Global Health Inequalities and Inequities

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Inequalities of one kind or another are a ubiquitous feature of human life. The more aspects of human experience researchers measure, and the greater the accuracy with which they measure them, the more inequalities they uncover. Some inequalities are generally thought to matter more than others: movements are formed to fight for greater income equality and equal rights to democratic participation, but not for an equal distribution of television sets. Inequalities in health are often thought to be particularly difficult to justify.

This article examines which health inequalities on a global scale are unjust, and considers who should have the duties to rectify these injustices. Making claims about the injustice of global health inequalities commits theorists both to claims about the role that health should play in a theory of justice, and to claims about the extent to which there are global duties of justice which would require significant redistribution. Both topics remain controversial. However, as the last section of this article explores, resolving these disputes is not necessary in order to determine which global health inequalities should be an initial priority, as a variety of reasonable perspectives converge on the judgment that the most egregious global health inequalities are indeed unfair.

The diversity of health inequalities

It is well known that health outcomes differ widely between countries. The scale and nature of health inequalities has shifted over time, with an overall long-term upward trend in life expectancy in virtually all countries. Precise figures will change from year to year and often markedly, based on the presence of conflict, natural disasters or the success of public health strategies. Nonetheless, it is worth briefly considering some figures for illustrative purposes. In 2012 according to CIA and World Bank datasets, a child born in Japan had a life expectancy at birth of 34 years longer than one born in Swaziland; the infant mortality rate in Mali was more than 40 times higher than it was in Singapore, and the lifetime risk of maternal death was more than 800 times higher in Guinea-Bisau than it was in Italy. (For up to date sources of datasets, see the web resources at the end of this article). Sometimes there are significant inequalities in health outcomes even within the same narrow geographical area: for example, the Commission on the Social Determinants of Health (2008) revealed that there was a 28 year age gap in life expectancy between men in the richest and the poorest part of the Scottish city of Glasgow. Looking beyond these headline figures reveals further very significant differences in health outcomes: for example, malaria is a major killer in sub-Saharan Africa, but makes a negligible contribution to the burden of disease in Western Europe.

There are also significant inequalities between countries in inputs relevant to health, such as the total amount spent on healthcare, which varied in 2012 from $16 per citizen per year in Eritrea to $8347 per citizen per year in the U.S., or the amount spent on health care as a percentage of GDP (from 2% in Myanmar to 17.9% in U.S. in 2012). Again, as researchers look beyond the top-line figures, additional inequalities become visible, such as the pharmaceutical budget per person, the percentage of the population that has access to improved sanitation, and the number of diseases for which there is an effective childhood vaccination policy. (Up to date

figures can be obtained from the WHO Global Health Observatory Data Repository and World Bank: see web resources.)

The relationship between health inputs and health outcomes

The relationship between health inputs and health outcomes is both epistemically and normatively complex. It is epistemically complex, because there are no simple causal principles that correlate changes in top-line health inputs such as size of healthcare budget with size of changes in top-line health outputs such as life expectancy. As Cartwright and Hardie argue, even where there is knowledge about the effects that a shift in a particular health input has on a particular health outcome in one country, there is little reason to be confident that shifts in that same health input will play the same causal role in other countries.

The variety of ways in which health inputs affect health outcomes has significant normative implications too. Making two countries more equal in one health input will often make them less equal in one or more health outcomes. Correlatively, making two countries more equal on a particular health outcome will often require making them less equal on one or more health inputs. Healthcare spending was over five times greater in the U.S. than in Costa Rica in the period 2000-2012 (WHO figures), but life expectancy was slightly worse for both men and women in the U.S., as revealed by Salomon et al in the Global Burden of Disease Report 2010. If a world government had equalised the amount spent on healthcare per person between the U.S. and Costa Rica, this would have increased, rather than decreased, the difference in life expectancy between the two countries. Given the different causal paths through which health inputs are translated into health outcomes in different countries, it is generally thought to be impossible to eliminate all health inequalities between countries.

Some health inequalities do not appear to be unfair. To give an example, a study of 1000 major European and North American pop stars 1956–2005 revealed that they 'experience significantly higher mortality (more than 1.7 times) than demographically matched populations in the USA and UK', (Bellis et al. 2007, 896), thus showing a significant health inequality between pop stars and the ordinary members of the public. But few would feel that the researchers had thereby uncovered an injustice that the European and US governments should be in a hurry to address, given that pop stars are a powerful and socially privileged group, whose decreased life expectancy appears to be due in large part to their choices to adopt high-risk behaviors.

The concept of a health inequity

Given that it is neither morally required to correct all inequalities in health, nor possible to do so, it is important to draw a distinction between health inequalities, that is, 'differences, variations, and disparities in the health achievements of individuals and groups,' (Kawachi et al. 2002, 647) and health inequities, that is health inequalities that are all things considered, unjust. So a more precise way of framing the central question of this entry would be: which global health inequalities are health inequities?

By far the most commonly cited definition of a health inequity is that by Whitehead (1990, 5), who defines health inequities as differences in health which are 'unnecessary and avoidable but, in addition are also considered unfair and unjust'. The idea that health inequities are by definition 'unnecessary and avoidable' leads Whitehead to the controversial conclusion that it is only inequalities that are caused by social factors as opposed to natural factors that are inequitable.

This arguably casts the net of health inequities in too narrowly. (Wilson 2011) Even if it would be unjust and undesirable to attempt to equalize health achievement across world, it would not follow that people whose disabilities cannot be

remediated through medical treatment have no claim to some form of rectification on grounds of justice. For example, doctors may not be in a position to give someone who is blind sight, and clearly it would be undesirable to blind the rest of the population to restore equality. But there are other possible interventions, such as ensuring that buildings are arranged for easy navigation by blind people, or ensuring that all official documents are available in Braille, which many people take to be required by justice.

Inequalities in health and quality of life as a result of disability have increasingly been recognized as a potential violation of human rights -- especially since the ratification of the UN Convention on the Rights of Persons with Disabilities (2006). Indeed, much of the mainstream philosophical writing on justice over the last 30 years has taken a 'luck egalitarian' direction -- assuming that undeserved disadvantages due to bad luck *do* raise issues of justice. Segall provides useful examination luck egalitarianism in the specific context of health.

Health Inputs, Health Outcomes and Justice

Any account of global health inequities needs to clarify which inequalities in health inputs and which inequalities in health outcomes are most morally objectionable, and why. There are a number of possible positions on this question. First, it could be argued that inequalities in health inputs do not really matter unless they have effects on health outcomes. On this view, if one country has twice the number of doctors per person, or spends twice as much on its health system as the other, but the significant health outcomes in each country are the same, there is no unfairness to those in the country with the less health expenditure and less doctors. (Some might have this intuition about the U.S. and Costa Rica example considered earlier).

Alternatively, it could be argued that it is only distribution of health *inputs* that matters fundamentally, and that inequalities in health outputs are morally objectionable only in so far as they are a result of an unfair distribution of health

inputs. Suppose two countries spend the same per citizen on their health system, but the first country prides itself on providing full access to all expensive new therapies, whilst the second country prefers to ensure that only maximally cost effective treatments are provided and puts a significant percentage of its health resources into prevention. It is highly likely that overall health outcomes such as life expectancy will be better in the second country than in the first. On the view that only health inputs matter, the resultant inequalities would not be unfair to the citizens of the first society -- so long as the prioritisation decisions were arrived at appropriately in both cases.

A third possibility would be that both distributions of health inputs and distributions of health outcomes can matter for their own sake. It might be argued that differences in health inputs that do not lead to differences in health outcomes can be unfair, as where a particular proportion of the society are unfairly excluded from access to a treatment that later proves to be ineffective. It might also be argued that differences in health outcomes that occur in spite of similar health inputs can be unfair: an example of this might be a case where two countries devote the same amount to their healthcare system, but the healthcare system in the second country faces much sterner challenges due to its geographical location or a disease epidemic that was not reasonably foreseeable.

Finally, one possibility that must be taken seriously is that inequalities in health -- whether inequalities in inputs or in outcomes -- are not of fundamental importance for justice. This would not necessarily be to say that health is unimportant, but merely to say that health does not matter fundamentally and separately for justice. For example, many views are committed to the claim that wellbeing or opportunity is the only good that matters fundamentally for justice. On this view, health would be significant for justice insofar as it affected wellbeing or opportunity but not apart from this.

Many of the large inequalities in health inputs and health outcomes that were considered earlier are likely to be correlated with significant inequalities in overall wellbeing or opportunity. Hence, many of the states of affairs that would be deemed unjust if one thought that health mattered fundamentally for justice would still be deemed unjust if one thought that wellbeing was the only thing that mattered, though the reasons for objecting to the state of affairs would differ. In the one case the fundamental problem would be a maldistribution of health, in the other, a maldistribution of wellbeing that was partially caused or constituted by a maldistribution of health.

As Hausman argues, things are more complicated in cases where inequalities in health come apart from overall inequalities in wellbeing. As of 2012, Paraguay had a male life expectancy of ten years greater than Russia, but Russia had a per capita income of over three times as high as Paraguay. Russia also scored higher on the Human Development Index. In considering this case, Hausman concludes that assisting Russia to improve its male life expectancy to the level of Paraguay would be likely to "amplify rather than mitigate the inequality in overall well-being" (2012, 43) between the two countries. He concludes that there is little reason to think that justice requires that a number of different goods such as health, income, and access to education are each equalized separately, and that allowing some cross-subsidy between the categories is more plausible.

Basic Equality and Global Justice

Equality has often been described as the master value for contemporary political philosophy. The idea that all human beings are of fundamentally equal moral status, and that any plausible account of justice must be expressive of, or at the very least compatible with, this basic equality is a starting point for all reasonable positions about domestic justice -- as Kymlicka and Sen have argued. There is more controversy about what, if anything, the equal moral status of human beings implies

about duties of global justice: the debate divides between various cosmopolitan positions, which argue that the basic equality of human beings straightforwardly implies that duties of justice have a global scope, and political accounts of justice, which deny this.

Cosmopolitan approaches can be more or less concessive to existing state-based approaches to justice. Scheffler distinguishes between extreme and moderate cosmopolitanism. Extreme cosmopolitanism claims that the *only* principles of justice that have true moral force are global ones, whilst moderate cosmopolitanism allows that there can also be considerations of justice that are important for their own sake which bind at a national or local level. Scholars such as Brock and Miller also distinguish between strong and weak cosmpolitanisms - where strong cosmopolitanism is committed to a demanding account of distributional equality (such as global equality of opportunity or a global difference principle), whilst weak cosmopolitanism is committed only to a less exacting goal, such as a minimally decent life for all.

Supporters of a political approach to justice argue that cosmopolitanism misunderstands the purpose and justification of claims of justice. According to the political approach, justice is a specifically political virtue which gives strong reasons for structuring existing political institutions, but does not set duties outside of the context of such institutions. In Nagel's (2005, 120) words,

> sovereign states are not merely instruments for realizing the preinstitutional value of justice among human beings. Instead, their existence is precisely what gives the value of justice its application, by putting the fellow citizens of a sovereign state into a relation that they do not have with the rest of humanity, an institutional relation which must then be evaluated by the special standards of fairness and equality that fill out the content of justice.

If this is correct, all obligations of justice are associative obligations, which apply only within the context of a given community. This would also imply that there is no

obligation to enter into the kinds of relationship with others that expose you to additional associative obligations.

The political view is first and foremost an account of the limits of obligations of justice. Its defenders would admit that the territories within which claims of justice can be made have expanded on a number of occasions -- for example with the Italian Risorgimento, or the creation of the European Union. So a key empirical question is whether global institutions already exist of the kind that political approaches would deem necessary for there to be obligations of global health justice. If there are such institutions, then political conceptions of justice would require us to recognise obligations of global justice.

As Buchanan argues, it is increasingly difficult to maintain that the institutions that would be necessary for obligations of justice to be global do not yet exist, given that there are both coercive and cooperative structures in place at a global level which profoundly shape the life-chances of members of all societies. There are a large number of global institutions such as the World Trade Organisation (WTO), the United Nations (UN), the World Bank, the International Monetary Fund (IMF) and International Criminal Police Organisation; in addition there are a number of significant transnational institutions such as the EU, the G8, and NATO which further deepen global and regional governance.

Human rights instruments such as the International Covenant on Economic, Social and Cultural Rights and the International Covenant on Civil and Political Rights have been ratified by the vast majority of countries. Moreover there is extensive economic interdependence between different countries around the globe, witnessed for example by the global financial crisis of 2008. These systems of interdependence cannot practically be avoided by citizens of poorer countries, and frequently impose a pattern of burdens and benefits that may not be to the greatest advantage of those who are worst off. In sum, it seems reasonable to assume that duties of justice should have a global reach in some sense -- though this leaves open the question of

how stringent such duties should be, and whether there may be reasons for legitimate partiality to one's fellow nationals.

Legitimate Partiality?

On an extreme reading of cosmopolitanism, the basic equality of human beings straightforwardly implies that distance, location and citizenship are irrelevant when it comes to justice (and more generally to moral duties). Peter Singer provides a simple and influential argument for this approach (though Singer, as a utilitarian is more interested in claims of moral obligation than in justice). Singer takes it that given basic equality, and the badness of suffering and death, it is obvious that all moral agents have a moral duty to prevent death and suffering, where they can do so without thereby sacrificing anything of comparable moral importance. He exemplifies this with the famous *Shallow Pond* example: if I am walking past a shallow pond, and see a child and see that a child is drowning, I ought to wade in and pull the child out, even though this will involve some inconvenience to myself.

On Singer's account, neither distance nor the number of other people in a position to help, make any difference to the duty to aid. (Whilst people often feel a psychological difference between cases where they do nothing to help whilst they are the only person who could possibly help, and cases where there are many potential rescuers, Singer argues that this does not present a plausible *moral* reason.) Singer concludes from this that basic equality entails that there are extensive duties to give money away—or to help in other appropriate ways— to prevent suffering. The argument thus has a clear implication when it comes to thinking about global health: from basic equality and the fact that much could apparently be done relatively cheaply to improve global health, all persons in wealthy countries have a clear duty to devote a significant proportion of their resources to alleviating this suffering.

However, there are others who argue that basic equality does not imply that factors like distance and nationality are irrelevant. Miller argues that most moral views

recognize the existence of agent-relative duties based on special relationships: any parent has a right (and also a duty) to devote more time and attention to the care of their own children than to children with whom they do not have a special relationship. Parents have such duties to their children despite the fact that their own children are objectively no more important than anyone else's. This argument establishes that it is plausible to think that special relationships create morally appropriate reasons to treat some more favorably than others.

Nationalists such as Miller argue that the ties that bind members of the same nation together can provide morally appropriate reasons for prioritizing the needs of fellow citizens over foreigners -- even though the suffering of a fellow citizen is objectively no more important than that of a foreigner. They acknowledge that the fact that people do feel ties and obligations to people in other countries provides *some* support for the irrelevance of nations; but argue that this is weak support given the greater obligations people do in fact feel to their fellow nationals. In addition, they argue that the attempt to institute genuinely global approaches to justice would significantly curtail national self-determination – a value that many feel they have reason to value highly.

One unresolved question is the level of partiality to fellow nationals that is compatible with giving due recognition to the equal moral status of all human beings. All current governments distribute their health budgets in a way that is highly partial to the health needs of their own citizens. For example, in 2012 the UK government spent around $192 billion to protect the health of its 63 million citizens through its National Health Service. Although the UK is one of the more generous countries in giving aid, in the same year it spent only around $11 billion on overseas aid. Only a proportion of this aid was health related, and the aid budget was spread between the seven billion persons on the planet who are not UK citizens. The net result was that the UK spent at least 2,000 times more per person to resolve the

health problems of its citizens than it did on resolving the health problems of citizens from other countries.

Does the global economic order cause the ill health of the poor?

Paying due regard to the relationships in which agents stand to one another could lead to the conclusion that it is more important, rather than less, to address the health problems of foreigners. Pogge argues that agents have a particular responsibility to ensure that they do not harm to others, and to make amends when they do injure others. This responsibility, he argues, is not sensitive to who the people are that the agent has harmed, or where they live: it makes no difference if they are fellow countrymen or foreigners. He concludes that "foreigners' medical conditions, if social institutions we are materially involved in upholding substantially contribute to their incidence, have greater moral weight for us than compatriots' medical conditions in whose causation we are not materially involved" (2002, p.72)

If the causes of the global burden of disease are as Pogge argues them to be, this is a highly significant point. Pogge argues that much ill health is caused by, or exacerbated by, poverty; and that the global economic order avoidably engenders much of this poverty. He further argues that those who are responsible for upholding this order, amongst whom he includes all citizens of wealthy democratic states who could campaign to change the terms of the global economic system but choose not to do so, are responsible for the harm that the system avoidably causes. Hence citizens of wealthy democratic states should give far more weight to removing the conditions which cause ill health amongst the global poor, and have a duty to rectify the harm that they have caused.

Obviously, such a claim is controversial. Initial reactions to it will range from the thought that it is obviously true, in virtue of the large numbers of people who die from poverty related diseases each year, to the thought that it is obviously false, because average life expectancy around the world has increased very significantly since the global institutions that Pogge blames for the immiseration of the poor were set up. Assessing the validity of Pogge's argument requires complex analysis that is beyond the scope of this entry, including an examination of the facts about global development, what should count as a harm in this context, and the degree to which it is reasonable to hold ordinary citizens of wealthy countries responsible for harms caused by institutions like the WTO. (Risse provides a useful analysis of these issues).

The diversity of objections to large global health inequalities

Whilst discussion of the global burden of disease is often framed in terms of health inequalities, it is less than clear on further analysis that inequalities in health are the only, or even the main, problem. The Global Burden of Disease Report 2010 revealed that citizens of Haiti then suffered from the worst healthy life expectancy in the world - 27.8 years for men, and 37.1 years for women. There are a number of different reasons that either stem from, or are compatible with, basic equality that could be put forward to support the claim that it is objectionable that people in Haiti enjoyed so little healthy life.

One reason could be the sheer fact of inequality: the thought could be that it is the inequality between the healthy life expectancy of Haitians and those of others which is the basic moral problem. Another reason could be that what is unfair is not so much that Haitians are living less long lives than other people, but that they are living less long lives than they ought to. This suggestion amounts to the claim that

we should compare their life chances to an absolute standard, namely to the conditions necessary for a minimally decent life, or more ambitiously, for a flourishing life. On this view, even if the rest of the world were to become much worse off, and so the Haitian healthy life expectancy became the median one for the world as a whole, the Haitians' health life expectancy would be no less unfair.

Still another set of reasons would focus on the causes of ill health in Haiti - perhaps (like Pogge) placing this at the door of the current global economic system, or looking further back into the specific circumstances that have led to the current poor health outcomes in Haiti -- including the reparations that the country was forced to pay to France after it threw off colonial rule at the end of the 18th century, the U.S. occupation in the early twentieth century, and the subsequent dictatorship.

In general, where it is possible to identify people who are unquestionably very badly off both in relative and in absolute terms, and badly off both in terms of health and in broader wellbeing, a wide variety of different theoretical perspectives will converge on the view that there is a duty to rectify the situation.

However, even where a situation is so bad that nearly all reasonable persons would agree that something needs to be done to rectify it, there are a further set of questions about what kind of help should be provided by citizens and governments of other countries. Some, such as Singer, have on occasion talked as if what is required is relatively simple: giving more money in aid. However, such a view has been criticized as over-optimistic. Others argue that the chief factor that makes the difference between slower and quicker development is a country's political culture and the nature of its institutions. To the extent that this institutional view of development is correct, any aid will have to perform the difficult job of helping to construct the political culture and institutions necessary for a country to prosper: giving money may do little to help and and of itself.

Conclusion

It is plausible to think that there are some duties of global justice. Either duties of justice are cosmopolitan, or they are not. If they are cosmopolitan, then the existence of global duties of justice immediately follows from the basic equality of human beings. If duties of justice are political in type, and only arise within the confines of an existing political community, then it is still implausible to deny that there are duties of global health justice. This is because the institutional structures of the world -- through entities like the WTO and the UN -- is such that there are both coercive and cooperative structures in place which profoundly shape the life-chances of members of all societies.

Whilst there may be some legitimate partiality to fellow-countrymen, it is unclear how large this legitimate partiality will be, in an era of increasing globalization of institutions and when citizens themselves increasingly look beyond their country's borders. The fact that there are also special duties to avoid harming others and to rectify harms that one has caused may mean that there are cases where it is more urgent to rectify ill-health abroad than domestically. The article mentioned, but did not settle the question of how large inequalities have to be before they trigger justified claims of unfairness, and whether health inequalities are more morally problematic than inequalities in other goods at a global scale. In any case, there appear to be a number of distinct reasons for thinking that some particularly large inequalities in health and wellbeing should be rectified.

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