Latham, Stephen R. "On Some Difficulties for Any Theory of Global Health Justice." *Global Health and International Community: Ethical, Political and Regulatory Challenges*. By John Coggon and Swati Gola. London: Bloomsbury Academic, 2013. 17–30. *Bloomsbury Collections*. Web. 26 Apr. 2023. <<http://dx.doi.org/10.5040/9781472544582.ch-001>>.

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1

On Some Difficulties for Any Theory of Global Health Justice

Stephen R. Latham

[Moral philosophy] has received more over-general and over-simplified systematization, while inviting it less, than virtually any other part of philosophy.

Bernard Williams¹

In theory, theory and practice are the same, but in practice, they're not
Yogi Berra

Introduction

In this chapter, I shall raise a number of different objections to the enterprise of creating any theory of global health justice. Some of these objections are simply applications to the global health justice arena of familiar objections to ethical theory-making in general, some are specific to the problems of theory-making about global health in particular. Different theories of global health justice can deal, to some extent, with some of the objections; but none, I think, can overcome them all.

Of course, one can't get very far with a critique of ethical theory without offering some definition of what it is that one is critiquing. Not every abstract discussion of matters ethical counts as the creation of an ethical theory, after all, and a large amount of such abstract discussion is tremendously useful. I mean here only to raise objections to a certain ambitious form of theorizing about global health justice: the form in which the theory, minimally, purports to explain most of our well-considered views about health justice by means of some fairly simple machinery which, when applied to new cases, can guide our judgements about justice and the steps we should take to establish it. I take theories of justice to be a particular variety of ethical theory. I take my view of 'ambitious' theory to be fairly straightforward, and to apply not only to rationalist and universalist ethical theories such as Utilitarianism and Kantianism, but also to

1 Bernard A. O. Williams, *Morality: An Introduction to Ethics* (Cambridge: Cambridge University Press, 1972), xx.

coherentist and historicist theories such as one might arrive at by way of a process of reflective equilibrium. Any plausible theory of justice will explain most of our well-considered views on the subject; if it did not, it would not be a plausible theory. Its explanation will come by means of some fairly simple machinery (a social contract mechanism, a utility calculation, a specification of a few basic and coherent principles). Complex and comprehensive descriptions of moral life such as one might encounter in a novel or a work of social history are therefore not theories. And finally, an ambitious ethical theory of the sort I am here challenging claims that its machinery can be used to guide our judgements and conduct in new or difficult cases. (I mean here to be following Bernard Williams's view of ethical theory as 'a philosophical structure which, together with some degree of empirical fact, will yield a decision procedure for moral reasoning'.²)

There is another preliminary matter to straighten out: it is important to understand that the claim that an ethical theory or a theory of justice cannot usefully capture or guide decisions about the demands of global health justice is not a denial that such demands exist. Certainly some anti-theorists in ethics have been anti-realists in meta-ethics,³ but the two positions needn't always come as a package. Scepticism about the functioning of ethical theory is completely compatible with a wide range of meta-ethical commitments, from realism to historicist relativism, about global health justice itself. It is completely consistent, for example, to claim that justice demands that we improve the health of children in Sierra Leone, while also claiming that no theory of global health justice can adequately capture our understanding of the requirements of global justice. The sceptical claim is simply that a theory of global health justice cannot get us all the way to an understanding of what justice actually requires, or all the way to concrete on-the-ground prescriptions for interventions; it will always need to be augmented by historical and situational considerations which the theory fails to marshal or organize. This position, I think, is not particularly novel. We can agree on what needs to be done without reference to a theory of justice that prescribes exactly what we've agreed to. And that is because no theory of justice can be as sensitive to historical and situational variables as we can. A theory of justice can, at best, set some outer limits to our judgements about what justice requires in particular circumstances.

Theory

There is good reason to be sceptical about the enterprise of ethics theory-making. Ethical theory can of course be illuminating, bringing to our attention various

2 Bernard A. O. Williams, *Moral Luck* (Cambridge, MA: Harvard University Press, 1981), ix–x.

3 See Stanley G. Clarke and Evan Simpson, 'Introduction: The Primacy of Moral Practice', in Stanley G. Clarke and Evan Simpson (eds), *Anti-Theory in Ethics and Moral Conservatism* (Albany: State University of New York, 1989), 12ff.

important considerations that inform our ethical judgements, and the contests among rival ethical theories are especially valuable insofar as they pinpoint tensions and contradictions among those various considerations. But there are many reasons to think that no normative ethical theory can either fully explain our settled ethical judgements or guide our responses to new ethical questions.

Scepticism about the enterprise of ethical theory-making can arise with regard to any of the parts of the definition of ethical theory that I've offered. Consider, first, the fact that nearly every ethical theory is constructed with (explicit or implicit) reference to our moral intuitions. An ethical theory, to be plausible, must confirm and underwrite at least an important percentage of our core ethical beliefs. But intuitions cannot simply be permitted to play the same role for moral theory creation as observations do in the creation of scientific theory.⁴ To the extent they are permitted to do so, then any ethical theory created on that basis risks being a mere formalization of our prejudices.

Second, consider the idea that ethical theory purports to capture and motivate the full variety of our ethical judgements using only a few relatively simple concepts and variables: a single telos, a small set of coherent principles, a single imagined procedure, a short list of basic human capabilities. That a small number of variables or principles should capture the universe of our ethical judgements is, on its face, quite unlikely, if we consider for a moment the complex historical and social roots of such ethics-laden phenomena as our notions of property ownership, of family structure, of social status, or of sexual ethics. All of these notions are both subjects of, and considerations within, day-to-day ethical judgements. Why *would* we expect a small number of concepts to bring order to this all-too-human mix?⁵ To the extent that ethical theory illuminates ethical judgement, it does so precisely by simplifying. This simplification shows the power of certain kinds of considerations. In fact, it is not too much to say that abstraction from real ethical cases and judgements is in the very nature of any theory of ethics, for it is precisely abstraction that permits any theory to apply across multiple and diverse circumstances, and to assist us in reasoning about novel cases. But it may be that the required abstraction actually comes at the cost of irrelevance, or impotence, with regard to particular cases; that is, the very simplification that seems to make ethical theory attractive and useful actually strips away all of the historical and social complexity which in fact informs many of our core ethical beliefs and judgements. Thus the language of ethical theory is often characterized by the use of highly abstract concepts such as justice, right, good and duty, and seldom employs more complex and situationally variable ideas such as indebtedness, regret, loyalty, admiration,

4 This point is made by Cheryl N. Noble in 'Normative Ethical Theories', in Clarke and Simpson (eds), *Anti-Theory in Ethics* 58ff.

5 See *ibid.*, 50ff.

humiliation, or cowardice. A novel or a social history is not a theory of ethics – but it may well be that ethical problems and decisions are better characterized in novels and social histories than in theories.

Consider, for example, the ethical question whether someone is justified in feeling affronted at another person's behaviour. Various well-known ethical theories will clearly concentrate on different aspects of the problem: the consequences of the behaviour in question, and of the affronted response to it; the virtues of the two people involved; the principles underwriting their actions. But it matters, in answering the question, whether our social pair is interacting in Tokugawa Japan, in Victorian England, or in contemporary Manhattan. Any reasonable account of 'justified affront' will have historical and cultural content that none of the theories can provide. It matters, also, what sort of personal history and mutual understanding our two characters share. A theory can attempt to import that detailed historical and personal content, under the rubric of 'consequences', for example – but this just means that much of the work in generating an ethical decision is done by ethical knowledge and understanding acquired, so to speak, from outside the theory. Of course, every reasonable ethical theory can generate answers to *some* ethical questions (else they'd be poor candidates for the title of 'reasonable ethical theory'). The questions it can best answer will be those where our judgement is dominantly driven by the kinds of considerations that the theory, by its selective simplification of moral judgement, highlights. But no ethical theory can capture all of the detailed nuances of real ethical decision-making. At best, it can call our attention usefully to one, or some, of the most important considerations guiding our final judgements.

The problem of abstraction and simplification in ethical theory raises the question whether ethical theory really can be action-guiding. But that question can also be raised in another way. Some philosophers have alleged that ethical theorizing simply does no necessary work: most people through most of history have successfully made ethical judgements without reference to ethical theory, and people who justify their judgements by reference to theory today may well be engaged in mere post hoc justification of their intuitions. There is also a related question whether knowledge of ethical theory is an effective motivator, let alone the most effective motivator, for ethical action.

These brief comments are little more than a swift summary of well-known arguments against ethical theorizing. I turn now to some considerations that bear more particularly on the question of theorizing about global health justice.

Health

The subject-matter of any theory of global health justice will necessarily be 'health'. This raises some notorious problems of definition for the aspiring

theorist: health has been defined narrowly as the absence of disease, and famously broadly (by the World Health Organization) as a complete state of physical, mental and social well-being. It has been seen by some theorists as a fundamentally normative concept, and by others as a purely descriptive one. It can be defined according to strict objective criteria, or subjectively according to the preferences and feelings of the patient or population in question. The choice of one (or some combination of) these definitions will of course have profound consequences for the shape of a theory of health justice.⁶

These well-known definitional problems apart, however, it remains that ‘health’, however defined, will be some state (broad or narrow, subjective or objective, normative or descriptive) of human beings. It cannot therefore be distributed among persons, and this makes it a difficult subject for any theory of justice. A theory of health justice will of course be concerned with health inequalities (those caused by, or indicative of, injustice), and will address itself to distributing something or other to rectify those inequalities. But what should the theory aim at distributing? It may appear simplest for the theorist to concentrate on distribution of and access to medical treatments. The have the virtue, at least, of being fairly easily quantifiable and of having an obvious connection to health. But that connection, though obvious, is not terribly deep. Improved access to medical treatment is far from synonymous with improved health. Particularly in the developing world (with which theories of global health justice are primarily concerned), health status is determined not primarily by access to medical interventions, but by non-medical health determinants such as access to clean water and nutritious food, access to education, peace, absence of social oppression, opportunity to work, control over reproductive choices and so on.⁷ Given this fact, even a theory of global health justice that uses a narrow and objectively determined definition of ‘health’ will find itself becoming a theory of the just distribution of everything. Such a broad range of social phenomena has implications for health that a ‘theory of health justice’ will have considerable difficulty defining its own limits.

An interesting consequence of this difficulty is a problem that we might term ‘the problem of misplaced concern’. It flows directly from the effort to create a theory of justice related specifically to health (as opposed to creating a theory of justice which in some way takes account of health). The theorist of global health justice will observe, for example, that women who lack reproductive autonomy

6 For a fuller discussion of these various definitional approaches and their consequences for theories of health justice, see John Coggon, *What Makes Health Public?* (Cambridge: Cambridge University Press, 2012), 11–23.

7 Jennifer Prah Ruger specifically declines, in her elaboration of Sen’s health-capability theory, to take account of the social determinants of health. Jennifer Prah Ruger, *Health and Social Justice* (Oxford: Oxford University Press, 2010), 98–103. Another Sen-inspired health-capability theorist, Sridhar Venkatapuram, takes her to task for this narrow approach, Sridhar Venkatapuram, *Health Justice* (Cambridge: Polity, 2011), 153–4.

are at considerable health risk from unwanted and ill-timed pregnancy. Health justice, then, will seem to require women's reproductive autonomy. But it requires reproductive autonomy for what immediately seems to be the wrong reason, or not the core reason; it requires reproductive autonomy for the sake of the woman's health, rather than on the more compelling ground that reproductive autonomy is what women, as persons, deserve. Similar difficulties will arise in connection with concerns for education, peace, job opportunities and so on: the global health theorist's concern for them will be based in health, because she is a health theorist, and that kind of concern for those important items will ring hollow.

Global

A theory of global health justice must necessarily include the whole globe in its concerns, and the globe is a large and complicated place. Any theory that can cover the whole globe will have to be fairly thin, and given that thinness will hover high above the troposphere. Its prescriptive reach will not extend all the way down to the ground.

A theory of justice in global health may purport to tell us to whom better health is owed, but it cannot tell us much about how that health is to be delivered without running into messy facts about governance, politics, law and logistics. 'Ought' implies 'can'; a theory of global health that directs us to do things that are in fact impossible on the ground is for that reason a poor theory. (This is not to say that a theory can't aim at helping us imagine and lobby for better institutions and strategies that would make some previously impossible tasks possible.) Where the rubber meets the road, and we contemplate delivering actual vaccines or water or building materials or money to those in need, theory will have to yield to the insights of politics, law, management and logistics. It is insights from those disciplines that will tell us which interventions are possible, how much those interventions will cost and how successful they are apt to be at improving human health. The practical disciplines will therefore determine how our priorities are set, and where scarce resources are to be deployed.

A number of important theorists of global health justice have recognized this point explicitly. Amartya Sen has drawn attention to the problem; practical problems are one reason why his view of justice remains 'incompletely theorized', and why the relative weights of different capabilities are to be determined differently in different cases.⁸ Norman Daniels admits that the principles of justice as fairness are 'too general and indeterminate to resolve many reasonable disputes about how to allocate resources fairly', and relies

8 Amartya Sen, *The Idea of Justice* (Cambridge, MA: Belknap/Harvard University Press, 2009).

instead on procedural principles of reasonableness and public accountability to guide concrete choices.⁹

Justice

Justice, let us agree, requires that people be given their due: a platitude, and one that leaves undone most of the work of specifying what it is that justice demands. But even the platitude is enough to raise for us the question: is there good reason to think that people all around the globe are due the same things, and that the demands of justice fall uniformly upon people around the globe?

Suppose, for example, that we follow Thomas Pogge in believing that much of world poverty (and the poor health that is closely associated with it) results not from bad luck, but from the deliberate and damaging policies of developed countries.¹⁰ Protectionist US agricultural price supports, for example, prevent developing countries from being able to export their agricultural products at decent prices and therefore keep farmers in those countries poor. Developed-world lending institutions prevent poorer countries from borrowing in useful and productive ways, and developed-world manufacturers dump their shoddy products into developing-world markets, and their industrial waste into developing-world landfills. These allegations are used by Pogge to ground a duty of rich countries to help poorer countries not in distributive justice, but in retributive justice – or, to put it another way, to ground the claims of the world's poor not in positive rights ('you must help us') but in negative rights ('you must stop hurting us'). The point is not just to eliminate an unfair inequality, but to eliminate an unfair inequality for which many of the wealthiest countries are directly culpable.

But these claims of Pogge's, as compelling as they are, nonetheless imply that the demands of justice do not fall uniformly on wealthy countries around the globe. The culpability of wealthy countries for the world's poverty is not perfectly general or uniform; it is grounded in particular countries' histories as colonial powers, as hosts to particular multinational firms, as sponsors of particularly damaging institutions and exponents of particular damaging policies. The United States, for example, is undoubtedly more to blame for the poverty of certain Central American states than is Kuwait – or, for that matter, Denmark. Kuwait and Denmark are both wealthy, but their wealth has not been established with policies that undermine the ability of Central American states to compete in world agricultural markets. Kuwait was not

9 Norman Daniels, *Just Health: Meeting Health Needs Fairly* (Cambridge: Cambridge University Press, 2008), 117.

10 Thomas Pogge, *World Poverty and Human Rights: Cosmopolitan Responsibilities and Reforms*, 2nd edn (Cambridge: Polity, 2008).

the home of the National Fruit company, did not support farming economies based on monoculture, and does not now have agricultural price supports that diminish central American countries' ability to export food. Similarly, there may be some poor countries – Kazakhstan, for example – whose poverty has comparatively little to do with US policy, and much more to do with the ruinous economic and environmental policies of the former Soviet Union. To the extent that health justice is bound up with retributive justice, in other words, it is a mistake to expect it to have some uniformly 'global' character. This is because injustice, both past and continuing, has its roots in complex stories about history, economics, geography and religion.

Particular details about the historical relationships among wealthy and poor countries may also have consequences for the best means of redressing injustice. Some poor countries enjoy special historical or geographical relationships with certain wealthier countries: former colonies, for example. Certain African countries have sent their elites to be educated in France, others in Spain. South and Central American elites have commonly been educated in the United States, and commonly also have relations there. These kinds of connections relate not only to past injustices, but also to the efficiency with which some countries are capable of addressing others' problems. On some theory of global health justice, the United Kingdom (perhaps as a nation, or perhaps as a convenient representative of all its individually obligated citizens) owes health-related assistance both to India and to Senegal. For a thousand different reasons, it will likely be more effective at delivering that assistance to India.

Most theories of global health justice are grounded not in past and continuing injustice, but in various assertions about what human beings as such need or deserve. The 'capabilities approach' associated with Amartya Sen and Martha Nussbaum bases claims of justice on certain core capabilities necessary for free human flourishing;¹¹ Daniels specifies basic health needs necessary to achieve the fair equality of opportunity that characterizes a just (Rawlsian) society;¹² Powers and Faden argue for six dimensions of human well-being (one of which is health).¹³ Any such approach, when applied not to a single society but to the global community, raises what might be termed a 'problem of address'. To whom are the demands of global justice – the demands of each needy human being – addressed? The countries of those in great need often lack the means or the political motivation to respond to the demands of justice. And above the level of the nation-state, there is a remarkable dearth of global institutions

11 See Sen, *The Idea of Justice*; and Martha Craven Nussbaum, *Frontiers of Justice: Disability, Nationality, Species Membership* (Cambridge, MA: Harvard University Press, 2007); Martha Craven Nussbaum, *Women and Human Development: The Capabilities Approach* (Cambridge: Cambridge University Press, 2001).

12 Daniels, *Just Health*.

13 Madison Powers and Ruth Faden, *Social Justice: The Moral Foundations of Public Health and Health Policy* (Oxford: Oxford University Press, 2006).

capable of carrying out the work of global health justice, however that might be described. In fact, most of the work currently being done to eliminate health inequalities is being done by wealthy countries, by foundations and by alliances of these. Many of those efforts are focused on particular diseases (AIDS, malaria) or particular interventions (fistula surgery, say, or childhood vaccination). It is difficult to see how most of these already-working institutions can be cast even as partial vindicators of the demands of any comprehensive theory of global health justice. Setting aside the question whether the diseases they target and the interventions they champion are precisely those that a theory of global health justice would prioritize, these institutions operate for the most part under the banner not of justice but of charity. Institutions of global health justice should be of the sort to which victims of injustice can address not requests, but demands. This near-absence of global-justice institutions poses a serious “ought” implies “can” problem for the framing of a theory of global health justice. It seems fruitless to prescribe actions which no one is well-situated to carry out, or to describe rights for which no one bears correlative duties – and equally fruitless, though not valueless, to imagine new global institutions which are quite unlikely to be created anytime soon.

Uniquely among global-health theorists, Peter Singer entirely avoids this problem of address. He is explicit that the demands of justice fall on each of us, individually.¹⁴ We may attempt to meet them, in part, by lobbying for better global institutions or greater governmental interventions in global health, but the obligations are ours. Each of us is obligated to help the world’s poor, using our own resources; it is wrong for us to permit human suffering to continue if we could alleviate it at a lesser cost (in terms of suffering) to ourselves.

This leads us, however, directly to another difficulty for theories of global health justice: the problem of ‘demandingness’.¹⁵ The problem has been most discussed in connection with utilitarian theory, though it is of broader applicability. The problem (using the familiar utilitarian example) runs this way: utilitarianism is the view that actions are good just insofar as they have the consequence of creating social utility (conceived variously as the net of pleasure and pain, welfare, preference satisfaction, etc.). It therefore demands that, as between any two actions, an agent should perform the one which will create the greatest net utility among the persons affected. The upshot of this is that a good utilitarian should always be doing the one action available to her which will produce the largest amount of utility. And what this means is that, taken seriously, the theory takes over her life, treating her as a machine for generating social utility, and leaving her no space to choose actions on

14 These arguments of Singer’s were first, and forcefully, made in Peter Singer, ‘Famine, Affluence and Morality’, *Philosophy and Public Affairs*, 1972, 1: 229–43.

15 This problem has its classic articulation in Bernard Williams’s essay in J. J. C. Smart and Bernard A. O. Williams, *Utilitarianism: For and against* (Cambridge: Cambridge University Press, 1973).

non-utilitarian grounds (e.g. because of their special meaning for her, or because of some non-moral preference of hers). Utilitarianism is therefore too demanding, not in the sense common to many moral views that its standards are too high for ordinary, erring mortals consistently to live up to, but in the sense that those standards leave the utilitarian agent no life of her own.

Peter Singer sees this issue and simply embraces it. He sees no reason to reject the idea that morality requires us to give of our resources to the poor until we spend ourselves all the way down to their level. This extreme view of course raises all kinds of issues internal to utilitarian analysis – notably questions about interpersonal comparisons of utility and lingering questions about our ability to judge the real utility effects of our intended interventions across the globe. It also raises important questions about utilitarian theory itself – for example, its discomfiting demand that we transfer our resources not to those most desperately in need, but to those whose lives the resources are most apt to improve. But our present concern is with demandingness. If, as Singer claims, justice demands that each of us devote our personal energy and productive capacity to the improvement of the lives of everyone less well-off than ourselves, this leaves very little for our lives to be about. Neither we nor those we assist, for example, are justified in devoting any of our resources to art or amusement while there exists a single person whose utility we could improve by more than the utility cost to us of bringing about the improvement. In any world with seriously scarce resources, the utilitarian moral life seems to consist entirely in our keeping one another (barely) alive.

The demandingness problem is conveniently illustrated by, but is certainly not limited to, utilitarian theory. So stark are global health inequalities that if any significant portion of them is properly conceived of as unjust, then the requirements of any general theory of global health justice that addresses its demands to individuals will threaten to consume the lives of the better off among us in something like this way. Again, this is not simply a question of the demands of global health justice hijacking all available social resources (though this is a problem, too); it is instead a deeper question of those demands, if taken seriously, requiring so much of our time and resources as to leave us no ability to lead our own lives. An analogous problem occurs for theories of global health justice addressing themselves to governments. What state could justify any investment in arts or education or medical research or highway construction if justice demands that it attend, first, to infant mortality and infectious disease in the poorest parts of the world? Is it not wrong for the United Kingdom to spend resources on medical research, or on historical research, given the dire levels of global health need?

These concerns with demandingness are easily caricatured either as selfishness or as hyperbole. An earnest concern with demandingness, the demanding theorist can jeer, is just convenient cover for the fact that we'd rather buy a new iPad than send money to help children in Africa. And how many of us, after all,

are in any real danger of reducing ourselves to poverty to meet others' health needs? Not even Peter Singer actually does that. Our wealthy governments are giving next to nothing in aid to the world's poor, and show no sign of failing to give priority to the needs of their own comparatively well-off citizens.

But the demandingness objection should not, I think, be so easily dismissed. Either a theory means what it says or it does not. If the consequences of a theory, were that theory to be fully realized, would be offensive to our deepest views about the meaning, point and best uses of a human life; or would threaten our core notions of the legitimate function of government; then the theory should not be able to excuse itself via claims that it is not, in fact, apt to be fully realized.

Next we must consider the vexed problem of conflict of values. Such conflicts will occur both within any theory of global health justice (Which diseases is it more important to eradicate? Should we allocate more funds to saving infant's lives, or to improving the quality of adult's lives?) and between the demands of health justice and other moral concerns (Should we allocate more resources to medical interventions or to lawyer training? Will we gain more utility by paying for healthcare for the poor, or by developing technologies to control climate change?). Theories that attempt to achieve health justice by addressing social determinants of health may find the former conflicts more vexing than the latter, because most any competing candidates for resource allocation (governance, education, security, physical infrastructure, trade) will have positive payoffs for health. But this leaves them, once more, with the problem of misplaced concern – supporting better education, for example, for the sake of its health payoffs rather than out of concern for the minds of those educated.

There will also be conflicts between the demands of health justice and other non-moral concerns. How important is health justice compared to other things that are important without being morally important? Should every country stop funding military bands and expensive non-combat dress uniforms in order to allocate those funds to health justice? Neither the ability to play the national anthem at ceremonial events, nor the appearance of crisp military whites, is morally important. They're just important.

The problem, in sum, is that no theory of global health justice can determine its own weight. This is a problem for any topic-specific ethical theory. A theory of medical ethics can articulate the demands of medical ethics, but cannot adjudicate conflicts between those demands and the demands of public economy. A theory of legal ethics cannot adjudicate conflicts between itself and democratic theory. The problem, which may seem trivial, is in fact serious. It means that no theory of global health ethics can ever do anything more than weigh in on an allocation problem from its own point of view. The answer to the question, 'What, all things considered, is to be done?' will always be determined from outside the theory, in the world where it competes with other theories, and struggles with other priorities both moral and non-moral.

Finally there is the purely prudential question, alluded to earlier, of the motivational power of any theory of global health justice. The fact that most of the world's existing global health institutions are structured as 'charitable', rather than cast as vindicating claims of justice, may be a mistake – but if it is, it is a mistake that speaks volumes about what motivates nations and people to help strangers. We are used, normally, to thinking that the claims of justice are stronger than the claims to charity, but there is no reason to expect this always to be true, and in global health it seems simply to be the fact that charitable motivations – along with the selfish desires for borders secure from disease and from uncontrolled immigration – are more motivating than the claims of global justice. What necessary role, then, does a theory of global health justice play in actually helping to meet the demands of justice?

The positive uses of ambitious theory

I have thus far argued that any theory of global health justice will stumble on definitional problems with health and on the problem of what to distribute in order to attain health justice, and ultimately founder on the 'problem of misplaced concern'; that no theory of global health justice will be able to supply practical, ground-level prescriptions, but will instead have to cede territory to the practical disciplines of politics, law and logistics; that no theory of global health justice will take adequate account of the historical and local character of claims in retributive justice; that the lack of institutions available to vindicate the actual demands of global health justice will act to render theories of global health justice irrelevant; that theories of global health justice will face a problem of demandingness; that they will never be able to resolve problems of conflicting values; and that they are, as a prudential matter, poor motivators to action compared to charity and security.

Of course, as J. L. Austin is said to have remarked, 'There's the part where you say it, and the part where you take it back'. None of my comments are meant to imply that the enterprise of ambitious theorizing about global health justice is not at all worthwhile. The implication is only that such theorizing cannot succeed on its own terms: it cannot fully explain or describe our convictions about what justice requires, or reliably guide us to correct judgements in novel cases. What it can do, though, is clarify our thinking in a large number of helpful ways: by highlighting, in a simplified and approachable way (as Singer's and Pogge's analyses have) specific considerations that ought to inform or challenge our settled beliefs about health justice; by offering (as the capabilities approach has done) powerful critiques of, or methods of evaluating, real-life global health interventions; by proposing potentially useful future institutions for the betterment of human health; and so on.

It might be worthwhile, in closing, to consider an analogy between the field of global health justice and the better-established field of clinical ethics.¹⁶ It is surely the case that ambitious moral theorists have helped bioethicists think through their ethical convictions in a number of important ways. Bioethics would surely be worse off without the contributions of such ethical theorists as Frances Kamm, Jeff McMahan, and, yes, Peter Singer.

But it is also worth recalling in this connection that practical, clinical ethics has long had a generally anti-theoretical cast, and that there have been both prudential and philosophical reasons for this. Clinical ethicists have avoided theory-talk mostly as a matter of prudence. Where a bedside decision needs to be made, discussions about background theoretical commitments are beside the point, and could create distracting disagreement unnecessarily. Moreover, reference to ethical theory could mark the ethicist as ‘flighty’ and out of touch with the realities of the clinic. Ethicists on public commissions and policy-making bodies have avoided discussion of theoretical commitments for similar reasons.

The two major ‘methods’ in clinical ethics – the Beauchamp and Childress ‘principles’ method¹⁷ and the so-called Four-Box method – are each explicitly anti-theoretical. The ‘Four-Box’ method, originating in Jonsen, Siegler and Winslade’s book *Clinical Ethics*,¹⁸ is essentially a method for focusing the discussion of cases in all of their concrete detail. It is designed to facilitate and guide a casuistic process of case analysis, so that new cases can properly be assimilated to previously considered paradigm cases. Discussion of each new case is focused around four topics (medical indications, patient preferences, quality of life and contextual features), each of which is further specified and broken down into sub-topics. No claim is made about the origins of these topics in any ethical theory; instead, the idea is to make every case discussion both uniform and thorough, so that areas of commonality with settled paradigm cases can easily be identified. Later versions of the approach note that discussion of each of the topics will be guided by consideration of ethical principles, and that analogies between new cases and paradigm cases will be drawn on the basis of principles; but again, no particular claims are made about the origins of principles in ethical theory.

Beauchamp and Childress have changed their view of the relationship of their ‘principles’ approach to ethical theory over time. Early editions of their classic

16 I am indebted, in this section, to John Arras’s extensive and illuminating discussion of the relationship of theory to bioethics in his ‘Theory and Bioethics’, *Stanford Encyclopedia of Bioethics*, Edward N. Zalta (ed.), available at <http://plato.stanford.edu/archives/sum2010/entries/theory-bioethics/>.

17 See Tom L. Beauchamp and James F. Childress, *Principles of Biomedical Ethics*, 6th edn (Oxford: Oxford University Press, 2009).

18 Albert R. Jonsen, Mark Siegler and William J. Winslade, *Clinical Ethics: A Practical Approach to Ethical Decisions in Clinical Medicine*, 7th edn (New York: McGraw Hill Medical, 2010).

Principles of Biomedical Ethics claimed that the ‘mid-level’ principles they use to frame discussion of bioethics cases could be generated by any number of ethical theories. Both Mill and Kant believed in the importance of permitting people to make their own choices, for example, and both were concerned to limit harm done by agents to others. Certainly both were committed to distributional justice. Their conflicting theoretical grounds for supporting these mid-level ethical principles could therefore safely be ignored, and the discussion of concrete cases begun without reference to them. In more recent editions of the same book, though, the story has changed. ‘Mid-level principles’, instead of having their origin ‘top down’ from any number of higher-order ethical theories, are imagined as having their origins ‘bottom up’, as generalizations from ground-level judgements about concrete cases.

These two main methods of clinical ethics have therefore drifted together over time. In one, concrete case discussion is treated as the core method, but ethical principles have an acknowledged role to play in framing case discussion and comparing cases. In the other, the core method involves application of ethical principles to new cases, but those principles are acknowledged as having had their origin in concrete case discussion. Both methods are well-established as practical and useful. In the United States, for example, thousands of hospitals have clinical ethics consultation services which make use of one or another of these methods, and dozens of legal cases have featured the testimony of clinical ethics experts versed in both. Neither method evokes, in its application, any connection to any full-blown ethical theory. Both rely on context-heavy intuition and judgement, especially when principles conflict, or when relevant paradigms seem inconsistent. Both methods are consistent with a broad range of meta-ethical commitments, as well as commitments to professional, religious and common secular moral views. Both have proven practically useful, and neither implies any scepticism about the reality of the ethical conclusions they facilitate.

It may be that what global health justice needs now is not better theory, but more attention to method.