totalling 40% of the world population, under-five mortality is decreasing fast. A further 51 countries, with 48% of the world population, are making slower progress: they will only reach the Millennium Development Goals if improvements are accelerated significantly. Even more worrying are the 43 countries that contain the remaining 12% of the world's population, where under-five mortality was high or very high to start with and is now stagnating or reversing.

At the beginning of the 21st century over 10 million children (more than 27,000 per day) die each year, although most of these deaths can be avoided. Each year some 3.3 million babies are stillborn and more than 4 million die within 28 days of coming into the world, and a further 6.6 million young children die before their fifth birthday, most of them from the poor countries. The main causes of death among children under five years of age are avoidable illnesses. Six illnesses account for 70% to 80% of all these deaths: acute respiratory infections, diarrhoea, malaria, measles, HIV/AIDS, premature birth and neonatal problems. Three quarters of neonatal deaths could be avoided if pregnant women received better nutrition and adequate perinatal care.

Infectious diseases

Infectious diseases continue to be a serious burden around the world, in developing as well as industrialized countries. Infections can cause illness, disability and death in individuals while disrupting whole populations, economies and governments. Transmissible diseases constitute the main cause of death in the poorest countries: 59% of deaths reported in the 20 poorest countries are caused by such diseases, compared with 8% in the 20 richest countries. WHO estimates for 2002 that some 11 million people died from infectious and parasitic diseases, 52% of them in Africa, 26% in South-East Asia and 3% in Latin America. The main causes of annual deaths from transmissible diseases were respiratory infections (4 million), HIV/AIDS (2.8 million), tuberculosis (1.5 million), diarrhoea (1.8 million) and malaria (1.3 million).

As people, products, food and capital travel the world in unprecedented numbers and at historic speeds, so, too, do the myriad of disease-causing microorganisms. Because national borders offer trivial impediment to such threats, especially in the highly interconnected and readily traversed 'global village' of our time, one nation's problem soon becomes every nation's problem. The worldwide resurgence of dengue fever, the introduction of West Nile virus into New York City in 1999, the rapid spread of human immunodeficiency virus (HIV) infection in Russia, and the global spread of multidrug-resistant tuberculosis (TB) are but a few examples of the profound effects of globalizing forces on the emergence, distribution and spread of infectious diseases. No nation is immune to the growing global threat that can be posed by an isolated outbreak of infectious disease in a seemingly remote part of the world. In addition to the known diseases, there are new epidemics such as SARS, which infected some 8,000 people in 30 countries in 2003, and avian influenza, which led to the slaughter of millions of animals in three continents, and experts fear that the virus could mutate and unleash a human influenza pandemic.

Chronic diseases

Heart disease, stroke, cancer, chronic respiratory diseases and diabetes are by far the leading cause of mortality in the world, representing 60% of all deaths. Out of the 35 million people who died from chronic disease in 2005, half were under 70 and half were women. Visual impairment and blindness, hearing impairment and deafness, oral diseases and genetic disorders are other chronic conditions that account for a substantial portion of the global burden of disease.

Deaths from infectious diseases, maternal and perinatal conditions, and nutritional deficiencies combined are projected to decline by 3% over the next 10 years. In the same period, deaths due to chronic diseases are projected to increase by 17%. This means that of the projected 64 million people who will die in 2015, 41 million will die of a chronic disease – unless urgent action is taken. Contrary to common perception, 80% of chronic disease deaths occur in low and middle-income countries. From a projected total of 58 million deaths from all causes in 2005, it is estimated that chronic diseases will account for 35 million, which is double the number of deaths from all infectious diseases (including HIV/AIDS, tuberculosis and malaria), maternal and perinatal conditions, and nutritional deficiencies combined. The total deaths from chronic diseases are projected to increase by a further 17% over the next

10 years, while deaths from infectious diseases, maternal and perinatal and nutritional deficiencies combined are expected to decline.

The threat is growing – the number of people, families and communities afflicted is increasing. This growing threat is an under-appreciated cause of poverty and hinders the economic development of many countries. Common, modifiable risk factors underlie the major chronic diseases. These risk factors explain the vast majority of chronic disease deaths at all ages, in men and women, and in all parts of the world. They include: unhealthy diet, physical inactivity and tobacco use. The burden of chronic disease has major adverse effects on the quality of life of affected individuals, causes premature death, creates large adverse – and underappreciated – economic effects on families, communities and societies in general: \$558 billion - the estimated amount China will forego in national income over the next 10 years as a result of premature deaths caused by heart disease, stroke and diabetes.

Despite global successes, chronic diseases have generally been neglected in international health and development work. Furthermore, these diseases have not been included within the global Millennium Development Goal targets. Chronic diseases hinder economic growth and reduce the development potential of countries, and this is especially true for countries experiencing rapid economic growth, such as China and India. However, it is important that prevention is addressed within the context of international health and development work even in least developed countries, which are already undergoing an upsurge in chronic disease risks and deaths.

Malnutrition

Malnutrition is still one of the major public-health problems in the world, as shown by the low nutrition indices in many countries of the South, but above all in East and West Africa (0.46 and 0.50 respectively). Furthermore, it is estimated that over 800 million people do not have access to good-quality food in sufficient quantity and that over 2 billion suffer from deficiencies of micronutrients such as vitamin A, iodine and iron. Every year, nearly 11 million children under-five die and almost all of these deaths occur in developing countries, three quarters of them in sub-Saharan Africa and South Asia, two regions that also record the highest incidence of problems relating to hunger and malnutrition. Generally, although these children do not die from famine but from neonatal ailments and a variety of curable infectious diseases, particularly diarrhoea, pneumonia, malaria and measles, most of these children would not die if their bodies and immune systems were not weakened by malnutrition. Finally, hunger and malnutrition are the main causes of destitution and extreme poverty, giving rise to criminal and violent behaviour.

Hungry children start attending school late (if at all), they finish their studies earlier and learn less, which impedes progress towards primary and secondary education for all. Under-nutrition of women is one of the most destructive results of gender inequality: it reduces their education and employment opportunities and impedes progress towards gender equality and women's autonomy. Hunger and malnutrition increase the incidence and lethality rate of the health problems that cause most deaths during pregnancy and parturition. Hunger and poverty destroy the immune systems of population groups, force them to adopt risky survival strategies and substantially increase the risk of infection and death from HIV/AIDS, malaria, tuberculosis and other infectious diseases.

DETERMINANTS OF HEALTH

General background

Today an unprecedented opportunity exists to improve health in some of the world's poorest and most vulnerable communities by tackling the root causes of disease and health inequalities.

According to WHO, *'the determinants of health include: the social and economic environment, the physical environment, and the person's individual characteristics and behaviours. The context of people's lives determine their health, and so blaming individuals for having poor health or crediting them for good health is inappropriate. Individuals are unlikely to be able to directly control many of the determinants of health. These determinants - or things that make people healthy or not - include the above factors, and many others such as:*

- *income and social status - higher income and social status are linked to better health. The greater the gap between the richest and poorest people, the greater the differences in health;*
- *education – low education levels are linked with poor health, more stress and lower self-confidence;*
- *physical environment – safe water and clean air, healthy workplaces, safe houses, communities and roads all contribute to good health;*
- *employment and working conditions – people in employment are healthier, particularly those who have more control over their working conditions;*
- *social support networks – greater support from families, friends and communities is linked to better health;*
- *culture - customs and traditions, and the beliefs of the family and community all affect health;*
- *Genetics - inheritance plays a part in determining lifespan, healthiness and the likelihood of developing certain illnesses. Personal behavior and coping skills – balanced eating, keeping active, smoking, drinking, and how we deal with life's stresses and challenges all affect health;*
- *health services - access and use of services that prevent and treat disease influences health;*
- *gender - Men and women suffer from different types of diseases at different ages'.*

Tackling major health determinants is of great importance for reducing the burden of disease and promoting the health of the general population. Action to reduce health inequalities aims to improve everyone's level of health closer to that of the most advantaged, to ensure that the health needs of the most disadvantaged are fully addressed, and to help the health of people in countries and regions with lower levels of health to improve faster.

Social determinants

Throughout the world, people who are vulnerable and socially disadvantaged have less access to health resources, get sicker and die earlier than people in more privileged social positions. The greatest share of health problems is attributable to the social conditions in which people live and work, referred to as the social determinants of health. Good medical care is vital to the well being of populations, but improved clinical care is not enough to meet today's major health challenges and overcome health inequities.

Without action on social determinants, those countries in greatest need will neither meet the health-related MDG nor achieve global targets for reducing chronic diseases such as cardiovascular diseases, cancer and diabetes. Problems are especially urgent in developing countries where the burden of chronic illnesses is growing rapidly on top of the burden of unresolved infectious epidemics.

Health status, therefore, should be of concern to policy makers in every sector, not solely those involved in health policy. To reduce inequalities in health across the world there is a need for a major thrust that is complementary to development of health systems and relief of

poverty: to take action on the social determinants of health. Such action will include relief of poverty but it will have the broader aim of improving the circumstances in which people live and work. It will, therefore, address not only the major infectious diseases linked with poverty but also non-communicable diseases - both physical and mental - and violent deaths that form the major burden of disease and death in every region of the world outside Africa and add substantially to the burden of communicable disease in sub-Saharan Africa. If the major determinants of health are social, so must be the remedies. Treating existing disease is urgent and will always receive high priority but should not be to the exclusion of taking action on the underlying social determinants of health. Disease control, properly planned and directed, has a good history, but so too does social and economic development in combating major diseases and improving population health. Wider social policy will be crucial to the reduction of inequalities in health.

Poverty. Links between poverty, increasing population, environmental degradation, poor health, human migration and strife are well known. One could be the cause and the effect of the other. A vast amount of data is now available to establish that the health problems of the poor differ significantly from those of the rich, within a country and between countries. The current trade and economic policies (the free flow of trade and money) around the world has brought economic growth for the fortunate in the largest and strongest economies but has also created widening gaps in wealth and health between and within the countries. To realize an environmentally sound, economically productive, socially responsible and behaviourally possible development requires a developmental strategy which ensures economic growth translated into human development: only then can it be sustainable.

Overpopulation. High fertility rates have historically been strongly correlated with poverty, high childhood mortality rates, low status and educational levels of women, deficiencies in reproductive health services and inadequate availability and acceptance of contraceptives. Poverty and population are linked so closely that their solution must go hand in hand. At the moment poor countries are unable to provide for the total resources required for this purpose. With the exception of sub-Saharan Africa much of the developing world is now well into a transition from high fertility and mortality rates to low ones. The world is thus both younger and older than ever before. Today half the population in developing countries is under 23 years old, an estimated 800 million people – 15% of the world's population is thus in their teens. This results in a 'demographic momentum' implying that even after the fertility rate falls below replacement levels, the population would continue to increase for several decades hereafter. A doubling of the number of older people in developing countries in the next 25 years will mount to 'an unprecedented demographic revolution'. Ageing populations add to the national pool of chronic debilitating diseases like cardiac and cerebrovascular disorders, degenerative arthritis, osteoporosis, dementia, Parkinson's disease, cancer etc., which add to the already rising cost of health care.

Malnutrition. Altogether it looks as if the global race between population and food is at best going to be rather too close, for the poorest communities (because the prices are rising) it is already being lost. Everyone agrees that the world's population will exceed 8 billion by 2025, an increase of 30% in 25 years. Future increases in food supplies, required to feed these extra numbers, must come primarily from rising biological yields, rather than from area expansion and large-scale irrigation expansion. The challenge is world wide, and both technological and political in nature. The technological challenge is enormous, requiring the development of new, high productive, more nutritious, environmentally sustainable production systems. New technologies such as genetically modified organisms (GMOs), post-harvest technologies, pest control, food storage etc. already known can help meet some of these challenges. It is not more of the same. Under-nutrition triggers an array of health problems like stunted growth, proneness to infections and worst of all mental retardation and cognitive impairment. Adverse socioeconomic circumstances during foetal life and in early childhood also have a specific influence on mortality from stroke and stomach cancer in adulthood, which is not due to the continuity of social disadvantage throughout life.

Deprivation in childhood influences risk of mortality from coronary heart disease in adulthood, although an additive influence of adulthood circumstances is seen in these cases.

Life styles. Evidence suggests that modern inactive life styles, affluence related over consumption of food, stress associated with 'get rich quick' or 'extremely competitive world', over indulgence in unhealthy food and beverages, smoking and recreational drugs, promiscuous sex, breaking down of conventional joint family systems are responsible for the emerging morbidity and mortality profile already prevalent in many developed countries. Obesity, diabetes, hypertension, cardio and cerebrovascular and mental disorders are already responsible for increasing cost of health care globally. The number of people suffering from diabetes worldwide is projected to more than double from 135 million now to almost 300 million by 2025. Globally, the prevalence of chronic, non-communicable diseases is increasing at an alarming rate. About 18 million people die every year from cardiovascular disease, for which diabetes and hypertension are major predisposing factors. Propelling the upsurge in cases of diabetes and hypertension is the growing prevalence of overweight and obesity - which have, during the past decade, joined underweight, malnutrition, and infectious diseases as major health problems threatening the developing world. The main culprit is an environment which promotes behaviour that causes obesity.

Lack of access to health care. Health care has a limited but not negligible role as a determinant of health. It has been estimated that 5 years of the 30-year increase in life expectancy achieved has been attributed to improved health services. Of these 5 years, it has been estimated that curative services contributed about 3.5 and clinical preventive services about 1.5 years. The greatest share of this gain from health care can be attributed to diagnosis and treatment of coronary heart disease, which contributes 1 to 2 of these additional years of life.

Physical environment. The physical environment affects health and disease in diverse ways. Safe water and clean air, healthy workplaces, safe houses, communities and roads all contribute to good health. Examples also include exposure to toxic substances that produce lung disease or cancers; safety at work, which influences injury rates; poor housing conditions and overcrowding, which can increase the likelihood of violence, transmission of infectious diseases and mental health problems, and urban-rural differences in cancer rates. The presence of natural or man-made hazards is a source of environmental diseases, which might be seen as the visible and clinical indication of inadequate environmental conditions. Key areas of action could be outdoor and indoor air pollutants, noise, indoor environment and housing conditions, water quality contamination, radiation and chemical exposures. The impact of these factors are felt in association with hearing problems, sleeping disorders, stress leading to hypertension and other circulatory diseases, skin and other cancers, asthma, or birth defects.

Genetic endowment. Genetic factors are recognized as having a significant influence on health, and it will be important to gain a better understanding of these influences. Genetic determinants are important constitutive factors for individual health; however, they presently fall beyond the scope of public health interventions. The field of genetics will become in future years more and more important as nearly every disease has constitutive and/or acquired genetic components. The identification of disease-susceptibility genes as well as the identification of acquired somatic mutations underlying a specific disease, e.g., cancer, can provide a wealth of new information vital to a more thorough understanding of many common illnesses. Such information can be used to determine both how diseases are diagnosed and how new treatments or more specific drug targets can be identified. For the most part, genetic factors are currently understood as contributing to a greater or lesser risk for health outcomes, rather than determining them with certainty. Genetic factors also interact with social and environmental factors to influence health and disease. It will be important to understand these interactions to learn why certain individuals with similar environmental exposure develop diseases whereas others do not.

Travel/Migration. The present world is characterized by increasing mobility of populations and individuals. Modern means of transportation facilitate greatly the speed and diversity of this mobility. International travellers now number nearly one billion persons per year. The vast majority travel for short periods of time for recreational or professional reasons. But there are some international migrants - approximately 150 million in the world – who travel primarily on a one way ticket, usually from poor to rich countries, their conditions of travel and living conditions in their new country may be difficulties with restricted access to medical services. And some (refugees) are forced to leave their country for reasons of insecurity and war. Those travellers and migrants will facilitate the transmitting the epidemic of the emergency and re-emergency diseases such as SARS Avian Flu, HIV/AIDS, TB...

Lack of access to safe water leads to 8 million deaths every year, as a result of water-borne diseases (cholera, typhoid, diarrhoea), half of them children. Currently, 1.4 billion people do not have access to safe drinking water and 2.6 billion, that is, 42% of the world's population, are not served by basic sanitation systems (sewage collection and treatment). The United Nations estimates that some 1.6 million lives could be saved each year if access to clean drinking water and to sanitation and hygiene services could be improved. Moreover, natural disasters are increasingly common and 90% of them are water-related. They are the result of improper land use. The case of Lake Chad in Africa is a striking example since it has lost nearly 90% of its surface area since the 1960s, mainly because of overgrazing, deforestation and large unsustainable irrigation projects.

Much of the same prospect - reflecting fast growing consumption in relation to expanding populations and environmentally adverse technology - applies to other strategic resource stocks such as topsoil, forests, grasslands, fisheries, biodiversity, climate and the atmosphere.

Environmental consequences of development. Development under the best of circumstances has some adverse effects on health by affecting the environment on one hand and life style on the other. These are further exacerbated when socio-political compulsions demand rapid economic 'development - development at all cost' - unmindful of their socio-cultural, administrative milieu - as happens in many developing countries. The inescapable, though commonly recognized fact is that the introduction of new technologies, necessary for development brings with it irreversible social, ecological and health consequences, which under certain circumstances can be harmful. A proliferation of water bodies for irrigation purposes increases the number of breeding sites for disease vectors such as mosquitoes resulting in resurgent malaria, dengue and Japanese encephalitis. Deforestation and soil erosion expand the habitat of sand flies, which transmit leishmaniasis. Increasing use of pesticides for purposes of agricultural production is estimated to be responsible for more than 2 million cases of human poisoning every year with a resultant of 20,000 deaths.

Some signals of threat to sustainability of our ecosystem are: global warming, enlarging ozone hole, acid rain, increasing loss of forests and biodiversity, diminishing availability of cultivable land, environmental pollution of air, water and land, threatened water resources, perceptible reduction in global food reserves, progressive depletion of non-renewable sources of energy, large scale population migrations - within a country (rural-urban) and across national boundaries - in search of sustenance, growing menace of urban slums, unacceptable levels of unemployment in most countries of the world, increasing inequities of wealth distribution between 'the haves' and 'the have nots' nationally and internationally resulting in social strife, criminality and wars.