Global Health: thinking responsibilities

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In this presentation I will start with a schematic illustration of the empirical situation and will then move to ethical and philosophical considerations in order to justify international obligations towards global health.

The 2010 Bulletin of the World Health Organization presents the following data: each year 8 million children die before they reach the age of 5, more than 300,000 women die in pregnancy and childbirth, and more than 4 million people die of AIDS, malaria or tuberculosis. By 2005, 80% of deaths from non communicable diseases were in developing countries.

Moreover, it is well known that one of these statistics describes the health of people living in the industrialized world, and the others relate to those living in developing countries: consider the life expectancy in most African countries or death because of preventable illnesses. What is undeniable is that we live in a world with persistent inequalities and discontent. And deprivation that happens so far from us is not as distant as perceived at first sight.

Within this picture there is no need to explain in detail the force of globalization. At this point it is a well known process. Regarding health and globalization, we should recognise that viruses do not respect borders (recall the panic and hysteria to the possibility of pandemics or unknown illnesses, such as SARS, bird flu coming from the East, and the swine flu that affected Mexico for a month and nearly halted the economy of that country). In this vein, the difficulty of maintaining strict borders and preventing diseases from crossing them is also acknowledged, because of continuous migration. Even the revolution in information technologies has an

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impact: it enables us to witness the emergence of transnational epistemic communities measuring and explaining health and disease. Therefore, presently, we are more aware than ever of the health problems of people from far away countries, which decades ago were unknown and distant. The transparency and availability of this information exhibits, in a quasi obscene way, an unacceptable world. A world that is willing to rescue banks and unhealthy wealthy financial systems and ignores the worst off – those people whose unlucky birth seals a never ending cycle of misery with almost no possibility of breaking it. This globalization process makes the world shrink and not only has an impact on health and our perception of it, but also can give rise to broader types of reactions such as social and political instability in many of these “forgotten” countries (health is just a piece of a complicated puzzle which is bigger and potentially dangerous).

This unfair and unequal picture of the world is a background we cannot deny. And it presses for some kind of solution. In order to address these inequalities and challenges we need to begin somewhere, and undoubtedly health seems to be a crucial place in which to start.

A first question to consider, therefore, is why health matters?

There are important arguments to support health as one of the relevant issues to work on. And access to good and appropriate health care as a way to foster it.

First we should acknowledge that nearly every valuable human activity is ultimately supported by health and undermined by illness. If we want to provide some ethical analysis it is undeniable that health has a strong impact on happiness or utility (a happy life is not guaranteed by good health nor ruled out by illness, yet there is a clear enough correlation to ground a utilitarian commitment to pro-health policies). Secondly, from a liberal egalitarian perspective, health affects the use of liberties and shapes the range of valuable options a person is able to pursue. Illness is a barrier to education, employment and political engagement. So health also fosters equal opportunities. Moreover, access to health can be thought of as a human right. In many national constitutions it is recognized as such. But even if we don’t want to go so far, we can think of health as a precondition for enjoyment of human rights. It is vital. Finally, leaving aside ethical arguments, the importance of good health can even be endorsed from economic considerations, because no society can prosper without a healthy workforce.3

Hence there are multiple general arguments to support the importance of health. Yet, even if we acknowledge the vital importance of health, a second issue to explore is how to think about responsibility in this field? And not only this, but how can we understand ethics and responsibility for global health? What ethical framework can help us in this? A cosmopolitan egalitarianism, where we think of ourselves as citizens of the world? Will utilitarianism do it? Is Pogge´s political model the best one? What about a humanitarian model? Or the more formal human rights perspective?

In order to explore the moral foundations of a global health ethics, let me outline some basic proposals.

From an egalitarian utilitarianism, Peter Singer was one of the first philosophers to point out the shame of global poverty and our obligations towards the poor. In 1972 he wrote a remarkable article “Famine, affluence and morality” which challenged the established ethics based on beneficence as the moral value justifying helping the so-called distant and absolute poor. Singer refused the rationale of helping the needy as a mere act of charity, an imperfect duty, depending on our good will and feelings. In this and other writings Singer asks if we have an obligation to help those whose lives are in danger; for example, those who may suffer a premature and preventable death. For him, sentience is the key characteristic relevant to moral standing. Thus suffering has a negative moral value. He provides a principle4: “If it is within our power to prevent something very bad from happening, without thereby sacrificing anything of comparable moral significance, we ought, morally, to do it”.5 Helping is not charity, a supererogatory act, praiseworthy if one does it, but not unfair or unjust to omit. It is something one has an obligation to do. Thus Singer moves out from mere beneficence to argue for an obligation to help. He suggests it is like a bystander that sees a child drowning in a shallow pond and has an obligation to rescue the child.

An even stronger argument is the one provided by Thomas Pogge from a cosmopolitan perspective. It is based on compensatory health-related moral obligations due to harm and the need to compensate those wronged. For Pogge we are not “innocent” bystanders (as Singer´s example suggests). We benefit from massive grievous wrongs done in the past – from slavery to colonization – as well as from the current economic order. 6 One of his arguments is that the life of the

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4 This is the strong version which will mean to reduce ourselves to the level of marginal utility. The moderate version, instead, implies giving away enough.

5 Singer, P “Affluence, famine and morality” in Lafolette p 586.

world’s rich and poor are inextricably linked because of harmful state-to-state actions. Currently existing transnational institutions secure high standards of living for the affluent and reinforce the deprivation of many of the global poor. Therefore compensatory justice implies there are moral obligations beyond borders. For Pogge, poor condition of health are caused directly or indirectly by the actions of powerful global actors. The strong concept involved is the one of harm and this implies we have a responsibility for such harms. Contrary positions\(^7\) criticize Pogge’s reasoning, arguing that it is impossible to quantify the actual harm done by the world economic order. Or disapprove of how to respond when health needs occur as a result of forces unrelated to the global world order. Let us think of a Tsunami or even terrible economic mismanagement.\(^8\) Even if we can recognize problems and criticisms, undoubtedly Pogge presents new arguments for a forceful commitment to the global poor.

In the bioethics field, the humanitarian model presented by Christopher Lowry and Udo Shucklenk follows Singer’s path. It is based on the idea that all human beings are fundamentally the same in terms of moral status. They argue that affluent global citizens’ moral obligations to assist less fortunate ones follow from the desirability of reducing disease and suffering in the world. Although they criticize Pogge’s proposal, they propose to supplement it with their “humanitarian reasoning”\(^9\) and point out that there is not much practical disagreement about assigning responsibility at the policy level.

In the same vein, even Buchanan and Decamp, from a more restrictive vision, focus on responsibilities for ameliorating the most serious health problems of the world’s worst off people. They claim: “This commitment can be seen as the focus of an “overlapping consensus” among quite disparate views of justice ranging from strict egalitarianism to an extreme prioritarianism according to which only the well being or resources of the worst off count from the perspective of distributive justice”.\(^10\) They point out that this strategy allows us to make progress on the problem of concrete responsibilities without having to determine which of a number of competing conceptions of justice is correct.

\(^7\) For example, M. Risse. See Lowry C and Shucklenk U., op.cit. p10.
\(^8\) Lowry C and Shucklenk U., op.cit. p10.
\(^9\) They base their priority assessment in terms of efficiency rather than need, while they point Pogge’s account is mainly based on responsibility. Lowry C and Shucklenk U., op.cit. p13-18.
The previous may be a too optimistic an evaluation. There might be some libertarian positions, following Robert Nozick’s path, who think the state should give minimal services, thus avoiding health care provision and even less global health assistance of any kind. Such views may not enter the overlapping consensus suggested by Buchanan and Decamp. However, there is no need for such a stringent requirement. As noticed above we can see a broad consensus on the importance of global health from different ethical approaches. Moreover, another strategy is to provide cumulative reasons pointing to the wealthy developed countries and their reasons to do more to improve global health.\textsuperscript{11} Hence, on the whole I agree with the idea that there is a broad ethical agreement – through different ethical approaches as well as through different ethical and prudential reasons or arguments – about the need to ameliorate the most serious health problems of the world’s worst off people.

However, even if we have arrived at a basic consensus, we have not finished yet. A third relevant issue to analyze is who are the responsible agents: individuals or collectives? State or non-state actors? Others?

We have just seen that philosophers such as Singer target \textit{individual responsibility}: each of us has a moral obligation. In Singer’s terms, we ought to exercise our duty to assist the needy. Currently, this is quite easy. The world has changed and, nowadays, through the internet for example, we can help and be connected to distant persons. And it is also true that, if each of us were more committed, there would be more possibilities and help available. This would mean a wider exercise of values such as solidarity through our moral obligations. Moreover, if the suffering of others, even distant and unknown others, truly mattered to us and we feel a moral obligation to help, we will probably enjoy a better and fairer world. Civil society and each of us as individuals are fundamental actors in a profound change. However, even if individual help may be needed and desirable, “general” and harmonized policies performed by collectives may fit better for sustainable global changes in health.\textsuperscript{12} And it is there we should look for other responsible actors.

Before following this strategy, we should also acknowledge that responsibility, as a moral concept, is typically attributed to individuals. We speak of the causal responsibility of moral agents for harm in the world, and we blame them for causing


\textsuperscript{12} In this sense we can adapt Buchanan’s argument for the need of enforcement of a decent minimum health. He starts from individual beneficence and moves to enforcement in order to ensure appropriate coordination and the incentive to cooperate. See Buchanan, A “The right of a decent minimum of health care”, \textit{Philosophy and Public Affairs}, vol 13, N 1 (winter 1984), pp 55-78.
harm.$^{13}$ Nonetheless, it is also true that in practice we blame groups, and we have emotional reactions to groups such as anger, resentment or moral indignation. Therefore, it can be argued that even if, in a strict sense, responsibility is attributed to individual persons, in a subsidiary sense we can also operate with the notion of collective responsibility as an intellectual construct.

Philosophical positions such as the one of Thomas Pogge could be applied to such entities. For him, not only citizens from the rich countries – that is individuals – but also elites from scarce resource countries and global institutions – that is collectives – are morally responsible for the extreme condition of the global poor. This proposal also appeals to human rights, which is another interesting perspective.

Regarding the human rights framework, we can also find different interpretations of their obligations. However, Article 25 of the Universal Declaration of Human Rights, Article 12 of the International Covenant on Economic, Social and Cultural Rights, the Convention on the Rights of the Child and the Convention on Elimination of All Forms of Discrimination Against Women – among other human rights texts – all speak of the right to enjoyment of the highest attainable standard of physical and mental health. This includes medical care, treatment and control of epidemic and endemic diseases, besides other issues.

While the human rights framework discourse and documents have been mainly focused on the recipients, a relevant question to consider is: who should be responsible for providing them? In this area, there are also different analyses about the proper agents of justice. For example, we can find “traditional” interpretations holding responsible each national state regarding the access to health care of its citizens. Another very interesting interpretation is the one provided by Onora O’Neill. She argues for a plurality of agents of justice. Primary agents (generally the national states) may construct other agents or agencies with specific competencies, and they may assign powers or build institutions with certain powers and capacities to act. They typically have some means of coercion. Secondary agents are thought to contribute to justice mainly by meeting the demands of primary agents, most evidently by conforming to any legal requirements they establish.$^{14}$

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$^{13}$ It is based on the assumption that actions begin with intentions and moral blameworthiness requires the existence of intention.

$^{14}$ O’Neill, O, op.cit. p. 189.
Within this framework, which can be the responsible collective entities or agents of justice for global health?

Global health obligations are typically carried out by national states. States should care for their people. Access to health care might be developed through public hospitals and policies and they are the best suited to do so. For example, when Gostin et al. propose a Joint Learning Initiative on National and Global Responsibilities for Health, as one of their proposals they outline governments’ obligations to their inhabitants and define what are the essential health services and goods. They explain that the World Health Organization estimates an annual cost of US$40 per person to cover those essential health services. However, this might be too difficult to achieve for weak and poor states. In 2001 in Abuja, Nigeria, African heads of states pledged to devote at least 15% of their national budget to the health sector. Yet in 2007 the average spend per capita was US$34 with an average of 9.6% budget allocation. There are at least two interpretations of this situation. The first and more benevolent one can be found in O’Neill’s words: “Weak states may simply lack the resources, human, material, and organizational, to do very much to secure or improve justice within their boundaries. They may fail to represent the interests of their citizens adequately in international fora and may agree to damaging or unsupportable treaties or loans. They may lack the capabilities to end or prevent rebellions and forms of feudalism…” A less charitable interpretation suggests many of these states do not carry out the needed efforts and regrettably money is spent on corruption, wars or unwisely. However, even if we can condemn this, still we should distinguish the role and responsibility of these inefficient or corrupted governments and the fate of the people suffering them in order to avoid punishing them even more. States as primary agents of justice may fail. Thus, we should leave aside these reprehensible cases and find ways to avoid the bad consequences of these governments.

Hence, another issue to consider is the responsibility of other states as bearers of global health obligations. These states vary in their ability to provide aid without suffering unreasonably high costs to their own population’s quality of life and wellbeing. That is, global health obligations increase in proportion to the agent’s capacity to assist. The more resources they have, the larger funding commitments they can achieve. Therefore, European rich countries, for example, seem to have a

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16 O’Neill, op.cit, p.197.

17 This is also pointed by Lowry and Shuklenk, op.cit, p.8.
stronger duty to assist. In this sense, Gostin et al., in exploring the responsibilities of all governments towards the world’s poor, points out that high income countries have not come close to fulfilling their pledges made in 1970 to spend 0.7% of their gross national product per annum on Official Development Assistance. Four decades later their average contribution stands at 0.31%. From a human rights perspective, we can point to the United Nations Charter. It aims for international cooperation for the solution of economic, social, cultural or humanitarian international problems. Articles 55 and 56 explicitly establish international cooperation, among other duties to health, as “an obligation of all states”. In the same vein, we can hold responsible international, interstatal or intergovermental agencies or programs such as the World Health Organization and UNAIDS. They belong to the United Nations system and were created for this and similar purposes. The constitution of the World Health Organization, for example, as the coordinating authority on international public health, states as its objective “the attainment by all people of the highest possible level of health”.

Hence, we can easily hold responsible all states for the health of their people, rich states for international cooperation and interstate organizations such as the World Health Organization as part of its mission to global health. If we leave aside these accepted targets as agents of justice, what is really interesting in O’Neill’s approach is her strategy to hold responsible international non-governmental organizations and, specially, transnational or multinational companies or corporations. Regarding international non-governmental organizations, she argues that their typical mission is to contribute to specific transformations of states, governments and policies – quite often to a single issue or objective. Although international non-governmental organizations cannot themselves become primary agents of justice, they can contribute to justice in specific ways in specific domains.\(^{18}\)

But even more stimulating and interesting for us is O’Neill’s position towards transnational or multinational companies or corporations. In response to the question of how transnational or multinational corporations could be concerned with justice, except insofar as justice requires conformity to law, she argues that what matters is what transnational or multinational corporations or companies can or cannot do; the capabilities\(^{19}\) they can or cannot develop. She claims capabilities

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\(^{18}\) They may contribute to justice precisely because the states are too weak, they can act opportunistically and secure an unusual degree of access to some key players…(op.cit, p. 199).

\(^{19}\) She takes this concept from Amartya Sen. She will say agent’s capabilities are not to be identified with their individual capacities or with their aggregate power. An agent or agency, considered in the abstract, may have various capacities or abilities to act. Capabilities are, instead, the specific capabilities of agents and agencies in specific situations, rather than the abstract capacities or their aggregate power (ibid. 197)
are more important than motivations: “...It is more important to consider the capabilities, rather than the (supposed) motivations of transnational companies. Many transnational companies are evidently capable of throwing their considerable weight in the direction either of greater justice, or of the status quo, or of greater injustice”. “Corporate power can be used to support or strengthen reasonably just states. Equally, they can accept the status quo, fall in with local elites and with patterns of injustice, and keep powers to keep things as they are – or indeed to make them more unjust.”

Hence, within this framework even transnational corporations can help with the improvement of health; for example, developing better health habits within their employees, promoting pro-health policies through their publicity, supporting local hospitals, or local efforts for providing better access to health, etc.

A final point: it is very frustrating when all these resources and help are not translated into actual health benefits and wellbeing for the people that need them, and when money and support is lost along the way. Because of this, it should be acknowledged that, while the world still does not address global health properly, it is also true that there has been an increase in assistance. For example, Gostin et al. ask why are health outcomes among the poor so awful when international health assistance has quadrupled over the past two decades? Is it because of self-interest and a non-harmonized approach? This is an important fact indeed and should make us think thoroughly about how to translate theory into good practice. Hence several questions still arise: how do we channel this and other efforts? Is it a priority of resources allocation? If it is, which criteria should be prevalent? Should we consider efficiency, need or a mixture of these? Should we bring in other criteria? How should these different actors identified interact? What should be the role and interface of donors? Should we have a harmonized approach? How can we achieve this without being too intrusive in the self-determination of countries? As we can see, there are still some issues to consider and continue working on. The task of solving these difficult questions will be the work of the following sessions at today’s meeting.

In conclusion, in this presentation I argued for the importance of health, I endorsed an overlapping consensus perspective pointing to similarities and complementariness, rather than distinguishing divergences and differences among ethical theories. I argued for a joint effort appealing to the responsibility of a multiplicity of agents and actors. Therefore, besides our traditional way of holding persons responsible, through the moral concept of responsibility, or through the

20 O’Neill, op.cit, p.201.
notion of collective entities, we can also endorse a non-traditional view of human rights and hold responsible various institutions and even transnational corporations with different levels and intertwining roles. I hope the previous arguments and sketchy framework presented justify the need to address global health issues seriously. I would like to finish by endorsing Gostin and Taylor’s words: “Allowing the world’s poor and less powerful to suffer needlessly and die prematurely harms the whole community by eroding public trust and undermining social cohesion!”

However, I should acknowledge that this is just the tip of the iceberg. Once this important need is identified or argued for to satisfaction, the question of how we are going to achieve this goal is, indeed, difficult and not a minor task.

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21 Gostin L and Taylor …(p56).