Explores the moral dilemmas posed by disparities in health across nations

Who bears responsibility for causing health inequalities? Who should take responsibility for ameliorating them?

Millions around the world die from preventable diseases. Millions more suffer from poor health as a result of extreme poverty. This volume considers whether health inequalities are a result of global distributive inequalities and are therefore of concern to those promoting global redistributive justice.

The contributors explore questions of defining and measuring health, and identifying moral responsibility for poor health outcomes as well as for remedying poor health around the world. There are also case studies of key issues such as the migration of health care practitioners from developing to developed nations, the social determinants of health outcomes, the effects of pharmaceutical legislation (and international bad practices more generally) on securing access to life-saving drugs in the developing world, and the differential effect of these practices on men and women, especially with respect to HIV/AIDS.

Key Features

• Gives readers a full sense of the ways in which global policy making is affecting health outcomes in poor countries
• Highlights the moral dilemmas of global policies with specific respect to health
• Outlines the scope of responsibilities which developed nations may have in order to remedy poor health in developing nations

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INTRODUCTION: HEALTH INEQUALITY AND
GLOBAL REDISTRIBUTIVE JUSTICE

Patti Lenard and Christine Straehle

It is now frequently observed that millions around the world die from preventable diseases, and that millions more suffer from poor health as a result of extreme poverty. However ‘health’ is defined and however it is measured – and there is considerable controversy about both defining and measuring health – the citizens of developing countries fare significantly worse than citizens of developed countries: life expectancy ranges from 40 (in some sub-Saharan African countries) to over 80 (in many western, developed nations); the number of doctors ranges from fewer than 5 per 100,000 people to nearly 600 per 100,000 (in many sub-Saharan African countries, and in Cuba, respectively); health expenditure ranges from less than US$3 per person per year to over US$5,000 per year (in many sub-Saharan African countries, and in the USA, respectively); and the infant mortality rate ranges from 3/1,000 in Iceland to nearly 200/1,000 in Angola (World Health Organization 2007). These statistics, even if well-known, are startling, and reveal the depth of the differences in health outcomes for citizens around the world.

The causes of the appallingly poor health outcomes in developing nations are complex, to say the least, as are the difficulties we face in identifying who, if anybody, is responsible for them and who should take on the responsibility to remedy them. For many, among them several contributors to this volume, it is increasingly clear that poor health in the developing world is not only a local problem, but also a consequence of multiple global decisions, for example, to permit global patents on life-saving drugs and to permit morally egregious health-care-worker recruiting policies in the developing world. Fortunately, for those who live in developing nations, concerns about global health inequalities are increasingly a matter of political attention. For example,
Canada recently announced its intention to focus on maternal health in the developing world during its G8 presidency, the United Nations Millennium Development Goals (MDG) focus on improving health outcomes, and much political and public attention is being paid to the Bill and Melinda Gates Foundation’s, and Warren Buffet’s, efforts to improve the quality of health in the developing world. But despite such increased attention, the prospects for health in developing nations are grim: the 2015 MDG goals are unlikely to be met; the G8 emphasis on maternal mortality is fraught with ideological conflict in developed nations; and the contributions that are being made by health research foundations are significant, but not adequate to turn the tide of poor health outcomes in developing nations.

This volume focuses on the moral dilemmas posed by these evident health inequalities, and examines to what extent inequalities in health pose problems for those concerned with justice in general, and global justice in particular. The demands of global justice have been debated for some time now, and many have argued that any plausible account of global injustice takes its starting point from accounts of wealth inequalities and an analysis of why such inequalities are unjust. This volume’s authors examine the extent to which global inequalities in health can be addressed as the product of global wealth inequalities more generally, or whether inequalities in health pose specific and distinct problems to moral and political philosophy, in particular at the global level.

Historically, political and moral philosophers have had little to say on the topic of health as a component of distributive justice (there are exceptions, of course, including Daniels 1981; Daniels 2008; Segall 2009; Venkatapuram 2011). When health has been addressed thus far, it has largely been so only in the context of rights. Scholars of human rights have sought to define the rights to which we are entitled by virtue of our humanity, and we have seen ongoing debate concerning whether the ‘right to health’, or the ‘right to healthcare’, should be considered a basic right (Mann 1996; Pogge 2005c; Nickels 2007). And while the United Nations Declaration on Human Rights includes the right to health on its list of basic human rights, it is more typically the case that the right to health is included in the category of ‘social’ rights, and social rights in general have not received the same attention in human rights debates as have political and civic rights (Shue 1996).
This ‘rights’ focus is an extraordinarily important one, as many of our authors suggest; but it falls short of addressing the fundamental inequalities in health, since a focus on rights as they have been framed so far suggests that our obligation is simply to refrain from violating them (Pogge 2002). In the view of many of the contributors here, however, the obligation of non-harm is inadequate, since it neglects the global economic institutions that affect health outcomes in many developing nations. These need to be analysed from a perspective that is more encompassing than ‘rights’, if our goal is to ensure justice in health (Gostin 2007). Thus, the contributions to our volume move beyond the rights debate, at least in its limited ‘non-harm’ form, to examine health inequalities in the context of global distributive inequalities, with the objective of pursuing global redistributive justice. In particular, four distinct conceptual questions, and one key empirical question, frame the contributions to this book:

1. What does a right to health entail?
2. How does this right connect to discussions of distributive justice?
3. Who bears responsibility for protecting the right to health?
4. Whose obligation is it to remedy health inequalities, in particular those that are the product of unjust wealth distribution across borders?
5. Once we have determined the content of the right to health, or of health equality, and the concomitant responsibilities, how can we measure whether a nation scores well or poorly in achieving these objectives?

These latter measurement questions are essential to determining where we need to focus our policies if our goal is to pursue ‘health equality’: is it in the domain of recruitment, or training of health professionals, for example, or simply in providing access to basic medical services, or elsewhere? These latter questions are tackled by the chapters featured in the final section of this volume.

PART 1: A RIGHT TO EQUAL HEALTH?

The first chapters of this book consider the notion of a right to health, in particular whether there is such a right, and if there is such a right, what it might entail, and once its content is defined, whether this right
can be equalised in any meaningful way. These are enormously difficult questions.

One difficulty stems from the connections between good health and socio-economic indicators of wealth. Wealthy people are healthier; more educated people are healthier; individuals who live in physically secure environments are healthier. These correlations indicate, for some, that health outcomes are merely dependent on levels of wealth and education more generally. On this view, any standard attempt to ‘equalise’ wealth will thus ‘equalise’ health outcomes. If we educate people, if we provide them with sufficient income, and provide for social stability, health will improve without our focusing on it directly. According to this argument, health is a function of socio-economic redistribution; there is therefore no need for independent theorising on the content of the right to health and the duties we acquire in light of acknowledging it.

The fact that health correlates so well with indicators of socio-economic wealth suggests to some that ‘health’ is not a distinct category of well-being with which we should be independently concerned.¹ But this is a mistake. For one thing, health (merely) correlates with other indicators of wealth; yet, many wealthy people are not healthy (indeed, one of the negative effects of development is the spread of dangerous, non-communicable, diseases that correlate with increasing levels of wealth) and many poor people are healthy. It would also be a mistake to equate wealth with improved access to healthcare since evidence taken from around the world shows that citizens of some countries have better access to quality in healthcare than others (at comparable levels of wealth). Second, the conditions under which healthcare can be made accessible are not entirely dependent on (considerable) resources. The infrastructure on which healthcare delivery depends can be constructed and maintained even in relatively less affluent areas, so long as it is prioritised to some degree. It is then not enough simply to redistribute wealth across societies and assume that health inequalities will be therefore addressed. Instead it is important to think about an independent right to health and define the content such a right would have.

This definitional challenge, however, is accompanied by other challenges. For one, health is not something that we can guarantee, even if we try very hard and even if we can agree on a definition of what provisions health requires. Whether an individual is healthy is
to a considerable degree a matter of luck, and there will be individuals for whom an infinite amount of healthcare will nevertheless fail to produce good health. We wouldn’t like to say that a person for whom this kind of effort is expended, to no avail, is denied a reasonably defined right to health. There is, ultimately, an imperfect relationship between the right to health (when it is respected) and health outcomes: positive or negative health outcomes are not sufficient to indicate whether the right to health is being respected. This is an observation that Adina Preda makes in the opening chapter. It may make more sense, she suggests, to define the right to health in terms of healthcare. We should identify an appropriate standard of healthcare, where when met, we can conclude that the right to health is respected. Exceptions to whatever rule we determine will undoubtedly exist as well; just as the right of all citizens to access a publicly provided library can require that additional efforts are made to ensure that individuals with limited mobility can enter libraries, the right to a standard of healthcare may demand that additional efforts be made with respect to specific individuals.

Preda’s chapter invites readers to consider, additionally, the connection between egalitarian political theory – much of which is concerned with the equal distribution of material resources – and the protection of a supposed right to equal health. Since, as we indicated above, we can never guarantee that a specific distribution of resources will produce equality in health outcomes, the precise application of egalitarian distributive theories of justice to questions of health – and in particular in protecting a supposed right to health – proves challenging, for reasons Preda explores.

In light of these challenges, Daniel M. Hausman rejects a strictly luck egalitarian approach to understanding the possible demands of a right to health. Luck egalitarianism tells us that our primary concern should be with neutralising the effects of bad luck – to the extent that our health status is a matter of luck, therefore, luck egalitarianism tells us that we should find ways to redistribute resources (in this case, access to healthcare) to those who are less healthy through no fault of their own. But, says Hausman, the luck egalitarian lens is too narrow: for example, it will tell us that we should be concerned to redistribute resources from Paraguay to Russia, since although Paraguay is considerably less wealthy than Russia, its health outcomes are considerably better. Instead, Hausman argues, we ought to take a ‘relational’
approach to understanding health inequalities: at the domestic level, a relational approach tells us that our central concern should be with whether individuals can interact with each other under conditions of equal respect; and at the global level, it tells us that to the extent that poor health impairs the capacity of a nation to interact with others on an equal basis, we should be concerned with redistributing resources to ensure equal access to healthcare across nations.

Taking a broadly relational approach focuses our attention on how others are doing, and how our ability to interact as equals depends on at least a minimal standard of health (among other things, evidently). Although framed differently, Lisa Eckenwiler’s chapter also asks readers to take a relational view seriously; she terms her approach ecological, by which she means that we should understand ourselves and others as necessarily situated in specific places that determine the nature of our relationships. An ecological approach can draw our attention to how our identities are both ‘intersubjectively constructed’ and ‘mutually constitutive’. The consequence of this emphasis will increase our understanding of our responsibility for others in general, and for their health outcomes in particular.

Whereas Hausman and Eckenwiler emphasise the ways in which we can best approach remedying health inequalities by focusing on the ways in which health outcomes are determined by human relations, Sridhar Venkatapuram and Phillip Cole both take a ‘capabilities’ approach to evaluating the dilemmas posed by health inequalities across borders. The capabilities approach in political theory self-consciously emphasises ‘what people are actually able to do and be’ and thus underlines ‘health’ as one among the capabilities that must be protected in order to secure human flourishing (Nussbaum 2000: 5; Nussbaum 2005). Furthermore, it emphasises the importance of protecting and promoting individuals’ abilities to make decisions about their own lives and to pursue valuable objectives over the course of them. The capabilities approach thus differs from a traditional rights approach by analysing not only the rights to which individuals must have access, but also the use that individuals can actually make of their rights in their specific social contexts, as Ventakapuram explains. Applying the capabilities approach at the global level helps to shed light on the challenges posed by health inequalities within and across societies.
PART 2: WHO IS RESPONSIBLE FOR REMEDYING GLOBAL HEALTH INEQUALITY?

Although the authors who contribute to the ‘rights’ debate do not agree on the justification for defining and protecting a right to health in Part 1, none denies the moral dilemmas posed by the depth of inequalities in health across the world. And even though wealth is not the only determinant of health, strong inequalities in health divide citizens of the wealthiest nations from those in the poorest nations. Yet, locating the agents who are a) responsible for these inequalities and, more importantly perhaps, b) responsible to remedy these inequalities is by no means straightforward, as several of our authors indicate.

In the opening chapter to Part 2, Garrett Wallace Brown outlines three different ways in which we might respond to health inequalities. A ‘lifeboat ethics’ approach takes its central insight from Thomas Malthus’ theories of population growth and argues that population growth would stall when resources became inadequate to support additional lives. This approach suggests that we ought to avoid extending aid to those who are suffering, on the idea that something like ‘natural selection’ is operating to sustain a manageable population. Aside from the cruelty associated with ignoring those in desperate need, this approach should be rejected for ignoring the extent to which our lives are influenced by the actions of those around us; Brown’s critique thus echoes some of Eckenwiler and Hausman’s concerns. Often, our health outcomes will be the result of actions taken by others, that we cannot control, rather than by ‘nature’ operating to protect the strongest among us. A second approach, the ‘proximity approach’, tells us that health inequality is problematic when it affects those nearest to us, that is, those who live within our national boundaries. On this view, although we should object to health inequalities within national boundaries, the health inequalities that divide health-rich from health-poor nations, though appalling, are not the responsibility of the wealthy. This view, says Brown, should equally be rejected, for violating a central intuition of much egalitarian political theory: that we should be held responsible only for what we can reasonably control. Those who are victims of poor health in developing nations find themselves in conditions they did not choose, and therefore they should not be held responsible for their health status. Instead, says Brown, and this is a view echoed in later chapters, we should adopt a cosmopolitan
approach to health inequalities: on this view, our main concern should be with instantiating a commitment to the equal moral worth of all individuals. As applied to the domain of health, this requires intervening in developing nations in which the health conditions are poor, with the purpose of offering aid.

Gillian Brock expands on one dimension of a cosmopolitan approach to health inequalities. In her view, we have remedial responsibilities to come to the aid of those in need; remedial duties are those that we have simply in virtue of our capacity to carry them out. Wealthy nations have the capacity to come to the aid of those who are health-deprived, which for Brock demands a more expansive focus than on health specifically, and includes additionally a focus on the ways in which the global economic system operates to sustain the poverty and poor health outcomes of those in developing nations. Some thinkers aim to allocate responsibility for health inequalities by pointing to those who are responsible for causing poor health in others; although Brock does not dismiss this strategy, her goal is to identify the role that wealthy nations can play in effecting what she terms ‘transitional justice’, that is, a transition from what we have now, a world plagued by health inequalities, to something that is closer to an ideal, a world in which health inequalities are not so vast. Wealthy nations, she argues, ought to show moral leadership in the domain of health. Brock’s chapter thus sets up the argument made by Angela Kaida and Patti Tamara Lenard. Kaida and Lenard’s chapter articulates how cosmopolitan political principles point towards the conclusion that wealthy nations – because they have adequate resources, because they have demonstrated the capacity to do so in the past, and because they have made promises to do so – are obligated to continue to fight the HIV/AIDS epidemic in sub-Saharan Africa, in particular as this epidemic continues disproportionately to affect the lives of women and children. Such obligations can be assigned even in the absence of a clear definition of the right to health: even if we can’t agree on the content of the right to health, we can certainly hold that it is violated if people die prematurely due to preventable, or treatable, diseases.

PART 3: MEASURING HEALTH OR HEALTH OUTCOMES
An analysis of the HIV/AIDS epidemic points to a related problem. If we take Kaida and Lenard’s chapter to indicate that there is an obliga-
tion to provide healthcare to those affected by the disease, we will still need to define the measures of that care: we can measure, as evidence (or not) that the right is being respected, the number of doctors per capita; infant mortality; incidences of river blindness; life expectancy; and so on.

Kristin Voigt tackles the challenges of generating appropriate mechanisms by which to measure global health, in particular with a goal of articulating the imperative of designing health measures in ways that are normatively unproblematic. Health measures can, if designed poorly, lead to injustices in the ways in which resources are allocated, for example. In her chapter, Voigt evaluates the way in which this concern – about unjust resource allocation – has influenced researchers associated with the Global Burden of Disease study, who have relied on disability-adjusted life-years (DALYs) to quantify the disease burden around the world. The DALY measurement considers the number of life-years lost as a result of premature mortality, the number of years individuals live with a particular health condition, and the severity of this condition. Voigt aims in her chapter to assess the challenges faced by researchers concerned to develop a morally neutral measure of global health – a measure, that is, that respects the moral equality of all human beings described by Brown in their specific social contexts. The DALY measurement, if implemented well, can give us a genuine understanding of where health conditions are poor and are in need of remedy as a condition of achieving global justice in health.

Yukiko Asada takes her lead from the capabilities approach described above, and suggests we move towards a ‘sufficiency’ view – since health is a capability, we can interpret having adequate ‘health capability’ as having attained health sufficiency, an attainment which, if met globally, would satisfy our moral requirements with respect to remedying health inequalities. Says Asada, we can then measure whether sufficiency has been attained with respect to health via a ‘health utilities index’ (HUI), which measures an individual’s functionality along eight dimensions (vision, hearing, speech, mobility, dexterity, emotion, cognition, pain) and converts these levels into a score based on social preferences of particular health states. Asada presents an example: ‘The HUI score for a near-sighted but otherwise fully functional individual is 0.973, and this score reflects the average societal preference, rather than the respondent’s assessment, of how good this particular
health state is compared to full health’ (pp. 164–5). We ought therefore to take the average HUI within a specific society as the measure of ‘sufficiency’, and aim to achieve that level of health within a society more generally.

This may help us unpack the question of responsibility for providing access to health, as framed by Nicole Hassoun. Hassoun’s central concern is to find a way to motivate pharmaceutical companies to contribute their research expertise to remedying global diseases. Modelled on the fair trade movement more generally, she proposes developing a rating system which she terms the ‘global health impact rating’, where the drugs produced by pharmaceutical companies that have contributed to remedying global disease will be labelled as such. Consumers in western healthcare-rich nations (in particular) will therefore be able to make choices among companies according to their contribution to health equality around the world. In order to develop this rating system, of course, we require a robust mechanism by which to measure whether a given drug has served to save or extend lives. This measurement mechanism, says Hassoun, must consider three issues: how we identify what counts as a health need; how we measure drug effectiveness; and how we measure drug access. Hassoun’s chapter makes positive proposals along each of these dimensions.

PART 4: BORDERS AND HEALTH

Of course we need not look across borders to witness health inequalities. Domestic political communities are often characterised by health inequalities, often pernicious ones. This observation frames Matthew R. Hunt and Ryoa Chung’s chapter, which considers the intersection of existing health inequalities and humanitarian disasters. In cases of pre-existing health inequalities in a given community, the onset of a humanitarian disaster serves only to exacerbate these inequalities. Chung and Hunt propose we take what they term a ‘structured vulnerabilities approach’, according to which post-disaster aid workers must be attentive to the fact that some populations – those that are already disadvantaged prior to the disaster – are even more vulnerable following the disaster. Aid workers should focus not simply on providing aid to those who are most vulnerable; they should also focus on dismantling the social structures that restrict some populations to conditions of persistent vulnerability.
Phillip Cole also worries about health inequalities within borders. Cole considers whether there is any justification within a territory to distinguish among residents with respect to healthcare access. In Canada and the United States, for example, non-permanent residents are not permitted access to public healthcare beyond emergency services; in these countries, the different access is justified at least in part in terms of ‘protecting’ resources, by barring non-permanent residents from participation in a whole host of social services. For many, however, this distinction is unjust; all those who contribute meaningfully to the economy, whether permanent residents or not, should have access to the full range of social services. Cole considers an even more controversial question, whether illegal migrants should have access to health services in the country in which they reside. Cole argues that since healthcare is a right, and since it is a right that can be justified for its contribution to human flourishing and in its status as a basic capability, attempts to deny irregular migrants access to healthcare amount to a fundamental injustice. Just as, in Cole’s view, there is no basis for distinguishing between insiders and outsiders, that is, people who live on different sides of borders, there is equally no moral basis for distinguishing between insiders and supposed outsiders who reside within shared, territorially delimited, boundaries.

If, as Cole and many other contributors to this volume suggest, borders should have no influence on any individual’s right to healthcare, we may have good reason to worry about the migration of medical professionals from developing nations to developed nations. One common explanation given for poor health outcomes in developing nations is the inadequate access these citizens have to healthcare. Citizens across developing nations often do not have access to doctors and nurses, and these medical professionals are themselves often hampered by inadequate access to the resources they need to treat the ill. Medical professionals are additionally asked to labour in poor conditions and often, in particular, for little remuneration. In light of this and the challenges that developed nations are having in providing the standard of healthcare to which their own citizens have become accustomed, we see considerable movement of healthcare professionals from poor nations to wealthy nations. The result is a de facto subsidy of rich nations by poor nations: poor nations educate health professionals, who then migrate to put their education to use in wealthy nations, for considerably higher incomes. This is particularly problematic when
such migration is prompted by aggressive recruitment by wealthy nations in poor nations.

We can evaluate this situation from the perspective of the health worker who chooses to migrate as well as from those left behind in developing nations. Together, Eszter Kollar’s chapter and Christine Straehle’s chapter consider the difficult normative issues that should inform responses to this form of migration. On the one hand, individuals – including those with valuable skills – should be permitted to exercise their right to migrate; Straehle emphasises the ways in which attempts to prevent the migration of health workers can, in most of their incarnations, violate their autonomy. On the other, says Kollar, the effect of the migration of health professionals renders the realisation of the human right to health impossible in developing nations. Kollar considers whether international law, which constrains movement in certain circumstances, some of which involve health (for example, migration is constrained when we are concerned with the spread of disease across borders), can serve to underpin restrictions on the movement of health professionals to prevent this human right violation; her analysis is inconclusive, however.

CONCLUSION

It is clear that there are profound inequalities that divide the healthiest from the least healthy members of our global community; and that these inequalities should give us moral pause. What is less clear is what the injustice is that is being perpetrated, who (if anyone) is perpetrating this injustice, and who is responsible for remediying this injustice. The chapters in this book tackle these difficult questions. Together, the authors attempt to identify a) the content of a positive right to health or to healthcare, b) the grounds on which the responsibility to protect this right can be attributed to specific actors, and c) the responsibilities these actors have for generating the best mechanisms by which this right can be protected. The challenges in tackling these tasks are exacerbated, as the contributors note, by the difficulties associated with measuring health inequalities: the measurement strategy we choose correlates heavily with the responsibilities that we assign and acknowledge.

Ultimately, the authors in this collection do not provide a unified answer to the difficult questions that motivated the collection initially.
They do, however, serve to highlight both the questions that must be asked and the range of factors that we ought to consider when answering them.

Note

1. For some discussion, see Hessler 2008: 31–43.