The Need to Address Global Health Disparities: Exploring Ethical Frameworks
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As the world is undergoing significant developments in modern technology, research, travel, and communication, the term “global health” is growing more and more widespread. One can simply enter the two words into a Google search engine and receive 386,000,000 results at her fingertips. This expanse of information allows different members of the globe to learn and connect on new levels. Nowadays, a student in Northfield can learn about infant mortality in Angola and Ebola in Liberia with the click of a button. Better yet, that same student can jump on a plane and experience the health care system in Peru firsthand by volunteering with a humanitarian aid organization. With this increased connectedness and awareness, great disparities in global health are coming to light. Statistics on life expectancies, infant and maternal mortality, disease rates, etc. reveal that although the globe may be growing more connected, great discrepancies still exist between both between and within countries and subpopulations. This influx of information and awareness of global health disparities is making people ask, what are we supposed to do? What sort of ethical obligations does this awareness bring? Is the United States responsible for lengthening the average life span in Somalia, or decreasing infant mortality in Zambia?

As we have discussed in class, a number of philosophers, ethicists, economists, etc. have offered their perspectives on these issues. Some argue that we should devote resources to address significant global health disparities in the name of protecting human rights, or because a small sacrifice can lead to big positive change. Others argue that we should not devote resources to address significant global health disparities because what we make is our own to keep. This paper explores such ethical arguments, among others, concerning the need to address global health disparities.

Given the globalization of the world today, it makes sense to think of each individual as not only being a citizen of his or her own nation, but also as a citizen of a global world. When applying this viewpoint to an ethical framework, we result in “cosmopolitanism”, an ethical perspective “that takes individual human beings – regardless of where they happen to reside and independently of what national or ethnic group they are members of – as the fundamental objects of moral concern” (Buchanan and DeCamp, p.119). Consequently, the cosmopolitan take provides a compelling argument for why we should devote resources to address significant global health disparities. Cosmopolitans argue that there is no moral distinction between countries, and that each person has duties of justice to all others regardless of where they live (Wolff, p. 109). The cosmopolitan case for providing aid revolves around this idea that, as global citizens, we must provide for others around the world as we would hope they would provide for us. Pogge offers a strong case for political cosmopolitanism in applying the Rawlsian Veil of Ignorance on a global scale. In this case, “participants do not know which society they will end up in”, and it would result in a call for redistribution of resources so that “the person in the worst off position would be as well off as possible” (Hunter and Dawson, p. 82). Through the employment of a global veil of ignorance, it is clear that the cosmopolitan perspective offers concrete reasons to provide aid for others around the globe.

One of the most compelling arguments for providing aid comes from the human rights perspective, arguing that health is a fundamental human right for all. Whether we approach this idea from a “negative rights” or “positive rights” perspective, many ethical theorists still arrive at
the same conclusion that there is some inherent human right to health, and consequently some duty for rich nations to aid poor nations. Even if we don’t come at this approach from a positive, beneficent angle, we can still argue that there is some negative duty to do no harm that impacts the human right to health. Pogge argues that wealthy countries harm poorer countries by creating a “deficit in human rights” through engaging in practices that make the health of these poorer countries worse (Daniels, p. 99). Imposing this harm is unjust, especially if there is an alternative order that would avoid such a deficit in human rights.

Wolff asserts that there is some sense of international agreement when it comes to the promotion of human rights in general (p. 116). Why then should the human right to health be so different? Furthermore, as Buchanan and DeCamp illustrate, even if we do not view the right to health as an essential human right, we cannot deny that health is critical to enjoying other human rights. Using the familiar language of human rights in the protection of human agency implies that we must treat health as something inherent to achieving equal human rights for all citizens of the world. As such, it is the obligation of wealthier nations to aid poor nations in achieving the human right of health.

Sreenivasan also provides a compelling argument for why rich nations owe poor nations at least “a little” based on the Good Samaritan principle. His specific version of this answer implies that the richest nations have a minimal obligation to transfer 1% of their GDP to the poorest nations. This “trivial cost” to rich nations would prevent grave harms from coming to the inhabitants of poor nations. His use of non-ideal theory furthers to illustrate why his suggestion of the “1% GDP approach” is so compelling. He argues that we do not necessarily need to aim to reach the final goal right away (ideal theory), but rather, that we can define “interim targets for practical action”. Selgelid furthers Sreenivasan’s argument in Chapter 7 of Global Health and Global Health Ethics, arguing that “Only a minor sacrifice by wealthy developed nations would be required to achieve tremendous benefits in terms of reduced suffering and saved lives in poor countries” (p. 95). These two theorists’ contentions that a little could go a long way provide a compelling reason for why it is our duty to devote resources to address global health disparities: it would not take much to do a lot of good.

There are also less compelling arguments addressing the obligation of rich nations to devote significant resources to the health of poor nations in order to alleviate significant health disparities. There might be glimmers of hope in these less compelling arguments, but their organization and/or lack of a solid ethical framework, like the human rights framework previously mentioned, leave us wondering how their theories would be implemented on a global scale. For example, in chapter 11 of Global Health and Global Health Ethics, authors Benatar, Dean, and Singer tell us that the human rights approach is not the right framework to address global health disparities. Instead, they believe that a new ethical framework should be introduced. Their framework includes the values: respect for all human life; human rights, responsibilities (duties) and needs; equity; freedom; democracy; environmental ethics; and solidarity. In theory, addressing these values on a global scale would alleviate many global health disparities. However, we take issue with the broadness of the individual values and the list as a whole. The implementation of each and every one of these values seems like an impossible task.

These compelling and less compelling arguments concerning the devotion of resources to address significant global health disparities are met by two main arguments against the devotion of resources. Sreenivasan categorizes distributive justice into three camps of thought: The global
rich are obligated to give a lot, a little, or none at all. As unpopular as it is to reside in the camp with the feeling that the global rich are not obligated to distribute any resources to the global poor, there are those who remain attached to that viewpoint. Sreenivasan believes that the libertarians reside in that camp stating in regards to the non-ideal theory that, “Libertarians may reject the idea that the 1% transfer is an obligation of justice, or that it is in any way obligatory, preferring to regard it as a humanitarian act of charity.” Rawls and his followers were also weary of the obligation of rich nations to devote resources to the global poor. Within the article, Sreenivasan states that Rawls would reject the “the idea of permanent obligations of international distributive justice” opting for an idea related to obligations of transitional justice. Transitional justice is a way in which a burdened nation will be able to meet the needs of its inhabitants whilst seeking order. Rawls is notoriously fearful that if aid is provided without first determining a cut off point, the aid cannot and will not be easily withdrawn.

Another ethical argument against the obligation to distribute resources to address global health disparities was presented by Garrett Hardin in 1974 in his essay Living on a Lifeboat. Hardin’s lifeboat theory states that the global rich (about 1/3rd of the global population) are comfortably living in a few boats while the global poor (the other 2/3rds of the global population) are living in many extremely crowded boats with limited resources that are on the verge of sinking or have already sunk. As a result, many of the global poor are in the water seeking to board the lifeboats of the rich nations or asking for “handouts” from the boats of the rich nations. Hardin’s theory leads us to believe that the more of the global poor that we let into our boats or provide resources to, the more likely we are to sink our lifeboats or decimate the population on our boat due to other factors such as disease.

After exploring each of these ethical arguments, we ultimately conclude that we should devote resources to addressing significant disparities in global health. We do not believe, however, that any one of the above arguments fully encompasses the ethics associated with global health disparities and aid. In order to fully address the issue, we need to combine the different perspectives. By taking pieces from the human rights, cosmopolitanism, and Good Samaritan perspectives, we create a very compelling argument supporting the need to address global health disparities. First, by discussing health in terms of human rights, we allow for progress and meaningful conversation. The existence of human rights is a concept that most people can agree on without getting hung up on specific definitions and minute details. Once we approach the conversation of global health in terms of human rights, it is important to incorporate the cosmopolitan perspective. In many ways, the world is growing increasingly interconnected and aware. If we agree that health is a human right, it is hard to say that the moral obligation to uphold this right is limited by borders. What is needed next is a plan addressing how upholding the universal human right to health will happen. Sreenivasan's 1% plan based on the Good Samaritan principle is a good start, as he provides clear logic and data supporting the idea that rich nations giving just a little can help global health a lot. As we become more aware and interested in global health disparities, it is important that we consider these ethical frameworks so that meaningful change can be implemented.