Beyond Helsinki: a vision for global health ethics

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continuity of treatment, then the totality of evidence strongly indicates no difference between specific counselling or drugs. Giving patients with major depression their choice of treatment and then assuring adequate intensity of treatment and follow up represent high quality care.

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Beyond Helsinki: a vision for global health ethics
Improving ethical behaviour depends on strengthening capacity

The fifth revision of the 1964 Declaration of Helsinki, published in October 2000, sets out international standards for conducting medical research with human subjects.1 Revisions of this or any other research ethics code are unlikely to make research more ethical throughout the world, however, without some means of strengthening capacity to promote and implement such standards.

Strengthened capacity in research ethics is needed in both developed and developing countries, though the need is particularly acute in developing countries. A recent Washington Post investigation into research in developing countries revealed “a booming, poorly regulated testing system that is dominated by private interests and that far too often betrays its promises to patients and consumers.”

Research in developing countries was a flash point of the fifth revision of Helsinki because the declaration retains the requirement that new treatments should be tested against the “best current” treatment. Critics argue that this standard does not allow the testing of low cost, sustainable treatments, such as aspirin for coronary artery disease, which might yield substantial health improvements in developing countries but are inferior to the best current treatment in developed countries. Bloom has argued convincingly that global health would be better served by adopting a standard of the “highest attainable,”1 and we have offered an expanded concept of the standard of care in research, advocating that visiting researchers need a deeper understanding of the social, economic, and political context of trials in developing countries.

But even another revision of Helsinki that incorporated these recommendations would not, in isolation, improve the ethics of research in developing countries. Rather, people are the key—to apply international codes to local circumstances, develop and enforce national codes, staff research ethics boards, and implement research ethics processes.

The Fogarty International Center of the US National Institutes of Health is spearheading the movement to strengthen capacity in research ethics by committing $5.6m (£3.7m) over four years to train faculty from developing countries in bioethics. These North-South partnerships will be further strengthened by South-South regional networks (such as the Forum for Ethical Review Committees in Asia and the Western Pacific) and global networks, such as the Global Forum for Bioethics in Research, which brings together researchers in developing countries and organisations that support clinical research.

The crucial step, yet to be taken, is to strengthen ethics centres and training programmes in developing countries. Direct support by international donors will be essential, at least initially. A model is the International Clinical Epidemiology Network (INCLEN), a programme initially supported by the Rockefeller Foundation that created a network of clinical epidemiology units around the world; we are proposing an INCLEN for ethics. With 30 training centres each producing 12 trainees a year, for example, 3600 people would be trained over 10 years to chair research ethics boards and teach research ethics to investigators, research ethics board members, students, and policy makers. The total cost would be about $100m.

Important questions remain about how to sustain this vision; the career paths of the trainees; selecting the centres; how communities, non-governmental organisations, and international organisations could be involved; and how to evaluate the effort. Moreover, how would this effort integrate with a broader vision of public health, and the process of strengthening national health—and health research—systems?
Any effort to strengthen capacity must recognise the current context of global health: 87% of the $2 trillion spent on health care globally is spent on 16% of the world's population; 10% of the global burden of disease attracts 90% of global expenditure on health research. Over the past 20 years the structural adjustment programmes of the World Bank undermined health systems and public health. Recent attempts by the World Trade Organization to "outlaw the use of cross subsidisation, universal risk pooling, solidarity, and public accountability in the design, funding, and delivery of public services" may further undermine health care in many countries. As J K Galbraith warned many years ago, it is time for privileged people to move beyond self satisfied complacency.

The creation of a global alliance for health ethics by the international donor community to pursue the vision outlined here could be tapped to influence the policies of international organisations. Its trainees would be opinion leaders to whom others turn for advice. They could form a global network of ethics opinion leaders which could help shape policy directions for the World Bank, World Trade Organization, and other international organisations, and thereby help to ameliorate the maldistribution of expenditure on health and health research.

If this vision of capacity strengthening proved effective in research ethics the model could be extended to other issues in global health ethics such as genomics and biotechnology, priority setting in health systems, women's health, end of life care, and others, as well as to sectors other than health.

By 2010 strengthened ethics capacity would advance the cause of ethical research in the world far more than even another revision of the Helsinki Declaration. Ultimately, strengthening ethics capacity will facilitate health research and help redress one of the greatest ethical challenges in the world—the unconscionable inequities in global health.

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Prescribing warmer, healthier homes

British policy to improve homes should help both health and the environment

Few people choose to live in cold damp homes that they cannot afford to heat well enough to protect their health. Yet for millions of British households this is the reality of poor quality housing, inefficient heating systems, and inadequate building insulation standards stretching back over generations. Last month, however, the British government launched a 10 year strategy to end fuel poverty in vulnerable households.

This encourages doctors and others to "prescribe" a warmer home for patients receiving benefits.

Over four million British households suffer fuel poverty, defined as needing to spend over 10% of their income on energy to maintain an adequate standard of warmth. Millions more are close to it. In high cost areas, such as Devon and Cornwall, the problem is aggravated by the further 10% of state pension income required for water and sewerage charges. Comparative studies show that British and Irish housing standards are worse than those in other comparable European countries. The only sustainable solution is through massive improvement in housing generally, and heating and insulation in particular.

The government's strategy to end fuel poverty in vulnerable households by 2010 is an important step towards improving housing quality and also achieving the targets on reducing energy consumption set at the Kyoto summit on the environment. Improvements in energy efficiency have taken place in social housing in recent years, but the new target is to bring 400 000 additional households in England up to reasonable standards by 2004. In the private and private rented sector action is also underway through the new "warm front scheme," which aims to provide grants to remove 800 000 English households receiving benefits from fuel poverty by 2004. Identifying vulnerable people in cold damp houses is where doctors and other healthcare professionals can help: anyone in a household receiving a wide variety of social security benefits can refer themselves or, with consent, be referred by a doctor or nurse to the warm front team. The team will organise a survey to identify the insulation improvements necessary, which will then be carried out by approved contractors. For many people aged over 60 central heating may also be provided, funded by grants of up to £2000 per household. The arrangements vary slightly in Scotland, Wales, and Northern Ireland, and there are also local authority budgets.