Chapter 13:
International Health Inequalities and Global Justice: A Concluding Challenge

Disturbing international inequalities in health abound. Life expectancy in Swaziland is half that in Japan.[1] A child unfortunate enough to be born in Angola has 73 times as great a chance of dying before age five as a child born in Norway.[2] A mother giving birth in southern sub-Saharan Africa has a 100 times as great a chance of dying from her labor as one birthing in an industrialized country.[3] For every mile one travels outward toward the Maryland suburbs from downtown Washington DC on its underground rail system, life expectancy rises by a year—reflecting the race and class inequities in American health.[4] Are the glaring, even larger, international health inequalities also unjust?

All of us no doubt think they are grossly unfortunate. Many of us think they are unfair or unjust. Why should some people be at such a health disadvantage through no fault of their own, losers in a natural and social lottery assigning them birth in an unhealthy place? Others of us are troubled by the absence of the kinds of human relationships that ordinarily give rise to the claims of egalitarian justice that we make on each other—for example, being fellow citizens or even interacting in a cooperative scheme. Who has obligations of justice to reduce these international inequalities? And do those obligations hold regardless of how the inequalities came about? What institutions are accountable for addressing them?

My account of just health, alas, gives us no simple or straightforward answers to these important questions about global justice. Some will see that as a serious shortcoming, perhaps insisting that an adequate account of justice and health must apply uniformly to all citizens of the globe or even the cosmos. Others are less troubled by the silence of my account because they reject the idea that justice can apply to people regardless of the relationships they stand in to each other. For them justice is fundamentally relational—indeed it depends on the relationship of being fellow citizens in a state-- and not cosmopolitan.

My task in this chapter is to point, in a very preliminary way, to a relatively unexplored middle ground where I hope it is possible to clarify what kinds of international obligations of justice exist. This effort, however, takes us into relatively unexamined territory. Unlike the applications of just health described in Part III, where I hope I have

suggested some of the power of the integrated theory developed earlier, in this concluding chapter I must be much more tentative about how to map this terrain. Though it is traditional for concluding chapters confidently to wrap things up, to look proudly backward over the route taken, I think it more important to point forward to a challenging new area of work. Just health, I shall argue, has global dimensions, but plotting them in more detail than I can suggest here is a future project we must all undertake.

When Are International Inequalities in Health Unjust?

Health inequalities between social groups, we saw in Chapter 3, count as unjust or unfair when they result from an unjust distribution of the socially controllable factors that affect population health and its distribution. We used Rawls's account of justice as fairness to give content to what an ideally just distribution of the socially controllable factors would be. Specifically, Rawls's principles of justice as fairness assure equal basic liberties and the worth of political participation rights, assure fair equality of opportunity through public education, early childhood supports, and appropriate public health and medical services, and constrain socio-economic inequalities in ways that make the worst off groups as well off as possible. Together, this distribution of the key determinants of population health would significantly flatten the socio-economic gradient of health and would minimize various inequities in health, including race and gender inequities.

Judged from this ideal perspective, we see that there are indeed many health inequities—by race and ethnicity, by class and caste, and by gender—in many countries around the world, both developed and developing. At the same time, not all health inequalities between social groups count as inequities. For example, the health inequality that results when a religious or ethnic group achieves better health outcomes than other demographic groups because of special dietary or restrictive sexual practices would not count as an inequity if appropriate health education were available to the other groups.

This account tells us when health inequalities between groups in a given society are unjust, not when inequalities between different societies are. It tells us what we as fellow citizens owe each other regarding the promotion and protection of health, but not what other societies owe, if anything, by way of improving the health of the population in less healthy societies. The account, for example, fails to address this issue: suppose countries A and B each do the best they can to distribute the socially

controllable factors affecting health fairly, and, as a result, there are no sub-group inequities within them. Nevertheless, health outcomes are unequal between A and B because A has more resources to devote to population health than B. Is the resulting international inequality in health a matter of justice? Suppose we vary the case: Now B, whether or not it has resources comparable to A, fails to protect its population health as best it can, leading again to population health worse than A's. Is the resulting health inequality a matter of international justice? Our account of just health informs us about intra-societal obligations to eliminate health inequities, but it is silent about important questions of international justice.

Recasting the problem as an issue of human rights, specifically a human right to health and health care,[5] does not help us answer these questions about international justice for two reasons. First, the international legal obligation to secure a human right to health for a population falls primarily on each state for its own population, as we saw in Chapter 12. Although international human rights agreements and proclamations also posit international obligations to assist other states in realizing human rights (CESCR 2000), the international obligations cannot become primary in the human right to health and health care. External forces cannot assure population health across national boundaries in the way they might intervene to prevent the violation of some other rights, even when they can afford some assistance. The primacy of domestic responsibility arises because assuring a right to "the highest attainable level of physical and mental health" requires securing a broad cluster of rights that impact on health by establishing legal structures and other institutions that properly distribute the socially controllable factors affecting health. Thus there is considerable practical agreement about where accountability lies for population health between a human rights approach and our account of just health (as we saw in Chapter 12).

Second, even when a right to health is secured to the degree it is possible to do so in different states, health inequalities between them may still exist. Since conditions do not always permit everything to be done to secure a right in one country that may be feasible in another, the right to health and health care is viewed as "progressively realizable" (UNCHR 2003/28) Reasonable people may disagree about how to best satisfy this right, given the trade-offs priority setting in health involves (see Chapter 12). Consequently some inequalities may fall within the range of reasonable efforts at progressive realization of a right to health. In addition, because of their unequal resources, different states may

achieve unequal health outcomes while still securing a right to health and health care for their populations. Arguments that depend on appeals to human rights cannot tell us whether these inequalities are unjust and remain silent on what obligations better-off states have to address these inequalities.

Though nearly all people recognize some international humanitarian obligations of individuals and states to assist those facing disease and premature death, wherever they are, there is substantial philosophical disagreement, even among egalitarian liberals, about whether there are also international obligations of *justice* to reduce these inequalities and to better protect the rights to health of those whose societies fail to protect them as much as they might. Nagel (2005), who affirms these humanitarian obligations, argues that socio-economic justice, which presumably includes the just distribution of health, applies only when people stand in the specific relation to each other that is characterized by a state. Specifically, concerns about equality are raised within states by the dual nature of individuals both as coerced subjects and as agents in whose name coercive laws are made. Rawls (1999) also did not include international obligations to assure a right to health on the list of human rights that liberal and decent societies have international obligations of justice to protect.

This "statist" view encounters a strong counter-intuition. Remember the child who is so much more likely to die before age five in Angola than the one in Norway, or the sub-Saharan African mother who is 100 times more likely to die in childbirth than one in any industrialized country. Many of us think there is something not just unfortunate and deserving of humanitarian assistance, but something unfair about the gross inequality.

Those who claim the gross health inequalities are unjust have quite different, incompatible ways of justifying that view. For example, those who believe that any disadvantage that people suffer through no fault or choice of their own is unjust (see Chapter 2) would assert that the disadvantage facing the Angolan child is therefore unjust. The underlying principle of justice is applied to individuals wherever they are in the cosmos and regardless of what specific relationships they stand in to others—contrary to the Rawls-Nagel account, which applies principles of justice to the basic structure of a shared society. The disadvantage of the Angolan child might also be thought unjust by those who, like Rawls or Nagel, thinks principles of justice are "relational" and apply only to a basic social structure that people share, but who, unlike Rawls or Nagel, believe

we already live in a world where international agencies and rule-making bodies constitute a robust global basic structure that is appropriately seen as the subject of international justice developed perhaps through a social contract involving representatives of relevant groups globally (Beitz 1979, 2000). Fair terms of cooperation involving that structure would, some argue, reject arrangements that failed to make children in low income countries as well off as they could be. Clearly, there may be more agreement about some specific judgments of injustice than there is on the justification for those judgments or on broader theoretical issues.

I shall briefly examine two ways of trying to break the stalemate between statist and cosmopolitan perspectives. One approach aims for a minimalist (albeit cosmopolitan) strategy that focuses on an international obligation of justice to avoid "harming" people by causing "deficits" in the satisfaction of their human rights (Pogge 2002, 2005b). It is a minimalist view in the sense that people may agree on negative duties not to harm even if they disagree about positive duties to aid. This approach handles some international health issues better than others, and to identify its limitations more clearly, I shall distinguish various sources of international health inequalities, some of which are not addressed by negative duties. A more promising (relational justice) approach, which I can only briefly illustrate, requires that we work out a more intermediary conception of justice appropriate to evolving international institutions and rule making bodies, leaving it open just how central issues of equality would be in such a context (Cohen and Sable 2006). Properly developed, such an approach may address more of the sources of international health inequalities.

Harms to Health: a Minimalist Strategy

If wealthy countries engage in a practice or policy—or impose an institutional order—that foreseeably makes the health of those in poorer countries worse than it would otherwise be, specifically, making it harder than it would otherwise be to realize a human right to health or health care, then, Pogge (2005b) argues, it is harming that population by creating this "deficit" in human rights. Since this harm is defined relative to an internationally recognized standard of justice, the protection of human rights, Pogge concludes that imposing the harm is unjust. Moreover, if there is a foreseeable alternative institutional order that would reasonably avoid the deficit in human rights, there is an international obligation of justice to produce the rights-promoting alternative.

There remains some lack of clarity about how the baseline against which harm is measured is specified. When is there a "deficit" in a human right to health? Whenever a country fails to meet the levels of health provided, say, by Japan, which has the highest life expectancy? Or is there some other, unspecified standard? Consider two examples.

The Brain Drain of Health Personnel

The brain drain of health personnel from low-income to OECD countries may exemplify Pogge's concerns. Rich countries have harmed health in poorer ones by solving their own labor shortages of trained health care personnel by actively and passively attracting immigrants from poorer countries. In developed countries such as New Zealand, UK, US, Australia, and Canada, 23-34% of physicians are foreign-trained. In 2002, National Health Service in the United Kingdom reported that 30,000 nurses, some 8.4% of all nurses, were foreign-trained.

The situation that results in developing countries is dire. Over 60% of doctors trained in Ghana in the 1980s emigrated overseas (WHO 2004). In 2002 in Ghana 47% of doctors posts were unfilled and 57% of registered nursing positions were unfilled. Some 7000 expatriate South African nurses work in OECD countries, while there are 32,000 nursing vacancies in the public sector in South Africa (Alkire and Chen 2003). Whereas there are 188 physicians per 100,000 population in the United States, there are only 1 or 2 per 100,000 in large parts of Africa. The brain drain does not cause the whole of the inequality in health workers, but it significantly contributes to it.

International efforts to reduce poverty, lower mortality rates, and treat HIV/AIDS patients—the Millenium Development Goals (MDG) agreed upon in 2000-- are all threatened by the loss of health personnel in sub-Saharan Africa. An editorial in the *Bulletin of WHO* points out that the MDG goals of reducing mortality rates for infants, mothers, and children under five cannot be achieved without a million additional skilled health workers in the region (Chen and Hanvoravongchai 2005). The global effort to scale up antiretroviral treatments poses a grave threat to fragile health systems, for its influx of funds—hardly a bad thing in itself-- may drain skilled personnel away from primary care systems that already are greatly understaffed (see Chapter 10).

What about causes? There is both a "push" from poor working conditions and opportunities in low-income countries and a "pull" from more attractive conditions elsewhere. Is this simply "the market" at work, backed by a "right to migrate"?

Pogge's argument about an international institutional order has more specific grip than the vague appeal to a market. When economic conditions worsened in various developing countries in the 1980s, international lenders, such as the World Bank and International Monetary Fund (IMF) insisted that countries severely cut back publicly funded health systems as well as take other steps to reduce deficit spending (see Chapter 9). In Cameroon, for example, in the 1990s, measures included a suspension of health worker recruitment, mandatory retirement at 50 or 55 years, suspension of promotions, and reduction of benefits. The health sector budget shrank from 4.8% in 1993 to 2.4% in 1999, even while the private health sector grew (Liese, Blanchet, Dussault 2004). As a result, public sector health workers migrated to the private sector and others joined the international brain drain. Cost cutting imposed on the country led to cuts in the training of health workers, increasing the shortage. Another consequence of salary cuts was an increase in "under the table" payments to secure domestic treatment and an increase in "shadow providers" who collected public salaries but practiced privately during public sector hours. The international institutional order thus increased the push and at the same time harmed the health system in various ways.

The "pull" attracting health workers to OECD countries is also not just diffuse economic demand. Targeted recruiting by developed countries is so intensive that it has stripped whole nursing classes away from some universities in the South. In 2000, the Labor Government in the United Kingdom set a target of adding 20,000 nurses to the NHS by 2004. It achieved the goal by 2002. The UK absorbed 13000 foreign nurses and 4000 doctors in 2002 alone. Recruitment from EU countries was flat (many of these countries also face shortages in face of aging populations), but immigration from developing countries continued, despite an effort to frame a policy of ethical recruitment (Deeming 2004). Arguably, even if there were a diffuse economic "pull," in the absence of active recruiting the harm would be much less.

The remedy for this harm is not a prohibition on migration, which is protected by various human rights. The UK has recently announced a tougher code to restrict recruitment from 150 developing countries. In addition it has initiated a US$100m contribution to the Malawi health system aimed at creating better conditions for retaining health personnel there. The UK has thus taken two steps that are intended to reduce both the push and the pull behind the brain drain. Other countries have not followed suit.

International Property Rights and Access to Drugs

The minimalist strategy becomes harder to apply in a clear way to other international health issues. The problem of international property rights and the incentives they create goes beyond the issue of access to existing drugs, such as the antiretroviral cocktails that were the focus of attention in recent years.[6] Big Pharma has long been criticized for a research and development bias against drugs needed in developing country markets. Indeed, it has responded to existing incentives by concentrating on "blockbuster" drugs for wealthier markets, including many "me too" drugs that marginally improve effectiveness or reduce side effects slightly. Funding the research needed to develop a vaccine against malaria, for example, has fallen to private foundations.

Do intellectual property rights and the incentive structures they support create a foreseeable deficit in the right to health that can be reasonably avoided? Pogge (2005b) argues that they do. Nevertheless, many drugs developed by Big Pharma under existing property right protections have filtered into widespread use as generics on "essential drug" formularies in developing countries. Health outcomes in those countries are much better than they would be absent such drugs. Since many of these drugs would not have been produced in the absence of some form of property right protections, people are not worse off than they would be in a completely free market with no temporary monopolies on products.

Arguably, however, different property right protections and different incentive schemes would make people in these poor countries with poor markets better off than they currently are. Which schemes ought we to select? Pogge (2005a) proposes that we revise incentives for drug development by establishing a tax-based fund in developed countries that would reward drug companies in proportion to the impact of their products on the global burden of disease. For example, drugs that meet needs in poor countries with very high burdens of disease would yield greater payment to drug companies, even if the drugs are disseminated at a cost close to the marginal cost of production. The tax, he admits, would be hard to establish, but it would be offset in rich countries by lower drug prices. The program could be limited to "essential drugs" leaving existing incentives in place for other drug products. Even so, the tax and thus the incentives could vary considerably, presumably with consequences of different magnitude for the global burden of disease. How do we pick which alternative to use as a baseline against which a "deficit" in the right to health is specified? Pogge does not tell us.

Leaving aside the problem of vagueness, Pogge's proposal cannot be justified by appealing to the "no harm" principle alone. The proposed incentive fund would better help to realize human rights to health, as Pogge argues, but "not optimally helping" is not the same as "harming" and so the justification has shifted. There may well be good reasons for an account of international justice to consider the interests of those affected by current property right protections more carefully than those agreements now do—but that takes us into more contested terrain than the minimalist strategy.

International harming is complex in several ways. The harms are often not deliberately imposed, and sometimes benefits were arguably intended. The harms are often mixed with benefits. In any case, great care must be taken to describe the baseline against which harm is measured. Such a complex story about motivations, intentions, and effects might seem to weaken the straightforward appeal of the minimalist strategy, but the complexity does not undermine the view that we have obligations of justice to avoid harming health.

Where Do International Health Inequalities Come From?

Pogge (2005a) emphasizes the fact that 18 million premature, preventable deaths are associated with global poverty. It is tempting, then, to infer that country wealth determines population health and that if rich countries help to keep poor countries poor, they thus harm the health of those populations. If this inference is sound, it gives the minimalist strategy considerable power in addressing international health inequalities. Unfortunately, the inference is not sound, since the relationship between country wealth and country health is more complex than the inference presupposes—as we saw in Chapter 3. We need to examine the sources of international health inequalities more systematically.

We can divide the sources of international health inequalities[7] into three categories:

1. Those that result from domestic injustice in the distribution of the socially controllable factors determining population health and its distribution. Included here would be inequalities by race, caste, ethnicity, religion, or gender, or geography in the distribution of the determinants of health. Also included are failure to fund adequately (relative to capacity) the health sector, including intersectoral public health measures, immunizations, and comprehensive community based primary care; misallocation of resources, for

example, diverting funds from public health and primary care to hospital care serving best off groups in response to their demand and greater political power (see Chapter 9 for further discussion of fairness in the health sector).

2. Those that result from international inequalities in other conditions that affect health. These include inequalities in natural conditions, such as poor natural resources, including arable land, or susceptibility to droughts and floods, or disease vectors, such as mosquitoes carrying malaria or dengue. They also include socially produced inequalities, such as significant inequalities in capital, in human capital, and in political culture.
3. Those that result from international practices—institutions, rule-making bodies, treaties --that harm the health of some countries. The harms can be direct, as in the case of the brain drain of health workers, or more indirect, as in failures to build worker health and safety protections into international trade agreements, or through international loans or other means that may perpetuate poverty.

These sources of inequality are not exclusive. Some international practices (category three) may help create the social inequalities in the second category that in turn increase health inequalities; they may also make it more difficult for states to distribute the determinants of health in a just way (category one). Some of the inequalities in the second category may also contribute to the injustices of the first. The minimalist strategy would have great scope if category three sources dominated categories one and two, but this seems unlikely. Only more robust accounts of international justice can address the broader sources of inequality.

To see why the kinds of inequalities referred to in the second category cannot exhaust the problem of international inequalities in health, return to an issue raised in Chapter 3: how much health inequality across countries is simply the result of wealth inequalities? Even if we do not believe that all international inequalities in wealth are unjust, we might believe some are, and if wealth inequalities then cause health inequalities, we would have reason to judge the resulting health inequality unjust in at least some cases. Indeed, if wealthy countries harm poor ones by sustaining their poverty through various international practices, and if poverty clearly causes poor national health outcomes, then the minimalist strategy may cover a significant part of the terrain of health inequality. Indeed, we saw in Chapter 3 (see Figure 1 in Chapter 3) that the wealth of a country has an effect on aggregate measures of health, at least up

to some fairly moderate level of aggregate wealth, say $6-8000 gross domestic product per capita (GDPPC). Above that level, there is little influence of aggregate wealth on aggregate health. This may be some evidence that international inequalities in wealth have some contribution to international health inequalities, and to the extent that wealthy countries cause or sustain that inequality, the minimalist strategy obtains a grip on the problem.

But even more striking than the fact that great wealth is not needed to secure high levels of population health is the amount of variation in life expectancy both above and below that middle-income figure. Some poor countries, with GDPPC less than $3000, such as Cuba, or the even poorer state of Kerala in southern India (which has lower income per capita than the average in India), have health outcomes rivaling those achieved in wealthy ones. Among the wealthiest countries, there are also significant differences in life expectancy.

In Chapter 3, we drew the conclusion from these facts that policy matters greatly: what is done with national resources explains much of the wide variation across countries that are equally rich or equally poor. Cuba invests great effort in public health, including ecologically sound environmental policies, as well as in basic education. It invests heavily in training health personnel (its doctor per population ratio is comparable to the U.S.), and it sends doctors abroad to worse off countries. Indeed, it does so despite U.S. economic and travel sanctions intended to undermine its government by inflicting economic harm.

Cuba's success in health outcomes despite the harms imposed by the U.S. does not show that other international practices play no causal role in producing poor health outcomes elsewhere. But the Cuban example shows how hard it is to specify the baseline against which harm is to be measured. The minimalist strategy supposes that international practices that make a country poorer than it would otherwise have been would thereby make it less healthy than it would otherwise be. But international practices may make a country poorer than it would otherwise be, but determined public policy may nevertheless result in much better health outcomes than is typical for countries with those levels of poverty. The harm to health can be specified only by assuming that no good health policy is put in place—but why that assumption holds when it does may have nothing to do with the economic harm.

Kerala, like Cuba, also invests heavily in basic education, securing high literacy rates even for poor women, as well as in public health and primary care. The positive treatment of women stands out as a contrast

with practices in many other areas of India and South Asia in general. In the case of Kerala, it is popularly believed that the lack of gender bias in education and in reproductive and marriage rights is the result of a left-wing state government, but the story is more complex. Kerala, in contrast to the rest of India, had a history of matrilineal property transmission for two thousand years. As a result, women could not be discounted as in many other states of India. Its cultural tradition was a base on which a more egalitarian social policy could take root. Given a culture in which women retain significant autonomy and power, both within and outside the home, more egalitarian education and control over reproduction are realistic social goals, and both contribute significantly to population health. Though Kerala, unlike Cuba, was not the victim of focused antagonism, its superior health outcomes were achieved despite a long period of slow economic growth. To the extent that the slow growth resulted from a lack of foreign investment prompted by fears of its left-wing government, we have an even stronger counter-example to the assumption that externally caused economic harm produces lower health outcomes.

Domestic social policy and social history matter in wealthy countries also. Many industrialized countries have better aggregate health outcomes than the U.S., despite the 50% higher U.S. health care spending than nearly any other country. To a significant degree, the better outcomes result from health promoting policies: universal health care coverage, more robust protections against poverty and unemployment, better child care, more leisure and better enforcement of workplace health and safety. Some of the outcome difference is a result of much more diverse U.S. population, both ethnically (and racially) and geographically. The social inequalities that are often associated with such diversity contribute to the lower aggregate health outcomes in the United States, though it would be hard to quantify just how much. Better policy, as in the other industrialized countries, might mitigate these effects, but again, we cannot say how much.

One key factor contributing to poorer U.S. health outcomes than other wealthy countries is the history of U.S. racism, legally supported in the American South until 40 years ago. Racism played an important role in dividing the working classes so they could not pursue common interests, as workers' movements did politically in Europe. This background not only partly explains the absence of more egalitarian and health promoting public policies, but it also explains some of the ongoing inequalities that better policies might not by themselves be able to eliminate (Kawachi,

Daniels, Robinson 2005). Even in a wealthy country, then, cultural practices that produce health inequalities both inside and outside the health system contribute to international health inequalities. One reason the U.S. performs less well on standard aggregate measures of health than most other industrialized countries is its homegrown production of race (and class) health disparities.

Gender bias in other regions contributes to international health inequalities the way racism has in the United States. In Chapter 11 we noted the health impact of cultural and legal policies that disempower women in sub-Saharan Africa and in South Asia. The example of race in the U.S. and gender inequality in Africa and Asia illustrate one reason that category two and category three sources of health inequality cannot cover the terrain of international health inequalities. These domestic practices arise independently of the level of country wealth and of international agreements, institutions, or practices that may in other ways contribute to health inequalities.

Of course, racism and gender bias do not exhaust the ways in which domestic injustice can contribute to international health inequalities. Internal demands on relatively scarce resources by politically and economically more powerful, better off groups may distort policy in ways that leave worse off groups more vulnerable to health risks and less able to access remedies for those risks. Wealthy land owners and industrialists may have so much political power that they can resist efforts to tax them, leading to under-funded public health systems. Domestic injustice in the distribution of the determinants of health contributes significantly to international inequalities in health, and it is unlikely that we can explain away all domestic responsibility for the injustice by pointing to the additional contributions of some international practices.

In short, good health policy in even poor countries can yield excellent population health, and poor health policy even in wealthy countries, like the United States, can produce worse-than-expected performance. Together these observations count as some evidence in favor of a point that many agree on regardless of other disagreements about international obligations: Primary responsibility for meeting rights to health and health care in a population should rest with each state. The fact that some poor states can and do produce excellent population health makes this point dramatically.[8]

Even if primary responsibility for population health rests with each state, that does not mean the state has sole responsibility. Where we can explain why states cannot do as well as others because of being harmed

by international practices, the minimalist strategy applies. Where other international inequalities are important, but they cannot be attributed to international practices, there may still be room for other considerations of global justice.

Do international health inequalities that clearly result from domestic injustice constitute international injustice? Are other states or individuals in them obliged to try to reduce them as a matter of justice? For example, if the U.S. population does worse than Norway's solely because of American domestic injustice, not attributable to category two or three sources, does that mean there is no issue for international justice? That conclusion would seem to ignore the fact that victims of domestic injustice are still victims of injustice—at a disadvantage through no fault of their own. Does the obligation to improve their lot fall only on the local state?

What about international health inequalities that clearly result from category two international inequalities and are not the result of category three practices? Suppose, for example, that country A is wealthier and healthier than country B. Nevertheless, B is well governed and arguably "progressively realizes" a right to health for its population as best it can within its resource limits. Perhaps this captures the difference between Norway or Japan and Cuba or Kerala (imagine Kerala is a country of 30 million people, not an Indian state). Is the resulting international health inequality unjust?

Because there are significant international health inequalities that are not plausibly addressed by the minimalist strategy, we must take on more robust approaches to international justice if we think they are unjust, or we must concede that these inequalities are not, after all, matters of justice.

The New Terrain of Global Justice: Where the Action Is

Global justice is a hotly disputed area of philosophical work in part because it is so new. Not only are the complex economic and social forces underlying globalization themselves fairly recent developments, but the international agreements, institutions, and rule-making bodies that regulate those forces are just emerging and evolving, forming a moving target for our understanding. Their powers and effects are newly grasped and felt, and moral understanding of their consequences and their potential is in its infancy. The content of a theory of global justice and the justification for it can only emerge from the work of a generation of thinkers and doers grappling with the problem. The process will involve

working back and forth between judgments, based on arguments and evidence, about what is just in particular practices or decisions of the operation of international agencies or rule-makers and more theoretical considerations. We need time for reflective equilibrium to do its work.

Accordingly, my modest goal here is not to provide a theory of international justice and global health inequalities, but to suggest where I think the most promising area of inquiry lies. Specifically, inquiry should focus on a middle ground between strongly "statist" claims that egalitarian requirements of social justice are solely the domain of the nation-state and its well-defined basic structure (Nagel 2005, Rawls 1999), and strong cosmopolitan claims that principles of justice apply to individuals globally, regardless of the relations in which they stand or the institutional structures through which they interact.[9] This intermediary ground consists of relatively recently formed and evolving international agencies, institutions, and rule-making bodies. Even if this intermediary ground is not equivalent in all its morally relevant features or functions to the basic structure of a state, some of its functions may have morally important similarities to such a basic structure. These similarities may justify seeking fair terms of cooperation for them, perhaps intermediary in content between strongly egalitarian concerns appropriate within a state and the skeptical rejection of international justice that strongly statist views make (Cohen and Sabel 2006). Working out what international justice means for these international institutions, including what it means for global health, is the crucial task facing political philosophy and international politics in the next generation.

To motivate exploring this intermediary ground, we need good reason to resist the pulls of both the cosmopolitan views and the strongly statist views that form the poles of the current debate. We also need some illustrations of what it would mean for these intermediary institutions to make decisions or implement practices that address gross international health inequalities as matters of justice. What results is not a roadmap of how to get to an account of international justice, let alone a blueprint of one, but at best a satellite map revealing some key features of the new terrain.

Resisting the Pull of the Cosmopolitan Intuition

Earlier, I invoked the powerful intuition that the vast gulf in life prospects between the Angolan child and the Norwegian one is not just unfortunate but unfair. Many people think such dramatic health inequalities are unjust when they occur between the rich and the poor or

between ethnic or racial groups within a country because morally arbitrary contingencies, such as the luck of being born into one group rather than another, should not determine life prospects in such a fundamental way. The same contingency, however, applies to being born Angolan rather than Norwegian, and it seems no less morally arbitrary and troubling. By abstracting from all relations that might hold among people, including the institutions through which they interact and can make claims on each other, the intuition seems to support egalitarian forms of cosmopolitanism.

The support the egalitarian intuition appears to give to cosmopolitanism derives in part from theoretical considerations that carry weight in many ethical theories, including non-egalitarian ones. A feature of many ethical theories is that persons or moral agents deserve equal respect or concern regardless of certain contingent differences between them. Equal concern or respect is, of course, a notion that is interpreted quite differently by utilitarians, who count each person equally as a locus of welfare even if they do not assure equal outcomes for each person, and many egalitarians, who want some kind of equality of opportunity or outcomes. Whatever the differences in the content of equal respect, there is considerable theoretical agreement on what counts as the contingent or morally arbitrary differences that equal respect must ignore: mere physical distance, the color of skin, religion, gender, and ethnicity. Nationality seems to be part of the same family. The egalitarian intuition about the Angolan and Norwegian children thus draws power from the broader theoretical agreement about what generally counts as a mere contingency and therefore a morally arbitrary difference between moral agents.

The agreement about what counts as contingency and morally arbitrary difference, however, slides past a significant point of controversy. If we think of nationality as one among many traits an individual may have, it seems no less contingent than other troublesome ones, like race. In the relevant sense of “could,” we could have been born into one race or another, one nationality or another. But, if we think of nationality as a set of relationships in which one stands to others, and if we think that being in certain political relationships with others, including interacting through certain kinds of institutions, has moral import, then being a member of one nation rather than another may be a less morally arbitrary fact than it first seemed. Of course, showing that this political relationship has important moral implications, for example, for considerations of distributive justice, requires an argument, especially in

light of the power of the view that ethical considerations apply to individuals in abstraction from these relationships. Indeed, the political view may seem plausible only in light of a theory that helps explain why this political relationship, or a range of other kinds of relationships, is so important. It would beg the question against a relational view, such as Rawls (1971, 1995), simply to affirm the intuition we have been discussing.

One of the strengths of a relational view such as Rawls's is that an account of the requirements of justice will have to include an explanation of how institutions that are just can remain stable and sustain commitment to them over time. Justice must be in this sense feasible. Indeed, principles of justice are not acceptable as such if conformance with them in a society's basic structure does not over time lead to a stable or feasible social arrangement. Strains of commitment, for example, must be tolerable, that is, less demanding than for alternatives.

By abstracting justice from any account of the institutions that can deliver just outcomes in a sustainable way, the cosmopolitan view risks falling into hand wringing. It can lament injustice, but it has failed to set itself the task of showing that justice is a stable product of institutions structured in certain ways. Making justice a set of outcomes among individuals, abstracted from the institutional structure through which individuals cooperate, is utopian in a strong sense: we have no real description of what can produce it. Although the cosmopolitan may admit that institutions and political relationships are instrumentally important in achieving what justice requires in the treatment of individuals, just outcomes are specifiable independently of those institutions and relations. The basic structure of a nation-state, on this view, may be instrumentally necessary for achieving domestic justice, just as a global state may be instrumentally necessary for global justice. At any level, the institutions may be viewed as unjust if they fail to yield just outcomes for individuals. But cosmopolitan theory by design says nothing informative about how a commitment to justice can be sustained by any of these institutions. Nor does it allow for any variation in the concerns of justice that might be appropriate to institutions of different types.

Though none of these points constitutes a refutation of cosmopolitanism, they may move us to resist its pull and to consider seriously a relational view of justice. We then face the prospect of a pluralist world. Justice may be one thing for people who stand in the relations defined by nation-state and maybe another for those who are members of different states and interact through other kinds of

institutions globally.[10] Principles of justice that govern nation-states might then differ from those that govern intermediary institutions among such states, and both may differ from what considerations of fairness might mean among individuals in yet other associations. Justice, on this relational view, is a multi-layered construction. Though we have well-developed relational accounts of justice for members of the same state (Rawls 1971, 1995), we have barely begun the process of thinking about what justice means or requires for international institutions and rule-making bodies.

Resisting Strongly Statist Versions of Relational Justice

An important obstacle to exploring this international space comes from one version of a relational theory of justice, a strongly statist alternative to cosmopolitanism. Nagel (2005), stimulated by Rawls's (1999) articulation of what a liberal state's foreign policy ought to include, argues that socio-economic justice, with its concerns about equality of opportunity and economic inequality (see Chapters 2 and 3), requires that people stand in the specific relationship to each other defined by a nation-state. Within such a state, socio-economic justice has application because the terms of fair cooperation must be justifiable, that is acceptable, to all, since all citizens are at once subject to coercion and a parties to laws made in their name. Outside the state, there is a moral order, but it is limited to more fundamental humanitarian obligations to assist those facing grave risks and having urgent needs; it must also not violate some fundamental human rights, and we must keep our agreements. We do not, however, have obligations of justice to distribute health fairly, or to protect equality of opportunity, or to assist other societies to become as well off as they can be with regard to the satisfaction of rights to health or education or political participation.

Why is it only within a state that we are obliged to mitigate or eliminate morally arbitrary inequalities and pursue social and economic justice? For Rawls, Nagel says, "What is objectionable is that we should be fellow participants in a collective enterprise of coercively imposed legal and political institutions that generates such arbitrary inequalities" (Nagel 2005:128). We can ignore extra-societal inequalities but not intra-societal ones, despite the fact that both have great impact on people's lives, because there is a "a special involvement of agency or the will that is inseparable from membership in a political society"(Nagel 2005:128) and so cannot arise internationally. This will is essential to the "dual role each

member plays both as one of society's subjects and as one of those in whose name its authority is exercised" (Nagel 2005:128).

As subjects of a state, individuals are exposed to coercively imposed rules, in contrast to the constraints imposed by voluntary cooperative enterprises for mutual advantage. The coercively imposed rules are imposed in the name of all citizens, who are putatively the authors of the rules. Consequently, they must take responsibility as authors and insist on the justifiability of the rules to all involved. In this context the concern for arbitrary inequalities becomes a matter for all to address.

In contrast, Nagel argues, international institutions and rule-making bodies, such as the World Trade Organization (WSTO), the World Health Organization (WHO), the World Bank (WB), or the International Monetary Fund (IMF), do not directly coerce individuals, as states do, nor do they make rules directly in the name of individuals. Where international rules or agreements are made, as in establishing the North American Free Trade Agreement (NAFTA), they are the result of voluntary agreements or bargains made by states and are not made in the name of citizens of those states. Since these two features are missing, Nagel concludes, the kind of engagement of the will that holds for citizens of states is missing from international institutions. Consequently, the condition that necessitates a justification of inequalities and a mitigation of morally arbitrary inequalities is missing. More specifically, whereas (to use his examples) Nagel's relation to the New Yorker who irons his shirts is a contract mediated by a complex configuration of laws defining contracts and property rights that forms a system of social justice, trade agreements within the Americas that establish his relations with the Brazilian who grows his coffee constitute much "thinner" agreements or "pure" contracts that pursue mutual self-interest at the state level. They contain no assurance that background conditions of justice are met and give rise to no obligations to make such assurances.

Nagel rejects the idea that we might work out a "sliding scale" of obligations that falls in between state-mediated justice and the cosmopolitan view, that is, in the space in which I am proposing we work out our obligations. He simply asserts that a "sliding standard of obligation is considerably less plausible than either the cosmopolitan... or the political... standard" (Nagel 2005:142). Since these international institutions "do not act in the name of all the individuals concerned, and are sustained by those individuals only through the agency of their respective governments or branches of those governments," they are

missing “the characteristic [the engaged will] in virtue of which they create obligations of justice and presumptions in favor of equal consideration for all those individuals...” Nagel’s plausibility claim is question begging because it merely asserts that the statist and cosmopolitan views exhaust the plausible alternatives

We should resist Nagel’s strong statism for two reasons. First, some international institutions impose conditions in a manner that is coercive and that arguably involves the wills of those in the participant states. Second, some obligations of justice may arise in institutions that are not coercive. Cohen and Sable (2005:29) address the first reason by noting that when the WTO sets certain standards, there is no way for citizens of a country to opt out of their application. “Opting out is not a real option (the WTO is a ‘take it or leave it’ arrangement, without even the formal option of picking and choosing the parts to comply with), and given that it is not—and that everyone knows that it is not—there is a direct rule-making relationship between the global bodies and the citizens of different states.” In effect, there is coercive application of rules, albeit by agencies not directly elected by the various citizenries. This mediated agency, however, is common within complex states and still involves rules made in the name of the citizens.

There is further evidence of the involvement of wills of citizens in various cases where there is disagreement with the rulings of an international body. For example, protestors, both individuals and organizations, including official international workers organizations, have demonstrated against some free trade agreements that were signed onto by their own nations. The protest is against the rule-making body, not primarily their own governments for endorsing them. They argue that they resent being implicated, even through the agency of their governments, in a policy they disagree with, such as the failure to impose appropriate labor health and safety considerations or environmental considerations into trade agreements. In effect, these protestors of the WTO and other associations and agreements believe there is a need to justify the terms of the agreements to all affected by them. Similarly, many Americans are embarrassed that the George W. Bush administration has refused to be part of the World Court, has walked away from international treaties to address global warming, and has tried to exempt itself from the Geneva Conventions regarding the treatment of prisoners of war. They think the international agreements impose obligations appropriately “in their name,” whereas their President’s unilateralism shamefully rejects what they want to uphold.

Consequently, even if Nagel is right about the characteristic by virtue of which egalitarian considerations arise within states, that is, the dual role of citizen as both subject and author of coercive rules and thus the engagement of citizens' wills, he is arguably wrong about the *scope* of institutions within which we may find functionally equivalent conditions that have the same moral import. We find examples that include coercion and that arguably engage the wills of citizens – enough to make them advocate, protest, and appeal to these organizations to consider their claims. Even if Nagel is right about what makes this dual role morally relevant, then some egalitarian concerns may still be appropriate even outside the state.

We may also resist Nagel's strong statist position because obligations of justice can arise in international institutions even if they are not coercive and do not engage the will of citizens as subjects and authors in the way Nagel says is necessary. Cohen and Sable (2006) argue that considerations about inclusion, falling short of fully equal concern or egalitarianism but still within the domain of justice, arise within a range of international institutions. Concerns about inclusion have implications for governance. If worker organizations were suddenly excluded from participation in the International Labor Organization, that would be seen to violate important concerns about inclusion (Cohen and Sabel 2006). Similarly, if a policy enables better off groups or states to advance their interests and leaves worst off groups with little or no benefits, and if significantly better benefits could be gained by the worst off groups at little sacrifice by others, then there has been inadequate inclusion of the interests of all in the deliberations of the institution (Cohen and Sabel 2006). Nagel is then wrong to insist that only humanitarian concerns apply internationally.

Illustrations of Obligations of Justice in International Organizations

Cohen and Sabel (2006:153) sketch three types of international relationships that might give rise to obligations of justice going beyond humanitarian concerns, international agencies charged with distributing a specific good, cooperative schemes, and some kinds of interdependency. Each may give rise to obligations of justice, such as concerns about inclusion. These may range from an obligation to give more weight to the interests of those who are worse off if it can be done at little cost to others, to obligations of equal concern, perhaps yielding far more egalitarian obligations. I shall illustrate each of these relationships and the

obligations they give rise to with examples focused on key issues of global health.

The World Health Organization plausibly illustrates the idea that institutions charged with distributing a particular, important good, such as public health expertise and technology, must show equal concern in the distribution of that good. The organization would be charged with being unfair if it ignored the health of some and attended more to the health of others. For example, this point about showing equal concern arises in other debates about the methodologies WHO employs. We saw (in Chapter 4) that cost-effectiveness analysis (CEA) ignores issues of equity in the distribution of health and health care. These criticisms of CEA thus challenge the unconstrained use of CEA by the WHO whether it is using the methodology to determine health policy within a specific country or across countries. WHO is constrained by its mission of improving world health to consider equity in distribution in all contexts in which it works—within and across countries.

Concerns about equity show up in WHO's programmatic discussions as well. WHO paid attention to equity in the distribution of anti-retroviral treatments (ARTs) for HIV/AIDS (Chapter 10). WHO also sponsors a Commission on the Social Determinants of Health that has a strong focus on equity in health. Both of these examples illustrate behavior compatible with and required by the institutional charge to WHO. Either this is a misguided focus of energy for WHO, as seems to be implied by Nagel's strong statist view, or it is an implication of the obligation of justice to show equal concern that arises within institutions charged with delivering an important good—whether they operate within states or across them.

Consider now the international bodies that establish rules governing intellectual property rights, including those that are key to creating temporary monopolies over new drugs. Such a scheme is "consequential" in that it increases the level of cooperation among affected parties in the production of an important collective good, research and development of drugs, and it does so in a way that has normatively relevant consequences (Cohen and Sabel 2006:153:n.12). Suppose we conclude that this mutually cooperative scheme generates considerations of equal concern, or at least that it must be governed by a principle of inclusion.

We might then view quite favorably Pogge's (2005a) suggestion about structuring drug development incentives so that they better addressed the global burden of disease. Earlier, I said Pogge's proposal could not be defended on the minimalist grounds that it avoided doing harm because of the problem of specifying the relevant human rights

baseline. Now, however, we have a new basis on which to defend the justice of Pogge-style incentives. Such an incentive scheme, supplementing existing property rights or modifying them appropriately, would greatly enhance the benefits to those who are largely excluded from benefit for a significant period of time, and it would do so at only modest cost to those profiting from the endeavor. Minimally, it illustrates what a more inclusive policy should include; one can build into it even stronger egalitarian considerations, if the cooperative scheme gives rise to concerns about equality and not simply inclusion. Exactly what form the policy would take, or the justification for it deriving from the form of cooperative scheme involved, remains a task for further work. With these issues worked out, we might then support Pogge's incentive schemes as a way of moving some countries closer to satisfaction of a right to health, connecting the effort to human rights goals as he does.

Consider again the example of the brain drain of health personnel from low- and middle-income countries to wealthier ones. Nagel (2005:130) notes that nations generally have "immunity from the need to justify to outsiders the limits on access to its territory," though this immunity is not absolute, since the human rights of asylum seekers act as a constraint. Still, the decisions different countries make about training of health personnel and about access to their territories have great mutual impact on them. There is an important interdependency affecting their well being, specifically, the health of the populations contributing and receiving health personnel. The British decision in 2000 to recruit 30,000 new nurses from developing countries rather than try to train more greatly affected the fate of people being served by health systems in southern Africa. I noted earlier that the under-funding of salaries for African nurses and doctors, in part a legacy of Structural Reform Programs imposed by the IMF and World Bank, but clearly continued by local governments, helps create the "push" factor driving these workers abroad.

Arguably, this relation of interdependence brings into play obligations of inclusion, perhaps those of equal concern, going beyond in any event humanitarian considerations. In addition to Pogge's "no harm" or minimalist approach, we thus have available obligations of inclusion requiring us to consider the interests of all those in the interdependent relationship. These obligations can be translated into various policy options that address the brain drain: it may be necessary to restrict the terms of employment in receiving countries of health workers from vulnerable countries; it may be necessary to seek compensation for lost

training costs of these workers; it may be important to contribute aid to contributing countries aimed at reducing the push factors; it may be necessary to prohibit active recruitment from vulnerable countries.

We might combine these relationships of interdependence with the relationships and obligations that arise from cooperative schemes. The International Organization for Migration, established in 1951 to help resettle displaced persons from World War II, now has 112 member states and 23 observer states. It "manages" various aspects of migration, providing information and technical advice, and arguably goes beyond its initial humanitarian mission. Suppose it took on the task of developing a policy that helped to coordinate or manage the frightening health personnel brain drain.

Minimally, it might seek internationally acceptable standards for managing the flow—standards on recruitment, on compensation, on terms of work. More ambitiously, it might seek actual treaties that balanced rights to migrate with costs to the contributing countries, countering at least some of the pull factors and even providing funds that might alleviate some of the push factors underlying the brain drain. In seeking these, it might work together with the ILO, with the WTO, with WHO, and with the UN. Such a cooperative endeavor would reflect the common interest in all countries of having adequate health personnel—and thus being able to assure citizens a right to health and health care—as well as the common interest in protecting human rights to dignified migration.

The Way Forward

My goal in this chapter has not been to provide a road map to a theory of international justice. Instead I argue more modestly that there is a fertile area of emerging international institutions where the task of working out considerations of international justice lies. This is where the action is. We must move beyond a minimalist strategy that justifies only avoiding and correcting harms. How far we go toward robust egalitarian considerations is a matter to be worked out. In any case, how far we can go will depend specifically on the nature of the international relationships in which we stand. It will depend on the institutional structures that are still developing. This work in progress has barely started, but it must break out of the framing of the problem posed by the poles of statism and cosmopolitan individualism.

Earlier I posed the question, When are international inequalities in health unjust? This chapter falls short of providing an answer because we

remain unclear just what kinds of obligations states and international institutions and rule making bodies have regarding health inequalities across countries. In Chapter 4, we characterized domestic health inequalities as unjust when they arise from an unjust distribution of the socially controllable factors that determine population health and its distribution—and we illustrated what was meant by a just distribution by reference to conformance to Rawls's principles of justice as fairness. Internationally, we must carry out the task of explaining the substance of international obligations for the various kinds of cooperative schemes, international agencies, and international rule-making bodies in order to specify when the internationally socially controllable factors affecting health are justly distributed and regulated.

My account of just health remains, then, a work in progress. I have suggested in various chapters where more work needs to be done: addressing the stability problems posed by global aging for distributive schemes (Chapter 6); developing an adequate framework for the ethical and scientific evaluation of social experiments on health (Chapter 9); improving our understanding of fair process in actual institutional settings (Chapter 10); developing quantified models of the equity-efficiency tradeoffs in contexts where justice tells us we have a reason to reduce health disparities and using those models to inform deliberation about policies aimed at reducing health disparities (Chapter 11); improving our grasp of the institutional embodiment of accountability for reasonableness in human rights contexts (Chapter 12). The relatively novel and difficult issues of international justice addressed here add to this list. Despite the lack of closure on these matters, the account developed here provides an integrated theory that helps us see he path to pursue in promoting population health and distributing it fairly globally as well as domestically.

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[1] 40 vs 80+ years. http://www.os-connect.com/pop/p1.asp?whichpage=10&pagesize=20&sort=Country

[2] http://www.unicef.org/sowc00/stat2.htm, accessed August 23, 2005

[3] WHO/UNICEF/UNFPA, http://www.childinfo.org/eddb/mat_mortal/

[4] Michael Marmot, presentation at Harvard School of Public Health, 2006.

[5] The right is affirmed inter alia, in article 25, paragraph 1, of the Universal Declaration of Human Rights, article 12 of the International Covenant on Economic, Social and Cultural Rights and article 24 of the

Convention on the Rights of the Child. See http://www.unhchr.ch/Huridocda/Huridoca.nsf/TestFrame/267fa9369338eca7c1256d1e0036a014?Opendocument, accessed August 23, 2005.

[6] Patent holders on antiretroviral drugs led a fight, until recently, to restrict access to generic versions of their drugs. The consequence was a direct harm to those who might have benefited from antiretrovirals and died instead. Still, the emergence of these generics that do save other lives would not have happened had there not been the incentives created by the existing patent system—or so the dominant view about intellectual property maintains.

[7] Not all international health inequalities plausibly raise questions about injustice, just as not all domestic inequalities between groups raise those questions. For example, religious or ethnic differences in lifestyle (diet, sex, social cohesiveness) might give rise domestically and internationally to health inequalities that we would not consider unjust.

[8] In *The Law of Peoples*, Rawls (1999) makes the claim that international inequality in wealth or income is quite compatible with well-ordered societies producing justice for their populations. He argues that if two well-ordered societies make different decisions about population policy, with the result that one becomes wealthier than the other over time, then the wealthier one should not then have to make transfers to the other in accordance with some international Difference Principle aimed at making the worst off as well off as possible. Arguably, an analogous point holds for health policy and health inequalities..

[9] Beitz (1979) holds a relational view, though it is global in scope, since he has argued that the emerging international institutions constitute a global basic structure, even if not a global state, that demands fair terms of cooperation. This view is distinct from the cosmopolitan individualism that is being contrasted with statism.

[10] Michael Blake (2002), for example, argues that liberal egalitarianism within nation-states raises questions about relative inequality, whereas global justice permits only considerations of absolute inequality.