# Health Equity Beyond Borders:
## The Demands of Justice in Global Health

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## *ABSTRACT*

Health is widely regarded as being among our most valuable goods and highest ideals. At the same time, the contemporary state of global health makes for grim reading with immense suffering and deprivation across mortality and morbidity, especially within developing countries. This thesis is a work of political philosophy which takes seriously the complex reality of global injustice in our world today. It provides a comprehensive political philosophical account of what justice demands in the sphere of global health.

My arguments in the thesis unfold over broadly two parts. In the first part of the thesis, I analyse some foundational debates in health and global health including how to conceptualise the nature and moral significance of health and healthcare, and how it ought to be balanced against other health and non-health pursuits both domestically and globally. These foundational discussions, together, provide the grounding for the forthcoming discussions while highlighting the importance of taking a global perspective in discussions of health justice.

In the second part of the thesis, I present a novel theory of global health justice I call *Genuine Opportunity for Health* (GOH). GOH argues that the currency of global health justice is pluralistic (incorporating health *outcomes* alongside considerations of health *security* and the *costs* of pursuing and maintaining health), and that everyone, regardless of nationality or place of birth, should have *genuine* opportunity to attain a decent and secure standard of health. GOH has important normative and practical implications across a range of dimensions, including in our conceptualisation of national responsibility, in the requirements of our rescue and global health duties, and in the permissibility of interventions to address brain drain.

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# Introduction
# THE PROBLEM OF GLOBAL HEALTH JUSTICE

The state of global health today is one characterised by immense suffering and deprivation across mortality and morbidity. A large proportion of us are especially alarmed by deprivations relating to health compared to deprivations in other dimensions of advantage – something that seems to hold across borders. When it comes to helping those beyond our immediate kin, many of us are often most willing to donate to causes that relate to health. We are especially moved, for example, by appeals from Médecins San Frontières or the Red Cross about a particular health emergency. Health is something that we seem to care about greatly – a view reflected across cultures and national borders.[1]

This thesis presents an account of what a just world would look like in which everyone, regardless of nationality or place of birth, has genuine opportunities to be healthy.[2] I call this the ideal of *health equity beyond borders*. As the thesis unfolds, I address three core questions that relate to *grounding*, *specifying*, and *realising* the ideal of health equity beyond borders. First, why is the ideal of health equity beyond borders a valuable ideal? Second, what is the nature and scope of this demand, and what are its limits? Third, what practical steps might we take to realise this ideal, here and now?

[1] I am not suggesting that we value health as the most important good, or that we are unwilling to make health versus non-health trade-offs. These claims are clearly false. Nevertheless, health has a morally salient value, which I defend as the thesis unfolds.
[2] I focus on nationality and place of birth as a shorthand term for broader features that cosmopolitan theorists of justice draw our attention to, and which may also include place of residence and ethno-cultural identity.

In this introductory chapter, I lay the conceptual and normative groundwork for the thesis as a whole. The ensuing discussion in this chapter is divided into five sections. In Section I, I very briefly paint a picture of the state of global health today. In Section II, I highlight some of the core concepts that will form an important part of the substantive discussions in the thesis. In Section III, I review and analyse the literature on (global) health justice and explain how my thesis contributes to this body of work. In Section IV, I offer some brief methodological comments, focusing on the relevance of political philosophy to the project of global health. In Section V, I provide a synopsis and outline of my thesis chapters.

## Section I: The State of Global Health

The state of contemporary global health is characterised by some striking facts. Virtually everyone will be aware of the general pattern of health in our world today, but it is worth highlighting the kinds of empirical backdrop a theory of global health justice is set against.

Someone born in the United Kingdom can expect to live to 81 years of age, while someone born in the Central African Republic can expect to live only 53 years.[3] Instances of maternal and infant mortality are rampant across many low- and middle-income countries.[4] Over 4,500 people die each day from something as preventable and curable as diarrhoea.[5] More than half of the world's population

[3] Max Roser, Esteban Ortiz-Ospina, and Hannah Ritchie, *Our World In Data: Life Expectancy* (2019), https://ourworldindata.org/life-expectancy.
[4] World Health Organization, *World Health Statistics 2023: Monitoring Health for the SDGs* (WHO, 2023); World Health Organization, *World Health Statistics 2019* (WHO, 2019), 10.
[5] C. Troeger et al., "Estimates of the Global, Regional, and National Morbidity, Mortality, and Aetiologies of Diarrhoea in 195 Countries," *Lancet Infectious Diseases* 18 (2018): 1211.

(55%) lack access to basic sanitation facilities.[6] The social conditions in which people live are often not conducive to good health. The prevalence of obesity is increasing, with worsening social risk factors in terms of fast-food outlet density and food marketing across many parts of the world. Levels of pollution around the world show no signs of improvement, with 99% of the global population breathing fine particulate matter above recommended safe levels.[7]

Amenable and manageable communicable and infectious diseases such as lower respiratory tract infections, diarrhoeal diseases, Hepatitis B, tuberculosis, and HIV/AIDS continue to account for nearly half of all deaths in low-income countries – conditions not reflected in the leading causes of death in high-income countries.[8] Access to basic healthcare services and vital medicines remain profoundly limited in many parts of the developing world.[9] The COVID-19 pandemic caused 14.9 million excess deaths worldwide in 2020 and 2021.[10] The initial rollout of the vaccines saw fewer than 1% of doses going to low-income countries, with over 80% going to high- and upper-middle-income countries.[11]

Actual health outcomes, as I shall argue, are only one measure of the state of global health justice. The conditions that promote and hinder health are also relevant, independently of health outcomes, and these differ significantly between and within countries. Evidence from the Commission on the Social Determinants

[6] World Health Organization, *World Health Statistics 2020* (WHO, 2020), 7.
[7] World Health Organization, *World Health Statistics 2023: Monitoring Health for the SDGs*, vii.
[8] World Health Organization, *World Health Statistics 2021*, WHO (2021), ix.
[9] Lukas Roth et al., "Expanding Global Access to Essential Medicines: Investment Priorities for Sustainably Strengthening Medical Product Regulatory Systems," *Globalization and Health* 14 (2018); World Health Organization, *World Health Statistics 2023: Monitoring Health for the SDGs*.
[10] World Health Organization, *World Health Statistics 2023: Monitoring Health for the SDGs*, vii.
[11] World Health Organization, *World Health Statistics 2021*, viii.

of Health demonstrates that the different social conditions in which we live, work, play, and age have a significant impact on our health.[12] This means that irrespective of their actual health outcomes, certain individuals and groups may have a much harder time achieving a good level of health due to their social, political, economic, and physical environment. Some reside in conflict zones that make it much harder to maintain their level of health, some suffer at the hands of illiberal regimes that violate their right to basic healthcare, many live in health-damaging environments and neighbourhoods, and social norms in particular contexts may make personal health much more costly to attain, to highlight just a few health promoting and hindering conditions. So-called lifestyle diseases (such as obesity) also raise concerns of global health justice, given their structural chains of causation and inequitable distribution within and across countries.

These facts and patterns – which, as I shall argue in due course, constitute an *injustice* – are similar across virtually all indicators of health, whether in terms of infant mortality, smoking rates, access to healthcare, or experience of the social determinants of health. To paraphrase Thomas Nagel, we do not live in a world with a just distribution of health outcomes and opportunities. That may be the least controversial claim to make in political theory.[13] What is less clear, however, is what health justice on a global scale might look like (especially given the complex reality of global health injustice) and what rights and duties it would entail. The overall aim of this thesis is to provide an answer to this question.

[12] Michael Marmot and Richard Wilkinson, *Social Determinants of Health*, 2nd ed. (Oxford University Press, 2006); Ronald Labonte, "Global Action on Social Determinants of Health," *Journal of Public Health Policy* 33 (2012).
[13] Thomas Nagel, "The Problem of Global Justice," *Philosophy & Public Affairs* 33 (2005): 113.

## Section II: Conceptual Preliminaries and Thesis Scope

It is important, at the outset, to clarify some core concepts that will be used throughout the thesis and to delineate the scope of the thesis as a whole.

### *Health, Healthcare, and the Social Determinants of Health*

Health is not as straightforward a concept as may initially appear. Our theoretical ideas of what health entails are shaky, and we cannot rely upon a solely *naturalist* account (whereby health is simply defined in value-free, biological terms) nor upon a solely *normativist* account (whereby health and disease are defined simply by reference to normative judgements about 'good' and 'bad', respectively, independently of whether or not it concerns biomedical function). I address the issue of defining health in more detail in Chapter 1, but for now we need simply to understand health as involving both a naturalist and a normativist component. *Health* refers to a state of biomedical function, sensitive to (but not derived solely from) considerations of social value. To foreshadow slightly, my core claim is that health must *necessarily* be related to biomedical function broadly construed, but health also has normative connotations and so it must be attuned to considerations of social value.

*Healthcare* refers to treatment and care provided by clinical professionals (such as doctors, nurses, pharmacists, paramedics, and other allied health professionals) for the purpose of protecting, restoring, and/or promoting our health. The delivery of healthcare is focused on individual patients and their specific health needs. Paradigmatic examples of healthcare include consulting our General Practitioner about our physical and mental health, surgical treatment in hospital, paramedics

rendering emergency medical assistance at the scene of an accident, pharmacists dispensing our prescriptions, and nurses providing clinical care in a hospital ward. It is common to assume that the distribution of *healthcare* is all there is to health justice. This is a mistake. Healthcare has an important role to play in any theory of health justice, as I shall establish in Chapter 2, but it is generally not the primary determinant of health outcomes when viewed in population terms and cannot be our only concern.

The *social determinants of health* are the conditions in which people live, and which are now accepted to be the primary determinant of how healthy a population is.[14] The social determinants of health include factors as broad as culture, social capital, housing, income and socioeconomic status, education, neighbourhood deprivation, and environment. Whether a population is healthy does not depend solely or even primarily upon their level of access to health*care*, but rather on the general social conditions in which they live. Factors as broad as neighbourhood design or transport policy, for example, can determine the levels of obesity in an area more than individual eating habits or access to clinical weight-loss services.[15] One of the foremost theorists of health justice, Norman Daniels, argues that he was mistaken in previous work to limit health justice to health*care* justice.[16]

[14] Marmot and Wilkinson, *Social Determinants of Health*; Commission for the Social Determinants of Health, *Closing the Gap in a Generation* (WHO, 2008).
[15] Boyd Swinburn et al., "The Global Obesity Pandemic: Shaped by Global Drivers and Local Environments," *The Lancet* 378 (2011).
[16] His initial influential book on the subject, *Just Health Care* was thus revised and written in the form of *Just Health* – the latter looking beyond healthcare to include the social determinants of health: Norman Daniels, *Just Health* (Cambridge University Press, 2007); Norman Daniels, *Just Health Care* (Cambridge University Press, 1985).

As I address in further detail in Chapter 2, many of these findings can be generalised globally, helping to explain how global social factors determine differential health outcomes across global populations. The World Health Organization (WHO) estimates that the social determinants of health are responsible for up to 55% of population health outcomes globally.[17] Other studies and empirical data paint a similar picture about the social determinants of health.[18] An account of (global) health justice must be attuned, therefore, not only to the distribution of healthcare but to the distribution of the social determinants of health more broadly. This desideratum broadens the scope of my thesis, explicitly reflected in the core theory of global health justice I outline and defend in Chapter 4.

***Global Health***

Theorists disagree on how best to conceptualise global health, as I highlight in Chapter 1. Some distinguish between *international* and *global health*, the former being concerned solely with institutional relationships between different countries' health systems and thus being narrower than the latter, which is generally concerned with the health of all people worldwide. This thesis adopts the broad interpretation of global health, using the term to refer simply to the state of health *globally*. The perspective of global health transcends borders and looks beyond the confines of particular countries' systems.

[17] "Social Determinants of Health," WHO, 2021, accessed 22 October, 2021, https://www.who.int/health-topics/social-determinants-of-health#tab=tab_1.
[18] OECD, *Universal Health Coverage and Health Outcomes*, OECD (2016), 6; Abigail Barker and Linda Li, "The Cumulative Impact of Health Insurance on Health Status," *Health Services Research* 55 (2020).

Someone interested in global health could be concerned with at least three different questions, which we can call *descriptive*, *explanatory*, and *normative* questions. First, one may have an interest in *descriptive* questions, such as what the global burden of disease is or what the prevalence is of a particular condition globally. Second, one may be concerned with *explanatory* questions, such as explaining why rates of HIV/AIDS are higher in one country compared to another. Third, we may be interested in *normative* questions, such as what our responsibilities are to those without adequate healthcare or how we ought to create social conditions that allow everyone in the world to be healthy. I address all three questions throughout the thesis, but my primary concern is with *normative* questions relating to global health.

***Justice***

The normative questions about global health I explore in this thesis primarily concern matters of *justice*. As I explore further in Section III, a large body of work addresses health and global health from a primarily ethical or moral perspective. An ethical or moral account focuses on what individuals *qua* moral agents ought to do at the bar of morality. A justice-based account, on the other hand, focuses on how political institutions should be structured, what we ought to do as a matter of public policy in response to global health challenges, and how individuals ought to act within these institutional and policy demands. The focus is not so much on what *I* as an individual moral agent ought to do in this specific situation, but rather what *public policies* ought to demand of institutions and individuals generally. Justice is concerned with providing general normative guidelines for the political realm, where we can define this simply as involving the domains of national and global

governments, social institutions, the public social and political culture, and laws and regulations.[19]

A justice-based account can also be contrasted with a mere charity- or beneficence-based normative account of global health.[20] Within political philosophy, *justice*-based accounts are frequently taken to entail enforceable rights and duties. Charity- and beneficence-based duties, on the other hand, are frequently treated as highly desirable and laudable actions that one ought morally to take, but there is no enforceable obligation to do so.[21] Failing to discharge duties of beneficence, on the mainstream understanding, may be viewed with disapproval but, unlike failing to discharge duties of justice, others may not compel us to do so. My thesis develops duties of global health *justice*, where these are *obligatory* and not merely desirable or optional – a point I return to shortly in Section III.

My account of health equity beyond borders relies upon a sufficientarian rather than an egalitarian framework, though one that generates robust rights and duties nevertheless. The sufficientarian framing is grounded on both pragmatic and non-pragmatic considerations – something I expand on in Chapter 4. For the sake of ecumenism, I am deliberately ambivalent about labelling my account 'cosmopolitan'. My account is cosmopolitan in the sense that the demands of health

[19] This is a deliberately ecumenical and broad definition of the political domain. It is not to trivialise existing debates about the domain of the political, and whether a coherent boundary can be set up between it and the 'moral' realm: Jonathan Leader Maynard and Alex Worsnip, "Is There a Distinctively Political Normativity?," *Ethics* 128 (2018); Elizabeth Frazer, "Political Theory and the Boundaries of Politics," in *Political Theory: Methods and Approaches*, ed. David Leopold and Marc Stears (Oxford University Press, 2008).
[20] Pablo Gilabert, "Justice and Beneficence," *Critical Review of International Social and Political Philosophy* 19 (2016).
[21] This need not overlook the distinction frequently drawn between *perfect* and *imperfect* duties. If we have perfect duties of beneficence which are also enforceable, I would simply treat these as duties of *justice*.

*justice* I defend apply *globally*, beyond borders. This may align with what Simon Caney calls *mild cosmopolitanism*, whereby we have universal duties of justice to all but may supplement these with additional duties to fellow nationals and compatriots.[22] Against this conceptual claim, however, David Miller has argued that 'mild cosmopolitanism' in the sense of defending sufficiency worldwide while having special duties to compatriots is not really cosmopolitan.[23] It would mean that everyone who believes that we have some basic duties of justice to someone outside our national community is a cosmopolitan. This would include anyone who subscribes to the Universal Declaration of Human Rights, for example, including Miller himself.

My primary goal in this thesis is to defend an account of global health justice with principles that apply beyond borders while leaving room for national-level priority-setting.[24] I am less concerned about how we label and classify my account, whether it is cosmopolitan in Caney's sense or non-cosmopolitan on Miller's account. I therefore prioritise the substance of my discussion and deliberately steer clear of labelling my account 'cosmopolitan' or 'non-cosmopolitan' to avoid distracting from the core debates. These labels would not significantly change the substantive principles and proposals I defend throughout this thesis. The sufficiency threshold I defend is robust and demanding (in a way that should satisfy cosmopolitans), though my account simultaneously leaves scope for national self-determination (in a way that should satisfy non-cosmopolitans). Note, in any case, that we may have

[22] Simon Caney, "International Distributive Justice," *Political Studies* 49 (2001).
[23] David Miller, "Caney's 'International Distributive Justice': A Response," *Political Studies* 50 (2002). See also David Miller, "'A Spoonful of Sugar Helps the Medicine Go Down': Gillian Brock on Global Justice," *Journal of Global Ethics* 5 (2009).
[24] I clarify and discuss these limits throughout the development of my thesis, especially in Chapters 4, 5, and 6.

reasons to favour a *sufficientarian* account of health justice even if we want a *cosmopolitan egalitarian* account of economic opportunities more generally (for example). This is because it may be that the pursuit and value of health ought to be limited to *sufficiency* when balanced against other priorities of global justice.

***The Subject and Target of Global Health Justice***

There are two important considerations about the conceptual and normative *scope* of my account of global health justice. This section provides a glimpse of what I develop further in the later chapters of the thesis, and discussion is necessarily brief at this stage.

The first question relates to what I call the *subject* of justice in global health. This is concerned with what global health justice wants to bring about. One aspect of the *subject* question is what distributive pattern we ought to favour for global health. Suppose, as I shall argue in Chapter 4, that the appropriate distributive pattern of justice to be brought about is sufficiency. Given this distributive pattern, another conceptual and normative aspect of the subject question arises: *what aspect of global health do we want sufficiency in?* The first possibility is that we want to have sufficiency in terms of actual *health outcomes*. The second possibility is sufficiency in *access to healthcare*. The third possibility is sufficiency in having the conditions necessary for good health (i.e. in terms of experience of the social determinants of health). These relate to the question of what the subject of global health justice is.

I am concerned with all three, albeit in different ways and subject to further caveats I explore in due course. *Remediable* health outcomes which are below a certain

threshold (and which are involuntarily incurred) are concerns of justice. This is grounded in the special significance of health and the presumptive obligation to promote it – something I develop in Chapters 1 and 4. Access to healthcare, even if it is statistically not the main determinant of population health outcomes, nevertheless has a morally salient function at the individual level. It is an important part of responding to the plight of needy individuals, here and now, which any theory of global health justice must be cognisant of – something I explore in Chapter 2. The relevance of the social determinants of health is derived from our general views about justice more generally, as I argue. More broadly, our experience of the social determinants of health and the conditions for health more generally are relevant at the bar of justice – something that forms a core part of my substantive account of global health justice. I explore the significance of social conditions and genuine opportunities for health in Chapter 4.

The second question is what I call the targets or *means* of justice in global health. One aspect of the *means* question concerns which agent or agents should discharge a duty or be responsible for bringing about the subject of global health justice. I address this in Chapter 5. Another aspect of the *means* question is upon what target of health we ought to act. That is, *on what factors should we act* to achieve the goals identified in the *subject* question? Several possibilities arise. The first possibility is to address the genetic and biological factors of disease – an inherently individualistic approach. That is, we can promote sufficiency in health by focusing on eliminating a particular biological factor that causes a particular health issue (such as the prescription of statins to treat cholesterol-induced cardiovascular disease).

The second possibility is to act on personal choices. For example, if we are concerned with minimising the global obesity epidemic, this approach entails focusing on people's lifestyle choices and individual diets. The third possibility is to focus on *domestic* health policies and practices, such as how to design local health systems or how to improve healthcare access across different regions. This is the most common approach in the health equity literature, as I show in Section III. The fourth possibility is to focus on *global* health policies and practices, such as reforming the WHO or designing a new global medicines patent system. The fifth possibility is to address broad and less tangible socio-structural factors (such as global norms, social ethos, and broad social practices). This could include, for example, generating a sense of solidarity to motivate everyone to alleviate health suffering, regardless of where it arises.

A convincing theory of global health justice must act upon and address all these aspects. A focus on just genetic and personal factors is not sufficient, as these themselves have a broader structural basis – something I flag in Chapter 3. The world is increasingly interconnected, and health outcomes are no longer determined purely by what goes on within a particular state. Focusing on *domestic* health policies and practices is unlikely to achieve either domestic or global health equity and a focus on *global* policies and practices is important. The fact that health holds universal value, something I explore in Chapter 1 and further develop in Chapter 4, lends support to a global perspective.

Over and above the tangible targets that a theory of global health justice can focus on, there are often intangible aspects that can nevertheless influence the outcomes and conditions of global health, identified in the fifth target above. These may relate to various social conditions and structural factors, as well as the general social norms and ethos that can impact on health globally. These include the glorification of risk-taking behaviour, social norms around health trade-offs, and health-impacting stigma (such as against HIV-positive people). The target of my account, then, is broad, reflecting the multifactorial and complex nature of global health. At the same time, the *means* question evaluates who, and on what grounds, ought to be responsible for acting upon and bringing about the appropriate *subject* of global health justice.

It may be evident that the *subject* and *means* questions are inter-related. If we are concerned about the social determinants of health, it necessarily means that we are not concerned solely with genetic factors or personal choices. Nevertheless, there is value in separating the two questions. The first is concerned with what end-goal we are interested in, and the second is concerned with what aspects we ought to target to get there.

## Section III: Literature Review and Thesis Contribution

My thesis develops an account of justice in global health, contributing to a literature in its relative infancy. Most normative work in health (whether this is done within the field of bioethics, public health ethics, or political philosophy) has tended to focus on the *domestic* realm. At the same time, much contemporary work in *global justice* has not addressed the demands of what we owe to each other in terms of

health. I am not aware of a systematic and general analysis of health within this literature. Where there is some literature on global health justice issues, these tend to be piecemeal rather than concerned with providing a general and systematic account. Most work on (global) health justice in the field of bioethics tends to take an individualised and narrow approach, rather than a more population-based, political philosophical approach. In what follows, I undertake a brief exploration of the literature on health and global health justice and show how my contributions in the thesis fit within this broader corpus of work.

There is a growing body of literature on health justice within the field of political philosophy. These include important works by Ronald Dworkin on the distribution of healthcare, Susan Hurley on health and its connection with perfectionism and excellence, Daniel Hausman on the public value of health in a liberal state, Brian Barry on the relevance of health for social justice, James Wilson on health inequalities and the right to public health, Norman Daniels and his influential Rawlsian theory of justice in health, Sridhar Venkatapuram and his capabilities account of health justice, and Shlomi Segall on luck egalitarian justice in health, to name a few examples.[25]

While this body of work is important, the overwhelming majority of work on health within political philosophy focuses on the *domestic* realm. Daniels' seminal theory

[25] Ronald Dworkin, "Justice in the Distribution of Health Care," *McGill Law Journal* 38 (1993); Susan Hurley, "The 'What' and the 'How' of Distributive Justice and Health," in *Egalitarianism: New Essays on the Nature and Value of Equality*, ed. Nils Holtug and Kasper Lippert-Rasmussen (Clarendon Press, 2006); Daniel Hausman, *Valuing Health* (Oxford University Press, 2015); Brian Barry, *Why Social Justice Matters* (Polity, 2005); James Wilson, *Philosophy for Public Health and Public Policy* (Oxford University Press, 2021); Daniels, *Just Health*; Sridhar Venkatapuram, *Health Justice* (Polity, 2011); Shlomi Segall, *Health, Luck, and Justice* (Princeton University Press, 2009).

of justice in health focuses exclusively on the domestic realm, with only passing remarks given about the need to find a 'middle-ground' in how we deal with global health injustice.[26] Daniels does acknowledge this gap in his account: "My account of just health, alas, gives us no simple or straightforward answers to … questions about global [health] justice".[27] Venkatapuram devotes a short chapter towards the second half of his book, *Health Justice,* to address the issue of *global* health justice, but falls short of presenting a systematic global account. Hausman focuses on the value of health *within* a liberal state but does not articulate how we ought to value health outside of this setting. Despite these important contributions to health in political philosophy, much more work remains to be done when it comes to theorising about *global* health and *global* health justice.

The majority of normative work on *global* health is presently done within the disciplinary domain of bioethics.[28] Mainstream bioethics is primarily concerned with ethical issues raised by biomedical technology, ethical issues in the practice of health*care* (most notably the relationship between clinicians and patients), and debates around medical care, research and policy more generally.[29] Its approach is generally individualistic and specific. It focuses on ethical reflections relevant to engaging with individuals (most often patients at the bedside) within a specific domain (such as vaccination ethics or obesity policy). Work on global health within bioethics is therefore generally narrow and individualistic. In contrast to

[26] Norman Daniels, "International Health Inequalities and Global Justice: Towards A Middle Ground," in *Global Health and Global Health Ethics*, ed. Soloman Benatar and Gillian Brock (Cambridge: Cambridge University Press, 2011); Daniels, *Just Health*.
[27] Daniels, *Just Health*, 333.
[28] Most of the forthcoming citations about the piecemeal approach, for instance, are bioethical in their approach.
[29] Tom Beauchamp and James Childress, *Principles of Biomedical Ethics*, 5th ed. (Oxford University Press, 2001).

mainstream bioethics, political philosophy (on one very plausible conception) is focused on normative guidance for institutions, policies and political practice – as well as how individuals ought to act *within* those structures. Examples of political philosophical approaches to *global health* which focus on institutional and policy-related questions are rare.

Many bioethicists have since acknowledged the need to broaden their agenda. Dan Brock, Onora O'Neill, and Norman Daniels have each called, separately, for the broadening of bioethics beyond its focus on individualistic matters at the bedside.[30] Michael Parker and colleagues, in this spirit, have addressed issues of unfairness and epistemic injustice in the kinds of global health research that receive funding and attention as well as noting the limitations of bedside-level bioethics and drawing attention to justice-related concerns such as system-level barriers to healthcare access.[31] A newly emerging field called *population-level bioethics* is gaining traction, with Daniel Wikler and Dan Brock among those arguing for bioethicists to engage more fully with political philosophy.[32] These calls for bioethics to engage more fully with the principles of political philosophy do not negate my core claim that bioethical approaches as a general rule are unduly focused on narrow and individualistic matters. The advent of population-level

[30] Dan Brock, "Broadening the Bioethics Agenda," *Kennedy Institute of Ethics Journal* 10 (2000); Onora O'Neill, "Public Health or Clinical Ethics: Thinking beyond Borders," *Ethics & International Affairs* 16 (2002); Norman Daniels, "Equity and Population Health: Toward a Broader Bioethics Agenda," *Hastings Centre Report* 36 (2006).
[31] Michael Parker and Susan Bull, "Ethics in Collaborative Global Health Research Networks," *Clinical Ethics* 4 (2009); John Kuumuori Ganle et al., "A Qualitative Study of Health System Barriers to Accessibility and Utilization of Maternal and Newborn Healthcare Services in Ghana After User-Fee Abolition," *BMC Pregnancy and Childbirth* 14 (2014); Napat Khirikoekkong et al., "Culturally Responsive Research Ethics: How the Socio-Ethical Norms Of Arr-Nar/Kreng-Jai Inform Research Participation at the Thai-Myanmar Border," *PLOS Global Public Health* 3 (2023).
[32] Daniel Wikler and Dan Brock, "Population-Level Bioethics: Mapping a New Agenda," in *Global Bioethics: Issues of Conscience for the Twenty-First Century*, ed. Ronald Michael Green, Aine Donovan, and Steven Jauss (Oxford University Press, 2008).

bioethics and the work of theorists such as Brock, O'Neill, Daniels, and Parker are an indication that bioethicists are starting to heed the view that political philosophy, with its focus on institutions and public policies, must be brought to bear more squarely on issues in (global) health.

The majority of existing work in global health justice, as well as taking place within the domain of bioethics, also takes the form of particular theorists writing on specific, isolated issues. These are what I call *piecemeal* approaches to global health justice theorising. Specific issues in global health are addressed by particular theorists in the absence of a broader framework of justice for global health. Piecemeal approaches stand in contrast to a general and systematic treatment of justice in global health.

To take some examples, the issue of access to pharmaceuticals has been addressed by Thomas Pogge, Christian Barry and Kate Raworth, Nicole Hassoun, and Thana Cristina de Campos, among many others.[33] Gillian Brock and Michael Blake, Nir Eyal and Samia Hurst, and Johannes Kniess discuss the issue of medical brain drain.[34] A significant body of work in the field of bioethics exists on research ethics and controversies around engaging so-called vulnerable subjects in the developing world as well as issues of how to determine research priorities in

[33] Thomas Pogge, "The Health Impact Fund: Enhancing Justice and Efficiency in Global Health," *Journal of Human Development and Capabilities* 13 (2012); Thomas Pogge, "Human Rights and Global Health: A Research Program," *Metaphilosophy* 36 (2005); Christian Barry and Kate Raworth, "Access to Medicines and the Rhetoric of Responsibility," *Ethics and International Affairs* 16 (2002); Nicole Hassoun, *Global Health Impact: Extending Access to Essential Medicines* (Oxford University Press, 2020); Thana Cristina de Campos, *The Global Health Crisis: Ethical Responsibilities* (Cambridge University Press, 2017).
[34] Gillian Brock and Michael Blake, *Debating Brain Drain: May Governments Restrict Emigration?* (Oxford University Press, 2015); Nir Eyal and Samia Hurst, "Physician Brain Drain: Can Nothing Be Done?," *Public Health Ethics* 1 (2008); Johannes Kniess, "Health, Migration and Human Rights," *Critical Review of International Social and Political Philosophy* 25 (2022).

the global health sphere.[35] The ongoing COVID-19 global pandemic has resulted in renewed interest in global health, with many theorists (including political philosophers such as Allen Buchanan, Cecile Fabre, Lisa Herzog, Kok-Chor Tan, and Jonathan Wolff) engaging in philosophical reflection on specific issues such as vaccine distribution, paternalism and immunisation, and the ethics of vaccine passports, to name a few topics.[36] The idea of health security, referring to infectious diseases more broadly, has also occupied much work in global health justice.[37]

The aforementioned topics are important concerns of global health justice. However, while a division of labour is important, *piecemeal* approaches cannot *on their own* provide us with a general and systematic account of what justice demands in global health more broadly and across a whole range of issues. Engaging solely in a piecemeal approach risks isolating specific issues in global health from the broader agenda of global health justice and may be open to accusations that their normative prescriptions are unduly *ad hoc*. The prevalence of piecemeal approaches highlights that, with some notable exceptions I turn to

[35] Lauren C. Ng et al., "Ethics in Global Health Research: The Need for Balance," *Lancet Global Health* 3 (2015); Bridget Pratt et al., "Exploring the Ethics of Global Health Research Priority-Setting," *BMC Medical Ethics* 94 (2018); Christian Simon and Maghboeba Mosavel, "Getting Personal: Ethics and Identity in Global Health Research," *Developing World Bioethics* 11 (2011); Bridget Pratt and Adnan Hyder, "Global Justice and Health Systems Research in Low- and Middle-Income Countries," *Journal of Law, Medicine & Ethics* 43 (2015); Solomon Benatar, "Imperialism, Research Ethics and Global Health," *Journal of Medical Ethics* 24 (1998); Bridget Pratt and Adnan Hyder, "Ethical Responsibilities of Health Research Funders to Advance Global Health Justice," *Global Public Health* 14 (2019).

[36] Ezekiel Emanuel et al., "An Ethical Framework for Global Vaccine Allocation," *Science* 369 (2020); Stephanie Johnson, "Advancing Global Health Equity in the COVID-19 Response: Beyond Solidarity," *Journal of Bioethical Inquiry* 17 (2020); N. Jensen, A. H. Kelly, and M. Avendano, "The COVID-19 pandemic Underscores the Need for An Equity-focused Global Health Agenda," *Humanities & Social Sciences Communications* 8 (2021); Efrat Shadmi et al., "Health Equity and COVID-19: Global Perspectives," *International Journal for Equity in Health* 19 (2020); Robert Elliott Allinson, "The Primacy of Duty and Its Efficacy in Combating COVID-19," *Public Health Ethics* 13 (2020).

[37] Michael Selgelid, "Ethics and Infectious Disease," *Bioethics* 19 (2005); Kari Pahlman et al., "Ethical Health Security in the Age of Antimicrobial Resistance," *BMJ Global Health* 7 (2022).

shortly, a systematic approach to global health justice is presently lacking in the literature.

Two recent works in global health justice are worth considering in more detail – one belonging to the capabilities tradition and the other to the human rights approach. These two accounts are worth considering because they are comprehensive accounts that could conceivably provide a general and systematic (rather than a piecemeal) account of global health justice, looking at institutions, policies, and systems and structures.

The first approach to analyse is Jennifer Prah Ruger's capabilities account of global health justice, articulated in depth in *Global Health Justice and Governance*. Ruger's work is worth analysing as it is one of the few works in the literature that explicitly aims to present an account of global health justice from a normative political theory perspective. Ruger presents a minimalist account of global health justice called *provincial globalism.*[38] Provincial globalism is a middle ground between statist accounts (which deny duties beyond the state) and cosmopolitan accounts (which create demanding obligations of assistance beyond borders). According to Ruger, our goal is to promote human flourishing, with what she calls 'central health capabilities' being a core component of such flourishing.[39]

The account of global health justice and governance presented by Ruger suffers from vagueness and ambiguity. Consider, for example, how Ruger answers what I have called the *subject* of global health justice (that is, what a theory of global

[38] Jennifer Prah Ruger, *Global Health Justice and Governance* (Oxford University Press, 2018).
[39] Jennifer Prah Ruger, *Health and Social Justice* (Oxford University Press, 2007).

health justice should aim to bring about). Early in her book, Ruger argues for an ostensibly limited goal, focused on reducing premature mortality and amenable morbidity through healthcare and health research: "Global health justice involves a duty to address premature mortality and escapable morbidity … [it] supports investments in biomedical and health research to prevent and treat vexing health deprivations."[40] Later in the book, Ruger widens her account, stating that "global players should promote health, focusing on all determinants of health".[41] A mere two pages later, Ruger appears to backtrack on this wider commitment, arguing that global health justice is about "providing medically necessary and medically appropriate health care and public health services for all" – an arguably much more limited goal.[42]

Ruger's earlier works limit health justice to this narrower sense, explicitly setting aside the social determinants of health:

> I argue that we are far from understanding the precise societal mechanisms that influence health or how to weight different social objectives. Thus, even in light of existing information on social determinants of health, it is unwise to attempt to improve health with broad non-health policies, such as completely flattening socio-economic inequalities, as prescribed by some. Such prescriptions cloud rather than clarify the means and ends of health policy and our ability to evaluate the impact of public policy on health.[43]

This rather extraordinary passage from a normative theorist of health justice is faulty on at least two counts. First, it is empirically questionable. Decades of

[40] Ruger, *Global Health Justice and Governance*, 82.
[41] Ruger, *Global Health Justice and Governance*, 123.
[42] Ruger, *Global Health Justice and Governance*, 125.
[43] Ruger, *Health and Social Justice*, 6.

evidence from the social determinants of health have highlighted the important mechanisms by which the social determinants of health impact on health outcomes.[44] Second, even if Ruger is right about the level of empirical specificity we have about the social determinants of health, we do not need to understand the 'precise societal mechanisms' to be able to act on the *general* findings. It is hard to see how being approximately right rather than squarely wrong would 'cloud' the pursuit of health justice.

Beyond this ambiguity about whether the appropriate subject of global health justice is limited to healthcare and public health services or something broader involving the social determinants of health, Ruger's theory is not as ambitious and comprehensive as her book's title may suggest. The focus is on global health *governance* rather than a comprehensive account of global health justice.[45] Theorising the issue of governance is worthwhile, but equally important are the wider goals that global health governance is meant to secure – something that needs to be supplied by an account of global health justice. Ruger does not defend a robust account of global health justice beyond gesturing towards provincial globalism and stating that the purpose of all social and political activity is to promote human flourishing.[46] In this sense, the scope and focus of my thesis project differs from Ruger's, transcending debates about governance to deal more squarely with an account of global health justice.

[44] See, for instance, my aforementioned discussions and citations on the social determinants of health in Section II.
[45] In any case, the account of global health governance she presents is vague and unconvincing.
[46] Ruger, *Global Health Justice and Governance*, 86.

The second approach worth considering in more detail is the *human rights approach* to global health justice, championed notably by Jonathan Wolff.[47] The human rights approach deserves additional consideration because it is generally held against institutions, namely, the state or the global community as a whole (thereby meeting our criterion of a political philosophical account) and because of its universal scope (thereby transcending the domestic realm). Some critics of the human right to health argue that it is ungrounded, vague, or infeasible.[48] Against the charge of vagueness, Wolff argues that we can further specify the human right to health so that it is made more determinate. He distinguishes between duties to *respect, protect, and fulfil* human rights, which entail different duties for different agents. Other theorists have argued that we also have duties to *implement* – that is, to support the creation of functioning institutions to meet first-order rights and duties.[49] To mitigate any charges of undue broadness and to prevent any unnecessary proliferation of human rights, Wolff also argues – following Henry Shue – that human rights provide protection only against *standard threats* rather than against all threats.[50]

I am not opposed to a human rights approach to health, but I think any defence of a human right to health is open to several worries, as I shall outline. Alleviating

[47] Jonathan Wolff, *The Human Right to Health* (Norton, 2012). See also John Tasioulas and Effy Vayena, "Getting Human Rights Right in Global Health Policy," *The Lancet* 385 (2015); John Tasioulas and Effy Vayena, "Just Global Health: Integrating Human Rights and Common Goods," in *The Oxford Handbook of Global Justice*, ed. Thom Brooks (Oxford University Press, 2020); Lawrence Gostin, *Global Health Law* (Harvard University Press, 2014).
[48] Carmen Pavel, "Healthcare: Between a Human and a Conventional Right," *Economics and Philosophy* 35 (2019). See also Jeremy Bentham, *Rights, Representation, and Reform: Nonsense Upon Stilts and Other Writings on the French Revolution*, ed. Philip Schofield, Catherine Pease-Watkin, and Cyprian Blamires (Clarendon Press, 2002); Onora O'Neill, "The Dark Side of Human Rights," *International Affairs* 81 (2005).
[49] Zahara Nampewo, Jennifer Heaven Mike, and Jonathan Wolff, "Respecting, Protecting and Fulfilling the Human Right to Health," *International Journal for Equity in Health* 21 (2022).
[50] Wolff, *The Human Right to Health*. See also Henry Shue, *Basic Rights* (Princeton: Princeton University Press, 1980).

these worries requires further theorising and justification, which brings us back to the core contribution of this thesis. Consider two core questions about relying on a human rights approach to global health justice.

First, what *grounds* such a human right? A human rights account of health must provide a response to this. This thesis articulates what it is that makes health morally significant and in a way that means it matters beyond borders. Such an account is necessary to defend a human right to health. In this sense, my account can be seen as providing the first-order principles and considerations about health and global health that can then be used to develop a human right to health.

Second, what does the human right to health demand? That is, how do we specify the rights and duties demanded by a human right to health. Recall our discussion of the *subject* of global health justice, referring to what our goal is. Are we concerned about the human right to health outcomes, to a minimal standard of healthcare, or something in between? On the other side of rights, what are our duties and responsibilities? Insofar as my thesis addresses these questions, theorists of human rights may well draw on and extend my arguments and principles towards a defence of a human right to health.

I am very sympathetic to the idea of a human right to health, along the lines defended by Wolff. In this sense, my thesis has synergies with and is not opposed to a human rights account of global health justice. However, we are unlikely to make theoretical or practical progress by taking it as a *starting* point. The first-order question of *why* we have such a right would remain, and those who remain

unconvinced by rights and duties of global health would not be placated. The human right to health, accordingly, is not something that *grounds* my theoretical exploration of global health justice in this thesis; it is the other way around. My defence of global health justice lends support to and may help ground the claim that health is a human right. The human right to health may be something that is established as a result of the framework and principles I outline in this thesis, but it is not something I can use as the grounding reasons for the principles I defend in this thesis.

Armed with an understanding of the general contours of the existing literature, together with an appreciation of some of its shortcomings, we are now in a position to understand the contribution of my thesis. Overall, this thesis articulates a systematic and general political philosophical account of global health justice. My thesis is characterised by three key features. First, the thesis has a *global focus*. There is a lot of work in health justice but there are few theorists that have explicitly addressed health at the *global* level in a sustained and unified way. Second, the thesis develops a *general and systematic* account. Taking the chapters of the thesis as a whole provides us with normative guidance across a comprehensive range of considerations in global health justice. As I have argued, issues in global health, where they are addressed, are often addressed in a piecemeal manner, focusing on isolated albeit important issues. I hope to contribute to this literature by outlining a broader account of global health justice. Third, the thesis lies in the domain of *political philosophy* with a *political philosophical* focus. My thesis aims to provide a political philosophical account of global health justice, with normative guidance

aimed at the design of our local and global institutions for the purposes of global health justice.

## Section IV: What Can Political Philosophy Do for Global Health?

For all the foregoing talk of political philosophy, many people tend to see it (and philosophy more generally) as an entirely abstract activity, devoid of any practical relevance to issues facing the real world. Activists and policymakers working in the sphere of health seldom engage directly with political philosophers or philosophical concepts that may be relevant to their work, even when dealing with matters that have a clear normative dimension, such as health *equity* or global health *justice*, not to mention the broader philosophical debate on the conceptualisation of health (as I turn to in Chapter 1). Philosophers often accept this charge of esotericism and abstraction as a badge of honour. Contrary to these positions, this thesis begins from the methodological standpoint that political philosophers ought to engage with practical issues in global health (and other issues more broadly), and that they have much to contribute to these debates.

First, political philosophers can contribute to global health debates by clarifying and helping to *conceptualise* the ideals that activists and policymakers are supposedly striving towards. Global health activists and policymakers frequently talk about concepts and issues as if they were obvious or uncontroversial. Pointing to the disparity in life expectancy between an Afghan and a Swiss child, for example, global health activists might take it for granted that the normative problem is inequality. The political philosopher, however, can highlight that it may not be our intuitions of egalitarianism so much as sufficiency that are being triggered. We are

alarmed not by the inequality as such, but by the degree of *insufficiency* experienced by the Afghan child.[51]

Second, political philosophers are well placed to make salient the *normative dimensions* of debates in global health. As James Wilson argues, the domain of health is a good place for moral and political philosophers to start making a contribution as it is a sphere in which ethical values are especially salient.[52] Health policy options are often couched in technical language that may cloak the fact that values are at stake. A highly technical debate about whether to fund a particular drug, for example, is nevertheless rife with value considerations. It relies upon a view about the relative value of health compared to other goods and the epistemic value we place on data about efficacy, among other considerations. The judgement to build a brand-new hospital instead of assisting a developing country establish its health system is a decision based on normative values, not all of which may be explicit or justifiable.

Third, political philosophers can help conceptualise experiences of injustice that are not otherwise presently able to be articulated – what Miranda Fricker famously refers to as hermeneutical injustice.[53] Political philosophy can contribute to global health justice by giving victims of injustice the *concepts* and *language* needed to articulate what is at stake in a way that makes it actionable for policymakers.

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[51] Derek Parfit, "Equality and Priority," *Ratio* 10 (1997); Harry Frankfurt, "Equality as a Moral Ideal," *Ethics* 98 (1987). Jonathan Wolff argues that we might also characterise health inequalities not as a pure issue of egalitarianism but as a tragic loss compared to what could have been achieved: Jonathan Wolff, "Justice and Tragedy: The Avoidability of Health Inequalities," *The American Journal of Bioethics* 15 (2015).

[52] Wilson, *Philosophy for Public Health and Public Policy*, 5.

[53] Miranda Fricker, *Epistemic Injustice* (Oxford University Press, 2007). See also Alison Jaggar, "Feminism in Ethics: Moral Justification," in *The Cambridge Companion to Feminism in Philosophy*, ed. Miranda Fricker and Jennifer Hornsby (Cambridge University Press, 2000).

Miranda Fricker has offered the concept of *epistemic injustice* to those unable to command the attention of policymakers due to their perceived inferior epistemic standing – an issue rife in global health.[54] Cosmopolitan political philosophers of various stripes, such as Simon Caney, Darrel Moellendorf, and Gillian Brock, have extended the language of *justice* and *unfairness* to the global realm, including in the sphere of health, providing disadvantaged people around the world with a moral language to conceptualise their grievances.[55]

While I do not explicitly defend my methodological approach throughout the thesis, my hope is to show that political philosophy can be a serious, theoretical enterprise with significant scope for practical engagement and application. The achievement of global health justice relies not just on the technical expertise of those working in health, but on the normative guidance that political philosophers can offer at the level of policy and practice. At the same time, I aim to highlight that political philosophers may also have much to learn by engaging with the practical reality of global health injustice. Applying existing theories and developing new normative frameworks in response to problems in global health can shed light on the nature of normative political principles and foundational concepts such as justice, fairness, rights, and duties.

## Section V: Thesis Outline and Synopsis

The overall purpose of this thesis is to develop a theory about the demands of justice in global health. Together, the chapters build a framework for understanding

[54] Fricker, *Epistemic Injustice*. See also Emilie Koum Besson, "How to Identify Epistemic Injustice in Global Health Research Funding Practices," *BMJ Global Health* 7 (2022).
[55] Simon Caney, *Justice Beyond Borders* (Oxford University Press, 2005); Darrel Moellendorf, *Cosmopolitan Justice* (Westview, 2002).

and securing global health justice – the ideal of health equity beyond borders. Ultimately, I develop an account of health justice in which everyone, regardless of nationality and place of birth, has genuine opportunities to live in conditions that protect and promote their health. I refer to this as the ideal of Genuine Opportunity for Health (GOH) for short, or as the ideal of *health equity beyond borders*. I argue that everyone having genuine opportunities to be healthy is best conceptualised as being protected against standard threats to health and living in conditions conducive to achieving a decent and secure level of health.

The structure of this thesis unfolds as follows which, together, builds towards my account of genuine opportunity for health:

Chapter 1 engages with several foundational questions about the concept and value of health. It engages with two core questions: first, what is health; and second, what, if anything, makes it morally significant? Contrary to our initial intuitions, defining health is not as straightforward as it may appear. Our initial thoughts about the value of health also need interrogation. For example, is health merely a specific instantiation of *welfare* and, if so, is welfare rather than health the ultimate concern of health justice?

The first chapter therefore examines the concept of health and proposes a working account that strikes a balance between two opposing camps: *naturalist* accounts (which argue that health can be defined purely in biological terms) and *normativist* accounts (which argue that health and disease are defined simply by reference to notions of ‘good’ or ‘bad’, respectively, independently of whether it relates to

biomedical function). I provide an argument for the special moral significance of health. I argue that health is *non-reducible* to generic metrics of justice (such as welfare or opportunity) and that it possesses various salient features that establish its *significance*. My strategy diverges from prevailing defences, in that it is pluralistic in nature and does not trace the value of health to a single, salient feature that always holds.

Chapter 2 continues the discussion of the special moral significance of health, focusing on the more specific issue of health*care* and its role in the pursuit of health justice. Given a body of empirical evidence that shows that the social determinants of health are the primary determinant of population health and given our concern with using our limited resources efficiently, it has been argued that justice may demand that we focus exclusively on improving the social determinants of health at the expense of health*care*. This chapter defends the moral significance of healthcare by reference to a central but neglected dimension – healthcare's expressive function. Over and above its influence on health outcomes and other metrics of justice (such as opportunity or welfare), and despite its relatively limited impact on population health outcomes, healthcare expresses respect for individuals in a distinctive and morally salient way.

Chapter 3 addresses the issue of how health relates to the theory and practice of justice more generally. There are many goods with moral significance, and further argument is needed to show how health ought to be balanced against these other pursuits. In Part I of Chapter 3, I address the issue of *health in justice* – that is, questions about how significant health is, how it ought to be weighed against other

goods with special moral significance, and how it relates to concerns of justice in other areas. I introduce Simon Caney's distinction between *integrationism* and *isolationism* but argue that it is too simple and does not capture important nuances. I reconstruct Caney's arguments for integrationism, showing that it is compatible with a limited form of isolationism consistent with my *non-reducibility thesis.*

In Part II of Chapter 3, I address the issue of *justice in health*, focusing on the issue of when there is a (global) health injustice. I argue that there are two ways we can conceptualise health injustice – the *direct* and *indirect* account – both of which are individually sufficient to identify a health injustice. This account provides us with a minimal, working definition of when there is a health injustice both domestically and globally. I eventually build upon this minimalist definitional framework to motivate a stronger, positive account of global health justice.

Chapter 4 moves beyond the minimalist definitional approach to my positive account of global health *justice*. I argue that an absence of health injustice in the minimalist sense does not entail the achievement of health justice. Chapter 4 also defends the presumptive value of health at the level of public policy, by which I mean that social conditions that promote health should be the default. I show that comprehensive approaches to health promotion are not necessarily paternalistic or perfectionist and can be made consistent with liberal neutralist commitments, defending this on the basis of arguments relating to the problem of choice architecture, the conditions of autonomy, and the need to positively shape children's future views, among other grounds.

The chapter takes up the idea of what global health justice demands beyond mere health outcomes and presents a general framework. This includes more substantive discussion around the *conditions* that promote or hinder health, over and above the resultant health outcomes. Health outcomes are merely one component of global health justice, and health outcomes are not all there is to the pursuit of global health justice. A person in a poor country may have the same health outcome as a person in a rich country, but the effort required to attain this (for example, in terms of costs and personal sacrifice) may be much greater or it may simply be a matter of sheer luck that they are not ill. The fact that they now happen to have equivalent levels of health (in terms of outcomes) is not sufficient to make a judgement that the state of affairs is just.

I argue that all people, regardless of nationality and place of birth, should have genuine opportunity to live in conditions that promote their health – something we can abbreviate to *Genuine Opportunity for Health* (GOH). This is the ideal of *health equity beyond borders*. By *genuine opportunity*, I mean opportunities that are robustly open for all and able to be reasonably pursued (without unreasonable costs or effort, and without unduly sacrificing personal values), and not merely something formally available to all.

Justice does not demand that everyone be accorded *equal* opportunity to live in conditions that promote their health, but it demands that they have *genuine* opportunity to do so. Everyone does not need to reside within the *same* driving radius of a major hospital, nor do they need to have *identical* exposure to the same social conditions that determine health. This explains why the person above who

lives slightly further away from the hospital may have genuine opportunity for health but not the aforementioned scenario of a person in a poor country who must incur significant costs to maintain her health. The cost of attaining an adequate level of health is unreasonable for the latter in a way it is not for the former. Social conditions should be such that everyone has a genuine opportunity to have their health protected and promoted – an ideal that (rightly) presumes the value of health but nevertheless leaves room for individuals to exercise personal trade-offs with their health relative to other pursuits. Justice demands that this ideal is one that all are well placed to meet, regardless of nationality and place of birth.

Chapter 5 deals with questions of *responsibility* in the realm of global health. The first part of the chapter focuses on the question of national responsibility and global health, specifically, investigating under what conditions, if any, it is just for the population of one country to have greater health disadvantage than that of another. Short of an interventionist approach to international relations, valuing autonomy and agency requires that we accept that different countries will often diverge in their policy priorities, with resultant health inequalities. I argue that so long as countries meet the demands of my framework of GOH, these inequalities from the exercise of national responsibility need not necessarily be considered unjust.

The second part of the chapter deals with the problem of remedial responsibility for global health injustice. Despite widespread agreement about the existence of profound global health injustice, agreement about *who, and on what grounds, ought to remedy such injustice* is lacking. I present a framework for allocating duties and responsibilities I call the *dynamic assistance account*. I argue that which

principles ought to govern our distribution of remedial responsibilities is a dynamic exercise dependent upon the nature of the injustice (including whether it is an emergency or not) and the kinds of ways in which prospective remedial agents are connected to it. I argue that forward-looking, assistance-based considerations have a special and often decisive role to play in instances of serious and urgent health injustices (i.e. emergencies), while less serious/urgent injustices may require the setting up of a fair procedure to allocate remedial duties.

Chapter 6 addresses the question of what is required to achieve global health justice in our non-ideal real world. I articulate some normative considerations and principles that can form the basis of more detailed work by policymakers on how to achieve GOH, including how we might combat the problem of medical brain drain and create social conditions conducive to health for all. I propose a series of policy proposals, including a global health tax as a means of promoting the social conditions for health, in accordance with the demands of GOH. I also show that in certain conditions, healthcare professionals' remedial responsibilities require a limited duty to stay (enacted through a compulsory service period) before they are permitted to emigrate. I also argue that developed countries who recruit and benefit from healthcare professionals from developing countries are required to pay compensation to offset some of the impacts of medical brain drain.

The chapter also deals with an important question in how we prioritise interventions to realise global health justice. For example, should we prioritise so-called downstream interventions that focus on securing access to healthcare for everyone, or so-called upstream interventions that deal with the social

determinants of health and the social conditions that influence people's health more broadly? I show that this is partly determined by the degree to which our world deviates from ideal theory.

In the Conclusion Chapter, I revisit the key lessons and insights from the thesis and highlight some remaining challenges.

## Conclusion

Health is a universally valued good, though one rich with normative theoretical and practical challenges. This thesis presents an account of global health justice in which all have genuine opportunities for health, where this involves protection against standard health threats and the ability to live in social conditions that enable us to pursue a life of reasonable health. The tools of political philosophy, with its focus on institutions and public policy, including how people within these systems and structures ought to act, provides a valuable lens by which to view the challenge of global health justice. In Rudolf Virchow's oft-cited adage, "medicine is a social science, and politics is nothing else but medicine on a large scale".[56] Empirical discussions of global health and medicine are enhanced by considering the demands of justice and reflecting on the insights of political philosophy and, conversely, political philosophy is enhanced by understanding the nature of (global) health and health injustice.

[56] Rudolf Virchow, "Der Armenarzt," *Medicinische Reform* 18 (1848): 125-27.

# Chapter 1
# HEALTH AND ITS SPECIAL MORAL SIGNIFICANCE

Health is a surprisingly slippery concept. Substantial disagreement and controversy exist about what health entails and what defines disease, on the one hand, and how best to conceptualise the value of health and disvalue of disease, on the other. This chapter engages with two core questions: first, what is health; and second, what, if anything, makes it morally significant? In Section I, I examine the concept of health and propose a working account that strikes a balance between the opposing naturalist and normativist camps. In Section II, I provide an argument for the special moral significance of health from the perspective of justice. I argue that health is *non-reducible* to generic metrics of justice (such as welfare or opportunity) and that it possesses various salient features that establish its *significance* at the bar of justice. My strategy in Section II diverges from prevailing defences, in that it is pluralistic in nature and does not trace the value of health to a single, salient feature that always holds. I address the issue of health*care* (and its relationship with health) more specifically in Chapter 2.

## Section I: What Is Health?

Philosophers disagree widely over how best to define health and ill health, with a significant body of philosophical literature on this front. It is not within the scope of my thesis to explore these debates in depth so, for the purposes of my thesis, I focus only on presenting a working definition of health that is theoretically plausible, relatively ecumenical across various philosophical conceptions, and is sensitive to how the term is used in theory and practice by health professionals, theorists of health justice and laypeople more generally. This working definition allows us to

have a clear starting point and enables me to outline some of my initial philosophical commitments, but the substantive accounts and principles I develop in this thesis are likely to be robust across most reasonable conceptions of health.

Philosophers of medicine concerned with defining health typically distinguish between *naturalist* and *normativist* accounts, neither of which, I shall argue, are plausible in their pure forms.[1] Naturalist accounts argue that we can define health and disease in a value-free manner, purely by reference to the biological function of the human body and how it aids in our survival and reproduction. The most influential naturalist theory of health is Christopher Boorse's *biostatistical theory of health*, whereby health is the absence of disease.[2] Disease, in turn, is defined simply as a statistical deviation from the range of normal function typical of the species.[3] Blindness deviates from the range of normal sight function among humans and is thus a disease. Normativist accounts, in contrast to naturalist accounts, maintain that health and disease are inextricably value-laden concepts that rely on normative input beyond considerations of biological function. Jerome Wakefield argues that health inherently involves notions of *harm*, which is necessarily a value judgement.[4] Lennart Nordenfelt articulates a concept of health that involves holistic evaluations of individuals' wellbeing and capacities to pursue

[1] For a survey of these positions, see Havi Carel and Rachel Cooper, eds., *Health, Illness and Disease: Philosophical Essays* (Routledge, 2012).
[2] Christopher Boorse, "Health as a Theoretical Concept," *Philosophy of Science* 44 (1977); Christopher Boorse, "On the Distinction Between Disease and Illness," *Philosophy and Public Affairs* 5 (1975).
[3] Influential adherents of Boorse's theory include Norman Daniels and Daniel Hausman, both of whom are themselves highly influential in normative theorising about health and health justice: Daniels, *Just Health*; Hausman, *Valuing Health*.
[4] Jerome Wakefield, "Disorder as Harmful Dysfunction," *Psychological Review* 99 (1992); Jerome Wakefield, "The Biostatistical Theory versus the Harmful Dysfunction Analysis, Part 1," *Journal of Medicine and Philosophy* 39 (2014).

vital goals.[5] For Nordenfelt, a person is healthy if and only if she has the ability to pursue her vital goals, with vital goals defined as those necessary for a minimal level of happiness. For naturalist accounts, health and disease are neither positive nor negative; they are simply neutral descriptors of biomedical function. For normativist accounts, *health* generally connotes something positive while *disease* connotes something negative, and this affects whether something is classed as a disease or not. If a condition is considered a 'disease' on the naturalist account but is not or ought not to be viewed as something negative, normativist accounts would not consider it a disease.

A desideratum for an adequate working conception of health is that it should be *sensitive* to the views of both health professionals and, given the ubiquitous nature of health in our lives as individuals, to the general populace. It must be theoretically plausible and align with our general views on standard cases, drawing the line between health and disease in a way that aligns with our considered judgements. By this, I do not mean that every single person on the street must agree with or be able to accept my working account. I mean something more modest, namely, that the account is something most people would recognise as concerning 'health' and 'disease' and is a definition that could be accepted after reasonable reflection. An account of health that told us cancer or stroke were not diseases/illnesses would not meet this criterion. This desideratum does not beg the question against a particular account, as whether the naturalist or normativist account better captures *standard* instances of health is an open question.

[5] Lennart Nordenfelt, *On the Nature of Health* (Springer, 1987).

Despite aspects of the naturalist and normativist accounts capturing important components of our considered judgements about health, *purely* naturalist and *purely* normativist theories of health fail this desideratum. First, against purely naturalist accounts, biostatistical function does not capture standard and general instances of disease. To use Elselijn Kingma's example, if my liver fails because of a paracetamol overdose, this is a *normal* response and something it is *statistically* designed to do in response to a toxin.[6] If we define disease by reference to a deviation from normal functioning, then it appears that paracetamol poisoning does not count as a disease because it is a species-typical response and not a statistical deviation from the liver's function.[7] Second, we seem to almost exclusively consider *downward* departures from normal functioning as constituting disease. Very poor vision and hearing may constitute a pathology, but not highly acute vision or hearing, despite both being statistical deviations from the norm.[8] Statistical deviation, then, does not always capture what we mean by disease. Third, naturalist accounts' focus on survival and reproduction can result in counterintuitive classifications of disease. Homosexuality, for example, may be considered a disease insofar as it inhibits reproduction and deviates from the majority condition of heterosexuality. While Boorse bites the bullet on this implication, his view is

[6] Elselijn Kingma, "Paracetamol, Poison, and Polio: Why Boorse's Account of Function Fails to Distinguish Health and Disease," *British Journal for the Philosophy of Science* 61 (2010); Elselijn Kingma, "What Is It To Be Healthy?," *Analysis* 67 (2007).

[7] One might attempt to rescue the biostatistical account by defining more specific 'reference classes' (i.e. normal function *amongst* those poisoned), but this is subject to concerns about smuggling in normativity in what is meant to be a value-free account of health and disease. See the exchange between Kingma and Hausman: Elselijn Kingma, "Situation-Specific Disease and Dispositional Function," *British Journal for the Philosophy of Science* 67 (2016); Daniel Hausman, "Is an Overdose of Paracetamol Bad for One's Health?," *British Journal for the Philosophy of Science* 62 (2011).

[8] One exception could be height. Someone who has an upward deviation and is 300cm tall may constitute a pathology on our considered judgements.

unlikely to find support among both health professionals and laypeople and is thus contrary to our desideratum.[9]

Second, and in contrast to naturalist accounts, purely normativist accounts risk smuggling in considerations of general welfare and human flourishing under the umbrella of health. Suppose being a professor of political philosophy is a vital goal of mine, but I am unable to achieve this promotion due to an ever-challenging academic job market and the fact of being drowned out by more experienced candidates. While my welfare is undoubtedly impacted by my failure to achieve my professorial ambitions, it is a stretch to say, à la Nordenfelt, that I am *unhealthy* in virtue of this failure or that my inability to achieve this goal is a *health* issue.[10] To do so stretches the concept of health as understood by health professionals and laypeople. Beyond this specific criticism of Nordenfelt's account, any purely normativist account is implausible because it is unable to distinguish between negative evaluations linked to biomedical function and those not linked to biomedical function at all, and only the former can plausibly be a conception of health.

Despite each account containing plausible elements, neither pure-naturalist nor pure-normativist accounts draw the line of health and disease in what we intuitively

[9] Christopher Boorse, "A Second Rebuttal on Health," *Journal of Medicine and Philosophy* 39 (2014). One might argue that the question is one of capacity i.e. gay people may still have the *capacity* to reproduce. Even if this is an adequate response – and I am doubtful – the other two concerns are sufficiently fatal to the biostatistical account.

[10] For similar critiques, see Thomas Schramme, "A Qualified Defence of a Naturalist Theory of Health," *Medicine, Health Care, and Philosophy* 10 (2007); Sridhar Venkatapuram, "Health, Vital Goals, and Central Human Capabilities," *Bioethics* 27 (2013). For Nordenfelt's response (which includes him biting the bullet on particular instantiations of this critique), see Lennart Nordenfelt, "Standard Circumstances and Vital Goals: Comments on Venkatapuram's Critique," *Bioethics* 27 (2013).

feel is the right place, and neither meets the core desideratum of a conception of health. The core question is therefore not whether we ought to favour a naturalist *or* a normativist account, but how much of each approach should feature in a plausible account of health. For an adequate definition and conception of health, values must come into play at some stage but so must considerations of biomedical function. I therefore propose a dualist naturalist-normativist working conception of health: health is the absence of pathology, where pathology is defined by reference to biomedical function (naturalist component) *and* value-based considerations (normativist component). I use the term *pathology* to be a broad, catch-all phrase that encompasses concepts such as 'disease', 'illness' and 'sickness', as space constraints do not permit me to distinguish further between these specific terms.[11] The condition must be related to biomedical function, as a *necessary* but not sufficient condition, for evaluations of health and pathology to apply. That is, *health*-related issues must be those that concern biomedical function. A condition is related to biomedical function when it is related to an anatomical structure or physiological function of the human body. Issues with sight, mobility, and psychosis, for example, are concerns of biomedical function, and so they pass our first test of being health-related issues.

Whether, and to what extent, this account includes *all* considerations of mental health is a complex question relating to the contours of biomedical function. Mental health poses important questions for my dualist-account of health, given that I predicate health and disease on relating to *biomedical* function and given that I am concerned about over-expansive notions of health that smuggle in considerations

[11] For an account that explores differences in these terms, see Bjørn Hofmann, "On the Triad Disease, Illness and Sickness," *Journal of Medicine and Philosophy* 27 (2002).

of welfare. It is beyond the scope of this section to evaluate these debates in depth, but *serious* mental health conditions can at least be included within, and does not pose a serious issue to, my working account of health and disease. This is because certain mental health conditions, such as psychosis, schizophrenia and moderate to severe cases of anxiety and depression are clearly related to biomedical function, as well as connotating negative implications per the normativist component, which I turn to shortly. They relate to and interfere with basic biomedical function, are amenable to clinical treatment and have a tangible anatomical or physiological aetiology – for example, excess dopamine in the subcortex in the case of psychosis and schizophrenia, or issues with serotonin reuptake and noradrenergic deficiency in the case of depression.[12] Even if the treatment for a mental illness is non-pharmaceutical (such as a doctor offering cognitive behavioural therapy), this still counts as *clinical* treatment and does not affect my claim about it being related to biomedical function.[13]

On the other hand, issues with academic success or employment prospects unrelated to any biomedical function are not health-related issues. This prevents concerns about health becoming an over-expansive notion merely synonymous with wellbeing. The criterion for something *relating* to biomedical function is

[12] I set aside the controversy of whether or not other non-health-related welfare considerations can similarly be reduced to serotonergic or endorphin-related explanations, and thus whether all *welfare* can actually be defined as health-related in a sense. Focusing on *serious* mental health conditions with clear-cut cases of biomedical involvement brackets away these complexities.
[13] In their clinical guidelines for depression and generalised anxiety disorder, for example, the UK's National Institute for Health and Care Excellence (NICE) dictates that clinicians prescribe non-pharmaceutical therapies as the first-line treatment option and explicitly recommends against drug-based treatment: National Institute for Health and Care Excellence, *Depression: Management* (2022), https://cks.nice.org.uk/topics/depression/management/initial-management/. National Institute for Health and Care Excellence, *Generalised Anxiety Disorder: Management of a Person with Generalized Anxiety Disorder* (2022), https://cks.nice.org.uk/topics/generalized-anxiety-disorder/management/management/.

deliberately thin, and the focus is merely about being *related* to biomedical function and not whether it deviates from some statistically defined norm.

Issues concerning biomedical function are necessary for being *health*-related, but merely being related to biomedical function does not provide us with a definition of *pathology*. Such a definition is necessary for understanding the positive component of an account of health. For a health-related issue to count as a pathology, considerations of value are necessary. Something counts as a pathology when it concerns biological function *and* our value considerations (broadly conceived) evaluate it as *negative* – for example, because it is harmful. This dualism, whereby naturalist and normativist considerations play a role in defining health and disease, is not *ad hoc*, but explicitly aligned with how the concept is commonly used in both theory and practice. To see this, consider an area that is gaining traction within mainstream moral and political theory: the issue of disability.

Consider a scenario where someone suffers from a physical disability, say, lower-limb paralysis. Physical disability is related to biomedical function and is thus an issue of health rather than merely one of general wellbeing. However, something being health-related in virtue of its biomedical function does not mean that it is pathological. This is the central insight advanced by proponents of the *social model of disability*, which traces the limitations associated with disability at least partly to the built environment rather than purely to some biomedical fact.[14] On the *social model of disability,* the pathology associated with disability is not simply traced to the lower limb paralysis as such, but to the social and built environment that hinders

[14] Tom Shakespeare, *Disability Rights and Wrongs* (Routledge, 2006).

access for those with particular biomedical features. If the environment is reformed, such that the disabled person has wide access to move about in her wheelchair (for example) her disability may cease to become something negative. Accordingly, the disability would stop being pathological, despite being a condition related to biomedical function. Correlatively, being 165 centimetres tall would be a disability if the design of society – say, the height of food shelves and door handles – only accommodated those who were at least 185 centimetres tall. In such a scenario, height (a biomedical fact) becomes imbued with negative value judgements and being below 185 centimetres tall becomes a pathology. While we can remain agnostic about the general plausibility of the social model of disability, there is an important grain of truth in its claim about the normative status of disability and the relevance of value considerations in delineating pathology even in cases clearly concerning biomedical function.

Because the dualist account can draw on normativist considerations, it is able to provide a fine-grained account of health and disease that is philosophically more plausible and better aligned with health professionals' and laypeople's understandings. It can determine disease not only by reference to social context (as in the case of disability), but it can also index health and disease by reference to *age cohorts*.[15] Whether a particular biomedical impediment counts as a disease requires the consideration of values and norms *for someone in that age group*. Lack of menstruation in a 20-year-old woman may be a relevant sign of a pathology affecting her reproductive organs, but not in an 80-year-old woman with the same

[15] For a discussion of the importance of reference classes in defining disease and the need for value-based considerations not open to naturalist accounts such as Boorse's, see Kingma, "Situation-Specific Disease and Dispositional Function."

condition. A moderate decrease in bone density is not typically seen as pathological for a 65-year-old person but may signify disease if present in a 20-year-old, who we expect to have peak bone density. Whether a feature of biomedical function – menstruation or bone density in these examples – counts as a pathology is indexed to a particular reference class, informed by normativist considerations of value, norms, and expectations.

A dualist conception of health provides a plausible framework that avoids fatal pitfalls associated with either account. My working definition of health is focused on the *absence* of pathology, where this is sensitive to biomedical function and values (including through indexing by reference to specific groups), but it is not an expansive, positive conception that traces health to the attainment of other goods. The debate between naturalist and normativist accounts of health has been at a deadlock for the past four decades or so, and it would be presumptuous to assume that I can settle that debate in a small section of a chapter in a thesis concerned principally about justice in global health. My focus is on providing a working definition to aid our discussions of (global) health justice and not on providing a robust philosophical conception of health. A dualist naturalist-normativist account is one plausible way in which we can define and conceptualise health and pathology *for the purposes of justice*, in a way that aligns with how health is frequently understood by health professionals and laypeople.[16]

[16] The right account of justice in health will depend in a large part on what conception of health and disease we adopt. For example, whether certain minority groups can claim *health*-related assistance for particular conditions is dependent on our conception of health: Johann Go, "Should Gender Reassignment Surgery be Publicly Funded?," *Journal of Bioethical Inquiry* 15 (2018).

With a working account of health established, a few related terms need defining. *Health status* refers to the state of individuals' health at a certain point in time. That is, their degree of freedom from pathology. The health status of an individual free from more pathologies is healthier than an individual who is afflicted with more pathologies, as indexed to the appropriate reference class and social context. *Health inequalities* refer to differences in health status and can be used as a normatively neutral term, since not all health inequalities constitute an injustice and not all injustice involves inequality.[17] In the most general sense, *global health* refers to health issues – a placeholder term I use for now, to avoid presupposing an *injustice* – through the lens of the world as a whole rather than merely through our particular states.[18] Someone concerned with global health is interested in *descriptive* questions (such as the distribution of health outcomes across different countries or the global burden of diabetes in the world as a whole), *explanatory* questions (such as how we explain differences in health opportunities between Country A and Country B), as well as *normative* questions (such as what our obligations are to a particular country with poor health status or what our obligations are to promote the health of *all* people in our world today).

## Section II: The Special Moral Significance of Health

Having proposed working definitions for health and its related concepts, my task now turns to establishing what (if anything) makes *health* of special moral

[17] James Wilson, "Health Inequities," in *Public Health Ethics*, ed. Angus Dawson (Cambridge University Press, 2011); Margaret Whitehead, "The Concepts and Principles of Equity and Health," *International Journal of Health Services* 22 (1992).

[18] Defining global health is not as straightforward as it may initially appear, with frequent debates regarding the best definition: Soloman Benatar and Ross Upshur, "What is Global Health?," in *Global Health and Global Health Ethics*, ed. Soloman Benatar and Gillian Brock (Cambridge University Press, 2011); Jeffrey Koplan et al., "Towards a Common Definition of Global Health," *Lancet* 373 (2009).

significance. That is, why is an absence of pathology of special moral significance from the perspective of justice? The idea that health is of special moral importance has become an increasingly controversial and unfashionable view to hold within contemporary moral and political philosophy, for various reasons.[19] Some theorists argue that health is solely an issue of *welfare* and can be reduced to generic considerations about welfarism; some, relatedly, deny the need to pay specific attention to health when thinking about justice; others simply deny the importance of health relative to other social pursuits. In this section, I hope to rescue this idea and show that we have strong reason to view health as having special moral significance.

By the 'special moral significance' of health, I mean that health cannot be reduced to a single, generic consideration of justice (such as welfare or opportunity) *and* that health possesses a series of morally salient characteristics that give it importance at the bar of justice in its own right. I defend these components respectively. First, on what I call the *non-reducibility thesis,* I argue that health has irreducible and independent value that cannot be captured *solely* by a monistic account of justice based (for example) on opportunity or welfare. Second, on what I call the *significance thesis*, I argue that health possesses certain features that makes it especially significant and salient *at the bar of justice*. I present these two components in turn.

[19] See, for instance, James Wilson, "Not So Special After All? Daniels and the Social Determinants of Health," *Journal of Medical Ethics* 35 (2009); Adina Preda, "'Justice in Health or Justice (and Health)?' How (Not) to Apply a Theory of Justice to Health," *Public Health Ethics* 11 (2018); Sudhir Anand, Fabienne Peter, and Amartya Sen, *Public Health, Ethics, and Equity* (Oxford University Press, 2004); Segall, *Health, Luck, and Justice*; Dworkin, "Justice in the Distribution of Health Care."

The way to think about the link between the *non-reducibility thesis* and *significance thesis* is as negative and positive components, respectively, of the argument for the special moral significance of health. The fact of *non-reducibility* functions as the negative thesis in the argument, dispelling common views that say health can be subsumed within generic*, monistic* considerations of justice – welfare and opportunity being the most popular and plausible candidates. The fact of *significance* functions as the positive thesis in the argument, establishing that health possesses salient and distinctive features *in its own right* which become central considerations at the bar of justice. Putting these together, we arrive at the view that health is of special moral significance – health is normatively significant in its own right and has independent value that cannot be reduced to a single generic metric of justice.

Some clarificatory remarks are in order. First, there is no single way in which the term 'special moral significance' is used in the literature, and the two features I present as capturing the special moral significance of health will not be uncontroversial. Norman Daniels, as we shall see, denies the fact that health is irreducible and yet he holds that health has special moral importance. I only use the language of 'specialness' to accord with how the debate usually unfolds in the literature, especially in response to Daniels, who is arguably the foremost proponent of the specialness thesis.

Second, the fact that health has special moral significance does not entail that it is the *only* good with moral significance in this sense. Furthermore, it does not entail that it should be valued above *all* other goods – after all, there may be multiple

goods with special moral significance. Third, and relatedly, establishing the special moral significance of health nevertheless imbues it with a certain level of normative priority compared to other goods without such special moral significance. Demonstrating the special moral significance of health is thus a worthwhile endeavour with important normative implications despite the fact that it leaves open many important questions – something I address in more depth in Chapter 3.

Fourth, I am concerned primarily with the special moral significance of health from the perspective of justice. My focus is on what Daniel Hausman calls the *public* value of health.[20] That is, how public institutions should think about health and what considerations about health are relevant for centralised action, rather than what individuals themselves value about health. The *public* value of health is narrower than the *private* value of health. There are lots of reasons individuals may privately value their health – for example, it may enable them to maximise the number of intimate dates they are able to go on – but these are not *directly* relevant to our claims about the special moral significance of health from the perspective of justice.[21] Like Norman Daniels, I am presenting an account of health for a theory of (global) health *justice*, and this necessarily limits the scope of our axiological analysis. Any references to the special moral significance of health hereafter refers to the public dimension of the value of health and its link to justice.

[20] Hausman, *Valuing Health*.
[21] It may be *indirectly* relevant insofar as health contributes to individual preference satisfaction, but this would be a more general benefit and not phrased in terms of maximising the frequency of intimate dates.

***The Non-Reducibility Thesis***

The first strand that establishes health's special moral significance is that it cannot be reduced merely to a *single* generic metric of justice, such as welfare or opportunity. I focus on welfare and opportunity as these are the most common (and plausible) metrics addressed in the literature. I explore other options for reduction, such as capabilities, in the later part of this section. Health has multiple sources and features of value, and it cannot be reduced to any single feature currently available in our axiological vocabulary. The disvalue of a pathology (such as a fractured arm or cardiovascular disease) cannot be *reduced* merely to its negative impact on our opportunity or welfare, and the value of being healthy is not merely a function of its positive impact on our welfare or its propensity for enabling us to pursue opportunities. The value of health is irreducible to any one of these considerations in an important way, which supports its specialness as a distinct consideration of justice.

My claim is not that opportunity or welfare is irrelevant to health but that the value of health cannot be merely reduced to either opportunity or welfare. Opportunity (or welfare) is not all there is to the value of health, and a reductionist strategy that considers the value of health in either of these terms *alone* cannot ground the special moral significance of health. My claim, similarly, is not that health is its own unique class of ultimate value; merely that it cannot be reduced to any single monistic entity currently available in our normative vocabulary.

Let us turn first to the idea of opportunity. Norman Daniels defends a highly influential opportunity-based conception of health, arguing that health is of special

moral significance because, and insofar as, it promotes opportunity.[22] Health secures and promotes normal species functioning (in the Boorsean, biostatistical sense), which in turn enables individuals to exercise their normal opportunity range. By normal opportunity range, Daniels means the set of life plans that reasonable persons (conceived in the Rawlsian sense) within a particular society can be expected to develop. For example, good health enables Jared to attain normal species functioning, which enables him to pursue his desired life plan as a concert pianist (which is part of the range of life plans reasonable persons in his society can be expected to desire). On Daniels' view, health is ultimately valuable because of its propensity to allow Jared to pursue his aspirations as a concert pianist as well as other life plans. Daniels ultimately reduces the value of health to its impact on opportunity, stating that "there is wide agreement on the importance of meeting needs required for normal functioning [i.e. health] *because people have a fundamental interest in maintaining a normal range of opportunities*"[23] and that "*opportunity*, not health care … remains the primary social good."[24] Health is valuable only because it realises opportunity, which is the fundamental concern of justice.

While Daniels' account is nuanced and well argued, I argue that he is mistaken to reduce the value of health to its impact on opportunity. Daniels' account is impaled upon a dilemma that makes his account unsuccessful at establishing the special moral significance of health. If Daniels adopts what I call a *narrow account* of opportunity (i.e. along the lines of the Rawlsian conception), he cannot justify health

[22] Daniels, *Just Health Care*; Daniels, *Just Health*.
[23] Daniels, *Just Health*, 36, my emphasis.
[24] Daniels, *Just Health*, 57, my emphasis.

interventions in cases where the health condition has no impact on the person's opportunity set or he would have to conclude that there is no *health value* to such interventions. If Daniels adopts what I call a *broad account* of opportunity (i.e. one that captures the widest sense of freedom and autonomy), he risks smuggling in other non-opportunity-based considerations that would undermine his *opportunity*-based conception and make him vulnerable to the charge of self-defeat.

Consider a scenario that supports the *non-reducibility thesis* with respect to opportunity conceived in a *narrow* sense. A doctor is treating two patients, Abdul and Basir, in an emergency department. Both Abdul and Basir have identical medical presentations, namely, a broken leg in need of remedy. The doctor begins asking Abdul and Basir questions about what use they have for their legs and how a remedied broken leg would enable them to carry out their life plans and goals. It transpires that Abdul is a directionless person who prefers to wander about life with no firm plans or commitments, and who would not have his opportunity curtailed if his fractured leg were not treated. In Rawlsian parlance, Abdul does not have a comprehensive conception of the good. He would barely benefit at the bar of opportunity considerations – conceived of in the narrow, Rawlsian sense – from having his broken leg repaired and would just continue to mooch around at home with no interest in pursuing opportunities or plans of life. Basir, in contrast, not only has a robust plan for his life but also spends his day on his feet as a structural engineer. Basir also goes skiing in the weekends.

If we think that the moral significance of health (being free from the pathology of a fractured leg, in this instance) is justified *purely* by reference to opportunity

conceived in this restricted and narrow way, then there is no *health value* in treating Abdul. The doctor should instead devote her time and resources to Basir, whose opportunity sets will be greatly enhanced by the treatment compared to Abdul, for whom the treatment will have no impact on his opportunities. This strikes us as the wrong conclusion. The impact of the health dysfunction on opportunity and the improvement to opportunity may be one important consideration – for example, in terms of understanding an important dimension of the health issue's effect on the patient – but it is not *all* there is to the situation. The fact that Abdul would not benefit from an opportunity perspective does not seem relevant to whether or not we ought to mend his broken leg. What gives health value, then, cannot be traced merely to its impact on opportunity, narrowly conceived.

I leave it open whether or not the narrow conception of opportunity might get it right about who ought to be *prioritised* for treatment, if we cannot treat both of them at the same time. Plastic and reconstructive surgeons, for example, will often consider patients' occupations (for example, if they are a builder who needs their hands to work) when drawing up the priority list for the limited number of trauma operations they can perform that day. Leaving room for prioritisation in this way does not challenge my critique about the narrow conception of opportunity. This is because the claim that we ought to prioritise Person 1 over Person 2 does not entail that Person 2 should not be treated at all. Treating Basir before Abdul does not entail that there is no health value to treating Abdul simply because he would not benefit at the bar of narrow opportunity.

One might point out that there is an implicit *subjective* element involved in Abdul's situation. That is, Abdul does not care about having his fractured leg treated, and this is relevant to why there is no health value to such an intervention. This misunderstands the scenario. Abdul may not have a comprehensive plan of life that features the use of his legs, but this does not mean that he would not like his fractured leg treated anyway. Even if Abdul wanted to have his broken leg mended – for example, to alleviate pain – a narrow account of opportunity would struggle to capture the moral value of *health* intervention, absent its impact on *opportunity*. Mending the broken leg has no impact on Abdul's opportunities *ex hypothesi*, even though it may bring about other non-opportunity related benefits. The subjective component is therefore a red herring. The narrow account of opportunity would fall prey to my objections, independently of whether or not a subjective component is present.

Daniels' account is also vulnerable to a further charge, arising in situations where a person has a comprehensive plan of life and wishes to pursue a diverse range of opportunities, but in which the health issue affecting them does not have a plausible impact on opportunity. To illustrate this second scenario, consider Shlomi Segall's critique of Daniels' account. Segall argues that Daniels' opportunity-based account of health is too narrow and under-inclusive, as it cannot capture the significance of health when there is no impact on opportunity.[25] For example, mild eczema or mild asthma does not affect a person's opportunity range, and the provision of palliative care cannot be said to promote opportunities for the person on their deathbed.

[25] Shlomi Segall, "Is Health Care (Still) Special?," *Journal of Political Philosophy* 15 (2007); Shlomi Segall, "Is Health (Really) Special? Health Policy Between Rawlsian and Luck Egalitarian Justice," *Journal of Applied Philosophy* 27 (2010).

Nevertheless, our considered judgements point towards the *health* value of providing such care. To these examples, we can add the issue of dental health. Gum disease or tooth decay do not generally directly impact one's opportunity, but most of us would regard treating gum disease and tooth decay as having *health* value. Accordingly, an opportunity-based conception diverges with our considered judgements about the significance of health in these circumstances which, while not paradigmatic in the same way as cancer or stroke, are nonetheless standard cases in our intuitive understandings of health.

An opportunity-based conception of health conceived in this narrow sense therefore cannot succeed at establishing the special moral significance of health. One potential way to address these shortcomings is to turn to a broader account of opportunity to attempt to capture the cases outlined above. There are two ways to broaden the concept of opportunity – what I call the *idealised opportunity range* approach and the *inclusive account of opportunity* approach – neither of which, I shall argue, succeeds.

The *idealised range of opportunity* approach seems to be Daniels' preferred conception of opportunity.[26] Daniels argues that we ought to focus on the baseline or idealised opportunity sets from the standpoint of what a *reasonable person* needs, rather than the effective opportunity available to a particular person here and now. For example, he discusses the differing impact for someone who loses their dexterity as a manual labourer compared with someone who is a teacher, agreeing that the loss of opportunity for the former is greater than for the latter in

[26] Daniels, *Just Health*, 58-60.

terms of *effective* opportunity.[27] However, Daniels argues that we ought to consider the 'normal opportunity range' rather than 'effective opportunity' – the former being a more idealised and thus broader account of opportunity. On an *idealised range of opportunity view*, the situation with Abdul is not troubling because we are not concerned with whether health realises *his* opportunities, but whether it would realise the opportunities of all reasonable persons with an array of different life plans and competing conceptions of the good.

The issue with broadening the account of opportunity in this way is that it may still not be broad enough to accord with our considered judgements about the value of health. Relying on the notion of reasonable persons does not mitigate concerns about those who have conditions that do not impact on the normal opportunity range, conceived of in the idealised 'reasonable person' test. In one sense, the charge of undue narrowness in cases such as mild eczema, mild asthma, and dental health which do not plausibly affect opportunity even when conceived of in a non-subjective, broad sense rears its head again. It is plausible that these conditions do not impact on our reasonable life plans. In another sense, consider a scenario where someone in an isolated country designed around agrarian pursuits wishes to pursue a vocation as an analytic philosopher. Such a pursuit, however, is considered far-fetched in this country and is not in any reasonable person's set of possible life plans.[28] If a particular health condition impacts on someone's ability to pursue this vocation, and the impact arises *only* in relation to the pursuit of this vocation in this society, then it would appear that there is no

[27] Daniels, *Just Health*, 45-46.
[28] Perhaps because the society cannot conceive of pursuing such an esoteric, non-practical endeavour.

health value to treating this condition – even on this broader conception of opportunity.[29] The *idealised range of opportunity* account is therefore still prone to the charge of being unduly narrow and of failing to capture our considered judgements about the value of health in these circumstances.

The second way in which we can broaden our account of opportunity is through what we can call the *inclusive view* of opportunity. On this account, opportunity is treated as an expansive and catch-all term that captures a plethora of morally relevant considerations. Disease that causes suffering, for example, could be seen as losses of opportunity – our 'opportunity' to lead a life free from pain is impacted. The issue with this move is that it smuggles in additional considerations that may go beyond considerations of *opportunity* – something not open to those who wish to reduce the value of health to a single feature of value. The conception of opportunity becomes so broad that it ceases to align with what we would generally consider *opportunity* to entail. The idea of opportunity to be free from pain, for example, clearly intrudes into the domain of welfare and is rightly thought of in terms of welfare rather than opportunity. An *inclusive view* of opportunity is thus self-defeating for an *opportunity*-based account of the moral significance of health. Such an account essentially attempts to make plausible the opportunity-account for health's special moral significance by introducing non-opportunity-based considerations, thereby undermining its central claim.

[29] Examples could include, for example, poor eyesight that renders one unable to read philosophical texts or damage to one's fine motor skills that results in one being unable to write, but neither being serious enough to impact on the basic motor skills required for farming.

We can now point to the overarching problem with conceptions that reduce the value of health to opportunity, whether narrowly or broadly conceived. This is the fact that the idea of opportunity alone does not fully capture what makes health valuable. The core reason is that there are many aspects of health that are not even linked to the impact on opportunity. Fixing Abdul and Basir's broken leg may be valuable or morally significant *not* because it would improve their opportunity sets, but because it would alleviate their pain and suffering or because having functioning legs is something they value *for its own sake* – features I return to in my discussion of the *significance thesis*. An account that grounds the special moral significance of health solely on opportunity grounds cannot point to the value of health in many circumstances in which we think it should be provided or, in an attempt to escape this implication, it undermines its own claim as an *opportunity*-based account, introducing considerations that go beyond what we would consider opportunity. Justifying the restoration of health solely by reference to opportunity mislocates the value and moral significance of health; health cannot be reduced to opportunity.

Consider, next, how we can dispel a more plausible view: the idea that health is reducible to welfare. This is more plausible, insofar as health evidently has a very large welfare component in a way that is not present with the concept of opportunity.[30] Take the scenario of Chen-Chen, who suffers from left ventricular heart failure. Fortunately, she has an extremely cheery and happy disposition, accompanied by substantial mental resilience. Her welfare is therefore not

[30] John Broome, "Measuring the Burden of Disease by Aggregating Wellbeing," in *Summary Measures of Population Health*, ed. C. Murray et al. (WHO, 2002); Hausman, *Valuing Health*.

diminished by her having this heart condition.[31] Despite Chen-Chen's welfare being well above any reasonable standard, we would not claim that she is *healthy* or that she does not require *health* treatment for her heart failure on grounds that her welfare is already more than sufficient. We may also assume that her (subjective) welfare cannot be maximised further, to meet the concerns of welfare-*maximisers.* If the special moral significance of health is justified solely on the basis of its influence on welfare, then Chen-Chen's condition does not register as a concern that warrants our attention. This strikes us as the wrong conclusion and it follows that health cannot be defined or valued purely by reference to welfare.

One obvious response is that we can be *objectivists* about welfare, with health listed as a category on such a conception, such that Chen-Chen's situation does not have the implication I am attributing to it. On an objective account of welfare, Chen-Chen's welfare is negatively impacted by heart failure regardless of her own subjective view about it. The core issue with this response is that it does not solve the issue of why *health* should be listed *as a specific and separate good* in an objective account of welfare in the first place. Reasons have to be given for why it should be included in such a list, and we can be sure that these considerations will not be reducible to (subjective) welfare or any single generic metric of justice.

This is the same response we could give to those who propose *resourcist* theories of justice, whereby health is to be listed as a resource.[32] The *non-reducibility thesis* would still hold, because the reasons that would justify health being a separate

[31] This is a version of Cohen's 'Tiny Tim' objection: G. A. Cohen, "On the Currency of Egalitarian Justice," *Ethics* 99 (1989): 918.
[32] For example, Ronald Dworkin, *Sovereign Virtue* (Harvard University Press, 2000), 286.

resource in the first place must draw on the non-reducible nature of health. The move from subjective to objective welfare, then, does not challenge the *non-reducibility thesis* and leaves us back where we started. The core claim of the *non-reducibility thesis* with regard to welfare thus stands. There are reasons to value and attend to health independently of welfare, and health cannot be reduced to considerations of welfare. There are important considerations of welfare and opportunity in health, but they cannot be *all* that there is to health.

One important point of contention remains, namely, whether health can be reduced to another currency that is not welfare or opportunity and thereby potentially immune to my critique of reductionism. I have focused on demonstrating the irreducibility of health to opportunity and welfare because these are the most common and plausible accounts in the literature. It is possible that we will eventually develop a sufficiently clear and persuasive metric of justice in our axiological vocabulary into which the value of health can be reduced. For the moment, however, I am not aware of such a metric. I alluded to the view that resourcist theories do not fare any better, as the reasoning that goes into developing a list of resources must invariably engage with the difficult questions I levied in my critique of value reductionism in health. The currency of *capabilities* may be seen as another promising candidate, though I do not regard it as a threat to the spirit of the non-reducibility thesis.

Even given some disagreement about the details of the capabilities approach, the metric of *capabilities* is inherently pluralistic and this has several implications for any discussion of health and its reducibility to capabilities. The in-built pluralism

means that capabilities are different to the main metrics of welfare and opportunity I explored, and it may not be as problematic to reduce the value of health to capabilities. After all, 'reducing' the value of health to a pluralistic 'cluster' of values is not reductionism in the same sense as reducing health to a much narrower value such as opportunity or welfare. Reducing health solely to $Value_1$ or $Value_2$ is mistaken, but reducing health solely to $Value_3$, where $Value_3$ inherently encompasses considerations of $Value_1$, $Value_2$ and many others has much less bite and is therefore less objectionable. If, for the sake of argument, the value of health can be reduced to capabilities, it would not pose a serious challenge to the *non-reducibility thesis* I am establishing. This is because my claim is not that health cannot be reduced to a *group* of other values (which is what the metric of capabilities can be conceived as), but that it cannot be reduced to any one generic metric of justice.

The *non-reducibility thesis* makes a relatively modest but significant claim: health has independent value that cannot be reduced to its impact on a *single generic metric* of justice, such as opportunity or welfare. There is more to the value of health than opportunity or welfare alone, even if – as I stated at the very start – they are among the many important considerations in understanding the special moral significance of health. Health has independent, non-reducible value and it is of special moral significance in this sense. In my forthcoming discussion, I show that opportunity- and welfare-based considerations are important for understanding the special moral significance of health. I demonstrate that we can incorporate the contribution of health to opportunity and welfare into a more comprehensive account without *reducing* the value of health to either one of these considerations.

There may be gaps in the welfare and opportunity conceptions individually but considering them together alongside other features as part of a broader, pluralistic framework covers these gaps. In adopting this pluralistic standpoint, my account does not inherit the issues canvassed in my discussion of the *non-reducibility thesis*.

***The Significance Thesis***

The second strand that establishes the special moral significance of health is the *significance thesis*, highlighting normatively salient features about health that warrant its consideration at the bar of justice. My argument is inherently pluralistic, showing that we ought to rely on several interlinking features to establish the special moral significance of health rather than drawing on the reductionist approach I have criticised. Prevailing accounts that try to capture the special moral significance of health (in terms of the *significance thesis*) typically proceed on the basis of identifying a salient feature of health and then arguing for its salience at the bar of justice on the basis of *this* feature. The most influential argument in this sphere, which we have already encountered, is Daniels' opportunity-based conception of health's specialness. The core problem with defending the special moral significance of health on a single salient feature alone is that the feature may neither be necessary nor sufficient. The feature may not obtain even when our considered judgements conclude that health is morally significant (i.e. for reasons of undue narrowness) or the feature may only be one among many relevant features that can ground the special moral significance of health (i.e. it is insufficient on its own).

However, the fact that a *single* feature cannot fully establish health's special moral significance does not mean that the project is a lost cause and that we ought to conclude that health is therefore not of special moral significance. The fact that a *single* brick cannot capture what the external structure of a house is does not mean that *considered in their totality*, the bricks, mortar, and timber cannot come to explain a house's structure. The fact that an individual strand of fibre cannot keep a ship docked to the wharf does not mean that lots of different individual fibres criss-crossing and mutually reinforcing each other – constituting a thick rope – and tied to supporting docking points cannot do so. Analogously, I argue that the best way to establish the special moral significance of health is through a pluralistic framework that considers a diverse set of overlapping, mutually supporting features linked to health rather than relying solely upon a single feature to ground its special significance. We should acknowledge the plurality of reasons, with none necessarily having lexical priority, that make health specially morally significant.

While I have argued against Daniels' opportunity-based account on these grounds, notice that the account *does* capture something important about the significance of health. Even if we do not want to support the opportunity-based conception of health, understood in Daniels' reductive sense, we may want to acknowledge the unique role health plays in enabling us to secure many opportunities. After all, I need to have a sufficient level of physical and mental health to be successful in my career as a surgeon or builder. The force of my previous critique, therefore, is not that Daniels is wrong about the link between health and opportunity, but that Daniels is wrong to ground the moral significance of health on this relationship

*alone*. The fact that health promotes and secures opportunity matters, but this is not *all* that matters about health.

Health has several important features, but no single feature is always sufficient or necessary to ground its special moral significance in terms of the *significance thesis*. It is through a more holistic, pluralistic evaluation of these features in their totality that we can come to understand the special moral significance of health. The pluralist justification strategy for the special moral significance of health has, surprisingly, received little or no attention in the philosophical or bioethics literature. One reason for this may be the enduring appeal of philosophical parsimony and having clear-cut justifications. The pluralistic strategy is admittedly more messy, less determinate, and requires more complex theorising since there is no single reason that makes health specially morally significant and no lexical ranking of the importance of particular features of health. However, while the pluralistic approach may be more difficult and less elegant, it does not fall prey to some fatal objections (unlike the parsimonious approach), and it strikes me as the only way to capture what is really morally significant about health. Responding to criticisms about the complexity of pluralism in his metric of justice, Amartya Sen notes aptly in his Tanner Lectures: "Why must we reject being vaguely right in favour of being precisely wrong?"[33] We should not let our desire for philosophical parsimony come in the way of philosophical plausibility.[34]

[33] Amartya Sen, *The Standard of Living: Tanner Lectures on Human Values*, Clare Hall, University of Cambridge (1985), 45.
[34] In a similar though broader spirit, James Wilson has emphasised the importance of 'complex systems' thinking in ethics, given the complexity of our social processes (including in the realm of health): Wilson, *Philosophy for Public Health and Public Policy*, 62-82.

In what follows, I explore several features that make health specially morally significant (per the *significance thesis*). These reasons should not be treated as either necessary or sufficient for establishing the special moral significance of health, nor should we see any lexical ordering of importance among them. The special significance of these features comes from being considered *in their totality*, in accordance with the pluralistic framework, for which I offer additional defences in the later part of this section. I also do not make the claim that health is the only good with these features. Rather, these features are morally salient for grounding the significance of health, per the pluralist method. In this sense, *special* qualifies moral significance in a much looser sense, merely pointing out the existence of morally salient features in terms of *non-reducibility* and *significance* (i.e. health having features that gives it value at the bar of justice in its own right) and without denying that other goods also have these features.[35]

First, health has special moral significance because it possesses what I call *radical instrumentality*. A minimal level of health is necessary for us to pursue all other activities and goals in life. Health may not be everything, but without at least a requisite level of it, you have nothing. Beyond the minimal threshold, health is still instrumental for a large variety of activities and goals in life. Health is not *merely* instrumental, but *radically* instrumental. Consider money, which is a paradigmatic case of a good with mere instrumentality. Money is instrumental for subsistence by enabling us to buy essentials and instrumental for happiness by enabling us to purchase products that entertain or make us happy. Health, on the other hand, is more radically instrumental. We can imagine an alternative scenario where money

[35] As I alluded to earlier in the chapter, I retain the language of *special moral significance* for the sake of aligning with how discussions about the value of health proceed in the literature.

will cease to have instrumental value (such as in a socialist utopia where we do not need money to buy essentials or leisure activities), but it is hard to imagine a scenario where our health will cease to have instrumental value. Money, in this sense, has mere instrumentality but health possesses radical instrumentality. The instrumentality of health is not contingent in the same way as the instrumentality of money.

The idea of radical instrumentality contrasts with the narrowness of Daniels' opportunity-based account of health's moral significance. Even if health does not always promote opportunity, it can nonetheless be radically instrumental in facilitating our ability to lead active and worthwhile lives. Mild eczema may not affect my opportunity set in Daniels' narrow sense, but it may nonetheless affect my ability to participate in various activities such as sitting still in meditative practice, impact on my engagement in sports, or affect my social standing and self-esteem. Dermatological health (including freedom from mild eczema) is instrumental for our ability to perform activities over and above what is required to promote our opportunities for jobs or social positions, conceived in the narrow sense of Rawlsian opportunity or in terms of Daniels' normal opportunity range. This account of radical instrumentality runs close to what I previously described as the *inclusive account of opportunity*, which I argued was not an option available to Daniels on pain of self-defeat. Notice, however, that this is not a problem for my account. Unlike Daniels, I am not defending a solely opportunity-based account of health's special moral significance, where everything must be cashed out in terms of opportunity (and not welfare or something else). I am therefore not concerned about the boundaries of opportunity giving way to other non-opportunity-based

considerations. Radical instrumentality, insofar as it mirrors the *inclusive account of opportunity* and lets in other considerations thought of as welfare rather than opportunity, poses no challenge to my non-reductive, pluralistic account.[36]

Second, health is of special moral significance because of its relationship with pain and suffering.[37] A significant amount of suffering for individuals and populations, especially at the global level, is health related. In support of this claim, few interventions in the developing world would have as much impact on alleviating suffering as interventions related to health. The aversion to pain and suffering, and the moral desire to alleviate it, is universal and one that is frequently seen as among the most salient priorities for any normative theory. The fact that health is linked to pain and suffering thus gives it moral salience and significance in an ecumenical manner acceptable to divergent theories.

The relationship between health and suffering is a narrower claim than the reductionist one that promotes the value of health in virtue of the fact that it promotes welfare more generally. The special moral significance of health comes from its link with pain and suffering (which is necessarily more restrictive) rather than the link with welfare more generally (which is necessarily broader). Our considered judgements about the value of health interventions support this claim. We are inclined to see as morally significant treatment for someone with a fractured arm that is causing pain or with a mental health condition that is causing significant

[36] Even if I am wrong about the case of mild eczema having an influence on opportunity conceived of in a broad and inclusive sense, it would not be an issue. The other relevant aspects of the special moral significance of health (such as its link to suffering) would still be able to identify what makes mild eczema an issue of justice in *health*.
[37] We do not need a complex account of pain or suffering. Our considered judgements about what pain and suffering entail is sufficient to motivate the claims of this section.

suffering in a different way to how we would see routine cosmetic enhancements that promote welfare more generally.[38]

Third, health has special moral significance because of the way it is *valued* by people *for its own sake*. This is a simple but vital claim frequently overlooked by theorists, who tend to focus on more abstract and sophisticated reasons. Health holds *intrinsic value* for most people and plays an important role in their lives. Most people value their health in some form, and many may even rate it as their most important asset. Martha Nussbaum, for example, identifies various components of health as part of her influential list of central human capabilities, which she argues is empirically informed.[39] Health may not be the *most* valuable good, but it is nonetheless intrinsically and immensely valuable to people. Insofar as we ought to respect people's non-objectionable values and preferences, and given that *most* people seem to hold health as such a value and preference, health gains moral significance. Acknowledging the special moral significance of health is one way we demonstrate respect for something that holds immense value to people's lives and, in so doing, we demonstrate respect for people directly.[40] Multiple theorists of justice have their own reasons to care about respect in this sense, whether intrinsically (as in the case of a deontologist or relational egalitarian) or instrumentally, as a proxy for preferences (as in the case of a utilitarian).

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[38] If the cosmetic procedure is required to alleviate significant suffering, however, it may have special moral significance: Go, "Should Gender Reassignment Surgery be Publicly Funded?."
[39] Martha Nussbaum, "Capabilities As Fundamental Entitlements," *Feminist Economics* 9 (2003). That people make health-related trade-offs does not mean that they do not see it as a loss of something intrinsic, even if it is a justified and desired loss, all things considered.
[40] Without agreeing with her specific argument, my line of reasoning here bears a structural semblance to Nussbaum's view about the importance of respecting people's central identity-conferring beliefs and that a failure to do so by some strands of political liberalism can constitute disrespect: Martha Nussbaum, "Perfectionist Liberalism and Political Liberalism," *Philosophy & Public Affairs* 39 (2011).

The special moral significance of health, as captured by the *significance thesis*, lies not in one particular feature, important though the respective feature may be, but in the *totality* of these features considered together. Consider the (special) moral significance of friendship. We can point to several features that are important to a friendship: the bond you have with each other, the length of time you have known each other, being able to act on shared interests, and the willingness to share personal secrets and insecurities. Each of these features is vital and significant but, taken on their own, they cannot establish the moral significance of friendship as such. I have many people with whom I have shared interests, I may have known the school bully longer than a good friend, I may be willing to share personal secrets and insecurities with a psychotherapist, and I may have a different but equally strong bond with my pet dog. If we try to explain what makes friendship important by pointing to a single feature – important though that feature might be – we risk failing to capture the full normative dimension of friendship. It is only when we take a step back and look at these features pluralistically, *in their totality*, that we find ourselves in a good position to articulate the special moral significance of friendship. My argument is that we should see the special moral significance of health in the same way.

The appeal of my pluralistic justification strategy is that we need not make judgements about whether or not a particular feature is necessary or sufficient for grounding the special moral significance of health – an endeavour that has generated much controversy in recent years. The pluralistic justification strategy enables us to look past this deadlock and theorise in a way that is more

ecumenical. We need not feel defeated by the fact that particular features of health are sometimes neither necessary nor sufficient to ground the special moral significance of health. On my account, health only gains its special moral significance when we look at all these features as a whole.[41] The fact that health is radically instrumental, linked to pain and suffering, and something valued intrinsically by people, *together*, provides us with strong grounds to consider health specially morally significant. The fact that health is not always valued by all people everywhere or that it may not be linked to pain and suffering in specific instances does not necessarily challenge its special moral significance. It is sufficient that health *generally* possesses these salient features.

John Searle's work on cluster theories of description may be helpful here. What matters is not that the special moral significance of health has a definite set of criteria that must be ticked like a checkbox, but that there are a "sufficient but so far unspecified" number of such features.[42] Ludwig Wittgenstein's idea of *family resemblance* also helps to illustrate my pluralist strategy. Wittgenstein argues that when we try to understand what a game is, we cannot find a set of necessary and sufficient conditions that always holds.[43] Understanding what a game is requires reasoning that is less formal and not necessarily criteria driven. It is only through looking at the *general* instance of games that we can identify certain features that characterise the concept, but which do not rise to the level of providing a set of necessary and sufficient conditions.

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[41] This leaves room for further negotiation when dealing with more contested cases, which reflects the normativist component present in health alongside its naturalist dimension.
[42] John Searle, "Proper Names," *Mind* 67 (1958): 171.
[43] Ludwig Wittgenstein, *Philosophische Untersuchungen: Philosophical Investigations*, ed. G. E. M. Anscombe, P. M. S. Hacker, and Joachim Schulte, Revised 4th ed. (Wiley-Blackwell, 1953/2009), SS66-77.

I have argued that we ought to view our reasoning about the moral significance of health in a similar way. There may be no single necessary or sufficient feature or set of features that explain health's special moral significance, but this does not give us reason to give up on the idea. Health has special moral significance for the *totality* of reasons explored, and this pluralistic justification strategy is something we ought to accept. Similarly, health generally possesses a *cluster* of features that demonstrate its special moral significance.

One important question relating to the *significance thesis* is why we have a universal healthcare system (or a Ministry of Health) but not a universal food system (or a Ministry of Food) despite food meeting many features of my pluralistic framework and despite it being equally important as health to our basic needs. One important response is to say that we *do* guarantee the provision of food as a matter of justice; it is just that this guarantee takes the form of providing cash payment (in the form of universal credit or welfare benefits) which the beneficiary can use to purchase food from the market.

Fundamentally, however, the existence of centrally funded universal healthcare is a response to the practical, policy- and market-related complexities of delivering healthcare, which is not present in food provision. This feature of *complexity* is inherent in health. At a micro-level, most people cannot perform surgery or diagnose a complex disease. At the macro-level, the provision of healthcare suffers from well-known market failures, from informational asymmetries leading to supplier-induced demand, adverse selection in private insurance markets, barriers

to entry and exit that stifle competition, and the pervasiveness of negative and positive externalities.[44] In contrast, most people can tell when they are hungry and we do not need a Ministry of Food to guarantee that most people can secure food, at least in normal circumstances. The provision of cash payments to beneficiaries is generally sufficient to secure this good as a matter of justice. The fact that health is complex in these ways is a relevant factor that justifies the existence of a universal health service but not a universal food service, despite food (and other basic needs) also fulfilling many of the features in my pluralistic framework.

These features of health I identified are global in scope and robust across different social and cultural contexts. This means that the special moral significance of health operates beyond borders and specific nations. I return, in more detail, to the implications of these observations, especially for the pursuit of global health *justice*, in Chapter 4. The radical instrumentality of health is universal and not limited to the particular boundaries of a state. Health enables not just the British to achieve their goals but also allows Bangladeshis and Brazilians to do the same. The link between suffering and health is universal and not limited to the boundaries of states. Malaria and dysentery entail suffering whether we are in Lagos, Lyon, London or Lusaka, and our aversion to them is universal. We have good reason to believe that people all around the world value their health and rate it as among their most important assets. Health is valued whether one is from Australia, Azerbaijan, or Afghanistan.[45] There may be further reasons specific to local contexts that make health morally significant, but my pluralistic justification strategy, grounded in the

[44] For analyses of some of these economic issues in health, see Sherry Glied and Peter Smith, eds., *The Oxford Handbook of Health Economics* (Oxford University Press, 2011).
[45] Indeed, Nussbaum's aforementioned list of central human capabilities is empirically informed and designed to hold cross-culturally.

totality of these three features, shows us that health has special moral significance beyond borders.

These features of universality defuse an influential line of argument developed by David Miller, claiming that there is generally no metric of justice that transcends culture and context, which therefore makes the pursuit of egalitarian justice in the global realm a futile endeavour.[46] Irrespective of its implications for egalitarian justice beyond borders more generally, the universal values associated with *health* bolsters the claim that the current state of global health is morally significant across multiple viewpoints and theoretical positions. Miller's metric objection thus cannot be used to oppose universal judgements about health on a global scale. Regardless of our other views on global equality, agreement about the value of health seems subject to a very stable overlapping consensus that transcends national communities.[47]

## Conclusion

This chapter has explored a number of foundational debates about the nature and moral significance of health. In the first section, I defended a 'dualist' working definition of health that captures naturalist and normativist intuitions about the concept. In the second section, I presented a pluralist justification strategy to establish the claim that health has special moral significance. The *non-reducibility thesis* and the *significance thesis* support the claim that health has special moral significance by which I simply mean that it has particular salience at the bar of

[46] David Miller, "Against Global Egalitarianism," *Journal of Ethics* 9 (2005).
[47] Miller himself does not apply the metric objection to the issue of meeting (basic) health needs globally, but it is an argument that other critics of global health justice may marshal in their own arguments.

justice. Per the *non-reducibility thesis*, I argued that health cannot be reduced to a single, generic consideration of justice, such as welfare or opportunity. Per the *significance thesis,* I argued that what makes health significant from the perspective of justice is not the strength of any one feature, but a variety of different features viewed in their totality, and that this aspect of moral significance holds beyond borders.

# Chapter 2
# THE EXPRESSIVE FUNCTION OF HEALTHCARE

Most of us value *healthcare* and regard it as an important aspect of justice in *health.* We value the existence of universal healthcare systems and consider it morally laudable that global agents provide medical aid to those in disadvantaged regions of the world. However, the aptness of these intuitions about the value of healthcare has recently been questioned on the basis of a large body of empirical evidence which shows that the link between the provision of health*care* and the improvement of population health outcomes is more tenuous than generally assumed. The core point of contention is the role (if any) of healthcare within the pursuit of health or justice more broadly, given various empirical and conceptual challenges against its significance. The challenge is to articulate the moral significance of *healthcare* (the practice of providing clinical care by health professionals) as opposed to the broader notion of health (a *state* of the absence of pathology) and *non-clinical interventions* (such as public health initiatives or action aimed at the social determinants of health).

This chapter delves deeper into the idea of health*care* and its role (if any) in a theory of global health justice and aims to square our considered judgements about the moral significance of healthcare with various empirical and conceptual challenges about its role in a theory of (global) health justice.[1] By moral significance in this chapter, I simply mean the fact of possessing normatively salient features such that it warrants inclusion as a central component of justice. For healthcare to

[1] The focus of this chapter differs from Chapter 1's, which focused on exploring the special moral significance of *health*.

have moral significance is for it to be a central component in our theory and practice of global health justice. This chapter presents an original argument for how we might think about the moral significance of healthcare – what I call its *expressive function* – and, in doing so, helps to highlight states' obligations of justice with regards to the provision of this good, both domestically and globally. As I explain in more detail in Chapter 5, I focus on the state as the primary (but not sole) agent of global health justice for both pragmatic and normative reasons. Pragmatically, theorising about health justice (domestically and globally) tends to focus on state responsibilities. There is value in continuing this assumption for the sake of simplicity. Conceptually, healthcare is a good that suffers from significant levels of complexity and is prone to market failure when delivered outside a highly regulated system. Focusing on states as the relevant agents acknowledges the low likelihood that *individual* agents can discharge duties of healthcare in the way states can.

My arguments in this chapter unfold as follows. In the first section, I analyse the relationship between health, healthcare, and non-clinical interventions (such as public health initiatives and actions aimed at the social determinants of health). I outline the prevailing account of healthcare's significance and show how the evidence on the comparative influence of public health and the social determinants of health may undermine the argument that healthcare is morally significant insofar as it promotes health. I also examine the implications of this argument for both domestic and global health theory and practice. In the second section, I argue that a central (though not exclusive) aspect of the moral significance of healthcare lies in its expressive function. That is, in its ability to express respect to individuals in a morally significant and salient way in light of our status as inherently vulnerable

individuals. In the third section, I explore several objections to my account, including general scepticism about the significance of respect and the expressive function and whether this is sufficiently strong to justify state policies; concerns about my account being too broad or too narrow; concerns that my account may be self-defeating; worries about paternalism; and general worries about extending my expressivist account of healthcare to the global realm.

## Section I: Health, Healthcare, and the Social Determinants of Health

### *Health and Healthcare*

Justice in health is frequently seen as synonymous with justice in health*care*. Crudely, justice in *health* concerns the distribution of population health outcomes (including the distribution of health resources and opportunities and the analysis of patterns of health outcomes), while justice in *healthcare* concerns the practice and distribution of specific *clinical care*. As articulated in the Introduction Chapter, by *healthcare*, I mean treatment and care provided by clinical professionals (doctors, nurses, pharmacists, paramedics, and other allied health professionals) for the purpose of alleviating pathology and promoting our health. *Health* is the absence of pathology, defined by reference to a hybrid naturalist and normativist account, which I canvassed in Chapter 1. *Individual health* concerns the health status of a particular individual, while *population health* concerns the aggregate level of health in the population as well as the distributive pattern of health within a population.

Just as justice in health is often seen as synonymous with justice in healthcare, discussions about health are commonly limited to discussions about *healthcare*. Domestically, most debates about health tend to centre around matters of

healthcare. Questions frequently centre on the state's ethical responsibilities to equalise access to clinical care, targets to reduce waiting times for elective surgery, and improvements to the health workforce in terms of increasing the numbers of doctors and nurses.[2] Globally, the situation is similar. Action on global health typically involves discussions about how particular medical goods such as medicines should be distributed, how a particular field hospital ought to be set up, or how many doctors and nurses are required for a particular humanitarian mission. Television advertisements invite us to donate to humanitarian campaigns aimed at providing vital medical supplies and clinical care for those unable to access these.

These intuitions capture the prevailing account of what makes healthcare morally significant for the pursuit of health justice. However, the idea that justice in health is synonymous with justice in healthcare is mistaken. Health and healthcare are conceptually distinct, and the fact that one is morally significant would not entail the moral significance of the other. The fact that health has special moral significance, as I have established in Chapter 1, does not entail the special significance of *healthcare*. This is because there may be other ways of securing the good of *health* independently of *healthcare*. Whether healthcare is valuable to health justice or not depends on how (if at all) it contributes to realising *health* or whether it possesses some other morally relevant feature that properly makes it a matter of health justice. An independent argument is therefore needed to provide reasons to value healthcare and include it at the bar of (health) justice.

[2] We do, of course, also discuss public health initiatives (such as water fluoridation) and environmental health issues (such as reducing pollution), but the first connotation of health justice for most people is health*care* justice. I return to these issues later in the chapter.

The most common and intuitive argument in this vein can be articulated as follows:

> *Health View:* The moral significance of healthcare lies in its ability to promote *health* – to alleviate, manage, and/or minimise pathology.[3]

On the *Health View,* healthcare serves the function of promoting *health* through mitigating or curing disease and managing chronic conditions. This seems to align with most laypeople's intuitive view about the function of healthcare, whereby we go to the doctor to get treated and have our health restored. After all, healthcare at the most intuitive level is *for* the promotion of *health*. The *Health View* is also the dominant language used by those involved in health activism. Proponents of universal healthcare, for example, support such a policy on the grounds that it would ensure everyone can be healthy, rather than limiting this privilege only to those who can pay. When advanced in the context of global health justice, notice that the *Health View* targets the *population* level. That is, that healthcare is good for improving the health of the population as a whole – a point I return to in setting up my defence of healthcare's moral significance.

The *Health View* is also aligned with many of our intuitions about what global health justice entails. For many people, few things represent action on global health better than media images of committed doctors and nurses from *Médicins San Frontières* working with local clinicians to improve the delivery of healthcare services in disadvantaged regions. The idea that healthcare is somehow special is an intuitive one. We justifiably think that domestic states are right to place healthcare policies

[3] The underlying thought of the *Health View*, for the sake of absolutely clarity, is that healthcare promotes the health of the *population*, and this is what makes it significant for a theory of justice.

as an integral part of their pursuit of health justice, and we think the actions of global aid organisations like *Médicins San Frontières* relating to the provision of *healthcare* are morally important. However, these ostensibly obvious intuitions about the importance of healthcare at the bar of justice are more difficult than may first appear to square with the empirical reality showing that compared to the social determinants of health, health*care* has a significantly smaller impact on population health outcomes than generally assumed by theorists of justice and the general public.

### *The Social Determinants of Health, Public Health, and the Relative Insignificance Objection*

Despite its initial plausibility in justifying the supposed point of healthcare, the *Health View* cannot establish the moral significance of healthcare in a sufficiently robust manner. Decades of empirical evidence around the impact of public health initiatives and the social determinants of health strongly refute the idea that healthcare is the primary determinant of population health outcomes.[4] The social determinants of health have a much greater impact on population health outcomes compared with healthcare. The WHO estimates that the social determinants of health are responsible for up to 55% of population health outcomes globally, while a recent study with a large sample showed that access to healthcare coverage (including through insurance) reduced the likelihood of poor health by only 10%.[5] An OECD report shows that universal healthcare is associated with around a 1-

[4] Marmot and Wilkinson, *Social Determinants of Health*; CSDH and Michael Marmot, *Closing the Gap in a Generation*, WHO (2008). Of course, this is not the same as saying healthcare has no significant impact on *individuals'* health. This is the crux of the constructive argument I develop in Section III.

[5] WHO, "Social Determinants of Health."; Barker and Li, "The Cumulative Impact of Health Insurance on Health Status."

year increase in life expectancy, but that education, high income, environmental air quality, and healthy environments contributed 3.75 years more.[6]

Non-healthcare public health initiatives, most notably in the area of improved nutrition and sanitation, are widely regarded as having a relatively greater impact on population health outcomes than healthcare. Historians of health argue that it was improved nutrition and sanitation, not healthcare advances, that was the primary contributor to increased life expectancy over the past few centuries.[7] More recent evidence on the effects of nutrition and environmental health initiatives also supports the view about the relatively greater impact of non-healthcare public health interventions on population health outcomes compared to healthcare.[8] These findings point to the fact that it is primarily the social determinants of health and non-healthcare public health-based interventions (especially in nutrition and sanitation) that are the primary influence on population health outcomes and not healthcare, universal or otherwise. Healthcare is, metaphorically speaking, merely the 'ambulance at the bottom of the cliff' and less significant for improving population health than commonly thought. Call this the *relative insignificance objection*.

The implications of the *relative insignificance objection* are not merely theoretical. The moral significance of healthcare determines the contours of the states' duties to provide healthcare services (including the stringency and content of this

[6] OECD, *Universal Health Coverage and Health Outcomes*, 6.
[7] Robert Fogel, "Nutrition and the Decline in Mortality Since 1700: Some Additional Preliminary Findings," (Cambridge: National Bureau of Economic Research, Inc, 1986).
[8] Holger Strulik and Sebastian Vollmer, "Long-run Trends of Human Aging and Longevity," *Journal of Population Economics* 26 (2013); Mohammad Mafizur Rahman, Rezwanul Rana, and Rasheda Khanam, "Determinants of Life Expectancy in Most Polluted Countries: Exploring the Effect of Environmental Degradation," *PLoS One* 17 (2022).

obligation), both domestically and in terms of its duties of global assistance. As we shall see, if healthcare is merely intended to promote *health*, then the empirical evidence seems to suggest – perhaps counterintuitively to many – that we are better off taking money away from the healthcare budget and diverting these towards non-healthcare interventions to improve the social conditions in which people live, whether in terms of the social determinants of health or population-targeted public health initiatives.[9] Accordingly, a *health*-based argument for healthcare may have the effect of undermining policies intended to provide universal healthcare and invalidating any duties we may have for providing healthcare as a matter of global health justice.

If we really cared about promoting better, more equitable population health outcomes, we would focus on non-healthcare-based interventions at the level of social policy. Not only would such interventions have a statistically greater positive impact on overall health outcomes, but they would also reduce the incidence of people falling ill and requiring the healthcare system in the first place. In fact, Gopal Sreenivasan argues that there is a strong case at the bar of justice to reallocate the entire healthcare budget towards non-healthcare interventions that focus instead on the social determinants of health.[10] As a striking example, the United States spends more on publicly-funded healthcare per capita than most developed countries, but is frequently at the very bottom in rankings of overall health outcomes among developed countries.[11] Most disturbing to many theorists of justice is the

[9] For such an argument, see Gopal Sreenivasan, "Health Care and Equality of Opportunity," *Hastings Centre Report* 37 (2007).
[10] Sreenivasan, "Health Care and Equality of Opportunity."
[11] Eric Schneider et al., *Mirror Mirror 2021: Reflecting Poorly: Health Care in the U.S. Compared to Other High-Income Countries*, Commonwealth Fund (2021).

fact that population health outcomes have not improved among the most disadvantaged groups even with the introduction of universal healthcare. Two influential reports published in the UK – the *Black Report* and the *Acheson Report* – showed that since the creation of the National Health Service, health outcomes among the poor and most disadvantaged populations have not improved and, in many cases, health inequalities have actually widened.[12]

There is, of course, the question of the right counterfactual to use. Even if universal healthcare has not improved population health outcomes among disadvantaged groups, it might be that they would have been *worse* without universal healthcare. From the fact that population health outcomes did not improve much with universal healthcare, we cannot infer that health outcomes would not have gotten worse without it. Even if it were true that health outcomes would have been relatively worse without universal healthcare, the overwhelming evidence still shows that the social determinants of health are greater in their influence on health outcomes regardless of how much healthcare we provide to all.

To be clear, the claim is not that healthcare does not improve overall (population) health outcomes. Rather, it is that the impact of healthcare is much less than commonly thought and *relatively* minimal when compared to non-healthcare public health initiatives and interventions targeting the social determinants of health. Given the distributive implications of moderate scarcity and given that there are competing priorities for the budget and a desire to make health policy as effective

[12] Douglas Black, Peter Townsend, and Nick Davidson, *Inequalities in Health: The Black Report* (Penguin Books, 1982); Donald Acheson, *Independent Inquiry into Inequalities in Health Report*, Department of Health and Social Care (1998).

as possible, policymakers and theorists of justice who defend healthcare on grounds that it promotes *health* are faced with the *relative insignificance objection*. Arguing for the moral significance of healthcare solely or primarily on the grounds that it promotes population health (*Health View*) is empirically questionable and thus the argument is significantly weakened.

The *relative insignificance objection* poses the same challenge to our pursuit of global health justice, and it is worth making this explicit at the outset. If global health justice is about improving health outcomes, then the *relative insignificance objection* seems to suggest that we would be better off refraining from providing healthcare aid to other states and instead assisting these states in securing the social conditions that would promote health. Instead of assisting through the provision of healthcare, health aid would be focused on securing public health goods (such as improving nutrition and sanitation) and providing generic social goods, such as housing, primary and secondary education, programmes to improve social capital, and so on.[13] Taken to its extreme, the *relative insignificance objection* suggests that healthcare has little role in a theory of global health justice. The work of *Médecins San Frontières* and others would be considered misdirected. This conclusion sits uneasily with most people. Our considered judgements are such that *healthcare* is morally significant and must have a central role to play in any plausible theory of (health) justice. Global health justice without the provision or promotion of healthcare and which is aimed merely at non-healthcare interventions strikes us as missing something vital. A theory of justice without healthcare would be incomplete.

[13] Whether vaccination fits under the remit of public health or healthcare is a more complicated issue, which I address in Section II.

One potential rejoinder against the *relative insignificance objection* is worth considering. Someone may argue that we can accept the implications of the *relative insignificance objection* (as an empirical issue) but nevertheless provide healthcare. This is because we can concede that acting on the social determinants of health and enacting public health initiatives would indeed *maximise* health outcomes, but we do not need to care about *maximisation*. It is enough that we achieve *good enough* health outcomes, and healthcare enables us to do this. Even if we grant that justice is concerned with securing a *good enough* level of population health outcomes rather than maximising it, this rejoinder would not establish the moral significance of healthcare or carve out an argument to value its provision.

Rejecting the ideal of *maximising* population health outcomes would not entail the moral significance of healthcare or guarantee a role for it. It remains open, for instance, that we should promote *some* of the social determinants of health to a sufficient level so that we can have a *good enough* level of population health. The problem of why *healthcare* is necessary or important for a *good enough* level of health remains unanswered. Unless healthcare has independent value, it is entirely open that it can be excluded in our aim for a *good enough* level of health. The *relative insignificance objection* cuts to the core of the *Health View*, and this holds independently of whether we care about maximising population health outcomes or not. We are therefore back to our primary challenge, namely, articulating reasons that enable us to square the powerful intuition we have about the moral significance of healthcare with the reality of the empirical evidence from non-clinical public health and the social determinants of health.

To successfully provide an argument for healthcare's moral significance, a function that is centrally related to healthcare needs to be advanced. In the face of the empirical evidence about the relative insignificance of healthcare when compared to public health initiatives and the social determinants of health, theorists sympathetic to the idea that healthcare is morally significant have turned to more intrinsic justifications based, for example, on public reason liberalism and care ethics.[14] In the remainder of the chapter, I take inspiration from this general method of defending the moral significance of healthcare by reference to something more centrally linked to it.

## Section II: Vulnerabilities, Respect, and the Moral Significance of Healthcare

Over and above the benefits of healthcare in terms of the *Health View*, I argue that healthcare possesses a unique expressive function that is central to its purpose and indispensable for grounding its moral significance:

> *Expressive View:* The moral significance of healthcare lies in its ability to express respect to *individuals* in a morally salient and distinctive way.

The *Expressive View* focuses on *individuals* (rather than populations) and it is the respect that healthcare expresses to *individuals* who are inherently vulnerable that

[14] Gabriele Badano, "Still Special, Despite Everything: A Liberal Defense of the Value of Healthcare in the Face of the Social Determinants of Health," *Social Theory and Practice* 42 (2016); L. Chad Horne, "What Makes Health Care Special? An Argument for Health Care Insurance," *Kennedy Institute of Ethics Journal* 27 (2017); Daniel Engster, "The Social Determinants of Health, Care Ethics and Just Health Care," *Contemporary Political Theory* 13 (2014).

imbues healthcare with its moral significance, doing so in a way that does not rely on the empirically and normatively contingent manner of the *Health View.* My argument is not that the *Health View* has no role to play in grounding the moral importance of healthcare but that it is incomplete and cannot ground the moral significance of healthcare by itself. The *Expressive View* is an overlooked and central component of establishing the moral significance of healthcare. Except for a very small handful of theorists, philosophers have not seen it apt to theorise the expressive dimension of healthcare.[15] In what follows, I develop the thought that what makes healthcare morally significant lies primarily in the respect it expresses to individuals rather than in its contribution to (population) health. I articulate the normative mechanism by which healthcare expresses respect to individuals and, in doing so, aim to 'rescue' healthcare from the *relative insignificance objection* and thereby establish its moral significance.

My argument for healthcare's expressive function proceeds in two key normative steps: first, to highlight the state of what we can call *inherent vulnerability* that everyone experiences *qua* human person, and second, to show that this intrinsic part of our personhood is something healthcare is able to address in a morally salient way. In doing so, it expresses respect to us as *individuals*, in flesh and blood, with precarious and variable health needs. It is through the reality of our inherent

[15] For notable exceptions, see: Daniel Weinstock, "How Should Political Philosophers Think of Health?," *Journal of Medicine and Philosophy* 36 (2011); Engster, "The Social Determinants of Health, Care Ethics and Just Health Care."; Kristin Voigt and Gry Wester, "Relational Equality and Health," *Social Philosophy and Policy* 31 (2015).

vulnerability and healthcare's ability to address it that gives it its moral significance and makes it a worthy focus of justice.[16]

### *Universal Vulnerability*

The first step in the argument is to highlight our universal vulnerability *qua* human persons. Human beings are inherently vulnerable creatures. Susceptibility to death and disease are central characteristics of our personhood. We are all but one mutation away from cancer; we are one misfortune or accident away from serious injury, disease, or death. The nature of our personhood as human beings is that we are fragile and vulnerable creatures, susceptible to a range of biochemical and physiological forces. Because this reality of vulnerability is inherently tied to our fragile nature as human beings – compared to, say, perfectly engineered robots free of such vulnerabilities – the vulnerability is a universal feature across every person. This view of vulnerability can be referred to as *inherent vulnerability*.[17]

Martha Albertson Fineman argues that "vulnerability is – and should be understood to be – universal and constant, inherent in the human condition … a universal, inevitable, enduring aspect of the human condition that must be at the heart of our concept of social and state responsibility".[18] Onora O'Neill points to the persistent and universal feature of inherent vulnerability:

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[16] For a more detailed account of the moral significance of vulnerability and why it matters for our normative theorising, see Robert Goodin, *Protecting the Vulnerable* (University of Chicago Press, 1985).

[17] Judith Butler, for example, has advanced an influential account of vulnerability along these lines she calls 'corporeal vulnerability': Judith Butler, *Precarious Life* (Verso, 2004); Judith Butler, *Frames of War* (Verso, 2009).

[18] Martha Albertson Fineman, "The Vulnerable Subject: Anchoring Equality in the Human Condition," *Yale Journal of Law and Feminism* 20 (2008): 1, 8.

> Human beings begin by being persistently vulnerable in ways typical of the whole species: they have a long and helpless infancy and childhood; they acquire even their most essential physical and social capacities and capabilities with others' support; they depend on long-term social and emotional interaction with others; their lives depend on making stable and productive use of the natural and man-made world.[19]

Alasdair MacIntyre draws attention to the fact that there is only so much individuals can do in response to their own inherent vulnerability:

> How we cope is only in small part up to us. It is most often to others that we owe our survival, let alone our flourishing, as we encounter bodily illness and injury, inadequate nutrition, mental defect and disturbance, and human aggression and neglect.[20]

Inherent vulnerability can be contrasted with the idea of *specific vulnerability*, prevalent in the bioethics and research ethics literature. Specific vulnerability focuses on individuals or groups who are seen as *particularly* vulnerable, such as the elderly, those with disabilities, or those who stand in a particular relationship to us. Robert Goodin's early account of the ethics of vulnerability – in addition to providing a general grounding for the significance of vulnerability in theorising our duties and responsibilities – is both laudable and significant in this respect.[21] For specific vulnerability, vulnerability is a deviation from the norm and something specific people experience rather than something universally experienced by all. While there is merit to focusing on specific vulnerabilities, the reality of inherent

[19] Onora O'Neill, *Towards Justice and Virtue* (Cambridge University Press, 1996), 192.
[20] Alasdair MacIntyre, *Dependent Rational Animals* (Duckworth, 1999).
[21] Goodin defends an object-centred account of vulnerability: A is vulnerable to B *iff* B's acts or omissions have the potential to (severely) impact A: Goodin, *Protecting the Vulnerable*.

vulnerability is frequently forgotten about. In doing so, we overlook a significant way in which we are *all* vulnerable and run the risk of failing to recognise the implications of *our own* vulnerability – for example, in our universal need for care.

It is true, of course, that these vulnerabilities and risks – not least those relating to health and healthcare – are not evenly felt and distributed.[22] However, even the richest billionaire is vulnerable to a heart attack or metastatic cancer, no matter what precautions she takes and no matter her surroundings. A member of the dominant group in society will still bleed when we prick him and die when we poison him. While the differences in degrees of vulnerability may itself be a concern of justice, there is something morally significant about the presence of vulnerability *simpliciter*. A useful thought is to consider the Kantian conception of personhood as linked to the possession of rationality.[23] Once we are above a certain *threshold* of rationality, we are considered persons in the Kantian sense. Our humanity does not diminish or increase in proportion to our level of rationality, such that the more rational one is, the more human or the more of a person one is. Above some relevant *threshold*, our status as persons and the corresponding rights and duties that come with this are equal.[24] Analogously, on this form of reasoning, the salient feature is the mere presence of vulnerability in *the morally relevant degree* in each and every human being rather than the relative degrees.[25]

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[22] Jonathan Wolff and Avner De-Shalit, *Disadvantage* (Oxford University Press, 2007); Jonathan Wolff, "Disadvantage, Risk and the Social Determinants of Health," *Public Health Ethics* 2 (2009).
[23] Immanuel Kant, *The Metaphysics of Morals*, trans. Mary J. Gregor, Revised ed., ed. Lara Denis (Cambridge: Cambridge University Press, 1797, 2017).
[24] I use this example merely for analogy and without supporting the Kantian conception of personhood which, as many have rightly pointed out, is ill suited to issues of health and disability: Eva Kittay, "At the Margins of Moral Personhood," *Ethics* 116 (2005); Martha Nussbaum, *Frontiers of Justice* (Belknap, 2006).
[25] Even if there are some things we can be 'certain' about – for example, by undertaking a genetic test that will confirm that one will not develop a particular disease – the human body is still prone to a whole raft of vulnerabilities. There are still unknown pathogens that could kill us, or we could

***From Universal Vulnerability to Respect***

The second step in the argument is to highlight the role of healthcare in relation to these universal vulnerabilities and how it connotes respect for individuals. Healthcare has an important expressive function, over and above its biomedical function and despite its relatively limited effect on population health outcomes. This expressive function comes from the way healthcare signifies respect to *individuals* given the reality of inherent vulnerability. Healthcare expresses respect through three principal normative mechanisms, which I call the *individuating mechanism*, the *conceptual mechanism,* and the *direct mechanism*. These mechanisms are not mutually exclusive, not exhaustive, and are consistent with valuing the *Health View.*

We can define respect, in the sense we are concerned with, as recognising the dignity, importance, value or significance of an entity independently of one's own feelings and sentiments towards it. It is tied with what Stephen Darwall calls *recognition respect*: "The most general characterization which I have given of recognition respect is that it is a disposition to weigh appropriately *some feature or fact* in one's deliberations. Strictly speaking, the object of recognition respect is a fact. And *recognition respect for that fact consists in giving it the proper weight* in deliberation."[26] This fact, using Darwall's description above, is the fact of inherent vulnerability. Recognition respect demands that we *recognise* the fact of inherent vulnerability and feature this in our actions and deliberations. Part of taking this

be involved in an accident on our way home. There are thus enough sources of vulnerability to motivate my account, for as long as our bodies remain inherently vulnerable in a plethora of different ways.

[26] Stephen Darwall, "Two Kinds of Respect," *Ethics* 88 (1977): 39, my emphasis. See also Stephen Darwall, *The Second-Person Standpoint* (Harvard University Press, 2006).

inherent vulnerability seriously, I shall argue, is the provision of healthcare to individuals (regardless of its limited impact on population health). Through providing healthcare to individuals, recognition respect is shown.

To understand respect in more practical terms, we can draw on a simple strategy used by Jonathan Wolff, who argues that we can understand the nature and demands of respect by reflecting on what it means for someone else to treat us with respect. Wolff argues that a comprehensive answer is not required: "It is not necessary to develop a full analysis of an egalitarian notion of respect, even if that were possible. … Rather I need only make plausible that certain forms of treatment undermine respect: that is, if I feel people are treating me in a certain way, this will either lead me to believe that they do not respect me, or lead me to lose my self-respect".[27] Both Darwall and Wolff's respective conceptions of respect – one more theoretical and one more practical – give us sufficient guidance for now to proceed with illustrating the expressive function of healthcare.

*Individuating Mechanism*

The *individuating mechanism* highlights healthcare's characteristic focus on the individual. Despite its limited impact on health outcomes at a population level (as the *relative insignificance objection* demonstrates), healthcare is innately focused on *individuals* and cognisant of the way inherent vulnerability manifests for specific persons. The inherent vulnerability of the human body means that even in a world with perfect population-level health policies, individuals will continue to fall ill and

[27] Jonathan Wolff, "Fairness, Respect, and the Egalitarian Ethos," *Philosophy & Public Affairs* 27 (1998): 107. This is not merely a *subjective* account of respect, whereby disrespect is present when or only if one *feels* disrespected. Rather, it is an illustrative tool for us to understand the demands of respect, akin to an (objective) ideal observer account of respect.

be afflicted by disease. For these people, it is scant reassurance to say that *population* health interventions have given them the best possible chance of overcoming their vulnerability. Healthcare plays a vital role in this regard, coming to the aid of individuals who fall prey to the vulnerable reality of the human condition.

To understand how this focus on individuals expresses respect, consider the contrast between healthcare and population-level interventions. Population health generally deals with anonymous statistical figures. When we create inclusive social structures that thereby reduce mortality and morbidity, for example, we cannot point to an individual and say that *she* is the one who benefited from a population policy. The effects of preventative and population-level policies are invisible at the level of the individual, due to the complexities of determining counterfactual outcomes for each individual. Compared to public health and broader policy interventions, healthcare focuses on the individual in a unique way. Healthcare may be the so-called ambulance at the bottom of the cliff, but it serves a vital role in relation to a central characteristic of our personhood, namely, addressing our vulnerability to ill health or at a time of health need. In doing so, it signifies respect to *individuals*, in flesh and blood rather than primarily as an epidemiological consideration. Even if we believe, as I think we should, that prevention and proactive public health measures and acting on the social determinants of health should have a central role in our policy concerns, it does not follow that there is therefore no need for healthcare and ambulances, any more than supporting crime prevention entails the negation of maintaining an emergency police service.

The *individuating mechanism* is reminiscent of the debate around identified and statistical lives.[28] This is the ongoing debate in bioethics and distributive justice about whether we may permissibly favour policies that advantage identifiable individuals (for example, rescuing two right here, right now) over policies that benefit an often greater number of anonymous, statistical lives (for example, erecting a fence to prevent a greater number of as-yet unidentified people from falling off a cliff). Of particular relevance to my *individuating mechanism* argument, Johann Frick has argued for the priority of identified over statistical lives on the grounds that we are giving identified individuals a concentrated benefit against certain harm, whereas the benefits to statistical individuals are necessarily more diffused.[29] In the structure of a typical case – something mirrored in the provision of healthcare versus action on the social determinants of health or public health initiatives – we are giving an identified individual a 100% certainty of benefit compared with giving 100 statistical individuals a 1% reduction in risk for a certain condition. My argument thus far is that we ought to favour identified over statistical lives *when it comes to expressing respect* in the form articulated, but I do not make the stronger (and I think mistaken) claim that we ought to favour identified over statistical lives *all things considered*.[30] After all, expressing respect is not all there is to the demands of morality or justice – an issue I return to in Section III.

Another way of expressing the link between healthcare and respect for *individuals* through the *individuating mechanism* is that healthcare respects the separateness

[28] Glenn Cohen, Norman Daniels, and Nir Eyal, *Identified Versus Statistical Lives* (Oxford University Press, 2015); Tony Hope, "Rationing and Life-saving Treatments: Should Identifiable Patients Have Higher Priority?," *Journal of Medical Ethics* 27 (2001).
[29] Johann Frick, "Contractualism and Social Risk," *Philosophy & Public Affairs* 43 (2015).
[30] Frick's argument for the priority of identified lives is similar, arguing that it is open what we ought to do, *all things considered.*

of persons. Unlike population health interventions, which is necessarily aggregative, healthcare focuses on the claims of each individual independently of aggregate benefit. This language appeals to the liberal conception of respect, whereby the ultimate unit of moral concern is the individual who generally has primacy over the collective's interests. This need not be in tension with the idea that inherent vulnerability requires us to rely on others for care. We can engage in interdependent relations and acknowledge our vulnerability and dependence on others while still believing that individuals are the ultimate unit of moral concern. Population health measures alone – to wit, an exclusive focus on public health initiatives and action on the social determinants of health – can lead to the neglect of *individuals* which strikes us as tragic and unbearable. The *Expressive View* adds a non-consequentialist dimension against a backdrop where much of the discussion is consequentialist in nature. The *Expressive View* does not challenge the consequentialist dimensions as such, as the aggregate population-level benefits are undoubtedly important; it merely adds a further consideration over and above these, justified at the altar of each individual's interests.

*Conceptual Mechanism*

At a more theoretical level, healthcare demonstrates a very particular kind of respect linked to a central feature of our humanity, in a way that the provision of other services may not do. Healthcare is linked, *conceptually*, with what it means to acknowledge our inherent vulnerabilities *qua* human beings. The concept of respecting persons imbued with vulnerability entails the provision of healthcare. We can establish this conclusion by drawing on our considered judgements about the moral and conceptual demands of respecting a vulnerable entity.

Consider how I would ‘respect’ a fragile and ‘vulnerable’ Fabergé egg compared to a rugby ball. By taking exceptional care in handling the Fabergé egg – covering it in silk, cradling it with soft cushions, taking exceptional care in my movements, storing it in a secure safe – I am respecting it *qua* vulnerable entity. The fragility and vulnerability of the Fabergé egg means that the demands on me are different to the rugby hall. The respect I show for the Fabergé egg is directly based on my acknowledgement of its vulnerability. I would not kick the Fabergé egg in the same way I would a rugby ball, and I would take additional care in how I handle and maintain it. Extending the structure of this *conceptual* argument, we show respect for human beings’ vulnerability by guaranteeing and providing healthcare, among other things. To fail to do so is to violate the very concept of what it means to respect human beings *qua* vulnerable beings. It is akin to rolling the Fabergé egg around the garden as a toy or failing to cushion and secure it. To be clear: the Fabergé egg example simply establishes the fact that certain features of vulnerability demand particular responses that directly connotate *conceptually* whether or not we treat it with respect. The argument is not that human vulnerability is like the Fabergé egg’s or that how we respect a Fabergé egg can be directly translated to how we respect a human person.

At this stage, one might turn the Fabergé egg example against my account of healthcare’s expressive function. Is it not the case, it might be argued, that we are taking *preventative* steps to stop the Fabergé egg from breaking in an analogous way to promoting public health initiatives and acting on the social determinants of health to prevent people from falling ill in the first place? Two responses can be

offered. First, as alluded to above, the example is designed to illustrate the *conceptual* demands of respect rather than to establish something more substantive about the similarities of vulnerability between Fabergé eggs and humans. Second, and notwithstanding the first reply, preventative healthcare focused on *individuals* is not the same as *population*-level prevention schemes focused on public health or the social determinants of health. A healthcare professional providing a *specific individual* with an immunisation against an infectious disease is not analogous to improving the neighbourhood's social and urban design (i.e. action on the social determinants of health) nor to a mass health campaign encouraging better hygiene and sanitation (i.e. public health initiatives) to prevent that same infectious disease across the population.

It may be said that my account focuses on the *ex-post*, as opposed to the *ex-ante*, dimension, with the *Expressive View* calling our attention to the significance of the *ex-post* dimension. That is, my arguments about healthcare are concerned with dealing with individuals *after* illness or injury (*ex-post*), whereas policies targeting public health initiatives and the social determinants of health focus on reducing risks *before* individuals fall ill or get injured (*ex-ante*). This characterisation of my argument is misleading, and we cannot reduce the debate about the moral significance of healthcare to a mere dichotomy between *ex-ante* and *ex-post* considerations. This is because healthcare is not limited to *ex-post* considerations and deals with many *ex-ante* considerations, including individual-level preventative interventions such as immunisation (which reduces, *ex-ante*, the risk of contracting a disease in the future). The expressive function of healthcare is therefore not concerned merely with *ex-post* considerations, and the expressive function

account cannot be collapsed merely to the thought that it is simply another way of articulating the importance of *ex-post* considerations. My argument for the expressive function of healthcare may track the focus on (identified) *individuals*, but it does not follow from this that I am committed solely to *ex-post* considerations.[31]

While the provision of healthcare to a particular individual *simpliciter* can meet part of the expressive function, only a system of universal healthcare in which each and every individual has fair access to healthcare fulfils the conceptual demands of respect and expresses the *Expressive View* in full.[32] This is because the recognition of our inherent vulnerability must be universal for it to serve the respect-expressing function, in the same way respecting and acknowledging fragility means treating *all* Fabergé eggs with care rather than only those we particularly like. To understand this shift, we can distinguish between two senses in which healthcare expresses respect:

> *Respect*$_1$ (Isolated Respect) – Respect is shown by a healthcare professional who provides treatment to a particular individual. The specific individual is respected in this instance.

[31] For further discussion of *ex-ante* and *ex-post* considerations, see: T. M. Scanlon, "Reply to Zofia Stemplowska," *Journal of Moral Philosophy* 10 (2013); Frick, "Contractualism and Social Risk."; Michael Otsuka and Alex Voorhoeve, "Why It Matters That Some Are Worse Off Than Others: An Argument Against the Priority View," *Philosophy & Public Affairs* 37 (2009).
[32] For the purposes of this chapter, I remain deliberately ambivalent about what 'fair access to healthcare' constitutes, as there are many compatible accounts, from single-payer systems such as the UK's NHS to multi-payer universal healthcare such as Australia's Medicare programme or universal social insurance schemes common in Europe.

*Respect*$_2$ (Generalised Respect) – Respect is shown by the healthcare system to each and every individual within its scope of responsibility.[33] All individuals are respected in this instance.

It is possible for *Respect*$_1$ to be realised without *Respect*$_2$*.* The US is a good example of this, where many individuals have access to high-quality private healthcare. When these individuals access such healthcare, respect is still shown to them *qua* individuals with inherent vulnerability. However, *Respect*$_2$ is a much more demanding condition. The focus is still on clinical intervention *for* an individual patient, here and now, but from the vantage point of the health system as a whole. The ideal of *Respect*$_2$ is whether or not *Respect*$_1$ obtains for each and every individual. This vantage point is not *ad hoc* and relates to the conceptual demands of respect as well as the reality of collective vulnerability. It starts from the generalised idea that all human beings are vulnerable and extends this thought to recognising the *collective* vulnerability of humanity. Some vulnerabilities are reinforced as a result of living in larger communities, such as the increased danger from the spread of pathogens or the risk of violence at the hands of others. This collective vulnerability can only be mitigated and addressed, by the mechanisms of respect identified, through the provision of healthcare that is universally accessible in some substantive way. Providing only some people with healthcare does not show respect in the substantive sense of *Respect*$_2$ because it does not recognise the feature of *universal* vulnerability that inheres in *all* individuals. *Respect*$_2$ does not collapse into population-level action on the social determinants

[33] 'Healthcare system' does not necessarily mean a *national* healthcare system. Nevertheless, seeing this as concerned with a national healthcare system is still compatible with obligations of global health justice to support other countries' healthcare systems.

of health as the focus is on the provision of clinical care by healthcare professionals to *individuals*, rather than on non-healthcare-based interventions with the explicit aim of improving population health.

*Direct Mechanism*

Healthcare can address and reduce our vulnerability more directly. If one is severely injured, healthcare reduces our vulnerability not only physically but also psychologically. In providing us with healthcare, respect is shown to us, generally at a time when we are at our most needy and fearful. To understand the force of this link, we have only to consider scenarios where we are in great health need and are *not* provided with the requisite healthcare. Stories abound of people in need being denied healthcare for all kinds of morally irrelevant reasons (including due to lack of ability to pay or because of nationality and ethnicity). Relying upon Wolff's strategy for understanding the practical demands of respect, we can see that such denial of healthcare is inconsistent with respecting persons, especially given that their vulnerability is inherent and unavoidable. The *direct mechanism* arguably draws on the moral significance of healthcare captured by the *Health View*, but it cannot merely be *reduced* to these considerations without also understanding the expressive function. After all, if the *Health View* is treated as capturing the totality of our moral considerations relating to the pursuit of (global) health justice, we simply fall prey to the *relative insignificance objection*.

Healthcare also provides us with a means to transcend, in a sense, our inherent vulnerability. It weakens the link between the practical reality of our lives and our inherent vulnerability. When riding a bicycle around town or going for a stroll along

the meadow, the availability of healthcare provides us with important assurance that we are looked after should misfortune strike us.[34] Healthcare, in this sense, is agency promoting in an important way. The mere knowledge that healthcare is available to us should something go wrong is anxiety-reducing and enables us to face our inherent vulnerability more candidly.

These three mechanisms are a set of non-exhaustive and non-mutually exclusive features that demonstrate the expressive function of healthcare. Another way to think of my aim in highlighting the expressive function of healthcare is to place the traditional focus on 'health' at the same level as the 'care' component of *healthcare*. Healthcare is significant not only in its impact on health, limited though it may be at the population level, but in the way it signifies respect (through the provision of care) to individuals characterised by inherent vulnerability.

## Section III: Objections and Concerns

The expressive function of healthcare may be a shift from how we typically view the moral significance of healthcare (and its role in global health aid) and is likely to elicit some objections. I explore five such major objections. The first objection casts various doubts about the moral significance of the 'expressive function'. The doubt can manifest in reservations about the value or possibility of expressivism, doubts about whether the expressive function can justifiably motivate demanding duties of justice, and scepticism about the significance of respect. The second objection points to a problem all accounts of health(care)'s significance must

[34] Jonathan Wolff mentions the importance of 'health security' in this regard: Jonathan Wolff, "Health Risk and Health Security," in *Medicine and Social Justice: Essays on the Distribution of Health Care*, ed. Rosamond Rhodes, Margaret Battin, and Anita Silvers (Oxford University Press, 2012).

grapple with, namely, whether the account strikes the right balance between being appropriately narrow and broad.[35] The charge is whether my account is too narrow to consider minor conditions such as mild eczema, on the one hand, and whether my commitment to healthcare on the grounds of its link to vulnerability is so broad that it also requires me to support the moral significance of other policies around social welfare or housing, on the other hand. The third objection concerns paternalism, and whether healthcare still has expressive value when provided against the will of individuals. The fourth objection highlights a way in which my account might be self-defeating, given that promoting public health initiatives or acting on the social determinants of health might also express respect. The fifth objection points to a concern about extending my general argument about vulnerability and the expressive function of healthcare globally, beyond particular national communities.

### *Objection 1: Doubts about the Expressive Function*

One powerful objection against grounding the moral significance of healthcare on its expressive function is to cast doubt on the idea of expressivism altogether. Writing in another context, Jason Brennan and Peter Jaworski criticise what they call *semiotic* or symbolic objections.[36] For Brennan and Jaworski, the social meaning of something does not in itself provide a normative reason to act or refrain from acting a certain way. Applying their argument to healthcare, the objection is that the social meaning healthcare expresses is highly contingent and socially constructed and does not provide us with sufficient normative reason to value it. In

[35] I addressed this issue in Chapter 1, in discussing how we ground the special moral significance of health without being either unduly narrow or unduly broad.
[36] Jason Brennan and Peter Jaworski, "Markets Without Symbolic Limits," *Ethics* 125 (2015).

response, notice that I am not concerned with the *social* meaning of healthcare. My argument is more conceptual, highlighting the demands of addressing vulnerability and the way this expresses respect given certain starting presuppositions (such as Darwall's recognition respect) in a way that does not rely upon highly contingent, socially constructed meanings. In this regard, Brennan and Jaworski's criticism of semiotic arguments may not land against mine.

To respond more fully to critics of expressivism, and those not satisfied with the above response to Brennan and Jaworski, we can point to the diverse ways in which expressivism (of which symbolic value is a component) occupies a central and inseparable role in our moral and social universe. The very act of a romantic kiss, for example, derives its meaning from the expressive and symbolic dimensions of what it connotes. Reducing the act to a description of the movement of the mouth muscles involved does not do justice to the social significance of such an action. Other examples abound in historical and contemporary societies: the obsession with national flags, anthems and other symbols; the idea of martyrdom and dying for one's cause; many acts of protest and civil disobedience; and countless social, cultural, and religious rituals. These actions all gain their moral significance in a large part because of their expressive function.

In *Portfolios of the Poor*, Daryl Collins and colleagues analyse how the world's very poor manage their money.[37] Surprisingly, they find that most families manage to get by on less than $2 per day. What tends to cause financial crises for the very poor are medical emergencies, weddings, and funerals. It is notable that two of

[37] Daryl Collins et al., *Portfolios of the Poor* (Princeton University Press, 2009).

these activities (marriages and funerals) are almost exclusively expressive in their functions. The third activity (healthcare), I have argued, has a vital and central, though not exclusive, expressive function. Collins and colleagues' findings are a powerful image of the universal significance of expressivism in day-to-day social, political and moral lives all around the world, even among those who are significantly burdened with material insufficiency.

To cast doubt on the idea of expressivism is to ignore a central way in which our lives are given meaning in the social and political universe we occupy – a view acknowledged by a wide variety of theorists, from Elizabeth Anderson to Robert Nozick.[38] Nozick explicitly acknowledges that the views he presented in *Anarchy, State, and Utopia* failed to take into account the importance of symbolic and expressive dimensions: "The political philosophy presented in *Anarchy, State, and Utopia* ignored the importance to us of joint and official serious symbolic statement and expression of our social ties and concern and hence … is inadequate."[39] This argument, however, may still leave some unconvinced about *healthcare* having an expressive function in this regard. In response to these sceptics, I can only point again to the starting point of inherent vulnerability experienced by each individual and the mechanisms in which healthcare *expresses* respect through the recognition of this fact, and to appeal to the conceptual understanding of respect

[38] Elizabeth Anderson and Richard Pildes, "Expressive Theories of Law: A General Restatement," *University of Pennsylvania Law Review* 148 (2000); Robert Nozick, *The Nature of Rationality* (Princeton University Press, 1993). For further philosophical work on expressive and symbolic value, see: Robert Merrihew Adams, "Symbolic Value," *Midwest Studies in Philosophy* 21 (1997); Ryan Davis, "Symbolic Values," *Journal of the American Philosophical Association* 5 (2019); Christian Schemmel, *Justice and Egalitarian Relations* (Oxford University Press, 2021).
[39] Nozick, *The Nature of Rationality*, 32.

and their considered judgements of what an alternative state of affairs might look like.

Another form of this objection is to argue that expressivism is not strong enough to motivate state action or individual obedience, on grounds that it is a morally irrelevant criterion for supporting a law or policy. The provision of healthcare demands significant regulation and tax payments, and there may be doubt whether the fact that it expresses respect is a strong enough reason to compel obligations on the part of citizens. In response, we can offer three rejoinders. First, we can double down and reassert the importance of expressing respect and the ways in which healthcare meets these conditions, as my foregoing arguments highlight. Second, we can point to analogous cases outside of healthcare where the expressive dimension of particular policies are central considerations. Joel Feinberg, for example, defends an influential account of punishment, whereby its role is to express disapprobation towards wrongdoers.[40] Much of the jurisprudence around anti-discrimination law (especially concerning indirect discrimination) is strongly motivated by ideas related to the symbolic and expressive wrong associated with it.[41] Many countries' provision of welfare benefits in cash, rather than in voucher form, is motivated strongly by concerns about expressing dignity to beneficiaries. The provision of many government services is thus already motivated by the expressive dimension.[42]

[40] Joel Feinberg, "The Expressive Function of Punishment," *Monist* 49 (1965).
[41] Cass Sunstein, "On the Expressive Function of Law," *University of Pennsylvania Law Review* 144 (1996); Anderson and Pildes, "Expressive Theories of Law: A General Restatement."
[42] For further discussion on the expressive dimension of state action, see Kristin Voigt, "Relational Equality and the Expressive Dimension of State Action," *Social Theory and Practice* 44 (2018).

Third, the claim is *not* that healthcare has *only* an expressive function and does nothing else. After all, if this were the case, it would remain an open question whether we ought instead to express respect to individuals in other, more effective non-healthcare-related ways. Instead, the claim is that healthcare may not have a significant role at the bar of population health when compared to public health initiatives and action on the social determinants of health (the *relative insignificance objection*), but it has a vital effect on *individuals'* health. This effect on health, albeit limited in form and focused on the individual level, is central to the *Expressive View* of healthcare. It is precisely because of the way healthcare addresses inherently vulnerable individuals' *health* needs that it expresses respect. The objection against the *Expressive View* on the grounds that we have no reason to support healthcare merely for the sake of expressivism is therefore misled, as the expressivism is itself tied to the provision of important *health* benefits for *individuals*.

A related concern is the vague and indeterminate nature of *respect*. Many moral and political philosophers are suspicious about the way in which 'respect' is carelessly thrown around as a catch-all term, coming to signify everything and nothing at once. Two responses can be offered against this objection. First, I am concerned with a particular notion of respect, namely, recognition respect. Insofar as I have provided a working definition of this concept, including its link to the *recognition* of the relevant fact and feature of inherent vulnerability in human persons, it is harder to accuse my account of vagueness, in the same way we might criticise (for example) the vague concept of 'dignity' in international human rights law. Second, there is a sense in which we can use the concept of respect as a

catch-all term. This is because not much actually turns on the precise term we use for what healthcare expresses. If we want, we can use the language of *equal concern* (healthcare expresses equal concern for our universal vulnerabilities), *interests* or *needs* (healthcare expresses the view that our interests or needs matter equally *qua* vulnerable entities), or *rights* (healthcare expresses rights that we have in virtue of, or grounded on the fact of, our shared vulnerable condition) instead of or alongside respect. The expressive function account, then, can be ecumenical and indifferent to our preferred language of justice without diluting its substantive claims.

***Objection 2: Simultaneously Too Narrow and Too Broad***

Consider, first, the charge of undue narrowness. One might be convinced that providing essential healthcare services (such as emergency medical treatment or cancer surgery) expresses respect for individuals in the sense I have articulated but voice scepticism at whether treating minor conditions (such as mild eczema) really expresses respect for individuals in the same sense. Several comments can be offered in response. First, minor conditions such as mild eczema or mild asthma are still linked to our inherent vulnerability. It is because of the reality of our inherent vulnerability that we suffer from conditions such as asthma and eczema, be they minor or serious in form. In this regard, my arguments about expressing respect through *recognising* and addressing our inherent vulnerabilities in Section II still holds. Second, we could imagine a situation in which we seek healthcare for minor eczema, (which is a nuisance and causes us itchiness but is otherwise benign) but are declined such care by the provider or state on grounds that the condition is minor. Using Wolff's strategy for understanding the practical demands of respect,

we would invariably conclude that such a policy does not express respect for us *qua* vulnerable individuals.

Third, the fact that something expresses respect gives us a central but nonetheless *pro tanto* rather than an *all-things-considered* reason for providing it as a matter of justice. We can accept that addressing minor conditions expresses respect to individuals without holding on to the view that addressing such conditions is *always* demanded by justice all things considered, or that addressing minor conditions is on a par with addressing more serious conditions. How exactly we ought to balance considerations of expressing respect and other competing demands of justice is beyond the scope of this chapter, but the fact that such balancing is possible should reassure sceptics who resist the thought that treating minor conditions expresses respect on the grounds that this would make healthcare justice unduly demanding.

Consider, second, the charge of undue broadness. This objection focuses on the implications of my account for other vulnerability-reducing goods in society, such as welfare benefit payments or social housing, and whether they are also morally significant due to their function in expressing respect for our vulnerability. In response, it is important to note that healthcare is innately focused on the individual, expressing respect through the three normative mechanisms, grounded in its relationship with our vulnerability as human beings. While the provision of other vulnerability-reducing, respect-promoting goods (such as welfare benefits) is important, they operate at a more superficial level compared with healthcare. The requirement for money in order to reduce our vulnerability to poverty (for example) is not fundamentally linked to our personhood. It is contingent upon, among other

things, an alterable structure that relies upon the commodification of essential goods. Our inherent vulnerability is significantly less alterable and makes healthcare much more central to our personhood. For as long as we are subject to the vicissitudes of our body's biomedical processes, from mutations to so-called lifestyle diseases, healthcare will continue to have a central role to play in addressing our vulnerabilities in a way that other social policies may not.

The objection is different, however, when it draws attention to other vulnerabilities that are similarly inherent in our human condition, such as our requirement for food, water, and shelter. At the same time, the response is simple. I do not make the claim that healthcare is the *only* good that possesses an expressive function, and it poses no problem to the account if other analogous vulnerability-reducing goods are also treated as parallel in moral significance. In the case of basic needs such as water and food, however, the *consequentialist* reasons are likely to be stronger than the expressive reasons we have for supporting its provision as a matter of justice. After all, the provision of basic needs at the population level is not prone to analogous objections such as the *relative insignificance objection*. As argued in Chapter 1, however, in response to the 'Ministry of Food' objection, this does not entail that we ought to provide these other vital goods in the same manner as we do with healthcare. The need for a universal healthcare service is a response to the practical, and policy- and market-related complexities of delivering healthcare, not present in food provision.

***Objection 3: Paternalism***

A third objection is concerned with the expressive function account opening the floodgates to paternalism. Because I have grounded the moral significance of healthcare on the way it addresses our vulnerability (and in doing so, expressing respect for us *qua* individuals), it might be an implication of the account that even non-consensual healthcare, insofar as it addresses our vulnerability, expresses respect for the individual. This implication, if it follows, would indeed be highly troublesome. One response is to argue, as many healthcare professionals do, that receiving healthcare to address a health need is objectively valuable whether or not one wants it. There is thus always a *pro tanto* respect shown in providing healthcare, but this might be outweighed in an all-things-considered way. This is not a particularly appealing response, however, as few of us would want to hold the view that there is even *one sense* in which forced healthcare is expressive of respect.

A second, more promising response is to focus on the way in which my account focuses on guaranteeing the *availability* of healthcare as a matter of justice, not on ensuring it is actually provided to patients. Of course, the provision should have robust desiderata around fair and equitable access, to ensure that those who need it can access it, but this does not mean that respect is expressed only when treatment is provided. While there is an important grain of truth to this response, it risks undermining the way in which the actual delivery of healthcare to a needy individual *does* express respect in the way I canvassed in Section II. A third (and I think the best) response is to simply observe that from the fact that something is good if it is freely chosen and accepted, it does not follow that something is still

good if it is not freely chosen and not freely accepted. Freedom is good if freely accepted but being forced to be free may not be. Engaging in sex is good when freely accepted but being forced to have it is evidently not good. Money may be good when freely accepted, but it is less clear that it is good if it is thrust upon someone who rejects it. Analogously, healthcare may express respect (and be good) when it is subject to widely accepted norms of consent and autonomy but it fails to express respect (and may express *disrespect* and violate rights) if it breaches these norms.

***Objection 4: Self-Defeat***

A fourth objection is whether my defence of the moral significance of healthcare is self-defeating on the grounds that it would still fall prey to the *relative insignificance objection*. The thought is that we would express respect equally, if not more, if we prevented people from falling ill in the first place through public health initiatives and broad action on the social determinants of health. Public health actions and interventions on the social determinants of health therefore also have an expressive function.

First, I have argued that there is something significant in the way healthcare focuses on needy *individuals*, here and now, in flesh and blood rather than as statistical considerations at a population level. This is something that public health initiatives and action on the social determinants of health, which are *necessarily* aggregative and population focused, cannot take into account. The expressive function of public health actions and interventions on the social determinants of health are much harder to establish *at the altar of each individual's right to respect*

and therefore does not meet the bar of expressing respect to *individuals* to the same level as healthcare. There are important reasons to act on the social determinants of health and to promote population-level public health initiatives, but this can be for reasons that are different from reasons for providing healthcare.

Second, as I noted in response to a previous objection, none of this precludes healthcare professionals from engaging with *individual* patients on preventative healthcare to prevent them from falling ill in the first place. Such treatment, such as giving proactive advice on mental health resilience or administering a vaccine, does not necessarily treat an actual or *ex-post* health need, but it is still focused on recognising the vulnerable nature of *individuals'* health.

***Objection 5: Concerns About Extension to the Global Realm***

A fifth and final concern is scepticism about the empirical applicability and normative plausibility of the *Expressive View* in the global realm. There are two distinct versions of this objection. The first variant of the objection casts doubt on the empirical relevance of the *relative insignificance objection* in the global realm. This objection focuses on the global applicability of the social determinants of health rather than the universality of public health initiatives, as the latter is subject to less empirical controversy about its effectiveness globally. The fundamental claim is that there are no *global* social determinants of health in the same way there are in the domestic realm, which means that the pursuit of global health justice need not be impeded by the *relative insignificance objection*.[43] Absent global social

[43] Given that the social determinants of health often focus on institutional and social mechanisms, this position is similar to the ones held by non-cosmopolitans who reject global justice on the grounds that some important relational feature does not obtain: Nagel, "The Problem of Global

determinants of health, the thought is that there would be no objection to the moral significance of healthcare and no qualms about making healthcare the core focus of *global* health justice. This objection misses the target on two counts.

First, we *do* have global social determinants of health. These global social determinants of health include explicitly global institutional arrangements that influence health outcomes worldwide such as the World Trade Organization and the trade-related aspects of intellectual property (TRIPS) agreement that governs the patents and production of medication; the WHO, which sets guidance for health policy and surveillance worldwide; and the Bretton Woods institutions (the World Bank and International Monetary Fund) which govern developmental aid and directly determines the economic conditions that impact population health. The global social determinants of health also include more subtle global influences, such as the obvious impact of international violence and conflict on health; the health effects of international trade, such as the impact of tobacco production; the implications of global climate change on health, including an increase in temperature making it easier for vector-borne diseases to thrive; and the existence of global poverty (which is easily amenable to global intervention) and its impact on access to health resources. I address the broader structural factors present in global health in Chapter 4.

Second, *even* if we grant that there are no global social determinants of health understood in the sense implied above, it would not matter to my fundamental analysis. The same issue simply arises *mutatis mutandis* because there would still

Justice."; Andrea Sangiovanni, "Global Justice, Reciprocity, and the State," *Philosophy & Public Affairs* 35 (2007).

be the debate of whether we ought to *support* particular countries improve *their own* social determinants of health or whether we ought to give healthcare aid instead. We would face the same question of how we ought to allocate £20 million in *health* aid for another country. For example, whether we ought to earmark it *solely* towards developmental aid that will build schools, establish community centres to improve social capital and build homes *or* if at least a portion of it should also be spent on healthcare in spite of the *relative insignificance objection*. This question arises whether or not there are *global* social determinants of health, so long as we have to decide between acting to support other states in promoting *their* social determinants of health or providing healthcare-related assistance. Furthermore, independently of the social determinants of health, there is the issue of other non-healthcare-based interventions such as public health initiatives. The question of how we ought to treat healthcare in relation to public health initiatives, given the *relative insignificance objection*, would remain even if we set aside the matter of the social determinants of health.

The second variant of the objection cuts much deeper to my substantive argument and casts doubt on the conceptual and normative plausibility of the respect and vulnerability argument in the global realm. The claim cannot be that inherent vulnerability is not global and universal since, *ex hypothesi,* it is. The more plausible thought is that the moral significance of vulnerability and respect may reflect a particular cultural phenomenon not able to be extended to the global realm.[44] Those of us in particular Western liberal democracies, it might be thought,

[44] For culture-based objections of this form, see David Miller, *National Responsibility and Global Justice* (Oxford University Press, 2007), Chapter 3.

appreciate the salience of responding to vulnerability in a way that those in non-Western non-liberal democracies do not. This objection fails for two reasons.

First, a moment's reflection shows that the salience of vulnerability and the respect shown in responding to it is a universal sentiment subject to a very strong overlapping consensus. We *all* see it as conceptually demanded that we treat vulnerable entities a certain way, we consider it an ethically salient demand to aid the vulnerable, and we appreciate healthcare aid rendered to us in a time of need. The respect-expressing value of responding to vulnerability is therefore ingrained in all of us. Second, the argument for the expressive function of healthcare is not empirical so much as normative. The demands of recognition respect are what we *ought* to do in response to the fact of vulnerability, not what we *actually* do. In this vein, it does not depend upon what people *in fact* do or believe, here and now. For these reasons, the expressive function of healthcare is universal and cannot be dismissed on the grounds that it applies only to a particular cultural context.[45]

## Conclusion

This chapter has argued that a central and overlooked aspect of what makes healthcare morally significant is its *expressive function*. Over and above its influence on health and other metrics of justice, and in spite of its relatively limited impact on population health outcomes, healthcare expresses respect for individuals in a distinctive and morally salient way. The respect-expressing dimension of healthcare is linked to the fact that healthcare characteristically focuses on individuals, addressing our inherent vulnerability as human beings in

[45] As I showed with a previous example from *Portfolios of the Poor*, the importance of expressivism and the symbolic value of many actions is something appreciated universally.

three central ways and, in doing so, signifying respect to us *qua* persons. This respect-expressing function of healthcare provides a central argument for acknowledging the moral significance of healthcare and for supporting its universal provision as a matter of justice, whether this is done domestically or globally (through provision of healthcare assistance or supporting other states develop their healthcare capabilities), in the face of the *relative insignificance objection*.

Not only does grounding the moral significance of healthcare on its expressive function escape many of the objections against the role of health in a theory of justice, but it also promises to bring the practise of healthcare closer to what many feminist theorists have pointed out all along: the importance of care, expression and communication, and the recognition of our inherent vulnerability and dependence. The work carried out by perhaps the paradigmatic agent of global healthcare, *Médicins San Frontières*, is valuable and morally significant for these reasons. Irrespective of the fact that public health initiatives and action on the social determinants of health would have a statistically greater impact on population health outcomes, the respect expressed through the provision of healthcare highlights an important reason to include it in our pursuit of global health justice.

# Chapter 3
# WEIGHING/BALANCING HEALTH AND DETERMINING GLOBAL HEALTH INJUSTICE

There are many goods with special moral significance and the world is full of different kinds of injustices. Health is of special moral significance, for reasons grounded in the *non-reducibility thesis* and the *significance thesis*, but it is equally plausible that education and access to basic needs such as food, water and shelter are also of special moral significance. This chapter is concerned with the normative relationship between justice and global health, which I simplify as the questions of *health in justice* and *justice in health*. The question of *health in justice* – that is, how we ought to treat health *in* a theory of justice and how health ought to feature within our pursuit of justice more generally – is a methodological and substantive question that looms large. The question of *justice in health* – that is, what justice demands in terms of the distribution of health opportunities and health outcomes – has resulted in many competing theories being proposed in recent decades. This is a broad question I develop throughout the thesis, and I focus only on a specific question that requires our attention in this chapter: *when is there a health injustice?*

These two questions concern the fundamental issue of the conceptual and normative relationship between justice and health, which is the central focus of this chapter. At the same time, I must make explicit at the outset that the question of *justice in health* (including global health) is much broader than the question of when there is a health *injustice*. I focus on this specific question in this chapter to outline a basic framework for (global) health injustice, before turning – in Chapters 4, 5, and 6 – to a more comprehensive discussion of the demands of justice in global

health. A more comprehensive account of global health justice would incorporate but also look beyond the simple outcome-based measures of health injustice I explore in this chapter.

This chapter unfolds as follows. In Section I, I address the issue of *health in justice*, relating to questions about how significant health is, how it ought to be weighed against other goods with special moral significance, and how it relates to concerns of justice in other areas. I introduce Simon Caney's influential distinction between integrationism and isolationism, which can help us understand the issues at stake when we think about theorising *specific* areas of justice as opposed to *general justice* more broadly, but I argue that the isolationist-integrationist distinction is too simple and does not capture important nuances. I reconstruct Caney's arguments for integrationism, showing that it is compatible with a limited form of isolationism consistent with my *non-reducibility thesis*. In Section II, I address the issue of *justice in health*, focusing on the issue of when there is a health injustice. I argue that there are two ways we can conceptualise health injustice – the *direct* and *indirect* account – both of which are *individually sufficient* to identify a health injustice. I also analyse issues of equality and sufficiency, aggregation and prioritisation, and its scope beyond borders.

## Section I: Health in Justice

Let us turn, first, to the question of health and its role in justice more broadly. On the one hand, health has special moral significance. On the other hand, the world is full of many things with special moral significance and the fact that health is one of these does not determine how it ought to feature in our pursuit of justice more

generally. For example, is health morally more significant than education or housing and does it deserve higher priority at the bar of justice? Underlying these concerns is the substantive and methodological question of how we ought to treat health and health justice within our pursuit of justice more generally. Before presenting my substantive analysis of health in justice, two preliminary comments are in order.

First, establishing the special moral significance of health, even in a world with multiple specially morally significant goods, provides us with at least one important point of guidance. This is the fact that it has relative priority and importance compared to goods that are *not* specially morally significant in the same way. Merely establishing that health is of special moral significance, even with the indeterminacy that comes with this classification, provides basic guidance about how our *priorities* of justice might be structured. Action on health policy would have a higher priority at the bar of justice than action on entertainment policy, for example, given that the former has special moral significance not present in the latter. Accordingly, establishing the special moral significance of health can at least provide some rough answers to the question of how much priority health should have. This priority need not be absolute.[1] Societies frequently trade off morally significant goods (such as health) against other ostensibly more trivial pursuits (such as art and entertainment). Evaluating this at the bar of overall justice is necessary to come to an overall judgement about the appropriate priorities of justice, as I explain in a forthcoming section, but it does not invalidate the *pro tanto* fact of health's specialness.

[1] How non-absolute priority should be understood, however, is a complex problem that is open to issues of aggregation, as I address in Section II.

Second, acknowledging the special moral significance of health is *not* equivalent to putting it on a pedestal and elevating it above all other goods. On a view Daniel Hausman labels *health exceptionalism*, health is viewed with supreme importance.[2] Any deviation from *ideal* (or equal) health constitutes an injustice in and of itself, regardless of other considerations of justice (or how it came about), *because* it concerns health. Health exceptionalism is not a plausible position. Even if health is very important, it is not clear that it possesses such *supreme* value. Rational and reasonable people do not consider their health to be of utmost importance and we believe that society is justified in not devoting endless resources to eradicating any and all forms of ill health.[3] Our considered judgements value health but we do not see it as a supreme good to be pursued at all costs. A parallel thought is the case of environmental protection. Even if we rightly place a high value on protecting the environment, and even if it would be possible to cease *all* industrial carbon emissions, it is unlikely to be a price worth paying. Other ideals of justice (such as the production of welfare- or health-enhancing technology) are important too and tolerating reasonable carbon emissions in the pursuit of these ideals is consistent with acknowledging the moral significance of the environment. By extension, we can value health but refuse to give it the supreme value that health exceptionalists do.

[2] Daniel Hausman, "What's Wrong with Health Inequalities?," *Journal of Political Philosophy* 15 (2007).
[3] Greg Bognar and Iwao Hirose, *The Ethics of Health Care Rationing* (Routledge, 2014).

### *Integrationism and Isolationism*

The role of health in justice can be analysed through what Simon Caney calls *integrationist* and *isolationist* modes of theorising.[4] Isolationism separates the issue being theorised from broader considerations of justice. What justice demands when it comes to a specific issue (such as health outcomes or greenhouse gas emissions) is evaluated in its own realm through its own norms and standards, without regard to other spheres and without regard to considerations of justice more generally. For example, a principle that supported strict equality of access to cancer treatment irrespective of patients' overall advantage levels (such as ability to pay) and independently of evaluating how cancer treatment should be treated alongside other priorities of justice would be isolationist in nature.

Integrationism, in contrast, does not treat the good being distributed in isolation from other considerations of justice. The demands of justice in health are evaluated at the bar of justice *more generally*, encompassing the demands of justice in other areas and considering other spheres of activity. We cannot know what justice in health demands without considering the demands of justice *overall* and its demands in other realms. For example, whether strict equality of access to cancer treatment is required depends on what our general theory of justice says, what a particular patient's overall level of advantage is, and how access to cancer treatment relates to priorities in other realms, such as housing, education, or law enforcement.

[4] Simon Caney, "Just Emissions," *Philosophy & Public Affairs* 40 (2012).

Considering the role of health *in* justice through the integrationist-isolationist distinction is helpful for two reasons. First, Caney's model is highly influential and has been applied widely in other areas to the problem of how we theorise a *specific* realm of justice while simultaneously being concerned about *justice* more generally – for example, in global trade and environmental justice.[5] Second, the integrationist-isolationist model provides us with a useful starting point to consider the issue of health *in* justice. Even if the model as Caney presents it is ultimately unconvincing, as I shall argue, the distinction nevertheless captures important issues that any theory must think through.

Caney rejects isolationism in favour of integrationism. His arguments against isolationism and in favour of integrationism are two-fold. First, on what I call the *aggregation argument*, Caney states that "if distributive justice is concerned with the fair share of a 'total package' of goods, then we have *no* reason to endorse a principle that applies solely to one particular item".[6] The thought is that insofar as we are concerned about *justice*, we do not need to pay particular attention to *health* justice, or *environmental* justice, or *educational* justice. Justice is about aggregating advantages *overall*, and there is no reason to specify the level of distribution for particular spheres or goods that make up the whole package. Second, on what I call the *substitution argument*, Caney argues that insofar as certain goods are substitutable, we have little reason to develop *specific* principles for good X or good Y. We do not need separate principles of distribution for bananas, apples, and grapes (for example) because they are substitutable in what

[5] Andrew Walton, "Trade Justice: An Argument for Integrationist, Not Internal, Principles," *Journal of Political Philosophy* 28 (2020); Derek Bell, "How Should We Think About Climate Justice?," *Environmental Ethics* 35 (2013).
[6] Caney, "Just Emissions," 271, original emphasis.

Caney calls a *narrow* sense.[7] Because health is just one aspect that determines how well our lives go as a whole – our *total advantage*, for short – and because lots of different things can compensate for a lack of health, the thought is that it does not make sense to speak of *health* justice or specific principles that govern the distribution of *health*, separate from advantage proper.

Caney's arguments against isolationism pose an important challenge for my arguments about health's special moral significance and the implication of this feature within a theory of justice. The thought is that my anti-reductionist view of health is inherently isolationist when it should be integrationist – health should be aggregated and substituted with other issues of advantage *proper* rather than devising specific principles for health and dealing with it via a specific sphere. In what follows, I defend the place of isolationism in health, showing that this is consistent with the most plausible reading of integrationism. My strategy for vindicating my isolationist mode of theorising has a critical and a constructive component. Critically, I show that Caney's arguments, as they stand, do not support the rejection of isolationism. Constructively, I show that the dichotomy between integrationism and isolationism has been overdrawn and that the degree each approach should feature in our account depends on the particular *level* at which we are theorising. I thus show that we can be isolationist in our theorising about health while simultaneously seeing our endeavours as integrationist at the higher level of analysis – a position I call *limited isolationism.*

[7] By narrow substitutability, Caney means that the substitution is direct and more or less like-for-like in terms of the aim the good secures.

The general argument against an isolationist theory of health, focusing on Caney's *aggregation argument*, can be reconstructed as follows:

(P1) "If justice is concerned with the fair share of a 'total package' of goods, then we have *no* reason to endorse a principle that applies solely to one particular item."[8]

(P2) Justice *is* concerned with the fair share of a 'total package' of goods.[9]

(C1) Therefore, we have *no* reason to endorse a principle that applies solely to one particular item.

(P3) Health forms part of the fair share of a 'total package' of goods that justice is concerned with.

(C2) Therefore, we have *no* reason to endorse a principle that applies solely to health.

The core problem with Caney's argument is that the underlying view in (P1) is false. We can agree that justice is concerned about total advantage (P2), but still reject the integrationist claim that we have no reason to endorse specific principles that apply to particular items within that total package (C1). The fundamental reason for this is that the fair share of a total package of goods can nevertheless contain *multiple, irreducible goods*. This total package of advantage could include goods such as education, health, housing, civil rights, and income. Even if what ultimately matters is someone's total level of advantage (i.e. the combined level of *all* these goods) it does not follow that we can ignore the distribution of particular goods

[8] Caney, "Just Emissions," 271, original emphasis.
[9] Caney's original phrasing was in the *conditional* sense ("if distributive justice is concerned…"), however, he proceeds in the rest of the paper with the view that the condition is met. I therefore accept that the conditional holds and critique the argument accordingly.

within that total package.[10] This counter-claim refutes (P1) by showing that a concern with total advantage does not entail the rejection of theorising principles specific to goods within that total package. Put in metaphorical terms, the jigsaw puzzle as a completed whole may be what ultimately matters, but we cannot infer from this that the distribution of individual jigsaw pieces does not matter.[11] The constitutive parts of this total package contribute *independently* towards the whole in a way that requires us to pay attention to specific pieces.

In many cases, of course, these goods may have to be traded off against one another. However, the fact that a trade-off is sometimes required rather than us merely conducting a pure aggregation approach of all the goods itself shows that we have independent reason to value particular components within this total package. The fact that there can be conflict does not mean that we should revert to a monistic view of value. If a trade-off has to be made – for example, between government policy that prioritises increasing income support over hip replacements – then there is moral 'residue' involved and justification has to be given for this trade-off. An integrationist account that takes Caney's claim in (P1) seriously would not need to offer a justification and there would be no *pro tanto* loss as the concern is merely about the total package, not its constitutive components. For these reasons, (P1) is false and the inference from (P2) to (C1) is therefore fallacious.

Consider, next, the *substitution argument*. Caney's position on this is more nuanced, and I present this argument for illustrative purposes only.

[10] Caney does seem to acknowledge this with regard to health, sleep and food – a point I return to.
[11] For example, we need to know that there are a certain number of particular pieces to complete the whole puzzle.

(P1*) If goods are substitutable in a narrow sense (that is, we can substitute them in a sufficiently direct and like-for-like manner) then there is no reason to develop specific principles of justice for these goods separately from the overall grouping of all those goods that fall within substitutable goods.

(P2*) Health is a narrowly substitutable good.

(C1*) Therefore, there is no reason to develop specific principles of justice for health.

The *substitution argument* is less applicable to health. This is because (P2*) is clearly false; health is not to welfare or opportunity like bananas are to apples or grapes. Caney acknowledges this fact, mentioning the case of health, sleep, and food as possessing a threshold beyond which one cannot drop if one is to possess a fair share of the total package of goods. This acknowledgement on Caney's part is important, but he falls short of endorsing a stronger version of the claim. Caney does not state explicitly whether he denies (P2*) outright *above* a certain basic threshold. The *substitution* argument, then, may remain open to health matters above some basic level of health. I have already provided reasons in my discussion of the *non-reducibility thesis* in Chapter 1 about why (P2*) must be false, and I will not rehash these here.

For the sake of completion, however, we can make a stronger and more general claim that refutes the core normative premise in (P1*), reminiscent of my strategy against the *aggregation* argument. We can agree that goods are narrowly

substitutable, but nevertheless see it as appropriate to develop specific principles that apply to particular goods. X and Y may be narrowly substitutable as a matter of empirical fact, but it does not follow, *normatively*, that we should therefore reject specific principles for governing the distribution of X and Y. Buses and trams in the city centre may be narrowly substitutable, but it does not follow that this fact invalidates any reason we have to theorise specific principles that should govern buses *and* trams, respectively. There is therefore an important normative premise missing in the *substitution* argument presented in (P1*).[12] Independently of this stronger and more general claim, however, the fact that *health* is not narrowly substitutable, contra (P2*), is sufficient to dispel the integrationist challenge to isolationist principles for the matter at hand.

The *substitution argument* makes two claims: first, that a lack of $Good_1$ can be made up for by more of $Good_2$; and second, the fact that $Good_1$ and $Good_2$ are substitutable means that we do not need specific principles for them. My core argument is that *even* if the first claim about substitutability is true, the second claim would not follow. This provides a general refutation of the *substitution argument* against isolationism. The fact, however, is that health fails even the first claim. It is not substitutable in the same way as city centre buses or trams. The *substitution argument* against isolationism in health, then, fails on two counts.

[12] Relatedly, Johannes Kniess also argues that just because we *can* substitute something for another thing, it does not follow that we *ought* to do so: Johannes Kniess, "Integrationism and Internalism in Global Justice Theory," *Working Paper* (2022).

***Revisiting Integrationism and Isolationism: Towards Limited Isolationism***

My critical arguments against the *aggregation* and *substitution* arguments thus far demonstrate that a commitment to integrationism is not necessarily opposed to isolationism. A commitment to the total advantage view or agreement with narrow substitutability does not entail the rejection of specific principles for particular goods. This coexistence is possible, I shall argue, because of important ambiguities in what we mean by integrationist and isolationist theorising. Specifically, the *level* at which we are theorising determines the extent to which we should be integrationist or isolationist – something not developed by Caney[13] – which in turn suggests that the dichotomy between these two modes of theorising may have been overdrawn.

There are elements of ambiguity in Caney's discussions and characterisation of integrationism and isolationism which are important to flag. At various points, the claim is that we have no reason to come up with *specific principles* for individual domains of justice and we should instead be concerned about overall, aggregate distribution.[14] At other points, the claim is that principles of justice for specific realms are *not freestanding* and are *derived from justice overall*.[15] At yet another point, the claim is that we cannot specify principles of justice for particular realms or practices without considering what justice requires in other domains.[16]

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[13] Caney does hint at this possibility in a footnote, but it is not clear whether he ultimately accepts or rejects it: Caney, "Just Emissions," Fn., 272-73.

[14] For instance, Caney states that there is no reason "that [x] should be governed by [its] own distributive principle … we have *no* reason to endorse a principle that applies solely to one particular item." Caney, "Just Emissions," 271, original emphasis.

[15] Caney argues that "the key is *not* to treat [x] in isolation, but rather to locate [x] in a more general theory of justice … and work back from that to deduce what share of [x] they are entitled to." Caney, "Just Emissions," 299, 292.

[16] Here Caney states that we ought "to distribute [x] in ways that take[s] into account the distribution of other goods. … [and consider] other issues (like poverty, trade, and development)." Caney, "Just Emissions," pp. 259, 282.

Despite these sources of ambiguity, we can nevertheless expound a sufficiently clear account of Caney's project, namely, as one concerned with articulating the conceptual and normative relationship between justice proper *and* the individual domains and components within this overall conception. The idea of aggregation, substitution, and sensitivity to broader considerations of justice all relate to the question of *how justice in one domain relates to justice as a whole*. For instance, how does justice in health relate to our ultimate theory of justice (say, in terms of achieving Rawlsian justice as fairness or Cohenite equality of access to advantage). It is in light of this general characterisation of the integrationism-isolationism debate that I ground my ensuing discussion.

To understand the relevance of these different ways in which Caney refers to integrationism and isolationism, consider three broad levels of justice which I call the *meta level*, the *meso level*, and the *micro level*. At the *meta level,* the concern is with articulating the *ultimate* relationship between justice in health and justice more generally. This may include meta-normative debates about the deductive (or inductive) process in which justice in health relates to justice proper and how other domains of justice relate to health at a theoretical level. At the *meta level*, discussions of the conceptual relationship between justice and justice in health take place at a high level of abstraction and generality.

At the *meso level*, we are concerned with the legislative and policy instantiation of *meta level* justice. We take the stance of a person or group of persons involved in policymaking *for health*. The *meso level* can be thought of as corresponding to the

remit of the Ministry of Health in a government, for example. The core concern of the *meso level* is the appropriate allocation of resources to health as compared to other domains of justice. The Minister of Health acknowledges the special moral significance of health, and she has a vested interest in increased funding for the domain, but she also understands her role as just one Minister in a Cabinet with many portfolios and will be prepared to negotiate with Ministers of other domains about funding allocations from the main pool of government funds.

At the *meso level*, we also understand the interconnected nature of health and its social determinants. These relate to the so-called *social determinants of health* – the broad and complex causal factors that determine population health beyond healthcare.[17] The policymaker is aware that seemingly non-health-related aspects of public policy, such as socioeconomic status, housing, social capital, education, and the built environment – and which are in the domain of other Ministers – all have a role in determining health outcomes locally, nationally, and internationally. It is for these reason that the *meso level* simultaneously develops *specific* principles for health while situating these within broader considerations of justice. For example, the Minister of Health understands that specific policies relating to the social determinants of health are significant not only in terms of their health benefits but also in terms of their impact on justice more generally.

At the *micro level*, we are concerned with interactional relations between particular individuals and professionals. The concern with this level can be thought of as the

[17] Marmot and Wilkinson, *Social Determinants of Health*; Health, *Closing the Gap in a Generation*; Norman Daniels, Bruce Kennedy, and Ichiro Kawachi, "Why Justice is Good for Our Health," *Daedalus* 128 (1999); Ichiro Kawachi and Bruce Kennedy, "Socioeconomic Determinants of Health: Health and Social Cohesion: Why Care About Income Inequality?," *BMJ* 314 (1997).

appropriate rules of regulation for the practice and delivery of health services, including standards of healthcare, norms of interpersonal health interactions (such as what justice and justice in health demand of doctors and nurses at patients' bedsides), and rules about eligibility for particular health procedures.

Once these levels are differentiated and the considerations relevant to each one articulated, it becomes apparent that it is entirely consistent to be integrationist and isolationist at the same time. The appropriate question is not whether we should be integrationist or isolationist *simpliciter*, but in what ways we should be integrationist and isolationist at particular levels of theorising. From the perspective of the *meta level*, it is clear that health justice is ultimately derived from *justice* overall, howsoever conceived. After all, health justice is still *justice.* In pursuing health justice, we should acknowledge the way in which normative principles such as equality, sufficiency, fairness, and rights as applied to health are grounded in a more general theory of justice. This claim seems trivially true. However, the truth of integrationism for the *meta level* does not entail the rejection of isolationism at the *meso* or *micro* levels of justice, where isolationism refers to theorising specific principles for particular domains. In this regard, Caney unjustifiably generalises a *meta-level* claim about integrationism to the *meso-* and *micro-level* and, in doing so, conflates several different claims.

Consider, first, the *meso level*. Recall that isolationism is sometimes contrasted with integrationism in the sense of being *sensitive* to considerations in other domains. The considerations at the *meso level* clearly acknowledge the importance of sensitivity to other domains but also support considering and endorsing specific

principles of distribution for health. The *meso level*, then, highlights another counterexample to the normative claims of the *aggregation thesis*. Even on Caney's characterisation, the *meso level* is simultaneously integrationist and isolationist. Reasoning at the *meso level* requires us to be a champion for health and advocate for its importance, as well as theorising the appropriate principles and norms that ought to apply specifically to it. At the same time, it requires us to be aware of the social determinants of health, and the way health benefits can spill over onto other domains (e.g. good health improves economic productivity) and the way other domains can affect health (e.g. housing policies have an effect on health outcomes).[18] The fact that the social determinants of health have a significant impact on population health outcomes requires a simultaneously integrationist and isolationist approach. It requires us to consider principles *specifically* for the health domain (isolationist-type reasoning) with the view that other domains of justice have impacts on health too (integrationist-type reasoning).

Consider, second, the *micro level*. At this level, we expect health professionals to exercise a high level of isolationism. We do not want doctors and nurses taking into account considerations of desert or total welfare at the bedside, or about how their time might be better spent improving the social determinants of health instead of providing clinical care, or about what distributive justice demands overall in terms of aggregation. We want the rules of regulation that govern healthcare at the bedside to be isolated from broader considerations of justice – at least in terms of considering patients' total advantage or the relative role and influence of other domains.

[18] Dan Brock refers to this as the problem of 'separate spheres' and 'indirect benefits': Dan Brock, "Separate Spheres and Indirect Benefits," *Cost Effectiveness and Resource Allocation* 1 (2003).

Consider a doctor deciding how to distribute a scarce health resource at the bedside, namely, which patient should be given a hip replacement in this current cycle of operations.[19] Assume that we have two patients with equivalent levels of need. Assume that both patients are in equivalent levels of discomfort, both are 60 years old, both would benefit equally in terms of the welfare and opportunity attributable to receiving the hip replacement, and neither is responsible (from a luck egalitarian standpoint) for the state of their hips. Further assume that the present state of their hips does not bring them below any plausible level of sufficiency. However, assume now that while both patients are similar in all these respects, $Patient_1$ is extremely well off and is in the top 1% of income earners. She has had an excellent life, with plenty of opportunity and happiness. She owns an opulent country estate and is a partner in a successful law firm. $Patient_2$, on the other hand, has had a comparatively less lavish life. He is a secondary school teacher, earning a modest but adequate salary and lives in a small two-bedroom flat.

As well as the requirement to consider the demands of justice in other domains, recall that one reading of Caney's integrationism claim is that we ought to consider *total* advantage. In the language of total advantage, $Patient_2$ is worse-off than $Patient_1$. $Patient_2$ having the hip replacement would not benefit him from a health standpoint any more than $Patient_1$, but it would benefit him more *overall* than $Patient_1$ in terms of the marginal gain in *total* advantage. Despite their different levels of total advantage, and despite the fact that prioritising $Patient_2$ for the hip replacement would close the gap in the level of total (non-health) advantage

[19] Assume that the next appointment would be 6 months away.

between him and Patient$_1$, we do not see it as appropriate for these facts to be integrated into the doctor's 'bedside' decision-making about how to allocate this scarce healthcare resource.[20] There is a sense in which we want the allocation of health resources in these interpersonal and so-called bedside scenarios to be performed *in isolation* from other considerations and domains of justice. In allocating scarce resources, the clinician should focus on health needs and health benefits alone, in isolation from broader considerations of justice including the patients' relevant disadvantage across the life course. Nevertheless – and this is an important claim – our *isolated* principles of health justice remain principles of *justice* at the *meta level*.

The fact that the doctor should not be making these decisions about *total advantage* at the bedside, however, does not mean that they cannot enact procedures that have been determined at the *meso level* to be applied at the bedside. Consider an example from Jon Elster about clinical decision-making regarding the criteria for organ donation in the US.[21] Elster argues that if we allocate purely on clinical match (i.e. compatibility between the donor and recipient), it will result in fewer organ transplants for black people. There are reasons of justice to widen the criteria for matching organ donors with recipients beyond pure clinical match, even if doing so results in fewer successful transplants

[20] For the distinction between general distributive justice and 'bedside' rationing, and the different ethical issues involved, see Marion Danis et al., *Fair Resource Allocation and Rationing at the Bedside* (Oxford University Press, 2015); Bognar and Hirose, *The Ethics of Health Care Rationing*.
[21] Jon Elster, *Local Justice* (Cambridge University Press, 1992); Jon Elster, "Local Justice," *European Economic Review* 35 (1991).

overall.[22] It might appear, therefore, that even the *micro level* should be open to integrationist considerations. However, this move is too quick.

There is a distinction between a clinician deciding how best to realise total advantage and justice more generally versus enacting guidelines decided at the *meso level*. A division of labour is important here. *Meso-level* theorists can create guidelines – as done by the UK's National Institute for Clinical and Care Excellence (NICE) for instance – that are then enacted by clinicians at the bedside. It is not the clinician's role, at the *micro level*, to consider total advantage, but this does not mean that they cannot apply clinical guidelines that already take such considerations into account. A parallel case is the literature on the so-called *rule of rescue*. We frequently expend significant resources to come to the aid of those who need rescuing, at the expense of statistical lives.[23] Who should be rescued is a debate that *meso-level* theorising can address, but we do not want the frontline *rescuers* at the *micro level* to be thinking about this when carrying out rescues.

A theory of health justice concerned *solely* with rules of regulation *within* the domain of health without any regard for other domains of justice – such as ignoring the fact that we ought *not* to be isolationist at the *meso* and *meta* level – would rightly be criticised as unduly isolationist. Such an account would be guilty of the opposite problem Caney faces, namely, taking what is true for the *micro level* and

[22] This view about trading off transplant efficacy against justice is not uncontroversial. For a parallel issue with relevance to the case at hand, see T. M. Wilkinson, "Racist Organ Donors and Saving Lives," *Bioethics* 21 (2007).
[23] For this debate, see Cohen, Daniels, and Eyal, *Identified Versus Statistical Lives*; Albert Jonsen, "Bentham in a Box: Technology Assessment and Health Care Allocation," *Law, Medicine, and Health Care* 14 (1986); R. Cookson, C. McCabe, and A. Tsuchiya, "Public Healthcare Resource Allocation and the Rule of Rescue," *Journal of Medical Ethics* 34 (2008).

generalising this to the *meso* and *meta levels*. Of course, the principles that we develop for the *micro* and *meso levels* should be sensitive to the *meta* viewpoint that health justice is still part of justice overall. This claim, as I have said, is trivially true and I know of no one who rejects integrationism understood in this *meta-level* sense. However, the fact that we think it appropriate to have different principles for the *meso* and *micro levels* is indicative that we can believe in integrationism at the *meta level* yet also support isolationist principles in specific domains. Doing so is consistent with recognising the foundational, *meta* claim about the relationship between justice and its different domains.

At the same time, we should acknowledge that the real world of justice and health is much more complicated than these three levels. The debate between integrationism and isolationism may take place along a continuum rather than merely across three levels and there are likely to be significant interactions between the levels. The model I present is a simplified one that merely helps us to clarify the sense in which we can be simultaneously integrationist and isolationist in different forms.

With this understanding of the different levels at which isolationist and integrationist concerns play out, we can now introduce a general distinction between what I call *limited isolationism* and *expansive isolationism*. We can construct *specific* principles of justice for a particular sphere (such as health) and pursue justice within this restricted sphere in accordance with these principles. This interpretation acknowledges that the isolationist principles are *specific* instantiations of the demands of justice more generally. Call this *limited isolationism*. Another

interpretation stipulates that *in addition* to the claims of *limited isolationism*, we can also carry out the pursuit of justice in one sphere (such as health) independently of, and in isolation from, the pursuit of justice in other spheres. This is the assumption that the *micro level* is *all* there is to theorising about health. Call this *expansive isolationism*. Notice that these two interpretations are distinct. Caney is rightly critical of what I am calling *expansive isolationism*, but it does not follow that *limited isolationism* should also be rejected. *Limited isolationism* – for example, exploring the principles of distribution for healthcare services – is compatible with seeing this pursuit as lying *within* the purview of justice more generally (i.e. integrationism).

My three-level disaggregative account helps to highlight that what is ultimately at stake in the integrationism-isolationism debate is not whether we ought to be integrationist *or* isolationist *simpliciter,* but rather, in what ways and at what levels justice demands that we integrate broader concerns or isolate ourselves from such concerns. The result is a kind of continuum between isolationist and integrationist concerns at the three levels. The health policy planner at the *meso level* must be more attuned to factors outside the health domain (including understanding the broad array of social determinants of health) than the doctor at the bedside of a patient in the *micro level*. Such an account is not only conceptually more accurate than the simple and misleading dichotomy that has pervaded much theoretical discussion of the topic, but it also highlights how health fits into justice substantively and methodologically.

The distinction between these three levels can also provide guidance on how we can see health in justice as integrated within the broader pursuit of global justice. I will have more to say about this in later chapters, but some cursory remarks at this stage using the language of integrationism and isolationism may be helpful. At the *meta level*, we focus on the demands of justice overall, where this is universal and operates across borders. This is by no means an uncontroversial claim, but we need not necessarily commit ourselves to the stronger cosmopolitan position frequently called *political cosmopolitanism*. At the *meta level*, we need simply commit ourselves to the ideal of *moral cosmopolitanism* – that is, the view that each and every person has equal moral status, and that our global and local institutions should be designed to take account of this feature.[24] Applied to health, the *meta level* acknowledges that health's special moral significance is global in scope – as we have already established – and that what justice demands with respect to health applies beyond borders.

At the *meso level*, we are concerned with instantiating the general, meta-level demands of justice in more specific ways. How should the New Zealand Ministry of Health, for example, enact the normative ideal of health justice, within the contextual reality of New Zealand and given its need to be sensitive to other priorities of justice at the domestic *and* global domain? At the *micro level*, what justice demands in the interpersonal aspects of health is analysed, such as what health professionals ought to do in their day-to-day performances of the duty. The idea of *limited isolationism* and the three-level account helps to clarify the sense in which we can integrate health and global health into justice more generally. It

[24] A distinction is sometimes drawn between equal *respect* and equal *claim*: Richard Miller, "Cosmopolitan Respect and Patriotic Concern," *Philosophy and Public Affairs* 27 (1998).

leaves space for context-dependent and nationally determined health policies *within* the general integrationist claim that specific principles of justice are ultimately derived from, and sensitive to, universal justice at the meta level.

***Why Care About Global Health Justice?***

*Limited isolationism*, insofar as it encompasses an isolationist component while accepting meta-level *integrationism*, also assists us in answering an important question underpinning the rationale of this thesis: *why care about global health (in)justice*? Specifically, why should we theorise global *health* injustice (as opposed to other kinds of global injustices) and why *global* health injustice (as opposed to domestic health injustices). My motives for theorising about, and developing a specific account of, global health justice simultaneously draw on integrationist and isolationist reasons, in the spirit of the disambiguation project I have been at pains to emphasise in this chapter. Health has special moral significance – something that operates globally – but questions of (global) health justice do not operate independently of the broader demands and principles of justice, and our account of when there is a health injustice and our motivating factors for theorising about global health injustice must be sensitive to concerns of justice more broadly. Two considerations – the *salience argument* and the *division of moral labour argument* – provide us with good reason to devote theoretical and practical attention to the problem of global health justice, compatible with *limited isolationism.*

The single strongest argument for caring about global health is that it is among the greatest injustices taking place right now. On what I call the *salience argument*, we begin by acknowledging that health injustices constitute a significant proportion of

current global injustice, with immense suffering involved. In many parts of the world, such as Sub-Saharan Africa and South Asia, few issues are more pressing than remedying widespread health injustice. It is arguably the single biggest cause of suffering for many in these regions. Due to the salience of health injustice on a global scale, a theory of justice cannot plausibly remain ignorant of the problem. We ought to focus on global *health* injustice as it is one of the most serious types of global injustice taking place in the world right now. Notice that this reason holds even if one rejects my claim about the special moral significance of health. We ought to focus on *global* health injustice as the most serious health injustices are taking place outside our immediate nation state and the form they take is one where the causes, effects, and solutions are global in scope.

Theorising about, and action on, (in)justice almost always takes the form of a division of moral labour, with particular experts and interested parties converging on specific issues. Call this the *division of moral labour argument*. We have policies and specific theories for issues ranging from gambling, housing and business, through to horticultural policy and multiculturalism. The fact that we have a specific theory or are devoting time to theorising something does not necessarily tell us how the respective areas ought to be treated in relation to other competing priorities of justice. Isolationism at the *micro level* does not entail isolationism at the *meta* or *meso level*. Nor does a specific theory for global health injustice entail that it is more important than other competing priorities of justice; it merely suggests that there are additional considerations or normative features at play that would be assisted by a division of labour. The Minister of Health engaging in reasoning at the *meso level* need not assert that health is the most important thing. She need

only claim that she has a particular 'fiduciary' or role obligation to advocate for its importance – well-grounded it may be – constrained by the demands of general justice. Through a division of moral labour, our *specific* theorising provides important theoretical inputs, enabling us to determine the nature and demands of global health injustice within a *limited isolationist* framework ultimately sensitive to integrationism at the *meta* and *meso levels*.

We ought to theorise and come up with *specific* principles for health and global health, but they are, without contradiction, part of justice and global justice. The *salience argument* and the *division of moral labour argument* both contain integrationist *and* isolationist components, showing once again the falseness of the dichotomy pervasive in the literature.[25] We can accept the aptness of specific theorising and specific principles of justice *for health* (i.e. isolationism) while acknowledging that these concerns are ultimately concerns of justice and are sensitive to considerations in other domains (i.e. integrationism).

## Section II: Justice in Health

I have so far been relying on intuitive ideas about the unjust state of affairs with regard to global health but have not yet developed a formal account of what exactly health injustice is. The literature on health justice and distributive justice more generally is divided on this question, with multiple competing accounts proposed. These include disagreements about what constitutes health equity and health justice, when health inequalities are unjust, and more general debates in the

[25] For other theorists who follow Caney in relying on this dichotomy, see Walton, "Trade Justice: An Argument for Integrationist, Not Internal, Principles."; Bell, "How Should We Think About Climate Justice?."

distributive justice literature about whether we ought to favour equality, priority, or sufficiency.[26]

When it comes to considering something to be *unjust*, whether domestically or globally, two powerful intuitions guide our judgements. First, we have the intuition that it is generally unjust that people are below some threshold of sufficiency through no fault of their own. The fact that many inhabitants of Country A do not have access to sanitation and basic healthcare facilities, for example, is a state of affairs we would generally regard as unjust. Second, and independently, we consider it unjust that particular social policies and institutions produce disparities between individuals (especially those from socially salient groups), even above the threshold of sufficiency. The fact that poor people have worse health outcomes than rich people, insofar as this is a reflection of the differential negative health impacts of particular social policies and institutions on different individuals and groups, strikes us as *prima facie* unjust.

These two core intuitions contain a sufficientarian and an egalitarian component, respectively. Conceptually, these intuitions map roughly onto what Fabienne Peter has called the *direct* and *indirect accounts* of health equity. A *direct* health injustice arises when individuals' health outcomes diverge from some prescribed pattern of

[26] See, for instance, Amartya Sen, "Why Health Equity?," *Health Economics* 11 (2002); Whitehead, "The Concepts and Principles of Equity and Health."; Johannes Kniess, "Justice in the Social Distribution of Health," *Social Theory and Practice* 45 (2019); Norman Daniels, "Reconciling Two Ethics Goals of Public Health: Reducing Health Disparities and Improving Population Health," in *Oxford Handbook of Public Health Ethics*, ed. Anna Mastroianni et al. (Oxford University Press, 2019); Daniel Hausman, "Egalitarian Critiques of Health Inequalities," in *Inequality in Health: Concepts, Measures, and Ethics*, ed. Nir Eyal et al. (Oxford University Press, 2013); Larry Temkin, "Equality, Priority, and the Levelling-Down Objection," in *The Ideal of Equality*, ed. Matthew Clayton and Andrew Wiliams (Palgrave-MacMillan, 2000); Parfit, "Equality and Priority."; Paula Casal, "Why Sufficiency Is Not Enough," *Ethics* 117 (2007).

distribution *of health* indexed to a reference group (such as an age cohort).[27] The relevant pattern of distribution I have focused on is *sufficiency* rather than equality, despite the latter being the prevailing account in the health arena. An *indirect* health injustice, on the other hand, does not evaluate the pattern of health outcomes *per se* but only insofar as it is the result of unjust social, political or economic arrangements. Both the *direct* and *indirect* mechanisms, I shall argue, provide answers to the question of when there is a health injustice. Notwithstanding some important qualifications, each one provides a *sufficient* condition for the definition of health *injustice*.

Fabienne Peter rejects the *direct approach* to health justice in favour of the *indirect* approach, arguing that health inequalities are unjust not when they diverge from a prescribed pattern of distribution applied to health, but *only* when they reflect unjust social, political or economic arrangements. For Peter, "social inequalities in health are wrong not simply because actual health outcomes deviate from some pattern of health outcomes that is considered ideal, but rather because, and insofar as, they are the expression and product of unjust economic, social, and political institutions".[28] A parallel thought to illustrate Peter's view is that inequalities in access to Lego toys do not constitute an injustice in itself, even if it diverges from a prescribed egalitarian pattern, but inequalities in Lego toys that arise as a result of parents being unable to afford toys for their children due to an unjust economic structure may be.

[27] Per our dualist conception of health, the threshold may vary depending on the reference group or the situation we are in. What is considered adequate mobility for a 25-year-old may be different for a 95-year-old.
[28] Fabienne Peter, "Health Equity and Social Justice," in *Public Health, Ethics, and Equity*, ed. Sudhir Anand, Fabienne Peter, and Amartya Sen (Oxford University Press, 2006), 94-95.

It is important for me to dispel Peter's concerns if the direct strand of my account of health injustice is to get off the ground. First, the *direct* approach may not be convincing when applied to goods that are generally not considered morally significant (such as Lego toys), but the *direct* approach becomes more plausible when applied to goods such as health that are of special moral significance. Our intuitions of justice are not generally triggered when a particular group does not have access to sufficient quantities of strawberry-flavoured chewing gum (for example) but the same group not having access to adequate housing or social welfare may alarm us from a justice perspective. The (special) moral significance of the good in question therefore influences to what extent we respond to insufficiencies in that realm. Health, as I have argued, is the kind of good in which such intuitions are triggered.

Second, notice that Peter is concerned with *inequalities* when she rejects the *direct* account. This is the dominant concern in much of the bioethics and philosophy of health literature, and it is understandable why she wishes to criticise the *direct* approach to health when the prescribed pattern is *equality*. A *direct* approach indexed to the pattern of equality is unappealing to Peter and others because it makes health injustice an overly expansive notion, akin to the health exceptionalist's view that any deviation from an egalitarian pattern of health is *prima facie* unjust. However, I shall argue that the appropriate pattern we ought to be concerned with in the *direct* account of health justice is *sufficiency* and that once we make this move, Peter's criticism of the *direct* approach is weakened. A *direct* health injustice indexed to the pattern of *sufficiency* rather than egalitarianism is

more closely aligned with our considered judgements about health injustice and does not run the risk of labelling too many health patterns as unjust.

### *The Direct Account of Health Injustice*

In its unqualified form, the *direct mechanism* conceives of health injustice as a state of affairs in which individuals are below a *sufficient* threshold of health. To use the language of the *direct* approach, the prescribed pattern of distribution is *sufficiency* in health. When health outcomes fail to track sufficiency, there is (generally) an injustice. The qualifications that limit insufficiency being *unjust* – which I go on to address – are when it is voluntarily incurred or when it cannot be remedied. The threshold of sufficient health should be defined by reference to a metric that combines both mortality and morbidity, of which there are a number of plausible accounts.[29] The importance of sufficiency is robust across any reasonable metric. There may be reasonable disagreement about the precise location of the threshold, but there is no reasonable disagreement about those *markedly* below any plausible threshold. This is an important concession, given that the current state of global health injustice in our world overwhelmingly takes this form.

A focus on sufficiency and those below any reasonable threshold of health, which generally captures the most serious instances of health injustice, enables ecumenical agreement on the central class of the most pressing problems in global health today, free from the distraction of more nuanced debate about the scope of health and injustice more generally. Whether one is a sufficientarian, prioritarian or egalitarian, or whether one is a cosmopolitan egalitarian or liberal nationalist, there

[29] For example, Roger Crisp defines this threshold as 80 *healthy years of life*: Roger Crisp, "Equality, Priority, and Compassion," *Ethics* 113 (2003).

is good reason to worry about individuals being below the level of sufficiency. Sufficientarians and prioritarians must obviously care about those worst-off or below the threshold, but egalitarians also have good reason to. Given that most egalitarians are pluralists, they cannot plausibly remain blind – even in their ultimate endeavour towards equality – to those particularly worse off.[30] Cosmopolitan egalitarians must care about *global* health injustice but liberal nationalists, who generally support a universal right to a minimally decent life, also have strong reasons to care about health injustice in the global sphere so defined.[31]

As Jonathan Wolff and Avner De-Shalit aptly argue, all plausible views about justice, despite their intricate disagreements, acknowledge the injustice involved in people being below the threshold of sufficiency and are in agreement about the importance of priority to the worse off:

> "[P]rovided that there are people in society who have not yet achieved sufficiency, and provided we have in mind limited, or at least finite, budgets and financial resources, then all of these views appear to converge on the same general policy prescription … *identify the worst off and take appropriate steps so that their position can be improved"*.[32]

Despite complications about aggregation and needs-based justice – which I turn to shortly – this basic agreement provides a solid starting point from which to build my account of global health injustice. This does not mean that there is no reasonable disagreement about the precise form of aggregation we ought to use

[30] Temkin, "Equality, Priority, and the Levelling-Down Objection."
[31] For example, Miller supports a 'global minimum' threshold based on meeting human rights and basic needs for a minimally decent life: Miller, *National Responsibility and Global Justice*.
[32] Wolff and De-Shalit, *Disadvantage*, 3, original emphasis.

to determine the worst-off, or what the right principles of redress are, but there is sufficient agreement about the injustice of individuals being markedly below any plausible threshold.

Some might think that this move is too quick and push back against my ecumenical characterisation of our priority instinct. Agreement about the threshold of sufficiency does not entail that we can resolve concerns about *how* we ought to respond to the health needs of the worst off in conditions of scarcity, and this can be as controversial as any major ethical debate.[33] Several points can be offered in response to this concern.

First, our concern with the worst off is arguably about *weighted priority* rather than *absolute priority*. Absolute priority would mean that we would have to divert all resources towards the worst off if doing so would improve their needs even minimally, at the expense of those who are the next worse off and more likely to benefit. The idea is not that we should give *absolute* priority to the claims of the worst off, but that we should give additional and proportional *weight* to someone's claim the worse off they are. The issue with the *weighted priority* view is that we can easily imagine situations in which a significant number of those with trivial ailments would yield a higher level of total priority than one very badly-off individual. A paradigmatic example is that paracetamol to relieve 1,000,000 people's *mild* headaches may outweigh 1 life-saving heart surgery.

[33] David Miller, "Needs-based Justice," in *Empirical Research and Normative Theory*, ed. Malte Ingo Meyerhuber, David Miller, and Alexander Max Bauer (De Gruyter, 2020); Erik Gustavsson and Niklas Juth, "Principles of Need and the Aggregation Thesis," *Health Care Analysis* 27 (2017).

Second, some level of interpersonal aggregation is inevitable and justified given the normative reality of public policy. The fact that 10 people would benefit from a treatment regime versus one where only 1 would benefit, given identical results, is a morally relevant feature. More controversially, it does not strike me as entirely implausible to favour 100,000 quality-of-life-improving but not life-saving hip replacement operations over 1 life-saving cancer operation. We are rightly troubled by instances of 1 life-saving operation being foregone to provide paracetamol tablets to 1,000,000 mild headache sufferers, but this is an objection about drawing the line appropriately rather than an objection against aggregation *simpliciter*. Strong contractualists who reject any form of interpersonal aggregation are therefore mistaken.[34]

Third, we can propose a hybrid model along the lines of what Erik Gustavsson and Niklas Juth have suggested.[35] Gustavsson and Juth suggest a hybrid account that combines sufficientarian and prioritarian intuitions. The double-threshold approach proposes two thresholds, separating groups into those who are below the first threshold and those above the first but below the second. The model allows aggregation and trade-offs only between adjacent groups – i.e. between those below the first threshold and those below the second *or* between those below the second threshold and those above the second threshold, but not between those below the first threshold and those above the second threshold. I remain ambivalent about the plausibility of this particular account, but we can imagine alternative theories with additional thresholds, as well as other hybrid models of

[34] Cf. T. M. Scanlon, *What We Owe to Each Other* (Belknap, 1998); Frick, "Contractualism and Social Risk."
[35] Gustavsson and Juth, "Principles of Need and the Aggregation Thesis."

prioritarianism – all of which converge on the importance of priority to the worst off in some way.[36]

Fourth, we can agree about the salience of needs and responding to the plight of the worst off but concede that a *procedural* aspect should be introduced to determine priority setting in *practice*. Norman Daniels and James Sabin develop one such procedural account, which they call *accountability for reasonableness.*[37] The procedure would be sensitive to the contextual and resource demands of particular contexts but constrained by important caveats and limitations.[38] These caveats and limitations could include considerations of existing rights that are immune to aggregation, creative threshold accounts (per Gustavsson and Juth's account), limitations against trade-offs between clearly fundamental and any amount of clearly trivial needs, and additional limits to aggregation justified on other moral grounds.

These disagreements are widespread and complex and occupy much work in moral and political philosophy. At the same time, we should acknowledge that there is widespread agreement about the normative salience of responding, *in some form*, to those who are worst off, even if the precise form this takes is subject to a plurality of different moral considerations. We care about priority to the worst off,

[36] Nicole Hassoun, "Meeting Need," *Utilitas* 21 (2009); Mark Siebel, *To Each According to His Needs: Measuring Need-based Justice*, DFG Research Group 2104 (2017). See also Alex Voorhoeve and Michael Otsuka, "Equality Versus Priority," in *The Oxford Handbook of Distributive Justice*, ed. Serena Olsaretti (Oxford University Press, 2018).
[37] Norman Daniels and James Sabin, "Limits to Health Care: Fair Procedures, Democratic Deliberation, and the Legitimacy Problem for Insurers," *Philosophy & Public Affairs* 26 (1997); Norman Daniels and James Sabin, *Setting Limits Fairly* (Oxford University Press, 2002).
[38] This is to avoid the results of Oregon's infamous priority-setting procedure: Robert Veatch, "Should Basic Care Get Priority? Doubts About Rationing the Oregon Way," *Kennedy Institute of Ethics Journal* 1 (1991).

but we also acknowledge that there is a plurality of justified ways in which we can respond to these needs, balanced with competing demands that characterise the realm of domestic and global justice. The *direct* account of health injustice captures these intuitions and is not threatened by the complications surrounding aggregation and priority setting.

One important concern with the *direct* account of health may be that it does not distinguish between voluntary and involuntary manifestations of health outcomes. A person who is below the threshold of sufficient health through her voluntary choices is seen as equivalent to a person who is below the threshold of sufficient health through no fault of her own. A person may bring herself below the threshold through imprudent and reckless behaviours (such as driving recklessly while drunk and thereby injuring herself) *or* due to a deliberate and conscious decision to prioritise other aspects of the good life that negatively impact on health (such as a conscious decision to undertake risky recreational activities despite the impact on health). The thought is that only the scenario of involuntary insufficiency constitutes an injustice – something that a simple *direct* approach based *only* on sufficiency cannot account for.

In response, we can qualify the *direct approach*, such that it need not be the case that all instances of insufficiency in health are necessarily unjust. The direct approach is not an *expansive isolationist* account, and it is open for theorists who support the *direct approach* to specify other considerations of justice that can provide guidance on whether particular scenarios of insufficiency constitute an injustice. It may be possible, for instance, to define the *direct* approach as cases of

individuals being below the threshold *where this is not the result of imprudence or a voluntary trade-off*. We need not take a view on the exact details for the *direct* account of health injustice to still hold at a general level. On the *direct* approach, there is health injustice when people are below the threshold of sufficient health, qualified by considerations of justice more generally. The consideration of other features of justice naturally leads us to the second mechanism in which health injustice can arise – the *indirect* account of health injustice – to which I now turn.

***The Indirect Account of Health Injustice***

The *indirect* account of health injustice is simultaneously broader and narrower than the *direct* approach. On the one hand, it is narrower because it does not consider insufficiency in individual- or group-level health a matter of injustice in itself, unless this insufficiency is a result of unjust social, economic, or political arrangements. On the other hand, it is broader because it allows not merely insufficiency but also *inequalities* in health to be considered unjust, insofar as and to the extent that these are traced to unjust institutional arrangements. Health *inequalities*, on the direct approach, are neither here nor there. The core focus is whether or not people are below the threshold of adequate health. Health *inequalities*, however, may constitute an injustice through the *indirect* account of health injustice.

Consider, for example, a situation where racism against a particular minority ethnic group is rife. The fact that this minority ethnic group has worse (and unequal) health outcomes than the dominant group which is *causally linked* to the unjust social, economic and political institutions would constitute a *health* injustice, on the *indirect*

mechanism, even if both groups are already above the threshold of adequate health. This is because the inequality in health outcomes between the minority ethnic and dominant group is *tainted* due to its causal connection to an unjust social structure permeated by racism.[39]

While health inequalities above the threshold *causally* attributable to the unjust social structures would be health injustices, we can imagine circumstances in which our society is unequal and unjust, but in which health inequalities are not causally linked to this unjust structure. A society may be rife with racism, yet the health inequalities might arise for other reasons independently of this fact. For example, particular cultural or religious groups may be personally reluctant to receive vaccinations which, in turn, places them at higher risk of particular diseases compared with other groups in society. A few comments about such situations are in order. First, the causal link between general injustice and particular health outcomes is complex, so we should be careful before dismissing a causal link between particular health outcomes and particular injustices.[40] We know from the empirical evidence about the strong link between *general* injustice and the ways these can impact on health in subtle but salient ways.[41] Second, if no causal link is found, it would indeed be the case that the *indirect* approach would not condemn the health inequalities as unjust. Third, even if health inequalities exist that are not

[39] I borrow the term 'taint' from the historical injustice literature: Chong-Ming Lim, "Vandalizing Tainted Commemorations," *Philosophy & Public Affairs* 48 (2020); Daniel Butt, *Rectifying International Injustice* (Oxford University Press, 2008); Jeremy Waldron, "Superseding Historic Injustice," *Ethics* 103 (1992).
[40] For instance, vaccine hesitancy may arise as a result of political mistrust due to previous experiences of injustice or because of past state abuse.
[41] Daniels, Kennedy, and Kawachi, "Why Justice is Good for Our Health."; Marmot and Wilkinson, *Social Determinants of Health*.

causally linked to the unjust structure, they can nevertheless be unjust on the *direct* mechanism if they bring individuals below the threshold of sufficiency.

While we can see how the *direct* account applies easily to *individuals* below the threshold of sufficient health, the *indirect* account seems to be concerned primarily about patterns and institutional actions, and it is harder to see whether the *indirect* account can function at an individual level. This concern, however, is premature. Both the *direct* and *indirect* accounts can be applied at the level of individuals or groups. To see this, consider two scenarios involving *individuals* above the threshold of sufficiency (indicating an absence of *direct* health injustice) but which seem to engage our intuitions about *indirect* injustice.

> *Erin Brockovich-type Scenario:* Alex and Erin live in two different houses across the road from each other. Erin develops a bothersome but otherwise benign pulmonary ailment while Alex does not. Both are above the threshold of sufficiency in health. The pulmonary ailment is due to the state dumping toxic waste on Erin's side of the street but not on Alex's.

> *Anti-Tattoo Hospital:* Josh and Hayden go into hospital for a routine outpatient appointment. Josh has a prominent but inoffensive sleeve tattooed on his left arm. Hayden does not have any tattoos. Both are above the threshold of sufficiency and are not seeking urgent or vital healthcare. Josh receives adequate but worse quality care compared to Hayden due to the hospital personnel disliking people with tattoos and, as a result, Josh has marginally worse health outcomes than Hayden.

These two scenarios demonstrate how injustice can be reflected at the level of individuals. Per the *direct* account, individual-level scenarios can be the appropriate subject of the *indirect* account of health injustice. Determining a pattern of *indirect* injustice between individuals is arguably more difficult than looking at patterns between groups, but this does not invalidate the conceptual and normative possibility of the *indirect* account applying at the individual level.[42]

This demonstrates how the *direct* and *indirect* accounts of health injustice fit together to answer the question of when there is a health injustice. Insufficiency in health, defined by reference to a reasonable threshold, is (generally) a health injustice, regardless of whether it can be traced to unjust social, economic, or political arrangements. This is qualified in cases where the injustice cannot be remedied – something I address in a forthcoming section – and in cases of imprudence or voluntary trade-offs, noting that ostensibly imprudent acts may have a social component that may challenge the judgement of voluntariness.[43] Health *inequalities*, even above the level of sufficiency, are unjust when they are the result of unjust social, economic, or political arrangements. Health inequalities not traceable to injustice in this way are not themselves unjust. These accounts can plausibly and coherently be applied to both groups and individuals. These two

[42] For further debate on individual- versus group-based measurements of health, see Kasper Lippert-Rasmussen, "When Group Measures of Health Should Matter," in *Inequalities in Health*, ed. Nir Eyal et al. (Oxford University Press, 2013); Yukiko Asada, "Is Health Inequality Across Individuals of Moral Concern?," *Health Care Analysis* 14 (2006); Hausman, "What's Wrong with Health Inequalities?."

[43] See, for instance, John Roemer, "A Pragmatic Theory of Responsibility for the Egalitarian Planner," *Philosophy & Public Affairs* 22 (1993); Johann Go, "Structure, Choice, and Responsibility," *Ethics & Behavior* 30 (2020).

criteria for health injustice – both of which are individually sufficient – capture the central intuitions with which we began this section.

***Residual Health Inequalities***

Those familiar with the literature on health injustice may notice an elephant in the room, namely, the problem of residual health inequalities. The problem of residual health inequalities refers to situations where health inequalities arise from an arrangement or structure that is considered just. Consider inequalities in income that are justified through desert or on grounds of Rawlsian incentives. The resultant income inequality, let us assume, is therefore just. Suppose, however, that even though the income inequality is justified and even though everyone is above the threshold of sufficiency, it results in richer people living longer and healthier lives through mechanisms explained by the social determinants of health.[44] As it stands, my account cannot condemn residual health inequalities above the threshold of sufficiency. This is because they cannot be traced to *unjust* social arrangements (since *ex hypothesi* they arise in situations of background justice) and because they are inequalities above the threshold of sufficiency. Neither the *direct* nor *indirect* account can capture the supposed injustice of these residual inequalities.

In response to the problem of residual health inequalities, a few comments can be made. First, the world is full of health injustice – in terms captured by the *direct* and *indirect* accounts – even without considering residual health inequalities. A theory of global health justice that takes seriously the imperative of remedying *direct* and *indirect* health injustice seriously would already generate highly demanding duties.

[44] Marmot and Wilkinson, *Social Determinants of Health*.

Second, my definitional account remains deliberately ambivalent about how residual health inequalities should fit into the definitions of health injustice.[45] This is because the core purpose of my *definitions* of health injustice (in terms of the *direct* and *indirect* accounts) is not to provide a comprehensive account of health justice but to outline a framework for dealing with the reality of serious and urgent injustice as it exists in our non-ideal real world today.

Third, and relatedly, Simon Caney argues that we ought to have a *maximal theory* and a *minimal theory* of justice.[46] A *maximal theory* of justice articulates principles of justice that we would ideally like to adopt if or when optimal circumstances obtain. A *minimal theory* of justice articulates principles that are designed with the limitations of our non-ideal world in mind, such as people's conflicting views of justice and reticence to act. While my own views are that residual health inequalities can sometimes be unjust, the account of health injustice presented here is designed to be a *minimal theory* of (health) justice. The fact that my account of health injustice cannot straightforwardly condemn residual health inequalities is thus not a problem, given this methodological standpoint. A more comprehensive account is explored in Chapter 4, expanding the demands of justice in global health.

[45] For contrasting viewpoints on the problem of residual health inequalities, see: Daniels, *Just Health*; Gopal Sreenivasan, "Ethics and Epidemiology: Residual Health Inequalities," *Public Health Ethics* 2 (2009).
[46] Caney, "Just Emissions."

***Remediability***

My account of health injustice focuses on remediable states of affairs.[47] This has the effect, again, of allowing greater convergence and avoiding complex debates about whether irremediable situations can count as cases of injustice or whether they are merely 'lamentable' but not unjust.[48] Whatever our view on this broader debate, we can agree about a central class of health injustice, namely, those that fit the *direct* and *indirect* criteria *and* are remediable. Injustice on the *direct* and *indirect* account is only unjust insofar as it is remediable. Remediability should not be treated as a *temporally* one-dimensional concept. A health injustice such as a serious pandemic sweeping through the world may be presently irremediable at $t_1$ but this does not mean that it will still be irremediable at $t_2$ once vaccines and antiviral treatments have been developed. Remediability is therefore a *diachronic* rather than a synchronic concept; irremediability now does not entail irremediability *simpliciter*.[49]

The distinction between remediable and non-remediable injustices, however, does not automatically track the distinction between natural and social injustice. *Direct* health injustice, as I present it, is not limited to injustice that results from the actions of individuals or institutions. Being below the threshold of adequate health through natural causes can nonetheless be an injustice, subject to the caveats around

[47] Some kind of ill health may be compensable even if it is not remediable. I use the term remediable to also refer to instances where health can be appropriately compensated. For the distinction, see Hausman, "Egalitarian Critiques of Health Inequalities."; Lippert-Rasmussen, "When Group Measures of Health Should Matter."

[48] David Miller, *Principles of Social Justice* (Harvard University Press, 1999). Cf. Kasper Lippert-Rasmussen, "Are Some Inequalities More Unequal than Others? Nature, Nurture and Equality," *Utilitas* 16 (2004).

[49] Whether something is *realistically* diachronically remediable rather than merely *theoretically* remediable is a complex matter. This complexity may mandate more specific theorising about the bounds of remediability, but it does not undermine my core claim about remediability not being temporally limited in scope.

involuntariness, so long as the state of affairs is remediable. What matters is not the genesis of the injustice, but the fact that we can *do* something about it within the appropriate confines of feasibility and cost, howsoever defined. Once we assume that an injustice is remediable in this way, the distinction between social and natural misfortune loses its bite. Even if the health system in its broadest sense is not causally responsible for a patient developing cancer at $t_1$, their response to this occurrence at $t_2$ (providing surgery and chemotherapy) are concerns of justice, given the special moral significance of health at the bar of justice (established in Chapter 1). The *neglect* to remedy such a situation can lead to the charge of injustice. This is not the same as saying it must be rectified at any costs. Rather, there is a *pro tanto* case of justice for it to be rectified.

In support of this position, we should notice that the distinction between 'social' justice and 'natural' misfortune further loses coherence when considered alongside our more general views of justice. We generally think that a person who spontaneously suffers a heart attack is entitled*,* at the bar of justice*,* to a response from agents of justice (for example, initial treatment from paramedics and an emergency operation in hospital). We do not dismiss it as a matter of bad luck if she is left to die simply on the grounds that the heart attack was a natural misfortune.[50] What is doing the work is not whether something is natural or social, but our underlying intuitions and considered judgements about suffering, wrongness, and justice, *given that we can do something about it*. From here, it is a simple task of reflecting on the kinds of 'bad' things taking place in the world right

[50] If we find ourselves unable to treat her – for example, due to considerations of feasibility and costs – we would owe her (or her close kin) a particular kind of explanation, in a way that we would not if it were not a matter of justice.

now and realising that they trigger our intuitions of justice regardless of whether they are social or 'natural'. Rejecting the normative significance of the distinction between social and natural misfortune but still accepting that we ought to limit our focus to remediable injustices makes this argument compatible with most plausible theories of justice.

Like my argument about the special moral significance of health having global purchase, the fundamental principles that determine whether there is an injustice in health at the global level are the same as the ones that determine whether there is an injustice at the local level. Accordingly, *global* health injustices arise via the *direct* or *indirect* account. I explore further arguments for this position in subsequent chapters, but we should note that this position remains ecumenically robust for several reasons. Consider, first, the *direct* account. As my previous discussion of sufficiency highlighted, theorists from liberal nationalists to egalitarian cosmopolitans agree that there is injustice when people are not positioned to meet their basic health needs.[51] Regardless of the debate around *egalitarian* justice beyond borders, the intuitions around those below the threshold of adequate health is one that holds globally.

Consider, second, the *indirect* account at the global level. Theorists have plausibly argued that there is a scheme of global structures that have important influence on people's health. The patent-system that restricts access to drugs arguably influences health outcomes to a large degree, as do laws around war and intervention, global economic policies and structures such as the World Bank and

[51] Such health needs may, of course, be contextually dependent. What is considered a basic health need for someone living in Antarctica is different for someone in urban India.

International Monetary Fund, and global norms and regulations on resources, national sovereignty, and labour.[52] However, even if one denies the existence of global institutions and norms of global justice that can appropriately reflect injustice in the sense required for *indirect* health injustice, the *direct* mechanism would still capture the majority of global health injustice in the world today. The overwhelming issue is not one of inequalities in health outcomes *per se*, significant though these are, but rather in the vast numbers of people below any reasonable threshold of health. A purely *direct* account of health injustice would still find much that is unjust about the state of global health today. The minimal working account of global health injustice captures this for now, but I expand on the demands of justice in global health in Chapter 4 and beyond.

## Conclusion

This chapter has evaluated the normative relationship between justice and health, focusing on two broad issues. First, I analysed the issue of *health in justice*, namely, how the pursuit of health should feature alongside more general considerations and priorities of justice. I disambiguated between three levels of theorising and argued that a *limited isolationist* position is the most convincing method we have for seeing how health features in justice more broadly. Second, I analysed the issue of *justice in health*, namely, evaluating what makes something a health *injustice*. I have argued that our considered judgements on this matter indicate a *direct* and *indirect* strand which, together, are individually *sufficient* to identify when there is a

[52] Thomas Pogge, *World Poverty and Human Rights* (Polity, 2008); de Campos, *The Global Health Crisis: Ethical Responsibilities*; Iris Marion Young, "Responsibility and Global Justice: A Social Connection Model," *Social Philosophy and Policy* 23 (2006).

health injustice. This initial working account holds beyond borders – a claim I return to.

At the same time, while the *direct* and *indirect* accounts are sufficient to capture the presence of health injustice, they track only the dimension of health *outcomes*. As I shall shortly argue, this may be the main component of global health injustice, but it is not the only relevant one. My aim in this chapter has been to present what Caney terms a minimal rather than a maximal *theory of* justice. I have drawn on widely held judgements and considered views about injustice and health to arrive at a broadly ecumenical but normatively compelling view about the normative relationship between justice and health.

# Chapter 4
# HEALTH EQUITY BEYOND BORDERS: TOWARDS *GENUINE OPPORTUNITY FOR HEALTH*

Health outcomes are unjustly distributed within and across countries. Some people live long, healthy lives while others die young from conditions readily amenable to health interventions. Beyond health *outcomes*, other axes of health (dis)advantage are distributed inequitably. Health is an exorbitantly costly endeavour for some to pursue while virtually costless for others. Some people are born to caring parents in peaceful environments with well-designed health systems and social conditions conducive to health. Many are born into conditions that stand in stark contrast, with violent and harmful environments welcoming them into the world. Public policies and social conditions in some societies make it easy to pursue a decent and secure standard of health, while conditions in others make it difficult. This chapter investigates the normative status of such states of affairs with a view to articulating what justice demands in the realm of global health. I argue that all people, regardless of nationality and place of birth, should have genuine opportunities to live in conditions that promote their health – something we can abbreviate to *Genuine Opportunity for Health* (GOH). This is the ideal of health equity beyond borders.[1]

My arguments in this chapter unfold as follows. In Section I, I address an initial liberal challenge, which suggests that health is a personal matter that concerns

[1] I use the phrase *health equity* as a general, placeholder term to mean a state of affairs where health justice obtains. This aligns with the way many non-philosophers working in health understand the term but does not commit me to a particular conception at the outset.

values subject to reasonable disagreement across individuals and cultures and is therefore an illegitimate pursuit for liberal political institutions.[2] Because the framework of GOH requires significant involvement in the design of social conditions, a successful objection of this form may be fatal to my account. I demonstrate that we can defend the legitimate pursuit of global health justice even if we start from within the liberal neutralist framework and that we are justified in making health-promoting conditions the *default* option from which one may not always be able to opt-out.

In Section II, I defend my preferred currency of global health justice, which I call the metric of *health disadvantage*. I argue that we ought to view health disadvantage (and health injustice) as pluralistic in nature. Health outcomes are too crude a metric, and we ought to be cognisant of dimensions relating to health security and health costs in coming to a view about individuals' levels of health disadvantage.

In Section III, I present an account of global health justice called *Genuine Opportunity for Health* which targets the pluralistic nature of health disadvantage. I argue that everyone, regardless of nationality or place of birth, should have genuine opportunities to achieve a decent and secure standard of health. The account is opportunity-based rather than outcome-based, albeit opportunity is conceived in a robust manner that takes into account considerations of the financial costs, effort, and sacrifice of values required for *individuals* to pursue health. The pursuit of GOH requires addressing the structural, global, political, economic,

[2] I use the term *political institutions* to refer to any entity that wields some degree of political power or coercion over individuals – a term I return to shortly.

social, personal, and other factors related to global health injustice, along the axes of health disadvantage (health outcomes, health security, and health costs).

I begin with a few definitions and clarifications. I shall use the term *political institutions* as a catch-all phrase to refer to any entity that wields some degree of political power or coercion over individuals, such as states (including local-, state-, federal- and national-level governments) and global political institutions (including global quasi-governmental organisations such as the WHO). I therefore do not presuppose the nation state as my unit of analysis in this chapter. I refer to *centralised action* as any official or coercive action performed by political institutions. This is a rough substitute for the widely used phrase 'state action', but one that does not presuppose actions are only carried out by states. This chapter is concerned primarily with articulating the ideal and general *framework* of GOH. It does not deal directly with more detailed questions around which agent, and on what grounds, ought to bear responsibility for discharging the duties GOH mandates. The question of duties and responsibilities is the topic of Chapter 5. Questions about the precise mechanism and policies needed to achieve GOH are also not the direct concern of this chapter and are postponed until Chapter 6.

## Section I: Paternalism, Perfectionism, and the Pursuit of Global Health

An important theoretical challenge rears its head at the very outset of this project, namely, how to reconcile the pursuit of global health justice with the liberal intuition that health is a private matter and concerns a sphere in which individuals should be allowed to make their own decisions, free from undue interference by domestic and global political institutions. It is commonly accepted that people have a right to

pursue (or not pursue) their own version of health, and this includes the freedom to participate in activities that harm or risk harming their own health.[3] We are generally reluctant to use the coercive power of political institutions – whether *domestically*, as a single state acting locally, or *globally*, as a global political agent or a conglomeration of states acting trans-nationally – to paternalistically mandate that individual persons refrain from any health-damaging behaviours.

More strongly, political neutralists argue that political institutions are not permitted to promote a particular conception of the good which may include the realm of health.[4] Insofar as my account of global health justice requires us to act upon the *conditions* that govern people's personal choices, the account is open to accusations of paternalism and perfectionism. The crux of this problem for my account is that political institutions must take actions to guarantee the conditions that reduce health disadvantage and promote health equity beyond borders. Such actions will invariably cost money and require taxation to fund, which require the coercive apparatus of political institutions to secure.[5] Centralised actions aimed at securing global health justice will also invariably restrict the actions available to individuals who wish to engage in particular activities that harm or risk harming their health – activities which may not be compatible with promoting the conditions for global health justice. Promoting global health justice therefore requires political

[3] Joel Feinberg, *Harm to Self*, vol. 3, The Moral Limits of the Criminal Law, (Oxford University Press, 1986), 4.3; John Stuart Mill, *On Liberty*, ed. Gertrude Himmelfarb (Harmondsworth: Penguin, 1985).
[4] As I turn to shortly, this is the view of Gerald Gaus: Gerald Gaus, "Liberal Neutrality: A Compelling and Radical Principle," in *Perfectionism and Neutrality: Essays in Liberal Theory*, ed. Steven Wall and George Klosko (Rowman & Littlefield, 2003); Gerald Gaus, *The Order of Public Reason* (Cambridge University Press, 2010). See also Jonathan Quong, *Liberalism Without Perfection* (Oxford University Press, 2011); John Rawls, *Political Liberalism* (Columbia University Press, 1993).
[5] Quong, *Liberalism Without Perfection*.

institutions to take a stance on the issue of health and its relative value compared to other pursuits.

If this strand of the liberal view is correct, political institutions are not permitted to make such judgements about health because to do so forces us to shape individuals' values and conceptions of the good. If so, this may undermine the scope within which political institutions may act to promote global health justice and would pose a fatal challenge to the framework of GOH. While public reason liberals are admittedly primarily concerned with neutral justification *within* a state rather than in the international sphere, their concerns are nevertheless relevant for global health justice. First, the pursuit of global health justice requires actions *within* states, and this raises important questions about what local citizens may be compelled to do. Second, some theorists have tried, in various forms, to extend the concept of public reason and neutral justification to the global realm, showing that the theory may admit of being generalised more broadly.[6]

Relatedly, the fact that global health justice may require political institutions and agents to act across borders may compound concerns about imposing a particular conception of the good on those who may not share similar values about health. It strikes many as unduly paternalistic and *prima facie* unacceptable to tell other countries how to structure their policy priorities and how to spend their money. We may agree that there are flagrantly unacceptable policies and spending priorities, but it seems plausible that within a region of acceptability (howsoever defined),

[6] For example, William Smith, "Deliberation Beyond Borders: The Public Reason of a Society of Peoples," *Journal of International Political Theory* 7 (2011); Alexander Brown, "On the Public Reason of the Society of Peoples," *Public Reason* 2 (2010).

countries should have the autonomy to choose their national values and funding regimen without external interference. I address this issue of national responsibility and global health justice more comprehensively in the forthcoming chapter. This section focuses on the question of global health justice and perfectionism and paternalism in relation to *individuals*, which is a more general and foundational question.[7]

### *Gaus Against Health Promotion*

Gerald Gaus, an ardent anti-perfectionist liberal, has propounded perhaps the strongest attack on the permissibility of centralised action to promote (global) health.[8] Political institutions are not permitted to take sides on issues of health and may not enact policies that make it easier to be healthy, such as smoking taxes or mandatory motorcycle helmet laws. For any law or policy to be justified, Gaus argues that it must be capable of *impartial justification*, which can be stated in basic form as follows:

> A reason *R* is a moral, impartial, reason justifying *Φ* only if all fully rational moral agents coerced by *Φ*-ing would acknowledge *R*, when presented with it, as a justification for *Φ*-ing.[9]

For Gaus, this means that if we enact a policy to reduce the burden of a particular health condition, we must be able to provide a reason that all fully rational moral agents who are affected would be able to accept as a justification. This test of

[7] If political institutions are not permitted to enact simple health-promoting initiatives aimed at individuals, the chances that they may do so across borders (aimed at interfering with *individuals* in other nations) are similarly doomed.
[8] Gaus, "Liberal Neutrality: A Compelling and Radical Principle."
[9] Gaus, "Liberal Neutrality: A Compelling and Radical Principle," 2.4. For a more detailed formulation, see Gaus, *The Order of Public Reason*, 263.

impartial reasons is reflected in some form in the thinking of other contemporary anti-perfectionist liberals, such as Jonathan Quong and John Rawls.[10] Gaus argues that no reason for health promotion can meet this requirement of impartial justification. Health is subject to reasonable disagreement, with people making different trade-offs and offering different justifications for these. Even if everyone values health in some form, as I suggested in Chapter 1, Gaus argues that this is insufficient to legitimise centralised action to promote health. This is because someone may agree about the badness of something (for example, smoking and its being bad for health) but still think that this badness is a worthwhile trade-off (for example, the pleasure they get from smoking outweighs the risk of lung cancer).

> Our main disagreements about the good are not about what is of value, but the relative importance of values. After all, what is a ranking of values but a 'conception of the good'? Although the badness of ill health caused by smoking can … be invoked in a neutral justification, that its badness outweighs the goodness of the pleasure of smoking cannot; and without that, no state policies discouraging smoking will be justified.[11]

To promote health is to impose a form of value ranking that is unduly paternalistic and perfectionist, and which cannot meet the liberal standard of impartial justification. These disagreements about ranking values may be even more objectionable in the pursuit of *global* health justice, given even more rampant disagreement about how values ought to be ranked across different cultural and social contexts. Formalising this claim, Gaus succinctly states this general view as follows:

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[10] Quong, *Liberalism Without Perfection*; Rawls, *Political Liberalism*.
[11] Gaus, "Liberal Neutrality: A Compelling and Radical Principle," 4.1; Gaus, *The Order of Public Reason*, 536-38.

> While we all may agree that *V* is a value, because we rationally disagree on the relative value of *V* and, say, *W*, no appeal to the superiority of *V* over *W* can provide an impartial reason of the required sort.[12]

Justifications for health promotion rely upon the view that health (*V*) is superior to other non-health values (*W*), such as the enjoyment of health-damaging activities, and this is unduly perfectionist. Agreement about the fact that health is valuable is not enough to justify centralised action to promote global health justice. It must be the fact that global health justice draws upon a ranking of values that is impartial and able to be shared by all. In what follows, I argue that we can respond to Gaus' challenge and show that global health justice is a legitimate action open to political institutions. In my first response to Gaus' challenge, I want to remain deliberately ambivalent about the plausibility of his principle of impartial justification and respond to this challenge from *within* his own theory. That is, to show that a Gaussian can still support the pursuit of global health justice. In my second response, I move beyond the Gaussian conception but nevertheless show that the pursuit of global health justice can be squared with core liberal tenets.

These disagreements are not merely theoretical nor the exclusive concern of those working in ideal theory. The issue of paternalism in public health has significant practical implications on the pursuit of health justice, as evidenced by extensive debates in the literature.[13] At the same time, many theorists working in health and

[12] Gaus, "Liberal Neutrality: A Compelling and Radical Principle," 4.3.
[13] Wilson, *Philosophy for Public Health and Public Policy*; Anne Barnhill and Matteo Bonotti, *Healthy Eating Policy and Political Philosophy* (Oxford University Press, 2022); K. Grill and S. O. Hansson, "Epistemic Paternalism in Public Health," *Journal of Medical Ethics* 31 (2005); Stephen Holland, "Public Health Paternalism: A Response to Nys," *Public Health Ethics* 2 (2009); Jonathan Pugh, "Coercive Paternalism and Back-Door Perfectionism," *Journal of Medical Ethics* 40 (2014);

(global) health justice, faced with the challenge from Gaus and liberal neutralists, have thrown up their arms and accepted the conclusions. If the pursuit of health and global health justice clash with the demands of political neutrality, they say, then so much the worse for political neutrality. Hafez Ismaili M'Hamdi argues that we need to adopt a form of perfectionism to justify the pursuit of health justice.[14] Daniel Weinstock uses the fact that the state would be barred from promoting health as a *reductio ad absurdum* argument against a particular interpretation of liberal neutrality.[15] James Wilson, whose arguments I return to in more detail later, argues that we are wrong to see the paternalistic state as worse than the alternative 'neglectful state' and that the virtues of the liberal, neutral state may have been overstated.[16] Angus Dawson argues more strongly that we ought to develop a new conception of public health ethics and abandon the dominant liberal framework of non-interference and neutrality.[17] I am sympathetic to many of these theorists' ideas, but I shall show that Gaus' case against the pursuit of (global) health justice fails on its own terms and that GOH can command wider support than it may initially seem.

My core rejoinder against Gaus' position is that the pursuit of global health justice can, in fact, meet his own standard of impartial justification. Suppose all individuals would prefer a system whereby the *set* of health policies [$P_1$ , $P_2$ , $P_3$ , $P_4$ , $P_5$] are pursued over a system where health is not pursued at all, but they would prefer a

T. M. Wilkinson, "Obesity, Equity and Choice," *Journal of Medical Ethics* 45 (2019); T. M. Wilkinson, "Smokers' Regrets and the Case for Public Health Paternalism," *Public Health Ethics* 14 (2021).

[14] Hafez Ismaili M'hamdi, "Neutrality and Perfectionism in Public Health," *American Journal of Bioethics* 21 (2021).

[15] Daniel Weinstock, "Neutralizing Perfection: Hurka on Liberal Neutrality," *Dialogue* 38 (1999).

[16] Wilson, *Philosophy for Public Health and Public Policy*.

[17] Angus Dawson, "Resetting the Parameters: Public Health As the Foundation for Public Health Ethics," in *Public Health Ethics*, ed. Angus Dawson (Cambridge University Press, 2011).

system where no health is pursued at all over a system that pursued policies in the set [$P_6$ , $P_7$]. To make this issue clearer, we can illustrate what such policies might include: $P_1$ (universal availability of primary healthcare, free at the point of use); $P_2$ (robust food safety regulations); $P_3$ (environmental health protections around clean air and pollution); $P_4$, (regulations to make essential medicines affordable); and $P_5$ (health education provided to all). We have good reason to believe that all rational and reasonable people around the world would support such a scheme, which I turn to shortly. The policies that are not preferred over a system with no policies at all are: $P_6$ (state-controlled occupation choice to increase the supply of health professionals) and $P_7$ (guaranteed social housing for all, on the grounds that this would promote the social determinants of health). Individuals who make these rankings are well aware of opportunity costs and the burdens that accompany their rational support of the policies. My claims are arguably *idealised* to an extent, but Gaus' general theory does the same. I am merely working from within this general method.

In this scenario, there seems to be an impartial justificatory reason to choose a policy from the set of [$P_1$ … $P_5$] but not [$P_6$ , $P_7$]. We can concede to Gaus that the fact that everyone values their health is not enough, because how they rank their values and decide on trade-offs between health and non-health issues also matters. However, the fact that *all* reasonable and rational people would at least prefer a core set of health policies to be pursued over no health system at all (knowing the costs required to support such policies) provides an impartial justification that speaks precisely to the issue of ranking values. Gaus may be right about smoking taxes and mandatory helmet laws not commanding impartial

justification. It does not follow from this, however, that no set of health pursuits can be impartially justified from the perspective of all rational and reasonable persons. Rational and reasonable people may disagree about whether or not they support a 50% tax on tobacco products, but rational and reasonable people do not disagree about the justifiability of having a scheme of basic health policies.

Gaus uses a similar argument in his conclusion about the justifiability of private property. He argues that there are schemes of private property rights that people would prefer to having over no property rights at all (as well as schemes in which people would prefer to have no system at all), and we have impartial reasons to choose from among the set that people would prefer over no system at all.[18] He then argues that the problem with smoking (and most public policy generally) is that not everyone would prefer smoking taxes to no policy at all. I am happy to concede that Gaus may be right about his smoking tax claim, but I can nonetheless extend his general method of argument to the issue of health and achieve the conclusion that we have impartial reasons to pursue health within a liberal neutralist theory of justice. Using Gaus' example of private property, the fact that some might disagree about the legitimacy of inheritance tax or compulsory purchase does not negate the justifiability of a *general* scheme of private property. In a similar vein, as Cass Sunstein has argued, we can have *incompletely theorised agreements*. We can agree on an outcome – in this case, the relative value of the set [$P_1 \ldots P_5$] – even if we do not agree on what best accounts for this theoretical position.[19]

[18] Gaus, "Liberal Neutrality: A Compelling and Radical Principle," 4.3.
[19] Cass Sunstein, "Incompletely Theorized Agreements," *Harvard Law Review* 108 (1995).

To illustrate my argument another way, we can imagine an indifference curve showing the relationship between health (on one axis) and its costs (on the second axis). Individuals value health but are also sensitive to trade-offs in its pursuit. Individuals value the state of being cancer free (for example) and are willing to bear costs up to a certain point. This is reflected at an optimal choice point or range of acceptable options on the indifference curve. My claim is that illustrated through an indifference curve, we will find that there is significant convergence among what rational and reasonable persons would be willing to bear in terms of costs for the pursuit of health. The optimal choice point across a core set of policies would be similar. This convergence, which I previously simplified as the set of [$P_1 \ldots P_5$], provides an impartial justification for the pursuit of health as a matter of justice. Moreover, impartiality demands that recognising this need for oneself requires recognising it for others in similar positions, and this extends the impartial reason of justice to the *global* sphere.

There are several reasons to be confident about such a convergence on the set [$P_1 \ldots P_5$]. First, the history of medicine is replete with examples of people and cultures willing to bear significant costs to guarantee a certain level of provision in the scheme of health, especially when it comes to emergency care.[20] Second, we can turn to more contemporary empirical evidence about what reasonable and rational people are willing to give up for the sake of health, to approximate their indifference curves. In a detailed study of the spending habits of the global poor, for example, Daryl Collins and colleagues demonstrated that people are willing to

[20] George Campbell Gosling, *Payment and Philanthropy in British Healthcare, 1918-48* (Manchester University Press, 2017); Stephanie Neuner, "Poverty and Sickness. The Precarious Lives of Lower-class Families in Würzburg and Göttingen, 1800–1850," *Medizin, Gesellschaft und Geschichte* 36 (2016).

incur significant costs to mitigate poor health, even to the point of risking financial ruin.[21] Third, and relatedly, consider that the average health expenditure per person in the UK for 2020 was £3,840.[22] These expenses are funded primarily through taxation so we can *very roughly* approximate, for the sake of illustrating this point, that an average British person contributes £3,840 in annual taxes towards the upkeep of the national health service. Despite this, the UK's NHS enjoys immense popular support, with general bipartisan commitment to promoting these services and many individuals pushing for even more health provision and expenditure. Beyond the UK, European social insurance models of healthcare paint a similar picture of convergence. Individuals are willing to pay large amounts, both through taxation and out-of-pocket expenses, for accessible and high-quality health services.[23] This shows a convergence in our indifference curves when it comes to the relative value and costs of a national health service that comprises core services encompassed in the set [$P_1 \ldots P_5$].[24]

This does not guarantee, admittedly, that it ought to be the state or a similar political institution who ought to provide such services. It might be the case, for instance, that the set is supported only on the grounds that the scheme will take the form of a generalised insurance scheme run by private providers. Considering the empirical reality of market failure in health, however, shows that coordinated provision in some sense is essential. Rational and reasonable persons who want

[21] Collins et al., *Portfolios of the Poor*.
[22] Office for National Statistics, *Healthcare Expenditure, UK Health Accounts: 2020*, Census 2021 (2022).
[23] Germany and France, for example, spent £4,432 and £3,737 per person, respectively, on healthcare in the year 2017, compared to the UK's £2,989 per person at the time: Office for National Statistics, "How Does UK Healthcare Spending Compare with Other Countries?," (2019).
[24] The scope of NHS services may exceed this set, but this would simply lend support to convergence on an even bigger scale.

to pursue all or part of the set [$P_1 \ldots P_5$] and who understand the market failures rampant in health provision more generally will not be able to support the provision of such core services through a solely free-market system. As I alluded to in Chapter 2, in my discussion of the expressive function of healthcare, health economists realise that health systems cannot be designed in the same way as food systems. Market failure is rampant, and centralised, coordinated action is essential to uphold the very market forces one values.[25] Even if the scheme is designed as a privately provided generalised insurance scheme, however, protecting this coordinated provision against market failures, I argue, would be indistinguishable from *de facto* centralised action by political institutions.

### *Beyond Gaus: Liberalism and Health*

My initial response to Gaus, from within his own account of impartial justification, shows that he is wrong to dismiss the pursuit of health and global health as being incompatible with impartial justification. On the contrary, I have demonstrated that the Gaussian principle of neutrality is able to impartially justify at least a minimal health-promoting political system. We are able to go further than this minimal health-promoting political system, however, once we explore justifications and considerations that go beyond the narrow brand of anti-perfectionist liberalism Gaus espouses.[26] In what follows, I present a series of further arguments to show that we are justified in pursuing health and global health justice in a much more

[25] For the moral significance of this observation, see L. Chad Horne and Joseph Heath, "A Market Failures Approach to Justice in Health," *Politics, Philosophy & Economics* 21 (2022).
[26] The anti-perfectionist liberalism of Gaus has been subject to extensive discussion in the literature, and it is not within the scope of this chapter to rehash these. See, for instance, David Enoch, "Against Public Reason," in *Oxford Studies in Political Philosophy, Volume 1*, ed. David Sobel, Peter Vallentyne, and Steven Wall (Oxford University Press, 2015); Steven Wall, "Perfectionism, Reasonableness, and Respect," *Political Theory* 42 (2014).

comprehensive sense. We can justifiably presume that all would want the *conditions* that enable them to pursue health. Health-promoting conditions should be the default, but it does not preclude those who wish to from pursuing activities that risk or damage their health. Nevertheless, I shall show that there are many instances in which one may not be able to fully opt out due to its other-regarding effects. The core justification for this argument is that promoting health can be conceived of as a demand of *justice* (and therefore a policy about the right) rather than a judgement about what conception of the good political institutions ought to support. Insofar as liberal neutralists accept the view that political institutions may use coercion to promote justice, the pursuit of health can therefore meet the standards of liberal legitimacy.[27]

The concern at hand, to be clear, is not whether we can act coercively to impose particular healthcare interventions on individuals against their will. That matter is clearly unjustifiable and not a matter of debate within the liberal framework I am working from. The concern is whether political institutions may compel individuals, as a matter of political obligation, to contribute to a scheme that pursues the idea of GOH over and above a minimal health-promoting political institution and even though they may be opposed to doing so. I answer in the affirmative, for reasons I explore in the remainder of this section.

[27] Quong, *Liberalism Without Perfection*. Some theorists argue that the distinction between matters of justice/the right and matters of the good is incoherent, and that accepting one may commit one to more perfectionist policies than one may want: Timothy Fowler and Zofia Stemplowska, "The Asymmetry Objection Rides Again: On the Nature and Significance of Justificatory Disagreement," *Journal of Applied Philosophy* 32 (2015); Simon Caney, "Liberal Legitimacy, Reasonable Disagreement and Justice," *Critical Review of International Social and Political Philosophy* 1 (1998).

My view is that the case of promoting the conditions for health is akin to promoting the conditions for liberty.[28] Someone who rejects the value of liberty is free not to exercise the full extent of this liberty, but they are still required to pay taxes that fund the agents and institutions that guarantee this ideal. Similarly, someone who rejects the idea of freedom of speech is free to 'opt out' of the default, in the sense of not deliberately offending politicians and not speaking out on controversial social or political issues. They are not free, however, to refuse to pay taxes that go towards maintaining the infrastructure that enables and promotes the right to free speech.

Just as the conditions for liberty cannot function as an opt-in system on an *ad hoc* basis, the conditions that protect and promote health cannot be opted into like a simple healthcare insurance scheme. The general conditions for protecting and promoting health resemble a public good that requires coordinated provision, as a matter of justice, from which one cannot opt out. It is a matter of justice for several reasons, which I shall turn to shortly. There is no way to fully opt out of the conditions for liberty, but the anti-liberty campaigner has no basis for complaint. These people are entitled to exercise their autonomy by opting out of the conditions that promote health to the extent that this is possible, but they are not entitled to impose this view on others, all (or most) of whom value the existence of conditions that protect and promote health. Someone who rejects the value of health may choose to exercise their autonomy by not availing of the benefits from the environmental health law around clean air – for example, by deliberately inhaling noxious substances – but they are not free to insist that political institutions abolish

[28] See also Kniess, "Justice in the Social Distribution of Health," 415.

the environmental health policy or that they be exempt from contributing to the initiative.

I ground this position on the fact that promoting the conditions for health, as mandated by GOH, is actually a demand of *impartial justice*.[29] I explore several strands of arguments, including highlighting the problem (and inevitability) of *choice architecture*, the *presupposition of health* for autonomy, and the issue of *children*. I also highlight that opting out of supporting health-promoting conditions has other-regarding effects and may be justifiably prohibited on grounds familiar to liberals, namely, consideration of Mill's Harm Principle. This explains why even if it were practically possible to opt-out – for example, through some system of hypothecated taxation – the demands of justice would oppose this.

Jonathan Wolff and Avner De-Shalit argue that we do not tend to celebrate the value of autonomy when people choose to act in ways that promote ill health.[30] We care that people choose *how* they can be healthy, but this does not extend to valuing the autonomy of those who fully neglect their health.

> We do not celebrate the freedom of choice of the men who die young [from excess drinking and smoking], but express concerns about the nature of their environment that has led them to make their choices. Freedom whether or not to achieve bodily health rarely seems valuable in itself.[31]

[29] In this regard, even the most demanding neutralist (such as Gaus) may be able to support my account. I do not explicitly engage with exploring this compatibility, however, and focus on presenting a freestanding case for health promotion as the default.
[30] Jonathan Wolff and Avner de-Shalit, "On Fertile Functionings: A Response to Martha Nussbaum," *Journal of Human Development and Capabilities* 14 (2013).
[31] Wolff and de-Shalit, "On Fertile Functionings: A Response to Martha Nussbaum," 163.

We do not necessarily have to agree with Wolff and De-Shalit's views about the value of autonomy in this sense, but they are surely right to point to the importance of the prior context in which these so-called autonomous choices are made. Political institutions' actions, whether enacted domestically or globally, provide the background conditions and contexts of choice for individuals to exercise the autonomy that liberals and neutralists care about in the first place.[32]

Consider what we can call the *problem of choice architecture*. Cass Sunstein and Richard Thaler provide a highly influential account of how individual behaviour is influenced by the design of a social context.[33] According to Sunstein and Thaler, minute details in a particular context can influence individuals' behaviours, from product placement increasing the likelihood of someone buying a certain item to the order on a list influencing what is treated as the default and most popular option. These have to do with the so-called *choice architecture* – conditions and contexts in which certain actions and behaviours are made easier or harder. The default option, for example, is easier than the non-default option, and this influences the choices that people make.

Theorists have pointed out that any action (and even no action) influences individuals to act a certain way. Cass Sunstein puts it aptly when he states that:

> Choice architecture is inevitable. … Any store has a design; some products are seen first, and others are not. Any menu places options at various

[32] For a brief survey of personal responsibility for *health* in the context of social policies, see Rebecca Brown, "Moral Responsibility for (Un)Healthy Behaviour," *Journal of Medical Ethics* 39 (2013).
[33] Richard Thaler and Cass Sunstein, *Nudge: Improving Decisions About Health, Wealth and Happiness* (London: Penguin Books, 2009).

> locations. … A website has a design, which will affect what and whether people will choose. Nor can the state avoid nudging. Any government, even one that is or purports to be firmly committed to laissez-faire, has to establish a set of prohibitions and permissions, including a set of default entitlements, establishing who has what before bargaining begins.[34]

In the context of health, political institutions have no choice but to inevitably influence health, whether for better or for worse. If it does $\theta$, then the effects on health will be $E_1$. If it does not do $\theta$, then the effects on health will be $E_2$. Regardless of whether a political institution does $\theta$ or *not-*$\theta$, it brings about an effect. If it taxes high-sugar drinks or redesigns the layout of streets in neighbourhoods to promote walking, it will have the effect of reducing obesity rates. If it does not tax sugary drinks and leaves the streets as they are, it will have the effect of maintaining (or increasing) obesity rates. If the WHO recommends the use of medical-grade masks to prevent the spread of a certain pathogen, it will influence policy and behaviour and result in decreased infection rates. If the WHO remains ambivalent about the use of medical-grade masks and does not release a statement either way, it will have the effect of favouring whatever is the status quo – in most cases, increasing infection rates as the default is for people not to wear masks.[35]

Gaus and other neutralists seem to neglect the inevitability of choice architecture and the fact that the relative costs of actions, which determine people's ranking of pursuing health relative to other values, are in fact primarily (or at least strongly)

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[34] Cass Sunstein, "Nudging and Choice Architecture: Ethical Considerations," *The Harvard John M. Olin Discussion Paper Series* Discussion Paper No. 809 (2015): 11.

[35] The WHO's ambivalent (and at times conflicting) views about the use of face masks in the early stages of the COVID-19 pandemic or its reticence to declare a 'public health emergency of international concern' are examples of omissions/non-actions nevertheless having an effect on global health.

influenced by political institutions. The relative cost of pursuing value *V* over value *W*, which features in how individuals rank their values, is strongly determined by policy decisions and choice architecture, which are within the control of political institutions. If health-promoting options are designed as the easy option, the set of policies that people would prefer over no policy at all would increase, thus expanding the scope of impartially justified global health justice.

At this stage, neutralists may invoke a distinction between *neutrality of justification* and *neutrality of effect*. The point of neutrality, so the argument goes, is not about making sure particular conceptions of the good are not made easier or harder than others, but that these considerations do not feature in the *justifications* for the policy. As Jonathan Quong argues, “Liberals do not intend that the state should be neutral regarding its effect on various conceptions of the good. …. [t]he liberal state, by allowing people to pursue their own conceptions of the good freely, creates a marketplace where some conceptions of the good may ‘lose out’ because they are unable to attract adherents.”[36] Whatever the plausibility of this response more generally, it strikes me as especially inadequate for the problem of health promotion, given the centrality of *preventative* measures in this domain. Political institutions who fail to enact reasonable preventative measures for health, such as routine screening and childhood immunisation programmes, are considered not only to have failed in discharging the demands of justice, but more relevantly to this point, to have prioritised other *reasons* above health. Inaction in the pursuit of health and the resultant structure of the choice architecture is therefore a

[36] Jonathan Quong, "The Scope of Public Reason," *Political Studies* 52 (2004): 233.

*justificatory* decision that cannot be dismissed merely as an issue of unintended effect.

Given the inevitability of choice architecture, it is a fair question to ask what political institutions ought to do. This question is especially pressing given that political institutions ought generally not to embrace hard-line libertarianism but instead espouse basic tenets of liberalism *alongside* other values, such as compassion and equality. Given this, I argue that there is a strong argument to make health-promoting conditions the default. Underlying the general analysis about the inevitability of choice architecture for health is a concern about how the state navigates the line between being paternalistic and being neglectful. James Wilson has argued that the *neglectful state* may be equally if not more objectionable than the nanny state.[37] The inevitability of choice architecture sets up a binary between promoting health (and being paternalistic) or refraining from promoting health (and being neglectful). Wilson argues that it is not clear that we should see state paternalism as more objectionable than state neglect. "We also need to guard against something arguably even worse [than a paternalistic state]: the Neglectful State. The Neglectful State is one that does not take easy steps that could have been taken to reduce risks to health."[38] This is especially so, given that political institutions gain legitimacy through actions that help people meet their basic needs.

Steven Wall has argued that it is unclear why *civility* (captured by the demands of neutrality and tolerance) should trump *content* (which may involve acting upon

[37] Wilson, *Philosophy for Public Health and Public Policy*.
[38] Wilson, *Philosophy for Public Health and Public Policy*, 20.

controversial but nonetheless correct ideas).[39] A parallel thought is to ask why accommodating the views and preferences of those who object to reasonable and proportionate measures to promote health should take precedence over the idea of making health-promoting conditions the default on the basis of justice, care, and compassion.[40] Wall also argues that we should not have to take people's beliefs as fixed, and that we show more respect by challenging people and engaging their rational agencies.[41] People's views about health, then, should not be taken as fixed and may instead be subject to criticism and epistemic evaluation to bring these into congruence with the pursuit of global health justice.[42]

The second core argument for treating health-promoting conditions as the default is that health and the conditions that promote it are important preconditions for autonomy – at least given our present social and cultural conditions.[43] Without overstating the point and trying to squeeze more out of the argument than it can conceivably bear, health is a precondition for autonomy in a *limited* but nevertheless important sense. A basic degree of health is necessary for the exercise of autonomy. A person must be free of serious mental illness to be autonomous, for example, and they must have the requisite level of physical health to be able to pursue their reasonable conceptions of the good. A person who does

[39] Steven Wall, *Liberalism, Perfectionism and Restraint* (Cambridge University Press, 1998), 80.
[40] I say the pursuit is reasonable and proportionate because it is still bound by general doctrines of liberalism. The measures must respect persons' liberty, including the ability to opt out of receiving particular healthcare treatments except in cases where there are other-regarding effects.
[41] Wall, "Perfectionism, Reasonableness, and Respect," 478.
[42] M'Hamdi has made a similar observation about challenging people's existing views about health values informed through pseudoscience: Ismaili M'hamdi, "Neutrality and Perfectionism in Public Health."
[43] My claim about autonomy and health, then, is consistent with the claims advanced by those working within the social model of disability, who claim that at least some of the effects of disability and poor health are contextually and socially determined: Pascale Allotey et al., "The DALY, Context and the Determinants of the Severity of Disease: An Exploratory Comparison of Paraplegia in Australia and Cameroon," *Social Science & Medicine* 57 (2003).

not have a minimal level of health cannot exercise their agential powers. In short, possessing a minimal level of health comes before exercising the autonomous choice to opt out of health. Those who choose to opt out of health are free to do so, but they cannot deny others the opportunity to make their own autonomous choice on the matter – an opportunity which requires a minimal standard of health to exercise, and which can be assisted by making health-protecting and health-promoting conditions the default.

This explains why the person who denies the value of health is free to opt out in the sense of declining to avail of the health-promoting default option, but they are not free to fully opt out in the sense of refraining from paying taxes or engaging in conduct that denies others the conditions to be healthy. The conditions that enable them to exercise that autonomous choice – to wit, a minimal standard of health – needs to be guaranteed for others, and fully opting out of contributing to the scheme has unjustifiable *other-regarding* effects. An extension of John Stuart Mill's Harm Principle is able to capture this intuition. We are free to act so long as our actions have purely self-regarding effects, but this freedom is curtailed once we start to generate other-regarding effects.[44]

Consider the third argument for making health-promoting conditions the default, which draws on observations from the two aforementioned arguments. Well before individuals develop any views and values about health and how it features in their comprehensive conception of the good, they must live in conditions that influence

[44] Mill, *On Liberty*. This is not to diminish some of the controversy about how we characterise and calculate harm: Joel Feinberg, *Harm to Others*, vol. 1, Moral Limits of the Criminal Law, (Oxford University Press, 1984).

their health (and their views about it) one way or the other. This is related to our observation about the inevitability of choice architecture. This reality is most pronounced for *children*, who have no choice but to occupy a context and environment. It is out of children's control whether or not they live in a polluted area with poor health infrastructure and health-damaging conditions, and whether or not they are surrounded by others who value or deny the value of health. It is this context and environment that will not only impact on their health, whether positively or negatively, but which will also shape the eventual views they will come to hold about the value of health. This is what I refer to as the *problem of children*.

It is a problem because political institutions must take a policy stand in light of the inevitability of choice architecture. Political institutions may either influence a child's health for better or they may influence it for worse. It is my proposal that given this, we ought to assume a precautionary approach and err on the side of a healthy future for the child. By the time the child is an adult, she cannot change a health-damaging upbringing in favour of one that yields better health outcomes for her in the future.[45] However, the future child, as an adult, can more easily 'throw away' the benefits they gained from a healthy upbringing through actions such as binge drinking, eating junk food, or residing in highly polluted areas, to name some examples. Borrowing Joel Feinberg's concept and phrase of a child's right to an open future, we might propose something akin to a *child's right to a healthy future*.[46]

[45] Evidence from developmental biology shows the pervasive influence of early experiences: Gabriella Conti, James Heckman, and Rodrigo Pinto, "The Effects of Two Influential Early Childhood Interventions on Health and Healthy Behaviour," *The Economic Journal* 126 (2016); Frances Campbell et al., "Early Childhood Investments Substantially Boost Adult Health," *Science* 343 (2014); David Barker et al., "Developmental Biology: Support Mothers to Secure Future Public Health," *Nature* 504 (2013).

[46] Joel Feinberg, "The Child's Right to an Open Future," in *Whose Child? Children's Rights, Parental Authority, and State Power*, ed. William Aiken and Hugh LaFollette (Rowman and Littlefield, 1980).

The child ought to have her health protected and promoted until such a time that she can decide what her attitudes and values about it are.[47]

On this argument, health-promoting conditions are the default – something that those who deny the value of health are not exempt from contributing towards – because they are required to promote *children's* right to a healthy future from which they can decide what their attitudes are about health. Political institutions have no choice but to take a stand on the matter of health for children, and a society concerned with justice, care and compassion *on balance* ought to favour conditions conducive to health. Adults who want to opt out of supporting the conditions that protect and promote health may not do so because the consequences of their non-compliance are not purely self-regarding but extend to affect the interests of children who are not yet in a position to determine their own views about health. Our regard for children's future interests lend support to making conditions that protect and promote health the default.

These arguments, all of which are consistent with the liberal ideal of respecting individuals and their autonomy, show that the pursuit of global health justice in the form of GOH is legitimate and permissible. Political institutions are justified in acting to ensure social conditions are conducive for the attainment of decent and secure health. This leaves us with a vital question: what does it mean for social conditions to be conducive to health? It is to this question I now turn, presenting my framework of *Genuine Opportunity for Health.*

[47] Of course, we will likely influence the child to have more positive views about health in the future, but this does not strike me as objectionable. The alternative of influencing them (explicitly or implicitly) to disregard health strikes me as more concerning.

## Section II: On the Currency of Global Health Justice

Having defused the liberal challenge to the pursuit of global health justice, the remainder of this chapter analyses what justice demands in the sphere of global health. My core argument – which I develop throughout Sections II and III – is that everyone, regardless of nationality or place of birth, should have *genuine opportunity* to live in *conditions conducive to decent and secure health*. This is the ideal of health equity beyond borders, encompassed by the framework of GOH.

A theory of global health justice must answer what the appropriate *currency* or *metric* is and, relatedly, what *distributive considerations* ought to govern this metric to tell us whether we are achieving our goal or falling short of it. I use the phrase *distributive considerations* as the term 'distributive principle' implies the existence of a simple principle to govern the metric of global health justice. As I shall show, the reality is much more complex, in part because the metric of global health justice is pluralist in nature and needs to be governed by a plethora of normative considerations. Section II focuses on the question of metric, while the forthcoming Section III introduces the kinds of distributive considerations relevant to a theory of global health justice.

The majority of political philosophers who analyse health injustice focus on health outcomes. Fabienne Peter, as we encountered in Chapter 3, focuses on conceptualising health outcomes as just or unjust based on her *direct* and *indirect* accounts.[48] Paula Braveman and Sofia Gruskin, in their influential work on health

[48] Peter, "Health Equity and Social Justice."

equity, define justice in health by reference to "the health *status* of the most socially advantaged group" in comparison with the least advantaged.[49] Theorists are increasingly turning their attention to the social determinants of health, but the overwhelming majority still conceptualise health justice by reference to health *outcomes*.[50] Health outcomes are an important measure of the state of global health justice and injustice, but they paint an incomplete picture and cannot be the sole currency of global health justice.

Consider two ostensibly equally healthy people, Mark and Mohammed. Both are 35 years of age, in reasonable levels of health with no significant diseases, and able to work and partake in recreational activities with their friends and families.

> *Mark* lives in an affluent suburb in Wellington, New Zealand. There is high-quality healthcare free for all at the point of use. There are robust social welfare provisions in place, protecting against the consequences of involuntary unemployment including through ill health. Fresh and healthy food is aplenty and available at reasonable prices. The neighbourhood is well designed, with plenty of green spaces, good public transport options, and low pollution levels. Rates of violent crime are low and social capital is high.
>
> *Mohammed* lives in the centre of Beirut, Lebanon. Public healthcare is limited as a result of an exodus of healthcare workers. Mohammed therefore

[49] Paula Braveman and Sofia Gruskin, "Defining Equity in Health," *Journal of Epidemiology and Community Health* 57 (2003): 254, my emphasis.
[50] For example, Wilson, "Health Inequities."

> relies on user-pays private healthcare, which is often very expensive. Social welfare provisions are low as a result of government corruption and rising inflation that has impacted on the government's ability to discharge its core obligations. The neighbourhood Mohammed lives in has recently been decimated by an explosion, and pollution levels are dangerous for long-term health.

Despite both Mark and Mohammed having equal levels of health, as measured in terms of current health outcomes, their level of *health disadvantage* is different. *Health disadvantage* is a broader metric I propose that considers a person's actual health *outcomes* alongside their level of health *security* and the *costs* of pursuing and maintaining health. This is the currency (or metric) of global health justice. I focus on the term health *dis*advantage (rather than health advantage) primarily to align the metric with how discussions proceed in the philosophy of medicine literature. In this literature, health is generally defined negatively, by reference to a negative state – for example, health as the *absence* of pathology. Our language of health, more generally, tends to focus on negative terms, such as illness, disease, and sickness.[51]

Someone's level of health disadvantage is a function of (a) their current health state (*health outcomes),* (b) how *secure* their current health state is given their personal and social conditions *(health security)*, and (c) how *costly* it is for them to maintain or pursue their health goals, where costs include financial and non-financial costs (*costliness*). Health outcomes may have a degree of lexical priority over health

[51] In any case, reframing my metric in terms of *health advantage* would not affect my substantive claims about the pluralism of global health (in)justice.

security and costliness (insofar as having highly 'secure' poor health and cheap-to-maintain poor health cannot compensate for a lack of good health outcomes), but it cannot be the *only* relevant factor for determining someone's level of health disadvantage. Mohammed has a much higher level of health disadvantage than Mark – something not captured by simply considering their present health outcomes, but which most of us intuitively agree with. We can interrogate the axes of health advantage more closely to explain why it is that Mohammed has a higher level of health disadvantage compared with Mark, despite them having equivalent health outcomes.

Consider, first, the axis of *health security*. This concept has multiple dimensions, but one major aspect is health *risk*. Two people, Ambrose and Brayden, may be free of cancer at $t_1$ and therefore have the same health status, but this does not mean they have equal levels of health disadvantage. Ambrose may live in a highly polluted area where factories release known carcinogens while Brayden may live in a remote area free from such pollutants. Ambrose in the highly polluted area experiences a greater level of health risk than Brayden and is likely to develop cancer at $t_2$ even if both are currently cancer free. Current health outcomes cannot capture the fact that Ambrose has a greater level of *health disadvantage* than Brayden.

Another aspect of health security is the *compensatory protection* available from the effects of ill health. Consider Charlotte and Darika, both of whom are at risk of contracting a disease that would render them unable to work. Darika has access to a robust social welfare system and has the support of family and friends.

Charlotte lacks access to a social welfare system and has only meagre savings upon which to rely. The consequences of poor health would be much worse for Charlotte than for Darika – something not captured by analysing the badness of a particular health outcome alone. Poor health would not be catastrophic for Darika in the same way it would be for Charlotte. Health security (as a component of health disadvantage) consists of a dimension that enables one to compensate for the effects of poor health. One cannot feel secure with one's health unless one is protected from its effects on other essential aspects of life. The feeling of security that accompanies the knowledge that one has compensatory protection available should something go wrong with one's health is an important axis of health disadvantage.

My claims about health security as a component of health disadvantage are reminiscent of arguments presented by Jonathan Wolff and Avner De-Shalit on the concept of disadvantage. Wolff and De-Shalit talk about having *secure* functionings, arguing that we should not pay attention merely to actual levels of functioning, but also to the prospects of sustaining that level of functioning.[52] Theorists working on the ethics of risk frequently acknowledge that imposing risk can disadvantage someone and even wrong them.[53] Extending this body of theoretical work, it is not controversial to suggest that health security is a relevant axis of disadvantage when it comes to analysing the state of health injustice globally. Even without these theoretical conceptualisations, however, the concept

[52] Wolff and De-Shalit, *Disadvantage*.
[53] An extensive literature on risk imposition, for instance, has developed: John Oberdiek, "The Moral Significance of Risking," *Legal Theory* 18 (2012); Claire Finkelstein, "Is Risk A Harm?," *University of Pennsylvania Law Review* 151 (2003); Adriana Placani, "When the Risk of Harm Harms," *Law and Philosophy* 36 (2017); Frick, "Contractualism and Social Risk."; Christian Barry and Garrett Cullity, "Offsetting and Risk Imposition," *Ethics* 132 (2022).

of health security I have been presenting – both in terms of *risk* and *compensatory protections* – are intuitive ideals that find widespread agreement.

Consider, next, the axis of *costliness*. Protecting ourselves from ill health and maintaining our level of health can be costly. Costs, on my account, include *financial* costs, physical and emotional *effort*, and sacrifices of *values* in the pursuit of health. How costly it is to attain and maintain our level of health is relevant to our level of health disadvantage, even with equal health outcomes. My focus, in this section, is merely to provide a descriptive account of the way costs relate to health disadvantage. I am not primarily concerned, for the time being, about whether these sources of health disadvantage are instances of injustice or not. Nor am I aiming to articulate at what *level* of costs something starts to warrant the language of justice and injustice. These issues will be explored in Section III.

The axis of costliness and its relevance to health disadvantage can be illustrated by considering a selection of people.[54] Lucy, Ethel, and Waheed all have equivalent health outcomes and levels of health security. Derek has a chronic health condition, which will become relevant in my forthcoming discussion.

> *Lucky Lucy* – Lucy lives in a region with high-quality free healthcare in widely accessible locations. The social environment makes being healthy easy, adapting to the reasonable needs of everyone.

[54] These scenarios, though simplified, are based upon the experiences of real people I have interacted with. Our discussion of health disadvantage through this thought experiment is therefore not a purely theoretical exercise but is grounded in the reality of health in the real world.

*Expensive Ethel* – Ethel is a working-class woman who lives in a state where she must spend over half of her modest income to maintain her health, due to the lack of subsidised healthcare.

*Warzone Waheed* – Waheed lives in a war-torn region. Staying healthy (and alive) requires significant effort, including staying indoors during armed clashes. The drive to the nearest health clinic is over 3 hours away by car. Waheed is unable to exercise outside due to his fear of violence, and if he wants to buy healthy food he must drive 45 minutes to the nearby food market.

*Dialysis Derek* – Derek has a chronic kidney condition that requires him to attend a specialist dialysis clinic three days a week. Derek is separated from his partner, and they share custody of their two young children with Derek having custody rights on Mondays, Fridays, and Saturdays. Derek must sacrifice time with his children on Fridays, in order to attend his dialysis appointment and maintain his health. He is also worn out by the procedure, such that he cannot do as many recreational activities with his children as he would like on the Saturday.

Taking *Lucky Lucy* as the comparator, we can see the way the axis of costliness manifests in different ways. I focus on comparisons and *relative* statements about health disadvantage between these cases for now, before turning to a more substantive discussion (in Section III) of *absolute* health disadvantage. Let us take the dimension of *financial* costs, exemplified through the case of *Expensive Ethel*.

The costs of attaining and maintaining her health, purely from the perspective of healthcare costs, is much greater for Ethel than Lucy, who has access to good, free healthcare. Even though Ethel and Lucy might have the same level of health, the pursuit of health is much more costly for Ethel (who must spend over half of her modest salary), and this is a source of disadvantage. Ethel's level of health disadvantage, then, is greater than Lucy's, *ceteris paribus*.

The financial costs of attaining and maintaining a certain level of health is an important component of health disadvantage, over and above the resultant health outcomes. Theorists of health equity have long commented on the contrast between advanced liberal democracies such as Australia, New Zealand, Canada and the United Kingdom (on the one hand) and the United States (on the other hand), which is an outlier.[55] Even if the United States were to have equivalent levels of health to the others – something it does not have, in any case – the fact that Americans must spend a significant portion of their disposable income on health-related expenditure is a source of health disadvantage. Americans are worse-off, health wise, than the British and Canadians, whose tax payments are significantly lower than what the average American pays in health insurance premiums.

*Warzone Waheed* highlights a slightly more abstract cost, namely, the amount of physical and emotional *effort* required to attain and maintain health. Even assuming the question of financial costs is equal, some people must exert a much higher level of effort to achieve the same health outcomes. Not only is Waheed at increased risk of injury and death (itself a source of disadvantage, per the first axis

[55] Schneider et al., *Mirror Mirror 2021: Reflecting Poorly: Health Care in the U.S. Compared to Other High-Income Countries*.

of health disadvantage), he must expend significantly more effort to keep fit and healthy and must travel comparatively longer distances than Lucy to access the same health resources. We intuitively feel the pull of the view that someone who must try harder than another person to get the same thing is worse-off in some important way than the other person.

*Dialysis Derek* is arguably the most complex of these cases, with the scenario relating to costs in terms of the sacrifice of *core values* for the pursuit of health. Attaining and maintaining Derek's level of health is costly to him in terms of having to sacrifice his core values of spending quality time with his children. In order to maintain his health and attend his dialysis appointments, Derek must give up a whole day with his children (over whom he has shared custody rights) and, as a result of undergoing the dialysis procedure, he cannot be as active with the children as he would like. If, in contrast, a single man (let us call him George) is happiest when he is alone in his own thoughts, the costs of dialysis to him in terms of his core values may be much less – at least concerning this particular aspect. In this respect, Derek has a higher level of health disadvantage than George given the differential costs to them of undergoing dialysis to maintain their health. A person who can meet his own demands of attaining and maintaining his health without sacrificing his core values is better off than someone who must sacrifice core values in his pursuit of health, *ceteris paribus*.[56]

Notice that my discussion of health disadvantage thus far has been articulated in terms of a *relative metric* – that is, as a way of making *comparisons* between

[56] This is the general intuition captured by Kymlicka in his discussion of multiculturalism from a liberal egalitarian perspective: Will Kymlicka, *Multicultural Citizenship* (Clarendon Press, 1995).

individuals' levels of health disadvantage. This does not, in itself, give us an *absolute metric* by which to judge whether or not the level of health disadvantage being experienced is unreasonable or *unjust*. Even if someone's core values are sacrificed in the pursuit of health, for example, our response might simply be, 'so much the worse for their core values'. Similarly, we might argue that fighting cancer requires significant physical and emotional effort, but it is not clear that this is an unjustified distribution of health disadvantage. I shall shortly turn to the matter of what *distributive considerations* the framework of GOH calls for in evaluating the metric of health disadvantage (in order to allow us to arrive at an *absolute metric*), but one important objection about my conceptualisation of the currency of global health justice needs to be addressed first.

It may be said that my conceptualisation of the different dimensions of health disadvantage misses the point about health justice. Issues of health security and health costs ought not to be considered aspects of *health* disadvantage so much as matters of non-health disadvantage or social justice more generally. Health disadvantage, it may be argued, is simply concerned with health outcomes, and the other axes and dimensions (such as costs) are simply the *effects* rather than components of health disadvantage. I reject this categorisation and argue that the aforementioned aspects are rightly considered dimensions of *health* disadvantage rather than merely non-health-related disadvantage.

Note that my claim is not that having poorer health security or greater health costs means one is less *healthy* than someone with better health security or someone with fewer health costs. This would rightly be regarded as a conceptually

suspicious claim. The claim is about *health disadvantage*, which is a more holistic metric of disadvantage related to someone's present state of health, as well as the disadvantage related to attaining and maintaining that state of health. Three arguments can be advanced to show why this is the most apt metric of global health justice and why *health disadvantage* (rather than merely health outcomes) should be our focus.

First, the initial intuitive argument should not be overlooked. Reflecting on the earlier scenarios of health disadvantage leads us to conclude that *Lucky Lucy* must be better off, from a health justice standpoint, than the others. It follows, accordingly, that our considered judgements regard not only health outcomes as relevant to questions of health disadvantage, but also how secure these outcomes are and what costs we need to incur to achieve or maintain them. If we did not care about this broader notion of health disadvantage, we would have to regard *Lucky Lucy, Expensive Ethel, Warzone Waheed, and Dialysis Derek* as equally well-off from the perspective of health justice, and this seems clearly mistaken.

Second, recall my methodological arguments in Chapter 3 about the integrationist and isolationist aspects of health justice. I argued that health and the pursuit of (global) health justice have direct and indirect effects on other spheres that cannot be overlooked. I further argued that a theory of global health *justice* must be cognisant of integrationist considerations, locating the pursuit of global health justice within the pursuit of *justice* more generally. The metric of health disadvantage allows us to do exactly this, by bringing health outcomes together with other dimensions relevant to theorising and pursuing global health justice.

Third, recall my arguments in Chapter 1 about what grounds the special moral significance of health. I argued that health cannot be collapsed into a purely normativist conception, whereby health is simply defined in relation to values or engineered by social construction, independently of its relation to biomedical issues. I also argued that health cannot be reduced solely to its impact on welfare or opportunity. Nevertheless, the fact that they influence these domains *is* relevant and forms a large part of what gives health its special moral significance. Health's radical instrumentality, explored in Chapter 1, is part and parcel of what gives health its special moral significance. Disadvantage that impacts on health's propensity to promote opportunity (for example) may therefore be characterised as health-related disadvantage (or what I have been calling health disadvantage for short). The metric of health disadvantage is more aligned with our account of health's special moral significance and therefore the appropriate focus of global health justice.

## Section III: The Framework of Genuine Opportunity for Health

Section II argued that the currency of global health injustice must go beyond mere health outcomes and also consider health *security* (in terms of risks and compensatory protection) and health-related *costs* (in terms of the finances, effort, and compromise of values needed to pursue health). Having defended the concept of *health disadvantage* as the appropriate metric of global health justice, I now address what *distributive considerations* ought to govern it as a matter of justice and, more generally, how the metric of health disadvantage features in the framework of *Genuine Opportunity for Health* (GOH).

GOH argues that *everyone, regardless of nationality and place of birth, should live in social conditions that enable them to achieve a decent and secure standard of health.*[57] If the conditions for GOH are met, it means that individuals should have robust and genuine opportunities to (a) achieve a decent standard of health, and (b) have *good prospects* for maintaining this standard of health and (c) be able to achieve and maintain that standard of health without it being *unduly costly* (both financially and non-financially). These demands – corresponding respectively to the axes of health outcomes, health security, and costliness – contain terms that need further unpacking, which I undertake in this section. Achieving GOH requires us to design *social conditions* so as to secure the demands of (a), (b), and (c).

The demands of global health justice are *primarily* focused on the design of *social conditions* rather than acting *directly* on particular individuals' levels of health disadvantage. GOH is an *opportunity*-based account of global health justice rather than an *outcome*-based one, which makes it simultaneously broader and narrower. In one sense, an opportunity-based conception makes the demands of GOH broader because – as I established in Section II – it demands that we go beyond merely looking at health *outcomes*. In another sense, an opportunity-based conception makes the demands of GOH narrower, since ideal health outcomes are not the aim, merely that people have genuine opportunity to achieve them. An opportunity-based account leaves significant room for individual autonomy, creating conditions in which individuals must still exercise their agency for health

[57] As previously mentioned, I focus on nationality and place of birth as a shorthand for broader features that cosmopolitan theorists of justice draw our attention to.

compared with an outcome-based account, where political institutions may act more directly to bring about particular outcomes.

GOH is a theory of health justice that is explicitly *global* in nature and orientation. As I shall show, it draws our attention not only to local and domestic social conditions that affect health but also to broad structural and global conditions. As I have already established in earlier chapters, the value of health is universal and subject to a strong, global overlapping consensus. Our considered judgements about health injustice, as I further explored in Chapter 3, also extend beyond borders. GOH piggybacks off these normative theoretical observations to arrive at a framework that is global in scope. The opportunity-based rather than outcome-based conception of GOH means it is appropriately demanding and compels important changes but is nevertheless sensitive to particular local contexts and leaves room for national self-determination, as I address in the next chapter.

***Social Conditions and Genuine Opportunities***

I use the term *social conditions* to refer to the broad array of factors in which people live, work, grow, play, and age, and which is within social and political control, broadly construed. Social conditions include *structural* factors (such as social norms that determine attitudes about health and health behaviours), *global* factors (such as the distribution of resources worldwide or the loss of healthcare professionals through brain drain), *politico-legal* factors (such as domestic policies and legislation about health), and *economic* factors (such as market forces that determine pharmaceutical pricing), among others. These conditions should be

designed so that individuals everywhere, regardless of nationality or place of birth, have genuine opportunity to achieve health.

*Genuine opportunity* means that the chance of having a decent and secure standard of health (as captured by the axes of health disadvantage), should be substantively and robustly open for all, and not merely in a formal way. Phrased another way, social conditions should be designed so that all have opportunities *not* to experience *unreasonable* health disadvantage (for example, in terms of costs) – something I analyse in depth shortly. At the same time, GOH is an opportunity-based rather than an outcome-based account, with scope for agency and individual responsibility. Respecting autonomy entails allowing individuals to opt out, inasmuch as this is possible and insofar as it does not challenge the broader demands of global health justice, as discussed in Section I.

*Genuine* qualifies *opportunity* in two ways, which help to highlight the aforementioned basic demands of GOH. First, in terms of genuine opportunity *for* health, individuals should be able to pursue reasonable opportunities for health without *undue costs* in terms of finances, effort, and compromise of values. I address this in the forthcoming discussion. Second, in terms of genuine opportunity to *opt out* of health, individuals are free to live in conditions not conducive to health, but such a decision must have come about through a meaningful exercise of autonomy and choice rather than through coercion, manipulation, or desperate circumstances.

Coercion is present when someone's genuine preferences are undermined through force or the threat of force. If Lucy (from *Lucky Lucy*) is threatened with force to leave her home and healthy environment to work in a highly polluted mine, her exercise of autonomy and use of opportunity is not genuine. Following Joseph Raz, we can accept that unlike coercion, manipulation does not change an agent's set of options, but instead "perverts the way that person reaches decisions, forms preferences or adopts goals".[58] An individual who takes up vaping after being exposed to sustained and misleading advertising about the view that e-cigarettes are not harmful, for example, is manipulated and their decision to opt out of the conditions for health may not be genuine. Desperate circumstances also challenge the genuineness of an exercise of choice. If Ethel (from *Expensive Ethel*) must make a choice between paying to repair a broken car to get to work or paying to see a dentist for a dental abscess, her decision not to see the dentist cannot be said to be genuine for the purposes of GOH. While I am confident that these issues will become clearer as my discussion unfolds, there is also no need to reinvent the wheel. Raz's work on autonomy and what counts as an undue interference with it is clear and authoritative, and this can serve as a general yardstick for interpreting what *genuine* opportunity means within the framework of GOH.[59]

The focus of GOH is not equalising health-promoting conditions for all but making sure these are *genuinely available* for all. We can view GOH as concurrently incorporating an egalitarian and sufficientarian component. From an egalitarian standpoint, GOH mandates that everyone, regardless of nationality or place of birth, has genuine opportunity to attain a decent and secure standard of health.

[58] Joseph Raz, *The Morality of Freedom* (Clarendon Press, 1986), 377-78.
[59] See, principally, his seminal work: Raz, *The Morality of Freedom*.

This ideal should be something available to all, and in this sense the ideal is egalitarian in form. From a sufficientarian standpoint, GOH focuses on everyone having *genuine* opportunity to attain a decent and secure standard of health rather than everyone having *equal* opportunities. A person who lives 500 metres from the local healthcare centre has *better* opportunities for health (*ceteris paribus*) than someone who lives 5 kilometres away, but as long as the social conditions promote genuine opportunity for health for both, the demands of GOH are met. The focus is on having good enough opportunities to pursue health, and this aligns with a sufficientarian ideal. We might therefore characterise GOH as a *sufficientarian* theory that has global and universal *scope*.

***Health Disadvantage, Health Injustice, and the Demands of GOH***

Having outlined the general scope of GOH and clarified what we mean by social conditions and genuine opportunity, the crux of the normative work now turns to specifying how social conditions ought to be designed with respect to the pluralistic dimensions of health disadvantage. That is, how should social conditions be arranged so that individuals do not suffer from unjust health outcomes, have health security, and do not experience unreasonable health costs?

A health disadvantage becomes a health injustice (thus providing us with a more general, *absolute* metric of global health) when *social conditions* threaten to bring individuals' health outcomes below a decent standard; when social conditions are not conducive to good prospects for maintaining individuals' standard of health; or when social conditions are such that it is unduly costly for individuals to achieve or maintain their standard of health. To understand these demands, I analyse how

each of the strands of GOH – (a), (b), and (c) – provide guidelines and set constraints on the kinds of social conditions required by the theory. There is significant overlap across (a), (b), and (c), and I make no claim that the specific normative prescriptions of GOH fit neatly and exclusively into each strand.

*Strand (a): Being well placed to achieve a decent standard of health*

The first strand of GOH is aimed at the dimension of health outcomes. This is arguably the most important aspect of health disadvantage, though I have been at pains to demonstrate that it is not the only relevant consideration. Social conditions should be designed so that individuals are *well placed* to achieve a *decent standard of health*. The italicised portions carry the normative weight of this strand. Let me begin with the latter of these.

A *decent standard of health* is one characterised by good overall length (a point I expand on shortly), and which is free from pain and serious pathologies (such as cancer, heart disease, or mental and physical disability) throughout each stage of the life course. Being free from pain and serious pathology is relatively straightforward and uncontroversial, and I need not spend time articulating this further. Note, however, that freedom from pain and serious pathology should be interpreted at each stage of the life course, rather than averaged across an overall span of life. The test of a decent standard of health is having a decent standard of health at each and every stage of one's life. A person who has had a pain- and pathology-free life for 78 years but who is *now* in pain in the last 2 years of her life does not have decent health, contra the claims of so-called *whole-life*

egalitarians/sufficientarians.[60] Evaluating freedom from pain and serious pathology in our decent standard of health has an important synchronic dimension, which is supported by our considered judgements about health and suffering.

We can define 'good overall length' by reference to several plausible metrics.[61] One possibility is to index the idea of 'good overall length' to the highest presently attainable level of life expectancy. A good overall length of life, for example, would be living to 90% of Japan's life expectancy. Another possibility is to work with Roger Crisp's suggestion of *80 years* of (healthy) life, as the point at which an impartial observer's compassion is exhausted.[62] A compassionate, impartial observer tasked with policymaking and theorising principles of justice for health ceases to be moved when someone who has had 80 years of healthy life dies for health reasons. This impartial observer is filled with compassion to act when someone dies at the age of 70, but not when someone dies at 90.[63] I take the relevant impartial observer to be a compassionate *policymaker* rather than a compassionate doctor, as some may say that the role obligations of a compassionate doctor mandate that she *always* ought to maximise life and health. This impartial observer metric, nevertheless, is incomplete. Suppose someone dies at the age of 80 but would have lived to 85 had it not been for a racist doctor refusing to discharge life-saving medical treatment on account of the patient's race. While Crisp's impartial observer compassion test may not register an issue with

[60] The idea of whether we adopt a 'complete life' account or not is an ongoing debate within theories of health and egalitarianism: Dennis McKerlie, *Justice Between the Young and the Old* (Oxford University Press, 2012); Anders Hertliz, "Health, Priority to the Worse Off, and Time," *Medicine, Health Care, and Philosophy* 21 (2018).
[61] My account is consistent with any plausible account of life expectancy, and nothing substantive turns on this.
[62] Crisp, "Equality, Priority, and Compassion."
[63] If we are unsatisfied with Crisp's threshold of 80, we can change this to something higher (such as 85 or 90) without this affecting the substance of his claim.

this on account that they lived to 80, we would be reluctant to deny that there is an injustice.

Recall that *health outcomes* can be unjust in one of two ways, as I argued in Chapter 3. On the *direct account*, health outcomes are unjust when they bring one below the threshold of sufficiency, subject to caveats around personal responsibility and remediability. Crisp's metric provides a plausible metric for the direct account. In addition to the direct account, however, the *indirect account* shows that health outcomes can be unjust when they are the direct result of injustice, even if one is already above the threshold of sufficiency. Relating to the above analysis of the racist doctor not treating someone who is above the threshold of a good length of life, a decent standard of health must mean that even if one is above the threshold of sufficiency, one's health does not suffer on the grounds of injustice. This is grounded in reasons I explored in Chapter 3 in my analysis of the *indirect account* of health injustice.

To be *well placed* to achieve a standard of decent health means that the context in which individuals live, work, play, and age are conducive to attaining this goal. This is partly an empirical question for health policy experts, but some general statements can be advanced. Externally, social conditions should be designed to respond seriously to the health needs of all. This means that the default conditions in society are health promoting, in accordance with my discussion in Section I. The healthy option should be the easy option. Quality healthcare to maintain or restore individuals to a decent standard of health should be universally available to all

without this threatening financial security.[64] It also includes preventative schemes that mitigate health risks and promote health security, as well as schemes to mitigate the burdens of poor health – aspects of health disadvantage I return to in more depth shortly. Social conditions should also be designed with action on the social determinants of health in mind – improving education, transport and housing, and promoting social capital, among others.[65] Internally, individuals should have sufficient knowledge of health to understand how to avoid health risks, be able to recognise pathology, and know how to seek health-related assistance. These internal conditions will require external social conditions, such as robust health promotion and educational practices, showing that the external-internal distinction is not a simple binary.

*Strand (b): Having good prospects for maintaining a decent standard of health*

A decent standard of health does not necessarily entail that such a standard is *secure*, and this dimension of health disadvantage is something Strand (b) of GOH is concerned with. GOH mandates that social conditions are designed so that individuals have *good prospects* for maintaining a decent standard of health. Having *good prospects* for health security means that individuals are protected from *standard threats against health*. Focusing on standard threats to health means that we need not protect against any and all possible risks to health. We can follow Jonathan Wolff in defining *standard* health threats as follows:

[64] Because this requirement is tied to the *proviso* of achieving a *decent* standard of health (rather than maximising health), some healthcare procedures may not be demanded by GOH. These include cosmetic surgery that do not alleviate pain or serious pathology.
[65] Health, *Closing the Gap in a Generation*.

> A condition seems to be a standard threat to health where, first, it is serious enough to count as a threat, and second, a solution could reasonably be expected to be in reach, either because treatment could be made available on a routine basis, or because the condition is widespread and urgent and there is every reason to think that the normal processes of scientific research would lead to a solution.[66]

GOH does not require us to factor in the most remote scenarios of health risks into our design of social conditions. We need only to support actions that can reasonably be provided on a routine basis and to intervene only in conditions that are likely to affect or cause a risk to the general population, per Wolff's account. I take Wolff's account as the correct one for delineating standard threats to health, though not much turns on this for the theory of GOH and my fundamental claim is compatible with any plausible conception of what constitutes a *standard* threat to health.[67]

Social conditions do not have to be designed to protect against any and all threats to health, regardless of feasibility and costs or regardless of its likelihood of affecting individuals. To do so would mean that extremely costly interventions for rare conditions or policies that reduce health risks in only an infinitesimal manner would have to be part of the design of our social conditions. As I articulated in my discussion of integrationist considerations in Chapter 3, this is implausible and brings us to health exceptionalism, where all social resources may have to be

[66] Jonathan Wolff, "The Demands of the Human Right to Health," *Proceedings of the Aristotelian Society Supplement* (2012).
[67] As I alluded to earlier, the broader philosophical literature on imposing risk, for example, may be helpful to understand what constitutes reasonable or standard risks: Barry and Cullity, "Offsetting and Risk Imposition."; Finkelstein, "Is Risk A Harm?."; Oberdiek, "The Moral Significance of Risking."; Stephen Perry, "Risk, Harm, Interests, and Rights," in *Risk: Philosophical Perspectives*, ed. Tim Lewens (2007); Placani, "When the Risk of Harm Harms."

diverted towards the pursuit of health, given its costliness – a demand contrary to the broader requirements of justice.[68] The realisation that the pursuit of global health justice sits alongside other priorities of justice tempers the degree to which we can commit to designing social conditions that protect against any and all threats to health.

Despite these limitations about what good prospects for maintaining health entail, designing social conditions to protect against standard health threats is likely to be broad and demanding, especially in the current, non-ideal state of global health. Protection involves the provision of quality healthcare to maintain or restore individuals to a decent and secure level of health. It also includes preventative schemes that mitigate health risks and promote health security, as well as schemes to mitigate the burdens of poor health. To protect against standard threats to health and promote opportunities for health that are genuine, GOH must pay attention to several factors which I explored in my discussion of Strand (a). These include designing structural, global, politico-legal, and economic factors so that individuals have genuine opportunity to pursue health.

In the presence of social conditions conducive to secure health, individuals can be said to have good prospects for maintaining a decent standard of health. I shall address some general practical proposals required for GOH in Chapter 6 but let us consider some illustrative examples of the kinds of social conditions needed to provide individuals with good prospects for maintaining their health. Social

[68] For further debate on these high-cost cases (so-called *rule of rescue* cases), see Jonsen, "Bentham in a Box: Technology Assessment and Health Care Allocation."; Bognar and Hirose, *The Ethics of Health Care Rationing*.

conditions should be designed so that presently healthy people are protected from standard health threats. Such interventions include regulating environmental pollution and the release of toxins, food safety regulations, providing proactive health checks for health conditions that pose a standard threat to health, general action to promote the social determinants of health, and fostering individuals' resilience and capacity to maintain a decent standard of health (for example, through education). Social conditions should also be designed so that those already experiencing pathology are protected from further deterioration and disadvantage. Prompt and effective treatment should be accessible and support should be available to mitigate any further health-related disadvantage.[69] These conditions should be guaranteed to *all*, and many interventions will require cooperation between multiple agents that transcend current national boundaries.

Because the primary subject of normative analysis is *social conditions* rather than specific individuals' health security, residual health disadvantage at the individual level (namely in terms of health outcomes and health security) may remain. Despite ideal social conditions focused on promoting health security, individuals may still encounter bad luck and find their standard of health being threatened. Consider a GOH utopia with efficient and equitable access to quality healthcare and a very healthy environment with solid action on the social determinants of health. Nevertheless, some individuals become ill, with many of them having incurable illnesses that cannot be treated by the healthcare system. Nevertheless, we may have to accept the conclusion that the demands of GOH are met and that the residual health disadvantage is not a case of injustice. GOH cannot mitigate all

[69] As we can see, the demands of upholding health *security* often intersect with the requirements for decent health *outcomes*.

instances of bad luck and if, after all reasonable steps to protect and promote health, some people nevertheless fall ill, this need not be labelled an injustice.[70] This is the conceptual demand of a (genuine) opportunity-based conception of global health justice rather than a strict outcome-based one. As I alluded to earlier, a strict outcome-based conception would be implausible not only in terms of concerns about health exceptionalism and bottomless pits, but because of its opposition to our liberal starting point of allowing people to opt out of certain healthcare interventions. Allowing people to opt out of certain healthcare interventions necessarily means that there will be instances of residual health disadvantage that do not constitute an injustice.

GOH requires the guarantee of genuine opportunities for health, where this is indexed to the conditions needed to protect against standard threats to health and what is needed to promote a decent and secure standard of health. It does not extend to providing any and all opportunities to secure the 'highest attainable standard of health', per the infamous WHO target.[71] Insofar as individuals have genuine opportunity to live in social conditions that protect them against standard threats to health, we can say that they have good prospects for maintaining a decent standard of health.

*Strand (c): Being able to achieve and maintain a decent standard of health without it being unduly costly*

[70] Daniels, Kennedy, and Kawachi, "Why Justice is Good for Our Health." For a contrasting analysis, see Sreenivasan, "Ethics and Epidemiology: Residual Health Inequalities."
[71] WHO, *Constitution of the World Health Organization* (WHO, 1946).

For the demands of GOH to be met, social conditions should be designed so that the pursuit of health is not *unduly costly*. Incurring costs in the pursuit of health is not necessarily an injustice. It naturally costs to keep fit and healthy; for example, in terms of the effort and time I must spend exercising and eating healthily. What matters for GOH is the absence of *undue costs*. Determining what counts as undue costs is not a straightforward process and there are likely to be controversies. Analysing each aspect of undue costs, however, provides us with enough guidance to rely on the framework of GOH for general normative guidance. The presence of undue costs threatens the *genuineness* of an opportunity for health and is therefore incompatible with the demands of GOH.

Consider, first, the issue of *financial costs* and what could constitute undue cost. Accessing quality healthcare should not threaten individuals' financial security. Spending large amounts on out-of-pocket healthcare expenses to the point that it affects our financial security constitutes an undue cost, given the importance we place on responding to our health needs.[72] Healthy options – for example, in terms of food – should be affordable. Paying significantly more to buy healthy options compared to non-healthy options may constitute an undue cost if these goods can be made much more affordable. Avoiding standard health threats should not be excessively financially costly. I may need to erect a cheap mosquito net in my desert home in Sub-Saharan Africa, but I should not need to install an expensive air filtration system to protect myself against toxic pollution. To do so would be an undue cost. Financial costs incurred in the pursuit of health, then, should not threaten our financial security nor should they be excessive for individuals relative

[72] See, for example, my arguments in Chapter 1.

to affordable alternatives.[73] What constitutes an undue cost is deliberately contextual and depends upon our more general views of justice, but this provides some general guidelines about the demands of GOH.

Consider, second, the issue of costs in terms of *effort*. Health can require significant effort, and I am not denying this. Undergoing chemotherapy for cancer is extremely taxing and galling, but the requirement to exert this much physical and mental effort is not necessarily contrary to the demands of GOH. The test for *undue* effort, I shall argue, is determined *counterfactually*, by reference to whether being healthy *needs* to be this difficult when weighted alongside the relevant alternatives. If a reasonably achievable and cost-effective alternative exists which requires less effort but the present conditions are designed contrary to this, then the effort may be considered undue.[74] Sabrina needing to drive five hours to see a doctor in a rural Mozambique town when better investment and simple aid would enable one to be stationed 45 minutes away constitutes an undue cost in effort, since an alternative arrangement is available which is cost-effective and reasonably achievable. If, on the other hand, there is no reasonably achievable and cost-effective alternative to a particular high-effort pursuit for health, then the effort is not undue. My previous example of cancer treatment may be an example. Treatments for cancer are extremely taxing and require much effort, but there are no plausible alternatives at present and the costs in effort is therefore not undue.

[73] To use the air pollution case, the alternative of paying modest taxes to regulate toxic pollutants is more affordable for the individual than having no regulations and having to buy an expensive air filtration system.

[74] This means that considerations of feasibility and justice must be brought to bear in our counterfactual analysis. For example, whether a particular alternative is in keeping with the demands of integrationist justice and other priorities of justice.

Consider, third and finally, costs in terms of the *unjustified compromise of values*. This is perhaps the most vague and controversial of the conditions for GOH. Consider the case of a conservative Muslim woman who is offered treatment by a male doctor but declines it because it is contrary to her beliefs about another male touching her. If she is compelled to receive emergency treatment from a male doctor in this instance, does this count as an unjustified compromise of her values in the pursuit of health?[75] In contrast, recall the scenario of Dialysis Derek, whose dialysis treatment robs him of the limited time in which he has custody of his children. Is this an unjustified compromise of his values?

Our considered judgements are likely to be mixed. On the one hand, it seems important for an opportunity to be genuine that it does not require us to sacrifice our deeply held value commitments. On the other hand, it seems clearly the case that not all compromises of values are unjustified. In some instances, the compromise of an individual's values may be a source of disadvantage for them, but we should nonetheless dismiss their complaint. The most obvious instance of this is where their values are objectionable, such as a racist patient refusing treatment from a doctor of a minority ethnic background. There are other less clear-cut cases, however, and analysing these will help clarify our considered judgements. Consider, first, a stylised scenario of Oscar Wilde, who values aesthetic beauty and architectural elegance. Are Oscar's values unduly compromised should he be treated in a poorly painted hospital with horrific architecture? Consider, second, an avid football fan whose medical appointment

[75] While not normatively authoritative in a philosophical sense, the United Nations' General Comment No. 14 talks about the importance of 'culturally appropriate' healthcare: Committee on Economic, Social and Cultural Rights, *General Comment No. 14: The Right to the Highest Attainable Standard of Health* (United Nations 2000).

clashes with a major match for her team. Are her values unduly compromised if we do not reschedule the appointment?

Cecile Laborde has argued that reasonable accommodation is justified for certain deeply held beliefs which are central to a person's identity – so-called *identity-protecting commitments* – as long as these are sincerely held and subject to certain minimal demands of morality.[76] Laborde's conditions provide us with useful guidance to proceed, in terms of demanding the condition of *sincerity* and *acceptability*. Assuming the condition of sincerity is met, the same counterfactual test based on the existence of a reasonably achievable and cost-effective alternative may be useful for determining the condition of acceptability and what is an *unjustified* compromise of values. If there is a reasonably achievable and cost-effective alternative which would not compromise a person's values – and accommodating this alternative is not contrary to morality and would not impede the general pursuit of GOH and justice more broadly – then not making this option open to the person may be an unjustified compromise of their values. Accommodating a person's values, even if sincerely held, must not set an unacceptable administrative precedent that would affect the discharge of other demands of GOH. Accommodating Oscar Wilde and the avid football fan's penchants would be unacceptable from an administrative standpoint and set an unsustainable precedent for anyone who demands that the health service accommodate their personal demands. This would challenge the very pursuit of GOH and is contrary to the demands of global health justice.

[76] Cécile Laborde, *Liberalism's Religion* (Harvard University Press, 2017).

Even if we accept for a moment that the fundamental demands of morality and justice may not change across societies, what is considered reasonably achievable and cost-effective may vary across different contexts. Each society (howsoever delineated) may have its own norms around accommodating values that affect this calculus. It may be accepted in Society A that patients can request a doctor of a certain gender but not in Society B, making the request unreasonable in Society B but reasonably achievable and cost-effective in Society A.[77] Society C may have a supply of home dialysis machines which Derek is eligible and clinically suitable for, making his clinic appointments an unjustified compromise of his values. These contextual features are relevant to our counterfactual evaluation of whether the opportunity to pursue health is unduly costly in terms of values compromise.

***Genuine Opportunity for Health and the Real World***

As highlighted by the empirical evidence on global health I outlined in the opening chapter of this thesis, the state of global health in our world today falls far short of the ideal of GOH. Individuals continue to suffer from poor health, well below the decent standard guaranteed by the first strand of GOH (i.e. in terms of health outcomes). A lack of health security (relating to the second strand of GOH) continues to afflict countless people who must live in conditions that threaten their health status. Social conditions continue to be designed so that those who pursue health are required to bear excessive and undue costs, financially or otherwise. A world that takes seriously the ideal of GOH, then, is very different from the one we occupy today.

[77] This is common in the NHS, for example, with many General Practitioner Clinical Commissioning contracts mandating the availability of female doctors.

While GOH specifies a general ideal and condition to be achieved, outstanding questions remain about the appropriate *mechanism* needed to achieve it and which *agents* are responsible for discharging duties that will realise it. The *mechanism* question focuses on the kinds of institutional arrangements (i.e. social, political, economic) and policies needed to bring about GOH. How can we bring our world closer to GOH? What kinds of health-promoting policies should we enact? How should local and global institutions prioritise different interventions that aim to bring about GOH?

The *agent* question focuses on who, and on what grounds, should be responsible for acting to bring about the ideal of GOH. What kinds of agents (for example, nation states, global institutions, individuals, or non-government organisations) are responsible for bringing about GOH? Is GOH akin to a human right, held primarily against states? If so, what should happen if states fail to bring about GOH for their citizens? These, and other related questions, are addressed in Chapters 5 and 6. While the theory of GOH presented in this chapter has deliberately taken place at a general level of theory, the forthcoming chapters focus on realising the demands of GOH.

## Conclusion

This chapter has covered significant theoretical ground over three core sections. I have argued that the pursuit of global health justice is a legitimate pursuit and can be squared with views about the personal and private nature of health and with the core tenets of liberalism. I have shown that Gaus' arguments do not preclude a minimal health-promoting political institution and, in any case, making health-

promoting conditions the default is consistent with (and demanded by) wider liberal considerations and the demands of justice.

The principal task of the chapter, however, has been to present the framework of *Genuine Opportunity for Health* (GOH) as a theory of global health justice. GOH relies upon the pluralistic metric of *health disadvantage*, incorporating axes of health outcomes, security, and costs. I have argued that health outcomes alone are an incomplete metric of global health justice, and considerations of how secure one's health is (health security) and how much it costs, financially and non-financially, to promote one's health (health costs) are relevant to understanding health disadvantage.

The framework of GOH simultaneously incorporates an egalitarian and sufficientarian component and argues that everyone should have genuine opportunity to live in social conditions that promote a decent and secure standard of health. It is an opportunity-based conception of global health justice which focuses on *social conditions* as the broad focus of normative attention. *Genuine* qualifies opportunity in that opportunities for health should be robustly available to all and able to be pursued without undue costs, and employing the opportunity to opt out of health should be exercised in the absence of coercion, manipulation, and desperate circumstances. Important normative questions remain, however, about how to bring about the ideal of GOH in theory and practice. It is this problem the remainder of the thesis addresses.

# Chapter 5
# RESPONSIBILITY FOR GLOBAL HEALTH JUSTICE

The core question addressed in this chapter is *who is responsible for global health justice*? In answering this question, I focus on two key conceptions of responsibility, corresponding broadly to what David Miller has called outcome responsibility and remedial responsibility.[1] The outcome responsibility component focuses on the question of national responsibility for global health. That is, *under what conditions (if any) is it just for the population of one country to have greater health disadvantage than that of another?* The remedial responsibility component focuses on determining which agents are tasked with realising global health justice. It asks *who, and on what grounds, ought to act to remedy global health injustice and/or bring about global health justice?*

Section I begins by outlining the scope and rationale for the chapter, highlighting the importance of focusing on responsibilities and duties alongside discussions of rights and entitlements. Thereafter, the chapter launches into a substantive discussion of national responsibility (Section II), remedial responsibility (Section III), and the link between them (Section IV). We can broadly characterise Section II as being concerned primarily with a backward-looking conception of responsibility and Section III as being concerned primarily with a forward-looking conception of responsibility.

[1] Miller, *National Responsibility and Global Justice*.

Section II addresses the issue of national responsibility and global health. After presenting the concept of national responsibility as outlined by David Miller, I introduce Shlomi Segall's specific critique of national responsibility for global health. I argue that Segall's critique can be responded to in a way that preserves significant scope for national responsibility. More positively, I show that the framework of *Genuine Opportunity for Health* (GOH) which I developed in the previous chapter naturally strikes a balance between the pursuit of global health justice and the legitimate exercise of national responsibility.

Section III deals with the question of remedial responsibility for global health injustice. I follow Miller in adopting a pluralistic and contextual account of remedial responsibility, whereby the appropriate principle to be used for assigning remedial duties to specific agents is dependent on the scenario at hand. However, I argue that we should adopt a distinction between *emergency* and *routine* remedial duties, with the former arising naturally and demanding a high emphasis on the principle of capacity, while the latter may need to be distributed via a fair allocation mechanism.

Section IV explores the link between national responsibility and remedial responsibility, asking what difference, if any, national responsibility makes to the nature of our remedial responsibilities. Overall, the chapter aims to elucidate our responsibilities for global health justice, in both a backward- and forward-looking manner.

## Section I: Agents, Duties, and Responsibilities

Onora O'Neill famously argues that too many theories of justice focus on rights and entitlements at the expense of duties, obligations, and responsibilities.[2] Discussions of duties and responsibilities are frequently neglected when it comes to theorising about justice, leaving the normative ideal indeterminate and at risk of going unfulfilled. Allen Buchanan and Matthew DeCamp diagnose a similar problem when it comes to duties and responsibilities for promoting global health, pointing out that we frequently 'dump' duties on everyone without further specification or justification.[3] At the same time, the idea of *responsibility* in theories of justice is subject to much conceptual and normative disagreement. Theorists frequently disagree about the right conceptualisation of responsibility and what normative relevance it has for theories of justice. The ongoing debates in the luck egalitarian literature on the significance of personal responsibility for justice, for example, is testament to this.[4]

Instead of rehearsing general arguments about responsibility and justice, this chapter focuses on two concepts of responsibility that David Miller has identified as being of particular relevance when it comes to questions of global justice. This is the idea of *outcome responsibility* and *remedial responsibility*.[5] Outcome responsibility is concerned with the extent to which an agent can be credited or debited for the results of their conduct. It is backward-looking, working to link an

[2] O'Neill, "The Dark Side of Human Rights."; Onora O'Neill, *Constructions of Reason* (Cambridge University Press, 1989).
[3] Allen Buchanan and Matthew DeCamp, "Responsibility for Global Health," *Theoretical Medicine and Bioethics* 27 (2006).
[4] See, for example, Carl Knight and Zofia Stemplowska, eds., *Responsibility and Distributive Justice* (Oxford University Press, 2011).
[5] Miller, *National Responsibility and Global Justice*, 81-110.

agent's prior conduct to the current results. Outcome responsibility is not the same as moral responsibility, as we are not concerned directly with whether a person is *morally* responsible or blameworthy for their conduct (though their level of outcome responsibility may be relevant for determining this), but merely whether it is apt to credit or debit them for the results of their conduct. I am especially interested in the extent to which individuals can be held outcome responsible for the health impact of their *state's* decisions and policies. Remedial responsibility, in contrast, starts with victims and asks which agent(s) should be responsible for assisting them. It is generally forward-looking, focusing on prospective duties and relates to what Christian Barry and Gerhard Øverland have called assistance-based duties.[6]

These two conceptions of responsibility bring us to what Miller has identified as the dual condition of vulnerability and agency in the human condition. Humans are simultaneously patient and agent, "needy and vulnerable creatures who cannot survive without the help of others, but at the same time people who can make choices and take responsibility for their lives".[7] This duality of vulnerability and agency is especially acute in the case of global health. On the one hand, we see a world in which countless people are suffering from severe health disadvantage, requiring assistance and support. On the other hand, we see individuals with agency, who reside in nation states that make domestic decisions and policies that impact positively or negatively on health. I deal first with this latter question of

[6] Christian Barry and Gerhard Øverland, *Responding to Global Poverty* (Cambridge University Press, 2016).
[7] Miller, *National Responsibility and Global Justice*, 1.

national responsibility (in Section II) before turning to the former question of assistance duties (in Section III).[8]

In contrast to Chapter 4, I now take the nation state as the starting point of my discussion, both in my analysis of national responsibility and remedial responsibility. I do this not because I think nation states necessarily carry intrinsic normative value, but because in the world as it is, nation states are the most relevant entities for health and health justice. As Jacob Levy aptly puts it:

> States are such well-entrenched features of the political landscape that, if 'can' constrains 'ought' at all, we are probably not morally obligated to abolish the state form in favor of some other form of political organization .... We must morally make the best of them, making do with what we have.[9]

I follow Levy in this pragmatic approach, deliberately remaining ambivalent about whether the nation state as a unit of political or moral organisation is justified all the way down. Given that I am concerned with developing a political philosophical account of global health justice for our non-ideal real world, these foundational questions about the political and moral legitimacy of the nation state are, in a sense, irrelevant to my project. For brevity and because not much turns on this for my discussion on global health justice, I shall use the term national responsibility

[8] I am not directly interested in this chapter with the question of personal responsibility and entitlement for healthcare, in the sense traditionally discussed by luck egalitarians. I have already conceded, in Chapter 3, that personal responsibility may be relevant to whether we treat a state of affairs as a health injustice.
[9] Jacob Levy, "National and Statist Responsibility," *Critical Review of International Social and Political Philosophy* 11 (2008): 495.

to refer to ‘nation state responsibility’, even though I realise nations may not be fully co-extensive with nation states.[10]

For the sake of clarity, note that my presentation of GOH in Chapter 4 did not take the state as a starting point. I emphasised the role of political institutions and centralised actions rather than states, allowing the core theory of GOH to be applicable beyond our current states-based global order. Questions of national responsibility and remedial responsibility (to be discussed in this chapter) and questions of policies to bring about GOH (to be discussed in Chapter 6), however, loom large in our non-ideal states-based political landscape. This chapter aims to offer guidance on the demands of global health justice in the face of these challenges, and starting from the perspective of our current states-based order is the most fruitful way of succeeding in this task.

## Section II: National Responsibility and Global Health

Consider a variation of a now-familiar thought experiment involving two democratic states who decide to pursue very different domestic policies, with the result that each state’s population goes on to experience different levels of health disadvantage. *Sanitas* and *Incuratus* are both upper middle-income countries that have recently received £500 million in unrestricted funding. They both have similar population sizes and demographics, and their existing political, social and health systems are the same. Suppose *Sanitas* and *Incuratus* make spending decisions as follows:

[10] There is a broader debate in the literature about the appropriate site and agential conditions of national responsibility: Levy, "National and Statist Responsibility."; Holly Lawford-Smith, *Not In Their Name: Are Citizens Culpable for Their States' Actions?* (Oxford University Press, 2019).

*Sanitas* – The citizens of Sanitas democratically decide to spend £480 million on health-related initiatives and £20 million on a sports stadium.

*Incuratus* – The citizens of Incuratus democratically decide to spend £20 million on health-related initiatives and £480 million on a brand-new, state-of-the-art sports stadium.

Ten years later, while both populations still have good enough health, *Sanitasians* have *excellent* health compared with *Incuratusites*. Rates of diabetes and cardiovascular disease, while still relatively low in both countries, are now much higher in *Incuratus* compared to *Sanitas*. Two interrelated questions relating to national responsibility arise, which capture respectively the *domestic* and *global* justice considerations at play when analysing questions of national responsibility in global health. First, to what extent can we hold the people of *Sanitas* and *Incuratus* responsible for their state's policy decisions and its impact on their level of health disadvantage? This is the *domestic* justice component. Second, is *Sanitas* required to assist *Incuratus* in the form of resource transfers to rectify this health inequality insofar as we think that responsibility can alter our judgements about something being an injustice? This is the *global* justice component. These two components are connected in an important sense. If a state exceeds its mandate (howsoever defined) such that citizens bear no responsibility for its actions, then the fact that national responsibility is exercised by the state would not change the fact that a global health injustice remains and that some form of assistance may

be required. My forthcoming discussion of national responsibility and the examples I draw upon deal with both the domestic and global components of the question.

This simplified scenario captures two broad intuitions we have about the importance of national responsibility, on the one hand, and the pursuit of global health justice, on the other. This conflict of intuitions relates to the dilemma identified by Miller earlier, between being simultaneously agent and patient. On one side of the scenario, we have strong views about the importance of national responsibility. Imposing external views on another country and its population seems to trigger concerns of paternalism and imperialism (which I alluded to in my earlier discussion in Chapter 4). We also view nation states as having agency and responsibility for the outcomes of their decisions. It seems appropriate that they should bear the benefits and burdens of the decisions they make. For example, we may admire Japan for having excellent train networks and hold Germany responsible for the Holocaust.

On the other side of the scenario, we have competing intuitions about the importance of global health justice and the way its pursuit may require interventions that cross national borders and impede states' ability to exercise their full agency. We feel strongly that the population of *Incuratus* should not have to suffer the health consequences of their government's policy decision, and the fact that it concerns *health* may be especially troubling for many. In more complex scenarios where we are not discussing national responsibility for *inequalities* but national responsibility for *insufficiencies* – something I discuss in the later part of this section – we may

have even stronger views against the idea that citizens can be held responsible for their state's decisions about health.

In what follows, I present what I take to be two of the strongest and most relevant arguments for and against national responsibility for global health. I outline David Miller's seminal arguments in favour of national responsibility and Shlomi Segall's critique of national responsibility for global health. I then show that Segall's critique can be responded to in a way that addresses his concerns while preserving significant scope for national responsibility. I do this by showing that GOH, as a theory of global health justice, naturally sets limits to the practice and legitimacy of national responsibility.

***Miller on National Responsibility***

David Miller argues, first, that *Sanitas* is not required to transfer resources to *Incuratus*. To do so assumes a global egalitarian principle, whereby inequalities between any two countries are matters of injustice that require remedy. Miller thinks this is implausible, along similar lines explored by John Rawls, as it would mean that countries like *Sanitas* who pursue prudent policies would have to endlessly subsidise countries like *Incuratus* who pursue imprudent policies.[11] Miller refers to this as the *dynamic problem*. "Provided that we attach some value to the idea that, in a culturally diverse world, political communities should be able to determine their own futures, we have a good reason to allow significant departures from global equality."[12] Miller's *dynamic problem* does not arise directly for my framework

[11] Miller, *National Responsibility and Global Justice*; John Rawls, *The Law of Peoples* (Harvard University Press, 1999).
[12] Miller, *National Responsibility and Global Justice*, 74.

because GOH is a sufficientarian rather than an egalitarian account, but it nevertheless highlights the conflict that can arise between national responsibility and global health justice.[13]

Miller argues, second, that the citizens of *Incuratus* can generally be held outcome responsible for the results of their state's conduct based on two models. On the first model, which he calls the *like-minded group* model, citizens are collectively responsible for the state's actions because they share aims and common outlooks, such that when particular members of the state act, they do so knowing that their actions are supported by other like-minded members.[14] Each member of a mob who goes rampaging through the streets and vandalising property is responsible for the collective damage that arises, regardless of the damage each particular mobster perpetrated. On the second model, which Miller calls the *cooperative practice* model, those who benefit from a common practice which is conducted fairly are also required to bear any costs that arise.[15] Benefiting from the protection and social goods provided by a nation state, for example, means also owning and bearing responsibility for its costs and negative features. Citizens of *Incuratus* benefit from, and take pride in, having an amazing stadium.[16] The same cooperative scheme that makes this stadium possible is the same scheme that brings costs to them in terms of their health disadvantage, and Miller would argue that this is something they ought to take responsibility for.

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[13] This is also dependent on the set-up of the scenario, with *Sanitas* and *Incuratus* both being above the threshold of sufficiency.
[14] Miller, *National Responsibility and Global Justice*, 114-18.
[15] Miller, *National Responsibility and Global Justice*, 118-21.
[16] It must be *expected* or *ex-ante* benefits that matter, not actual or *ex-post* benefits. As Kasper Lippert-Rasmussen argues, Miller must conceive of benefits in *ex-ante* rather than *ex-post* terms, otherwise an agent who acts unjustly expecting to gain benefits that do not happen to materialise would be exempt from responsibility. Kasper Lippert-Rasmussen, "Responsible Nations: Miller on National Responsibility," *Ethics & Global Politics* 2 (2009).

Miller's account of national responsibility has both a synchronic and diachronic dimension. That is, not only can citizens of a nation state be held responsible for the results of their current actions but also for the results of their past actions. Citizens of *Incuratus*, 50 years after the decision to spend money on the state-of-the-art stadium instead of health initiatives, would remain responsible in some form for the impact on their level of health disadvantage.[17] Even if citizens 50 years on may not be held responsible in the same way as present-day citizens due to the diffusion of responsibility, a degree of outcome responsibility is still apt insofar as these citizens continue to benefit from the state's existence. Germans today bear some degree of collective responsibility for the Holocaust, even if in a distinct way to the responsibility of Germans in the 1930s and 1940s. We can acknowledge that diachronic responsibility is different from synchronic responsibility without abandoning the possibility of the former. The general claim is that states' exercise of national responsibility alters our judgement of justice and injustice. Just as individuals' voluntary trade-offs and actions can alter our view of a situation that would otherwise be unjust, a state of affairs that would otherwise be considered unjust can cease to be so if it can be traced to the exercise of national responsibility (for example, a state's policy decisions).[18]

Implicit within the discussion of national responsibility in the context of global health is also a concern I alluded to in the previous chapter around paternalism and perfectionism. The idea that we can impose a particular view of health on *Incuratus*

[17] Miller, *National Responsibility and Global Justice*, 135–62.
[18] I previously addressed this issue in Chapter 3, arguing that the *direct* approach to defining health injustice can admit of exceptions when a particular health insufficiency is considered an injustice, one of them being individual responsibility.

(and other states) strikes many of us as objectionable. It seems that a pluralist world must leave political communities at least some room for autonomy in determining the relative value of health and other goods. However, whether and to what extent this demand is defeasible is a matter that remains open, even among those who value national responsibility.

### *Shlomi Segall Against National Responsibility for Global Health*

Shlomi Segall has argued against Miller's idea of national responsibility, specifically in the context of global health. Segall presents both empirical and normative objections against the idea of national responsibility for global health. Empirically, Segall argues that Miller and those in favour of national responsibility are mistaken about the influence of domestic and national factors on a country's level of wealth, wellbeing, and health. Following Thomas Pogge's well-known critique of *explanatory nationalism*, Segall claims that domestic policies are not forged in a vacuum and that the global economic order determines and constrains the exercise of domestic decision-making.[19] Success stories in health, such as Kerala and Cuba, are the exception rather than the norm:

> Owing to the policies of the IMF and the World Bank it is quite difficult for developing nations to pursue extensive public spending [for health-related initiatives] … It would therefore be wrong to assume that the blame for low health prospects in developing nations rests with domestic institutions, at least not the way the current global economic order is structured.[20]

[19] Thomas Pogge, "The Bounds of Nationalism," *Canadian Journal of Philosophy Supplementary Volume* 22 (1996): 497-502; Segall, *Health, Luck, and Justice*, 158-60.
[20] Segall, *Health, Luck, and Justice*, 159-60.

Normatively, Segall argues that even in ideal democratic conditions with global institutions that do not constrain states' domestic policies, national responsibility for health would still be problematic. First, Segall argues that there is the problem of holding dissenters responsible for the health effects of policies they opposed. He argues that dissenters are especially problematic when it comes to national responsibility *for global health*, because "those bearing the greater share of the global burden of disease seldom otherwise benefit from the policies that have led to their poor health status".[21] Recall that benefiting from a cooperative scheme was one of the possible conditions listed by Miller for being held outcome responsible in the context of national responsibility. Segall gives the example of the Zambian government investing in football stadiums instead of hospitals. In this case, Segall argues that Zambians with poor health do not benefit from the stadiums, and this is a requirement for holding dissenters responsible for outcomes they otherwise did not support.

Second, Segall highlights the problem of holding *children* and future generations responsible, which he regards as the 'Achilles heel' of national responsibility.[22] It seems clear, Segall argues, that we ought to at least equalise health prospects for each generational cohort in order to ensure children do not suffer health disadvantage because of the state enacting policies over which they had no say. Segall argues that we cannot assume that children will simply adopt the same views and values as their society, any more than we can assume that people residing in certain rough neighbourhoods will go on to become criminals.[23]

[21] Segall, *Health, Luck, and Justice*, 162.
[22] Segall, *Health, Luck, and Justice*, 163.
[23] Segall, *Health, Luck, and Justice*, 163-64.

Despite his empirical and normative objections to the idea of national responsibility for global health, Segall leaves room for the view that it may not be unjust for one country to have worse health prospects than another as a result of their domestic decisions. He proposes several conditions that need to be met for citizens to be held collectively responsible, among them the fact that dissenters benefit from any imprudent health decisions, that countries do not interfere in each other's population health policies, that citizens have some influence in their country's health-affecting policies, and that each successive generation starts with an equivalent standard of health as previous generations.[24]

***Reconciling National Responsibility and Global Health Justice***

Miller and Segall's arguments capture the conflict, identified earlier, between our intuitions about national responsibility on the one hand and global health justice on the other. I shall show that we can respond to Segall's general challenge against Miller and, moreover, that we can meet Segall's conditions for national responsibility for global health. In short, we can take seriously Segall's support of global health justice and his concerns about national responsibility while leaving scope for national responsibility in Miller's sense. Beyond my critical analysis of the debate between Segall and Miller, I show more positively that the theory of GOH I developed provides us with a general framework to determine the scope of legitimate national responsibility in our current states-based order.

[24] Segall, *Health, Luck, and Justice*, 169-70.

We should acknowledge, at the outset, the causal complexity of health disadvantage and global health highlighted by Segall's empirical objection to national responsibility. States' decisions about health are not forged in a vacuum but rather take place in a globalised and interconnected world. Different states experience varying degrees of external influence, ranging from physical constraints and pressures through to outright coercion and violence. This reality, however, does not invalidate the concept of national responsibility. First, as Miller himself accepts, if external agents forcefully undermine a state's institutions, this may invalidate the attribution of national responsibility.[25] It is consistent to accept the idea of national responsibility *and* hold that there are conditions that need to be met for it to be legitimate. We may not wish to hold responsible a state subject to coercion and hostilities from external states, for example, and we may not wish to hold citizens accountable for the actions of a regime that coerces and brainwashes its citizens.

Second, even in our imperfect non-ideal world, people frequently attribute agency and responsibility to states without this coming across as inappropriate. States retain a degree of autonomy and scope, within these constraints, to make important decisions that have an impact on health. This level of autonomy is admittedly a matter of degree, but it does not undermine the general claim that national responsibility is possible. The question of national responsibility, in some cases, might be whether states have made the most of the circumstances in which they find themselves. To understand the force of this point, consider different states' responses to the recent COVID-19 pandemic. New Zealand responded 'hard and

[25] Miller, *National Responsibility and Global Justice*.

early' to the virus, by restricting travel and shutting its national borders, instituting a quarantine regimen, and mandating a strict national lockdown.[26] The UK instituted a less strict lockdown, prioritising an efficient and comprehensive vaccine rollout and procuring hundreds of millions of doses early in the pandemic.[27] Sweden took a different approach, refusing to institute a lockdown and largely permitting the virus to circulate freely through society.[28]

The pandemic was a global event that imposed unprecedented constraints on states' decision-making. It is undeniable that the pandemic spread through a globalised structure, over and above the policies of particular states. It is also undeniable that access to vaccines were subject to economic forces and pharmaceutical mechanisms outside the direct control of individual states. Despite this, New Zealand, the UK, and Sweden all made particular decisions that had an impact one way or another on the health of their populations.[29] Common discourse suggests that we think it was appropriate to use the language of national responsibility, *despite* the scientific, economic and social constraints each country faced. The UK was praised for its highly effective early vaccine rollout; New Zealand was praised for its effective lockdown measures, at least during the early stages of the pandemic; and Sweden was criticised (and also admired) for its laissez-faire approach to the virus. The fact that such language of responsibility

[26] Alexis Robert, "Lessons from New Zealand's COVID-19 Outbreak Response," *Lancet Public Health* 5 (2020).
[27] Chris Baraniuk, "Covid-19: How the UK Vaccine Rollout Delivered Success, So Far," *BMJ* 372 (2021).
[28] Gretchen Vogel, "Sweden's Gamble," *Science* 2020.
[29] I return separately to the issue of developing countries' COVID-19 responses, as their lack of access to vaccines raise issues of *insufficiency* that bring us to a discussion about injustice and the limits of national responsibility.

was appropriate highlights that questions of national responsibility can arise even in instances where states' actions are constrained by global factors.

Miller has argued that there is a danger of inconsistency in our treatment of collective responsibility in the global justice space.[30] Lots of theorists, Pogge most notable among them, are prepared to say that citizens of rich countries are collectively responsible for the harms they inflict on the global poor through their state's actions, but they are less prepared to say that members of poor nations may also be collectively responsible for the actions of their states. Let me call this the *asymmetry of national responsibility*. If we are to hold Pogge's view that the rich are responsible for the harm they inflict on the poor, Miller thinks we must also be prepared to accept that citizens of poor states may be collectively responsible for their state's decisions. We ought, then, to reject the asymmetry of national responsibility.

Another form of asymmetry in the national responsibility debate about global health is the view that we can hold other countries (and their citizens) responsible for the outcomes of certain *other* decisions – maybe those involving luxury goods such as football stadiums – but that *health* is too special to be included in this same brush of responsibility. It is possible to read Segall's arguments as being against national responsibility for (global) *health* rather than against national responsibility *simpliciter*. That is, that health is an exception when it comes to national responsibility arguments because of its unique features. For example, Segall's claims about imprudent health policies not benefiting those affected by its health

[30] David Miller, "National Responsibility and Global Justice," *Critical Review of International Social and Political Philosophy* 11 (2008): 388.

impacts, in contrast to other forms of dissent, seems to be a particular claim about health. I do not, in fact, think that this is Segall's view, but it is worth showing that such a health exceptionalist position would not be untenable. We cannot isolate the idea of health from national responsibility for other policies. Global health is much more complex than evaluating other areas for national responsibility because almost all social policies have an effect on health. It is not plausible to argue that national responsibility applies to everything except matters relating to health. This would preclude just about every policy decision, given what we know about the social determinants of health. Decisions about sports stadiums, as I highlighted in the scenario of *Sanitas* and *Incuratus*, carry opportunity costs for and have impacts on health. There is no convincing methodological or normative argument for treating questions of national responsibility for *health* separately from questions of national responsibility more generally even if we acknowledge my arguments (in Chapter 1) about the special moral significance of health.

Segall's first normative objection to national responsibility is based on his view that dissenters cannot generally be held responsible for states' imprudent *health* policies because, in general and unlike other democratic dissenters, they do not stand to benefit from the imprudent health policies they reject.[31] Segall is very brief on this point, but I take his general claim to be that dissenting people do not tend to benefit from, say, stadiums because they are too ill to make it there. Those affected by imprudent *health* decisions are thus unable to be held responsible through the exercise of national responsibility. The empirical aspects of this claim are questionable. First, it is not at all clear that those who are affected by ill health

[31] Segall, *Health, Luck, and Justice*, 162.

correspond to those who dissented from a policy that prioritised stadiums over health. It may be that those who are now ill actually voted for the policy based on *ex-ante* benefits at the time. Second, it may be true that a very small segment of the ill cannot benefit, but the majority will not have their health impacted to such a degree that they cannot see the stadium or watch matches played in it (whether physically or via television).

Third, I think Segall is wrong about his overly narrow understanding of benefit. Even if the dissenters in *Incuratus* never visit the state-of-the-art stadium and do not benefit in this direct way, they nevertheless benefit from the prestige of being part of a country that can boast such a stadium. A resident in Cornwall may dissent from the HS2 rail project and may not be able to directly benefit (in the sense that the train would not go to Cornwall), but they would still benefit from improved economic activity throughout the UK and international respect for the completion of the technological feat. Segall's claim about the lack of benefit in imprudent health cases is thus empirically and normatively untenable. I am not necessarily saying that this benefit is enough to hold them responsible in terms of national responsibility, but it is a *benefit* to them nonetheless.

Segall's second normative argument against national responsibility relates to the problem of children and intergenerational fairness, most of whom have no control over the state's national decisions. This is a much more challenging objection to address in the context of global health justice. Miller's response to this and other similar critiques is that being socialised into a particular social and cultural context is not sufficient to obviate the attribution of national responsibility. Using the

example of a reluctant Mafioso born into a high-ranking Mafia household, Miller argues that unless he were to do everything he reasonably could to leave the Mafia and object to its unjust policies, the reluctant Mafioso would still be collectively responsible for the gang's behaviour.[32] By analogous reasoning, it would seem that a child cannot escape responsibility for the state's decisions simply because those decisions took place before the child was born.

While Miller's response may mitigate against the charge of socialisation more generally, it does not successfully defuse Segall's concerns about children and intergenerational health justice. Consider an infant who, because of their state's poor antenatal policies, is born prematurely with significant health complications. Our concern with children is not just about socialisation (though that is one aspect), but also about how to assign outcome responsibility and make judgements of injustice on matters concerning the child's own health disadvantage, as in the premature infant case above.

The issue is that children, in general, are unable to actively object to state policies harmful to health. If an infant is in hospital due to the state's lack of investment in antenatal services – *ex hypothesi* something prior to its existence – and even if they *benefit* from the state's national resources in other ways, it is hard to see how they can do all they can to object in a way that would satisfy Miller's usual conditions. The rejoinder might be that the *children* cannot be held responsible for their state's actions, but that other *adults* can be. I suspect that all but the most

[32] David Miller, "Collective Responsibility and Global Poverty," *Ethical Perspectives* 19 (2012): 639.

ardent externalists about responsibility would hold this view.[33] The suffering premature infant is evidently not the appropriate subject of responsibility, but the doctrine of national responsibility would hold other adults in the infant's state responsible for its level of health disadvantage to the extent that this can be attributed to the state's policy decisions.

Even if this response is correct in terms of our *attribution* of responsibility, however, it does not solve the issue of how we ought to view the justice or injustice of the *situation*. For example, should other states transfer resources to support the premature infants even though it was the exercise of national responsibility by the adult population that landed them in this mess in the first place? Recall the general view held by supporters of national responsibility that an outcome which would otherwise be considered an injustice can cease to be so if it can be traced to the exercise of national responsibility – for example, a state making a policy trade-off between antenatal services and faster commuter trains. In this instance, the two interrelated questions of national responsibility I posed earlier come to light: first, can citizens be held responsible for their state's actions, and second, ought our judgement of global health injustice be revised in light of the fact that citizens are responsible for their state's actions? The issue of children complicates this terrain because it breaks the link between those who are responsible for acting and those who must bear the consequences (the domestic justice component of the national responsibility question) and, accordingly, it is harder for the international community to dismiss the state of affairs as anything other than a health injustice (the global justice component of the national responsibility question).

[33] By *externalist*, I mean the view that attribution of responsibility does not require an agent to have caused, controlled or contributed to a particular outcome.

Scenarios resembling the suffering premature infant strike us as unjust, but I submit that the issue is not because it concerns children *per se*. After all, on a diachronic view of national responsibility which most of us regard as intuitively plausible, present-day Americans and Germans can be asked to bear collective responsibility for the harms of slavery and the Holocaust, respectively. The issue, instead, is to do with *insufficiency*. While we might be prepared to hold citizens responsible for the actions of their states above some threshold of sufficiency in health – for example, deciding whether to invest in a bullet train system or a more innovative orthopaedic treatment – we may feel that the scope of national responsibility ought to be constrained in matters that threaten sufficiency – at least in general. This does not challenge what I have been arguing thus far about the importance and place of national responsibility, but it shows that the link between national responsibility and global health justice may not be as simple as it appears. National responsibility is a relevant consideration of justice, but it cannot constrain the demands of justice and necessarily make an injustice disappear.

The idea of national responsibility (including the view that it can cease to make an otherwise unjust situation unjust) does not constrain the demands of global health justice; it is the other way around. As Kok-Chor Tan argues, justice restricts the scope of responsibility, not the other way around. “We make sense of moral agents’ responsibilities in light of what justice permits and requires of them. That is, the requirements of justice determine the scope of responsibility, not the other way

around."[34] *If* justice demands GOH – which is the case, as I argued in the previous chapter – then this *constrains* the scope of national responsibility.

GOH delineates the scope within which nation states can *legitimately* exercise national responsibility and within which cases of health injustice are otherwise dismissed as not unjust, but because GOH is a moderately demanding *sufficientarian* rather than egalitarian theory of global justice, significant scope remains for the exercise of national responsibility. To see this, recall the scenario of *Sanitas* and *Incuratas*. The framework of GOH would not mandate transfers from *Sanitas* to *Incuratas* despite their inequalities as long as both countries are realising the demands of genuine opportunity for health. If Austria and Switzerland are both successfully promoting GOH and citizens have genuine opportunity to achieve a decent and secure standard of health, then it is open on my account for Austria to spend its €200 million on a new entertainment park (at the cost of *even better* health for its citizens) while Switzerland spends its €200 million on a programme to improve the social determinants of health further. Global health justice can obtain even while countries make their own decisions about how to prioritise health above a certain threshold – decisions that will have effects on their citizens' levels of health disadvantage and over which they may have no complaint.[35] So long as GOH is met, these disparities do not raise concerns of global health injustice and need not require transfers between states.

[34] Kok-Chor Tan, "National Responsibility, Reparations and Distributive Justice," *Critical Review of International Social and Political Philosophy* 11 (2008): 458.
[35] Subject to the conditions around having at least some say in the political process.

In contrast, consider a more complex case. A middle-income country has poor healthcare infrastructure and high levels of pollution, to which the government has turned a blind eye given that it affects primarily the poor, industrialised areas. There is poor action on the social determinants of health, with subpar housing and a lack of educational equity. Instead of acting to pursue GOH and improve levels of health disadvantage, this country decides to divert the equivalent of £3 billion towards a space programme to boost its national prestige.[36] Even if there is a majority who support the space programme, this exercise of national responsibility at the expense of health is illegitimate. GOH is a demand of justice, and I have argued that justice necessarily constrains the scope and practice of national responsibility rather than the other way around.

One way of interpreting (and justifying) my view about national responsibility and global health justice is that the question of *attributing* responsibility is a separate one from the question of evaluating the *injustice* of a particular state of affairs. Serena Olsaretti has argued that pro-responsibility theories have to decide which causal consequences of an agent's action they ought to be held outcome responsible for. There is an inevitable normative dimension to questions of outcome responsibility.[37] In a similar vein, even if we concede the metaphysical and normative case for collective national responsibility, it remains an open question first, whether a situation where citizens are collectively responsible ceases to be an injustice, and second, what (if anything) other external agents should do to rectify the situation. In cases where the conditions for GOH are met

[36] This scenario is a stylised version of India's decision to pursue a national space programme (established in 1969), despite the presence of widespread health disadvantage in the country.
[37] Serena Olsaretti, "Responsibility and the Consequences of Choice," *Proceedings of the Aristotelian Society* 109 (2009).

and states are deciding to pursue their own projects in accordance with their agency, I have argued that the balance swings in favour of judging the situation as not unjust and letting the consequences of health disadvantage lie where they fall. In cases where conditions for GOH are being violated or not being met, I have argued that the balance swings in favour of judging the situation as unjust and intervening (in some way) to rectify the health disadvantage.

To see how attributions of national responsibility might come apart from judgments about injustice, consider a country which is exceptionally reckless and knowingly pursues policies for national prestige at the expense of GOH, with a majority in support. Further suppose that this country is a serial offender. Should we really be obligated to assist them continually on the grounds that national responsibility is constrained by the demands of sufficientarian justice? A solution that retains national responsibility and global health justice is in hand. We may not be permitted to *abandon* countries that make reckless health decisions and we may regard the state of affairs as an instance of global health injustice, but those countries may have to pay back some of the short-term assistance we give, or they may have to give binding undertakings that they will desist from performing a certain action. This enables responsibility to be attributed and acknowledged without outright *abandoning* needy citizens, many of whom may not be implicated in the state's reckless policies.[38]

The general framework of national responsibility for global health I have sketched in this section reconciles our competing intuitions about national responsibility and

[38] This scenario may take us closer to the issue of remedial responsibilities rather than national responsibility, which I turn to shortly.

global health justice, but it also aligns with some other general views I have defended throughout the course of this thesis. My defence of the role of national responsibility in the context of global health can be linked with my view about integrationism and the appropriate role of health within the broader ambit of justice. I argued, in Chapter 3, that we cannot treat health as exceptional and separate from other priorities of justice at the general level. Allowing people (via states) to pursue other goods above health, once we are above a certain threshold, is one important way of respecting this ideal. My arguments, in Chapter 2 and beyond, about the normative salience of vulnerability and care for all is also upheld. GOH focuses on the most vulnerable, by ensuring that the state's duty to provide genuine opportunities for a decent and secure standard of health is open to all, and the scope of national responsibility need not encroach on this.

Global health justice and national responsibility can therefore coexist, and our competing intuitions can be reconciled. GOH is a demand of justice that ought to be guaranteed for all. It is something that states ought not to have moral discretion over whether or not to pursue. This protects children and future generations, by ensuring that each successive generation is guaranteed at least good enough and genuine prospects for a decent and secure standard of health – something Segall demands as a condition for national responsibility. Above this robust sufficientarian ideal, states may exercise their agency to pursue policies that prioritise other ideals over health. So long as citizens benefit from and have reasonable input into the state's policies, they can be held collectively responsible for such actions undertaken by the state on their behalf. Where GOH fails to be pursued by particular states, remedial action to assist citizens may be called for, independently

of our judgements about the attribution of responsibility. The nature of these remedial actions is a subject to which I now turn.

## Section III: Remedial Responsibility for Global Health

The other side of agency and national responsibility is the reality of vulnerabilities and need for remedial responsibilities, which is the focus of this section. My discussion here is divided into two key parts. First, I introduce the problem of distributing remedial responsibilities and present Miller's influential *connection theory*. While Miller is correct to defend a contextual account of remedial responsibilities whereby the allocation of remedial responsibilities is determined on a case-by-case basis, I argue that more specific guidance is available. Second, I provide a general framework for allocating remedial responsibilities for global health injustice, which I argue depends on the nature of the health scenario at hand and the kinds of remedial duties which need to be allocated. There is a conceptual and normative distinction, I argue, between allocating *emergency duties* and mere *assistance duties*.

### *The Concept of Remedial Responsibility*

*Remedial responsibility* is concerned with identifying the most appropriate agent(s) that should act, here and now, to remedy or contribute towards the remedy of an injustice.[39] It focuses on the victim(s) in need of help, working to identify the agent(s) that should be picked out to put the situation right. We continue to take states as our starting point, though this is not to negate the remedial responsibilities of other non-state individual and collective agents. As Onora O'Neill observes,

[39] David Miller, "Distributing Responsibilities," *Journal of Political Philosophy* 9 (2001); Miller, *National Responsibility and Global Justice*.

states may be the primary bearers of responsibility in our world today, but this does not negate the need for secondary duty-bearers.[40]

Despite widespread agreement about the existence of profound global health injustice across multiple axes of disadvantage, agreement about *who, and on what grounds, ought to remedy such injustice* is lacking. As Christian Barry and Gerhard Øverland aptly state, "it is one thing to recognise a terrible problem and quite another to establish who, if anyone, is responsible for doing something about it and what they might sensibly do".[41] Thomas Nagel observes that it is uncontroversial that we live in an unjust world but less clear what we ought to do about it.[42]

The all-too-common response of allocating responsibilities for global health injustice is to assign these to *everyone*. Allen Buchanan and Matthew DeCamp characterise this as 'duty dumping' – the practice of ascribing blanket duties and obligations to large groups of individuals and institutions without adequate justification.[43] As well as more general concerns about justifiability, blanket ascriptions of responsibility without a strong principled basis often results in non-compliance, with individuals thinking they can simply 'pass the buck' and rely on the actions of a great many others. The central requirements of a theory of remedial responsibility are that it must be action-guiding and principled: it must provide guidance for acting, here and now, and it must do this with adequate justification. A theory that assigns these duties wantonly to, say, cat-loving men with blonde hair

[40] Onora O'Neill, "Agents of Justice," *Metaphilosophy* 32 (2001).
[41] Barry and Øverland, *Responding to Global Poverty*, 1.
[42] Nagel, "The Problem of Global Justice," 113.
[43] Buchanan and DeCamp, "Responsibility for Global Health."

or anyone who lives in a pink house would likely fail due to a lack of action-guidingness and principledness.

Christian Barry and Gerhard Øverland helpfully distinguish between *assistance-based* and *contribution-based* principles for determining who should act to remedy an injustice.[44] Contribution-based principles allocate remedial duties in virtue of an agent having causally contributed to a particular injustice. Assistance-based principles, on the other hand, allocate remedial responsibilities merely by reference to the fact that an agent is capable of acting to remedy the situation. Utilitarians such as Peter Singer and Peter Unger, for instance, support the distribution of remedial duties solely by reference to assistance-based principles.[45] The majority of theorists of justice, however, support a hybrid approach whereby both assistance-based and contribution-based principles are relevant for determining the appropriate distribution of remedial responsibilities.[46]

David Miller has proposed perhaps the most influential account of distributing remedial responsibility, which he calls the *connection theory*.[47] Miller's connection theory – combining both assistance- and contribution-based principles – outlines six principles that can connect a victim with an agent, such that the latter can be called upon to remedy an injustice: *community* (being from the same community

[44] Barry and Øverland, *Responding to Global Poverty*.
[45] Peter Singer, *The Life You Can Save* (Picador, 2009); Peter Singer, "Famine, Affluence, and Morality," *Philosophy & Public Affairs* 1 (1972); Peter Unger, *Living High and Letting Die* (Oxford University Press, 1996).
[46] For instance, Simon Caney places significant emphasis on capacity (viz. an assistance-based principle) but his account is sensitive to contribution-based considerations too: Simon Caney, "Climate Change and the Duties of the Advantaged," *Critical Review of International Social and Political Philosophy* 13 (2010). Those interested in remedying historical injustice also acknowledge the relevance of both backward- and forward-looking approaches: Butt, *Rectifying International Injustice*.
[47] Miller, "Distributing Responsibilities."; Miller, *National Responsibility and Global Justice*.

as the victim); *capacity* (being capable of remedying the injustice); *benefitting* (having benefited from the injustice and/or victim's suffering); *causal responsibility* (being a causal factor in an injustice, even without intention or foreseeability)[48]; *outcome responsibility* (being responsible for actions that one could reasonably foresee as causing injustice); and *moral responsibility* (being blameworthy in some sense for an injustice). The stronger the connections that exist between a victim and an agent – either or both in terms of the total number and individual strengths of connections – the more likely that person can be called on to act as the remedial agent.

According to Miller, there is no way of lexically ordering the principles. No principle carries additional weight, with the relative importance of each principle depending on the particular context and injustice in question.[49] To use Miller's example, if I am from the same *community* as the family of a missing child, I may be called upon to help find the missing child. If I am babysitting the child and end up leaving her for a few minutes (thereby contributing *causally* to her disappearance), I may also be called upon to remedy the situation. Allocating remedial duties proceeds on a case-by-case basis, based on the particular connections that exist between the prospective remedial agent and the victim. This means that there is no way of developing a more specific framework of remedial responsibilities in advance of knowing a particular injustice.

[48] For a clear distinction between outcome and causal responsibility, see David Miller, "Holding Nations Responsible," *Ethics* 114 (2004): 245-46.
[49] Miller, "Distributing Responsibilities," 467. For a critique of this viewpoint, see Thom Brooks, "Rethinking Remedial Responsibilities," *Ethics & Global Politics* 4 (2011).

While I think that Miller is right about the tentative nature of these principles in determining remedial responsibility, we can provide more specific guidance by distinguishing between global health situations that are rare, unexpected and serious *and* which require urgent intervention (*emergencies*) and situations which do not have all of the aforementioned features (*routine* situations).[50] My core argument is that when it comes to distributing remedial responsibilities for emergency situations (*emergency duties*, for short), the principle of *capacity* carries the most weight out of all the principles. Emergency duties, however, are *sui generis* and limited in form, and the procedure for allocating them does not necessarily translate to allocating remedial responsibilities for non-emergency situations (*assistance duties,* for short). Allocating assistance duties is more contextual, requiring a fair procedure for its distribution and reflecting Miller's connection theory. The requirement for a fair procedure, however, implies a duty to *institutionalise* the allocation of remedial assistance duties, after which we may be justified in allocating demanding duties of global health justice.

Two preliminary comments are in order before we proceed with our substantive discussion of remedial responsibilities. First, it is generally accepted that the level of costs we have to incur in our capacity as remedial agents is relevant for delineating the limits of our duties. There are many different ways of conceptualising the level of costs we should be willing to bear, but all theorists agree that there is a level after which remedial duties are no longer required as a matter of justice, and these become merely supererogatory.[51] I follow this general

[50] I return to this distinction in more detail in the next part.
[51] Peter Singer defends a very demanding threshold of costs, while Christian Barry and Gerhard Øverland defend a more moderate account: Singer, "Famine, Affluence, and Morality."; Barry and Øverland, *Responding to Global Poverty*.

view, though I do not take a concrete view about what level of costs remedial agents must be prepared to incur since this has little bearing on my forthcoming discussion. I also accept Christian Barry and Gerhard Øverland's argument that the costs threshold before an excuse of over-demandingness can be made should be higher for outcome responsible agents.[52] Someone who is outcome responsible for toxic pollutants causing poor respiratory health in a country, for example, may be expected to bear much higher costs to remedy that crisis than would otherwise be expected of a non-outcome responsible agent.

Second, there is an important methodological and normative question about whether my account is specific to remedial responsibility for global health injustice or whether it is applicable as a more general account of remedial responsibility for global injustice. I am concerned primarily with certain features in global health that make my dynamic framework compelling as a theory of remedial responsibility in this realm. It may be that the arguments I present for responding to global health injustice are applicable more generally, but I remain deliberately ambivalent about this position and will not defend that view here.

***The Dynamic Assistance Framework***

The appropriate principle for distributing remedial responsibilities for global health injustice depends upon the nature of the injustice and, relatedly, the type of duties being distributed. I call this general approach the *dynamic assistance framework* of remedial responsibilities. The *dynamic assistance framework* distinguishes between emergency and routine instances of global health injustice, with these

[52] Christian Barry and Gerhard Øverland, "The Implications of Failing to Assist," *Social Theory and Practice* 40 (2014).

scenarios calling for different weightings in the principles to be used for allocating remedial responsibilities.

*Remedial Responsibilities for Emergency Situations*

Emergencies are health situations which are *rare*, *unexpected*, *serious*, and *require urgent remedy*. All four aforementioned conditions must obtain for a situation to properly be considered a health emergency. First, emergencies are *rare*. They are not occurrences that we ordinarily come across or hear about in our day-to-day lives. It is hard to quantify this in more specific terms, but we might say that it is the kind of situation that most people will only fall victim to once or twice in their own lifetime and which will only come to our attention (*qua* prospective remedial agents) once or twice in a decade. Second, emergencies are *unexpected*. It is not enough that a situation is rare, it must also be unexpected. A rare event that predictably happens every $n_{th}$ year is not an emergency on this account. Third, emergencies are *serious*. Not only must an injustice be rare and unexpected, but it must also be serious and involve intrusion on basic health needs and/or cause significant health suffering or have the potential to do so absent immediate intervention. Fourth, and relatedly, emergencies *require urgent remedy*. Timely intervention is required to prevent or mitigate significant health suffering and intrusion on basic health needs. Health emergencies are occurrences that shake us morally and which bring to the fore our instincts of *rescue*.

A paradigmatic case of an emergency health injustice is the global COVID-19 pandemic, especially during the 'first wave'. The language of injustice is deliberately chosen and appropriate. This is because as I argued in Chapter 3, so

long as the situation is remediable and the victims are not responsible for their own affliction, *insufficiencies* may be considered injustices even if they arise 'naturally'. The event was rare. For most of us, it was the first time we witnessed a global pandemic of such scale, duration, and impact.[53] The event was unexpected. People had, of course, been warning about the possibility of a global pandemic for some time, but the fact that it was a *novel* coronavirus with significant uncertainty about its trajectory and scale shows that it meets our criterion of being *unexpected*. COVID-19 and its scale were unexpected, even if a global pandemic of some kind was not. The event was serious, with millions of deaths worldwide and countless more suffering serious morbidity. The event required urgent action to save lives, most notably in terms of increasing ventilator supply and intensive care capacity and developing and rolling out antiviral treatments and vaccines.

Consider a scenario based on the 2010 Haiti earthquake, arguably another paradigmatic example of a health emergency:

> *Haiti* – As a result of a powerful earthquake, Haiti's health infrastructure is decimated. All the country's major hospitals have been damaged and authorities are struggling to provide even basic healthcare. 50,000 people have died so far, with another 20,000 in need of urgent medical attention that Haiti cannot currently provide.

[53] Events that come the closest are the 1968 Hong Kong flu pandemic and the 1957-58 Asian influenza pandemic.

Who should be called upon to remedy this emergency health situation?[54] Recall Miller's connection theory, which argues that we ought to consider the particular connections that exist between Haiti and potential remedial agents in our distribution of these responsibilities. Consider some notable possibilities. France has links with Haiti as a result of its history of slavery and colonialism, which have influenced Haiti's present-day infrastructure and culture. France has *benefited* from Haitian slaves, and the post-colonial relationship more generally raises question of *causal*, *outcome*, and *moral responsibility*. The US (in virtue of its disaster deployment capabilities) and the Dominican Republic (in virtue of its spare hospitals and proximity to Haiti) highlight the principle of *capacity*. Haiti has especially close social and political links with the government and people of Cuba, akin to norms of *community*. Further afield, there are lots of wealthy and capable countries in Europe, Australasia, and parts of Asia and the Middle East that could assist in the emergency operations.

Contra Miller's claim that no principle carries additional weight in advance of a particular injustice at hand, I argue that the principle of capacity is the primary principle we ought to rely upon when it comes to determining remedial responsibilities for emergency situations. Capacity, in emergency circumstances, carries additional weight compared to the other principles and our primary focus must be about identifying capable agents who can remedy the emergency at hand, often independently of other connections that may exist between the victim and prospective agent(s). This explains why the US and the Dominican Republic, as I shall show, may have the strongest reasons to be called upon to come to Haiti's

[54] Note that this question is separate from the more general one of who should come to Haiti's assistance in other areas. I focus on *health* in this section.

assistance, even though France's post-colonial connections to Haiti (in terms of benefit and causal, outcome, and moral responsibility) are arguably more profound.

It is important to first clarify what we mean by capacity and to distinguish between at least three different uses of the term.[55] The first sense of capacity is *effectiveness*. *A* is effective if they can remedy an injustice $\Psi$. Effectiveness is dynamic and context-sensitive in the sense that having capacity to remedy $\Psi$ does not necessarily mean having capacity to remedy $\Delta$. Effectiveness can be a matter of degree and comparison. *A* is more effective than *B* if they can remedy $\Psi$ to a better extent. To understand what we can mean by better extent, consider *C*, who is in need of emergency assistance. *B* can assist *C* – say, by air-dropping pallets of medical aid – but not without causing some injury. *B* will give some citizens in *C* large grazes in the process of air-dropping the aid. *A*, on the other hand, can assist *C* in the same scenario without causing anybody any injury due to their superior air-drop accuracy. *A* can therefore be seen as more effective than *B* given that they can assist *C* without any injuries in the process.[56] To take a more concrete example, China can offer its Sinopharm COVID-19 vaccine to Brazil while Germany can offer Brazil the industry-leading Pfizer/BioNTech. Germany's aid will be more effective than China's, insofar as more lives would be saved in Brazil with the use of the Pfizer vaccine, even if both vaccines are technically effective.

[55] Miller, for instance, points to the sense in which capacity contains both an effectiveness and costs component.
[56] We might say *A* is the *best-placed* agent to rescue *C*, though *B* is also *adequately placed* to rescue *C*.

The second sense of capacity is agent-relative *costs* – that is, how much effort (in terms of costs, value sacrifice, time, and so on) a remedial agent must expend to remedy an injustice.[57] If both *A* and *B* can achieve $\theta$, but the *costs* of doing so are much higher to *B* than they are to *A*, then *A* may be seen as having better capacity than *B* for $\theta$. Consider an example adapted from Miller. *A* or *B* can rescue *C* from drowning in the river. *B* is a strong swimmer, but the rescue would be costly for him to undertake because (despite being a good swimmer) he has a fear of river swimming. *A* is also a strong swimmer but, unlike *B*, does not have the same fears about river swimming. In this sense, *A* is more capable than *B* because it would be less costly for him to undertake the rescue while still achieving the same outcome $\theta$.

As Stephanie Collins argues, however, *agent-relative costs* should focus on *net* costs rather than *gross* costs.[58] Suppose it would be challenging (though nevertheless within the bounds of obligation) for *A* to remedy $\Psi$. However, *A* knows that the rescue would her bring significant positive media coverage which she would relish. There is therefore a positive, reward component to her performing the duties to remedy $\Psi$. Russia and China's aid distribution of their Sputnik V and Sinopharm vaccines, respectively, had gross benefits to them in terms of nationalistic pride, for instance. The appropriate calculation of costs *for the agent*, Collins argues, must take into account not only the agent-relative costs of the rescue but also the agent-relative *benefits* of the rescue. The net costs of the

[57] For different kinds of costs considerations, see Stephanie Collins, "When Does 'Can' Imply 'Ought'?," *International Journal of Philosophical Studies* 26 (2018).
[58] Collins, "When Does 'Can' Imply 'Ought'?."

rescue would therefore be lower for someone like *A* (who enjoys the media attention) compared to someone like *B* (who is neutral about media attention).

The third sense of capacity is *timeliness*. *A* is more capable than *B* if they can act more quickly than *B* to (sufficiently) remedy $\Psi$. Note that this characterisation leaves open (a) how *costly* their respective remedies would be, or (b) how *effective* their respective remedies would be. If we hold effectiveness and costs fixed – that is, the same outcome obtains in both scenarios and agent-relative costs are identical – then *A* would be more effective than *B* if they can remedy $\Psi$ in less time than *B*. However, in the real world of injustice, considerations of costs and effectiveness often have to be balanced with timeliness. An injustice in urgent need of remedy may demand a prompt but costly intervention, or a prompt but marginally less effective intervention instead of the maximally effective alternative. It remains open that *B,* who can act in a timely way but is marginally less effective than *A*, may be considered more capable than *A*, who is marginally more effective (i.e. would achieve a better end outcome) but would take longer to enact the rescue. My claim is not just that additional time may cause a wound to fester, for example, which would collapse the timeliness component into effectiveness. My claim is that the *duration* spent suffering seems to be a relevant feature of how badly a victim is harmed, making timeliness a distinct component of capacity.

With this finer-grained understanding of capacity, let me illustrate and then justify the view that emergency health situations call for treating the principle of capacity as the primary consideration in distributing remedial responsibilities – especially in terms of *effectiveness* and *timeliness*. Returning to the scenario of Haiti, the

Dominican Republic, in virtue of its proximity to Haiti and the availability of hospitals, should be remedially responsible for providing aid. Proximity is often (though not always) a good proxy for all three components of capacity – effectiveness, timeliness, and costliness. The US has a quick reaction force able to deploy highly trained and highly equipped military and humanitarian personnel and aid at very short notice. These include field hospitals (each with capacity for several hundred patients), as well as the hospital ships *USNS Comfort* and *USNS Mercy* (with a combined capacity of 2,000 hospital beds onboard) all with medically trained personnel.

My account treats states as the primary though not exclusive agents of remedial responsibilities for global health, for reasons I have already canvassed in my earlier discussion of national responsibility. In the world as it stands, states exercise the most influence, both negative and positive, over levels of health disadvantage. They are also most likely to possess the minimal capacities necessary to respond to global health situations. The fact that states are primary agents, however, does not negate the need for secondary, non-state remedial agents.[59] Non-governmental organisations (such as the Red Cross), multi-national corporations (such as pharmaceutical companies), and international institutions (such as the WHO) all have roles to play in our remedial responses. Non-state agents may be called upon to supplement the responsibilities of primary remedial agents and, in cases where these agents are either unable or unwilling to act, to take the place of primary remedial agents.

[59] O'Neill, "Agents of Justice."

Most global health emergencies (including the Haiti earthquake) admittedly require complex responses that cannot be discharged by a single remedial agent. This does not challenge the general view that capacity should be our primary consideration. Our standpoint merely switches to that of evaluating the capacity of various *collectives* and the mechanics of how duties ought to be apportioned within this collective in accordance with the principle of capacity.[60] A certain degree of coordination may be required, but this does not invalidate the view that we have emergency duties. To see why the need for coordinated collective duties does not invalidate the stringency of our emergency duties, consider coming across the scene of a serious single-car accident. Five of you arrive first on the scene, with no clear view of how to proceed. Alexandria, an off-duty paramedic, proceeds to give everyone instructions about what to do. She allocates one agent to direct traffic, another one to call the emergency services, another to assist her, and the other to check for other potential patients who might have been thrown from the crashed vehicle. I return to the issue of coordinating duties in more detail in my discussion of routine assistance duties, but the mere fact that coordination is required does not absolve the capable agents who happen to come on scene first from discharging emergency duties.[61]

The core reason emergency duties arise is that there are particular agents 'on scene' who are *uniquely placed* to perform the remedial duties given the serious and urgent nature of the situation. What being uniquely placed entails, however, is a dynamic idea that differs on the situation. In the car accident scenario, being first

[60] For a discussion of collectivisation duties, see Stephanie Collins, "Collectives' Duties and Collectivization Duties," *Australasian Journal of Philosophy* 91 (2013).
[61] Which agent does the coordinating may not be especially significant since they are merely performing an instrumental function to assist in the mechanics of discharging existing duties.

on scene and having the capacity to render basic first aid and call for further assistance may be enough to make one uniquely placed. In the case of the Haiti earthquake, merely being first on scene does not necessarily mean one is uniquely placed to discharge emergency duties. The Dominican Republic is uniquely placed, in virtue of its proximity and hospital capacity, to assist Haiti by receiving casualties via land into its hospitals. The US is uniquely placed, in virtue of its immense humanitarian response capability, to rapidly deploy medical equipment and personnel to assist the victims. Other states may be uniquely placed in other ways to support the emergency effort. The salience of being uniquely placed to affect a rescue (often in terms of proximity) is commonly cited by those working in the ethics of rescue.[62] Proximity may be a relevant consideration in determining whether we are uniquely placed, but this is not the only criterion.[63] The operative component of my account is *being uniquely placed*, however, so even if proximity is not a concept that translates easily from individual rescue cases to *Haiti*-type scenarios, my general conclusion stands.

In emergency situations, being uniquely placed corresponds strongly with the principle of *capacity*, given the need for urgent remedy and the high stakes at play should this not be discharged. To be uniquely placed to help in an emergency is therefore primarily about having the capacity to do something, especially in terms of effectiveness and timeliness. Several points can be marshalled in support of this position.

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[62] For example, Miller uses the idea of proximity (in terms of physical distance), which I have argued can often be a useful though imperfect proxy for capacity: David Miller, "The Nature and Limits of the Duty of Rescue," *Journal of Moral Philosophy* 17 (2020).

[63] For scenarios about how we can be uniquely placed even without physical proximity, see Frances Kamm, "Does Distance Matter Morally to the Duty to Rescue?," *Law and Philosophy* 19 (2000); Frances Kamm, *Intricate Ethics* (Oxford University Press, 2007).

First, emergency situations call for simple and predictable ways of distributing remedial responsibilities. Focusing on capacity is simple and predictable and able to be applied with ease to every global health emergency. Countries may of course try to shirk their duties by underplaying their level of capacity, but this is generally easier to verify externally than with other principles (such as benefitting). Even if there is disagreement about a country's level of capacity, a capacity-first approach is simple and predictable in contrast to a contextual, balancing approach involving multiple remedial principles. The features of simplicity and predictability are especially important in the case of (health) emergencies. Emergencies are characterised by the need for quick, effective, and decisive action. Given that emergency situations, *ex hypothesi*, are rare and unexpected, a general deference to the principle of capacity ensures that the process for determining remedial responses is simple and predictable.

Second, *health* emergencies, as distinct from other kinds of emergencies, tend to be characterised by remedial complexity, and a capacity-first approach is particularly suited to this realm. In contrast to other emergencies, not all agents have the capacity to remedy a health emergency, especially one that is large-scale. Remedying health emergencies, especially in a timely and effective way, requires particular agents with special skills. To use a crude example, while most agents can give money as short-term emergency aid, fewer agents have the capacity to mobilise a cadre of healthcare personnel skilled in advanced emergency medicine. The capacity-first account simplifies our remedial considerations by focusing on

those uniquely capable of providing much-needed health support *in a timely manner*.

Third, health emergencies (in contrast to routine situations) are *rare* conditions characterised by desperation, vulnerability, and great need. In such instances, our primary concern may turn to what Simon Caney has called *harm avoidance justice*. Instead of debating how we ought to fairly allocate remedial burdens among prospective agents (what he calls *burden sharing justice*), we ought to prioritise the alleviation of harm and suffering.[64] Because of the exceptional nature of emergencies, our focus turns to harm avoidance justice over fair burden sharing and this, in turn, calls for a focus on the principle of capacity in the distribution of remedial responsibilities.[65] A capacity-first account recognises the salience of vulnerability and great needs, in the rare and unexpected instance of emergencies, and directs our remedial priorities to identifying particularly capable agents.

Fourth, and in anticipation of objections about over-demandingness, emergency remedial duties are just that: *emergency* duties. Emergency duties arise only in cases of health emergencies, where all four conditions are met. Because of this, there are natural limits to their demandingness. Analogous to rescue duties, emergency duties are *sui generis* duties that may not be applicable to other situations of injustice. We have good reason, then, to accept my argument about the primacy of capacity in emergency situations without this risking a bottomless

[64] Simon Caney, "Two Kinds of Climate Justice: Avoiding Harm and Sharing Burdens," *Journal of Political Philosophy* 22 (2014).
[65] I make no claim about how we ought to prioritise harm avoidance justice in *non-emergency* situations.

pit of obligation, or what David Schmidtz refers to as being “islands in a sea of obligation”.[66]

*Remedial Responsibilities for Routine Situations*

Routine injustices do not have all four features present in emergency situations and identifying the relevant normative principles for allocating remedial responsibilities proceeds in a much more contextual manner, reminiscent of Miller’s connection theory. These injustices are routine in the sense of being part of our everyday landscape, distinct from emergency situations, though this is not to deny that they can be serious and morally troubling. The longstanding HIV/AIDS epidemic in Sub-Saharan Africa, stubborn rates of infant and maternal mortality across much of the developing world and the presence of living conditions not conducive to GOH are instances of routine injustices that are nevertheless profoundly troubling and important for us to address.

One important normative characteristic that distinguishes emergencies from routine situations is that the latter cannot be dealt with using norms of emergency duties without significantly intruding upon remedial agents’ other moral and personal pursuits. Responding to these situations using the capacity-first account I articulated for emergency situations would mean remedial agents have to be permanently vigilant and constantly engaged in remedying injustice. Such a state of affairs would rob remedial agents of goods of moral significance and would mean they could not pursue their own projects or plan other priorities for their citizens (*qua* states). In simple, individualised terms, it would be akin to a Singerian pond

[66] David Schmidtz, "Islands in a Sea of Obligation: Limits of the Duty to Rescue," *Law and Philosophy* 19 (2000).

rescue situation whereby the person with an office nearest the pond is called upon every few hours to rescue a drowning child, ruining multiple pairs of shoes and trousers and limiting her severely in going about her daily life. Relying upon the primacy of capacity in routine instances would therefore be unduly demanding and exceed what can be appropriately demanded of remedial agents. This does not mean, however, that we ought to abandon the systematic remedy of global health injustice and merely let particular remedial agents exercise an imperfect duty using their discretion.

Assistance duties, unlike emergency duties, are not natural duties that arise without further specification and allocation. They are held collectively and are enforceable only once they are allocated through a fair mechanism.[67] The appropriate way of fairly distributing assistance duties is along the lines of what Miller has already articulated, namely, the connection theory. We ought to evaluate the connections (or reasons) that particular agents might have that make them liable to be called upon to remedy a specific scenario. While the *connection theory* approach may be philosophically correct, however, it is difficult to put into practice given the complexities and scale of real-world health injustice. Prospective agents may disagree about whether they are the ones appropriately tasked to do so and may object on various grounds, both on principled and self-interested grounds. The solution, I argue, is to *institutionalise* assistance duties for global health injustice by creating a fair mechanism for allocating health duties, sensitive to the principles of the *connection theory*.

[67] There are multiple ways to conceptualise a fair mechanism. An institutional mechanism or informal arrangement, for example, may meet the criteria for a fair mechanism for distribution. I defend a more formal mechanism shortly.

Margaret Moore, writing in the context of climate change, has similarly argued that respecting remedial responsibilities entails the creation of institutions tasked with coordinating our duties, including through enforceable arrangements.[68] Robert Goodin argues that imperfect duties (so-called duties of charity) can be made concrete and enforceable by institutionally specifying them.[69] Presently imperfect and optional duties can be made stronger and brought into the realm of justice by taking an institutional approach. Allen Buchanan argues that coordinating institutions should (a) make duties concrete and specific, (b) fairly distribute them, and (c) have effective disincentives to promote compliance.[70]

The *institutional approach* to remedial responsibilities for global health injustice I am proposing calls for the creation of an impartial, transnational body charged with evaluating which states should have remedial responsibilities for particular situations. The demands of transnationality and impartiality can be achieved (or at least approximated) by having a rotating system of representation by various states, akin to key UN committees and international courts. For example, the body tasked with allocating remedial responsibilities for health could be a sub-committee of the World Health Assembly. Such a body would be charged with weighing the various principles relevant to distributing remedial responsibilities to particular agents and making a decision, in accordance with principles of the *connection theory* and the demands of GOH more broadly. The body would also have powers

[68] Margaret Moore, "Global Justice, Climate Change and Miller's Theory of Responsibility," *Critical Review of International Social and Political Philosophy* 11 (2008).
[69] Robert Goodin, "Duties of Charity, Duties of Justice," *Political Studies* 65 (2017).
[70] Allen Buchanan, "Perfecting Imperfect Duties: Collective Action to Create Moral Obligations," *Business Ethics Quarterly* 6 (1996): 28.

of enforcement, including through coercion and orders of compensation. As a quasi-judicial body, it would be called upon to give robust reasons for its judgements, to ensure fairness and impartiality in its responsibility allocation decisions. Such a proposal need not merely be theoretical. As James Pattison argues, we have good reason to create formal mechanisms for allocating the task of humanitarian intervention, and I see no reason why this cannot be extended to health-related remedial duties.[71]

Institutionalising remedial responsibilities acknowledges the large-scale problem of global health injustice, with the need for coordinated, collective action. Unlike emergency duties, assistance duties arise frequently in our non-ideal world, and we cannot rely merely upon agents who would be effective and timely. As I argued, this would be unduly demanding and rob agents of their agency. In addition, most global health injustices require collective remedy that needs to be coordinated for it to be effective and fair. Agents may be called upon to perform various functions as part of a collective, in proportion to their connection with the situation, and a coordinating body is needed to determine and enforce these. $Agent_1$ may be remedially responsible for $Task_1$, $Agent_2$ for $Task_2$, and so on. We also ought to distinguish between those responsible for *acting/intervening* and those responsible for *paying*. This may or may not coincide.[72] A coordinating body can make these determinations, including mandating that *ex-post* compensation be made by the

[71] James Pattison, *Humanitarian Intervention and the Responsibility To Protect: Who Should Intervene?* (Oxford University Press, 2010), 219-39.
[72] The humanitarian literature more broadly emphasises this distinction: Fredrik Hjorthen, "Who Should Pay for Humanitarian Intervention?," *European Journal of Political Theory* 19 (2020); Fredrik Hjorthen, "Who Should Intervene?," *Res Publica* 23 (2017).

outcome responsible agent if they are unwilling or unable to act at $t_1$ and a less appropriate remedial agent ends up taking their place.

The distinction between agents responsible for *acting/intervening* and those responsible for *paying* enables us to illustrate the appropriate role of secondary remedial agents, such as NGOs. Consider a case where the coordinating body allocates remedial responsibilities to aid a rural village *V* collectively to $State_1$ and $State_2$ (on grounds of benefiting and outcome and causal responsibility) and $NGO_1$ (on grounds of capacity). Given that *V* has experienced past abuse from $State_1$ and $State_2$, it may not be appropriate to task them with providing health assistance 'on the ground'. In this case, $NGO_1$ (who is viewed by *V* as more legitimate) may be identified as having secondary remedial responsibility to assist *V*, while $State_1$ and $State_2$ are remedially responsible for *paying* $NGO_1$ for the intervention. This situation is illustrative of responses to global health injustice today, and the fact that NGOs frequently take up the slack for states – who, as primary agents, have the strongest responsibility and largest influence over the state of global health – does not mean that states are let off the hook.[73]

The need to institutionalise the allocation of remedial responsibilities is a key demand of justice that is implied by the very idea of remedial responsibilities. We know something must be done, but we disagree on who should do it. Consider a simple example to illustrate this claim: Multiple neurosurgeons know that every two

[73] Theorists who defend the duty to take up the slack, for example, frequently acknowledge the need for slackers to compensate slack-takers: Zofia Stemplowska, "Doing More Than One's Fair Share," *Critical Review of International Social and Political Philosophy* 19 (2016): 604-05; Anja Karnein, "Putting Fairness in Its Place: Why There is a Duty To Take Up the Slack," *Journal of Philosophy* 111 (2014): 606-07.

days on average, a seriously injured person will be brought into the hospital needing surgery at night, when no neurosurgeon will be on duty. We know that there will be confusion about who is responsible for operating. Do we call up the most senior and experienced surgeon every time, per the principle of capacity? Do we allocate the case to the surgeons living nearest to the hospital? These questions, which are foreseeable, can be resolved *ex-ante* by having an effective institutional mechanism for fairly selecting the appropriate surgeon. For example, a rota system of being on-call, and keeping tabs on which particular expertise and level of response is needed for particular cases. The surgeons and the hospital's management team shirk their duties of remedial responsibilities and justice more generally if they fail to institute a system for coordinating such duties. The fact that a fair mechanism is required to distribute assistance duties, then, does not challenge our general obligations to aid, given that we have a *prior* duty to create such mechanisms.[74]

## Section IV: Linking Remedial Responsibility and National Responsibility

In this final section, I link the two core parts of this chapter and address how the practice of national responsibility may be relevant to determining our remedial responsibilities. As I argued in Section II, a country who is responsible for its state of health disadvantage may have to bear this burden on grounds of agency and collective responsibility. The implications of national responsibility for remedial responsibility may appear straightforward: where a country makes a decision that leaves it in a position that requires health assistance, respecting national

[74] For the idea of prospective duties, see Chiara Cordelli, "Prospective Duties and the Demands of Beneficence," *Ethics* 128 (2018).

responsibility does not call for remedial duties. There are elements of truth to this general view, but I shall that the reality is more complex.

The first possibility is that national responsibility may invalidate our remedial responsibilities altogether. This is not a plausible position. First, as I have argued, national responsibility is constrained by considerations of justice and GOH, and insofar as these sufficientarian considerations are captured by our emergency duties, this would leave at least these remedial responsibilities. Second, and relatedly, national responsibility is consistent with rescuing the needy, here and now, even in non-emergency circumstances. Holding citizens collectively responsible does not mean *abandoning* them at a time of great need, in the same way as a careless motorcyclist who does not wear a helmet can be held responsible without this implying that they ought to die by the roadside.[75] Just as the motorcyclist may be fined or asked to pay for their care, we may ask the country for compensation or at least an apology after the remedy. At the same time, we ought to be cognisant of the possibility of aid dependence and think creatively about how we structure incentives for global health justice.

Third, the existence of genuine dissenters and non-responsible citizens – those who, per Miller's criteria, do all they can to object and distance themselves from the state's policies – may complicate the terrain. It is a balancing act at the bar of *all-things-considered* justice whether holding the majority of people collectively responsible (i.e. respecting national responsibility) is more important than the imperative of aiding those who dissented and who are not responsible, *even if it*

[75] Carl Knight, "Abandoning the Abandonment Objection: Luck Egalitarian Arguments for Public Insurance," *Res Publica* 21 (2015).

*means having to assist those who are outcome responsible*. There is a parallel thought here to the welfare state as it exists in many developed countries. There are 'benefit cheats' and fraudsters, which we can approximate, but the question is whether we should nevertheless provide welfare benefits even though we know that a large proportion of it will go to people who do not need it. The answer, very often, is affirmative. We can consistently respect the idea of national responsibility (just as we can oppose benefit fraud) *and* decide that at least in some cases, aiding the collectively responsible citizens is a price worth bearing to deliver health assistance to genuine dissenters in need.

The second possibility is that national responsibility does not cancel our remedial duties altogether but can modify it in some way. David Miller has argued that being responsible for one's predicament may modify others' duty to rescue in a variety of ways.[76] We can extend this thought to the issue of national responsibility and remedial responsibilities. First, national responsibility may modify the *cost threshold* indexed to the excuse of over-demandingness. States responsible for their own health predicament may lower the cost threshold above which remedial agents do not have an obligation to assist. Second, national responsibility may reduce the *priority* of our remedial responsibilities.

I think there are two ways in which our priorities might change in the context of remedial responsibilities for global health. One variant of priority modification is that national responsibility may act as a tiebreaker between cases where we have limited resources and need to decide which state to assist. A state responsible for

[76] David Miller, "Responsibility and the Duty of Rescue," *Journal of Applied Philosophy* 39 (2022).

its own state of health disadvantage may have lower priority in getting assistance compared to a state that is not responsible, *ceteris paribus*. Another variant of priority modification is that our duty of assistance to help a responsible state may be reduced in comparison to other pursuits of justice. When deciding between helping a negligent state and pursuing a new domestic housing programme, we may find that our housing programme should be prioritised over the remedial duty, whereas the remedial duty would otherwise take priority were it not for the state being responsible for their own state of affairs.

The crux of why remedial responsibilities should be sensitive to national responsibility is this: collectively irresponsible citizens inflict harm on citizens of other countries whose governments must respond and assist them, at the expense of pursuing initiatives and policies to improve their own health. Remedial responsibilities carry opportunity costs for the agents involved, not all of which are compensable. One might object that collective irresponsibility does not necessarily affect *health*; it might simply affect whether the would-be remedial agent gets a new railway system or not. First, it is not always possible to separate different spheres in this way, given what we know about the social determinants of health and its complex relationship with all areas of public policy. Second, even if the opportunity costs of assisting are not about health directly, it nevertheless affects a country's ability to develop and determine its direction – qualities we have conceded are valuable. Being called to assist a careless biker who injures himself outside my house while I am enjoying a dinner with friends disrupts my evening. Even if it is not the most important thing for me to be doing, and even if I ought to assist him, it

nevertheless has an impact on my agency and direction of life, and I may rightly complain.

The *dynamic assistance framework* acknowledges the realities and complexities of remedial responsibilities for global health injustice while recognising what Simon Caney refers to as the imperative of harm avoidance. The principle of capacity carries the most weight when it comes to distributing emergency duties because capacity corresponds strongly to what it means to be *uniquely placed* to remedy a health emergency. Being uniquely placed to remedy an emergency is generally taken to be sufficient to trigger *sui generis* rescue duties (subject to the reasonable costs rider), and emergency duties for global health injustice can be seen as being in this same category. Unlike emergency duties which are necessarily limited in form, assistance duties for routine injustices arise regularly. Distributing assistance duties for health proceeds through a more contextual evaluation of prospective agents and their connection with the situation (per Miller's *connection theory*), though the obligation to institutionalise the duty by establishing a coordinating body means these duties can become directed and enforceable.

The account presented in this section focuses on remedial responsibilities for global *health* injustice, and these will undoubtedly be part of a wider package of remedial responsibilities. How *health* duties ought to feature within the broader set of remedial responsibilities is beyond the scope of this chapter and can only be evaluated by a more general theory of global justice once we understand our other non-health-related remedial responsibilities. We can be confident that remedial

responsibilities for health will be a salient component, but the precise demands cannot be known in advance.

## Conclusion

This chapter has focused on responsibilities for global health, outlining several important considerations relating to national responsibility, remedial responsibility, and the link between the two. Section I outlined the centrality of discussion of duties and responsibilities alongside rights when it comes to understanding the demands of global health justice. Section II addressed the issue of national responsibility for global health. I argued that the framework of GOH constrains the exercise of national responsibility, though in a way that still leaves significant scope for countries to determine their own policy priorities. Section III addressed the problem of remedial responsibility for global health injustice. I proposed the *dynamic assistance framework*, where our remedial responsibilities are dynamic and the salience of principles for determining remedial responsibilities depend upon whether we are dealing with emergencies or non-emergencies. Section IV explored the link between national responsibility and remedial responsibilities, evaluating whether the former affects the duties implied by the latter.

# Chapter 6
# REALISING GLOBAL HEALTH JUSTICE: FROM THEORY TO POLICY AND PRACTICE

The world is a long way from achieving global health justice. There is no need to recite the statistics presented at the start of the thesis to acknowledge this fact. For many people around the world, health outcomes fall far short of the threshold demanded by justice. Countless more people lack health security, experiencing precarious health needs without the mechanisms to respond. Pursuing health is often prohibitively costly (both in financial and non-financial terms) for billions across the world. This chapter is concerned with realising global health justice, specifically the ideal of *Genuine Opportunity for Health* (GOH) I developed in Chapter 4. My focus is on illustrating some normative principles that can be used as a basis for more detailed policies, and which are explicitly informed by the arguments and theories developed in the preceding chapters.

I frame my normative analysis in this chapter by reference to three key obstacles that impede the achievement of GOH, namely, issues around healthcare supplies and medicines, the availability of healthcare professionals, and the social conditions that determine health. First, there are serious deficiencies in access to healthcare supplies and infrastructure for poor and developing countries, especially in terms of essential medicines and medical technology. Second, there is the problem of medical brain drain (whereby doctors, nurses and other health professionals emigrate in droves from poor countries to rich countries), thereby leaving poor countries' health systems in precarious states and impacting negatively upon the health of remaining citizens. Third, the general social

conditions in which people live are often not conducive to good health. Effective action on the social determinants of health, locally and globally, is frequently lacking. The problem of healthcare supplies and medical brain drain concern challenges relating to healthcare (targeting the so-called *downstream* determinants of health), while the lack of action on the social determinants of health concerns the broader social conditions that give people the opportunity for health (targeting the so-called *upstream* determinants of health).[1] These three obstacles illustrate the scope of GOH (concerning both downstream and upstream interventions) and the importance of normative considerations across a range of policy solutions.

This chapter unfolds as follows.[2] Section I addresses the issue of healthcare supplies, focusing on the issue of access to essential medicines and medical technology. I present Thomas Pogge and Aidan Hollis' widely discussed proposal on improving access to essential medicines. Section II analyses the problem of medical brain drain. I argue that in certain contexts, healthcare professionals have an enforceable time-limited *duty to stay*, grounded in the requirements of remedial responsibility I developed in Chapter 5. I also defend a partial *recruitment ban* (forbidding developed countries from recruiting healthcare professionals serving their compulsory service period) grounded in a negative duty not to harm, and a *compensation payment scheme* (whereby rich countries who recruit healthcare professionals from poor countries owe compensation to these countries' health systems) grounded in considerations of reciprocity and fairness.

[1] For a definition of the downstream-upstream terminology in population health, see "Glossary of Essential Health Equity Terms: Upstream/Downstream," 2023, https://nccdh.ca/glossary/entry/upstream-downstream.
[2] I spend the most time on Section II, primarily because the justice questions in this area are more complex.

Section III deals with the general social conditions that influence our health, including public health interventions and the broader social determinants of health at the local and global level. I defend a *global health tax* scheme, comprising a negative strand aimed at deterring the consumption of health-damaging goods and a positive strand aimed at raising revenue for the promotion of social conditions conducive to health. I show how this proposal is grounded by the requirements of GOH and the normative demands of remedial responsibility more generally. With the understanding that my outlined proposals are not intended as a full solution for the realisation of global health justice but merely as examples of the types of policies that will be needed, Section IV analyses how we should balance global health justice priorities, specifically, between devoting energy to securing universal healthcare and broader actions to promote healthy conditions for all. I show that the insights from my account of the *expressive function of healthcare* (developed in Chapter 2) can assist policymakers to balance this conflict, alongside appreciating the non-ideal reality of global health.

## Section I: Healthcare Supplies and Essential Medicines

There is significant inequity in the distribution of, and access to, healthcare supplies globally, especially when it comes to essential medicines and medical technology.[3] This impedes the delivery of healthcare, which is a core component of achieving GOH. Millions of people around the world lack access to essential medicines and medical technology, either because these medicines and technologies are too

[3] de Campos, *The Global Health Crisis: Ethical Responsibilities*; Aidan Hollis and Thomas Pogge, *The Health Impact Fund: Making New Medicines Accessible for All* (Incentives for Global Health, 2008); Hassoun, *Global Health Impact: Extending Access to Essential Medicines*.

expensive for poor governments and poor people to afford *or* because medicines and technologies that treat conditions primarily affecting the poor do not exist. Patented medicine is often extremely expensive. Until its patent expired recently, Truvada, a patented antiretroviral medication for HIV pre-exposure prophylaxis, was sold by Gilead for around US$20,000 per patient per year.[4] Other patented antiretroviral medication for HIV treatment average around US$10,000 per patient per year.[5] A six-month course of bedaquiline, a lifesaving drug to treat tuberculosis, is sold by Johnson & Johnson for US$30,000 per patient in high-income countries, $3,000 per patient in middle-income countries, and between $900 and US$1,200 per patient in low-income countries.[6] These prices virtually exclude all but the wealthiest individuals around the world and are often prohibitive for governments in poor countries.

In addition to the prohibitive costs of essential medicines, there are also significant inequities in the kinds of conditions that treatments are developed for in the first place. Pharmaceutical companies focus almost exclusively on developing medicines and technology for conditions that affect those in rich, developed countries where profit can be made from sales, especially while the drug is under patent.[7] Less attention is paid to the so-called neglected tropical diseases and other diseases primarily affecting populations whose governments are unable to

[4] Owen Dyer, "Gilead to Give Up Truvada Exclusivity and Donate Drug to Some in US," *BMJ* 365 (2019).
[5] Marleen Boelaert et al., "Do Patents Prevent Access to Drugs for HIV in Developing Countries?," *Journal of the American Medical Association* 287 (2002).
[6] WHO, *The Selection and Use of Essential Medicines: Report of the WHO Expert Committee, 2015*, World Health Organization (2015), 29; Medicins Sans Frontieres, *MSF Demands Johnson & Johnson Reduce Price of Lifesaving TB Drug* (2019), https://www.msf.org/johnson-johnson-must-halve-price-lifesaving-tb-drug-bedaquiline.
[7] Hassoun, *Global Health Impact: Extending Access to Essential Medicines*; Pogge, "Human Rights and Global Health: A Research Program."

afford the high prices demanded by pharmaceutical and medical technology companies. There are some promising developments with the increase in public-private partnerships promoting access to essential medicines for developing countries (such as the Gates Foundation and GAVI, the Vaccine Alliance) but, as Nicole Hassoun argues in recent work, the problem of pharmaceutical companies lacking incentives to address diseases that primarily affect poor countries remains.[8]

Thomas Pogge and Aidan Hollis have proposed a reform to the medicines patent system to encourage attention to neglected diseases primarily affecting the developing world, for which there is little financial incentive for pharmaceutical companies to develop treatments. Pogge and Hollis argue that we ought to institute a second voluntary incentives system to run alongside the existing patent system, which they call the Health Impact Fund.[9] The Health Impact Fund would exist as a prize pool set up through contributions from states, and from which pharmaceutical companies can receive rewards based on their impact on global health as measured by the number of Quality-Adjusted Life Years (QALYs) saved.[10] The Health Impact Fund would leave the existing incentive structure of the patents system in place while adding an additional voluntary incentive for pharmaceutical

[8] Hassoun, *Global Health Impact: Extending Access to Essential Medicines*. For examples of work by the Gates Foundation and Gavi on improving access to essential medicines, see "Our Alliance," GAVI, 2023, https://www.gavi.org/our-alliance; Bill and Melinda Gates Foundation, "Bill & Melinda Gates Foundation Commits up to $120 Million to Accelerate Access to COVID-19 Drug for Lower-Income Countries," news release, 2021, https://www.gatesfoundation.org/ideas/media-center/press-releases/2021/10/gates-foundation-commits-120-million-for-molnupiravir-covid-19-drug-accessBill & Melinda Gates Foundation Commits up to $120 Million to Accelerate Access to COVID-19 Drug for Lower-Income Countries.

[9] Pogge, "The Health Impact Fund: Enhancing Justice and Efficiency in Global Health."; Pogge, "Human Rights and Global Health: A Research Program."; Hollis and Pogge, *The Health Impact Fund: Making New Medicines Accessible for All*.

[10] The metric of QALYs could be revised or interpreted more broadly to address objections raised by disabled people against its propensity to discriminate without this affecting the spirit of the Health Impact Fund: Lucio Esposito and Nicole Hassoun, "Measuring Health Burden Without Discriminating Against the Disabled," *Journal of Public Health* 39 (2017).

companies to receive prize payments for developing medicines that can alleviate significant suffering in the developing world.

Significant attention has been devoted to the issue of improving access to essential medicines, as highlighted by the work of Pogge and Hollis and other theorists such as Nicole Hassoun and Thana Cristina de Campos. One simple observation to note is that Pogge and Hollis' Health Impact Fund can be extended more generally to medical technologies without affecting their fundamental proposal. Affordable and accessible technologies to assist in the delivery of healthcare in resource-poor, rural settings, for example, are especially lacking in the current market of healthcare supplies. These include technology for cold-chain storage of vaccines and medicines, affordable portable imaging devices (such as x-ray machines) that do not rely on electrical power, scalable technology for HIV viral load testing in resource-poor settings, and digital health solutions for hard-to-reach areas. There is no reason why the Health Impact Fund cannot award such medical technologies based on their impact on QALYs, given that such technologies are able to be patented in the same way as medicines. Together with existing schemes that aim to assist developing countries in accessing essential medicines (such as GAVI), reforming the incentives structure through Pogge and Hollis' Health Impact Fund would make progress towards improving one of the barriers impeding the achievement of GOH.

## Section II: Medical Brain Drain

One of the most striking facts about realising global health justice is the inequity in the distribution of the health workforce across the world. A 2007 study highlighted

that Sub-Saharan Africa accounted for over 24% of the global burden of disease yet only 3% of the world's health workforce and less than 1% of the world's health resources.[11] The distribution of the global health workforce continues to pose a challenge, with a recent study showing that health workforce density is 6.5 times greater in high-income countries compared with low-income countries – a pattern that is expected to continue through to 2030.[12] The supply of healthcare professionals in many poor countries falls far below any reasonable threshold of adequacy.

Consider the case of Liberia and Sierre Leone, two countries with some of the highest levels of health disadvantage globally. There were only 51 doctors for the whole of Liberia's population of 4.5 million in 2017, while Sierra Leone had 136 doctors for its population of 6 million.[13] New Zealand, a developed country with a similar population of around 5 million, has 18,308 practising doctors as of 2021.[14] Finland and Norway, both of whom have among the highest per capita numbers of doctors in the world, record 30,272 and 31,848 doctors, respectively, for their populations of around 5.5 million.[15] The distribution of nursing personnel reflects a similar pattern, with an average of 9.1 nurses per 10,000 population in low-income

[11] Stella Anyangwe and Chipayeni Mtonga, "Inequities in the Global Health Workforce: The Greatest Impediment to Health in Sub-Saharan Africa," *International Journal of Environmental Research and Public Health* 4 (2007).
[12] Mathieu Boniol et al., "The Global Health Workforce Stock and Distribution in 2020 and 2030: A Threat to Equity and 'Universal' Health Coverage?," *BMJ Global Health* 7 (2022).
[13] Kingsley Ighobor, *Diagnosing Africa's Medical Brain Drain*, Africa Renewal (United Nations, 2017), https://www.un.org/africarenewal/magazine/december-2016-march-2017/diagnosing-africa's-medical-brain-drain
[14] Medical Council of New Zealand, *The New Zealand Medical Workforce in 2021* (2022), https://www.mcnz.org.nz/assets/Publications/Workforce-Survey/d9d2757aad/Workforce-Survey-Report-2021.pdf.
[15] Finnish Medical Association, *Physicians: 2019* (2020), https://www.laakariliitto.fi/site/assets/files/5256/sll_taskutilasto_en_220620.pdf; "General Statistics on Doctors in Norway," 2019, https://www.legeforeningen.no/om-oss/legestatistikk/english/.

countries and 107.7 nurses per 10,000 population in high-income countries.[16] These patterns are most acute when it comes to doctors and nurses but is also reflected in shortages of other healthcare professionals such as midwives, physiotherapists, and pharmacists.[17]

The primary issue is not the inequalities in the number of doctors between poor and rich countries *per se*, but the fact that the supply of healthcare professionals in many poor countries falls below any reasonable threshold of adequacy. The WHO believes that a health workforce density of less than 23 healthcare professionals per 1,000 people and less than 1 doctor per 10,000 people is not compatible with a functioning health system – a figure countless countries fall below.[18] The primary focus of global health justice, per my sufficientarian account, is to meet these minimal standards rather than (for example) ensuring that Liberia has the same number of doctors as New Zealand. Nevertheless, I highlight these health workforce inequalities between countries because they illustrate my ensuing discussion about the issue of emigration and healthcare professionals moving from poorer to richer countries.

While the primary cause of these health workforce deficiencies is the lack of funding to support healthcare professionals and health systems, a major driver of these low levels of healthcare professionals in low-income countries is medical

[16] Andrew Brown, Maura Soucy Brown, and Nina Pruyn, *Scope for a Future of Health Workforce Initiative*, Africa-Europe Foundation (2022), 24, https://back.africaeuropefoundation.org/uploads/AEF_MSH_future_health_workforces_ad89c58ad1.pdf.
[17] Christoph Aluttis, Tewabech Bishaw, and Martina Frank, "The Workforce for Health in a Globalized Context: Global Shortages and International Migration," *Global Health Action* 7 (2014).
[18] Alexandra Peters, Rafael Palomo, and Didier Pittet, "The Great Nursing Brain Drain and Its Effects On Patient Safety," *Antimicrobial Resistance & Infection Control* 9 (2020).

brain drain. Doctors and nurses emigrate in droves from poor countries to rich, developed countries for better pay and working conditions, and in response to targeted recruitment drives. Figures from 2000 showed that one in five African-born doctors and one in ten African-born nurses were working overseas in a developed country.[19] In 2003, Zimbabwe produced 40 pharmacists, but over 60 left the country, meaning it was unable to sustain its own health workforce.[20] A 2004 WHO report found that half (49.3%) of all Cameroonian healthcare professionals intended to migrate, mainly to the UK, United States, France, and Canada.[21] The problem is not limited to poor countries, with middle-income countries such as Egypt facing similar challenges with medical brain drain. A recent study reported that 89.4% of medical students and young doctors there want to emigrate.[22]

So severe are these health workforce deficiencies that they have been labelled by many theorists as being among the most pressing global health challenges of our time. There are both push and pull factors that explain these patterns. Push factors include poor working conditions, low pay, the risk of contracting HIV/AIDS from patients in high-prevalence countries, poor standards of living in the country more broadly, and professional dissatisfaction at resource constraints impeding the ability to practise to their full technical potential.[23] Pull factors include better pay

[19] Michael Clemens and Gunilla Pettersson, "New Data on African Health Professionals Abroad," *Human Resources for Health* 6 (2008).
[20] David Katerere and Lloyd Matowe, "Effect of Pharmacist Emigration on Pharmaceutical Services in Southern Africa," *American Journal of Health-System Pharmacy* 60 (2003).
[21] Magda Awases et al., *Migration of Health Professionals in Six Countries: A Synthesis Report*, WHO (2004).
[22] Ibrahim Kabbash et al., "The Brain Drain: Why Medical Students and Young Physicians Want to Leave Egypt," *Eastern Mediterranean Health Journal* 27 (2021).
[23] Tikki Pang, Mary Ann Lansang, and Andy Haines, "Brain Drain And Health Professionals: A Global Problem Needs Global Solutions," *BMJ* 324 (2002). A recent story from Afghanistan's struggling health system highlights the conditions that clinicians often have to work in: Yogita Limaye, "Afghanistan: 'Nothing We Can Do But Watch Babies Die'," *BBC* 2023, https://www.bbc.co.uk/news/world-asia-65449259.

and working conditions in developed countries, and higher standards of living. Developed countries actively promote the recruitment of healthcare professionals from developing countries, either through direct means (such as agencies and recruitment drives that target doctors and nurses in developing countries) or through indirect means (such as prioritising visas for medically trained immigrants). Because of this, moralised language is frequently used to explain these practices, with rich countries accused of 'poaching', 'plundering' and 'stealing' health workers from developing countries.[24]

In financial terms, medical brain drain is damaging to the source country's economy. According to a 2006 study, the cost of educating a doctor in Kenya was US$65,997 and US$43,180 for a nurse.[25] The investment loss incurred from each doctor and nurse emigrating was estimated at US$517,931 and US$338,868, respectively.[26] In 2011, the subsidised portion of a doctor's medical education was US$21,000 in Uganda and US$58,700 in South Africa.[27] A human capital analysis from the same study showed that medical brain drain costs source countries significantly in terms of the lost investment: South Africa lost the equivalent of US$1.41 billion as a result of doctors emigrating while Nigeria lost out on US$674.26 million.[28] In contrast, net receiver countries such as the United Kingdom and United States benefited from the emigration of these healthcare

[24] Joses Muthuri Kirigia et al., "The Cost of Health Professionals' Brain Drain in Kenya," *BMC Health Servies Research* 6 (2006); "Ban the Poaching of Health Care Workers from Low-Income Countries," 2022, https://www.cugh.org/blog/ban-the-poaching-of-health-care-workers-from-low-income-countries/.
[25] Kirigia et al., "The Cost of Health Professionals' Brain Drain in Kenya."
[26] Kirigia et al., "The Cost of Health Professionals' Brain Drain in Kenya."
[27] Edward Mills et al., "The Financial Cost of Doctors Emigrating from Sub-Saharan Africa: Human Capital Analysis," *BMJ* 343 (2011).
[28] Mills et al., "The Financial Cost of Doctors Emigrating from Sub-Saharan Africa: Human Capital Analysis."

professionals to the tune of US$2.7 billion (for the UK) and US$846 million (for the US) based on the 2011 analysis.[29] This is partly because the costs of educating a doctor or a nurse is much higher in developed countries than it is in developing countries. The cost of training a doctor in England, for example, is £230,000, highlighting the immense savings the UK makes when it sources overseas-educated doctors.[30]

In non-financial terms, more importantly, medical brain drain is damaging to the health systems of source countries, directly contributing to poor health outcomes and greater levels of health disadvantage. When Zimbabwe trains 40 pharmacists a year and loses 60, as mentioned, this leaves the health system unable to function. When there is a chronic haemorrhage of doctors and nurses from developing countries, the ability of already fragile health systems to provide adequate care to populations is challenged. This fuels a vicious cycle. Health workforce shortages create additional challenges for remaining healthcare professionals, worsening their already poor working conditions. These factors create strong push factors for remaining healthcare professionals to emigrate.[31]

### *Responding to Medical Brain Drain*

The reality outlined above raises the question of who should act to remedy the problem of brain drain and what policies ought to be instituted, especially given the

[29] Mills et al., "The Financial Cost of Doctors Emigrating from Sub-Saharan Africa: Human Capital Analysis."
[30] "More Undergraduate Medical Education Places," Department of Health and Social Care,, 2017, https://www.gov.uk/government/news/more-undergraduate-medical-education-places.
[31] While this is beyond the scope of the health system, healthcare professionals (especially doctors) are also often community leaders, and the loss of community leadership may be another relevant impact of medical brain drain.

presence of both push and pull factors. This section defends a two-pronged normative approach for dealing with medical brain drain that simultaneously targets the role played by emigrating healthcare professionals and the often-exploitative nature of health sector recruitment undertaken by rich countries. I argue that healthcare professionals may justifiably be allocated remedial duties based on their being uniquely placed to render health assistance (per the *dynamic assistance framework* I developed in Chapter 5), and the form these remedial duties take can plausibly be a time-limited duty to stay. I argue that a concurrent scheme of compensatory payments should be instituted, whereby employers from rich countries who recruit healthcare professionals from under-served health systems and benefit from their skills must pay compensation to the source country. Rich countries should also be prohibited from recruiting healthcare professionals who are still serving their compulsory service periods.[32] These obligations are grounded in a negative duty not to harm as well as the demands of fairness and the beneficiary-pays principle.

*Healthcare Professionals' Remedial Responsibilities: The Duty to Stay*

A policy proposal that source countries struggling with medical brain drain should enact is a compulsory service period which healthcare professionals trained in the country must fulfil before emigration. This policy is justified in limited circumstances where source countries are unable to meet the core demands of GOH as a result of health workforce deficiencies due to brain drain, as I expand on shortly.[33] I do

[32] The question of how this ought to be enforced is primarily a matter for policymakers, but it could plausibly take the form of a binding treaty, domestic law, or an organisational code of conduct (such as one enacted by NHS England).

[33] I do not explicitly address the issue of whether compulsory service periods are justified in circumstances beyond this, such as enacting compulsory service periods to be served in *rural* settings within developed countries. For an analysis of this issue, see Nir Eyal and Till

not commit to an exact period of compulsory service that might be justified as this will need to be contextually determined, but the period could plausibly range from one year to five years of service after completion of training.[34] Relevant contextual features include the degree of need and level of brain drain and the costs of staying (i.e. how poor the pay and working conditions are). I accept that there can be an apparent paradox in this case, as countries that have the most need are often those that have the poorest pay and working conditions, though these are considerations that will have to be fleshed out at the policy design and implementation stage. My aim is not to defend a detailed proposal so much as to present normative principles and considerations that can guide the development of policies by relevant policymakers.

The compulsory service policy should come with certain conditions and safeguards. The compulsory service period should pay a salary that allows healthcare professionals to live at least a minimally decent life, and the society should respect civil and political rights as a condition of legitimacy that allows it to enforce a remedial duty to stay. The compulsory service period can legitimately be broken unilaterally by the health professional should their civil and political rights not be respected in the country, to enable them to seek asylum elsewhere. A gay doctor in Uganda, for example, may legitimately violate his duty to stay due to the country's anti-homosexuality legislation (especially given the availability of the death penalty for same-sex activity).

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Bärnighausen, "Precommitting to Serve the Underserved," *American Journal of Bioethics* 12 (2012).

[34] Some, such as Eyal and Bärnighausen, propose 15-25 years of compulsory service, though this strikes me as excessive and illiberal.

There should also be a buy-out clause, with the penalty amount indexed to the amount of compulsory service time remaining, partly to allay concerns about domination. This rate should be sufficiently high to strongly disincentivise emigration prior to completing the compulsory service period and to compensate for some of the costs of medical education, but not so high that individuals cannot access it at all.[35] The existence of buy-out clauses may admittedly advantage those who are wealthy, but this is a moral cost that must be balanced against the importance of having safeguards to protect against domination.

Government approved exemptions from compulsory service should also be available, including on compassionate grounds (for example, if the health professional wants to relocate overseas to be with a relative dying of a terminal condition). Enforcing a compulsory service period need not mean enforcing restrictions on temporary absences from the country – for example, for the purpose of the health professional undertaking international travel and tourism. While it is possible that some healthcare professionals may abscond and attempt to shirk their compulsory service periods in this way, the alternative of a total emigration ban would be disproportionate.

A compulsory service period can be defended on grounds of reciprocity and remedial responsibility, though I shall argue that only the latter can provide the robust grounding we are after. Reciprocity-based justifications for compulsory service periods hold that as a result of public investment in their expensive education, healthcare professionals ought to reciprocate by completing at least a

[35] Eyal and Bärnighausen explore some normative considerations that can go into setting this buy-out rate: Eyal and Bärnighausen, "Precommitting to Serve the Underserved."

certain period of service in the country. Gillian Brock argues that because of the tertiary education healthcare professionals have received at the expense of taxpayers, they are required to assist their compatriots.[36] Luara Ferracioli and Pablo De Lora advance a novel reciprocity-based argument, arguing that because medical students inflict a significant risk of harm on the public during their clinical training, they are required to compensate them for this risk by fulfilling a certain period of service after graduating.[37]

Reciprocity-based arguments may be sufficient to convince many, but they depend primarily on the costs that the society has incurred in training the healthcare professional. This means that the reciprocity-based obligations may be lower for a doctor who has privately funded her medical education, which may raise issues of fairness. The reciprocity-based argument more generally strikes me as missing the core reason why a duty to stay is appropriate, namely, that healthcare professionals should not be able to turn their backs on the health needs of those around them when they are uniquely placed to assist, irrespective of the financial support they have received for their education. Thus, even if reciprocity-based considerations have justificatory force in defending healthcare professionals' time-limited duty to stay, I shall show that a stronger way of grounding a duty to stay is by applying the *dynamic assistance framework* of remedial responsibility I developed in Chapter 5 to the problem of medical brain drain.

[36] Brock and Blake, *Debating Brain Drain: May Governments Restrict Emigration?*
[37] Luara Ferracioli and Pablo de Lora, "Primum Nocere: Medical Brain Drain and the Duty to Stay," *Journal of Medicine and Philosophy* 40 (2015). While I am not personally convinced by Ferracioli and de Lora's arguments, it is an example of the kinds of reciprocity-based considerations that could ground a duty to stay.

In developing the *dynamic assistance framework*, I argued that being *uniquely placed* through having capacity is a relevant factor in being called upon to act as a remedial agent, subject to the constraints of reasonable demandingness. Indeed, it can be a decisive factor in rescue cases, such as in the context of health emergencies. In the context of under-served health systems, healthcare professionals have a unique role in being able to meet their compatriots' basic needs.[38] Because of this, healthcare professionals have a remedial duty to stay by means of completing a compulsory service period after their training. In the language of remedial responsibility, explored in the previous chapter, healthcare professionals may be called upon to assist their compatriots on the basis of the principle of *capacity.*

The language of being *uniquely placed* helps defuse a potential challenge that theorists of political obligation (writing in another context) have called the *particularity problem*.[39] That is, if one has assistance-based remedial duties (which are general) rather than reciprocity-based duties (which are targeted), why should the healthcare professional stay and help in a particular country, rather than going somewhere else where she is also needed? Rejecting the reciprocity-based argument as the primary basis for healthcare professionals' remedial responsibilities to stay need not leave one exposed to the particularity problem. This is because the *dynamic assistance framework* I defended focuses on agents being uniquely placed, and we have good reason to believe that healthcare

[38] For a similar observation, see Brock and Blake, *Debating Brain Drain: May Governments Restrict Emigration?*
[39] A. John Simmons introduces the *particularity requirement* in A. John Simmons, *Moral Principles and Political Obligations* (Princeton University Press, 1979), 31-35.

professionals will be uniquely placed in the country where they completed their medical training compared to somewhere else.

The country where one completed one's medical training is likely to be where one can be most effective, since one would be familiar with the health system and the broader social, political, economic, and cultural structures relevant to healthcare.[40] Even if healthcare professionals are unable to deploy the full scope of their technical medical skills (compared to moving to a developed country where they will be able to do so), it would likely remain the case that they would still be most effective in this context. This is because the most impactful forms of healthcare (especially in developing countries) are those relating to primary healthcare – vaccinations, midwifery, basic healthcare interventions, and treatments for common diseases – rather than more advanced secondary and tertiary healthcare.[41]

Justifying a compulsory service period by means of a remedial duty to stay flows directly from the account I developed. Discharging remedial responsibilities often already involves a 'duty to stay' component. To see this, consider the case of Alexandria the clinician from Chapter 5 who comes across the car accident. Despite being on her way to a social engagement, the context now requires her to *stay* and assist, given her being uniquely placed to respond to the plight of the

[40] In cases of significantly unequal need between poor countries, however, none of my foregoing statements preclude the possibility of healthcare professionals working in even poorer countries as a means of discharging their assistance duties. Rescue duties may arise, for example, whereby even poor countries with under-served health systems are required to assist other countries in a short-term health emergency, as I alluded to in my discussion in Chapter 5.
[41] This was first acknowledged by the WHO in the famous Declaration of Alma Ata: World Health Organization, *Report of the International Conference on Primary Health Care, Alma-Ata* (1978).

patients in front of her. Illustrated in this manner, it becomes clear that the account of remedial responsibilities I developed in the preceding chapter can naturally be extended to healthcare professionals having a duty to stay and fulfil a compulsory service period. Just as the passing clinician must stay and fulfil her remedial duty of assistance before driving on to her social engagement, so the healthcare professional in an under-served health system must fulfil a compulsory service period prior to emigrating. It is clear that there is an inherent duty to stay contained within her remedial responsibilities, and staying to assist in under-served health systems is simply an application of this more general obligation. In the same way that Alexandria the off-duty clinician is required to stay for only a limited time at the scene of the car crash (i.e. until further help arrives, rather than following the patient through to the hospital and beyond), the healthcare professionals' compulsory service period is time-limited and thus remains within the appropriate bounds of demandingness.

Another way of articulating the remedial responsibility-based argument for a compulsory service period is through the language of vulnerability. In fragile health systems characterised by scarcity in human health resources, compatriots are especially vulnerable to the actions of healthcare professionals including their mobility decisions. This is akin to the injured motorist in Chapter 5 being particularly vulnerable to the mobility actions of the passing clinician, with his health dependent on her staying and assisting and not leaving the scene. Robert Goodin has argued that we have duties to protect those who are particularly vulnerable to our actions.[42]

[42] Goodin, *Protecting the Vulnerable*. For a similar thought, see Christine Straehle, "Healthcare Migration, Vulnerability and Individual Autonomy: The Case of Malawi," in *Health Inequalities and Global Justice*, ed. Christine Straehle and Patti Tamara Lenard (Edinburgh University Press, 2012).

In light of this, healthcare professionals have additional obligations, on grounds of others' vulnerability to their actions, to stay and assist. These vulnerability-based considerations are not present in other high-skilled occupations, such as accountants and IT technicians, for example. Meeting our basic needs is not as tied up to their actions as it is to those of healthcare professionals. The language of vulnerability provides us with another way to articulate the same point about the salience of our remedial responsibilities.

A compulsory service period is a way to *institutionalise* the remedial duty to stay. By institutionalising this duty, we make it fairer, more determinate, and enforceable.[43] Instead of an imperfect duty to stay, where some healthcare professionals feel duty bound to stay for 20 years while others interpret the duty as demanding only six months of service, institutionalising the duty into a concrete compulsory service policy allows a clear, time-limited obligation. This means the burden can be distributed more fairly and the obligations made clearer for each healthcare professional, reducing the burdens and pressure of having to take up the slack and allowing greater scope for future planning. It also means that the compulsory service period has broader applicability and need not depend on there being a health *emergency* – this being one of the conditions I stipulated in Chapter 5 for relying upon a capacity-first approach to allocating remedial responsibilities.

A compulsory service period is an effective, feasible, and normatively justified policy that can assist in the pursuit of global health justice.[44] There is some

[43] Buchanan, "Perfecting Imperfect Duties: Collective Action to Create Moral Obligations."
[44] Even Kieran Oberman, for example, who generally opposes migration restrictions, acknowledges that there are strong grounds to support a duty to stay: Kieran Oberman, "Can Brain Drain Justify Immigration Restrictions?," *Ethics* 123 (2013).

evidence that those who undertake compulsory service are more likely to remain in the area once they have completed the mandatory period of service.[45] Theorists have hypothesized that this could be because healthcare professionals form new ties and commitments to a place, their values of social justice are reignited or developed as a result of working in under-served areas, or they discover that they were overly pessimistic about the compulsory service prior to commencing it.[46] Nevertheless, the policy of a compulsory service period may be objected to on at least three grounds. I present these objections and demonstrate that they can be overcome.

The first and arguably most powerful objection is that a compulsory service policy is illiberal and contrary to respecting autonomy. Michael Blake has argued that states may not interfere in its citizens freedom to exit the state, any more than it can restrict an individual's right to exit their religious community.[47] Carwyn Hooper notes that scholarships conditional upon serving a compulsory service period connotate 'serfdom', 'debt bondage', and 'slavery'.[48] A few responses are available.

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[45] Donald Pathman, Thomas Konrad, and Thomas Ricketts, "The Comparative Retention of National Health Service Corps and Other Rural Physicians: Results of a 9-Year Follow-up Study," *Journal of the American Medical Association* 268 (1992); Howard Rabinowitz et al., "The Impact of Multiple Predictors on Generalist Physicians' Care of Underserved Populations," *American Journal of Public Health* 90 (2000); Robert Brooks et al., "The Roles of Nature and Nurture in the Recruitment and Retention of Primary Care Physicians in Rural Areas: A Review of the Literature," *Academic Medicine* 77 (2002); George Holmes, "Does the National Health Service Corps Improve Physician Supply in Underserved Locations?," *Eastern Economic Journal* 30 (2004).

[46] Till Bärnighausen and David Bloom, "Financial Incentives for Return of Service in Underserved Areas: A Systematic Review," *BMC Health Services Research* 9 (2009); S. J. Reid, "Compulsory Community Service for Doctors in South Africa: An Evaluation of the First Year," *South African Medical Journal* 91 (2001).

[47] Brock and Blake, *Debating Brain Drain: May Governments Restrict Emigration?*

[48] Carwyn Hooper, "Adding Insult to Injury: The Healthcare Brain Drain," *Journal of Medical Ethics* 34 (2008): 686.

First, there are many ways to fulfil compulsory service periods that reduce the risk of domination. These include having safeguards and exemptions, especially when the state fails to uphold civil and political rights in the country. As Nir Eyal and Till Bärnighausen note, the compulsory service period need not be owed to only one employer. Doctors are free to move about the country, working for various hospitals and clinics.[49]

Second, and in response to Blake's concerns about constraining the freedom to exit, I have argued that states may not enact blanket emigration restrictions. Healthcare professionals are still permitted to travel and move about, making compulsory health service qualitatively distinct from his example of being forced to remain in a religious community. The freedom to *permanently* exit may be temporarily affected, but significant scope would remain for mobility. This defuses the power of Blake's critique. In any case, Blake's religious exit analogy strikes me as a poor one, as the effect of this is almost exclusively self-regarding, whereas a healthcare professional's decision to exit in the context of a fragile health system has other-regarding effects.

Third, the demands of justice in non-ideal circumstances may change the contours of our rights and the scope of our autonomy, as I showed in my preceding arguments around the demands of remedial responsibility. The autonomy of the clinician to drive straight to her social engagement is constrained by the need for her to discharge medical assistance as the person uniquely placed to do so. This is also obvious in the case of private property. Our freedom to regulate our private

[49] They may even be permitted to go into private practice if this is consistent with, and does not undermine, the pursuit of global health justice.

well may be suspended if that well is the only water supply available in the village, for example, and our right to private property in our own home may be temporarily suspended if a neighbour needs to seek refuge from an axe-wielding murderer on a rampage. The fact that others are especially vulnerable to our actions changes the scope of our autonomy. The non-ideal circumstances of global health, most notably in terms of medical brain drain for our policy, may change the contours of our right to free exit without fully invalidating it.[50]

A second objection is that the policy may be counter-productive if it disincentivises people from training to become healthcare professionals in the first place. Javier Hidalgo argues that compulsory service periods may disincentivise people from training to become doctors, such that the health system becomes worse off than before.[51] Hidalgo highlights an important concern, but this objection can be defused. To see this, consider a stylised example where one must choose between two occupations: a doctor or a rickshaw driver. It is costlier to become a doctor than a rickshaw driver (not least because the former occupation now comes with emigration restrictions), but the salary and benefits are nevertheless far superior to that of a rickshaw driver. In short, for as long as $S_D - C_D > S_R - C_R$ (where $S$ is the salary and $C$ is the cost of pursuing the occupation), the incentives to become a doctor would be significant and the benefits superior *even* given the increased costs in the form of the compulsory service period. A compulsory service period may put off a few people from training to become doctors, but so long as it is designed with people's general incentives structure in mind, it should achieve the

[50] Johannes Kniess has noted that there may be more limitations to the freedom to exit than its proponents acknowledge: Kniess, "Health, Migration and Human Rights."
[51] Javier Hidalgo, "The Missing Evidence in Favour of Restricting Emigration," *Journal of Medical Ethics* 43 (2017).

desired effect on the health workforce without this being counterproductive. Nevertheless, policymakers ought to be cognisant of these incentive-based considerations to ensure that the policy does not impede the achievement of global health justice by significantly reducing the number of those who become healthcare professionals in the first place.

Another way to respond to Hidalgo is to realise that the net healthcare contribution made by the health workforce of a particular country is represented by $N \times T$, whereby $N$ is the number of healthcare professionals trained and $T$ is the average length of service performed in the country. Even if a compulsory service period decreases $N$ on incentives grounds, the increase in $T$ may offset the decrease in $N$ to create a net increase in healthcare provision. The precise impact is an empirical question, but I have already shared some preliminary empirical evidence about the positive impacts of compulsory service periods.

A third objection is that compulsory service periods unfairly place the burden of achieving global health justice on the shoulders of healthcare professionals instead of reforming the broader push and pull factors. Michael Blake argues that emigration restrictions are unfair because they place a disproportionate share of our obligations of global justice on skilled, educated healthcare professionals.[52] Phil Cole argues that it is more appropriate to hold other powerful agents responsible for causing and solving the issue of medical brain drain.[53] Christine

[52] Brock and Blake, *Debating Brain Drain: May Governments Restrict Emigration?*
[53] Phil Cole, "Comment on Brock and Blake: Debating Brain Drain," *Journal of Medical Ethics* 43 (2017).

Straehle rejects emigration restrictions in favour of placing the burden of responding to medical brain drain on the part of receiving countries.[54]

In response to Blake, we cannot forget that healthcare professionals have an extraordinary level of influence on compatriots' basic health needs in under-served health systems. This makes it appropriate, per my remedial responsibility-based argument, for a significant but reasonable share of the burden to be placed on them, at least temporarily. In short, with great power comes great responsibility. In response to Cole, Straehle and others, nothing I have articulated about the compulsory service period entails that it should be a standalone policy. As I shall shortly argue, beneficiaries of medical brain drain (namely, receiver countries) have significant duties of justice to source countries. Enacting a compulsory service policy does not absolve what Cole rightly identifies as powerful agents causally implicated in the brain drain issue.

*Receiving Countries' Obligations: Partial Recruitment Ban and Compensation Payment Scheme*

While emigration restrictions in the form of a compulsory service period will go a long way in combatting the immediate effects of medical brain drain, significant progress towards global health justice will not be made without concurrent action being taken by receiving countries. A significant pull factor for healthcare professionals wanting to emigrate are the direct and indirect practices undertaken by developed countries to recruit healthcare professionals to serve in their own health systems. These practices deprive under-served source countries of

[54] Straehle, "Healthcare Migration, Vulnerability and Individual Autonomy: The Case of Malawi."

healthcare professionals even further – consequences that developed countries are fully aware of. These recruitment practices have been condemned as exploitative and unjust, while some may defend it on grounds that countries have a legitimate prerogative to bolster their own healthcare systems.

Rich countries should be prohibited from recruiting healthcare professionals serving their compulsory service period, including those who would otherwise be serving their compulsory service period were it not for them exercising their buy-out clause. This restriction ensures that there is no room for rich countries to buy out the emigrating healthcare professional's compulsory service period in order to then recruit them into the receiving country's health workforce. Such a recruitment ban is not without precedent. NHS England has recently adopted a voluntary recruitment code that prohibits it from actively recruiting healthcare professionals from the most under-served countries.[55] Though the code is voluntary, it highlights the feasibility and potential scope of such a policy.

A core justification for this recruitment ban can be derived from Thomas Pogge's arguments that, independently of our positive duties, we have first and foremost a negative duty not to harm others.[56] The active recruitment of healthcare professionals serving their compulsory service period is an example of such a harmful act given what we know about the context of medical brain drain, and our

[55] Department of Health and Social Care, *Code of Practice for the International Recruitment of Health and Social Care Personnel in England* (2023), https://www.gov.uk/government/publications/code-of-practice-for-the-international-recruitment-of-health-and-social-care-personnel/code-of-practice-for-the-international-recruitment-of-health-and-social-care-personnel-in-england. There are some exceptions to this policy, including where the UK Government has a prior workforce agreement with the source country.
[56] Pogge, *World Poverty and Human Rights*.

negative duty not to harm justifies such a recruitment ban. The case at hand is perhaps more complex, as I am extending the idea of the negative duty not to harm to include a duty not to offer a third party an inducement that would lead to another party being harmed. Reflecting on the legal principle of *tortious interference* lends support to the extension of Pogge's negative duty not to harm argument in this way. In simplified terms, tortious interference refers to a party (e.g. a rich state's health system) interfering with the relationship between others (e.g. a doctor in a poor country and a patient in need) in a way that causes damage.[57] Such damages are grounds for civil action and remedy in a court of law. The fact that the inducement takes place during the healthcare professional's compulsory service period makes the legal concept especially applicable, since inducing a party to breach a contract is a paradigmatic case of tortious interference.[58] Using similar principles and reasoning, Pogge's negative duty not to harm can be extended to ground the outlined recruitment ban because of the damage that the inducement offered to the healthcare professional will have on the patient.

There are two principled reasons why I defend a *partial* ban (applying only to recruiting healthcare professionals serving their compulsory service period) rather than a total ban on the recruitment of healthcare professionals from under-served contexts. The first reason is primarily empirical. If an outright prohibition on recruitment is instituted, this will likely disincentivise people in under-served

[57] Thomas Reuters Practical Law, "Tortious Interference," (2023). https://uk.practicallaw.thomsonreuters.com/5-382-9829?transitionType=Default&contextData=(sc.Default)&firstPage=true.

[58] While the principle of tortious interference tends to presuppose a legal duty between A and B, we can extend this reasoning to instances where there is a *moral* duty between the parties, such that the duty not to offer a third party an inducement that would cause A to harm B can be applied more broadly to countries that do not have any existing contractual arrangements around healthcare recruitment.

countries from training to become healthcare professionals in the first place. A career choice that would limit or close off one's migration prospects is certain to put off significant numbers of people, many of whom pursue high-skilled professions precisely to give themselves the opportunity for emigration.[59] It is better that people train to become healthcare professionals, serve their compulsory service period, and then still emigrate rather than for them to not pursue a healthcare career at all. A total recruitment ban would therefore be contrary to the aims of the policy and harmful to the health needs of those in under-served contexts.

The second reason against a total recruitment ban from under-served countries is a more normative one, derived from my earlier discussion of national responsibility. On the understanding of national responsibility I defended in Chapter 5, it is apt to attribute at least *some* responsibility for medical brain drain to source countries' policies and practices (for example, in how they deal with the push factors for emigration). A total recruitment ban would place a significant burden on rich countries' prerogative to admit skilled healthcare migrants at the expense of acknowledging the agency and responsibility of source countries' governments in dealing with at least some aspects of brain drain. For the sake of clarity, my claim is not that source countries are primarily responsible for the push factors that cause brain drain, merely that there are at least *some* aspects of the brain drain problem that are within the control (and responsibility) of even under-served countries – something a total recruitment ban may fail to acknowledge. Without overstating the

[59] Even a compassionate person who would be happy to serve a time-limited compulsory service period as a doctor (rather than to pursue another profession without such restrictions) may find their compassion being tested if the emigration ban is *total* rather than limited.

empirical claim about national responsibility, it may be made more palatable once we consider my second proposal, around a scheme of compensatory payments from rich receiver countries to under-served source countries to better enable source countries to deal with the push factors that drive brain drain.

A compensatory payment system should be levied on developed countries that receive healthcare professionals from under-served source countries, even after these healthcare professionals have completed their compulsory service period. The one-off payments would be levied per head and paid by the recruiting institution (whether public or private) to the health system of the country in which the emigrating health professional undertook their core medical training.[60] This does not necessarily mean paying the government of the country, as some countries' governments are corrupt or dysfunctional. It could mean payment being made to NGOs working on the ground to provide healthcare. For example, since the Fall of Kabul and the rise of the Taliban in 2021, Afghanistan's health system has been predominantly run by foreign NGOs with aid going directly to these NGOs. Without committing to a concrete amount, as this will be a matter for public policy experts to determine, these one-off payments could plausibly be in the region of between £20,000 and £100,000 per health professional, depending on their current skill level and the length of training they have received.

Recall that the average cost of educating a doctor in England is £230,000 compared to US$21,000 in Uganda and US$58,700 in South Africa. These figures

[60] An analogous scheme is FIFA's policy of transfer fees when professional footballers trained by one association football club transfers to another, grounded in the rationale of compensating the club that spent money on training the footballer: FIFA, *Regulations on the Status and Transfer of Players* (2022), 40.

do not include post-graduation specialty training. Given the significant savings in training costs for receiving countries' health systems, these levies are unlikely to fully deter developed countries from recruiting healthcare professionals from source countries. The difference will be that source countries would now receive some compensation for the impact of their healthcare professionals emigrating to serve in other health systems.

Together with the compulsory service period, this compensation policy will mitigate against the effects of brain drain and enable the funds received by the source countries to further develop their health systems. This in turn will have a positive, flow-on effect on the push factors. Improved funding received through the compensatory payments will mean that source countries' health systems can afford to invest in better healthcare services, improve working conditions, and pay healthcare professionals better. This will mitigate some of the push factors that drive medical brain drain. In this sense, there is also an assistance-based component to the policy. We are not merely compensating for the training costs but also discharging assistance duties to support under-served countries' health systems per the demands of the *dynamic assistance framework*.

As well as the grounds of fairness explored above, the compensatory payment policy can further be supported by the demands of the Beneficiary-Pays Principle (BPP). The BPP-based justification argues that benefiting from an injustice can generate duties of justice on the part of the beneficiary.[61] Receiving countries benefit from the supply of healthcare professionals at the expense of developed

[61] Daniel Butt, "On Benefiting from Injustice," *Canadian Journal of Philosophy* 37 (2007).

countries. The fact that receiving countries often target these healthcare professionals fully aware of the adverse effects this has on the health systems of source countries points towards an injustice. The BPP can therefore be marshalled in support of the compensatory payment policy, for both public and private employers. Public employers (such as the UK's NHS) are justified in drawing upon tax-funded resources to make these compensatory payments because the ultimate beneficiaries are the citizens of the receiving country. Private employers benefit through reduced costs, and the resources needed for the compensatory payments can justifiably be taken out of company profits and shareholders dividends.[62]

## Section III: Health-Promoting Conditions

Enacting policies aimed at promoting equitable access to healthcare and securing a sustainable health workforce, of which I have provided some examples in my foregoing discussion, are necessary but not sufficient for the achievement of global health justice. The account of GOH I developed demands that the social *conditions* in which people live, work and play are conducive to health. This means that we need public health interventions and action on the social determinants of health. We do not need to look far to see that our world is falling far short of these aims. On the account of health disadvantage presented in Chapter 4, I argued that health outcomes concern only one component of GOH, and health security (how secure and robust our present health status is) and health costs (the financial and non-

[62] It might be noted that private providers also benefit from publicly trained *domestic* healthcare professionals. If this is meant as a consistency challenge to the brain drain compensation scheme, I am willing to accept the full implications and argue that private providers may also be required to compensate the domestic public health system (e.g. medical schools, public teaching hospitals) for their reduced training costs in some way.

financial costs of achieving and maintaining our health status) must be reflected in any theoretical and practical account of global health justice.

One policy proposal that flows directly out of the normative demands of GOH, and which can be thought of as an extension of a health policy that is effective at more local levels, is to create a *global health tax scheme*. My proposed scheme, as I outline shortly, focuses on deterring goods that harm health as well as generating revenue that can be used to promote the conditions for GOH more generally. As Thomas Pogge highlights, international institutional arrangements, from the rules of trade to tax arrangements, can support or undermine the conditions for domestic and global justice.[63] Gillian Brock argues that our current international tax regime, rampant with legal tax avoidance, undermines the ability of countries to collect revenue that enable them to meet citizens' basic needs in relation to health and healthcare.[64] Action on taxes at a global level therefore has the potential to significantly improve our ability to promote the conditions mandated by GOH, and it is a natural proposal to explore in our pursuit of global health justice.

My proposed global health tax scheme would have two components, relating to what I shall call its *deterrence* and *assistance* functions. The first component is a global health tax aimed at deterring the consumption of goods that have significant net negative effects on health. This is the *deterrence function* of the tax scheme. The second component is a form of 'assistance' tax, whereby agents are taxed in

[63] Pogge, *World Poverty and Human Rights*.
[64] Gillian Brock, "Taxation and Global Justice: Closing the Gap between Theory and Practice," *Journal of Social Philosophy* 39 (2008); Gillian Brock, "Global Justice, Cosmopolitan Duties and Duties to Compatriots: The Case of Healthcare," *Public Health Ethics* 8 (2015).

order to bolster the funds available for local and global institutions to secure the conditions that promote health. This is the *assistance function* of the tax scheme.

Consider the deterrent component of the tax. A global tax should be introduced on products that have significant net negative effects on health, most notably tobacco products, alcohol, and sugar-sweetened beverages.[65] The function of this component is to deter the consumption of products harmful to health. This supports the creation of conditions that are conducive to health, per the demands of GOH.[66] The practical arrangements of the global health tax would be a matter for policymakers to deliberate on, but existing tax schemes on tobacco offer a useful template that can be generalised to other goods. The taxes would be collected by national governments, who could keep a portion of it for their own health-related needs associated with the consumption of these products. A portion of the taxes would then be paid into a neutral body, such as a delegated committee of the WHO or the World Trade Organisation, or a new international organisation created for the task, who is then tasked with coordinating its global disbursement in accordance with the demands of GOH and agreed-upon principles and priorities.

While considerations of offsetting negative health externalities are part of the justification for this part of the proposal, the deterrent component of the global health tax is not designed merely as an externality tax. This is because while part of the tax will go towards offsetting the negative externalities associated with the

[65] By *net* negative, I mean that the overall impact on health is unequivocally negative. The production of ambulances, for example, arguably releases carbon emissions that impact on health. Overall, however, it is reasonable to suppose that ambulance production does not result in *net negative* impacts on health.
[66] James Wilson has explored political institutions' obligations to uphold public health more broadly: Wilson, *Philosophy for Public Health and Public Policy*, 110-25.

aforementioned goods, the scope of the tax goes above and beyond this. The deterrent component of the tax will contribute towards creating global social conditions more conducive to health by discouraging the consumption and in turn decreasing the incentives for production and importation of such goods. The global health tax is designed not only to offset negative externalities, but also to create social conditions that promote health by deterring consumption, in accordance with the normative demands of GOH.

At this stage, one might question how the deterrent tax proposal aligns with the *opportunity*-based conception of GOH. If people already have the opportunity not to smoke (or drink alcohol and sugar-sweetened beverages) but choose to do so, is this really a concern of justice and something that GOH ought to be concerned about? A few comments can be offered. As I argued in Chapter 3, and as observed by John Roemer, lifestyle choices often have a significant structural component that track existing axes of disadvantage.[67] This means we have good reason to be critical of attributing full responsibility to individuals absent just background conditions. Relatedly, GOH focuses on creating *genuine* opportunity for health, where genuine qualifies the conditions that make exercises of opportunity valid. As I presented in Chapter 4, this means creating social conditions such that decisions about pursuing (or not pursuing) health is performed against a background condition where health-promoting conditions are the default but from which one may individually opt out. The deterrent component of the global health tax, insofar

[67] Roemer, "A Pragmatic Theory of Responsibility for the Egalitarian Planner."

as it promotes these background conditions, is therefore consistent with GOH and the opportunity-based dimension of global health justice.[68]

Consider, next, the assistance component of the global health tax. Instead of serving a deterrence function, the second component of the global health tax scheme serves a broader *assistance* function, using a variety of global taxes to generate financial resources that can be used to secure the conditions that provide all with genuine opportunity to pursue health. The justification for such taxes is not grounded primarily in deterring the consumption of a particular good due to its health impacts, but on our duties of assistance and remedial responsibility more positively. As I argued in Chapter 5, remedial responsibilities for non-emergency routine injustices (what I called *assistance duties*) require an institutional mechanism to fairly and effectively coordinate and allocate between multiple agents.

The assistance component of the global health tax proposes a tax scheme into which agents (such as countries) must contribute. The precise rate is a matter for policymakers, but we could imagine a progressive rate of 0.5% of GDP for upper-middle-income countries and 1% of GDP for high-income countries, with low-income countries exempt from contributing. Such a scheme would potentially raise hundreds of billions in resources for global health justice annually.[69] Individual

[68] The trade in weapons and arms is responsible for significant net negative health impacts, so it is plausible that the global health tax scheme could be extended to tax the import of arms by national governments: Eran Bendavid et al., "The Effects of Armed Conflict on the Health of Women and Children," *Lancet* 397 (2021); Salahaddin Mahmudi-Azer, "Arms Trade and its Impact on Global Health," *Theoretical Medicine and Bioethics* 27 (2006).

[69] This estimate is based on Pogge's calculation, who argues that a 1% tax on global resources, for example, would already generate over $300 billion per year based on 2001 wealth levels: Thomas Pogge, "Eradicating Systemic Poverty: Brief for A Global Resources Dividend," *Journal of Human Development* 2 (2001): 67.

taxpayers ultimately bear the costs of such global health taxes, but this merely reflects the *coordination* of existing assistance duties they had anyway. The funds would be pooled and disbursed by the aforementioned neutral body in accordance with the demands of GOH.

My general proposal does not negate the need for further investigation and detailed analyses by policymakers on the strategies needed to mitigate against the risks of corruption, aid dependency and other perverse effects.[70] These are important though not insurmountable challenges. The fact that the WHO coordinates and delivers health aid in various forms around the world shows that well-designed policies that work towards the achievement of global health justice are possible. I also leave it open to policymakers to decide how far countries' current contributions towards global health aid should defray their obligations under the proposed assistance tax scheme. My rough view is that it should perhaps make *some* difference to their obligations under the assistance tax scheme but not a significant difference. This is to protect against undue donor-centrism and to ensure that the pursuit of GOH is not undermined by uncoordinated actions and disparate agendas.[71]

The assistance component of the global health tax provides such a coordinated mechanism for the discharge of our GOH-related assistance duties, ensuring this

[70] For discussions of the issues with aid, see Larry Temkin, *Being Good in a World of Need* (Oxford University Press, 2022); Leif Wenar, *Blood Oil* (Oxford University Press, 2016); Dambisa Moyo, *Dead Aid* (London: Allen Lane, 2008).
[71] For discussions of donor-centrism in health aid, especially as it relates to the WHO's funding and the disproportionate influence of the Gates Foundation, see Devi Sridhar and Lawrence Gostin, "Reforming the World Health Organization," *Journal of the American Medical Association* 305 (2011); Lawrence Gostin, "World Health Organization Reform: Lessons Learned from the Ebola Epidemic," *Hastings Center Report* 45 (2015); Tim Mackey, "The Ebola Outbreak: Catalyzing a "Shift" in Global Health Governance?," *BMC Infectious Diseases* 16 (2016).

is done with considerations of fairness and effectiveness in mind. I am not the first to suggest global taxes with the aim of raising revenue to secure people's basic needs. Thomas Pogge has proposed his Global Resources Dividend, a tax on those who extract natural resources from within their territory, with proceeds going towards the alleviation of global poverty.[72] James Tobin has suggested his so-called Tobin Tax to prevent currency speculation and assist countries with financial stability.[73] More specific to the realm of health, a levy is applied to airline tickets sold in over a dozen countries (including the UK, Brazil, Chile, France, Korea, and Norway) with proceeds going to UNITAID, an organisation that distributes funds to support global health initiatives.[74]

The assistance component of my global health tax scheme arises directly from the normative demands of GOH. To understand this, consider the idea of prospective duties.[75] If justice requires that I do $\varphi$ but $\varphi$ing requires that I acquire $\lambda$ beforehand (where $\lambda$ is a reasonably-attainable skill or resource), then it is plausible that the demands of $\varphi$-related justice require me to also prospectively acquire $\lambda$. Put in terms of GOH, if justice requires the promotion of social conditions conducive to health, and promoting social conditions conducive to health requires financial resources and institutional mechanisms, then justice may demand that I acquire the financial resources and enact the institutional mechanisms so that I can then be in a position to promote the social conditions that promote health. Just as

[72] Pogge, "Eradicating Systemic Poverty: Brief for A Global Resources Dividend."
[73] James Tobin, "A Proposal for International Monetary Reform," *Eastern Economic Journal* 4 (1978).
[74] "UNITAID: About Us," 2023, https://unitaid.org/about-us/#en.
[75] I borrow this term from Chiara Cordelli, although I acknowledge that she is dealing with a slightly different theoretical problem: Cordelli, "Prospective Duties and the Demands of Beneficence."

securing a decent standard of health in the domestic setting requires a prospective duty to generate revenue through taxation, so achieving GOH requires a prospective scheme of global health taxes to enable its demands to be met.

A global health tax scheme, comprising a deterrent component and assistance component, extends the general case for global taxes to the realm of global health. It also builds on existing arguments for remedial responsibility I explored in Chapter 5. The deterrent component works negatively, by mitigating known health risks and reducing the impact of health-damaging products to create more health-promoting social conditions. The assistance component works more positively, by providing resources to proactively create social conditions so that all can have genuine opportunity for health. A global health tax promotes the social conditions for health by simultaneously deterring the consumption (and indirectly, the production) of goods that are harmful to health and bolstering the financial resources that local and global political institutions have at their disposal to promote the conditions for health more generally. Instituting a global health tax scheme, alongside supporting the institution(s) that would manage it, is another way for global agents to coordinate our imperfect duties and discharge it in a feasible, effective, and normatively compelling manner.

## Section IV: Priority-Setting for Global Health Justice

The proposals explored in Sections I, II and III will contribute towards the achievement of genuine opportunity for health for all, regardless of nationality or place of birth. However, in our characteristically non-ideal world, there is the important question of how we ought to set our policy priorities. Perhaps the most

pressing conflict is between pursuing short-term policies with immediate impacts (often relating to healthcare aid) and long-term policies that target the social conditions and social determinants of health with potentially larger but more diffused impacts over a longer time horizon. This section argues that the reality of our non-ideal conditions is a significant consideration in how we distribute our efforts and resources between these two priorities. I shall also show that my defence of healthcare in Chapter 2, namely by reference to its expressive function, can offer important reasons to focus on healthcare-related interventions alongside policies targeting the broader social conditions, even if the latter is statistically more likely to improve global health outcomes than the former.

Consider first a contrary view advanced by Lawrence Gostin, who defends a strongly population health-focused approach to global health, arguing that we ought to prioritise action on the social conditions that impact health.[76] Our priorities for realising global health justice, on Gostin's account, must tackle the upstream determinants of health:

> Justice in health is not primarily realised by delivering heroic medical interventions or through courtroom victories vindicating an individual's right to some particular therapy. Rather, justice will primarily be embedded in features of day-to-day life that are often taken for granted: the tap flowing clean water, the toilet that flushes, the neighbourhood market selling affordable nourishing food, public sanitation … well-regulated industries, and so on.[77]

[76] Gostin, *Global Health Law*.
[77] Gostin, *Global Health Law*, 425.

For Gostin, policy proposals aimed at securing the general conditions for health (such as my global health tax proposal) would take priority over my proposals relating to healthcare (such as my proposals around combating medical brain drain and instituting Hollis and Pogge's Health Impact Fund).

At the other end of priority-setting for global health justice is the dominant approach of most private donors in the space of global health, who prefer to prioritise short-term, tangible healthcare interventions aimed at acute conditions where they can see clear evidence of the benefits of their intervention. Disease-specific programmes that operate over a limited time horizon such as vertical/standalone programmes on HIV/AIDS and malaria are paradigmatic examples of this approach. Ezekiel Emanuel argues that this is the dominant approach to donors' priority-setting in global health today.[78]

While I am sympathetic to the spirit of Gostin's proposal, as should be apparent from my framework of GOH, I think he is mistaken to commit unequivocally to the prioritisation of action on the social conditions over discrete healthcare actions. Equally mistaken in my view is the dominant approach of always prioritising time-limited, disease-specific, healthcare-focused interventions. The issue of priority-setting in global health justice is highly complex, involving considerations of aggregation and risk calculations (including how we balance statistical and identified lives) and being sensitive to the context and reality of global health injustice.[79] It is unrealistic to expect a precise weighting solution, but two general

[78] Ezekiel Emanuel, "Introduction," in *Global Health Priority-Setting: Beyond Cost Effectiveness*, ed. Ole Norheim, Ezekiel Emanuel, and Joseph Millum (2019).
[79] I alluded to such debates in my discussion of healthcare versus preventative social interventions and issues of partial aggregation in Chapters 2 and 3.

considerations are available to help us answer the question of priority-setting in global health justice.

First, as I argued in Chapter 2, healthcare has a vital *expressive function*. Over and above its limited impact on population health outcomes, nationally and globally, it expresses respect for individuals *qua* vulnerable agents in a morally salient way. This insight provides us with an important reason not to neglect healthcare-related interventions even if they are statistically less likely to bring about the long-term population health benefits that come from action on the global conditions for health. Gostin's motivations for always prioritising action on the social determinants of health ignores the moral salience of health needs and the way these manifest in the sphere of global health. As the oft-cited global health statistics show, significant suffering amenable to *healthcare* is taking place here and now, and no plausible theory of global health justice can turn away from dealing with these on the grounds that the ultimate priority is intervention on the upstream determinants. Appreciating the expressive function of healthcare, per my argument earlier on in the thesis, puts into focus the salience of responding to the needs of agents characterised by inherent vulnerability who are standing before us in flesh and blood, even if a statistically greater number of unidentified lives could be saved with Gostin-type prioritisation of the social determinants of health.

In addition to appreciating the expressive function of healthcare, note that the demand of GOH for social conditions to be conducive for genuine opportunity for health is not incompatible with strong action to promote access to healthcare (such as through enacting the Health Impact Fund and interventions to combat brain

drain). In fact, robust access to healthcare is among the conditions needed to achieve global health justice. Nothing within GOH implies that securing health-promoting conditions more generally must trump shorter-term incremental changes relating to healthcare. GOH sets out an ideal, but the precise path we are required to take to achieve that ideal is an open question at the policy stage. Considering the salience of healthcare and its expressive function highlights that there is at least a *pro tanto* reason to pay serious attention to my proposals around combatting medical brain drain to improve the worst-off people's access to healthcare.

Second, policies to realise global health justice naturally take place in a non-ideal world and this should be reflected in our priority-setting. My view is that priority-setting for the sake of achieving GOH is determined to a large extent by how far our circumstances deviate from the conditions of ideal theory. Following John Rawls, by the conditions of ideal theory, I simply mean a state of affairs where there are generally favourable social conditions and where everyone is generally aware of, and willing and able to comply with, the principles of global (health) justice.[80]

In highly non-ideal circumstances, where there is widespread lack of adherence to the demands of GOH and global health justice, there may be strong reasons to prioritise the implementation of policies with clear, short-term and tangible benefits that focus on the basic health needs of those in need. It may be appropriate to focus on, and prioritise, the kinds of *emergency duties* I explored in my account of remedial responsibility in Chapter 5. These are admittedly limited *sui generis* duties of rescue, but they are generally uncontroversial. These policies are much more

[80] John Rawls, *A Theory of Justice*, Revised ed. (Belknap, 1999).

likely to receive the support of otherwise reluctant governments and other political actors, who are generally under pressure from their citizens to demonstrate discrete and quantifiable policy successes. Being able to show that the government disbursed 100,000 vaccine doses to children in urgent need is an easier sell to their citizens than the claim that the government committed £1 million towards a housing programme which will improve average population health outcomes over a 20-year time horizon. Reluctant governments who would otherwise shirk their global health responsibilities can often support discrete policies with a proximal time horizon.

In non-ideal circumstances characterised by a greater degree of compliance and willingness to abide by the demands of GOH, greater inroads can be made, such as targeting universal healthcare provision for the worst-off through interventions to address medical brain drain alongside reforms to the global pharmaceutical patents system. Vertical (disease-specific) programmes, which are an easier sell to funders and politicians, may also be implemented in these circumstances, as a second-best alternative to comprehensive, horizontal (integrated) programmes. As the WHO notes, vertical programmes may have an important role to play when health systems are very weak and fragile but where there is funding available, even though such programmes are generally inferior to horizontal approaches.[81]

In circumstances moving more towards ideal theory, resembling greater compliance and solidarity in global health, we can start to prioritise more ambitious, integrated policies that act on all aspects of healthcare, the health workforce, *and*

[81] Rifat Atun, Sara Bennett, and Antonio Duran, *When Do Vertical (Stand-alone) Programmes Have a Place in Health Systems?*, World Health Organization (European Observatory on Health Systems and Policies, 2008).

the social determinants of health. More demanding policies that target the broad social conditions, such as the global health tax, can be pursued as part of prioritising all aspects of health disadvantage.

The fact that our priority-setting ought to be sensitive to the level of compliance is not about holding GOH ransom to governments and other actors' unwillingness to act. The primary rationale is to ensure that we do not cause more harm than good by letting our pursuit of the ideal get in the way of incremental progress that can nevertheless have very real impacts on reducing global health disadvantage and promoting global health justice. It is about ensuring that perfection does not become the enemy of the good. The reality of global health injustice complicates the single-minded pursuit of GOH, and barriers to achieving global health justice in our non-ideal world is simply the context for which the theory of GOH must be designed. From a normative policy perspective, the controversial issue is not whether we ought to have short-term healthcare-related policies or long-term action targeting the social determinants of health, but how we ought to design policies that give us the best chances of achieving GOH*, here and now,* given our non-ideal circumstances.

## Conclusion

This chapter has focused on realising the demands of global health justice and achieving GOH, moving from the realm of theory to policy and practice. I have demonstrated how earlier arguments and principles defended in the thesis, from my account of remedial responsibilities and the expressive function of healthcare through to my conception of health disadvantage and national responsibility, give

us important normative guidance about the nature and scope of what is required to achieve GOH. This chapter has taken an explicitly non-ideal perspective, cognisant of the complexities and realities of global health injustice in our world today. The principles and considerations I have explored are useful starting points and opportunities to bring our world closer to the demands of GOH, but they are by no means exhaustive nor sufficient. Working towards GOH will likely be an arduous and complex process, but it is something that we cannot delay for the sake of the millions suffering around the world every day. My arguments in this chapter have highlighted some relevant normative principles and considerations that policymakers can use as a basis for more detailed policy proposals. In this sense, it provides a normative blueprint to aid the creation of policies to achieve global health justice that are effective, feasible, and normatively compelling.

# Conclusion
# KEY INSIGHTS, LESSONS, AND REMAINING CHALLENGES

This thesis has provided a comprehensive political philosophical exploration of the demands of justice in global health, sensitive to the complex reality of global health injustice in our world today. In this concluding chapter, I will summarise the core insights and lessons from my thesis. I will begin by recapitulating some of the specific contributions my thesis has made through the individual chapters, before zooming out to consider the overall contribution of the thesis as a whole. Rather than summarising the precise arguments chapter by chapter, I will focus on highlighting the core insights advanced in each chapter, emphasising how they advance the debate and challenge existing ideas in the literature. I shall show that not only has my thesis contributed to our understanding of global health justice, but my key arguments have broader implications for non-health-related theories of justice and political philosophical theorising more broadly. I identify three central insights and themes advanced in the thesis. I conclude with some reflections on scope for future work.

In Chapter 1, I addressed some foundational issues relevant to the ensuing arguments in the thesis. Chapter 1 advances our understanding of some foundational debates in global health justice in two important ways. First, I made an intervention in the philosophy of medicine literature, clarifying how we might adopt a working hybrid *naturalist-normativist conception of disease* whereby health and disease are biomedical concepts that nevertheless involve a vital normative and social component. I demonstrated that a plausible working definition of health and disease combines naturalist and normativist considerations, reflecting its

simultaneous biological and social nature. This blend of naturalist and normativist considerations is an approach that informs much of what I develop in the rest of the thesis, whereby global health justice theorising requires considerations of both natural and social dimensions.

Second, I offered a pluralistic defence of the way in which health has special and universal moral significance in a way that moves beyond existing arguments. I argued that health is special because it is *non-reducible* to any single metric of justice currently available in our axiological vocabulary and that it has multiple features that lend support to the view of its *significance*. My arguments in this chapter stand in contrast with how existing arguments in the literature have tried to conceptualise the special moral significance of health. Rather than looking for necessary and sufficient conditions for health being special per the prevailing approach, which I argued is bound to fail, I outlined a different pluralistic approach that captures the inherent normative and conceptual complexities of health and global health.

In Chapter 2, I advanced a novel argument around the *expressive function of healthcare*. With few exceptions – notably Daniel Weinstock and Kristin Voigt[1] – virtually no work has been done exploring the non-consequentialist features that make healthcare provision significant. Chapter 2 fills this gap by showing that we have good reasons to support healthcare provision nationally and globally, even if there are more effective ways to maximise global health *outcomes*, because of its salient expressive function. Given the doubt cast by the social determinants of

[1] Weinstock, "How Should Political Philosophers Think of Health?."; Voigt and Wester, "Relational Equality and Health."

health on the impact of healthcare on population health, my arguments about the importance of healthcare's *respect-expressing* dimension provides us with a vital justification for its continued provision. The fact that the work of *Médecins San Frontières* and others immediately come to mind when many of us think about global health justice highlights the salience of healthcare in this sense and the way my expressive function argument can conceptualise this intuition. My arguments about the expressive function of healthcare highlight, more generally, that there can be very good reasons to pursue public policies, within or beyond the domain of global health, that do not realise or maximise optimific outcomes. The expressive dimension of particular policies is an important (even if not decisive) consideration.

Alongside providing a working definition of global health injustice, Chapter 3 developed a framework for balancing the pursuit of health and global health justice in a world with multiple other competing priorities of justice. My core contribution to this debate is a framework I call *limited isolationism*, which analyses how global health justice fits within justice more broadly from both a substantive normative and methodological standpoint. Theorising justice in global health need not be about creating an entirely *standalone* theory from the ground up, but nor is it a matter of simply *applying* existing theories and principles to the matter of global health. These two positions have frequently been discussed in the context of Simon Caney's distinction between isolationism (whereby health should be treated in isolation from other considerations of justice) and integrationism (whereby health is simply one among several issues of justice that ought to be considered as a whole without the need for a separate theory).[2]

[2] Caney, "Just Emissions."

I argued that a more nuanced understanding is required between these two positions, with me defending a model I call *limited isolationism*. The question is not whether global health should be isolated from broader considerations of justice, but whether and to what extent particular aspects of global health should be aggregated with, and considered alongside, other dimensions of justice and (dis)advantage in particular contexts. *Limited isolationism* acknowledges that global health justice should be sensitive to considerations of justice more broadly but, depending on the particular context and level of theorising, we are justified in bracketing away other considerations of justice and (dis)advantage. A clinician at the bedside should bracket away considerations of the patient's immense wealth and consider her health needs in isolation, while the Minister of Health should champion health while being cognisant of competing priorities of non-health justice.

Not only is *limited isolationism* useful for thinking about how to balance health and global health in a world with multiple competing priorities of justice, but it also has a significant contribution to make in how political philosophers think about public policy trade-offs. *Limited isolationism* provides a normative blueprint for how we can think about trade-offs in public policy priorities more generally. The fact that considerations of opportunity costs and broader (dis)advantage is appropriate for policymakers at a meta-level does not entail that it is appropriate for service deliverers at the more micro-level – an observation that applies beyond healthcare, to questions of law and punishment, rescue duties, education, and more.

In Chapter 4, I developed the core philosophical theory of health equity beyond borders, namely, my framework of *Genuine Opportunity for Health* (GOH). This framework engaged with the background conditions that drive and influence health disadvantage for all, reflecting the importance of social conditions in our theorising about global health. This theory is framed explicitly in contrast to most of the existing literature on global health justice, which focuses solely on health *outcomes*. I argued that the right target of global health justice is not merely health *outcomes*, but also health *security* and considerations of health *costs*. Not only do health outcomes in many parts of the world fall below any reasonable threshold, many experience health insecurity and have to incur undue costs to pursue health. Achieving GOH requires reforming the social and political environment in which people live, work and age, to ensure social conditions are conducive to the pursuit of health – an ideal that includes, but goes above and beyond, the provision of health*care*.

GOH functions not only as a standalone framework of global health justice, but its general justification has normative implications for existing debates about perfectionism and neutrality. My critical analysis showed that even the most ardent anti-perfectionist liberals, including Gerald Gaus, cannot block the pursuit of global health justice in the form of GOH on grounds of neutrality.[3] My arguments about GOH also have broader implications for theories of liberal neutrality. The reasons we have to promote GOH show that liberal neutralist theories permit a broader scope of health promotion than is frequently accepted. The analysis of the currency or metric of health disadvantage used by GOH also makes a broader contribution

[3] Gaus, *The Order of Public Reason*; Gaus, "Liberal Neutrality: A Compelling and Radical Principle."

to how we conceptualise the pluralistic nature of disadvantage in a way that builds upon other work in distributive justice, most notably Jonathan Wolff and Avner De-Shalit's work on disadvantage.[4]

In Chapter 5, I addressed questions of responsibilities in global health justice in both the backward- and forward-looking sense, especially given our current states-based order. First, with the exception of Shlomi Segall[5], I am not aware of any theorist who has applied the idea of national responsibility to the question of global health justice. My work in this chapter brings arguments about national responsibility (primarily as championed by David Miller[6]), squarely into conversation with debates about global health. I did this by showing that opposing imperialistic tendencies and adopting a limited isolationist perspective requires us to acknowledge that health inequalities between countries that come about through the exercise of national responsibility need not necessarily be unjust so long as these are above a certain threshold.

Second, I developed a framework of remedial responsibility for global health injustice I called the *dynamic assistance framework*, whereby the appropriate principles for allocating remedial duties depend on the nature of the health injustice at hand. The framework contributes to the global health justice literature by investigating more closely our intuitive drive to advocate demanding duties to remedy global health injustice and showing that there is a difference between *sui generis* rescue-type duties in emergency situations and more routine, long-term

[4] Wolff and De-Shalit, *Disadvantage*.
[5] Segall, *Health, Luck, and Justice*.
[6] Miller, *National Responsibility and Global Justice*.

assistance duties. As well as defending several substantive positions, this analysis brings the topic of remedial responsibility squarely into conversation with work on global health. My arguments around the principled distinction between emergency (rescue) duties and non-emergency (assistance) duties has broader applications beyond global health injustice and is likely to be a convincing way to address other instances of global injustices in a way that simultaneously acknowledges the complexities and costs of remedying global injustice while aligning with our drive to jump in and help.

In Chapter 6, I explored some practical steps to bring about the ideal of GOH. This chapter makes both a substantive and methodological contribution to our understanding of global health justice and political philosophy more broadly. Substantively, I defended a series of proposals grounded in the principles and frameworks explored earlier in the thesis. These include novel justifications for time-limited compulsory service periods for health workers to combat medical brain drain and novel arguments in defence of a global health taxation scheme to realise GOH. Methodologically, the chapter highlights the role political philosophers and theorists of global health justice can play in bringing about a world of health equity beyond borders through championing effective, feasible, and normatively compelling principles.

Having summarised the significant contributions that each chapter of this thesis makes to the literature and to our understanding of global health justice and justice more generally, we are now in a position to see the overarching contributions of my thesis to the literature on global health justice.

This thesis has provided a *systematic and general account of what justice demands in global health*, per the goal I set myself in the Introduction Chapter. The thesis began by analysing some foundational issues (including health and its moral significance beyond borders), before developing an overarching view of global health justice (in the form of GOH) and providing more specific normative guidance across a range of issues, from national responsibility and remedial responsibility to the kinds of policies that are required by GOH. The thesis has focused on the demands of *justice* (the domain of political philosophy) rather than beneficence or law (often the domain of bioethics) across a *comprehensive* range of issues and contexts, and with an explicitly *global* starting point. The thesis is the first such account I am aware of, presenting a comprehensive political philosophical account of *global* health justice.

Through my contributions in the foregoing chapters, this thesis has advanced three central insights and themes.

*Health for all as a core demand of justice*. Beginning with the foundational chapters concerned with the special moral significance of health and the salient expressive function of healthcare, this thesis has highlighted the central role of health and healthcare for everyone, regardless of nationality or place of birth. The theory of GOH developed this core insight further, showing that health for all is a key demand of *justice*. The theory of GOH functions not only as an ideal of justice, but also as a yardstick to show how far our current world is falling short of the demands of justice in global health. That health for all is a core demand of justice may seem

like an uncontroversial claim, but I have shown that this view has important and demanding implications across a range of normative dimensions and policy areas. It limits what countries may otherwise do in pursuit of their own national priorities, it can mandate fairly demanding duties of rescue on the part of capable agents, and it can restrict rights to emigrate in certain circumstances.

*The complex reality of achieving and pursuing global health justice.* The universality of our drive to alleviate health injustice across borders may mask the theoretical and practical complexities of pursuing and achieving global health justice. The thesis has highlighted these complexities, from issues with conceptualising health and balancing health versus non-health priorities through to the practical challenges of global health policy. The thesis has shown that these complexities are part and parcel of global health justice. Global health activists who present a simple narrative about achieving health for all gloss over important theoretical challenges, while political theorists and philosophers who see global health as simply another issue to which a general theory of justice can straightforwardly be applied are equally mistaken. These complexities may make the theory and practice of global health justice more difficult, but they are unavoidable and should feature in any plausible theory of global health justice. I shortly identify two complexities that would benefit from further analysis in future work.

*The central role of political philosophy for global health justice.* This thesis is a work of practical philosophy. Throughout the thesis, I have shown how political philosophy can be brought to bear on practical challenges in global health. The

thesis is empirically informed and sensitive to the realities of our non-ideal world. It is realistically utopian but starts from the problems we face and proposes solutions that are normatively compelling, effective, and feasible. A core feature of the thesis has been to show that questions of health and global health justice are not merely technical and *natural* phenomena for scientists and doctors to deal with but are issues within the control of institutions and social structures requiring normative analysis and interrogation. More strongly, through the various chapters, the thesis has shown that political philosophy is *necessary* to fully understand the nature and demands of justice in global health. This admittedly simple insight, again, stands in stark contrast with how global health justice has hitherto been pursued, with little engagement with philosophical ideas on the part of activists and policymakers and limited engagement from political philosophers on matters of global health.

Despite the thesis addressing a wide range of issues, however, there are some important remaining challenges that ought to be addressed in future work. First, further questions remain around balancing and weighing health and global health pursuits compared to (a) local and national health priorities and (b) other local and global non-health priorities. I have provided the general normative framework of *limited isolationism* and a model of national responsibility to help us think about the place of health and global health in justice and global justice, but this strikes me as perhaps the most difficult question in the thesis and one that I have only made a start on. The complexities of aggregation and prioritisation, at both a normative and practical level, require further detailed investigation that exceeds the scope of this thesis. How we fill in the details will determine the real policy implications of much of what I say in this thesis, both nationally and globally.

At the same time, many of these questions admittedly concern what we might call *rules of regulation* that can be explored further with the help of the general frameworks and theories I develop in this thesis. That we do not have a concrete answer for these questions does not challenge (for example) the *limited isolationism* framework I developed in Chapter 3 or the contextual approach to determining priorities between health*care* and broader interventions aimed at the social determinants of health I explored in Chapter 6. Future work could further develop how to operationalise the normative frameworks I presented in the thesis.

Second, I have mostly taken for granted the stability of the overlapping consensus on health, arguing that health is universally valued across cultures and national borders. However, critics might cast doubt on this claim and worry that this simply reflects a dominant Western-centric view of health.[7] There is also evidence in light of the COVID-19 pandemic that health is becoming an increasingly polarised concept. For example, one's attitudes on mask wearing, vaccines, and the role of the WHO has become more aligned with partisan lines irrespective of the empirical and normative arguments, especially in the United States.[8] Given these observations, some may question whether the overlapping consensus that motivates many aspects of the thesis' arguments is sufficiently strong and stable.

[7] Michael Walzer discusses some changes in how secular societies conceptualise healthcare in contrast to spiritual pursuits, for example, in a way that may not extend to non-secular societies: Michael Walzer, *Spheres of Justice* (New York: Basic Books, 1983), 86-91.
[8] Matt Howard, "Are Face Masks a Partisan Issue During the COVID-19 Pandemic? Differentiating Political Ideology and Political Party Affiliation," *International Journal of Psychology* 57 (2022); Jieun Shin et al., "Mask-Wearing as a Partisan Issue: Social Identity and Communication of Party Norms on Social Media Among Political Elites," *Social Media + Society* 8 (2022).

There are good reasons to believe that the overlapping consensus is stable and strong. The first reason, which I articulated earlier on in the thesis, is that (following Daniel Hausman[9]) I am concerned with defending a *public* conception of the value of health for the purposes of justice. I am concerned with the public reasons we have for supporting health as a matter of justice, not necessarily the *personal* reasons one might have. The public reasons I have relied on in the thesis (for example, the role of health in relation to our universal aversion to pain and suffering) need not reflect personal reasons, with these more readily tracking cultural differences. The second reason is that the overlapping consensus that informs the thesis' view of health and its value only requires *convergence* as such rather than strict consensus. So long as we have sufficient public reasons to value health, it does not matter what those particular reasons are. The near-unanimous support for the Universal Declaration of Human Rights lends support to this optimistic view. Despite countries having widely disparate cultures, ideologies, and histories, they were able to use reasons that converged on the principles contained within the Declaration.[10]

Nevertheless, alongside an increasingly polarised view of health, the concern may remain that the overlapping consensus upon which many of the normative prescriptions and frameworks in the thesis depend may not be as universal or stable as I am making it out to be. Future work may be needed to uncover the limitations of my claims about the overlapping consensus in health and its universally accepted value. Such work might also further interrogate the

[9] Hausman, *Valuing Health*.
[10] Wolff, *The Human Right to Health*, 20; Jacques Maritain, *Man and the State* (Chicago: University of Chicago Press, 1951), 77.

preliminary views I presented early on in Chapter 1 on the value of health, and whether more can be said about the reasons why, in the end, it matters that our bodies and minds are healthy. The answer to this question will, to a large extent, determine the contours of the demands of global health justice and how it ought to sit alongside other priorities of justice.

While health and global health have important natural and biomedical components, these are strongly determined by, and take place within, a background condition of social and political policies and priorities. It is important that these background conditions are interrogated and justified by principles of justice, and not merely accepted as they are. Health is simultaneously a natural and a social good, and this thesis has shown what justice demands in its global distribution.

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