The global distribution of health care resources

Robin Attfield University of Wales College of Cardiff

Author's abstract

The international disparities in health and health-care provision comprise the gravest problem of medical ethics. The implications are explored of three theories of justice: an expanded version of Rawlsian contractarianism, Nozick's historical account, and a consequentialism which prioritises the satisfaction of basic needs. The second too little satisfies medical needs to be cogent. The third is found to incorporate the strengths of the others, and to uphold fair rules and practices. Like the first, it also involves obligations transcending those to an agent's relations and fellow-citizens. These conclusions are applied to international health-care provision, which they would transform.

Introduction

There has been a salutary increase of late in the study of medical ethics, and many philosophers have been applying their skills to themes such as informed consent, *in vitro* fertilisation and choices between lives in matters such as the allocation of kidney machines. This study has probably already been of assistance to individual physicians and health administrators, and, even if it has seldom been of assistance to national governments, this has not been the fault of the philosophers.

Much less, however, has been heard about international priorities in health care, and this despite the well known disparities between facilities in the poorest countries and those in the more developed ones. This could be because, besides the staff of the World Health Organisation, there are few professionals liable to be influenced by such reflection. Or it could be because problems which are difficult enough at local and national levels seem to become mind-boggling and intractable when writ large and considered in their international version. This journal in particular has carried little or nothing on international disparities of

health and health care, to judge from its own recent thematic review of past issues (1). Yet health and sickness know no boundaries, any more than morality and justice do; and it is high time for some of the global aspects of medical ethics to be explored as well as more circumscribed and familiar issues. Indeed the task of defending the tendency among medical ethicists to limit themselves to the problems of wealthier societies would be an unenviable one, were anyone bold enough to attempt it.

In this paper I shall therefore be investigating the requirements of justice in health care at an intersocietal and international level. After reviewing some of the current imbalances in health care, I shall investigate what different accounts of justice involve, and what policies, in present circumstances, those agents and agencies capable of affecting health care provision might, accordingly, be expected to adopt. But as little more than an exploratory excursion can be made into this subject here, my principal aim is to stimulate others to develop these themes much more thoroughly and in much greater detail.

The gravest problem of medical ethics

Currently life expectancy in most of Africa, at about 50 years, is considerably lower than in most of Northern Europe and North America, where it is over 70 years (2). As the life prospects of individuals depend to no small extent on life expectancy, this already constitutes a serious and, on almost any account, an unacceptable imbalance. There again, this imbalance is accompanied by others: by imbalances, that is, in the infant mortality and infant morbidity rates of those regions, in their immunisation rates, and also in the ratios of doctors, of hospitals and of dispensaries to potential patients. Further, many Asian and Latin American countries fare not too differently from most of Africa with regard to these various rates and ratios. Granted also the prevalence of diseases like schistosomiasis and of the various famine-related diseases in the poorer countries, the impression of radical inequalities in health and health care between most developed and most Third World countries is readily confirmed.

Now these inequalities are, of course, related to more fundamental imbalances between levels of wealth and of development, which are attested further by

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differential rates of literacy, productivity, investment and trade; and this is sufficient warning against regarding the problems as relating to the distribution of medical resources and facilities alone. Yet these health care imbalances are considerable enough in themselves to constitute what must be considered by those with a sense of proportion as the gravest of the many problems of medical ethics.

Justice: Rawls, Nozick, and needs

The most influential theory of justice of recent years, that of John Rawls, as presented in *A Theory of Justice* (3), has relatively little to say about a just international order. Rawls envisages a contract being made between self-interested but rational individuals who, from behind a veil of ignorance about their own life prospects, choose rules for their shared life in society. But these individuals are assumed to be potential members of the same geographical community, rather than potential members of international society. Now Rawls occasionally recognises that the principles which the contracting parties are said to choose are appropriate to societies where basic material needs can in general be met, implicitly allowing that different principles might be chosen for other circumstances. But little or nothing is specified about the principles which would be chosen to govern intersocietal relations, whether of diplomacy, communications, trade or mutual aid.

The deficiency is, however, attended to by Brian Barry in *The Liberal Theory of Justice* (4). There it is urged that Rawls's contractors would select rules for international relations which would pre-empt the need for them to live in an underprivileged society, and which would provide, as far as possible, for basic needs to be met in general in every society. Without endorsing Rawls's fundamental but questionable assumption (the assumption that the rules which self-interested but rational contracting parties choosing behind a veil of ignorance would select will be just ones) Barry here points the way towards a development or extension of Rawlsian contractarianism which would both cope with international relations and, if implemented, have a world-shaking impact on global health-care provision.

By contrast the rival theory of justice supplied by Robert Nozick's *Anarchy, State and Utopia* (5) appears systematically at odds with the kind of redistribution which contractarianism is capable of advocating. This historical theory of justice, with its concern for the upholding of entitlements and with its defence of a minimal, night-watchman state, leaves little room for re-distribution within any one society, let alone for international re-distribution. Indeed it explicitly rejects appeals to non-historical grounds for re-distribution, such as current needs.

Admittedly Nozick's theory calls for a revision of holdings where present holdings result from violence or deception in the past, as long, presumably, as the claim that this was so can itself be proved; and certainly

there would be a basis here for the advocacy of reparations between societies, as long as present deprivations could be clearly ascribed to past exploitation. But if this were the only allowable basis for international re-distribution, the prospects of poor countries would be poor indeed, granted the scope for challenges to such historical explanations of poverty. As long as needs are not counted in themselves as grounds of obligation, the obligations of rich countries would often be exhausted well before the lack of health care resources in poor countries had been as much as alleviated. But the implication that there is nothing unfair or unjust about people in their millions inheriting wretched life prospects which are far worse than those of millions of others, and through mere accidents of birth at that, puts a great strain on the credibility of any theory which carries it.

This in turn suggests a theory of value which locates high value in the satisfaction of basic needs. Things are here understood to be of *value* when there are interpersonal reasons for promoting or preserving them. This granted, a theory of obligation and of justice is readily suggested which requires agents to maximise the satisfaction of basic needs. Or rather, such a theory is readily suggested unless, as is surely implausible, other goods outstrip the satisfaction of basic needs in point of value. The resulting theory is of the consequentialist type, but is much more plausible than one requiring the maximisation of happiness or the minimisation of unhappiness, a utilitarian theory which theorists such as Rawls understandably reject. On such a theory, if there are unsatisfied basic needs in one country, however far away, their satisfaction would generally take priority over other goods, even if the other goods would arise much closer to the agent's home.

Further, this form of needs-consequentialism can justify obligations to conform to rules or practices overall compliance with which would enhance differentially the satisfaction of basic needs, and can do so for the reason that where people act together and conform to such rules, a greater difference is made to the satisfaction of needs than would otherwise be made. (Accordingly this theory is not a version of act-consequentialism, or open to the standard objections to which that kind of theory is liable.) Hence rules of trade which take into account the interests of primary producers as well as those of consumers and entrepreneurs would be upheld by this kind of consequentialism, every bit as much as by the extended contractarianism introduced earlier (6).

There again, rules requiring reparations on the part of the agents or the beneficiaries of unjustified violence or deception would again be upheld by this kind of theory just as much as by historical and libertarian accounts such as that of Nozick. This type of theory can thus account for justifications such as appeals to reparations, appeals which are apparently a strength of Nozick's theory. (By contrast, Nozick-like theories cannot consistently be revised to find room for non-historical considerations such as needs.) By combining

the justifications of redistribution found in other theories of justice, and through its capacity to appeal without inconsistency to basic needs, consequentialism thus supplies a strong basis for tackling international obligations in the matter of health care, deserving thereby to receive a readier acknowledgement of its own intrinsic merits as a theory of obligation and of value (7).

Some implications

It follows that much more effort is called for, in the forms both of treatment and of prevention. More doctors and nurses, more hospitals and dispensaries are needed in much of the Third World; but also much more effort should be given to ensuring for people everywhere clean water, adequate sanitation, improved nutrition and the control of pollution. These issues, indeed, interact with ones of health care, and in at least two ways; for they are in many cases preconditions of improved health, and, there again, improved health prospects often form a necessary condition of the success of population policies, and thereby for progress in economic and social development in general.

But it does not follow that hospitals and health systems should be transplanted from the more developed countries to the less developed, either literally or as models. On the one hand the basic needs of people in the former countries matter too; and on the other hand these institutions will not easily transplant, and will not function at all unless supplied with sufficient recurrent resources. Agents have to take account of the world as it is; and only if large numbers of agents or if powerful agencies co-operate are the contexts and the limits of possible action likely to change. Until that happens the typical ethical problem confronting agents is how, while resources remain inadequate, to make the most difference to the ocean of unsatisfied basic needs; and at the same time how to foster self-help among the people concerned, so that the fruits of intervention are multiplied and development becomes self-perpetuating. If the likeliest way of achieving this is through training paramedicals and barefoot doctors (rather than for example through building modern hospitals) then that is how action should be shaped; and the same applies if the likeliest way consists in supporting a new and more just social order, and leaving the citizens of that order to confront their health problems without further intervention.

Yet health care is an international project in more ways than this would suggest, and concerns more than the bilateral relations of any pair of countries. Infectious diseases are an international and sometimes a global threat; while much medical research is and perhaps must be of an international character. (This applies also to research into the sociology of medicine, and the study of, for example, why doctors all over the world prefer on average to ply their trade in cities rather than in the countryside, and of how, in face of such problems, to provide for rural health care.) In

such matters, whatever the merits of self-help and local autonomy, collaborative effort is often vital, as well as being in the interest of each and every country; and, even if a creaking international bureaucracy must be endured, each of them has an obligation to take part in one way or another. International divisions, barriers and hostilities obviously inhibit and sometimes prevent such collaboration; but this is but one of the many reasons for eroding them.

How obligations 'to our own people' can be overridden

So far, the activities delineated may suggest that greater effort on the part of (and support for the efforts of) international organisations such as WHO and charities such as Oxfam is the greater part of what theories of justice call for, if supplemented with some amount of aid from the governments of the more developed countries. But this is to ignore some of the ethical dilemmas facing both individuals and governments. For where the same outlay of effort or resources would make more difference to the satisfaction of basic needs if directed to a poor country rather than to one's own rich country, consequentialism apparently calls for it to be directed to the former; and this holds good of the agency of governments as well as of individuals.

Now it is widely held that the first duty of either an individual or a government is to assist one's own family, district or country; and indeed if everyone belonged to a family, district or country where concerted action was viable and enough people assisted their relations or their fellow-citizens, there would be much less call than there is for assistance to strangers and aliens. Indeed this is, perhaps, enough to justify effort to provide for one's family, at least as far as the satisfaction of basic needs is concerned. But the world is such that in some countries concerted action, for example in matters of health care, is not viable, whether because of famine, poverty or corruption; and that, for these or other reasons, not enough local people are capable of showing solidarity with one another. But this suffices to bring out fatal defects in the view that agents may quite generally give priority to their own family, district or country.

Admittedly the pressures on agents will often be such that giving priority to the basic needs (health care needs included) of faraway people is out of the question. But often it is not. There are governments which would have the support of a sufficient proportion of their electorate to be able to dedicate at least one per cent of gross national product to aid Third World countries, or to negotiate better terms for these countries in international trade or (for example, through participation in the counsels of the IMF or the World Bank) in negotiations to re-schedule international debt. And the resulting changes could make enough difference to satisfy unsatisfied health needs on an enormous scale. These governments lack the excuse of inability to act, and should accordingly do as justice demands, as many individuals and many voluntary

organisations (such as churches) do already, and many more individuals and organisations should also do.

For some medically qualified individuals, then, this could well mean practising in the Third World, where the need is great, rather than in the West, where the need is sometimes less great. For others, granted their situation, abilities and the medical needs of their own community it would not mean this, but it would mean reviewing intelligently their own sphere of operations from time to time to discover where, in the circumstances, most difference can be made.

The inescapability of commitment

Those who reject the kind of consequentialism advocated above might be thought to be under no obligation to adopt these conclusions, and free, perhaps, to regard medical ethics as limited to individual and intrasocial dilemmas rather than to the problems which I have been discussing. Yet any theory which recognises the importance of the satisfaction of needs, whether consequentialist or not, is likely to generate the same conclusions; and, there again, any contractarianism which does not insist that the contract is a purely local one is likely to yield them too, as has been seen. Only a theory restricted to the defence of current entitlements and liberties is likely to be able to resist these conclusions; but such theories diverge so far from the widespread moral beliefs of humanity both about right and wrong and about justice that theorists who defend them risk loss of credibility and governments resort to them at their peril.

Thus any credible account of obligations or of justice upholds the above implications for action, which apply to agents and agencies able to make a difference whether they recognise all this or not.

Conclusion

I have argued for the relevance of medical ethics to international and intersocietal issues, and maintained that the most plausible normative theory, a kind of consequentialism, and indeed other normative theories besides, generate far-reaching obligations with regard to meeting the unsatisfied basic health care needs of people in poor countries. Given these obligations, there are far-reaching practical implications for governments, for international bodies, for companies (which often have the power of international bodies), for voluntary organisations, and for individuals. In

addition there are special implicit obligations for medical ethicists to ensure that the international aspects of medical ethics are in future much more extensively pursued, and that the practical implications are much more explicitly drawn and publicised (8).

Dr Robin Attfield is a Reader in Philosophy at University of Wales College of Cardiff. He read Literae Humaniores at Christ Church, Oxford and Theology at Regent's Park College, Oxford, and after a period of research at the University of Manchester was appointed to a lecturing post in 1968 in Cardiff, where he was subsequently awarded a PhD in Philosophy. He has also taught at the Universities of Ife, Nigeria and Nairobi, Kenya. His publications include God and the Secular (1978), copies of which are available from the author, The Ethics of Environmental Concern (1983), A Theory of Value and Obligation, London, New York and Sydney: Croom Helm, 1987, and a number of articles on moral philosophy, the philosophy of religion, environmental ethics and the history of ideas. He and his wife have three children, and are members of the Society of Friends.

References and notes

- (1) Thematic review of past issues. *Journal of medical ethics* 1989; 15: 99–106.
- (2) *Sixth report on the world health situation, 1973–77*. Geneva: World Health Organisation, 1980: part 1: Global analysis: 38f.
- (3) Rawls J. *A theory of justice*. London, Oxford, New York: Oxford University Press, 1972.
- (4) Barry B. *The liberal theory of justice*. Oxford: Clarendon Press, 1973.
- (5) Nozick R. *Anarchy, state and utopia*. Oxford and New York: Basil Blackwell: Basic Books, 1974.
- (6) I believe this point to survive such objections as that rules like these would remove salutary incentives.
- (7) Such a theory (including an attempt to specify basic needs, including self-respect, and to locate the boundary between acts of obligation and of supererogation) is elaborated and defended in Attfield R. *A theory of value and obligation*, London: Croom Helm, 1987. A related theory of the nature and limits of supererogation is supplied in Attfield R. Supererogation and double standards, *Mind* 1979; 88: 481–499.
- (8) I am grateful to Martyn Evans, to participants (including Dieter Birnbacher and Ruth Chadwick) in the Eighteenth World Congress of Philosophy (Brighton, 1988) and to the referees of this journal for comments on an earlier draft of this paper.