Equity and Population Health

Toward a Broader Bioethics Agenda

by Norman Daniels

Bioethics’ traditional focus on clinical relationships and exotic technologies has led the field away from population health, health disparities, and issues of justice. The result: a myopic view that misses the institutional context in which clinical relationships operate and can overlook factors that affect health more broadly than do exotic technologies. A broader bioethics agenda would take up unresolved questions about the distribution of health and the development of fair policies that affect health distribution.

In its early decades, bioethics concentrated on problems arising in two important areas: the dyadic, very special relationships that hold between doctors and patients and between researchers and subjects, and Promethean challenges—the powers and responsibilities that come with new knowledge and technologies in medicine and the life sciences, including those that bear on extending and terminating life. The dyadic relationships yield important goods, impose significant risks, are rife with inequalities in power and authority, and yet are bound by complex rights and obligations. They provide a rich field for ethics to explore. The Promethean challenges are the favorites of the media: how god-like can we become in our relations with people, with animals, and with our environment without losing our moral footing? They attract serious inquiries about how to use knowledge and technology responsibly for the individual and collective good. Unfortunately, they also form the frontline trenches for the contemporary culture wars.

Bioethics’ focus on the largely noninstitutional examination of these dyadic relations and the emergence of exotic technologies means other important issues concerning population health and its equitable distribution are not addressed (although there are exceptions to this generalization). The doctor-patient relationship and the researcher-subject relationship do have a bearing on population health since medicine and medical research affect the health of indi-
Equity in Health?

What Must We Do to Pursue

Health is clearly narrower than the widely quoted definition offered by the World Health Organization: “Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.” The WHO conception erroneously expands health to include nearly all of wellbeing, so it can no longer function as a limit notion. People who actually measure population health, such as epidemiologists, concentrate on departures from normal functioning. As we shall see, understanding health as normal functioning is quite compatible with taking a broad view of the determinants of health revealed by the social determinants literature.

This characterization of health has implications for what counts as pursuing equity in health. Every society has some healthy and some unhealthy people. One natural way to understand the goal of equity in health—the goal of health egalitarians—is to say that we should aim, ultimately, to make all people healthy; that is, to help them to function normally over a normal lifespan. Pursuing equality means “leveling up”—bringing all those in less than full health to the status of the healthy. The ultimate aim of health maximizers is identical to that of health egalitarians: We maximize population health if all people function normally over a normal lifespan. Health is clearly different from income (and possibly wellbeing). There is no natural stopping point for income—the rich can always be richer—but health is a limit concept. Being completely healthy is being completely healthy (functioning normally).

Despite convergence on ultimate aims, health egalitarians and health maximizers generally support different strategies or policies for achieving their common ultimate aim of producing a completely healthy population. A maximizing strategy or policy will seek the highest achievable aggregate measure for resources invested, regardless of how the health is distributed. Someone concerned with equity in health will put important constraints on how the health is distributed.

Unsolved rationing problems. A family of unsolved distributive problems has been discussed by people in the social sciences and bioethics. In these problems, maximizing strategies are pitted against fairness or equity considerations. For example, when we select an intervention because it has the best cost-effectiveness ratio, we are maximizing health benefits at the margin regardless of how the benefits are distributed—a maximizing strategy that conflicts with concerns about equity in three ways. First, it gives no priority to those whose ill health makes them significantly worse off and puts them in greater need than those less ill. Most people want to give some priority to those who are worse off, even if they do not want to give them complete priority, possibly creating a “bottomless pit” for those who benefit very little, while sacrificing significant benefits for others somewhat less ill. How much priority should we give? That is the priorities problem. Second, cost-effectiveness analysis allows us to aggregate minor benefits, such as curing minor headaches, to larger numbers so that they outweigh significant benefits, such as saving lives, to fewer people. But even though most people accept some forms of aggregation, they reject unrestricted aggregation, refusing to allow, for example, lifesaving treatments to a few to be outweighed by very minor benefits to very large numbers. The aggregation problem asks, When should we aggregate? Third, cost-effectiveness analysis...
doggedly pursues “best outcomes”—for example, living many years after treatment—while denying fair chances for some benefit to those with worse outcomes, such as living only several years after treatment. Yet most people reject a strict maximizing strategy, preferring to give even people who have worse outcomes fair chances at some benefit. How should we balance best outcomes against fair chances? This is the best outcomes/fair chances problem. We have considerable trouble agreeing on what the appropriate middle ground is in each of these problems.

**Reducing health inequalities and unsolved distributive problems.** The same distributive problems arise when we think about eliminating health inequalities, even unjust ones. Five of the eight internationally negotiated Millennium Development Goals would reduce inequality by aiming at poverty reduction or providing primary education to those who lack it. The three health targets, however, are stated in terms of reducing population aggregates of key measures—for example, mortality of children under age five. David Gwatkin models two extreme approaches to these aggregate goals. A maximizing approach aims at rapid achievement of the target goal by directing resources to those who are already better off but easier to reach with strategies for improvement. An egalitarian approach aims to help those who are worst off first, then the next worst off, and so on. Program incentives and the geopolitics surrounding the MDG program mean that the maximizing strategy is more likely to be implemented, since funders want rapid results, although it actually increases health inequality in the population.

The unsolved distributive problems are raised in contexts where it is not morally problematic that some are worse off—they are just sicker than the others for whatever reason. In the MDG problem, as in the concern about intergroup health inequalities generally, the baseline distribution is itself morally problematic because there is some social responsibility for creating the basic health inequality. Racial disparities in the United States, ethnic disparities in the United Kingdom, and gender inequalities in the prevalence of HIV/AIDS in sub-Saharan Africa may be clear examples. The injustice of the existing baseline may give extra weight to the concern that we minimize inequalities, giving impetus to efforts to draw attention to race disparities in health in the United States and to stronger efforts to reduce class disparities in the United Kingdom, Sweden, and elsewhere in Europe. Indeed, the WHO Commission on the Social Determinants of Health encourages broad attention to health disparities and their origins in the inequitable distribution of various other goods.

How much should this consideration of the injustice of the baseline outweigh our concern that we are not achieving best outcomes in the aggregate? Some may object that if we single out some groups as “more deserving” because they were wronged, then we are abandoning the principle that in medical contexts we ought to focus only on need. We should not, then, give priority to fixing the broken leg of the innocent mugging victim over that of the risk-taking skier. When the Chinese decided to give priority in access to antiretroviral treatments to victims of infected blood, they were criticized for stigmatizing as less deserving those people infected in another way.

Moral disagreement about these conflicting concerns will be sharp. There will be disagreements about who is really responsible for the baseline, and some will try to explain its injustice away (perhaps in the form of victim-blaming). The unsolved distributive problems are thus made even more difficult. Bioethics has barely risen to the challenge of solving them when the baselines are morally neutral. It must also address the added challenge posed by inequitable baselines.

**Social determinants and health inequalities.** Most Americans, and I suppose most British, who are asked, “What does it take to assure people of equity in health?” will respond with what they take to be a truism, “Give people equal access to appropriate medical care,” such as through a universal coverage insurance scheme. At best, this apparent truism is but a small part of the answer; at worst, it is misleading in important ways.

Equal access to medical services does not by itself assure equity if we have made the wrong trade-offs in our health system between equity and the maximization of aggregate health benefits. Just as important, we cannot produce equity in health simply by distributing medical or even public health resources equitably. Health inequalities have more complex origins. We know from the longitudinal Whitehall studies of British civil servants of different employment ranks, for example, as well as from other studies, that health inequalities in a population may not decrease, and may increase, even with universal coverage. The Whitehall study involves a study population that suffers no poverty and has had basic education. Our health is thus affected not simply by the ease with which we can see a doctor or be treated in a hospital, and not simply by the reduction in risks that come from traditional public health measures—though these factors surely matter—but also by broader aspects of social policy interacting with our social position and the underlying inequality of our society.

If we accept as otherwise just the inequalities we allow in our society, but these inequalities contribute to health inequalities, then should we view these health inequalities as themselves just? Or are significant health inequalities across groups always grounds for altering the distribution of other goods? Our answer may depend on the kinds of other inequalities that we see as producing health inequalities.
Turn from class, for the moment, to race. American data reveals a significant but complex independent effect of race—or racism—on health. African Americans have worse health than whites at every income and educational level. Institutional and overt racism must be included as further social determinants of health. For example, the increasing de facto residential segregation that we see in America contributes significantly to these inequalities. The complex pattern by race and ethnicity of key behavioral risk factors (diet, tobacco, alcohol, substance use and abuse, violence) contributes to, but does not account for, race and ethnic inequalities in health. In addition, medical treatment patterns differ by race—a result, perhaps, of conscious and unconscious stereotyping. A society that has a legacy of caste structure and exclusion creates psychosocial stresses in many institutional settings (schools, the workplace, shopping malls) that are implicated in health inequalities. Similar issues affect many immigrant ethnic minorities in European countries.

Racial inequalities seem to be the easy case. What about the inequalities we began with—those induced by socioeconomic status? We live in societies that tolerate and even encourage some significant degree of inequality—as incentives, as justifiable desert, as an expression of diversity. Should we count as unfair or unjust health inequalities that result from other social inequalities that we think acceptable or justifiable?

In earlier work, I argued that Rawls’s principles of justice as fairness quite unexpectedly capture what the social epidemiological literature picks out as the key social determinants of health—ranging from effective political participation rights to education and early childhood training to significant restrictions on income and wealth inequalities to supports for the social basis of self-esteem. Conforming with them would flatten socioeconomic gradients of health more than any we see around us. Social justice—that is, fair terms of social cooperation developed in abstraction from thinking about health—is good for our aggregate health and leads to a more equitable distribution of it.

This conclusion is portrayed in the following argument:

1. Completely maximizing population health requires making all people healthy. Making all people healthy also achieves complete equity in health. (This is a conceptual point.)

2. There is no social justice without equity in health. (This is a widely held normative belief.)

3. There can be no equity in health without social justice. (This is an empirical and causal claim that depends on what we know about the social determinants of health, combined with the hypothesis that distributing them in accord with Rawlsian principles of justice flattens health inequalities.)

4. Therefore, achieving the best level of population health by making all people healthy requires (causally) that we pursue social justice more broadly.

If social justice is important to population health and its fair distribution, then the policies aimed at equity in health must be intersectoral in scope. All socially controllable factors that affect the distribution of health become the concern of those pursuing equity in health. In a striking way, this perspective challenges one version of the view that we should treat health as a separate “sphere”—focusing on health benefits without thinking about the contributions that health makes across spheres.

We live in a nonideal world that does not comply with Rawlsian principles of justice. We face important questions left unanswered by ideal theory. Many health-improving interventions we may undertake increase the levels of health of all parts of the population even as they may increase health inequalities. For example, black infant morality rates were 64 percent higher than white rates in 1954 but were 130 percent higher in 1998, even though white rates dropped by 20.8 per thousand and black rates dropped by 30.1 per thousand. David Mechanic concludes from this and other cases that we may reasonably accept increasing health inequalities caused by policies that improve population health, as long as the health of all groups is being improved.

Suppose, however, that we have two interventions (whatever sector, whatever novel technology) that both raise the health of all groups. If intervention A does less than B for those who are worse off but much more for those much better off, then both interventions satisfy Mechanic’s criteria. Yet we may have strong views about whether to pursue A or B, depending on further facts about the magnitude of the effects or other facts about the sizes of the groups and thus the total impact of the programs. If society is responsible for causing the initial inequality through unfair policies, it may have special obligations to give more weight to equity than maximization and to consider the speed at which it rectifies the effects of past injustice.

The complexity of inequality itself: Policy choices about reducing health disparities are especially complex because they are at the interface of claims about injustice and standard distributive problems about which reasonable people disagree. Unfortunately, another source of complexity derives from what Larry Temkin has identified as the complexity of inequality itself.
Temkin describes situations in which two or more groups of individuals differ in their levels of wellbeing. He then asks the normative, not descriptive, question. Which group has the worse inequality? Someone who is worse off has a complaint about the unfairness of the inequality, and the strength of that complaint depends on whether we compare those who are worst off with (a) those who are best off, (b) all those better off than they are, or (c) the average. To determine when one inequality is worse than another, we must not only assess the strength of each complaint, but aggregate those complaints within each situation. There are three approaches to aggregation: a “maximin” egalitarian view, an additive view, or a weighted additive view. The nine combinations of these bases for judging inequalities better or worse yield divergent judgments about cases, including ones with multiple groups and ones involving welfare transfers among groups. All nine approaches, for example, prefer to make the worst-off individual or group better before adding comparable benefits to any of the other individuals or (equal-sized) groups, but they differ on judgments about other cases.

Temkin argues that none of these nine combinations can be dismissed outright as inconsistent or otherwise completely implausible. Consequently, Temkin’s egalitarian must accept the fact that reasonable people will often disagree about when one situation is worse with regard to inequality than another. Since egalitarians will give more weight to reducing worse inequalities than ones that are not as bad, they will have reasonable disagreements about which inequalities to give priority to reducing. This explanation for the disagreement in judgments about when one inequality is worse than another may underlie some disagreements about how much priority to give worst-off individuals or groups.

Broadening the bioethics agenda. Bioethics is not the right field to find the relevant policy levers to reduce health inequalities. That is a task of social epidemiologists and other social scientists. But bioethics should provide guidance, in light of the complexity we have discussed, to the policy decisions that involve different ways of trading off equity against maximization. There are two key dimensions to that body of work.

First, there is the purely normative work of searching for consensus on principles that might guide us in the range of cases posed by our policy options, including those that arise in developing and disseminating new technologies. These bioethics agenda items bear on this normative work:

1) advance the existing ethical work on the unsolved distributive problems;

2) clarify when a health inequality is unjust;

3) explain how that injustice affects the unsolved distributive problems;

4) clarify what counts as a reasonable rate of progress toward reducing health inequalities; and

5) test the implications of 1-4 in the context of actual policy choices about reducing health disparities, including those that involve the dissemination of new technologies.

Second, bioethics must consider what to do when we cannot achieve consensus on principles that can resolve the disagreements we encounter in these five agenda items. All these problems must be solved in ways that are perceived to be fair and legitimate in real time. Where we lack consensus on distributive principles, we must rely on procedural justice to give us fair and legitimate resolution to moral disagreements. In effect, procedural justice must supplement principled approaches to problems wherever the principles we can agree on are too indeterminate or coarse-grained to resolve disputes.

Jim Sabin and I developed an approach we call “accountability for reasonableness,” and we have used it to examine medical resource allocation in managed care contexts in the United States.17 The approach appeals to key elements of deliberative democratic theory to characterize the features of fair process in a range of decision-making contexts and institutions. I have used it, for example, to address issues of equity in scaling up antiretroviral treatments in countries with high rates of AIDS, in the context of the WHO effort to “treat 3 million by 2005”—the “3 by 5” program.18 It is also being used to improve the legitimacy of decision-making about coverage of treatments within the catastrophic insurance scheme of the Mexican Seguro Popular. It is cited as a framework for ethical deliberation about the implications of cost-effectiveness analysis in a recent IOM report on regulatory contexts.19 Others are using it to improve decision-making in publicly managed systems in Canada, Norway, Sweden, New Zealand, and the United Kingdom (where the National Institute of Clinical Evidence’s citizens council derives some support from our approach). Still, there are many problems in developing appropriate versions of this approach at the various institutional levels where policy regarding health inequalities is made and implemented.

My expanded agenda calls for bioethics to:

6) develop the general account of fair process so that reasonable people who disagree can view policies as fair and legitimate; and

7) apply the account to the various institutional contexts at which they must be addressed.
EQUITY BETWEEN AGE GROUPS AND BIRTH COHORTS IN THE CONTEXT OF SOCIETAL AGING

Societal aging, especially in developing countries, will emerge as a major public health problem of the twenty-first century. Societal aging intersects with and complicates two underanalyzed problems of intergenerational equity. Although I have earlier written about the problems of equity between age groups and equity between birth cohorts, I underestimated the difficulty of integrating solutions to these problems in the face of persistent societal aging.

Societal aging is greeted as a crisis in many recent book titles (which refer to an “age quake,” “age wave,” or “generational storm,” to note a few of the popular terms20), even though it is a result of the success, not the failure, of widely pursued health and family planning policies aimed at reducing mortality and fertility rates. It is accentuated when some birth cohort is much larger than the one following it—as with the American postwar baby boom or the Chinese cohort that enjoyed dropping mortality rates but preceded the “one child” policy. Societal aging is a global phenomenon that has broad impacts on social structure, not just health.

In the United States, Kotlikoff and Burns observe that “walkers replace strollers.”21 By 2030, nearly 20 percent of the U.S. population will be sixty-five or over, whereas only 4 percent were in 1900. By 2040, the number of Americans over eighty (26.2 million) will exceed the number of preschool children (25 million).22 European countries, including the United Kingdom, have already reached “zero population growth.” In Italy, the fertility rate (1.2 children for every couple) is well below the level at which a population can reproduce itself (2.1), and the working age population is already shrinking (as it also is in Japan).23 America’s fertility rate of 2.1 helps insulate it from the more extreme aging Italy faces. The United Nations predicts that Italy will have a median age of fifty-four by 2050, second only to Spain. But Italy is not alone. All the European G-7 countries are below the replacement level in fertility rates. By 2050, half of Continental Europe will be forty-nine or older, and well before that, by 2030, one of every two adults in developed countries will have reached retirement age. The United Nations projects that the ratio of working age adults to elderly in the developed world will drop from 4.5 to 1 today to 2.2 to 1 in 2050.

While the proportion of the elderly in developed countries is due to double over the next fifty years, from 15 percent to 27 percent, it is due to triple in East Asia, from 6 percent to 20 percent. By 2050, there will be 332 million Chinese sixty-five years or over, equivalent to the entire world’s elderly population in 1990.24 The two billion people over age sixty who will live in our aging world by 2050 will mostly be living in developing countries.

The rapid societal aging in developing countries will take place without the wealth and the sophisticated economic institutions that exist in developed countries. As one commentator noted, China will grow old before it grows rich.25 And China is not alone. The rate of increase in the number of older people between 1990 and 2025 is projected to be eight times higher in developing countries, such as Colombia, Malaysia, Kenya, Thailand, and Ghana than it is in the United Kingdom and Sweden.26 By 2050, the transitional economies of Eastern Europe will have populations with 28 percent elderly, and Latin America will have over 17 percent, well over the U.S. rate today.27

POLICY CHOICES ABOUT REDUCING HEALTH DISPARITIES ARE ESPECIALLY COMPLEX BECAUSE THEY ARE AT THE INTERFACE OF CLAIMS ABOUT INJUSTICE AND STANDARD DISTRIBUTIVE PROBLEMS ABOUT WHICH REASONABLE PEOPLE DISAGREE.

Two effects of societal aging. Societal aging dramatically changes the profile of needs in a country, creating new and intensified forms of competition between age groups for scarce resources. It also reduces society’s ability to sustain measures for meeting those needs, sharpening competition between birth cohorts. Together these effects bring questions about intergenerational equity to the fore that may have not been noticed under different demographic conditions.

We all know, for example, that the rapid growth of those over seventy-five—Bernice Neugarten’s “old-old,” those elderly who face especially increased disability and dependency—will bring with it increased burdens for the management of chronic disease and long-term care.28 Despite the presence in some developed countries of publicly funded, long-term care, most care is provided by family members, so the burden of societal aging will increasingly fall on adult working children, usually women. Yet nearly a quarter of all the elderly in the United States in 1989 had no children, and another 20 percent had only one child. With more women in the workforce, the problem of providing family care is intensified, since women have traditionally been the primary caregivers. Pressures will increase to provide costly public pro-
aged parents living with adult children, as in China. China, for example, must face the specific consequence of the success of its very strict population policy: one child for urban couples, two for rural ones. Like the United States, China will have many elderly with no children, and it will have even more elderly with only one child to support them than is the case in the United States. The Chinese refer to this as the “1-2-4” problem: one child must care for two parents and four grandparents. In 1996 the Chinese government made it a legal requirement that adult children support their elderly parents, obviously anticipating that traditional filial obligations would be strained to the breaking point by the new demographic realities. But the law is not going to solve the problem. Nor would such a law work in other developing countries in which rapid aging, extensive urbanization and industrialization, and a lack of existing health care and income support systems for the elderly collide with traditional family values.

The increase in medical needs and the shift in the profile of those needs with societal aging is much broader than the problem of long-term care for frail, elderly people. With societal aging there are increases in the prevalence of cardiovascular disease, chronic pulmonary disease, diabetes, arthritis, and cancer, as well as Alzheimer disease and other dementias. The increased cost of treating the greater prevalence of these illnesses imposes enormous strains on resources and intensifies competition for them in developed countries. The problem will be even worse in developing country health care systems that have barely begun to gear up to meet the needs posed by chronic diseases. In poorly funded systems, beans up medical services for the chronic illnesses of middle and older age means diverting resources from primary care and preventive care for the whole population.

Age groups and birth cohorts: two distributive problems. Age groups and birth cohorts are easy to confuse, for the term “generation” is ambiguous between them. But they are different. Birth cohorts age, but age groups do not. At any given moment, an age group consists of a birth cohort; over time, it consists of a succession of birth cohorts.

The age group problem raises these questions: How do we treat age groups fairly within distributive schemes, such as health care systems? What is a just allocation of resources to each stage of life, given that needs vary as we age? When is a distributive scheme age-biased in an unfair way? Is age itself a morally permissible criterion for limiting access to new technologies?

Medicare in the United States recently approved three very expensive technologies: left ventricular assist devices as “destination therapy” for patients ineligible for heart transplants but suffering from advanced congestive heart failure; lung volume reduction surgery for select patient groups with chronic obstructive pulmonary disease; and implantable defibrillators. Only the last one fell within any usual cost-effectiveness threshold. No consideration of opportunity costs entered the deliberation. Since Medicare is a system only for the elderly, unlike universal coverage systems in other countries, equity issues in allocation over the lifespan were impossible to raise. We could, for example, produce more health for both the young and the old were proper screening and treatment for high blood pressure implemented instead. The billions spent on these technologies would arguably be better spent on other forms of care for the elderly themselves.

How should we think about health care resource allocation across age groups? The key to thinking about this age group problem is the observation that we all age, though we do not change race or sex. Treating people differently at different ages, provided we do so systematically over the lifespan, creates no inequalities across persons. Treating people differently by race or class or gender creates inequalities that are always in need of justification. Indeed, treating ourselves differently at different stages of life can make our lives go better overall—we invest in our youth, at some sacrifice of immediate revenues and pleasures, in order to be rewarded more later in life. We take from ourselves in our working years in order to make our later, retired years go better.

Prudent allocation over the stages of life should be our guide to fair treatment among age groups (even if prudence is not a general guide to justice). This “prudential lifespan account” must be properly qualified by assuming we already enjoy just distributions across persons and that we will live with the results over our whole lifespan. Specifically, we should allocate health care so that it promotes the age-relative fair share of opportunities (or capabilities).

On this view, rationing by age is permissible under some scarcity conditions because it would not be imprudent to so allocate. This argument does not rely on specific, contested intuitions about the fairness of age rationing (as do Allan Williams’s claim that the old have had their fair innings or Frances Kamm’s claim that the young need extra years more than the old). It relies only on the general prudential allocation model. Since reasonable people disagree about the acceptability of this model and about specific issues, such as age rationing, we will need fair procedures of the sort I noted before to resolve disputes about priority setting among age groups. Properly used, a transfer scheme based on prudential allocation or on some other view of fair outcomes that emerges from fair process would solve the age group problem.

A solution to the age group problem must also be compatible with solutions to the birth cohort problem. Imagine that over time, different birth cohorts pass through a scheme that solves the age group problem to our satisfaction. These cohorts are each treated fairly, I proposed two decades ago, if they have comparable
“benefit ratios” as they age through the schemes. New technologies that were not available for the elderly when they were young but will be available over the lifespan of those now young pose a special problem of intercohort equity.

This approach to the birth cohort problem can adjust for temporary demographic shifts, such as those produced by the U.S. baby boom cohort. It is less clear how it can be modified to accommodate persistent population decline. That is the new challenge we find in global aging, and it has some similarities to stability problems in seniority and related schemes.34

The bioethics agenda I am proposing must:

8) address the distributive issues raised by the age group problem, including the impact of new technologies on resource allocation over the lifespan; assess the permissibility of rationing by age; consider age-bias in health systems, such as the inadequacy of long-term care in the United States and elsewhere, and in our methodologies, such as cost-effectiveness analysis; and consider fair process where reasonable people disagree about these issues; and

9) address how persistent societal aging affects the complex problem of treating cohorts equitably while at the same time not undermining proper solutions to the age group problem.35

International Equity and Health

I suggested earlier that health inequalities are unjust if they arise from an unjust distribution (as specified by Rawls’s principles of justice as fairness) of the socially controllable factors affecting population health. Judged from this ideal perspective, there are indeed many health inequities—by race and ethnicity, by class and caste, and by gender—around the world. Health inequity is pervasive globally.

This account is unfortunately silent about important questions of international justice. When are inequalities between different societies unjust? What do better-off societies owe as a matter of justice (not charity) by way of improving the health of the population in less healthy societies? Suppose countries A and B each do the best they can to distribute the socially controllable factors affecting health fairly, and there are no glaring subgroup inequities. Nevertheless, health outcomes are unequal between A and B because A has many more resources to devote to population health than B. Is the resulting international inequality in health a matter of justice? Suppose B democratically chooses not to protect its population health as best it can, preferring instead other social goals, leading again to population health worse than A’s. Is the resulting health inequality a matter of international justice?

Recasting the problem as an issue of a human right to health and health care recognized by international treaties and proclamations does not improve the situation for two reasons. First, the international, legal obligation to secure a right to health for a population falls primarily on each signatory state for its own population. Although international human rights agreements and proclamations also posit international obligations to assist other states in securing human rights, the international obligations cannot become primary in the human right to health and health care. External forces cannot assure population health across national boundaries in the way they might intervene to prevent violation of some other rights, even when they can afford assistance.

Second, even when a right to health is secured in different states, health inequalities between them may exist. Since conditions do not always permit everything to be done to secure a right in one country that may be feasible in another, the right to health and health care is viewed as “progressively realizable.”36 Reasonable people may disagree about how best to satisfy this right, given the trade-offs that priority setting in health makes necessary. Consequently, some inequalities may fall within the range of reasonable efforts at “progressive realizability.” In addition, because of their unequal resources, different states may achieve unequal health outcomes while still securing a right to health and health care for their populations. Arguments that depend on appeals to human rights cannot tell us whether these inequalities are unjust and remain silent on what obligations better-off states have to address these inequalities.

Though nearly all people recognize some international humanitarian obligations of individuals and states to assist those facing disease and premature death wherever they are, there is substantial philosophical disagreement, even among egalitarian liberals, about whether there are also international obligations of justice to reduce these inequalities and to better protect the rights to health of those whose societies fail to protect as much as they might. Nagel, who affirms these humanitarian obligations, argues that socioeconomic justice,

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which presumably includes the just distribution of health, applies only when people stand in the explicit relation to each other that is characterized by a state. Specifically, concerns about equality are raised within states by the dual nature of individuals both as coerced subjects and as agents in whose name coercive laws are made. Rawls also did not include international obligations to assure a right to health on the list of human rights that liberal and decent societies have international obligations of justice to protect.

This “statist” view encounters a strong counternutation. Life expectancy in Swaziland is half that in Japan. A child born in Angola is seventy-three times likelier to die before age five than a child born in Norway. A mother giving birth in southern sub-Saharan Africa is one hundred times likelier to die from her labor as one birthing in an industrialized country. Many of us think there is something not just unfortunate and deserving of humanitarian assistance, but something unfair, about these gross inequalities.

Those who claim that gross health inequalities are unjust have quite different, incompatible ways of justifying that view. For example, those who regard as unjust any disadvantage that people suffer through no fault or choice of their own would assert that the disadvantage facing the Angolan child is therefore unjust. The underlying principle of justice is applied to individuals wherever they are in the cosmos and regardless of what specific relationships they stand in to others—contrary to the Rawls-Nagel account, which applies principles of justice to the basic structure of a shared society. The disadvantage of the Angolan child might also be thought unjust by those who, like Rawls or Nagel, think principles of justice are “relational” and apply only to a basic social structure that people share, but who, unlike Rawls or Nagel, believe we already live in a world where international agencies and rule-making bodies constitute a global basic structure appropriately seen as the subject of international justice, developed perhaps through a social contract involving representatives of relevant groups. Fair terms of cooperation involving that structure would, some argue, reject arrangements that failed to make children in low-income countries as well off as they could be. Clearly, there may be more agreement about some specific judgments of injustice than there is on the justification for those judgments or on broader theoretical issues.

I shall examine briefly two ways of trying to break the stalemate between statist and cosmopolitan perspectives. One approach aims for a minimalist (albeit cosmopolitan) strategy that focuses on an international obligation of justice to avoid “harming” people by causing “deficits” in the satisfaction of their human rights. It is a minimalist view in the sense that people may agree on negative duties not to harm even if they disagree about positive duties to aid. This approach handles some international health issues better than others. A more promising (relational justice) approach, which I can only briefly illustrate, requires that we work out a more intermediary conception of justice appropriate to evolving international institutions and rule-making bodies, leaving open just how central issues of equality would be in such a context.

Harms to health: a minimalist strategy. If wealthy countries engage in a practice or policy, or impose an institutional order, that foreseeable makes the health of those in poorer countries worse than it would otherwise be—specifically, making it harder than it would otherwise be to realize a human right to health or health care—then, according to Pogge, it is harming that population by creating a “deficit” in human rights. Since this harm is defined relative to an internationally recognized standard of justice—the protection of human rights—Pogge argues that imposing the harm is unjust. Moreover, if there is a foreseeable alternative institution-

al order that would reasonably avoid the deficit in human rights, there is an international obligation of justice to produce the rights-promoting alternative.

Some confusion remains, however, about how to specify the baseline against which harm is measured. When is there a “deficit” in a human right to health? Whenever a country fails to meet the levels of health provided, say, by Japan, which has the highest life expectancy? Or is there some other, unspecified standard? Consider two examples.

The brain drain of health personnel. The brain drain of health personnel from low-income to OECD countries may exemplify Pogge’s concerns. The situation is dire. Over 60 percent of doctors trained in Ghana in the 1980s emigrated overseas. In 2002 in Ghana, 47 percent of doctors’ posts and 57 percent of registered nursing positions were vacant. Some seven thousand expatriate South African nurses work in OECD countries, while there are thirty-two thousand nursing vacancies in the public sector in South Africa. Whereas there are 188 physicians per 100,000 people in the United States, there are only one or two per 100,000 in large parts of Africa. The brain drain is hardly the sole cause of the inequality in health workers, but it significantly contributes to it.

International efforts to reduce poverty, lower mortality rates, and treat HIV/AIDS patients—the Millennium Development Goals agreed upon in 2000—are all threatened by the loss of health personnel in sub-Saharan Africa. An editorial in the Bulletin of the World Health Organization points out that the MDG goals of reducing mortality rates for infants, mothers, and children under five cannot be achieved without a million additional skilled health workers in the region. The global effort to scale up antiretroviral treatments poses a grave threat to fragile health systems, for its influx of funds—hardly a bad thing in itself—may drain skilled personnel away
from primary care systems that already are greatly understaffed.

What about causes? There is both a "push" from poor working conditions and opportunities in low-income countries and a "pull" from more attractive conditions elsewhere. Is this simply "the market" at work, backed by a "right to migrate"?

Pogge's argument about an international institutional order has more specific grip than the vague appeal to a market. When economic conditions worsened in various developing countries in the 1980s, international lenders, such as the World Bank and International Monetary Fund (IMF) insisted that countries severely cut back publicly funded health systems as well as take other steps to reduce deficit spending. In Cameroon in the 1990s, for example, the measures included a suspension of health worker recruitment, mandatory retirement at fifty or fifty-five years, suspension of promotions, and reduction of benefits. The health sector budget shrank from 4.8 percent in 1993 to 2.4 percent in 1999, even while the private health sector grew. As a result, public sector health workers migrated to the private sector and others joined the international brain drain. The international institutional order increased the push.

The "pull" attracting health workers to OECD countries is also not just diffuse economic demand. Targeted recruiting by developed countries is so intensive that it has stripped whole nursing classes away from some universities in the southern hemisphere. In 2000, the Labor Government in the United Kingdom set a target of adding twenty thousand nurses to the National Health Service by 2004. It achieved the goal by 2002. The United Kingdom absorbed thirteen thousand foreign nurses and four thousand doctors in 2002 alone. Recruitment from European Union countries was flat (many of these countries also face shortages in the face of aging populations), but immigration from developing countries continued despite an effort to

frame a policy of ethical recruitment. Arguably, even if there were a diffuse economic "pull," in the absence of active recruiting, the harm would be much less.

The remedy for this harm is not a prohibition on migration, which is protected by various human rights. The United Kingdom has recently announced a tougher code to restrict recruitment from 150 developing countries. In addition, it has initiated a $100 million contribution to the Malawi health system aimed at creating better conditions for retaining health personnel there. The United Kingdom has thus taken two steps that are intended to reduce both the push and the pull behind the brain drain. Other countries have not followed suit.

International property rights and access to drugs. The minimalist strategy becomes harder to apply in a clear way to other international health issues. The problem of international property rights and the incentives they create goes beyond the issue of access to existing drugs, such as the malaria, for example, has fallen to private foundations.

Do intellectual property rights and the incentive structures they support create a foreseeable deficit in the right to health that can be reasonably avoided? Pogge argues that they do. Nevertheless, many drugs developed by big pharmaceutical companies have filtered into widespread use as generics on "essential drug" formularies in developing countries. Health outcomes in those countries are much better than they would be absent such drugs. Since many of these drugs would not have been produced in the absence of some form of property right protections, people are not worse off than they would be in a completely free market with no temporary monopolies on products.

Arguably, however, different property right protections and different incentive schemes would make people in these poor countries with poor markets better off than they currently are. Which schemes ought we to select? Pogge proposes that we revise in-

Though nearly all recognize some international humanitarian obligations to assist the ill wherever they are, substantial philosophical disagreement exists—even among egalitarian liberals—about whether there are also international obligations of justice to reduce inequality and better protect the health of those whose societies fail them.
hard to establish, but it would be offset in rich countries by lower drug prices. The program could be limited to “essential drugs,” leaving existing incentives in place for other drug products. Even so, the tax and thus the incentives could vary considerably, presumably with consequences of different magnitude for the global burden of disease. How do we pick which alternative to use as a baseline against which a “deficit” in the right to health is specified? Pogge does not tell us.

Leaving aside the problem of vagueness, Pogge’s proposal cannot be justified by appealing to the “no harm” principle alone. The proposed incentive fund would better help to realize human rights to health, as Pogge argues, but “not optimally helping” is not the same as “harming,” and so the justification has shifted. There may be good reasons for an account of international justice to consider the interests of those affected by current property rights protections more carefully than those agreements now do—but that takes us into more contested terrain than the minimalist strategy.

International harming is complex in several ways. Often, the harms are not imposed deliberately, and sometimes it may be that benefits were intended. Also, the harms are often mixed with benefits. In any case, great care must be taken to describe the baseline against which harm is measured. Such a complex story about motivations, intentions, and effects might seem to weaken the straightforward appeal of the minimalist strategy, but the complexity does not undermine the view that we have obligations of justice to avoid harming health.

In any case, international harming is only one of three causes of international health inequalities. International health inequalities are also the result of (a) domestic failures to promote population health adequately or fairly; and (b) differences across countries in levels of human and natural resources and in the natural conditions that contribute to the prevalence of disease (such as malaria). Thus the minimalist strategy fails to address many inequalities that some believe raise questions of international justice.

The new terrain of global justice: where the action is. Although I noted the strong pull of the cosmopolitan intuition about the unfairness of international health inequalities, there is also a strong intuition that obligations of justice arise only when people stand in certain specified relations to each other (“relational justice”). If we abandon the idea that such relations can arise only within states, we may find attractive the view argued by Cohen and Sabel.53 They sketch three types of international relationships that might give rise to obligations of justice going beyond humanitarian concerns: international agencies charged with distributing a specific good, cooperative schemes, and some kinds of interdependency. Each may give rise to obligations of justice, such as concerns about inclusion. These may range from an obligation to give more weight to the interests of those who are worse off if it can be done at little cost to others to obligations of equal concern, perhaps yielding far more egalitarian obligations. I shall illustrate each of these relationships and the obligations to which they give rise with examples focused on key issues of global health.

WHO plausibly illustrates the idea that institutions charged with distributing a particular, important good, such as public health expertise and technology, must show equal concern in the distribution of that good. The organization would be acting unfairly if it ignored the health of some and attended more to the health of others. This point about showing equal concern arises in other debates about the methodologies WHO employs. We saw that cost-effectiveness analysis ignores issues of equity in the distribution of health and health care.54 These criticisms of cost-effectiveness analysis thus challenge its constrained use by WHO, whether WHO is using it to determine health policy within a specific country or across countries. WHO is constrained by its mission of improving world health to consider equity in distribution in all contexts in which it works—within and across countries.

Concerns about equity show up in programmatic discussions as well. WHO paid attention to equity in the distribution of antiretroviral treatments for HIV/AIDS. I noted earlier WHO’s sponsorship of a Commission on the Social Determinants of Health, with its focus on equity. Both of these examples illustrate behavior compatible with and required by the institutional charge to WHO. Either this is a misguided focus of energy for WHO, as seems to be implied by Nagel’s strong statist view, or it is an implication of the obligation to show equal concern that arises within institutions charged with delivering an important good—whether they operate within states or across them.

Consider now the international bodies that establish rules governing intellectual property rights, including those that are key to creating temporary monopolies over new drugs. Such a scheme is “consequential” in that it increases the level of cooperation in production of an important collective good—the research and development of drugs—and it does so in a way that has normatively relevant consequences.55 Suppose we conclude that this mutually cooperative scheme generates considerations of equal concern, or at least that it must be governed by a principle of inclusion. Then we might view quite favorably Pogge’s suggestion about structuring drug development incentives so that they better addressed the global burden of disease. Earlier, I said Pogge’s proposal could not be defended on the minimalist grounds that it avoided doing harm because of the problem of specifying the relevant human rights baseline. Now, however, we have a new basis on which to defend the justice of Pogge-style incentives. Such an incentive scheme, supplementing existing property rights or
modifying them appropriately, would greatly enhance the benefits to those who are largely excluded from benefit for a significant period of time, and it would do so at only modest cost to those profiting from the endeavor. Minimally, it illustrates what a more inclusive policy should include; one can build into it even stronger egalitarian considerations, if the cooperative scheme gives rise to concerns about equality and not simply inclusion. Exactly what form the policy would take, and the justification for it (deriving from the form of cooperative scheme involved), remain tasks for further work. With these issues worked out, we might then support Pogge’s incentive schemes as a way of moving some countries closer to satisfaction of a right to health, connecting the effort to human rights goals as he does.

Consider again the example of the brain drain of health personnel from low- and middle-income countries to wealthier ones. Nagel notes that nations generally have “immunity from the need to justify to outsiders the limits on access to its territory,” although this immunity is not absolute, since the human rights of asylum seekers act as a constraint. Still, the decisions different countries make about training health personnel and about access to their territories have great mutual impact on them. There is an important interdependency affecting their wellbeing—specifically, the health of the populations contributing and receiving health personnel. The British decision in 2000 to recruit thirty thousand new nurses from developing countries rather than try to train more greatly affected the fate of people being served by health systems in southern Africa. The underfunding of salaries for African nurses and doctors—in part a legacy of Structural Reform Programs imposed by the IMF and World Bank but clearly continued by local governments—helps create the “push” factor driving these workers abroad. Arguably, this interdependence brings into play obligations of inclusion, even those of equal concern; in any case, they go beyond humanitarian considerations. In addition to Pogge’s “no harm” or minimalist approach, we thus have available obligations of inclusion requiring us to consider the interests of all those in the interdependent relationship. These obligations can be translated into various policy options that address the brain drain: it may be necessary to restrict the terms of employment in receiving countries of health workers from vulnerable countries; it may be necessary to seek compensation for lost training costs of these workers; it may be important to give aid to contributing countries aimed at reducing the push factors; it may be necessary to prohibit active recruitment from vulnerable countries.

We might combine this interdependence with the relationships and obligations that arise from cooperative schemes. The International Organization for Migration, established in 1951 to help resettle displaced persons from World War II, now has 112 member states and twenty-three observer states. It “manages” various aspects of migration, providing information and technical advice, and arguably goes beyond its initial humanitarian mission. Suppose it took on the task of developing a policy that helped to coordinate or manage the frightening health personnel brain drain. Minimally, it might seek internationally acceptable standards for managing the flow—standards for recruitment, compensation, and terms of work. More ambitiously, it might seek actual treaties that balanced rights to migrate with costs to the contributing countries, countering at least some of the pull factors and even providing funds that might alleviate some of the push factors underlying the brain drain. In seeking these, it might work together with the International Labour Organization, with the World Trade Organization, with WHO, and with the United Nations. Such a cooperative endeavor would reflect the common interest in all countries in having adequate health personnel—and thus being able to assure citizens a right to health and health care—as well as the common interest in protecting human rights to dignified migration.

The fuller development of a plausible account of justice in these intermediary institutions is a task for the expanded bioethics agenda I have been charting. Bioethicists must:

10) assess the implications of the obligation not to harm for reducing health inequalities internationally;

11) develop an account of justice for the evolving international institutions and rule-making bodies that have an impact on international health inequalities; and

12) examine Promethean challenges from the perspective of their impact on international health inequalities and obligations of justice regarding them.

Preparing the Field

The broader bioethics agenda I have described poses two distinct and significant challenges to the field. The first challenge is one of training. Many of the problems take us outside the more familiar domain of ethics

In order to broaden its agenda to meet these challenges, the field of bioethics would have to expand its focus beyond ethics and the clinical practice of medicine to the far less familiar terrain of political philosophy and the social sciences.
and the clinical practice of medicine into the far less familiar terrain of political philosophy and a wide range of social sciences. The relevant philosophical literature is less familiar to many in the field, and it would have to be mastered by both those who teach bioethics and those who engage in it. Some training programs in bioethics already include some of this material, but many would have to expand their focus.

The second challenge is political. An implication of my earlier argument is that social justice is good for population health and is essential to its fair distribution. But engaging in the pursuit of social justice and not simply justice in health care can be divisive in a novel way. Many people already agree that we have social obligations to give people equal access to an appropriate array of health care interventions. Perhaps this is because they see the threat of disease and disability as a part of the struggle of humans against nature. In that battle, we are united in our vulnerability. We hope that technology will rescue all of us. The Prometheus battle of humans against nature—and our own human weaknesses—is in a certain sense unifying.

Many fewer people, however, understand the broad ways in which the distribution of other goods affect health inequalities, let alone agree about how to distribute those goods. Indeed, this is a context in which we cannot all easily unite against nature. Rather, there are divisions of interest and perspective among all of us, including across nations. Shifting a bioethics agenda to address the causes of health inequality can thus be politically divisive, both domestically and internationally.

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References

1. This characterization is neutral between a value-free, stochastic account of normal functioning, such as Boorse’s, and a modestly normative, etiological (or evolutionary) account, such as Wakefield’s account of mental disorders as harmful dysfunctions. Neither account views pathology simply as an “unwanted condition” without providing a clear, objectively ascribable view of what makes it a dysfunction at some level within the organism. See C. Boorse, “On the Distinction between Disease and Illness,” *Philosophy and Public Affairs* 5, no. 1 (1975): 49-68; C. Boorse, “A Rebuttal on Health,” in *What is Disease?*, ed. J.M. Humber and R.F. Almeder (Totowa, N.J.: Humana Press), 1-134; J.C. Wakefield, “The Concept of Mental Disorder: On the Boundary between Biological Facts and Social Values,” *American Psychologist* 47 (1992): 373-88.


4. Rawls’s social contract situation involves a simplifying assumption that all people are fully functional over a normal lifespan. We might take this to be an egalitarian default position. See J. Rawls, *A Theory of Justice* (Cambridge, Mass.: Harvard University Press, 1971).

5. My health egalitarian behaves like Parfit’s “prioritarian”: one would not level down the better health of some to make them more equal with those in worse health (blind the sighted to equalize health states with the blind) if there were no reasonable offsetting gain to those who are in worse health. Doing so would frustrate the ultimate egalitarian goal of making all fully normal over a normal lifespan. D. Parfit, “Equality or Priority?” University of Kansas, Lindley Lecture, 1995.

6. I set aside ethical and conceptual problems that arise in the construction of summary measures of population health, which allow us to aggregate across various health conditions of different seriousness and length.


13. Ibid.

14. Suppose we flatten SES gradients of health as much as the principles of justice would seem to require us to, but socioeconomic inequalities remain that induce some health inequalities. Are these residual health inequalities just? Or must we eliminate all social and economic inequalities that contribute to health inequalities? Some might interpret the priority Rawls gives to opportunity as requiring this response. Then, Rawls’s theory becomes more egalitarian than was supposed. Alternatively, we might come to understand the mechanisms through which health inequalities are pro-
duced by other inequalities and intervene to reduce them without having to reduce otherwise justifiable inequalities. On another reading, Rawls's theory may not specifically answer this question about residual health inequalities. See Daniels, Kennedy, Kawachi, "Why Justice Is Good for Your Health."


17. N. Daniels and J.E. Sabin, Setting Limits Fairly: Can We Learn to Share Medical Resources? (New York: Oxford University Press, 2002).


25. Ibid.


27. Center for Strategic and International Studies, Meeting the Challenge of Global Aging, chapter 3.

28. B.L. Neugarten, Age or Need? Public Policies for Older People (Beverly Hills, Calif.: Sage Publications, 1982).


31. Ibid.


33. F. Kamm, Morality, Mortality.


35. Privatization strategies do not solve the problem; they just represent one conclusion about what such equity requires, and they do so without allowing us to use a scheme that addresses the age group problem at the same time. In addition, privatization is not even a starter for lifespan health systems the way it is for income support.

36. The UN Commission on Human Rights “urges States to take steps, individually and through international assistance and cooperation, especially economic and technical, to the maximum of their available resources, with a view to achieving progressively the full realization of the right of everyone to the enjoyment of the highest attainable standard of physical and mental health by all appropriate means, including particularly the adoption of legislative measures.” UN Commission on Human Rights, “The Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health,” Commission on Human Rights Resolution 2003/28.


52. Ibid.


54. Daniels and Sabin, Setting Limits Fairly.
