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Needs, Obligations and International Relations for Global Health in the Twenty-First Century

Solomon R. Benatar

There is a crisis in the world today, now felt even by those of us who enjoy the power and privilege at the top of the world. There is a crisis of violence, . . . There is a crisis of misery, and threat of poverty . . . There is a crisis of repression, and threat of repression of all human rights . . . There is a crisis in the environment . . . At the root of the crises is not resource scarcity or price increases or population pressure, but the world structure.¹

Introduction

Global health has increasingly become a major focus of interest in recent years. The context is a world that, while greatly transformed by spectacular advances in science and medicine and major growth of the economy, is characterized by widening disparities in health, well-being and the achievement of human rights.² Such a world, shaped by powerful social, economic and political forces (particularly over the past 30 years through economic policies associated with neo-liberal ideology) that have benefited a small proportion of the world's population maximally and the rest minimally (if at all), is now under severe threat.

This is evidenced by several longstanding trends, most recently the global economic crisis, that have serious implications for health. Inadequate constraints on financial and other trading processes, excessive consumption within a consumerist way of life associated with endless entitlements and economic policies that are designed to ensure accumulation of wealth by a few have

1 Johan Galtung, *True Worlds* (New York: Free Press, 1981).

2 Solomon R. Benatar, 'Global Disparities in Health and Human Rights: A Critical Commentary', *American Journal of Public Health*, 1998, 88: 295–300; Solomon R. Benatar, 'Millennial Challenges for Medicine and Modernity', *J Roy Coll Phys Lond*, 1998, 32: 160–5; Solomon R. Benatar and Gillian Brock (eds), *Global Health and Global Health Ethics* (Cambridge: Cambridge University Press, 2011).

entrenched and exacerbated widespread poverty and poor health for many.³ Almost 50 per cent of all people in the world lack access to even the most basic health care, and live under conditions of severe poverty and environmental degradation in both rural and urban contexts.⁴ People of color, females and the very young are heavily overrepresented among the global poor.

Disparities in health and well-being at a global level

Wide disparities in quality of life, health and access to health care can be succinctly illustrated with a few statistics: (i) life expectancy at birth ranges from about 40 years in such countries as Sierra Leone, Angola and Afghanistan to over 80 years in others such as Japan, Switzerland and Australia; (ii) mortality in children under 5 years of age ranges from less than 5:1,000 live births to over 180:1,000 live births; (iii) maternal mortality is a high of 1 in 7 pregnancies in Somalia and as low as 1 in 11,000 pregnancies in Canada; (iv) annual per capita expenditures on health care is below \$15 in many poor countries, over \$8,000 in the United States, and averages about \$4,000 in many countries.

Africa is the region most severely afflicted by poverty, infectious diseases and premature deaths. Of over 800,000 deaths globally from malaria each year 91 per cent are in Africa, with 85 per cent of such African deaths in children under 5 years of age. Five million African children under 5 years old die each year of preventable diseases. Of 33 million people who were living with HIV in the world in 2008, 22 million were in Africa. Of the estimated 536,000 annual maternal deaths globally, 99 per cent occur in developing countries. Eighteen million deaths each year (one-third of all deaths) are due to poverty-related causes with 50 per cent of these deaths in children under 5 years of age.⁵ Chronic diseases are also increasing globally bringing new challenges to health systems in both rich and poor countries.⁶

Disparities within countries are also striking. So, for example, in the United States, CEO earnings compared to average workers have increased from 25-fold in the 1970s to 90-fold in 2,000 and to 500-fold in 2004. Between 1980 and 2006, the wealthiest 1 per cent of Americans tripled their after tax per cent of national income, while the share of the bottom 90 per cent dropped

3 Solomon R. Benatar, Stephen Gill, Isabella Bakker, 'Global Health and the Global Economic Crisis', *American Journal of Public Health*, 2011, 101(4): 646–53.

4 Global Health Watch, *Global Health Watch 2005–2006* (London: Zed Books, 2007).

5 See many chapters in Benatar and Brock (eds) *Global Health and Global Health Ethics*, for these and other factual data on disparities.

6 Abdallah S. Daar, Peter A. Singer, Deepa Leah Persad, Stig K. Pramming, David R. Matthews, Robert Beaglehole, et al., 'Grand challenges in chronic non-communicable diseases', *Nature*, 2007, 450: 494–6.

by 20 per cent. Between 2002 and 2006, 75 per cent of national economic growth went to the top 1 per cent who own 70 per cent of national wealth. Four hundred US billionaires own more than 155 million Americans combined. The US health care system is the most expensive in the world, yet 50 million citizens are without health care, and the United States ranks thirty-seventh in health status in the world. Almost one-and-a-half million Americans filed for bankruptcy in 2009, a 32 per cent increase from 2008. Medical bankruptcies accounted for 60 per cent, and 75 per cent of these were filed by people with health insurance.⁷

Global health

Interest in global health has developed against a background of longstanding involvement in international health that has its focus on health across regional or national boundaries and on the provision of health care assistance in one form or another by health personnel or organizations from some areas or nations (usually wealthy) to other (usually poorer) people or nations.⁸ As Ross Upshur and I have described elsewhere, global health goes beyond this. While its scope remains contested, it can be thought of as:

the science and art of preventing disease, prolonging life and promoting physical and mental health through organized global efforts for the maintenance of a safe environment, the control of communicable disease, the education of individuals and whole populations in principles of personal hygiene and safe living habits, the organization of health care services for the early diagnosis, prevention and treatment of disease, and attention to the societal, cultural and economic determinants of health that could ensure a standard of living and education for all that is adequate for the achievement and maintenance of good health.⁹

In the chapter referred to above we have also suggested that paraphrasing Richard Lewontin in his book ‘Biology as Ideology’¹⁰ allows a view of global health as:

a social concept about which there is a great deal of misunderstanding, even among those who are part of it. Those who work on global health view the topic through a lens that has been moulded by their social experience.

7 David DeGraw, ‘The Economic Elite Have Engineered an Extraordinary Coup, Threatening the Very Existence of the Middle Class’, 2010, www.alternet.org/economy/145667.

8 Paul K. Drain, Stephen A. Huffman, Sara E. Pyrtle and Kevin Chan, *Caring for the World: A Guidebook to Global Health Opportunities* (Toronto: University of Toronto Press, 2009).

9 Solomon R. Benatar and Ross Upshur, ‘What is Global Health?’, in Benatar and Brock (eds) *Global Health and Global Health Ethics*.

10 Richard C. Lewontin, *Biology as Ideology* (New York: Harper Collins, 1991).

David Stuckler and Martin McKee have described five metaphors that could be applied to global health.¹¹ *Global health as foreign policy* (here the motive is political and relates to strategic interests and economic growth); *Global health as security* (where the primary aim is to protect against infectious diseases and bioterrorism); *Global health as charity* (emphasizes ‘victims’ and the consequences of poverty and disempowerment); *Global health as investment* (based on the idea that improving health is a major factor in maximizing economic growth). Finally and perhaps most plausibly, *Global health as public health* has the purpose of decreasing the global burden of disease, and most especially those diseases that make up the largest proportion of this burden. These authors acknowledge considerable overlap between the attitudes that lie behind these perspectives and that powerful nations will differ on which they consider to be their dominant priority.

Processes contributing to widening disparities in health

It is interesting to recall that improved health and life-expectancy for many were achieved during the industrialization era in ‘developed countries’ (through improvements in the social conditions of life) long before modern medical treatments became available. For example, with better nutrition and living conditions in the United Kingdom the annual mortality rate from tuberculosis fell from 500 per 100,000 people in 1750 to 50 per 100,000 in the early 1940s before anti-tuberculosis medications were discovered.

Between 1945 and 1970, a second wave of improvements in health and well-being followed through reconstruction of a global economy that had been severely compromised by the Great Depression and two World Wars. Job creation, widespread use of innovative technology, regulation of banking and other financial activities, appropriate redistributive mechanisms and strengthening of essential social and community services such as access to education and health care all contributed to narrowing of disparities.

This is the background against which modern medical advances could be effectively applied to facilitate the eradication of many epidemic infectious diseases. Much was achieved in wealthy countries by the 1970s, as exemplified by further reduction in the annual death rate from tuberculosis to about 2 per 100,000 in the United Kingdom.

However, since the late 1970s, neo-liberal economic policies (now acknowledged as based on flawed economic theory and dogma) stimulated economic growth and improved medical care largely for the benefit of the top

11 David Stuckler and Martin McKee, ‘Five Metaphors about Global-Health Policy’, *The Lancet*, 2008, 372(9633): 95–7.

20 per cent of the global population. For the remaining majority, post-war trends towards improvement in wealth and health began to reverse under such policies. The extent to which these policies aggravated the impact of HIV/AIDS in poor countries has been well-documented.¹² It should be noted that in South Africa apartheid policies largely limited economic and health advances to white people, and it is not surprising that multi-drug-resistant tuberculosis, and the emergence and spread of HIV became additional markers of the longstanding poor health of the black majority, despite the availability of modern drug treatments.

John Kenneth Galbraith, in his mid-twentieth-century books identified individualism, unlimited wants, self-interest and 'rationality' (characterized as dominated by calculating and measuring) as the myths underlying mid-twentieth-century economics.¹³ Charles Taylor described individualism, the primacy of instrumental reason (mathematical calculation of the most economical means to ends, and loss of the sense of sacredness), together with restriction of choices by the politics of a technical industrial society, as the three malaises of modernity.¹⁴ Among others, Robert Heilbroner¹⁵ and Ursula Franklin¹⁶ have expressed similar concerns about the implications of a mechanical and technologically dominated trajectory of progress.

I concur with these authors that distorted values lie at the heart of global disparities and portend a potentially bleak future. Hyper-individualism, unlimited wants, narrow and short-term self-interests and restricted conceptions of freedom, rationality and rights, described very synoptically here, are prominently exhibited by those of us who are the most privileged.

Hyper-individualism

Hyper-individualism can be defined as taking to an extreme the hard won achievement of much valued (and now highly vaunted) freedom of the individual. A focus on the 'anomic' self (minimally connected to community or society), results in the erosion of a sense of solidarity and of connection to others and society, and loss of a sense of awe about life and our natural environment. There is also significant lack of moral imagination regarding the plight of so many fellow creatures, and of our complicity in creating and

12 Rick Rowden, *The Deadly Ideas of Neoliberalism: How the IMF Undermined Public Health & the Fight against AIDS* (London & New York: Zed Books, 2009).

13 John K. Galbraith, *The Affluent Society* (Boston: Houghton Mifflin, 1958); John K. Galbraith, *The New Industrial State* (Boston: Houghton Mifflin, 1976).

14 Charles Taylor, *The Malaise of Modernity* (Toronto: House of Anansi Press, 1991).

15 Robert Heilbroner, *An Inquiry into the Human Prospect* (New York, NY: W. W. Norton, 1974).

16 Ursula M. Franklin, *The Real World of Technology* (Massey Lectures 1989), Revised Edition (Toronto: House of Anansi Press, 1999).

sustaining systems that ignore and aggravate the plight of the less fortunate.¹⁷ It is interesting to reflect on the asymmetry between intense interest in the sanctity of life when abortion and the use of stem cells are debated, as compared with the minimal value seemingly accorded to the (in)dignity and suffering of children already born who are neglected, hungry and die prematurely of preventable disease.

Narrow concept of freedom and of self-interest

A narrow concept of freedom associated with hyper-individualism emphasizes freedom 'to' do what whatever one wishes (liberty), over the concept of freedom 'from' want of basic survival needs (e.g. food and water) and freedom from oppression. The addition of *narrow self-interest* further eclipses notions of duty, obligation and commitment to others and society and allows short-term considerations to trump longer-term interests.

Market and consumerist ideology

A market and consumerist ideology that increasingly pervades all aspects of life encourages *unlimited wants* as the norm. Consequently many individuals and nations, who view the accumulation of wealth and material possessions as the major goals of life, become deeply indebted while living beyond their means, often in pursuit of frivolous goals. In such a world the acquisition of private (consumer) goods overshadows much-needed attention to the essential public goods (education/healthcare) required to hold societies together and nurture the next generation. Exponential consumption, dominance of corporate goals in health care,¹⁸ greed and seemingly insatiable personal wants/entitlements overshadow the notion of at least some degree of austerity as an important value for a good life and a good society. The professions have not escaped such trends, and there is widespread evidence of the erosion of professionalism.¹⁹

Restricted notion of rationality

A restricted notion of rationality focusing on calculable and measurable outcomes is associated with the view that 'science' offers *the* solutions to

17 Solomon R. Benatar, 'Moral Imagination: The Missing Component in Global Health', *Public Library of Science Medicine*, 2005, 2(12): e400.

18 Eliot Freidson, *Professionalism, The Third Logic* (Chicago: University of Chicago Press, 2003); William H. Wiist, 'Public Health and the Anticorporate Movement', *American Journal of Public Health*, 2006, 96(8): 1370–5.

19 Anthony T. Kronman, *The Lost Lawyer: Failing Ideals of the Legal Profession* (Cambridge: Harvard University Press, 1993); Hebert M. Swick, 'Academic Medicine Must Deal with the Clash of Business and Professionalism', *Academic Medicine*, 1998, 73: 741–55; Matthew K. Wynia, 'The Short History and Tenuous Future of Medical Professionalism: The Erosion of Medicine's Social Contract', *Perspectives in Biology & Medicine*, 2008, 51(4): 565–78.

all problems. While it is not disputed that science and medical advances are necessary, it is surely problematic to consider these to be sufficient. Much is lost when the quest for new knowledge is valued more than old knowledge, and when all knowledge is valued more than wisdom in the application of knowledge. Moreover, spiritual and ‘compassionate rationality’, and the value of caring are not easy to measure and are therefore undervalued in a world in which monetary value and technological practices dominate over inter-personal caring skills.

Narrow conception of human rights

A narrow conception of human rights that emphasizes civil and political rights tends to ignore social, economic and cultural rights (even though all the rights listed in the UDHR are supposed to be indivisible and inalienable). Such a conception of rights also eclipses the reciprocal responsibilities that form part of the conceptual logic of rights, and avoids identification of the bearers of such reciprocal duties. While we focus our attention on individual perpetrators of human rights abuses within nations, and fail to see the world moving towards a post-Westphalian conception of global interdependence, inadequate attention is directed to the powerful *systems forces* that undermine human rights across national boundaries at the level of whole populations.²⁰

As a general result of all of the above there is disjunction between economic growth, advances in science, technology and medical care and the ability to use these to improve health more equitably within nations and more widely.²¹ A specific result is the erosion of our capacity to reproduce the caring social institutions (health, education, child nurturing) so essential for healthy societies.²² When countries like the United States do not seem to respect their own citizens sufficiently to provide universal access to health care more equitably, and the pursuit of increasing wealth for a minority takes place at the expense of the basic needs of majority, there is a need to be profoundly sceptical of the reigning value system.²³ ‘Inequality is corrosive. It rots societies from within.’²⁴ It has also been previously argued that:

substantial improvements in global health will depend on acknowledging that poor health at the level of whole populations reflects systemic dysfunction in a complex world . . . (and that improving global health) will require greater moral

20 Solomon R. Benatar and Len Doyal, ‘Human Rights Abuses: Balancing Two Perspectives’, *International Journal of Health Services*, 2009, 39(1): 139–59.

21 Benatar, ‘Global Disparities in Health and Human Rights’.

22 Stephen Gill and Isabella Bakker (eds), *Power, Production and Social Reproduction* (London: Zed Books, 2003).

23 Tony Judt, *Ill Fares the Land* (New York: Penguin Books, 2010).

24 Cited in *ibid.*, 21.

imagination (the ability of individuals and communities to empathize with others) to break the impasse we currently face in improving global health.²⁵

A world in entropy

A composite evaluation of these trends reveals what Stephen Gill has called a 'global organic crisis', made up of multiple, deep and interlinked crises that include crises in many aspects of human security – healthcare, education, energy, food, governance, territory and information.²⁶ Other manifestations of a world undergoing entropy include recrudescence of infectious diseases (when it was thought that these had been largely vanquished), clashes of civilizations, the global economic crisis and environmental degradation.²⁷

The health and lives of billions of people are being, and will continue to be affected by climate change – through direct long-term effects on water security, food chain integrity, population migration and displacement, redistribution of vector borne diseases and significant short-term health impacts from catastrophic extreme climatic events.²⁸

There are also significant environmental health concerns globally that are not directly associated with climate change such as the cruel manner in which humans 'farm' animals in mass production facilities, and contaminate food and water supplies with cumulative amounts of toxic industrial agents.²⁹ These are all global in nature, but may have differential local health impacts worsened by systematic, often remediable, disadvantaging of whole populations. Climate change, together with competition for resources, marginalization of the majority of people in the world and global militarization are arguably major potential threats to world peace.³⁰

Obligations

The potential foundations for international obligations to improve health globally could be conceptualized through a range of overlapping 'lenses'. Rather

25 Benatar, 'Moral Imagination'.

26 Stephen Gill and Isabella Bakker, 'The Global Crisis and Global Health', in Benatar and Brock (eds) *Global Health and Global Health Ethics*.

27 Solomon R. Benatar, 'Millennial Challenges for Medicine & Modernity', *Journal of the Royal College of Physicians of London*, 1998, 32: 160–5.

28 Sharon Friel, Colin Butler and Anthony McMichael, 'Climate Change and Health Risks and Inequities', in Benatar and Brock (eds), *Global Health and Global Health Ethics*.

29 David Benatar, 'Animals, the Environment and Global Health', in Benatar and Brock (eds) *Global Health and Global Health Ethics*.

30 Solomon R. Benatar, 'War, or Peace and Development: South Africa's Message for Global Peace and Security', *Medicine, Conflict and Survival*, 1997, 13: 125–34.

Table 4.1 Moral lenses through which to view international obligations

Historical	Retributive and compensatory justice
Social justice	Distributive justice
Self-interest and security	Medium- and long-term mutual advantage
Ecological	Preserving the environment for future generations
Human rights	Comprehensively understood and applied
Needs	As distinct from rights
Solidarity	Humanitarian obligations of global citizens
Finite resources	Duty to set priorities explicitly
Moral global economy	Fairness in accumulation and distribution
International professional standards	Virtue in professionalism
Global crises	Facing complexity

than attempting to provide detailed arguments from each of these perspectives, only a brief taxonomy and synopsis is provided here (Table 4.1).

Historical

Viewing the distal, upstream causes of wealth distribution around the world through the lens of slavery, colonialism and other forms of exploitation (e.g. racism in apartheid South Africa) enables us to see that arguments for retributive justice have the powerful potential to sensitize us to the obligations of those beneficiaries of practices that have had a deep and sustained adverse impact on many generations of people in affected countries. Good arguments for compensation to victims of the Holocaust and to those who appealed to the Truth and Reconciliation Commission in South Africa provide some examples of moral justification for retributive justice.³¹

Social justice

While there may be disagreement among philosophers and others about exactly what social justice means and how it could be achieved, there is surely no disagreement that when access to the basic needs for a minimally decent human existence are denied to so many, both within wealthy nations and across the globe, there is moral urgency to at least begin to diminish such injustice.³²

Madison Powers and Ruth Faden provide guidance on how to think about health inequalities within an approach that views social justice as

31 Martha Minow, *Between Vengeance and Forgiveness: Facing History after Genocide and Mass Violence* (Boston: Beacon Press, 1998).

32 Jonathan Glover, 'Poverty, Distance and Two Dimensions of Ethics', in Benatar and Brock (eds), *Global Health and Global Health Ethics*.

the foundation of public health and public health policy.³³ Gillian Brock's cosmopolitan account of global justice defends the equal moral worth of every person globally without ignoring all considerations such as nationality or other identities.³⁴ Following a review of criticisms and defenses of Rawls's Law of Peoples, she provides a theoretical account of cosmopolitanism and some practical suggestions for reducing gross global injustices through protection of individual liberties, reduction in poverty and protection of public goods.

Norman Daniels and James Sabin, noting as many others have done that there is no agreement on any substantive account of distributive justice, have described a procedurally fair process ('accountability for reasonableness') for setting priorities in the allocation of health-care resources.³⁵ While many see this as an acceptable means of setting priorities in the context of limited resources,³⁶ Richard Ashcroft has chastised bioethicists for taking this 'easy way' out of a persisting dilemma.³⁷ While agreeing with him that tough issues should continue to be pursued intellectually, within the current globally dominant economic system no country, regardless of how wealthy, can provide all that medicine could offer to everyone all the time. Therefore, setting priorities is a pragmatic reality that must be faced. With constructive changes to the global economy (see below), the resources available for providing more health care could be greatly increased, with resulting less stringent need for setting priorities.

With regard to pursuing social justice in relation to the global distribution of resources for health, there are also no easy answers. I suggest that making progress here would be dependent on a series of changes. These would include wealthy and powerful nations accepting the need for, and working towards less social injustice within their own borders, some changes to the way in which the global economy functions to reverse widening disparities in the accumulation of wealth, and imaginative approaches to redistribution that would require some constraints on 'casino-like' economies.³⁸

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

34 Gillian Brock, *Global Justice: A Cosmopolitan Account* (Oxford: Oxford University Press, 2008).

35 Norman Daniels and James Sabin, *Setting Limits Fairly: Can We Learn to Share Medical Resources?* (Oxford: Oxford University Press, 2002).

36 Douglas K. Martin and Solomon R. Benatar, 'Resource Allocation: International Perspectives on Resource Allocation', in Kris Heggenhougen and Stella Quah (eds) *International Encyclopedia of Public Health*. Vol 5. (San Diego: Academic Press, 2008).

37 Richard Ashcroft, 'Fair Process and the Redundancy of Bioethics: A Polemic', *Public Health Ethics*, 2008, 1(1): 3–9.

38 Benatar, Gill and Bakker, 'Global Health and the Global Economic Crisis'; Jeffrey Sachs, *The Price of Civilization* (New York: Random House, 2011); Solomon R. Benatar, 'Justice and Priority Setting in International Health Research,' in Richard Ashcroft, Angus Dawson, Heather Draper and John R. McMillan (eds), *Principles of Health Care Ethics*, 2nd edn (Chichester: John Wiley and Sons, 2007).

Self-interest and security

The emergence and rapid spread globally of many new infectious diseases (HIV, SARS and Avian flu having the highest contemporary profile) are stark reminders of the major threats to individual and population health posed by emerging infectious diseases.³⁹ Increasing resistance to drugs used to treat many diseases (e.g. tuberculosis, malaria and HIV) pose additional global threats. Moral arguments favouring expenditure on reducing the emergence and spread of such diseases are supported by the potential for saving many lives.⁴⁰ Arguably, those with knowledge and resources have at least some responsibility to prevent such tragedies in the future. Human security is similarly threatened in the medium- and long-term by food, water and shelter insecurity.⁴¹ These not only lead to immediate harms for many but also have the potential to lead to mass migration, increased numbers of refugees living under desperate conditions and wars of redistribution associated with reciprocal devaluation of lives.

Ecological

Considerations of the current impact of climate change and environmental degradation and of the ongoing implications for health of future generations as such change escalates provide a moral basis for taking preventive actions.⁴² Excessive consumption of meat, the production of which is less food energy efficient than production of vegetable forms of protein, enhances environmental damage and should provide motivation for preventive action that could considerably improve global health.⁴³

Human rights

The Universal Declaration of Human Rights of 1948 (UDHR) and all the energy devoted to attempting to ensure that such rights are widely satisfied have not met with the extent of success many have long hoped for.⁴⁴ Nevertheless,

39 Solomon R. Benatar, 'The Coming Catastrophe in International Health', *Canadian Journal of International Affairs*, 2001, 56(4): 611–31.

40 Michael Selgelid, 'Justice, Infectious Diseases and Globalization', in Benatar and Brock (eds), *Global Health and Global Health Ethics*.

41 Anne-Emanuelle Birn, 'Addressing the Societal Determinants of Health: The Key Global Health Ethics Imperative', in Benatar and Brock (eds), *Global Health and Global Health Ethics*; Lynn McIntyre and Krista Rondeau, 'Food Security and Global Health', in Benatar and Brock (eds), *Global Health and Global Health Ethics*.

42 Friel, Butler and McMichael, 'Climate Change and Health: Risks and Inequities'.

43 Benatar, 'Animals, the Environment and Global Health'.

44 Solomon R. Benatar, 'Global Health and Human Rights: Working with the 20th Century Legacy', Annual Human Rights Lecture, University of Alberta 2011, www.uofaweb.ualberta.ca/humanrightslecture/.

the language and motives of the human rights endeavour are potentially powerful means of promoting improvements in health and well-being globally.⁴⁵

Extending the discourse on human rights beyond the popular rhetoric of civil and political rights to include all the indivisible and inalienable rights proclaimed in the UDHR will require attention to systems forces that promote human rights abuses in addition to seeking out and punishing and/or educating individual perpetrators.⁴⁶ The Declaration of Human Duties and Responsibilities, which could have a role in extending the reach of the UDHR, also deserves a higher profile.⁴⁷

Needs

The extent of unmet basic human needs is revealed by the statistics provided earlier. These are augmented by a few additional facts: two-and-a-half billion people lack access to basic sanitation, 2 billion lack access to essential medicines, 1.6 billion lack electricity, 1.02 billion are chronically undernourished, 924 million have inadequate shelter, 884 million do not have access to safe water, 774 million adults are illiterate and 218 million children are child labourers.⁴⁸

Few would contest that health could be defined as the ability and the opportunity to utilize one's natural endowments to achieve the potential to live a full and satisfying life. Achievement of health requires attention to the social and societal needs that so powerfully influence health and disease. A lifelong supportive environment is required, and should include good pre-natal care, safe childbirth, a nurturing childhood, adequate education, prevention of avoidable diseases and opportunities to flourish physically, socially and intellectually. Modern health services, over and above such social forces, should provide access to affordable, effective health care with recognition of the limits of medicine, particularly at the end of long lives or in the face of irremediable prolonged suffering, where alleviation of pain and comfort care may be the most appropriate.

45 Jonathan Wolff, 'The Human Right to Health,' in Benatar and Brock (eds), *Global Health and Global Health Ethics*; Stephanie Nixon and Lisa Forman, 'Exploring the Synergies between Human Rights and Public Health Ethics: A Whole Greater than the Sum of Its Parts', *BMC International Health and Human Rights*, 2008, 8(2); Gurcharan Bhatia, John O'Neill, Gerald L. Gall and Patrick D. Bendin (eds), *Peace, Justice and Freedom: Human Rights Challenges for the New Millennium* (Alberta: University of Alberta Press, 2000).

46 Benatar and Doyal, 'Human Rights Abuses'; Solomon R. Benatar, Abdallah S. Daar and Peter A. Singer, 'Global Health Ethics: The Rationale for Mutual Caring', in Benatar and Brock (eds), *Global Health and Global Health Ethics*.

47 M. C. Patricia Morales, *The Declaration of Human Duties and Responsibilities: From Human Rights to Responsibilities of the Global Community*. Available at www.onlineunesco.org/conferencias/tele6/human%20duties%20and%20responsibilities.ppt#256,1.

48 Thomas Pogge, 'The Health Impact Fund: How to Make New Medicines Accessible to All', in Benatar and Brock (eds), *Global Health and Global Health Ethics*.

Distinction between needs and rights

The UDHR has led to 'Human Rights' as a 'new standard of civilization' for judging nations.⁴⁹ This Declaration, supported by growing legislation to promote and enforce rights, has achieved many successes and it is widely acknowledged that both the concept and the language of rights are powerful. However, as noted by Michael Ignatieff:

Rights language can meet some needs but not all . . . For example the need for respect and consideration, fraternity, love and belonging that engender a sense of worth . . . Rights language offers a rich vernacular for the claims an individual may make on or against the collectivity but it is relatively impoverished as a means of expressing the individual's need for the collectivity. It is because fraternity, love, belonging, dignity and human gestures which confer respect, cannot be bought, nor rights guarantee them as entitlement, that any decent society requires a public discourse about . . . human needs.⁵⁰

Anne Robertson has proposed that a language of need provides a moral discourse for promotion of health and the common good – 'a moral economy of interdependence' that is more appropriate to the notion of common good. She argues that such language goes beyond an individualistic oriented 'political economy', accounts for the inherently 'political nature of need' and situates the definition and adjudication of needs within community life. Notions of reciprocity are also incorporated that go beyond the dichotomy of dependence and independence.⁵¹

Len Doyal and Ian Gough argue on moral grounds that the freedom to develop one's potential must be coupled to 'freedom from want' of basic needs. They view security of the person and access to first-order biological needs (food, clean water and shelter) as some of the essentials for decent lives. They also contend that a sense of empowerment and control over ourselves is essential for human flourishing. Human flourishing requires respect for the basic needs and dignity of others, respect for the full range of human rights, belief in the rule of just law, the willingness to take responsibility for one's actions and societal well-being, deriving satisfaction from work well done, contributing to new knowledge and the freedom to develop one's full potential. Twelve broad categories of 'intermediate needs' that define how the need for physical health and personal autonomy are fulfilled are described by them: adequate nutritional food and clean water; adequate protective housing; a safe environment for working; a supply of clothing; a safe physical environment; appropriate health care; security in childhood; significant primary relationships with others;

49 Jack Donnelly, *Universal Human Rights in Theory and Practice* (London: Cornell University Press, 1989).

50 Michael Ignatieff, *The Needs of Strangers* (New York: Viking Press, 1984).

51 Ann Robertson, 'Critical Reflections on the Politics of Need: Implications for Public Health', *Social Science and Medicine*, 1998, 47(10): 1419–30.

physical security; economic security; safe birth control and child-bearing; and appropriate basic and cross-cultural education. Determination of how needs should be satisfied requires rational identification of needs using the most up-to-date scientific knowledge, the use of the actual experience of individuals in their everyday lives and democratic decision-making.⁵²

As rights alone are insufficient, more attention must be focused on needs, for example the needs of children. Declarations of the rights of children are potentially powerful but realistically only become relevant when the basic duties of care and affection that parents and societies should have towards the needs of children are failing (duty here is a conceptually different notion from the duties reciprocal to rights). Moreover, rights cannot guarantee love, a sense of belonging and of being valued for one's existence and potential. Meeting these needs is of crucial importance, as eloquently stated by Michael Ignatieff (see page 75).

Solidarity

Solidarity as global citizens, supported by valid moral arguments,⁵³ is widely expressed through the efforts of many humanitarian endeavours. Solidarity can be considered as:

[A]ttitudes and determination to work for the common good across the globe in an era when interdependence is greater than ever and in which progress should be defined as enhancing capabilities and social justice . . . Without solidarity it is inevitable that we shall ignore distant indignities, violations of human rights, inequities, deprivation of freedom, undemocratic regimes, and respect for the environment. If a spirit of mutual caring could be developed between those in wealthy countries and those in developing countries, we see constructive change as being possible.⁵⁴

Finite resources

Given that endless economic growth is not feasible and that our planetary resources are finite, there is a great need to foster better understanding of the limits of our entitlements, and what our societies 'owe' us. Setting priorities is an unavoidable feature of life, in the context of limited resources. When priorities are set through transparent, explicit and accountable processes that involve representatives of all relevant stake-holder groups, and opportunities for appeals and revision are built into the process, setting priorities within

52 Len Doyal and Ian Gough, *A Theory of Human Need* (London: McMillan, 1991).

53 Peter Singer, *One World: The Ethics of Globalization* (New Haven: Yale University Press, 2001); Glover, 'Poverty, Distance and Two Dimensions of Ethics'.

54 Solomon R. Benatar, Abdallah S. Daar and Peter A. Singer, 'Global Health Ethics: The Rationale for Mutual Caring', *International Affairs*, 2003, 79(1): 107–38.

achievable limits could be more easily accepted and applied. Some recent examples in health care show the way.⁵⁵

Moral global economy

Dissatisfaction with the way the global political economy operates to the disadvantage of the majority of the world's people has been the subject of debate over many decades.⁵⁶ The outcome of seminars on social progress in Copenhagen was acknowledgement that the forces of economic globalization are erosive of democracy, and that good reasons could be mounted for developing a more moral economy.⁵⁷ More recently John Kenneth Galbraith,⁵⁸ Stephen Gill,⁵⁹ Justin Fox,⁶⁰ Jeffrey Sachs⁶¹ and Tony Judt,⁶² among others, have written eloquently of the serious shortcomings in economic theory and practice that led to the still unfolding economic crisis – confirming what Galbraith had predicted many decades ago, and that is now becoming obvious to more people:

The present age of contentment will come to an end only when and if the adverse developments that it fosters challenge the sense of comfortable well-being. As well as the strong and successful political appeal to the disadvantaged I have already mentioned, there are three other plausible possibilities as to how this will happen. They are: widespread economic disaster, adverse military action that is associated with international misadventure, and eruption of an angry underclass.⁶³

Reflection on the fact that the United States has spent \$1 trillion on the war in Iraq, and that this is equal to 30 years of US foreign development aid reveals the potential dividend for alternative uses of resources. The implications of the 'Occupy Wall Street' movement, as one form of long pursued 'globalization

- 55 Douglas K. Martin, Peter A. Singer and Mark Bernstein, 'Access to ICU Needs for Neurosurgery Patients: A Qualitative Case Study', *J Neurology, Neurosurgery and Psychiatry*, 2003, 74(9): 1299–303; Jens Mielke, Douglas K. Martin and Peter A. Singer, 'Priority Setting in Critical Care: A Qualitative Case Study', *Critical Care Medicine*, 2003, 31: 2764–8; Samia A. Hurst, Nathalie Mezger and Alex Mauron, 'Allocating Resources in Humanitarian Medicine', in Benatar and Brock (eds), *Global Health and Global Health Ethics*.
- 56 Susan George, *A Fate Worse than Debt* (London: Penguin Books, 1988).
- 57 *Building a Global Community. Globalization and the Common Good* (Copenhagen: Royal Danish Foreign Ministry for Foreign Affairs, 2000).
- 58 John K. Galbraith, *The Economics of Innocent Fraud: Truth for Our Time*, (Boston: Houghton Mifflin, 2004).
- 59 Stephen Gill, *Power and Resistance in the New World Order*, 2nd edn (New York: Palgrave MacMillan, 2008).
- 60 Justin Fox, *The Myth of the Rational Market: A History of Risk, Reward, and Delusion on Wall Street* (New York, NY: Harper Business/Harper Collins, 2009).
- 61 Jeffrey Sachs, *The Price of Civilization* (New York: Random House, 2011).
- 62 Judt, *Ill Fares the Land*.
- 63 John K. Galbraith, *The Culture of Contentment*, (New York: Houghton-Mifflin Company, 1992), 156–7.

from below'⁶⁴ is another example of the relevance of Galbraith's perspicacity. Guidance is also available from Adam Smith:

No society can surely be flourishing and happy, of which the far greater part of its members are poor and miserable.⁶⁵

International professional standards

Many deeply held values within the health-care professions and in the scientific community are believed to be universal. For example, within the medical profession these include respect for human dignity, empathy and compassion, dedication to excellence, the desire not to harm and to do good, seeking equity in the delivery of health care and pursuit of new knowledge without exploiting the vulnerable.⁶⁶ In science, simplicity and elegance of theory, internal consistency, predictive value, the potential for unifying diverse observations, good judgement, curiosity, intuition and creativity are universal values.⁶⁷ Commitment to widespread propagation of these standards could add to the force with which the view through the other lenses described above may be implemented.

Global crises

The complex organic crisis, to which Stephen Gill has referred,⁶⁸ and the implications of such for the future of our planet and of all life provide yet another lens through which to perceive some of the moral obligations (based on their access to knowledge and resources) for wealthy nations to accept and act on their role to ameliorate the human condition and improve the future. Arguments from an understanding of a systems perspective⁶⁹ and of the interactions of technology and society⁷⁰ become relevant here.

What can be done? Some practical considerations

While it is utopian to consider that equity can be achieved in such a world, the future looks bleak if we do not soon embark on measures that could at least

64 Jeremy Brecher, Tim Costello and Brendan Smith, *Globalization from Below: The Power of Solidarity* (Cambridge, MA: South End Press, 2000).

65 Cited in Judt, *Ill Fares the Land*, 12.

66 Ros Levinson, Steve Dewar, Susan Shepherd, *Understanding Doctors: Harnessing Professionalism* (London: King's Fund, 2008).

67 Committee on the Conduct of Science, *On Being a Scientist*, US National Academy of Sciences, 1989, available at www.pnas.org/content/86/23/9053.full.pdf.

68 Stephen Gill (ed.), *Global Crises and the Crisis of Global Leadership* (Cambridge: Cambridge University Press, 2011).

69 Anatol Rapoport, *General System Theory* (Tunbridge Wells: Abacus Press, 1986).

70 Franklin, *The Real World of Technology*.

begin to reverse some of these seemingly inexorable trends. It is credible to suggest that 'business as usual' will not work and that innovative social ideas and action are required to achieve meaningful progress in health and human rights in the twenty-first century. John Kenneth Galbraith reminds us that it is not utopian to pursue achievable goals.⁷¹

We should begin with some introspection to allow re-evaluation of our current paradigm of thought, entitlements and actions. I shall not reiterate here the arguments for the examined life, but the need for each of us, and especially those who are privileged, to accept this, is surely unquestionable. Second, we need to promote the development of a global state of mind about our interdependence as global citizens, and enhanced moral imagination regarding the interconnectedness of all life. These ideas have been described more fully elsewhere.⁷²

The next focus of attention should be the global political economy, which has been described as '*the result of a combination of negligence, hubris and wrong economic theory*'.⁷³ It has now become an imperative to strive actively to achieve wider public acknowledgement that the global economy is based on a flawed economic paradigm and policies. As the economic crisis is a manifestation of a world made more unstable in part by (exponential) patterns of consumption that deplete resources, the inevitability needs to be widely accepted that doing better with less will be one of the characteristics of progress. Privatization of profits and socialization of losses can no longer continue to be the norm.⁷⁴ The massive recent losses that have profoundly affected health and well-being of many globally should be addressed by short-term, medium-term and long-term restructuring of the global political economy with social justice foremost in our minds.⁷⁵

These tasks require re-shaping of public conversations, a more responsible media and new social attitudes to life. It is reasonable to claim that it is not beyond human ability to modify the 'free-market' through reasonable constraints and improved accountability. Tax avoidance, tax evasion and international taxation all need to be reviewed.⁷⁶ In addition, trade rules that have been locked into place over recent decades in line with neo-liberal economic policies and the 'new constitutionalism' could be modified in a constructive manner.⁷⁷

71 John K. Galbraith, *The Good Society* (Boston: Houghton Mifflin, 1996).

72 Benatar, Daar, Singer, 'Global Health Ethics'; Benatar, 'Moral Imagination'.

73 Stephen Gill and Isabella Bakker, 'The Global Crisis and Global Health', in Benatar and Brock (eds), *Global Health and Global Health Ethics*.

74 Benatar, Gill S. and Bakker, 'Global Health and the Economic Crisis'.

75 Ibid.

76 Gillian Brock, 'Taxation and Global Justice: Closing the Gap between Theory and Practice', *Journal of Social Philosophy*, 2008, 39(2): 161–84.

77 Meri Koivusalo, 'Trade and Health: The Ethics of Global Rights, Regulation and Redistribution', in Benatar and Brock (eds), *Global Health and Global Health Ethics*.

A 'new common sense' to achieve this would include measures to 'bolster the social commons . . . in ways that are consistent with greater democracy, social justice and social and ecological sustainability'.⁷⁸ Achieving this would require, inter alia, a more equitable broad-based tax-system where capital and ecologically sustainable consumption are taxed more than labour. How to best achieve such goals should become the goal of a multi-disciplinary research thrust.

Finally there is a need to set moral examples. The example of South Africa's peaceful transition from apartheid to democracy in the early 1990s, with the development of a model constitution, is one such example of a visionary compromise when facing the abyss.⁷⁹ While many mistakes have been made by the new government, few would contend that South Africa would have been better off if the negotiated political transition had not been made in 1994. As difficult as it was to achieve that transition, and as complex as the ensuing steps required to lead to a more socially just society may be, such complexity is no excuse for not trying.⁸⁰

Conclusions

I conclude by reiterating the recommendation previously made by Anne-Emanuelle Birn that the lead taken by some to fund ambitious programmes to develop vaccines for AIDS, malaria and tuberculosis should be matched by the formulation and pursuit of several alternative Grand Challenges aimed at finding solutions to some of the problems outlined in this chapter.⁸¹ In the same way that a multitude of ambitious researchers from diverse fields of biology and science have come together to address complex scientific challenges, so it would seem to me that a range of committed and adequately funded scholars in the social sciences could work together in a productive manner to seek and find imaginative and workable solutions to the humanly constructed social complexities we face in the twenty-first century. New ways of thinking could assist us in breaking away from the current impasses to achieve meaningful human progress.⁸²

78 Isabella Bakker and Stephen Gill, 'Towards a New Common Sense: The Need for New Paradigms of Global Health', in Benatar and Brock (eds), *Global Health and Global Health Ethics*.

79 Allister Sparks, *Tomorrow is Another Country* (New York: Hill and Wang, 1995).

80 Solomon R. Benatar, 'South Africa's Transition in a Globalizing World. HIV/AIDS as a Window and a Mirror', *International Affairs*, 2001, 77(2): 347–75; John K. Galbraith, *The Socially Concerned Today* (Toronto: University of Toronto Press, 1998); Judt, *Ill Fares the Land*.

81 Anne-Emanuelle Birn, 'Gates' Grandest Challenge: Transcending Technology as Public Health Ideology', *The Lancet*, 2005, 366(9484): 514–19.

82 Solomon R. Benatar, 'Global Leadership, Ethics and Global Health: The Search for New Paradigms', in Stephen, *The Global Crisis and the Crisis of Global Leadership* (Cambridge: Cambridge University Press, 2011).