Health and Global Governance: Why Justice Matters

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Outline

- Global Health Equality and Inequality
- Health Disparities Among and Within Countries, Indicators Associated with Health Inequalities
- Alternative Paradigms, Health Equity & Moral Responsibility
- Health Governance: Why Justice Matters
- Theoretical Grounding: Ethical Commitments & Moral Norms
- Duties and Responsibilities: Global and State Roles and Obligations
- Conclusion
Global Health Equality and Inequality

- Attainment vis-à-vis shortfall equality (Aristotle)
- Attainment equality: equal absolute levels of achievement
- Shortfall equality: equal use of respective potentials, shortfall from a desired value or target (acceptable level)

- Global health goals:
  - Reduce shortfall inequalities:
  - Reduce the gap between the possible maximum and actual achievement to fully realize a given individual’s or group’s health potential
Global Distribution of Disparities in Under-five Mortality

Mortality Rate, Under-five (per 1,000 live births)
- **Group 1 (Better-off):** Mean=20.6 (13.7), Range=3.9 ~ 60.0
- **Group 2 (Mid-level):** Mean=105.6 (26.4), Range=66.0 ~ 156.0
- **Group 3 (Worse-off):** Mean=207.3 (38.9), Range=160.0 ~ 316.0
- **No data available**

Ruger and Kim, Global Health Inequalities: An International Comparison
Global Distribution of Disparities in Adult Mortality (Male)

Mortality Rate, Adult Male (per 1,000 male adults)
- **Group 1 (Better-off):** Mean=173.5 (48.8), Range=80.4 ~ 250.0
- **Group 2 (Mid-level):** Mean=331.8 (58.5), Range=258.0 ~ 449.0
- **Group 3 (Worse-off):** Mean=583.7 (74.9), Range=460.0 ~ 725.0
- No data available

Ruger and Kim, Global Health Inequalities: An International Comparison
Time Series Trend of Child Mortality

Figure 3a. Time Series Trend of Child Mortality

Ruger and Kim, Global Health Inequalities: An International Comparison, JECH
Figure 2a. Time Series Trend of Adult Mortality

Ruger and Kim, Global Health Inequalities: An International Comparison
Rate of Change in Child Mortality

Figure 3b. Rate of Change in Child Mortality

<table>
<thead>
<tr>
<th>Year</th>
<th>Group 1 (Better-off)</th>
<th>Group 2 (Mid-level)</th>
<th>Group 3 (Worse-off)</th>
</tr>
</thead>
<tbody>
<tr>
<td>60 – 70</td>
<td>0.292</td>
<td>0.153</td>
<td>0.124</td>
</tr>
<tr>
<td>70 – 80</td>
<td>0.375</td>
<td>0.240</td>
<td>0.141</td>
</tr>
<tr>
<td>80 – 90</td>
<td>0.376</td>
<td>0.225</td>
<td>0.062</td>
</tr>
<tr>
<td>90 – 2000</td>
<td>0.326</td>
<td>0.110</td>
<td>0.056</td>
</tr>
</tbody>
</table>

Ruger and Kim, Global Health Inequalities: An International Comparison
### Rate of Change in Adult Mortality

#### Figure 2b. Rate of Change in Adult Mortality

<table>
<thead>
<tr>
<th>Year</th>
<th>Group 1 (Better-off)</th>
<th>Group 2 (Mid-level)</th>
<th>Group 3 (Worse-off)</th>
</tr>
</thead>
<tbody>
<tr>
<td>60 ~ 70</td>
<td>0.138</td>
<td>0.035</td>
<td>0.086</td>
</tr>
<tr>
<td>70 ~ 80</td>
<td>0.120</td>
<td>0.061</td>
<td>0.099</td>
</tr>
<tr>
<td>80 ~ 90</td>
<td>0.118</td>
<td>0.083</td>
<td>0.037</td>
</tr>
<tr>
<td>90 ~ 2000</td>
<td>0.066</td>
<td>0.018</td>
<td>-0.317</td>
</tr>
</tbody>
</table>

Ruger and Kim, Global Health Inequalities: An International Comparison
## Health Inequalities Within Countries

Under-five mortality (per 1000 live births)

<table>
<thead>
<tr>
<th>Country</th>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
<th>Q5</th>
<th>Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cambodia</td>
<td>90.3</td>
<td>82.8</td>
<td>68.4</td>
<td>48.5</td>
<td>30</td>
<td>40</td>
</tr>
<tr>
<td>Egypt</td>
<td>49</td>
<td>36.1</td>
<td>32.2</td>
<td>27.2</td>
<td>18.9</td>
<td>21</td>
</tr>
<tr>
<td>Ethiopia</td>
<td>137</td>
<td>121</td>
<td>96</td>
<td>100</td>
<td>86</td>
<td>68</td>
</tr>
<tr>
<td>Ghana</td>
<td>128</td>
<td>105</td>
<td>111</td>
<td>108</td>
<td>88</td>
<td>72</td>
</tr>
<tr>
<td>Indonesia</td>
<td>70</td>
<td>43</td>
<td>39</td>
<td>34</td>
<td>23</td>
<td>31</td>
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<tr>
<td>Nepal</td>
<td>75</td>
<td>66</td>
<td>64</td>
<td>59</td>
<td>36</td>
<td>42</td>
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<tr>
<td>Pakistan</td>
<td>121</td>
<td>102</td>
<td>90</td>
<td>79</td>
<td>60</td>
<td>86</td>
</tr>
<tr>
<td>Zambia</td>
<td>124</td>
<td>148</td>
<td>155</td>
<td>140</td>
<td>110</td>
<td>89</td>
</tr>
</tbody>
</table>

Data obtained from MEASURE DHS (funded by USAID and UNICEF) and the World Bank
Indicators Associated with Health Inequalities

Social / Economic

- Extreme poverty
- Inflation and currency instability
- Lower % of GDP in trade
- Living in rural areas
- Poor communication and information technology
- Female illiteracy
Indicators Associated with Health Inequalities

Public Health / Health Care

• **Health Care System**
  - Lower per capita spending on health care
  - Lower per capita outpatient visits
  - Lower per capita hospital beds
  - Lower physicians and nurses per capita

• **Public Health**
  - Lower immunization rates
  - Lower rates of access to improved water
  - Lower rates of access to sanitation

Ruger and Kim, Global Health Inequalities: An International Comparison
Alternative Paradigms

- Economic Neo-liberalism (income and wealth)
- Utilitarianism (utilities, pleasures, desires)
- Libertarianism (procedures for liberty)
- Rawlsian Justice as Fairness (primary goods) and society of states (law of peoples)
- Cosmopolitanism (foreign aid – duty of rectification) and nationalism
- Human flourishing (human lives, substantive freedoms), Provincial Globalism and Shared Health Governance
Health Equity and Moral Responsibility

- Health inequalities represent failures to discharge global and domestic obligations (positive duties) of global health equity.

- Health/human flourishing morally central aim shared by all persons by virtue of their humanity, being human itself, our common humanity, confers moral status, proper end of global social and political activity.

- Health is a morally salient human characteristic that warrants respect and requires protection and promotion, meet health needs to flourish.

- Health inequalities reduced through social organization/collective action at global and domestic level – reforms of global/domestic health governance required.
Tackling Health Inequalities

- Health inequalities reflect broader social, political, economic environment in which people live.

- Health inequalities not reduced through market mechanisms alone: government and public policy is required -- Health inequalities not reduced by health care sector alone.

- International/national responses to health inequalities rooted in ethical values about health – treat all people equally in morally relevant ways – respect all people by respecting their health/human flourishing.

- Global health governance as shared health governance focused on global health equity rather than rational actor model based on self and national interest alone.
Health and Global Governance: Why Justice Matters

- Reducing health disparities requires *social organization* in form of:
  - Redistribution of Resources
  - Related Legislation and Public Policy
  - Public Regulation and Oversight
  - Creation of Public Goods

- Health and global governance should place individual health and human flourishing at the center of health governance – shared health governance and provincial globalism (Global Health Constitution to coordinate shared responsibility)
Redistribution of Resources

- **Between Groups**
  - From wealthy to poor
  - From well to sick
  - From middle-aged to elderly and young

- **Policy Measures**
  - Progressive taxation
  - Equitable and efficient risk pooling
  - Economies of scale
  - Redistributive expenditure patterns
  - Subsidies and cash transfers
Legislation and Policy

- Health Policy Sector
  - Financing health care: health insurance
  - Public provision of health services where market fails to deliver
  - Provision of public health information, surveillance and services
Legislation and Policy

- **Other Policy Sectors**
  
  - Expand economic opportunities: reduce poverty and unemployment
  
  - Improve educational opportunities, especially for women
  
  - Tackle structural inequalities in social programs, political processes
  
  - Institutional reforms to reduce corruption, increase participation in politics and promote legal equity in legal systems
  
  - Reduce social barriers to asset and skill development
  
  - Investing in risk reduction measures
  
  - Protecting against catastrophic financial risk (old-age, disability)
Public Regulation and Oversight of Private Markets

- **Health Care and Public Health Sector**
  - Health care services
  - Health insurance
  - Health providers
  - Pharmaceutical companies
  - Medical devices

- **Other Policy Sectors:**
  - Clean air and pollution control
  - Use of toxic substances
  - Occupational safety
  - Housing and building codes
  - Managing risk
Theoretical Grounding: Ethical Commitments

- **Commitments**
  - Health and human flourishing end goal of health governance
  - Requires a genuine ethical commitment toward end goal of providing all individuals opportunity to be healthy
  - Without this ethical commitment not possible to socially organize and redistribute resources because effort to do so must be voluntary
  - Avoid coercive measures – both from global to national community and within national community from one group to another (nudges fine)
  - Ethical commitments freely entered into by individuals are obligations

- Ruger, Right to Health, YJLH
Theoretical Grounding: Norms and Obligations

Internalizing Public Moral Norms

- Individuals internalize public moral norms to motivate social action
- Public moral norm: health is of such importance that it is worthy of societal recognition, investment and regulation to achieve
- Individuals willing to give up some autonomy and resources (through collective action) to achieve this goal

Individual and Societal Obligation

- Individuals and society (as will of people) freely obligate to help the person whose human flourishing and health is threatened
Individual and Societal Obligations:

- **Individuals**

  - Obligation of individuals requires them to give “serious consideration” to providing “reasonable help” to the person whose human flourishing and health is threatened.

  - Threatened or inequitable health is that which differs from maximum feasible.

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Ruger, Right to Health, YJLH
Individual and Societal Obligations

**States and Global Entities**

- By extension duty of States and Global Entities (as mechanisms of implementing will of people) require them to give “serious consideration” to providing “reasonable help” to the person whose human flourishing is threatened.

- Threatened or inequitable health is that which differs from maximum feasible.

Ruger, Right to Health, YJLH
Duties and Responsibilities: Global and State Roles

- **State Actors and Institutions**
  - Assume primary responsibility for creating societal conditions in country for fulfilling all individuals’ opportunity to be healthy
  - Reduce the shortfall between potential and actual health (within nations)

- “Provincial Globalism”
  - Provincial consensus accompany global consensus on health morality

Ruger, Health and Social Justice, Lancet
Ruger, Global Health Justice, PHE
Duties and Responsibilities: Global Roles

- **Global Actors and Institutions**
  - Supportive and facilitative role – create conditions in which societies can develop and flourish and promote health of their populations
  
  - Broad-based approach addressing all determinants of health and poverty (not narrow technical approach)

- Create level playing field and remedy global inequalities in affluence, power, social, political and economic opportunities
Duties and Responsibilities: State Roles

- State Actors and Institutions
  - Assume primary responsibility for creating societal conditions to fulfill individuals’ opportunity to be healthy
  - Take efforts to reduce the shortfall between potential and actual health (within nations)
Global Responsibilities

- **Macro-Social Environment (Multi-Lateral/Bi-Lateral)**
  - Facilitate economic growth in developing countries
  - Promote global financial stability
  - Financing international global public goods
  - Developed country participation in global fora
  - Debt relief and development assistance
  - Fair trade – market-opening by developed countries
  - Technical assistance and know-how
  - Global public goods; information and knowledge
Global Health Institutions

- Generate and disseminate knowledge and information (WHO, WB, NGOs, UN)

- Empower individuals and groups in national and global forums (UN)

- Provide technical assistance, financial aid and global advocacy for equitable and efficient health systems and public health programs

- Coordinate and link to other institutions to enhance impact, eliminate redundancies
Generate and Disseminate
Knowledge and Information

- Help create new technologies (e.g., an HIV/AIDS vaccine)
- Transfer, adapt and apply existing knowledge (e.g. prevention of malaria transmission)
- Manage knowledge and information (e.g., statistics on inequality in infant/child mortality and best practices)
- Help countries develop information and research capacity (e.g., health surveillance and information systems)
Empowering Individuals and Groups

- Greater citizen participation in decision-making
- Reform of state and local institutions
- Encourage political will for public action
- Help governments improve public administration
- Greater voice in national and international forums
Health System Development

- **Technical Assistance**
  - Equitable and efficient health financing (WB)
  - Training of medical and public health professionals (WHO, UN)
  - Management of tertiary, secondary and primary care facilities (NGOs)
  - Regulatory agencies (e.g., FDA or OSHA type facility) (WB)
  - Standardized diagnostic categories (WHO)

- **Financial Aid**
  - Health system development (WB)
  - Specific disease areas (Global Fund, pharmaceutical companies)

- **Global Advocacy**
  - Medicins Sans Frontiere
States’ Obligations

- **Institutional Framework for Health Sector**
  - Regulate medical equipment, medicines, facilities, work-sites
  - Oversee training, licensing, accreditation of personnel
  - Provision of sufficient hospitals, clinics, other health-related facilities
  - Generate and disseminate health-related knowledge and information

- **Equitable and Affordable Health Insurance System**

- **Equal access to quality health-related goods and services**
  - Ensure provision of necessary health care and public health
  - Ensure equal access to proximal and controllable determinants of health (e.g., nutritiously safe food and potable drinking water, basic sanitation adequate housing and living conditions)
Conclusions

- Responding to health inequalities requires a normative framework

- International and national responses to health inequalities be rooted in core ethical values about health and its distribution

- Ethical principles have the power to motivate, shape global and national obligations and hold actors accountable for goals

- Without ethics business as usual will prevail and health inequalities will go unaddressed