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Right to Health, Biopower and Bioethics

Direito à Saúde, Biopoder e Bioética

Derecho a la Salud, Biopoder y Bioética

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ABSTRACT
The right to health is being more and more affected by the Biopower new configurations, no more only determined by the State, as in Foucault's analyses, but mainly by the symbolic power of the market. The biotechnological enterprises stir up increasing claims for consuming in health. These products are techno-semiotic agencies of the subjectivity in health, rendering their use as a right. In this situation it is important to return to the Right to Health comprehension of the International Conventions and the Alma-Ata Conference, proving the interdependence between Human Rights in general and the Right to Health in particular, mainly aiming at the social determinants of health that define more basic rights. The Human Rights perspective permits the proposal of a public health bioethics, different from the clinical bioethics, more appropriate for considering the collective implications of the right to Health, not reduced to a mere consumption of technologies.
Key-words: Human Rights. Right to Health. Technologies. Biopower. Bioethics.

RESUMO
O direito à saúde está sempre mais afetado pelas novas configurações do biopoder, cujas intervenções não são mais determinadas unicamente pelo Estado como aparece nas análises de Foucault, mas principalmente pelo poder simbólico do mercado. As empresas biotecnológicas suscitam crescentes demandas de consumo em saúde. Estes produtos são agenciadores tecno-semiológicos da subjetividade em saúde, tornando seu consumo objeto de um direito. Nesta situação é importante voltar à compreensão do direito à saúde presente nas convenções internacionais e na conferência de Alma-Ata, mostrando a interdependência entre os direitos humanos em geral e o direito à saúde em particular e, principalmente, apontando para os determinantes sociais da saúde que definem direitos mais básicos. A perspectiva dos direitos humanos permite propor uma bioética da saúde pública, diferente da bioética

clínica, mais adequada para pensar as implicações coletivas do direito à saúde, não reduzido a um mero consumo de tecnologias.
Palavras-chave: Direitos Humanos. Direito à Saúde. Tecnologias. Biopoder. Bioética.

RESUMEN
El derecho a la salud está siempre más afectado por nuevas configuraciones del biopoder, ya no determinadas solamente por el Estado, como aparece en Foucault, sino principalmente por el poder simbólico del mercado. Las empresas biotecnológicas suscitan crecientes demandas consumistas en salud. Estos productos son agencieros técnico-semiológicos de subjetividad en salud, haciendo su consumo objeto de derecho. En esta situación es importante volver a la comprensión del derecho a la salud de las convenciones internacionales y de la conferencia de Alma-Ata, mostrando la interdependencia entre los derechos humanos en general y el derecho a la salud en particular, señalando los determinantes sociales de la salud que definen los derechos más básicos. La perspectiva de los derechos humanos permite proponer una bioética de la salud pública, diversa de la bioética clínica, más adecuada para pensar las implicaciones colectivas del derecho a la salud, no reducido a un mero consumo de tecnologías.
Palabras-llave: Derechos Humanos. Derecho a la salud. Tecnologías. Biopoder. Bioética.

INTRODUCTION

The right to health was one of the greatest achievements of the Brazilian social movement for democratization. It was legally recognized in the citizen constitution of 1988 and used as legal basis for the beginning and further development of the Brazilian Unified Health System (SUS). The view that guided the discussions on this right was grounded on social health determinants resultant from the fight of movements which proposed a new understanding and organization of health. In academia, this fight was expressed by the constitution of collective health as a scientific field and by the creation of ABRASCO (the Brazilian Association of Collective Health).

However, the right to health did not include only the basic social conditions for good health, but it also involved equal access to different necessary resources (financial, technological and human resources) for health recovering and better quality of life. Since resources are scarce and for distribution to be based on equal premises, it was necessary to create public policies that would favor access to vulnerable groups and the discussion in health councils about the criteria of justice to access to these resources.

The growing technification of medicine with last generation equipment, tests and drugs, together with the ideology of perfect health and the consequent cultural trend of identifying health with the consumption of products that "sell health", have caused a gradual increase in expenses resultant from this tendency that the public budget will not be able to cope with. Which implications does this ideological conception have to the right to health?

This discussion is important because large biotechnology multinational companies sell these products through a symbolic *marketing* which produces the subjectivity of health users by showing the consumption of those products as a necessity and claiming that having access to them is a legally required right. For this reason, it is essential to be aware of the growing biopower of biotechnology companies that stimulate biopolicies which identify the right to health simply with the right to consume products that "sell" health. The fact that points to this influence is reported by several professionals in basic health units who, on Monday morning, face a demand of users asking for tests and drugs with miraculous effects presented on the Sunday night Brazilian TV show called "Fantástico", broadcasted by Globo TV.

This article aims to discuss the understanding and scope of the right to health not on a legal basis but from a bioethical perspective. It proposes a hermeneutic reflection on deep implied ethic issues. In order to do so, firstly, it is necessary to understand the right to health in international conventions of human rights and its meaning in the Brazilian constitution. We need to do so in order to be able to make explicit new forms of biopower and their respective biopolicies so that, finally, and bearing these principles in mind, reflect upon the right to health from the bioethics point of view.

In order to do that, however, it is necessary to overcome the solely clinical and casuistic view of bioethics and propose a hermeneutical bioethics that considers health in a collective perspective, reflecting ethically upon the principles and main issues of sanitary problems. Deeply reflecting on the right to health may be an exercise and an example on how to build up a public health bioethics.

Right to Health in International Conventions.

No human right is understood by itself without being related to others. Indivisibility and interdependence of human rights are based on three basic values that constitute the core of its doctrine: "liberty, equality and participation". They remind the motto of the French Revolution: "liberty, equality and fraternity". The third element of the motto has not been included because it is more a moral attitude than a legal claim. It was, therefore, replaced by participation.

Those three values should not be split, but considered in its mutual correlation. Thus, each of the human rights should be explained regarding the three values, even if it might be closer to one of them. This principle should work as a hermeneutical rule to understand these rights (Huber, 1979).

Interdependence of different human rights is clearly seen when we consider the right to health. This is evident in article 25 of "the Universal Declaration of Human Rights" of 1948.

> 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 the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control (United Nations, 1948).

Health is defined as quality of life that depends on different socioeconomic factors. Article 12 of the "International Covenant on Economic, Social and Cultural Rights" states that "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"(United Nations, 1976) and when it defines the necessary measures to reach this aim, it points out the social determinants of health.

The "Declaration of Alma-Ata" from the International Conference on Primary Health in 1978 defines health as

> a state of complete physical, mental and social wellbeing, and not merely the absence of disease or infirmity, it 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.
>
> (WHO, 1978).

This declaration goes beyond the reductive view of health as purely biological determinants, comprising mental and social conditions. Consequently, it emphasizes the importance and priority of primary health care, including services of health promotion, prevention, cure and rehabilitation.
Comments related to the convention of fundamental rights of a more social nature emphasize that health is an essential right to exercise other human rights because being able to enjoy the highest possible standard of health is a condition for a dignified life, the primary purpose of the proclamation of rights. On the other hand, the right to health depends on the realization of other human rights such as liberty, equality, privacy, non-discrimination, the right for food, housing, work, education, the right not to be tortured, to associate and get together with other people, to move freely, since all those rights are comprehensive components of health. Thus, as health is a condition for enjoying a dignified life, preciput aim of the set of human rights, so is the satisfaction of other rights to have a healthy life, as they are indispensable components of a comprehensive view of health itself (Vanderplat, 2004).
The right to health comprises elements of justice and autonomy. In this sense, it involves several socioeconomic factors as justice conditions and determinants for a healthy life, also including the prerogatives of having access to a system of health protection with equal opportunities. On the other hand, the right to health includes elements of autonomy, comprising the freedom to administrate one's own health and sexuality free from interference and use of non-consented treatments (Vanderplaat, 2004).
Awareness of public health movements and international organizations related to the importance of applying human rights in health has increased in the new millennium. The "Committee on Economic, Social and Cultural Rights" established in its General Comment No. 14 of 2000 the scope and normative content of the right to health.

> It is important to point out that the Committee interpreted the right to health as an inclusive right, considering not only health care but also access to health resources, acceptance to cultural practices, quality of health services; and it also pointed out the social health determinants related to access to good quality and drinking water, appropriate sanitation, education and health information (Apud Nygren-Krug, 2004, p.15).

Right to health in the Brazilian Constitution
As most of the First World countries were starting a process of dismantling the state of social welfare, following the neoliberal doctrine, Brazil bet on a public health system based on universality and equity of access to the necessary resources for a comprehensive health care. This national option resulted from an agreement negotiated throughout the years with great political and social efficiency by the Brazilian Sanitarian Movement.
The 8th National Health Conference may be considered the most relevant event in the process of building the platform and strategies of the movement for democratization of health in Brazil. This social movement and political articulation resulted in the Constitution of 1988, where health is defined as a universal right and a duty of the State.
According to Schwartz (2001), as we analyze Article 196 of this constitutional text, it is possible to realize that the universal right to health includes both curative health, presented by the word "recovery"; preventive health, presented by expressions such as "reductions of disease risk" and "protection"; and quality of life, related to the term "promotion". Morais (2003) argues that the core of this concept is in quality of life, once it identifies health with elements of citizenship and life promotion.
In the perspective of the Declaration of Alma-Ata, health is always understood as quality of life. To Fagot-Largeault (2001), quality of life is a multidimensional concept, involving both individual

aspects, such as ways to enjoy a pleasant and happy life; and collective aspects, which comprise not only being able to enjoy economic goods, but also political, cultural and demographic issues.
This twofold dimension of life quality appears when we bear in mind the interdependence of the right to health with the rights explicit in two international agreements: some more related to individual rights, identified with political and civil rights and others more related to collective rights, identified with economic, social and cultural rights. Considering the interdependence and indivisibility of different rights, it is not possible to separate them and even less to oppose them in terms of efficiency and effectiveness since one requires the other in a continuity of legal logic. This continuity is evident when the double legal perspective present in both types of rights is considered. There are rights of defense, which limit the State power, safeguarding the liberty of individuals and imposing the duty of abstention to the State. On the other hand, there are rights of provision, which obliges the State to provide goods and services, which, at a first glance, seem to be only identified with social rights but also include the creation of rules and collective institutions that enable the implementation of both social and civil rights (Sarlet 2007; Figueiredo 2007).
The right to defense is more focused on the individual's freedom, while the right to provision is more focused on the demand to build instruments in the collective world as a condition to establish rights. Therefore, due to its interrelation with other rights, it is possible to state that the right to health also has the dimension of defense and provision. Health as quality of life identifies itself, above all, with the independence to decide to search for it, a right that should be guaranteed against the interference of the State, but, on the other hand, it comprises the provision, by the State, of collective goods and services that provide conditions and means to make it possible for one to have quality of life. Thus, the right to health needs to unite the protection of individual autonomy and collective provision of means to implement this right.
Universal possibility of access, integrated actions, decentralization of services, public relevance of actions and services and the community's participation are the collective foundations of the Brazilian Unified Health System to establish the right to provision of goods and services that materialize health as a universal right and a duty of the State.
The Brazilian Unified Health System follows the spirit of the International Conference of Alma-Ata, which emphasized the priority of primary care as a universal right, enabling universal access to basic necessary actions for a comprehensive health care. It also stressed the proximity, participation and public relevance of services that provide these actions. The Brazilian Unified Health System (SUS), however, has not been restricted to these primary cares. It has organized universal and comprehensive access to procedures and to medium and high complexity technology. In these cases, in many situations, the public health system makes use of complementary provision of health services from the private system. The introduction of the concept of biopower is necessary in order to understand the logic and implications of this relationship.

Biopower and Right to Health.
The exercise of the right to health has always been more related to structures of biopower. This concept was developed by Foucault (1979).
If, in the past, the State had the power over life and death of individuals, killing or letting live by the power of war and death punishment, from the XVII on, the political power has taken over the task of managing life through the discipline of bodies and regulatory controls of populations. These are the two axes on which the organization of power over life was developed: the anatomo-political discipline of individual bodies and the biopolitical management of populations. The emergence of social medicine and the consequent concern of the State with public health have responded to that goal. Thus, the function of power is no longer to kill, but to invest in life. The power of death is replaced by the administration of bodies and the calculating management of life. To Foucault, the organization of biopower was needed for the development of capitalism because, on one hand, it was necessary to

include the disciplined bodies of workers in the production unit and, on the other hand, it was also necessary to regulate and adjust the population phenomenon to economic processes (Foucault, 2001, 1979).

The Italian philosopher Giorgio Agamben (2004) revisits the theme of biopower explaining new facets of legal and political nature. What makes biopolitics possible is the restriction of life to its precarity and vulnerability or the reduction of the human being to its bare life. In order to understand this phenomenon, Agamben bases himself on the Greek distinction of the two meanings of life: "bios", identified with the public sense of moral and political life, which differentiates human life from animal life; and "zoe", physical or natural life in a private sense, which places human beings and animals in the same level. In modern times, moral and political *bios* has always been more reduced to the sense of private awareness and the natural *zoe* has become part of public realization of power. The concept of life in its bare physical sense, included in the management of biopolicies, was complete new in relation to the ancient world. This reduction of life to its natural precarity creates the conditions to include it in the management of power. That makes it possible to establish a legal system of exception, through which, law, created to protect the individual, is continuously broken because the subject, restricted to their bare physical life, is deprived from protection is at mercy of biopower.

Hardt e Negri (2002), in their analysis of the Empire, insist on the productive dimension of biopower, since the realization of imperial power takes place in a biopolitical context. The subject is built within a biopolitical process of social construction. Not only is there a control over life but the biopolitical context itself in which life is developed is constituted by the imperial system. The ontology of this production has changed substantially in the new world order because it does not relate to a State control anymore. Nowadays the great industrial and financial corporations do not produce products only but also subjectivities. They produce agented subjectivities within a biopolitical context, creating needs, social relationships, bodies and minds; in other words, they produce the system's creators. The media plays a major role in this production of subjectivity, as it legitimates the imperial system. As a result of this integrating process, the Empire and its biopower system tend to make economic and political constitution coincide.

What are manifestations and incidences of biopower in health nowadays? Proliferation of always more sophisticated medical technologies of diagnosis and clinical therapy and future possibilities open to genomic medicine through genetic treatments create and feed the utopia of perfect health, which has been gradually transformed into a consumption ideology. The belief that one day it will be possible to eliminate all kinds of diseases through genetic intervention is part of this utopia (Sfez, 1996).

Health, in late modern times, has become more than cultivated; it has become a cultural mania of collective health called by Nogueira (2001, p.64) "hygiomania" (from "hygies", in Greek: sound, healthy, robust). The great objective of "hygiomania" is to separate the concept of health from any possible association to disease, death and old aging. Its narcissism does not allow it to face these contingencies of human life. "Hygiomania" is more an expression of the modern "hubris" in the intention of creating immortal human beings. Nogueira (2001, p.71) questions "immortal? What for? Maybe to remain consuming forever and ever".

The realization of this utopia takes place through the consumption of technologies that offer health. In other words, health is turned into a product to be consumed. This consumerist dynamic has already been well explained taking into account the medical- industrial complex of production of medicines (Cordeiro, 1985).

Nowadays, this dynamic is much more complex because the offer of technologies which promise health are symbolically much more remarkable and sophisticated. That is what Teixeira (2001) calls techno-semiotic assemblage of subjectivity production. It is not just the case of consuming a product that sells health, but, rather, of producing a new subject in health. The idea of techno-semiotic assemblage points to the position of agent taken by the subject in the collective processes of production of subjectivity, in which he/she is not faced as external, inert in this relationship.

Biotechnologies create demands in health that produce subjectivity. When the author qualifies these assemblage processes by making a semantic fusion of techniques and signs, he states that these processes take place in a techno-semiotic context. This context determines the collective processes of cultural production of subjectivity. “What we effectively place in the world as technical objects are not merely material technologies, but large composed and complex systems, which are indistinct and inseparable from techniques and signs.” (Teixeira, 2001, p.56).

The biotechnological offers in health create techno-semiotic complex and strong systems that are the cultural contexts which assemble new sanitary subjectivity with new demands in health, obliging us to rethink the right to health itself. This symbolic investment in techniques to provide health provides a new configuration to biopower because it enables the emergence of a techno-semiotic assemblage power of demands to those who have biotechnologies, due to the connection between techniques and signs that provide the product “health” with symbolic efficiency.

If, in the past, biopower was manifested by the calculating management of the State of biological life of bodies and populations; nowadays, it is shown as a symbolic assemblage process of techniques to provide health from the biotechnological industry. In both cases, the control of biopower is present. The former shows a more direct biological perspective while the latter has a more subtle, consumerist and symbolic nature.

This new configuration of biopower makes the right to health to be understood as simple access and consumption of technologies, disregarding the social determinants of health as a right of the individuals and a duty of the State. This perspective makes it possible to understand, in other ways, the problem of universalism and targeting, so widely discussed at the beginning of the implementation of the Brazilian Unified Health System (SUS). Targeting in services was a way to achieve universal access; it was not a contradictory, but a complimentary dyad. However, due to biopower, universalism and targeting may have been distorted by techno-semiotic assemblage processes, responding only to private demands of consumption of technologies.

Based on this fact, Cohen (2005) argues that health should be considered from the perspective of poverty, relativizing the emphasis on demands of consumption and introducing the dyad of exclusion and inclusion as more appropriate than universalism and targeting. The lack of access to health is determined in the poorest population by the lack of realization of economic, social and cultural rights as indispensable conditions to exercise the right to health. Therefore, one could question whether policies of social inclusion could not help more health universalism and integration than only policies of targeting on demands of consumption of health products and technologies.

The force of techno-semiotic biopower is deeply expressed when the logic of the market (responding to growing individual demands in health) is introduced in a public system like SUS, showing that the simple denomination of a service as governmental does not guarantee that it will have public relevance (Bahia 2005; Heiman, Ibanhes, Barboza 2005).

Insisting on the concept of right to health as pure consumption of medicines and sophisticated technologies is interesting for the private health system, and that burdens the public health system, required, in many cases, to pay for services by court order. The comprehensive conception of health that bases the SUS is, then, distorted, because health is gradually reduced to its curative aspect, and aspects such as prevention, education and promotion of health are relativized. The current logic of biopower empties subtly, and little by little, the perspective of sanitary inclusion which was the final objective of the democratization of health. Thus, it is necessary to go back and insist on the social and cultural determinants of health and fight for policies of inclusion from the perspective of economic, social and cultural rights as basis for the realization of the right to health.

The discourse of Right to Health in Bioethics.

Clinical and public health differ because the first is essentially worried about diagnosing and treating individuals while the second focuses on public policies in favor of the health of populations. Public

health is concentrated on the epidemiological profile of populations while clinical health focuses on biophysical and psychological analysis of individuals. Professional competences required in these different areas are diverse, and require a diversity of ethical points of views. This distinction has its implications for ethics in health, showing the importance of a public health bioethics together with the traditional clinical or hospital ethics.

Although the public health had its origin in a social movement focused on the collective, several public health programs take for granted that individuals have complete control over their behaviors. According to this notion, individuals should be provided with information on risks for different morbidities and expected to follow this sanitary advice. However, if public health concentrates on populations, it deals with the collective and sociocultural context has an essential influence on the behavior of individuals, determining the health profile of that group. Therefore, public health policies need to focus more on sociocultural conditioning that determines the collective health profile rather than on the individuals' behavior. From this point of view, it is acceptable, in certain cases, that individual interests are sacrificed for collective well being (Fortes, Zoboli, 2003).

In general, public health policies do not work due to three basic elements: the determinant concrete social factor of that community has not been identified; the common factor that overpasses different health problems in that context has not been pointed out or named; and there is no consensus on the direction of the necessary social transformation to change the sanitary conditions of that population (Mann, 1999).

Thus, it is not possible to use the moral language of clinical medicine to reflect upon public health ethical challenges. The principles of clinical bioethics – autonomy, beneficence and justice – have been thought to face problems in relationships among individuals and cannot be transferred to the public context of health because their collective and social peculiarities will be lost. The discourse of public health ethics should be based on collective and social values.

Therefore, Mann (1999) e Gruskin e Tarantola (1999) suggest that the modern human rights should work as a basis to organize the ethical discourse of the public health, as, since the beginning, they have pointed to social conditioning of human well being and because, nowadays, there is more awareness of interdisciplinary relationship among the right to health and other individual and social rights.

Mann and others (1994) demonstrate the consistency of proposing that public health ethics should be based on human rights by pointing out three inter-relationships between health and human rights:

> The positive or negative impact of public health policies, programs and practices on the improvement of human rights - because sanitary actions of the public power enable social conditions and citizenship awareness to fight for rights.
>
> Violations of human rights have direct impacts on the health of populations and individuals - because it denies them basic sanitary conditions and, through discrimination, halt access to necessary health goods and services.
>
> The proposal that the promotion and protection of human rights are closely interrelated to challenges to promote and protect health comes from the recognition that the health perspective and human rights are complementary and converge to the definition and growth of life quality or human well being of the populations. If health is the complete physical, mental and social well being, then human rights are integrating parts of health.

In Latin America, Schramm and Kottow (2001) present a coherent public health bioethics proposal as ethics of protection, understood as "the attitude of providing rescue or meeting essential needs, those which must be satisfied for the affected person to be able to meet other necessities and interests" (2001, p.953). It is a matter of protecting social and economic human rights related to provision that do not focus so much on the individual but on the collective. Therefore, to these authors, public health bioethics needs to be understood and presented as a bioethics of protection.

For Latin American asymmetric and unequal societies, the political perspective of equality and isonomy, typical of rich countries in which citizens are aware and make use of their rights, cannot be valid. For them, the demand for rights is reduced to the defense of freedom and individual initiatives against the power of the State. Where these full awareness and enforcement of rights do not exist, people suffer from specific social vulnerabilities also called susceptibilities from which the State has the duty to protect, ensuring provision rights. One of these social rights is the right to health. Public health is the political expression of this provision duty. Its sanitary measures aim, above all, to provide vulnerable groups with care and protection in order to prevent them from getting sick and to promote well being and quality of life (Schramm, 2006, 2005, 2003; Kottow, 2005).

Public health bioethics, understood as protection of social and economic provision rights, is based on Agamben's distinction between moral and political life ("bios") and bare life ("zoe"). When citizen participation is not assured in the first perspective, human beings in that society are reduced to their condition of bare life, excluded from human rights of the political community, fully susceptible to risks, unprotected and subject to be eliminated. In that situation, the State must protect the ones who are reduced to the vulnerability of bare life (Schramm, 2006, 2005).

Kottow (2005, p.40) discusses the distinction between ethics for preventive health protection and ethics of protection aimed to meet needs of medical care, or between public health of a universal nature and targeted medical attention, a conflict which has not been conceptually solved. Only the social practice inspired on justice is universal, although it may be applied to specific needs of people susceptible to social risks, i.e., targeted on social actions that favor the neediest citizens. Protection tries to join the universality of justice with actions targeted at those who are excluded and suffer from situations of injustice. The recognition of the social structure of inequality in Latin America brings the bioethics of protection,

> concerned with a "res publica" and its relationship with a community composed by majorities who suffer from restrictions that range from reduced freedom to deprivation, lack of empowerment and predispositions to ailments due to increased susceptibility (Kottow, 2005, p. 43).

Garrafa has a similar proposal that distinguishes a bioethics of emerging situations which comprises health ethical issues resultant from the fast technological development that affects mainly the countries of the first world. The other is a bioethics of persisting situations that discusses problems of discrimination and social exclusion which keep affecting the life and health of millions of people in peripheral countries of the third world. In this context, bioethics cannot keep discussing technological news that reach the minority of the population, it needs to consider the suffering of majorities as its object of reflection and action, using human rights as reference and implementing a bioethics of intervention (Garrafa, Porto, 2003).

The focus of the bioethics of protection or intervention, grounded on human rights, appears in the "Universal Declaration of Bioethics and Human Rights" (Unesco, 2005). Article 14 comprises specifically the matter of "Social responsibility and Health" stating that "the promotion of health and social development for their people is a central purpose of governments that all sectors of society share". On the other hand, "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", the right to health should be enhanced to include access to high quality primary care and essential medicines, access to appropriate nutrition and drinking water, improvement of life conditions and environment, elimination of marginalization and exclusion, and reduction of poverty and illiteracy.

When the bioethics of public health establishes the protection of human rights as reference for its ethical reflection, it is in better conditions to think and measure the scope and implications of the right

to health as it understands it as inseparable and interdependent of other rights. Thus, it may propose a hermeneutical criticism of symbolic conditionings and possible ideological distortions that the right to health may suffer in the current sociocultural context of construction of subjectivity in health.

Conclusion

If we consider the biopower resultant from a semiotic assemblage based on new biotechnologies that sell sophisticated products and procedures that promise health, it is necessary to rethink the meaning and scope of the right to health. There is a tendency to reduce it to the individual interpretation of defensive rights against the State. Deep inside there is the idea that the State is abridging freedom of access to consumption of products that sell health as it does not provide them.

Thus, the right to health has been included within political and civil rights. However, it is, instead, a social right; being, then, primarily part of the provision rights, and demanding a collective reply and structure to be enforced. In this sense, it cannot be protected without being interdependent and inseparable from other rights, mainly the social ones.

The consumerist ideology aims to reduce the right to health to the clinical relationship between doctor and customer, when it is, first of all, a public health issue because it is interdependent of social rights. Therefore, the bioethics of public health, grounded on the ethics of protection of social provision rights, rather than on the classic principles of clinical bioethics, can reflect more effectively the scope and implications of the right to health.

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