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The Trinity papers

“Rationality is interpreted here, broadly, as the discipline of subjecting one’s choices—of actions as well as of objectives, values, and priorities—to reasoned scrutiny.”

Amartya Sen

What are the prospects for human health in a world increasingly threatened by AIDS, terrorism, environmental destruction, and political indifference? The answers are unknown. And so our responsibilities as physicians and citizens in addressing these and many other issues pertaining to our security and survival remain obscure. One way to clarify strategies for alleviating the burden of human disease is to think critically about the assumptions—the concepts and categories—that underlie health systems and public-health programmes. These assumptions are rarely challenged. They are far too ingrained within international institutions, too embedded in government policies, to be evaluated seriously. Yet to make progress in diminishing human suffering surely demands resistance to these comforting orthodoxies and long-held conventions.

In October, 2003, a group led by Professor Amartya Sen, then Master of Trinity College, Cambridge, UK, gathered to discuss the foundations of global health and the values underpinning those foundations. Entitled “Rights, Dignity, and Inequality”, the meeting was held in Trinity College and convened under the auspices of the Centre for History and Economics at King’s College, Cambridge. The papers presented at that meeting are what follow. Thanks go to Amartya Sen, Sabina Alkire, Sudhir Anand, Giovanni Berlinguer, Lincoln Chen, Tim Evans, Melissa Lane, Michael Marmot, and Jennifer Prah Ruger for organising and contributing to this meeting. The conference was supported by a generous grant from the Rockefeller Foundation.

Richard Horton

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1 Sen A. Rationality and Freedom. Cambridge: Harvard University Press, 2002.

Global health and moral values

Sabina Alkire, Lincoln Chen

Soon after assuming office on July 21, 2003, the new Director-General of WHO, Lee Jong-wook, announced plans to launch several global health initiatives: re-energising primary health care to achieve the Millennium Development Goals (MDGs), launching the ambitious 3 by 5 initiative to expand access to antiretroviral drug treatment to 3 million HIV-positive people by 2005, and accelerating country-based action through strengthening human resources. A similar pattern of new global initiatives characterised the opening phase of the previous WHO administration led by Gro Harlem Brundtland, launching programmes such as Roll Back Malaria, Stop TB, tobacco control, polio eradication, and partnerships such as GAVI (Global Alliance for Vaccines and Immunization).1

Ethics and moral values are invariably invoked to mobilise support for these global initiatives. Earlier on in May, 2003, Lee used the terms social justice and security in his address to the World Health Assembly.2 On assuming office, he underscored that “global health work must be guided by an ethical vision”. Recently, he wrote: “Both technical excellence and political commitment have no value . . . unless they have an ethically sound purpose.”3

If ethics are the foundation for global health initiatives, how should moral philosophy guide policy choices and shape the way such programmes are undertaken? In this essay we argue that clarity regarding morality underlying global health initiatives is important, both for why and how programmes should be undertaken. Common moral values might be used to justify new global programmes, suggesting that the programmes might be
shaped differently depending on the morals espoused. A rights-based or equity approach, for example, would be expected to differ from a utilitarian or humanitarian approach. Also, an initiative is only partly justified by its moral expediency. Of critical importance are factors shaped by knowledge and by institutional interests. Moral soundness about why particular global programmes should be advanced may need to be balanced against the imperative of achieving consensus among people of many different moral views. Yet, as we argue in the conclusion, moral clarity—as well as knowledge and institutional interests—can usefully shape what, when, and how health initiatives should best proceed.

**Schools of moral thought**

To stimulate discussion, we have selected four major schools of moral values commonly used to justify global health initiatives: humanitarianism, utilitarianism, equity, and rights. We could have analysed other schools, but these four, we believe, encompass a good range of moral positions. There are, of course, both large and important variations within each school.

**Humanitarianism: acting virtuously towards those in need**

The appeal for charitable acts to meet pressing humanitarian needs is arguably the most common ethical basis for global health action. Humanitarianism can be a form of virtue ethics but it also often a humanistic response to evident social problems. The ethos of humanitarianism is embedded in nearly all religions. In a humanitarian approach, people respond to human suffering and realise human fulfilment by acting in a virtuous manner based on compassion, empathy, or altruism. The virtues might be specific or broad. Examples of specific acts are charitable tithing among Baptists or zakat (charitable donations) among Muslims. Broadly proscribed virtues encompass such human qualities as generosity, honesty, trustworthiness, integrity, and fairness. Among the wealthy, these virtues might be expressed as philanthropy, which often focuses on health.¹

Humanitarianism provides the primary ethical basis of voluntary action undertaken by non-governmental organisations (NGOs), and is also an important base of public support for official foreign aid. US president George Bush in announcing US$15 billion in assistance for HIV/AIDS control described the pledge as a “work of mercy”. Public opinion polls in the USA consistently show that alleviating world hunger and providing drinking water are worthy of foreign aid from the USA. Emphasis on voluntary generosity and self-expression (rather than on duties or obligations) gives humanitarianism a broad appeal to many social groups, corporations, and governments.

Contemporary appeals to people’s humanitarian impulses focus on the giver: who a person becomes by acting well, and how a person realises a sense of accomplishment or fulfilment. There are dangers that those who are helped can be placed in a dependent position, treated as victims not agents. Also, the underlying societal rules and structures that generate the social ills are not necessarily addressed. This approach might be more relevant to humanitarian catastrophes than structural approaches that attempt to correct the root causes of social problems.

**Utilitarianism: maximising aggregate subjective happiness**

In a utilitarian framework, the value of health is determined by the subjective utility (happiness, pleasure, or desire satisfaction) that it creates for an individual.² Across all individuals in a society, the ideal state is one that maximises the aggregate utility. Health could be valued because it generates utility directly, or because good health is instrumental to other utility-generating states, including opulence, or both. Many contemporary health policies are based on a form of utilitarianism in which good health is valued as instrumental to maximising aggregate utility. For example, the WHO Commission on Macroeconomics and Health calculated the costs and benefits of burdens of disease and argued that investing in health would generate economic growth, thereby enhancing incomes and aggregate utility.³

The utilitarian approach underscores important interconnections between health and other variables. It can show how improving the health of the deprived can be “in everybody’s interest”—including the self-interest of people not inclined to altruism. Its difficulties, however, are several. First, the instrumental valuation of health demeanes it as an intrinsically valued goal in all societies. Second, people’s self-assessments do not...
necessarily match their observed health status. For example, the self-reported morbidity rates in the Indian state of Kerala, where life expectancy is 70–75 years, are significantly higher than in Bihar, where life expectancy is significantly lower; and self-reported morbidity in the USA is higher still. Third, it is rather difficult, even theoretically, to aggregate very different kinds of utility together into a single entity. Finally, a utility-maximising approach is not directly sensitive to distributional concerns.

**Equity: achieving a fairer distribution of health capabilities**

Equity is a relational concept in which ethical assessments are—at least in part—based on distributional features of one or more variable. Fortunately, considerable intellectual work has recently been done on health equity and social justice.

Building on the work of political philosopher John Rawls, Amartya Sen has addressed some key features of health equity. First, he poses the question of “equity of what?” Should equity be evaluated with reference to health achievement or access to health care? Sen argues that equity in health should be assessed in terms of health capabilities and achievements rather than health-care activities. After all, health care is a human activity; what people actually value is the capability to attain good health. He further notes that equitable social processes should inform evaluations of equity in the health space.

In some equity domains, such as gender, completely equal distribution of health achievement could be considered unfair because women—whose lifespan in the absence of gender discrimination exceeds that of men—should, under an equity framework, enjoy longer life expectancies.

An equity-based evaluation considers not only allocation of a fixed set of health resources, but also allocation of resources between health and other social objectives. Equitable approaches to health have carried considerable power in mobilising support for health components of international development. Striking disparities in health achievement and emotively powerful arguments of preventable suffering can animate the public and political leaders. An example is the recent call for public funds to expand antiretroviral treatment to HIV-positive people in poor countries. The disparity between the health of those with access to life-saving drugs and the avoidable deaths among all others evokes the moral imperative to alleviate preventable human suffering caused by the inequitable access to antiretroviral drug therapy.

**Rights: fulfilling our obligations so others are dignified**

Human rights in health are embedded in several UN declarations, and they have deep and wide moral bases. Legal formulations were created to specify what was argued in the 17th century to be an inalienable moral claim grounded in the ontological dignity of human beings. Human rights can be described as “things which are owed to man because of the very fact that he is man.” Some human rights can be expressed in the space of capabilities—for example rights to health, or to inclusion. Yet rights also add to the capability perspective by invoking duties and obligations on the part of others. Because each human being is recognised as an “end”, human rights demand obligatory behaviour on the part of the state, firms, groups, and individuals. Obligations may be “perfect” (as enshrined in law) or “imperfect” (a general duty to do what one can to help).

Calls for a rights-based approach to global health have recently grown. Extensions of human rights to children and women both contain references to freedom from preventable suffering and freedom to exercise health choices. The application of human rights to good health has drawn attention to the duties and obligations that people and institutions have towards human beings, viewed squarely as an “end” worthy of dignity. A human rights approach often assumes some health minimum that all people should be able to realise for human dignity. The challenge is to implement the corresponding “incomplete obligations” among communities, institutions, and states where good health depends upon resources, knowledge, technologies, and social action.

**Knowledge and institutions**

These ethical schools do not track precisely to any specific health initiative. None of the schools dominates any specific health action, and several schools are often relevant to any single initiative. At present, whether the 3 by 5 initiative was evaluated according to aggregate utility (increasing the utility of people with HIV/AIDS) or distributional equity (increasing the numbers of people in developing countries who are given antiretroviral treatment), human rights (for health care), or the need
for humanitarianism (to alleviate the suffering of those with HIV/AIDS), in all cases action is morally imperative. Ensuring a minimal threshold of health might similarly fit well with humanitarianism and human rights, and equity and justice values will require action on behalf of the most disadvantaged. Beyond moral values, the selection of global health initiatives is shaped by other, often implicit but no less valid, factors. Among these are knowledge and institutions.

To a large degree, ethical assessments will rest not only on the ethical perspective chosen, but also on the information selected for examination. The selection of information is shaped by political and scientific forces as well as by moral theories. Paul Farmer has written eloquently about the selective scrutiny of information that shapes health action. Tuberculosis, especially multidrug-resistant tuberculosis, became recognised as a health crisis when it achieved rapid transmission in New York City. Yet tuberculosis—before, during, and after the New York crisis—kills 2 million people annually, most of whom are poor. Because of informational selectivity, tuberculosis is a silent crisis among the world’s poor, invisible to the rich and powerful. Similarly, severe acute respiratory syndrome (SARS) achieved front-page news because of its lethal nature and the paralysing effect it had on global commerce. Yet, “SARS-like” health catastrophes take place daily in thousands of rural villages in low-income countries. These health problems likewise severely affect families and communities, who are invisible to better-off and protected communities.

Scientific knowledge provides the basis for research and development of health technologies, such as vaccines and drugs. Breakthroughs in health research raise moral challenges because they make feasible treatment for conditions that were hitherto incurable—for example, antiretroviral drugs for HIV. Morally, there is a big difference between inevitable human calamity and suffering that can be prevented by modern technology. Growing knowledge gaps between technological potentiality and health realities present huge ethical challenges. Contention is further fuelled if the gap is accentuated by commercial interest. Recent debates over affordable access to life-saving antiretroviral drugs have focused on the fairness of international regimes of intellectual property rights that are perceived to favour commerce over human health.

Global health, like other fields, has a cluster of institutional stakeholders. Governments and intergovernmental agencies like the UN and the World Bank are mandated to play technical, financial, and operational roles. Since health is a major component of the global economy, corporations have interests in profits as well as in protecting their public reputations. Civil society organisations have many roles, ranging from the direct delivery of services to advocacy on public policies. Institutions, like all actors, are endowed with certain capabilities and also seek to advance their bureaucratic, political, and financial agendas. One typical driver of organisational behaviour is to gain command over resources that can translate into more jobs, higher status, and more numerous activities. Tracking of financial flows in global health initiatives can help reveal institutional winners and losers.

Historical studies have examined these institutional motivations in global health. The work of the Rockefeller Foundation overseas, for example, was often linked to corporate interests and political propagation of capitalism. In an excellent historical analysis of tuberculosis control in mid-20th century, Sunil Amrith postulated that the conduct of tuberculosis programmes was primarily shaped by the state of knowledge and the capabilities of global institutions. Field research had shown that directly observed therapy (DOTS) was highly effective in curing tuberculosis in home-based settings. Endowed with new knowledge, yet limited by institutional capacity and scarce funding, WHO decided to pursue tuberculosis control through vertical programmes involving cadres of specifically tasked field workers rather than attempt to build holistic village-based primary services. The latter approach would have been far more demanding institutionally and financially.

Consensus and advocacy
A common usage of moral values is to mobilise public support. Sometimes, however, advocates of global health do not give an accurate representation of distinct ethical schools, simply because they want everyone to agree.
Braveman and Groskins, for example, argued that the concepts of equity and rights are essentially identical, and lead to similar strategies. Their aim seems to have been advocacy for certain types of health actions rather than for clarification of distinctive moral schools. De Cock argued that a public health rather than a human rights approach should frame responses to HIV/AIDS in Africa, but again this analysis is based on a very narrow example of both ethical schools. We argue that clarity in thinking is essential, because different moral schools do indeed raise distinct considerations and it can be useful to evaluate these carefully. At the same time, the urge to seek consensus is also valid, and can be sought without either exaggerating differences, or claiming (inaccurately) that differences between moral schools do not exist.

A common usage of moral values is advocacy, often to rich and powerful leaders, institutions, and nation states with the goal of mobilising resources—finance, political will, human motivations—on behalf of particular health action. But here we run into an apparent paradox: how can one use moral values as advocacy tools, when the moral schools are distinct, and when people argue passionately among them? In order to achieve the support, global health programmes also must build consensus among a diverse constituency of resource-holders as to the central value of the initiative. So when it comes to the language of why support for global health is important, we recognise, with Cass Sunstein, the wisdom of seeking “incompletely theorized agreements” in the moral discourse surrounding global health.

In his 1994 Tanner Lectures in human values, Sunstein argued that in some cases consensus can be achieved if participants refrain from elaborating their moral positions, because if they scrutinised these positions in depth, consensus could fracture. By contrast, he advocates an approach that “enlists silence, on certain basic questions, as a device for producing convergence despite disagreement, uncertainty, limits of time and capacity, and heterogeneity”. Sunstein’s approach has the advantage of opening space for dialogue, exchange, and discussion, thereby promoting deliberative democracy, political accountability, and reason-giving. Incompletely theorised agreements satisfy diverse constituencies who might have very different reasons, including incompatible values, for supporting a particular activity.

There is a further point against requiring everyone to agree on only one ethical justification for global health. For not only might different approaches appeal to different groups, different people might also have distinct understandings of what the terms “rights”, “equity”, or “humanitarianism”, actually mean. After all, the support base of global health initiatives is diverse, ranging from heads of state to private-sector executives to religious leaders to activists from NGOs to opinion-setters and journalists. It is highly unlikely that these constituencies will share an identical understanding of ethical terms.

A global health initiative can receive emphatic support from people who do not necessarily agree on the ethical foundations for their support, and in fact may very clearly disagree with one another as to why a programme should proceed—ie, its ethical or metaphysical justification. Advocates of global health initiatives would thus do well to proceed with a general appeal to moral concepts such as social justice and compassion, and this generality belies prudence rather than a lack of moral rigour.

Moral clarity
Yet an eclectic appeal to moral values in order to garner support of global health initiatives is not to imply that distinctions among moral values are trivial. Beyond clarifying why an action is important, adopting a particular moral approach can influence health action in other deeply important ways.

First is the scope of health action. An example is the programmatic implication of pursuing access to health care versus equitable distribution of health outcomes. In the former case, the programme would invest heavily in building health clinics and outposts, and perhaps in increasing the ratio of medical personnel per citizen. This sounds very appealing until one recognises that a country may have many rural health outposts, and many

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Field research has shown that DOTS is highly effective in home-based settings
doctors on salary role, but if these doctors do not turn up to work, and the outposts do not have adequate pharmaceutical supplies, the population’s health outcomes might remain very poor. On the contrary, to achieve an equitable distribution of health outcomes it would be necessary to make sure that the investment in health care results in better health across the population. It would also then be necessary to address broader social determinants of health, such as that raised in Michael Marmot’s intriguing research on the under-recognised relation between socioeconomic inequality and health.

Second, different ethical schools (and different groups within them) may shape how global health programmes are undertaken. Charitable acts might treat people as passive recipients of generosity, whereas rights-based approaches would encourage “voice” and participation to strengthen the agency of people for achieving their inherent rights.

Third, advocacy might use moral values to advance a global health agenda—because they are effective in advancing a global agenda. To mobilise a compassionate response, a picture of a feeble, emaciated, and large-eyed child might be used to stir pity among donors. Such advertisements tend to view the poor as helpless victims, rather than people who could be empowered to care for themselves. Arguably, much harm has been done by such dehumanising advocacy techniques. Yet, it could be argued that such moral approaches are legitimate to use because they are more effective in evoking public support than other moral approaches.

When people speak of ethics, the contribution that most readily leaps to mind is motivational: that an appeal to moral values will motivate people to support a set of actions. Yet this is only one of the ways in which moral values can support global health initiatives, and is not necessarily the most powerful. Discussions on whether to frame the objective of global health initiatives in terms of access to health care, or capabilities for good health, or utility maximisation, help to clarify what global health initiatives seek to accomplish. Consideration of how health activities contribute to or block non-health objectives such as the support of agency, or the rights to self-determination, clarify the importance of how health initiatives are carried forward. Thus global health may be far easier to achieve if we pause to follow through different moral analyses and thereby clarify what, which, and how global health initiatives can best proceed.

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