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Bioethics, Philosophy, and Global Health

Maria Merritt

INTRODUCTION

This Article addresses the present state and future prospects of the field of bioethics. The subject is open to more than one attitude of address. Possibilities include preoccupation with the professional status of bioethics, critical scrutiny of its research programs and methodologies, and anxiety about whether some areas of bioethics have become intertwined with—and perhaps co-opted by—extra-professional, extra-academic agendas, such as those that drive profit-making enterprises (pharmaceuticals, biotechnology, HMOs) or partisan politics (debates over abortion, stem cell research, withdrawing artificial nutrition and hydration from patients like Terri Schiavo). These attitudes, whatever their merits, are all somewhat self-focused. Without denying the importance of the problems they target or the necessity of continual self-critical reflection among the practitioners and friends of bioethics, this Article assumes a more straightforward, outward-looking stance.

This stance is meant to complement the inward-looking attitudes and to affirm the values that motivate them. Those of us who work in bioethics can demonstrate the professional and academic value of our field only through the substance of the contributions we make in its name. With respect to worries about inappropriate involvement with corporate or partisan agendas, the issue is protecting the intellectual integrity we need in order to make headway on problems whose solutions cannot be left to the rough-and-tumble of the market and the political arena. We ought to set our own research agenda, rather than acquiesce in its distortion by external interests, political pressures, and popular sensations du jour.¹

Hence the straightforward question: What belongs on our agenda? One item

¹ Distortion by external factors is a danger to which bioethics is exposed by its interdisciplinary orientation, which may tend to loosen the ties that anchor scholars to their home disciplines. Thanks to Dennis F. Thompson for this observation.
that certainly belongs on it is global health. This Article surveys a constellation of global health problems that exert increasing influence in bioethics today and indicate promising directions for future research.

"Global health" is an expression used to talk about issues in health policy that reach beyond or across national boundaries. The authors of a recent article in the American Journal of Public Health characterize its meaning partly by contrasting it with another expression used for similar purposes—"international health":

"International health" was already a term of considerable currency in the late 19th and early 20th century, when it referred primarily to a focus on the control of epidemics across the boundaries between nations. . . . "Global health," in general, implies consideration of the health needs of the people of the whole planet above the concerns of particular nations. 2

A distinct interest in "global health" is on the rise, as measured by the frequency of its mention in the scholarly literature and its visibility in the names of academic, government, and philanthropic organizations concerned with transnational matters of public health. 3

From the viewpoint of ordinary morality, the notion of global health captures several interconnected themes. First, it seems obviously wrong that poor people across the world, many of them infants and small children, should suffer the ravages of illness and death from conditions (like pneumonia, diarrhea, malaria, tuberculosis, AIDS, and even childbirth) that can be treated, prevented, or managed by methods readily available to most people in rich countries. Two further themes bring in causal interconnections related to the globalization of trade, labor, finance, transportation, communication, culture, and climate change. We all participate in the institutional systems that perpetuate or could alleviate the conditions of poverty that prove so lethal to the most vulnerable populations. Finally, we are also all embedded in—and ourselves potentially vulnerable to—the biological, social, and environmental systems through which globalization affects health, as already threatened by infectious diseases like SARS, West Nile virus, avian flu, and drug-resistant forms of tuberculosis. 4

Academic bioethics is beginning to pick up these same themes, generally with greater emphasis on the first two. 5 In so doing, bioethics follows a pattern of


4. Lee & Yach, supra note 2, at 687-89.

5. See, e.g., Gopal Sreenivasan & Solomon Benatar, Challenges for Global Health in the 21st
concern established by moral and political philosophy in the latter part of the twentieth century. The harms suffered by the world’s very poor, together with the causal involvement of the affluent in the global systems that perpetuate these harms, invite continuing examination of a central question in moral philosophy: Who owes what to whom? In political philosophy, a form of the same question re-emerges at the institutional level: What do affluent states, acting both on their own and through international agencies, owe to the poor in other countries? This question of global distributive justice defines one of the most active areas of current political philosophy. At the same time, philosophers are participating in the formation of global health policy with increasing frequency.

Responding to problems of public health that occur in both domestic and international contexts, some bioethicists have begun to urge a shift in perspective to “population-level bioethics.” “Where clinical bioethics speaks of the rights and responsibilities of patients and doctors, bioethics at the population level assesses the obligations of societies toward their members and each other and the norms governing complex relationships of individuals, groups, and the state.”

Yet, even from the viewpoint of this shift in perspective, individuals do not drop...
out of the picture altogether as subjects of moral inquiry. Rather, inquiry about what is owed to individuals must stem in part from their circumstances as members of populations. Likewise, inquiry about what is owed by individuals must stem in part from their circumstances as contributors to institutional actions. This Article focuses on the latter branch of inquiry and discusses recent and emerging scholarship that highlights the moral obligations of affluent individuals to the global poor, in two types of institutional roles. Part I develops the idea of a human right to health and considers how the duties imposed by such a right could possibly be distributed among affluent individuals in their causal role as participants in global institutional systems. Part II addresses the obligations of medical professionals, as affected by their institutional roles in two types of organizations that attempt to help the global poor: humanitarian aid organizations and not-for-profit scientific research organizations.

The unifying theme of this Article has to do with the spirit in which it makes sense to consider our obligations to the global poor. Determining the nature and extent of our obligations is an intellectual challenge worthy of the best minds in moral philosophy, but it is at most only a first step toward meeting the practical challenges of global health. Even if moral theory shows why the human rights of the very poor require the affluent to help alleviate the global health crisis, the truly hard problems begin with working out how to do so. How can proven preventive and therapeutic health interventions be delivered with all due haste to those vulnerable people who need them most urgently? How can failed health systems be transformed into functional ones that protect people from ever becoming so vulnerable in the first place? These problems occupy some of the most distinguished scholars in every discipline of public health, not to mention the world's most talented entrepreneurs and financiers. But, this Article concludes, no amount of intellectual firepower can bring about socially enduring solutions except through systematic efforts to include, consult, and empower the people who actually experience the problems.

I. A HUMAN RIGHT TO HEALTH?

The idea of a human right to health expresses noble aspirations to promote and protect health for all persons. Critics of such a right argue that no matter how praiseworthy those aspirations may be, the attempt to act on them by insisting on a human right to health is either misconceived or, even if well-conceived in principle, incapable of delivering specific policy guidance beyond a minimal starting point of simply acknowledging the right in question. Recent philosophical advances bring fresh conceptual resources to this debate.

At the outset, we must distinguish between legal and moral conceptions of human rights. Under the legal conception of human rights, the specification of the content of such rights, the identification of those who hold them, and the identification of those who bear obligations to protect or fulfill them are determined by the actions of government entities empowered to make, enforce,
and interpret the law. Under the moral conception of human rights, the content of
such rights is to be specified, and right-holders and duty-bearers are to be
identified, through analysis of moral considerations, regardless of whether any
government entities do in fact recognize them. This Article adopts the moral
conception of human rights. It presupposes, but does not argue for, a plausible
view of the relationship between the moral conception and the legal conception.
In light of the seriousness of the relevant moral considerations, together with the
minimal conditions for the moral legitimacy of government entities, the
vindication of any human right by moral considerations constitutes a strong
moral reason for government entities to recognize such a right by force of law. 11

The standard idea of a human right to health, understood as a moral right,
can be clarified by attending to its three component concepts: right, human,
and health. At the core of the idea of a human right to health is the concept of a right.
Moral philosophy contains longstanding controversies about how best to
understand the function and justification of rights. 12 Nonetheless, there is
widespread agreement on the logical structure of rights. 13 This provides a few
anchor points for discussing the human right to health. First, if there is a human
right to health, it is what rights theorists call a claim right. Any assignment of a
claim right to one party logically entails the assignment of correlative duties to at
least one other party. That is,

\[
A \text{ has a claim that } B \varphi \text{ if and only if } B \text{ has a duty to } A \varphi. 14
\]

Thus, if I have a right to health, then at least one other party must have at
least a duty not to actively harm my health, and possibly also duties to promote
and protect my health. This is an instance of the second anchor point, which is
that duties correlative to claim rights may be either negative or positive. In other
words, "\( \varphi \)" in the formulation above may symbolize either refraining from some

11. See generally THOMAS W. POGGE, WORLD POVERTY AND HUMAN RIGHTS: COSMOPOLITAN
RESPONSIBILITIES AND REFORMS 52-70 (2002) (introducing the distinction between moral and legal
conceptions of human rights and explicating the moral conception).

12. See generally Leif Wenar, Rights, in STANFORD ENCYCLOPEDIA OF PHILOSOPHY (2005),
available at http://plato.stanford.edu/entries/ rights/ (outlining the main rival schools of thought on
these questions). As Wenar explains, the function of rights is a matter of what they do for the right-
holder; justification involves determining what rights there are and why we ought to respect them.
Id. § 2.

13. Id. § 2.

14. Id. § 2.1.2 (summarizing the widely endorsed analytical framework developed in WESLEY
NEWCOMB HOHFELD, FUNDAMENTAL LEGAL CONCEPTIONS AS APPLIED IN JUDICIAL REASONING
(Walter Wheeler Cook ed., Yale Univ. Press 1919). Although Hohfeld, a legal theorist, developed
this framework for use in thinking about legal rights and duties, it is readily transferable to moral
rights and duties. See also Brenda Almond, Rights, in A COMPANION TO ETHICS 259, 262-63 (Peter
(2005) (applying the Hohfeldian logical point about the correlation between claim rights and duties
to the discussion of human rights); George W. Rainbolt, Rights Theory, 1 PHIL. COMPASS 11, 11-13
action (in the case of a negative duty) or performing some action (in the case of a positive duty). Negative duties correlative to a right to health would include duties not to inflict sickness on people. An example is the duty not to supply a population with drinking water known to contain bacteria that cause cholera. Correlative positive duties would include the provision of health care and of other social goods, such as literacy, that significantly improve health outcomes.

Third, the bearers of duties correlative to rights may be either individual persons or other kinds of agents. With respect to the idea of a right to health, a standard assumption is that, for each right-holder, the bearer of the correlative duties is the government of the state where the individual resides. In cases of impoverished, ineffective, or failed states, perhaps the governments of other, better-functioning states should be the bearers through efforts coordinated by international agencies like the World Health Organization (WHO).

There are two aspects of the moral duties that would be correlative to a right to health: an individual aspect and a population aspect. First, each individual’s right to health would entail correlative duties to avert harms and provide services insofar as they have a causal impact on that individual. For example, a right to health would impose a correlative duty to provide timely treatment of an infection from which an individual is suffering. Second, assuming every individual member of a population has a right to health, this collective state of affairs further entails correlative duties to avert harms and provide services insofar as they make an impact on the health of the population. If increasing the rate of female literacy will significantly improve health outcomes and the equity of their distribution across the population, then the duty to promote female literacy...
literacy is a duty both to the individual girls and women who could benefit directly from it and to all members of the population to which they belong, male or female.

A problem in public health ethics is that it may sometimes be necessary to make trade-offs between duties owed to individuals directly and duties owed to individuals qua members of the population. For example, in deciding how to ration vaccines in the event of an influenza pandemic, one might develop a rationing scheme based on asking which individuals have priority in their claim to the vaccine, a question that is itself a difficult one to answer (the most vulnerable individuals? the individuals most likely to survive? the individuals likely to reap the greatest benefits from the investment they have already made in their lives?). But any such prior-claim scheme could be in tension with the overarching objective of minimizing transmission throughout the population (also operating for the ultimate benefit of its individual members), which would dictate that those individuals most likely to transmit the virus to others should get the vaccine first (regardless of whether they would otherwise have any prior claim).

Turning to the next component concept, to regard a right as a human right is to find that each individual holds that right simply by virtue of being a person—that is, simply because morality requires that all persons be treated in a certain way. The right-holder’s moral status as a person suffices as the moral ground of his or her claims against bearers of the correlative duties. For this reason, human rights are universal. The moral status of persons is independent of institutional contingencies like citizenship or residence in one state or another. For instance, an uncontroversial human right is the right not to be enslaved. Even where the government of a state tolerates the practice of slavery, all of its residents nonetheless have the right not to be enslaved, simply by virtue of their moral status as persons. Individual slaveholders violate a duty correlative to this right—the duty not to enslave others; states that tolerate slavery violate a correlative duty to protect all individuals from being enslaved by others. From the standpoint of morality, agents have the duties correlative to human rights and may be culpable for violations, whether or not they have voluntarily assumed


20. Whether or not there is a human right to health, this kind of trade-off remains a problem for agencies charged with protecting and promoting the public health.

21. Different theories of what morality requires offer differing accounts of the specific ground for the moral status of persons. The main alternatives are: (1) the distinctively rich and complex capacity for well-being and suffering (based on utilitarian moral theory); and (2) the capacity for rational agency (based on Kantian moral theory). See infra Subsection I.A.1).

22. Unfortunately, the age-old practice of enslaving others remains alive and well in various parts of the world. Nonetheless, the right not to be enslaved is uncontroversial, in the sense that anyone who agrees that persons as such have moral status should straightforwardly accept the claim that every person thereby has the right not to be enslaved.
these duties. If there is a human right to health, any state or other party bearing the correlative duties with respect to the members of a given population will stand in violation of those duties if it willingly neglects them or adopts policies contrary to their fulfillment.

The universality of human rights means that states’ breaches of them cannot be morally excused or made good by claims to political sovereignty. The recognition of any right as a human right thus carries grave political consequences, especially to the extent that the correlative duties lie with state governments, because it clears a space for the principled moral justification of external intervention (political or economic, if not military) in the domestic affairs of sovereign states. This is one of the factors that perennially politicizes and polarizes international discussions of which rights are human rights. The question of a human right to health is a case in point.

The last component concept is health. Given that a claim right entails correlative duties, and given the political consequences of recognizing any claim right as a human right, the conception of health as the object of a human right is bound to weigh heavily in determining precisely what the correlative duties are and who bears them. Leading proponents of a human right to health have typically drawn on a conception of health that is comparatively ambitious in several respects. The preamble to the WHO Constitution defines “health” comprehensively as “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.” Even if health is understood so broadly, it may yet come in degrees, and the preamble goes on to declare that “[t]he enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being.” Furthermore, it is crucial that the object of the declared right is health, not (only) health care. A right to health encompasses far more than a right to health care, because the determinants of health reach far beyond access to care. If there is a human right to health, its correlative duties must be duties to address a variety of socially controllable determinants of health, including levels of income and education.

Critics of the idea of a human right to health address two different types of problems: problems of conception and problems of implementation. This Part

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23. That said, even when moral considerations about human rights count in favor of intervention, there may also be moral reasons to refrain from intervention, and in particular cases the reasons to refrain might outweigh the reasons to intervene. This form of argument is often used by those who oppose military interventions ostensibly undertaken in the name of human rights.

24. ANNAS, supra note 18.


26. Id.

27. “Only a small fraction of the variance of health status among populations can reasonably be attributed to health care; health care is necessary but clearly not sufficient for health.” Mann et al., supra note 18, at 8.

28. Daniels, supra note 9, at 24-25.
discusses each type in turn, together with some representative current efforts to respond on behalf of the moral aspirations that typically motivate the assertion of a human right to health.

\[A. \text{ Problems of Conception}\]

Onora O’Neill presents a critique of declarations of a human right to health, taking the WHO’s declaration as a representative target.\(^{29}\) Noting that a claim right entails correlative duties, she presses the point that the right itself cannot be defined unless its correlative duties are allocated to identifiable parties: “[W]here anyone is to have a right there must be identifiable others (either all others or specified others) with accurately corresponding obligations.”\(^{30}\) She accuses the “international human rights culture” of being “often muddled or vague, or both” about this duty-allocation problem.\(^{31}\)

O’Neill observes that explicit attempts to allocate the duties correlative to human rights, as in the International Covenant on Economic, Social, and Cultural Rights (ICESCR) of 1966, have assigned them to states that are signatories to relevant Covenants.\(^{32}\) But, as O’Neill points out, this approach to the allocation problem fails to capture the universality of human rights, in two ways.\(^{33}\) First, it confines the allocation of duties to states that voluntarily assume them, contrary to the foundational understanding of human rights as claimable by all persons solely by virtue of their moral status. Human rights are supposed to be rights whose correlative duties fall to duty-bearers independently of voluntary transactions like signing a covenant. Second, the allocation of duties only to signatory states implies that the correlative rights themselves likewise derive from institutions, such as international covenants: If there were no covenant, the duties and the rights alike would be unjustifiable. In contrast, the justifiability of human rights is supposed to be pre-institutional.

A promising answer to this line of criticism proceeds in two steps. The first step is to identify precisely what is so morally troubling about how things stand in global health, such that for anyone who is paying serious attention, it can make intuitive sense to seek the global fulfillment of a human right to health. To what state of affairs are the most vigorous practical advocates of such a right responding, as they dedicate their work in medicine and public health to the Herculean task of securing a right to health worldwide? The second step is to re-examine how the conceptual resources of moral philosophy might support a

\(^{29}\) O’Neill, \textit{supra} note 14, at 429.
\(^{30}\) \textit{Id.} at 431.
\(^{31}\) \textit{Id.} at 428.
\(^{33}\) O’Neill, \textit{supra} note 14, at 431-32.
principled response to this state of affairs that is both sensitive to what is at stake and capable of resolving conceptual worries like those articulated by O’Neill.

Thomas Pogge has summed up the answer to the first question with eloquent rhetorical restraint. The catastrophic facts and figures speak for themselves.

Some eighteen million human beings die prematurely each year from medical conditions we can cure—this is equivalent to fifty thousand avoidable deaths per day, or one-third of all human deaths. Hundreds of millions more suffer grievously from these conditions. The lives of additional hundreds of millions are shattered by severe illnesses or premature deaths in their family.... This huge incidence of mortality and morbidity is not randomly distributed. For a variety of social reasons, females are significantly overrepresented among those suffering severe ill health.... Being especially vulnerable and helpless, children under the age of five are also overrepresented, accounting for about two-thirds of the death toll.... But the most significant causal determinant is poverty: Nearly all the avoidable mortality and morbidity occurs in the poor countries... particularly among their poorer inhabitants. 34

How might the awareness of this state of affairs motivate the intuition that there is a human right to health? We know that ill health is the proximate cause of avoidable death for some eighteen million people per year, about ten million of whom are under five years of age. 35 This is what makes it seem sensible to focus on health as the content of the deficit that would, in a better world, be made good. But why does it seem sensible to make health the object of a claim right, which requires the allocation of correlative duties, and moreover to conceive of that claim right as a human right, which gives rise to the problems of universality exposed by O’Neill?

If we have reason to believe that the medical conditions in question are treatable and preventable at a reasonably low cost, the next intuitive step is to look for some agent or group of agents who can do something about it. A further thought is that if there is somebody who can do something about it, especially at comparatively little cost to themselves, then they ought to do something about it. 36 But this line of reasoning runs into an elementary problem of moral

34. Thomas Pogge, *Human Rights and Global Health: A Research Program*, 36 METAPHILOSOPHY 182, 182-83 (2005). Pogge’s text provides sources for the data cited and lists the specific medical conditions causing preventable mortality (for example, pneumonia and other respiratory infections, HIV/AIDS, perinatal conditions, diarrhea, tuberculosis, malaria, measles, maternal conditions, malnutrition, sexually transmitted diseases, meningitis, and hepatitis) and morbidity (for example, all of the above, plus dengue fever, leprosy, sleeping sickness, river blindness, leishmaniasis, lymphatic filariasis, and schistosomiasis).


36. See Jennifer Bryce et al., *Can the World Afford To Save the Lives of 6 Million Children Each Year?*, 365 LANCET 2193 (2005); Gareth Jones et al., *How Many Child Deaths Can We Prevent This Year?*, 362 LANCET 65 (2003).
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philosophy: Under what conditions do we owe a duty of assistance to others, as contrasted with the duty not to harm them?

This problem is one of a broad class of problems collected under various labels: action versus omission; killing versus letting die; doing harm versus allowing harm. The contested issue about duty is whether to mark a morally important distinction between different types of causal role that an agent’s behavior might play in the occurrence of bad consequences. Some conceptions of morality focus only on the badness of the consequences, so that what matters is simply whether an agent might have produced different consequences by behaving differently. On this view, non-helping by omission can be as serious a wrong as active harming, provided the consequences in each case are the same.

Other conceptions of morality insist on a morally important distinction between different kinds of contribution that an agent might make to the occurrence of a harm. In one representative version, we look for the agent’s “most direct contribution” to the harm and ask whether that contribution is an action or an omission (for example, “pushing the head under water or refraining from throwing a life preserver”).

A quarter-century ago, philosopher Philippa Foot expressed her version of the latter view as follows:

Most of us allow people to die of starvation in India and Africa, and there is surely something wrong with us that we do it; it would be nonsense, however, to pretend that it is only in law that we make the distinction between allowing people in the underdeveloped countries to die of starvation and sending them poisoned food. There is worked into our moral system a distinction between what we owe people in the form of aid and what we owe them in the way of non-interference.

Let us bracket the question of whether affluent individuals only “allow” the harms suffered by the global poor or whether we are culpably implicated in active harming, not by any action so overtly hostile as sending poisoned food, but rather by other actions of routinely accepting, participating in, and benefiting from the institutions that regulate global trade, labor, finance, and other features in the background of severe chronic poverty. Suppose it is only a matter of

37. For a helpful overview, see Frances Howard-Snyder, Doing vs. Allowing Harm, in STANFORD ENCYCLOPEDIA OF PHILOSOPHY (2002).
38. See, e.g., Singer, supra note 6, at 231 (providing a famous example).
39. Id. at 235.
40. Howard-Snyder, supra note 37 (discussing Warren Quinn, Actions, Intentions, and Consequences: The Doctrine of Doing and Allowing, 98 PHIL. REV. 287 (1989)).
41. PHILIPPA FOOT, VIRTUES AND VICES 26-27 (1981). For selecting this quotation and locating it the context of the present discussion, credit is due to Kasper Lippert-Rasmussen, 3 J. MORAL PHIL. 97, 97 (2006) (reviewing POGGE, supra note 11).
42. Making the case for the claim that we actively harm the global poor is the aim of Pogge. POGGE, supra note 11. For an excellent debate on this issue, see Mathias Risse, Do We Owe the
allowing the global poor to suffer harm. (Figuratively, suppose that what we are doing is more like refraining from throwing life buoys, and less like pushing people’s heads under water.) Are we thereby neglecting a duty to give assistance? More to the point, even if we have a duty to give assistance, is it the kind of duty that we have because it correlates with the human rights of others? (If so, “our” moral system should be revised to acknowledge it.) Finally, even if the answer to both these questions is yes, how is it possible to allocate to several billion affluent individuals the duties that correlate with the claim rights of one to two billion impoverished individuals? 43

Here is where recent philosophical advances in thinking about human rights can offer at least a partial solution. Elizabeth Ashford, a philosopher, has recently proposed a novel conception of the human right to basic necessities. 44 While this is not the same as a human right to health, the object of a human right to basic necessities would include secure access to certain crucial determinants of health, such as clean water, sanitation, and adequate nutrition, as well as to basic health care. In addition to this overlap in content, the two rights have a similar logical structure: A human right to basic necessities would entail both negative and positive correlative duties, similar to the examples mentioned above in connection with the idea of a human right to health. Since the claim that human rights give rise to negative duties is comparatively uncontroversial, the discussion of Ashford’s work that follows will focus on her arguments about positive duties. 45 Addressing the question of who owes how much to whom, Ashford argues that the two dominant philosophical accounts of the moral status of persons, utilitarianism and Kantianism (both to be outlined below), converge

43. “One in five people in the world—more than 1 billion people—still survive on less than $1 a day, a level of poverty so abject that it threatens survival. Another 1.5 billion people live on $1-2 a day. More than 40% of the world’s population constitute, in effect, a global underclass, faced daily with the reality or the threat of extreme poverty.” UNITED NATIONS DEV. PROGRAMME, HUMAN DEVELOPMENT REPORT 2005: INTERNATIONAL COOPERATION AT A CROSSROADS: AID, TRADE AND SECURITY IN AN UNEQUAL WORLD 24 (2005), available at http://hdr.undp.org/reports/global/2005/pdf/HDR05_complete.pdf. Existence in extreme poverty burdens more than 850 million of these people—“including one in three preschool children”—with chronic malnutrition; more than 1 billion of them with no access to safe water; and approximately 2.6 billion of them with no access to improved sanitation. Id.


45. As Ashford articulates the distinction, negative duties are duties “to forbear from initiating a threatening causal sequence of events” (such as actively supplying the population with water known to be contaminated), whereas positive duties are duties “to actively aid someone.” Id. (manuscript at 5).
in their implications for a human right to basic necessities—and this is so despite the fact that they represent systematically opposing conceptual frameworks in moral philosophy.\textsuperscript{46} They both reasonably impose "positive duties to secure persons' access to basic necessities," and these positive duties are "sufficiently morally urgent to constitute human rights claims."\textsuperscript{47}

A selective reconstruction of Ashford's argument for this position will help to explicate the idea of a human right to basic necessities and its potential for addressing the duty-allocation problem. Let us begin with an overview. As Ashford notes, the justification of any human right has two parts. The first part is to show that its object has such fundamental moral importance as to be owed to all persons simply by virtue of their moral status.\textsuperscript{48} The second part is to show "that the duties generated by the right can reasonably be imposed on agents," since a human right is a claim-right logically correlated with duties.\textsuperscript{49} Moreover, the duties whose imposition on agents must be shown to be reasonable will take a particular form: they are duties of justice, in the sense that human rights entitle right-holders to make moral claims on duty-bearers. This is in contrast with duties of benevolence, also known as humanitarian duties or duties of charity, which do not entitle would-be recipients of aid to make moral claims on would-be benefactors.\textsuperscript{50}

Finally, Ashford rejects the assumption that, in order to allocate the duties correlative to human rights, it must be possible in every instance to "match up" individual right-claimants with "specific addressees."\textsuperscript{51} Instead, in the case of a human right to basic necessities, right-holders can justifiably make moral claims not only against institutional agents such as their own governments, but also against all affluent individuals, because the condition of affluence itself puts one in a causal position to help alleviate severe chronic poverty. Moral responsibility is distributed among the affluent, in ways that make sense in light of the actions that we are typically able to perform as private individuals. This distribution of responsibility does not require anything like the manifestly impossible process of tracing actual causal links—through complex global systems of trade, labor, finance, politics, climate, and so on—between specifiable affluent individuals and specifiable individuals suffering from severe chronic poverty. Instead, the upshot is simply that each affluent individual has certain positive duties to do at least his or her fair share in supporting effective aid and pressing for institutional reform.\textsuperscript{52}

\textsuperscript{46} Id. (manuscript at 1).
\textsuperscript{47} Id. (manuscript at 6).
\textsuperscript{48} Id.
\textsuperscript{49} Id.
\textsuperscript{50} Id. (manuscript at 27).
\textsuperscript{51} Id. (manuscript at 32).
\textsuperscript{52} Id. (manuscript at 32-33).
1. The Moral Status of Persons and the Importance of Basic Necessities

Ashford’s starting point is the assumption that underlies the claim that there are such things as human rights: “[T]hat each person without exception has moral status and can therefore justifiably demand not to be treated in ways that are fundamentally incompatible with that moral status.”\(^{53}\) The two dominant philosophical accounts of the moral status of persons are found in utilitarianism and Kantianism.

Utilitarianism, in its classic formulation, defines right action as the maximization of well-being (technically “utility,” also known as “welfare”), as assessed from an impartial perspective that encompasses all persons and all sentient beings. The maximization of well-being requires, among other things, the alleviation of suffering. Utilitarianism has many variants emphasizing different accounts of the good(s) that ought to be maximized and, consequently, emphasizing different aspects of the moral importance of personhood. A centrally influential version of utilitarianism grounds the moral status of persons in the richness and complexity of our capacity for both well-being and suffering.\(^{54}\) It is this version of utilitarianism that Ashford deals with in her discussion of human rights.\(^{55}\)

The label “Kantianism” indicates an approach to moral theory rooted in the legacy of Enlightenment philosopher Immanuel Kant (1724-1804). Kantian theories ground the moral status of persons in the capacity for autonomous rational agency; roughly, the capacity to make one’s own choices about what to do.\(^{56}\) This is in contrast to being manipulated or pushed around like a mere object, whether by the actions of others or by the compulsion of one’s own unmet needs (such as hunger, thirst, pain, illness). Perhaps the most culturally influential Kantian expression of the criterion of right action, and the one most closely associated with human rights discourse, is one of Kant’s own formulations: “Act in such a way that you treat humanity, whether in your own person or in the person of another, always at the same time as an end and never simply as a means.”\(^{57}\) In more colloquial terms, Kantian moral theory demands that we act always according to principles that respect and support the dignity of persons (ourselves and others), in particular the capacity to choose one’s own

\(^{53}\) Id. (manuscript at 2).

\(^{54}\) Roger Crisp & Tim Chappell, *Utilitarianism*, in *Concise Routledge Encyclopedia of Philosophy* 909, 909 (2000); *see also J.S. Mill, Utilitarianism* (Roger Crisp ed., 1998) (1861) (introducing a classic foundation for the philosophical tradition that informs the version of utilitarianism most relevant to this article).

\(^{55}\) Ashford, *supra* note 44 (manuscript at 3).


To establish that basic necessities have fundamental importance by the standards of both utilitarian and Kantian accounts of the moral status of persons, one needs to show that without secure access to basic necessities—such as sanitation, clean drinking water, adequate nourishment, and the level of medical care necessary for survival plus some decent modicum of health—people are condemned to suffering and deprived of well-being or indeed of life itself, and that they are also deprived of meaningful agency. For a clear appreciation of these points, we have only to consider the horrendous quality of existence suffered by the very poor. Ashford presents it as follows:

When people lack secure access to basic necessities their lives are drastically impoverished and stunted. Chronic poverty imposes very severe restrictions on the range of options they can pursue. It may undermine their most central goals and commitments that are absolutely integral to their ability to live out their conception of a decent life, such as their goal of raising flourishing children if, for example, they are unable to provide their children with the food or basic medical care they need for health or even survival. Malnutrition can cause chronic lethargy, which restricts persons' ability to pursue any activity. It can moreover cause brain damage and so permanently impair persons' rational autonomous faculties, and it can cause other permanent debilities. It can also cause extreme physical pain (from hunger or disease) and mental pain (through the preventable death of several close family members, for example). Lack of basic necessities can therefore preclude a minimally decent and autonomous life.

To some extent, it is the very experience of chronic insecurity about access to necessities like water, sanitation, and food (in addition to the absence of these necessities themselves) that also precludes meaningful agency. Not only does such insecurity curtail one's most basic options for choosing what to do; it also goes hand in hand with abject humiliation. Life on the edge of survival is felt by the very poor as a constant assault on their dignity. In sum, from the utilitarian viewpoint, secure access to basic necessities is indispensable for well-being;

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58. Hill, supra note 56, at 489 (offering the following gloss on Kant's formulation: "To value rational persons as ends, we must not use them for ends that, in some sense, they cannot share. . . . Kant adds that persons, conceived as members of a kingdom of ends, have a dignity, which is grounded in their autonomy of will. . . . Dignity is an 'unconditional and incomparable worth,' above all price and 'without equivalent.' Thus dignity is a value that is independent of a person's social status and utility."). For a sustained discussion of Kantian moral theory and human rights, see James Griffin, Discrepancies Between the Best Philosophical Account of Human Rights and the International Law of Human Rights, 101 PROC. ARISTOTELIAN SOC'Y 1 (2001).

59. Ashford, supra note 44. (manuscript at 6-7). See generally Keith P. West, Jr. et al., Nutrition, in INTERNATIONAL PUBLIC HEALTH, supra note 2, at 187 (surveying scientific literature on food security, population spectrum of nutritional status, undernutrition, micronutrient deficiencies, diet and undernutrition, malnutrition among older persons, and more).

likewise, from the Kantian viewpoint, it is essential to sustaining meaningful agency.

2. Positive Duties Correlative to a Human Right to Basic Necessities

The greater philosophical challenge is to make the case for the reasonableness of the positive duties that a human right to basic necessities would impose upon agents. Starting with utilitarianism, Ashford reminds us that because it is concerned with occurrences of suffering or well-being, whether or not they result from a given agent actively introducing them into the world, it makes no intrinsic distinction between that agent’s allowing harm (e.g., failing to relieve famine) and causing harm (e.g., sending poisoned food), supposing the consequences are identical. If omissions may have the same consequences for suffering and well-being as would active harms, then rights should protect right-holders against omissions as much as against active harms. 61

But this is not yet the whole story. Since utilitarianism defines right action from a viewpoint that is impartial across persons, a utilitarian analysis of human rights must accommodate the prospect of interpersonal trade-offs. Some states of affairs, such as secure access to basic necessities, are so important for a person’s well-being that for purposes of measurement and interpersonal comparison, we should arguably register a discontinuity in the scale of value, so that “one person’s human right could never be outweighed by any number of others’ trivial interests.” 62 For instance, suppose that the choices of one thousand people to eat as much beef as they want for dinner every night for a year adds up to a quantity of aggregate pleasure that would, on a strictly continuous scale, cancel out the suffering that one severely and chronically malnourished person would endure, over the same time period, as a result of agricultural policies that divert a population’s grain supply to the feeding of beef cattle for export. The fact that severe chronic malnourishment undercuts one’s very capacity to experience well-being at all counts in favor of stipulating a discontinuity in the scale, so that such pervasive suffering on the part of any person cannot be “cancelled out” by any quantity of trivial pleasures enjoyed by others. At the same time, utilitarian analysis must continue to register the possibility that “the basic interests protected by human rights could be outweighed by the comparably serious interests of several others.” 63 This means that, for utilitarianism, the importance of the interests that a putative human right would protect must be weighed against the cost to others of protecting those interests. Accordingly, “[t]he question of what human rights there are will be determined by examining how much sacrifice would be required from how many for the sake of how much gain

61. Ashford, supra note 44 (manuscript at 5).
62. Id.
63. Id.
What it would actually take to eradicate severe chronic poverty, and what it would cost, are questions that lead beyond the scope of this Article. The point of principle is that insofar as the cost of securing basic necessities for the poor could be distributed among the affluent without threatening any comparably significant interests of ours, it is entirely reasonable to recognize a human right (to basic necessities) whose correlative duties would impose that level of cost upon the affluent. This point of principle leaves open the question of effective and feasible means. It cannot by itself determine which solutions will work, and in particular it does not privilege simple donation or massive wealth transfer over context-sensitive programs that might include better governance, the establishment and enforcement of universal property rights under the rule of law, economic growth, market-based mechanisms like for-profit microfinance, or pricing schemes that would protect supplies of potable water better than wasteful giveaways. The point is only that whatever the cost of eradicating poverty might be, through whatever means are effective and feasible, it is reasonable to impose that cost on the affluent insofar as it threatens no comparably significant interests of ours.

Ashford’s utilitarian argument for a human right to basic necessities is reminiscent of a principle famously articulated in 1972 by the utilitarian philosopher Peter Singer, also in the context of challenging the complacency of the affluent toward global poverty: “If it is in our power to prevent something bad from happening, without thereby sacrificing anything of comparable moral importance, we ought, morally, to do it.” While Ashford’s analysis substantially extends and fleshes out the line of thought earlier opened by Singer, her most striking innovation is her Kantian argument for the claim that a human right to basic necessities reasonably imposes positive duties upon agents.

Ashford’s Kantian argument draws on the model of Kantian contractualism developed by T.M. Scanlon. Contractualism is a method for the moral

64. Id.
65. For a recent estimate, drawing on the latest figures compiled by the United Nations and showing that the eradication of severe chronic poverty is easily within the financial reach of the world’s affluent in aggregate, see Peter Singer, What Should a Billionaire Give—and What Should You?, N.Y. TIMES, Dec. 17, 2006, § 6 (Magazine), at 58. For other examples of steps in this direction, see Thomas W. Pogge, Eradicating Systematic Poverty: Brief for a Global Resources Dividend, 2 J. HUM. DEV. 59 (2001); Gopal Sreenivasan, International Justice and Health: A Proposal, 16 ETHICS & INT’L AFF. 81, 83 (2002).
67. Singer, supra note 6, at 231. Singer updates the application of this principle to the present-day global situation in Singer, supra note 65.
assessment of proposed principles to regulate individual or institutional conduct. In brief, it works by specifying a set of hypothetical conditions and asking what principles it would be reasonable for parties to accept, or what it would not be reasonable for them to reject, under those conditions. Kantian contractualism grounds the acceptability of principles in the requirement of equal respect for each party as a rational autonomous agent. This means that the acceptability of a proposed principle depends on whether each affected individual, from a position of equal moral standing, could reasonably agree to it. Recognizing the equal and fundamental moral importance of each individual nevertheless allows for comparison between the strengths of different individuals’ reasons for accepting or rejecting a principle.69

Consider the proposed principle that affluent agents have a duty to help the victims of severe chronic poverty to gain secure access to basic necessities, when they can do so without significant cost to themselves. Clearly, each poor individual’s reasons for accepting this principle are stronger than any reason an affluent individual might give for rejecting it. Thus, the affluent have some duty to aid the poor. The important question, Ashford argues, is “whether this duty of aid should be seen as a duty of benevolence or as a duty of basic justice to which the chronically poor are entitled as a human right.”70 The interestingly controversial comparison, then, is between two candidate principles for specifying the nature of the duty to give assistance. The principle specifying it as a duty of benevolence would be something like, each affluent agent has a duty to help some chronically poor individuals some of the time. The rival principle specifying it as a duty of basic justice would be something like, each affluent agent has a duty to do his or her fair share to secure every chronically poor individual’s access to basic necessities.71

Consider what it would be like for affected individuals to accept the principle specifying the duty to give aid as a duty of benevolence. For any given poor individual, helping that person would be “morally optional”; no particular poor individual could claim any entitlement to basic necessities.72 By contrast, the duty-of-basic-justice specification entitles every poor individual to make claims on affluent agents, at least in the aggregate, which in practice translates into claims on the governments of affluent states and the international institutions in which affluent states participate. On this specification, no poor individual’s lack of secure access to basic necessities can be permissibly excluded from

69. Ashford, supra note 44 (manuscript at 4).
70. Id. (manuscript at 26). A duty of “basic justice” here is a pre-institutional or extra-institutional duty. That is, its moral force does not require that the parties involved be related through any social institutions; to the contrary, it serves as a criterion of justice for the critical examination of social institutions. In particular, the duties correlative to human rights are duties of basic justice, in virtue of the universality that is part of the concept of a human right.
71. My formulation of the principles to be compared is meant to summarize Ashford’s more detailed discussion. See id. (manuscript at 27).
72. Id.
consideration on the grounds that helping that individual is "morally optional." Each poor individual thus has strong reasons for rejecting the duty-of-benevolence specification in favor of the duty-of-basic-justice specification. And given what is at stake for severely impoverished individuals, as in the case of the principle that acknowledges the duty to assistance in the first place, each poor individual's reasons are far stronger than the opposing reasons that any affluent individual could present.

In addition, Ashford argues that affluent individuals have compelling reasons of their own to prefer that the duty to aid be specified as a duty of basic justice rather than as a duty of benevolence. The full comparative argument between the two candidate specifications, as they would affect affluent individuals, is too complex to summarize here. The main point is that a duty of basic justice would underwrite a system of enforceable compliance, fairly distributing the burdens of giving aid across all affluent individuals, so that each individual would be required to give no more than his or her fair share. But even if we leave aside this strand of the argument, the prior point is that the affluent cannot reasonably reject the claims of each poor individual to being treated with respect for their agency, specifically in the form of securing their access to basic necessities—the material prerequisites of meaningful agency—where doing so would burden affluent individuals very little. This point suffices to vindicate a construal of the duty to aid as one owed by right to each individual person in severe chronic poverty.

3. Duty Allocation

We are now in a position to revisit the duty-allocation problem that troubles O'Neill in her criticism of the human right to health. The implication Ashford draws from her argument for a human right to basic necessities is that the correlative duties are shared by all affluent individuals. She acknowledges that, as a matter of fact, only entities on the order of national governments and global institutions are typically able to command the economic resources and political clout necessary to address the root causes of chronic severe poverty. Nonetheless, even if the complex set of background conditions affecting the global poor is dominated by institutional actors, individuals remain responsible for their actions and omissions with respect to influencing how these actors operate. Affluent individuals hold positions of non-negligible power within the global order, so that their positive duties include pressing for reform of the institutions whose activities determine the background conditions so pervasively.

Exceptionally influential individuals, by collaborating with governments and

73. Id.
74. Id. (manuscript at 28).
75. Id.
76. Id. (manuscript at 7).
global institutions to transform their modus operandi, can make significant progress in altering the global order on behalf of the poor. For example, in the words of a *Time* article naming the rock star Bono a 2005 Person of the Year along with Bill and Melinda Gates, “Bono charmed and bullied and morally blackmailed the leaders of the world’s richest countries into forgiving $40 billion in debt owed by the poorest; now those countries can spend the money on health and schools rather than interest payments—and have no more excuses for not doing so.” And since 1986, former U.S. President Jimmy Carter and his wife Rosalynn have worked with WHO and others in an effort to eradicate neglected diseases, such as Guinea worm disease, trachoma, river blindness, schistosomiasis, and lymphatic filariasis, which are suffered exclusively by hundreds of millions of the poorest and most dispossessed people in the world.

The positive duties of ordinary individuals include contributing at least their fair share of resources to an effective aid or development agency. In addition, if Ashford’s arguments succeed, individuals ought to supplement donations with efforts to promote institutional reform in order to sustain a morally adequate response, both to the utilitarian requirement to take responsibility for the important consequences of one’s actions and omissions and to the Kantian contractualist principle specifying the duty to give assistance (up to the point of securing access to basic necessities) as a duty of basic justice.

Even individuals who lack the public visibility of rock stars and former presidents can exert remarkable leverage in transforming global institutions. A recent success story is the development of a new market mechanism, the Advance Market Commitment (AMC). The AMC guarantees that a market will exist for new vaccines designed to avert the leading causes of child mortality among the poorest populations, who would otherwise be unable to pay for them. The goal is to encourage manufacturers to produce such vaccines sooner and more cheaply than would otherwise be feasible, and to reimburse resource-challenged national governments for distributing them to the poor. The pilot AMC project, funded at $1.5 billion, aims eventually to vaccinate seventy million to one hundred million children against pneumococcal disease, which now causes approximately one million child deaths per year. While it takes powerful

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79. Peter Singer has estimated that donating one percent of one’s annual income toward overcoming world poverty is “the minimum that one must do to lead a morally decent life.” PETER SINGER, *ONE WORLD: THE ETHICS OF GLOBALIZATION* 194 (2d ed. 2002). For a proposal about reasonable levels of donation stratified by income, see Singer, *supra* note 65.

80. Andrew Cole, *Governments Unite to Fund Vaccine for Poor Countries*, 334 BMJ 29
in institutional actors to finance and execute such a project (in the case of pneumococcal vaccine, these are Italy, the U.K., Norway, Russia, Canada, and the Bill and Melinda Gates Foundation), it is only through the day-to-day efforts of individual scientists and policy analysts that such schemes actually come to exist. Far from being pop icons, the people who work behind the scenes are more like the colleagues you might routinely meet in your office corridor.81

To the extent that a human right to basic necessities does require that correlative duties be delegated to states and global institutions, much work remains to be done toward specifying the details.82 But on Ashford’s account, this does not have the paradoxical consequence of pairing a supposedly universal right with duties borne only by the self-selected group of institutional actors that volunteer to take them on. Rather, the universal right is paired with duties borne primarily by all affluent individuals as a non-optional matter of what morality requires and only derivatively by the institutional actors necessary to carry out those moral duties effectively. Ashford’s argument can deliver this result because it confers the status of human right only upon object-based claim-rights that satisfy two conditions. First, the lack of the object makes even the most minimal degree of well-being and meaningful agency untenable. Second, the means to secure the object could be provided by other individuals (the affluent), regarded in aggregate, without significant loss in well-being or meaningful agency for anyone, so that to accept a state of affairs in which some (not to say a billion or two) individuals suffer this lack is to deny their moral status as persons. Secure access to basic necessities meets both of these conditions.

Arguably, those two conditions are not satisfied by the WHO Constitution’s more ambitious understanding of health as the object of a human right: “a state of complete physical, mental, and social well-being” enjoyed at the “highest attainable standard.”83 Indeed, it proves challenging enough to argue for basic necessities (including basic health care and adequate provision of other determinants of health) as the object of a human right correlated with positive duties to give assistance.84 Establishing the universality and morally well-founded enforceability of any such right—that is, giving it teeth as a human right—requires careful calibration in the conception of its object. Pruning back the currently expansive conception of health as the object of the right may well be the price of developing a solution to the duty-allocation problem.

At the same time, we should preserve a sharp distinction between brute
political feasibility and the calibration of morally principled limits on duty-bearers’ burdens. 85 For any putative human right, on both the utilitarian model and the Kantian contractualist model, specifying the content of the right’s object \( O \) requires asking what burdens would be imposed on duty-bearers \( D \) by the protection of morally fundamental \( O \)-related benefits for right-holders \( R \). On the utilitarian model, the theoretical limit is reached at the point where the burdens on \( D \) would threaten any of \( D \)’s interests in well-being in ways that are comparable in gravity to the morally fundamental \( O \)-related aspects of \( R \)’s well-being. On the Kantian model, the theoretical limit is reached at the point where the burdens on \( D \) would make it reasonable, on grounds of respect for \( D \)’s agency, for \( D \) to reject any principle requiring \( D \) to assume those burdens. In real-world attempts to specify the content of health-related human rights, the application of either or both of these models leaves as an open question precisely how expansive the operative conception of “health” should be. Regarding affluent individuals and poor individuals, respectively, in global aggregate, one might think that demands on the affluent could be greatly stepped up before we would reach either the utilitarian or the Kantian theoretical limit.

Nevertheless, in the countries and cities where the global poor live, suffer, and die in greatest numbers, health systems and other determinants of health present fiendishly complex problems that either cannot be solved simply by an influx of resources or, even if they could be, must in the meantime be addressed in the absence of adequate resources. 86 As described below, realities that are far from ideal may affect the specific entitlements that people can claim in the name of their health-related rights. 87

B. Problems of Implementation

Critics who focus on problems of implementation are, for the most part, sympathetic to the spirit in which advocates of a human right to health assert such a right. Their critical concerns have to do with the daunting conceptual and political complexity of determining how to secure any such right in real-world settings.

Norman Daniels argues that so far as states bear duties to secure the health-related rights of their individual citizens, even if these rights are construed as human rights and thus as universal, the claims that individual right-holders can thereby make on their state for specific goods and services will be in practice

85. Thanks to Chad Flanders for his illuminating comments on this issue.
relative to that state’s available resources. Limited resource-availability means
that states will need to set priorities in allocating resources toward the realization
of health-related rights. The upshot is that regardless of whether foundational
philosophical arguments can establish the universality of health-related rights,
states will nevertheless, in the attempt to realize them, confront several classic
“unsolved rationing problems.”

Undoubtedly, such problems are inevitable when states must set priorities
for the allocation of limited resources. And a fair deliberative process, as
developed for instance by Daniels in the form of “accountability for
reasonableness,” presents a philosophically well-grounded and practically viable
approach to the problems of priority-setting. But there is still room in this
picture for differences to be made by foundational arguments for the universality
of certain health-related rights.

One potential difference is in the severity of the limitation on a state’s
available resources that affluent global on-lookers can accept, compatible with
recognizing the moral status of each individual person. If there is a human right
to basic necessities, and basic health care is by definition a basic necessity, then
there is a human right to basic health care. But how are we to understand “basic
health care?” A powerful criterion is available in the form of Ashford’s argument
that the object of any universal claim-right is specified jointly by (a) the
importance of what each right-holder stands to lose and (b) the reasonableness of
requiring each duty-bearer to contribute their fair share to the protection of right-
holders against that loss. So, if some citizens of a given state suffer levels of
morbidity and mortality that (a) subvert any prospect of well-being or meaningful
agency and (b) could be avoided by health care measures or public health
measures (water, sanitation) deliverable at little cost, yet the state’s available
resources are so meager as to be unable to support delivery of even these
relatively cheap measures, then affluent agents in the rest of the world have
duties of basic justice to make good on the deficit. A universal right to basic
health care would thus establish a limit on the severity of priority-setting

88. Daniels, supra note 9, at 23-24; see Norman Daniels, Just Health (manuscript on file with
author).

89. NORMAN DANIELS & JAMES E. SABIN, SETTING LIMITS FAIRLY: CAN WE LEARN TO SHARE
MEDICAL RESOURCES? 43 (2002). Because reasonable disagreement about priority-setting is to be
expected, the process used to reach decisions must be one that even those who lose out can accept
as legitimate. This requires that justifying reasons be both transparent and rationally defensible to
all parties, whether or not they benefit from the decisions reached. Daniels and colleagues also
include accountability for reasonableness in a set of “benchmarks for fairness” developed as a
policy tool for health care reform. Norman Daniels et al., An Evidence-Based Approach to
Benchmarking the Fairness of Health-Sector Reform in Developing Countries, 83 BULL. WORLD
HEALTH ORG. 534 (2005); Norman Daniels et al., Benchmarks of Fairness for Health Care Reform:
A Policy Tool for Developing Countries, 78 BULL. WORLD HEALTH ORG. 740, 745-746 (2000).

90. Elizabeth Ashford, Lecturer in Moral Philosophy, Univ. of St. Andrews, Scot., Comments
on Presentation by Norman Daniels at Harvard University Conference on Equality and the New
Global Order (May 13, 2006).
problems that a state should have to face.

The 2005 Montreal Statement on the Human Right to Essential Medicines provides a template for recognizing and implementing a human right to basic health care. The Statement’s first point establishes the importance of what is at stake for people who lack essential medicines—"Two billion people lack access to essential medicines. This deprivation causes immense suffering: pain, fear, loss of dignity and life. Forty-thousand people die daily as a result, the vast majority of them children under five years old." Points (2) and (3) make the case for the reasonableness of requiring affluent agents to protect the global poor against the deprivation of essential medicines:

Poor people lack access to essential medicines because research and development do not address their priority health needs, because health systems are inadequate, and because existing medicines are unaffordable to them.... Existing policies, rules, and institutions foreseeably give rise to deprivations on a massive scale. Alternative designs are feasible; reforms are urgently required. . . . At a minimum, trade agreements, intellectual property laws, loans, aid, and other international arrangements as well as national institutions, laws, and policies must be designed so as to avoid violation of this right.

Point (4) attributes to states a “core obligation to respect, protect, and fulfill the right to essential medicines” for their own populations, an obligation that “requires immediate and effective measures and is not subject to progressive implementation.” This rules out priority-setting choices that would deprive a state’s citizens of essential medicines if the state has the resources to supply them. Accordingly, “[t]he human right to essential medicines requires that national health systems guarantee at all times that the population receive all essential medicines in adequate amounts, of assured quality, at the appropriate time and in the appropriate dosage... at a price the individual and the community can afford.” In addition, taking a human right to essential medicines seriously commits outsiders to ensuring that states have the resources to supply them.

91. The Montreal Statement is the result of a workshop held in 2005 by individuals representing NGOs, governments, international agencies, and academia. See Thomas Pogge, Montreal Statement on the Human Right to Essential Medicines, 16 CAMBRIDGE Q. HEALTHCARE ETHICS 97, 104-07 (2007) (reprinting the Montreal Statement). Credit is due to John Arras for pointing out that essential medicines are a powerful example of how to understand “basic health care.” Arras & Fenton, supra note 87, at 34.
92. POGGE, supra note 91, at 104.
93. Id.
94. Id. The Montreal Statement limits its explicit attribution of this obligation to state signatories to international human-rights treaties. But if there is a human right to basic necessities, including essential medicines, then every capable state has the same obligation.
95. Id. at 105.
96. Does it also commit outsiders to intervening in states that have the resources but still neglect their population’s basic needs? Non-governmental aid organizations often take the liberty
The responsibility of governments for the fulfillment of human rights includes international assistance and cooperation. "Affluent countries must, therefore, ensure fairer trade and investment, eliminate crippling debt, and contribute equitably to international assistance aimed at facilitating the full realization of the right to essential medicines." 97

Moreover, the Montreal Statement (Point 5) pegs its conception of "essential medicines" to the WHO's Essential Drugs List. 98 Which medicines count as essential is to be specified by reference to "the priority health care needs of the population, in light of their public health relevance, proven quality, efficacy and safety, and comparative cost-effectiveness." 99

But not all worries about the implementation of health-related human rights can be addressed by focusing primarily on specific health care interventions like access to essential medicines. For one thing, even those efforts must be anchored in health system reform, as noted in the Montreal Statement's Point 7. In practice, the reform of national health systems must take place in a local or regional context of broadly problematic political, economic, and institutional circumstances. 100 In addition, the successful uptake of medical interventions that health systems might attempt to make available is often inextricable from complex cultural factors. For instance, suppose that a key risk factor in children's death from diarrhea is whether women have the effective freedom to take children to the doctor, even when a male relative is not available or willing to accompany them. More generally, preventive and therapeutic interventions based on biomedical science may compete for cultural uptake with long-entrenched belief systems that attribute illness to supernatural or other non-biomedical causes. 101 Simply making material resources available may be of little, if any, help. In order to make serious headway, greater availability of material resources must be supplemented with research into the operations of health systems in order to identify and study context-specific obstacles to the population-wide delivery of proven interventions. 102

The global AIDS epidemic exemplifies, on a larger scale, the danger of intervening in such cases. Here is one plausible view. As with civil and political rights, so too with socio-economic rights: a state's violation of human rights counts as one reason in favor of intervening, but this reason may in particular cases be outweighed by other reasons, including moral reasons, against intervening; or some specific forms of intervention may be ruled out by the countervailing reasons, while others may be permitted.

97. POGGE, supra note 91, at 106.
99. POGGE, supra note 91, at 105.
100. Phyllida Travis et al., Overcoming Health-Systems Constraints To Achieve the Millennium Development Goals, 364 LANCET 900, 901-02 (2004).
101. Susan C. Scrimshaw, Culture, Behavior, and Health, in INTERNATIONAL PUBLIC HEALTH, supra note 2, at 43, 47.
102. Travis et al., supra note 100, at 903-04.
associating health-related human rights too closely with an imperative to make treatment interventions available. Daniels points out that in the late 1990s, advocates of human rights appealed to a form of a right to health, in particular a right to health care, in order to derive a universal right specifically to antiretroviral medication for AIDS. As a result, treatment was prioritized over prevention in the global response to the HIV/AIDS crisis, even though redirecting at least some efforts toward prevention might have saved more lives at lower cost over time. 103

Arguably, this was a case of misidentifying, through over-specification, the object of the relevant health-related right in the attempt at implementation. Whatever is supposed to be protected by health-related rights, prevention and treatment might both contribute comparably to protecting it for different persons. It is an error, from within the perspective of accurately recognizing the importance of what is at stake for each person, to regard the risk of becoming infected with HIV as having only secondary relevance in comparison with the burdens of being infected with HIV. The risk of infection is a risk of suffering exactly the same burdens. If people who are infected with HIV have a right not to suffer those burdens when their infection could be treated at little cost to others, people who are at risk of infection equally have a right not to be exposed to that risk when their exposure could be prevented at little cost to others. Thus, recognition of health-related human rights only brings into focus the fact that there is a problem of how to allocate resources between treatment and prevention. It cannot on its own determine the solution in favor of treatment or prevention. 104

Another problem with the idea of “basic” health care is that needs which are basic in the sense of essential to survival cannot always be met by interventions that are basic in the sense of cheap and simple. For many persons, in the face of life-threatening conditions prevalent in their population, staying above even a minimal threshold of well-being and meaningful agency may require access to relatively highly-skilled medical personnel and to a broadly functional health system. One signal example in global health is maternal health and survival. Every year, an estimated 529,000 women die in pregnancy or childbirth, an estimated 9.5 million women suffer serious illness related to pregnancy, and an estimated 20 million suffer pregnancy-related disabilities. 105 The disabilities include a conservatively estimated 50,000 to 100,000 cases per year of obstetric fistula, a condition of total urinary and bowel incontinence that often results in

103. See DANIELS, supra note 88, (manuscript at 372).

104. For a currently influential epidemiological analysis of the prevention/treatment question, see Joshua A. Salomon et al., Integrating HIV Prevention and Treatment: From Slogans to Impact, 2 PLoS MED. e16 (2005).

humiliation and social exclusion in addition to horrible debilitation.\textsuperscript{106} The distribution of these burdens between affluent and poor populations is tremendously inequitable. For instance, estimated in terms of a woman’s chances of dying as a consequence of pregnancy or childbirth over her lifetime, the risk of maternal death ranges from 1 in 6 (Afghanistan and Sierra Leone) to 1 in 30,000 (Sweden).\textsuperscript{107}

Maternal health and survival could be vastly improved by expanding women’s access to emergency obstetric care, delivered by health professionals who are qualified and equipped to perform procedures like caesarean sections.\textsuperscript{108} Yet, one of the greatest obstacles to improved maternal health for the girls and women who need it most urgently is “the dire scarcity of skilled providers and health-system infrastructure.”\textsuperscript{109} This state of affairs raises a problem of policy, in which the investment of different amounts of time and resources needed to train birth attendants must be traded off against rapidly expanding the extent of coverage for women who need obstetric services.\textsuperscript{110} It also highlights the systemic problems that contribute to maternal morbidity and mortality in poor populations, such as the acute crisis of health-related human resources, and the fragility of the transportation and communication infrastructure.\textsuperscript{111}

Indeed, some experts warn that the billions of dollars now becoming available for global health may conceivably end up doing more harm than good, due to adverse impacts on the functioning of severely strained health systems.\textsuperscript{112} At the heart of the problem on the donor side is lack of coordination. Many donors, aid programs, and non-governmental organizations (NGOs) are each focused on specific diseases, to the neglect of overall health system improvement. For example, HIV/AIDS programs have reduced the prevalence of HIV-infection in Haiti from six to three percent between 2002 and 2006, but by every other indicator the health status of the population worsened during this period.\textsuperscript{113} Generally, the influx of donor monies to fund disease-specific programs may create an internal brain drain, siphoning skilled health workers away from general health-care facilities.\textsuperscript{114} This exacerbates the ill effects of the

\begin{footnotesize}
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\item \textsuperscript{108} Margie Koblinsky et al., \textit{Going to Scale with Professional Skilled Care}, 368 LANCET 1377 (2006).
\item \textsuperscript{109} \textit{Id.} at 1377.
\item \textsuperscript{110} \textit{Id.}
\item \textsuperscript{111} \textit{Id.}
\item \textsuperscript{112} Richard Horton, \textit{Healthy Motherhood: An Urgent Call to Action}, 368 LANCET 1129 (2006).
\item \textsuperscript{113} \textit{See, e.g.,} Laurie Garrett, \textit{The Challenge of Global Health}, 86 FOREIGN AFF. 14 (2007).
\item \textsuperscript{114} \textit{Id.} at 23.
\end{enumerate}
\end{footnotesize}
external brain drain caused by wealthy countries’ active recruitment of nurses and physicians from poor countries.\textsuperscript{115}

One sensible proposal is that donor efforts should be coordinated not around specific diseases, but around such basic goals as increasing maternal survival and increasing overall life expectancy.\textsuperscript{116} Beyond their intrinsic importance, maternal survival and overall life expectancy are excellent proxy indicators for overall health-system functioning.\textsuperscript{117} In order to fulfill the human right to basic necessities to the greatest extent possible, it would seem that donors interested in global health should focus primarily on helping to build local, internally sustainable capacity to improve such indicators among the poorest and most vulnerable members of populations. An emphasis on reaching the neediest people would ideally be built into every stage of health system capacity-building: consulting stakeholders in each location to prioritize needs and identify specific constraints on health-system performance; continuously monitoring and evaluating programs introduced; and systematically collecting data to facilitate global information-sharing about factors that contribute to failure and success.\textsuperscript{118}

\section*{II. GLOBAL HEALTH AND PROFESSIONAL ETHICS}

Whatever the nature of affluent individuals’ duties to meet the health-related needs of the global poor, one important means of acting on them is to support the activities of health professionals whose work reaches across national borders. NGOs like Médecins Sans Frontières (MSF) offer aid in the form of medical care and other basic necessities.\textsuperscript{119} Government bodies, such as the U.K. Medical Research Council (MRC) and the U.S. National Institutes of Health (NIH), and charities, such as the Bill and Melinda Gates Foundation and The Wellcome Trust, figure prominently in medical research aimed at meeting the needs of poor populations.\textsuperscript{120} More broadly, global humanitarian efforts on the ambitious scale

\textsuperscript{115} Daniels, supra note 8, at 30-31. Daniels argues that the external brain drain should be alleviated not by restricting migration (itself the object of certain human rights) but by measures such as contributing financial resources to help poor countries retain skilled health-care personnel by improving their working conditions.

\textsuperscript{116} Garrett, supra note 112, at 23.

\textsuperscript{117} Id.

\textsuperscript{118} See, e.g., David H. Peters et al., \textit{Research for Future Health Systems}, 3 GLOBAL F. UPDATE ON RES. FOR HEALTH 133 (2006), available at http://www.futurehealthsystems.org/publications/index.htm (outlining the research program of Future Health Systems: Innovations for Equity, a consortium of researchers from Uganda, Nigeria, India, China, Bangladesh, the U.K., and the U.S., funded by the U.K. Department for International Development). For a specific working example of this approach to reviving a shattered national health system, see David H. Peters et al., \textit{A Balanced Scorecard for Health Services in Afghanistan}, 85 BULL. WORLD HEALTH ORG. 146 (2007).


\textsuperscript{120} Nuffield Council on Bioethics, \textit{The Ethics of Research Related to Healthcare in...
of the Global Fund to Fight AIDS, Tuberculosis, and Malaria ultimately depend on the work of physicians and scientists to carry out their aims.\footnote{121}{Gill Walt & Kent Buse, Global Cooperation in International Public Health, in INTERNATIONAL PUBLIC HEALTH, supra note 2, at 649.}

It is debatable whether physicians and scientists as individuals, simply by virtue of their professional qualifications, have special duties to help the global poor that others do not have.\footnote{122}{See John D. Arras, Fair Benefits in International Medical Research, HASTINGS CENTER REP., May-June 2004, at 3; Samia A. Hurst & Alex Mauron, Allocating Resources in Humanitarian Medicine (unpublished manuscript, on file with the author).} Does every individual trained in obstetrics and gynecology have a duty to spend at least several weeks a year helping women in poor countries who suffer from obstetric fistula or helping to build local capacity in emergency obstetric care to prevent maternal death and disability?\footnote{123}{LaFraniere, supra note 106.} Maybe, but that is not a problem that this Article takes up here. The point for present purposes is rather that, if all affluent individuals have some duty to help the global poor (be it a duty of benevolence or a duty of justice), then, in order to act on that duty effectively, most of us must depend on others who both hold the relevant professional qualifications and choose to employ them in the service of this cause. Physicians and scientists, acting as agents of the donors, sponsors, and organizations who fund their programs, then find themselves offering health care or conducting health-related research in locales where available resources can hardly begin to meet even the basic needs of the resident population.\footnote{124}{A professional who works with poverty-stricken populations may be either an expatriate citizen of an affluent country (e.g. a French physician working in South Africa), an expatriate citizen of another country where people suffer from poverty in large numbers (e.g. a Sudanese scientist working in Malawi), or a co-citizen with members of the local population (e.g. a Ugandan scientist working in Uganda). In any case, questions about obligations to the poor arise from professional-role ethics in the context of access to institutional resources.}

This Part considers this question under two distinct headings: aid and research. What the aid versus research distinction tracks here is not primarily the qualifications of individual professionals, but rather the aims of the organizations for which they work. Organizational aims determine these individuals’ institutional roles, thereby strongly influencing the nature of their obligations as professionals.

At this point, a brief terminological aside is in order. In this Part, “organization” and cognate terms are used to refer to particular corporate agents like MSF or specific kinds of corporate agents like NGOs and research universities. A corporate agent is an agent whose policies are typically determined, and whose actions are typically executed, through the organized activity of multiple individual persons acting in roles established by the agent
itself in keeping with the specific kind of agent it is. (So, for example, a hospital is the kind of corporate agent that normally must establish roles for executives, board members, legal counsel, administrators, physicians, nurses, social workers, and so on.) “Institution” and cognate terms are used to refer to the type of social impact and consequent ethical accountability that many such corporate agents have. Somewhat like individual persons, and unlike states, institutions exercise considerable freedom to set their own policies and act accordingly. They are often not bound by any formal constitutional or contractual relationships to outside individuals whose conduct the institution will affect. Yet, more like states and less like individual persons, institutions may have an extensive, enduring, and causally traceable impact on the surrounding society through the activity of setting and executing their policies. Finally, discussion of the “institutional role” of individuals alludes to two facts: (1) their professional responsibilities are ordered and regulated to a great extent by the policies of the organizations for whom they work; and (2) in carrying out those responsibilities, individuals participate in the broader social impact that their organization is making.

In organizational and professional ethics generally, a great deal more research is needed on the problem of how institutional roles ought to shape the professional obligations of the individuals who occupy them. Dennis F. Thompson’s essay, The Institutional Turn in Professional Ethics, offers a helpful framework for discussion.\textsuperscript{125} Thompson distinguishes two problems of institutional ethics, the problem of representation and the problem of authority:

\begin{quote}
The general point is that an institution needs to have a policy, which means that (a) the rules may require individuals in the institution to act in ways that they may not otherwise act on their own; and (b) someone has to decide what the rules are. The first is the problem of representation, and the second, the problem of authority.\textsuperscript{126}
\end{quote}

Both problems are prominent in the operation of institutions that reach across borders in the service of global health. Section A considers examples of these problems as they occur in the transnational activities of non-governmental aid organizations. Section B looks at the activities of research organizations that are based in affluent countries but study scientific questions of importance to poor populations elsewhere.

A. Non-Governmental Aid Organizations

MSF is a good example because its operations have been carefully studied by researchers using methods of social science and, in the case of at least one

\textsuperscript{125} Dennis F. Thompson, The Institutional Turn in Professional Ethics, in RESTORING RESPONSIBILITY: ETHICS IN GOVERNMENT, BUSINESS, AND HEALTHCARE 267 (Dennis F. Thompson ed., 2005).

\textsuperscript{126} ld. at 269.
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researcher, philosophy as well. In collaboration with Eric Goemaere, head of MSF’s South African Mission, medical sociologist Renee Fox has been studying the process of “patient selection” for antiretroviral treatment (ART) in MSF’s project in Khayelitsha, South Africa.127 Meanwhile, philosopher Lisa Fuller has been engaged in a multi-stage collaborative study of “ethics, principles, and decision-making” in the activities of MSF-Holland.128 Fuller first studied field operations through MSF-Holland’s Nairobi Office and its projects in Galcayo, Somalia, and Mandera, Kenya, and then studied the organizational decision-making process at MSF-Holland’s Amsterdam headquarters. While Fox’s and Fuller’s studies should be understood in the first instance as windows onto the particular MSF units they observed, the interpretations offered by both researchers also lend themselves to generalization, at least with respect to ethical analysis of the problems in institutional ethics and institution-related professional ethics that MSF exemplifies.

In brief, the background of MSF’s Khayelitsha project is as follows. As Fox and Goemaere recount, the residents of Khayelitsha are some 500,000 extremely impoverished people, many suffering from lack of running water, electricity, and decent shelter. Rates of unemployment and violent crime, including domestic violence, are high. Prevalence of HIV/AIDS among pregnant women is approximately twenty-six percent. At the time of writing, the MSF Khayelitsha project was providing ART to roughly 2000 of the 8000 patients with HIV/AIDS who frequent the MSF clinics. With the support of the Global Fund, financing for ART is now ample, but its provision is constrained by the brain drain of physicians and nurses from South Africa to higher-income positions in other countries (mainly the United States, United Kingdom, Canada, and Australia). Thus, MSF must still practice patient selection, in effect rationing treatment.129

MSF clinicians provide the leadership and main membership of several selection committees in Khayelitsha, one committee per HIV clinic.130 In order to be selected for ART, prospective patients must in principle satisfy the whole of an extensive set of criteria, including medical, social, and behavioral components.131 In practice, however, as Fox and Goemaere report, “the most

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129. Fox & Goemaere, supra note 127, at 302-04. A cautionary note: Presumably, as in any organization, MSF procedures are open to change, and might be different by the time this Article is published. This Article discusses the procedures that Fox and Goemaere reported to be in place at the time of their 2006 publication in the Cambridge Quarterly of Healthcare Ethics.
130. Id. at 304. Although each committee also includes a patient, Fox and Goemaere focus on the feelings and deliberations reported by clinical personnel and do not report on patients’ contributions or reactions to committee proceedings in their article.
131. Id. at 304-06. Behavioral components of the selection criteria are meant to indicate the
The striking feature of [committee] deliberations is the inward pressure they feel to accept patients for treatment.\textsuperscript{132} They tend to admit even patients who do not satisfy all the criteria; indeed, they almost never reject candidates, preferring instead to categorize them as needing further preparation with respect to social and behavioral criteria.\textsuperscript{133} The pressure they feel to start patients on ART intensifies “when they are confronted with patients in a very advanced, rapidly evolving stage of HIV/AIDS who have a high risk of imminent death.”\textsuperscript{134} Clinicians are inclined to accept these patients ahead of up to 500 patients who also satisfy basic medical criteria (primarily, a CD4 count of less than 200/ml)—even though they know that prioritizing such desperately ill patients “will not only delay the treatment of other patient-candidates who may have been waiting longer, but may also contribute to the further deterioration of their immune function because of the extended waiting time.”\textsuperscript{135} 

MSF’s Khayelitsha project, as described in this scenario, exemplifies classic problems of priority-setting and public health ethics.\textsuperscript{136} Ruth Macklin and Solomon Benatar have offered comments analyzing Khayelitsha in those terms.\textsuperscript{137} My purpose here is to look at the same scenario from the viewpoint of institutional ethics.

Thompson’s problem of representation appears in the anguished attempts of MSF’s Khayelitsha clinicians to apply principled criteria in selecting patients for ART. As Thompson writes, the problem is that the rules of an institution’s policy “may require individuals in the institution to act in ways that they may not otherwise act on their own.”\textsuperscript{138} He further specifies the problem as follows: “Whom does the individual professional represent when acting as an official of the institution?”\textsuperscript{139} It seems that MSF clinicians in Khayelitsha feel torn between two attitudes toward treating their clinic’s patients. They feel that they should serve as advocates for each individual patient, responding most intently to the patient whose needs of the moment are most urgent. At the same time, they occupy an institutional role as committee members allocating limited resources to serve their organization’s client population, all of whom are extremely needy. If

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likelihood of adherence to treatment. Part of the rationale for emphasizing adherence is to avert the development of drug-resistant strains of HIV.

132. \textit{Id.} at 306.

133. \textit{Id.}

134. \textit{Id.} at 308.

135. \textit{Id.} at 308-09.

136. Daniels, supra note 9, at 23-24.


138. Thompson, supra note 125, at 269.

139. \textit{Id.} at 271.
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each of these physicians were acting "on their own," they would probably be strongly inclined toward acting on the individual-patient-advocate attitude. But the institutional role that they occupy requires, at least formally and in principle, that in their decisions as committee members they respond primarily to the needs of patients as a population.

These MSF clinicians lack certain luxuries present in situations that lie closer to the institutional ideal. Consider Thompson's sensible prescription for the operation of hospitals: "Some division of moral labor is necessary in any complex institution. The doctor at the bedside should not have cost containment uppermost in his mind, and the CEO of the HMO (even if he is a doctor) cannot give absolute priority to the individual welfare of each patient." 140 A combination of dire circumstances and organizational aims may often force practitioners of humanitarian medicine into the position of attempting to fill both kinds of roles, which may be psychologically untenable for someone who cares about professional integrity. A plausible interpretation of the MSF clinicians' tendency to subvert their own formal patient-selection criteria is that doing so is a way to relieve this acute tension, even if only temporarily and with uncomfortable residual doubts. Their experience highlights an important point about the problem of representation, as emphasized by Thompson. It is not merely a problem facing individuals who wish to maintain professional integrity, but more deeply a problem that the institution must address in its design of the roles it will ask professionals to occupy. 141 An institution's policies stand in need of revision if they regularly place professionals in the type of bind suffered by MSF clinicians in Khayelitsha.

Regarding the design of institutional policy, the problem of authority presses the still deeper question of who should participate in making policy and in what ways. In particular, organizations that provide services like health care need to confront the issue of how to involve, or at the very least how to consult, the populations they purport to serve. 142 A tremendously challenging version of this problem for aid organizations like MSF is the issue of their accountability to needy populations, including both actual and potential recipients of medical aid. This has been the subject of Lisa Fuller's research with MSF. 143

Fuller addresses MSF's procedures for deliberating and deciding on questions of resource allocation on the largest scale. Where, and when, should MSF open, close, or restructure specific medical aid projects? MSF and other NGOs are vital in the provision of health care among extremely needy populations. Yet strikingly, in contrast with government agencies (such as Ministries of Health), which also need to decide how to allocate health care resources, the operational autonomy typical of NGOs leaves them with

140. Id. at 272.
141. Id.
142. See id. at 272-73.
143. Fuller, supra note 128.
"complete discretionary power" over all their allocation decisions, including the most fundamental ones of where, when, for how long, with what aims, and by what measures of success or failure they should operate their programs. Until recently, as a matter of formal organizational accountability, populations of the kind these NGOs purport to serve have not had much of a say in such decision-making. Fuller reports that NGOs are just beginning to explore mechanisms to improve accountability to their intended beneficiaries.

As a first step toward developing "a full theory of NGO accountability to recipients in need of medical care," Fuller critically examines the justifications most often used in MSF's decisions on large-scale resource allocation. She does so with an eye to the legitimacy of these justifications from the viewpoint of those who need medical assistance. She analyzes the allocation of scarce NGO-provided medical aid as a case of decision-making that calls for justification through a deliberative process incorporating "accountability for reasonableness." In the case of MSF and similar NGOs, due attention to accountability for reasonableness would acknowledge "that potential recipients of aid have a vital interest in MSF's decisions, while at the same time accommodating the fact that resources are limited and so not all suitable populations can be benefited."

Fuller finds that MSF medical personnel feel a strong obligation to stay and work with communities with whom they have become involved through existing projects dedicated to general health care. In contrast, projects narrowly focused on a single short-term outcome, such as the control of a specific disease outbreak, allow for statistical measures to determine when the outcome has been achieved, providing an identifiable reason for MSF to end its relationship with the community at a particular time. General health care projects are more problematic for personnel to close, even if they have achieved overall improvements to the point where other emergencies elsewhere clearly present greater need from an impartial perspective. Personnel feel that they have committed to a relationship with the people who live in the community, so that if no government or other system is prepared to take responsibility for meeting the

144. Id. at 60.
145. Id.
147. Fuller, supra note 128, at 60.
148. Id.; see also DANIELS & SABIN, supra note 89, at 44. Thompson, supra note 125, at 274, also suggests procedures modeled on deliberative democracy as a way for institutions to handle the problem of authority.
149. Fuller, supra note 128, at 63.
150. Id.
151. Id.
community’s general health care needs, they feel obligated to stay.\textsuperscript{152}

Another kind of case presents similar difficulties. MSF’s policy for certain HIV-treatment programs is to demonstrate treatment feasibility in selected low-resource or politically unstable environments.\textsuperscript{153} What drives the policy is the long-term goal of helping to make HIV treatment available to as many people as possible, in contrast with the alternative of making treatment available to fewer people by running permanent programs in only a few places. To this end, MSF sometimes employs a time-limited strategy, staying in any given host country no longer than roughly five years. During this period, the organization’s aims are (a) to demonstrate the feasibility of HIV treatment in the local setting, and (b) to find or pressure other agencies, which may include the government of the host country, to continue care for HIV patients after the temporary MSF program closes.\textsuperscript{154}

Yet MSF field staff, influenced by sensibilities of the kind Fuller has observed, say that they find it very hard to leave the host country at the appointed time, especially when they are uncertain about whether local efforts to continue therapy will be successful.\textsuperscript{155} They have in some cases actually reversed organizational close-down decisions, prolonging the stay of their clinics past the designated time to leave.\textsuperscript{156} This could undermine the very policies that ostensibly form the \textit{raison d’être} for the programs they serve. For one thing, if the MSF program prolongs its stay indefinitely, it may have the unwelcome effect of actually relaxing pressure on other capable agencies: Why should they commit resources if MSF will take care of it? More important for the present discussion, another consequence of staying too long is that while the local population gains further benefits in addition to what they have already received, other needy populations elsewhere lose the opportunity to have any such benefit at all.

When attachments to communities already being served dominate decision-making at the level of headquarters as well, the organization is in effect systematically making decisions that seriously affect candidate populations elsewhere for reasons that might not be legitimately justifiable to these populations. Fuller distinguishes between a “relational” perspective more appropriate to field staff who feel the pull of existing community ties, and a “comparative” perspective more appropriate to headquarters, which in the ideal case impartially considers fairness in the feasible distribution of good outcomes for all candidate populations, whether they are current beneficiaries or

\textsuperscript{152} Id.
\textsuperscript{153} Interview by Samia Hurst, Maitre assistante, Institute for Biomedical Ethics, Geneva University Medical School, with MSF personnel, June 5, 2005 (on file with author). Thanks to Samia Hurst for her explanation of this MSF policy and its underlying rationale.
\textsuperscript{154} Id.
\textsuperscript{155} Id.
\textsuperscript{156} Id.
prospective beneficiaries.\textsuperscript{157} She suggests a number of adjustments that might facilitate due incorporation of the comparative perspective into the organization’s decision-making. For instance, she proposes a constraint on the content of justifications for continuing existing projects, to rule out “[t]he mere fact that MSF-H[olland] has been engaged with a given group of people for some time.”\textsuperscript{158}

While Fuller is on the right track in emphasizing organizational accountability to all needy populations, her proposed adjustments include such populations in the decision-making process only by turning the minds of organizational officials in the direction of an impartial perspective. What about more directly seeking real input from the people who actually have the needs? One researcher, Stuart Rennie, has recently proposed a study of community attitudes toward ART rationing in the Democratic Republic of Congo (DRC).\textsuperscript{159}

As of 2004, only about two percent of people in the DRC who needed ART were receiving it. The DRC’s national plan estimates that, at best, only sixty-nine percent of approximately 340,000 people who need ART can receive it by 2009, in part because of the exodus of skilled health care personnel (again, brain drain) and the country’s devastating recent history of violent conflict.\textsuperscript{160} Rationing ART will in all likelihood be inevitable in the DRC for some time.

Rennie asked MSF-Belgium headquarters for permission to interview its DRC field personnel in support of his inquiry. He reports his astonishment upon finding that MSF was unwilling to participate, due to what he portrays as an ideological rejection of the very idea of rationing. An editorial in Developing World Bioethics (the journal that published Rennie’s critique of the position he attributes to MSF, alongside a response by MSF officials) accuses MSF of “taking some kind of pride in not having any kind of ethical resource allocation process in place.”\textsuperscript{161} The editorial’s authors rest their accusation on two sources: first, Fuller’s findings, which the authors interpret as evidence that MSF has no “uniform, transparent policies” for deciding when, where, and why to open, close, or modify its projects; second, the words of the responding MSF officials themselves, which characterize rationing as “a tactical acceptance of injustice.”\textsuperscript{162}

The worry expressed in MSF’s stated position is that those who accept

\textsuperscript{157} Fuller, supra note 128, at 69.
\textsuperscript{158} Id. at 64-65.
\textsuperscript{159} Stuart Rennie, Is It Ethical To Study What Ought Not To Happen?, 6 DEVELOPING WORLD BIOETHICS 71 (2006).
\textsuperscript{161} Willem A. Landman & Udo Schuklenk, Médecins Sans Frontières Under the Spotlight, 6 DEVELOPING WORLD BIOETHICS iii (2006).
\textsuperscript{162} Id. (quoting Rony Zachariah et al., Do Aid Agencies Have an Ethical Duty To Comply with Researchers? A Response to Rennie, 6 DEVELOPING WORLD BIOETHICS 78 (2006)).
rationing as inevitable may be indulging their own and others’ complacency toward the shortfall of resources available to meet the needs of the poor:

We consider rationing as a tactical acceptance of injustice that aims to respond to imbalances by offering only limited assistance for a chosen few. Some may view this as a naïve starting point, but that is what principles aspiring for justice should be inspired by. MSF believes that a technical approach to political distortions will only refine injustice. When people die, a technique that allows discrimination between who will die fairly or unfairly doesn’t seem the right answer.\(^{163}\)

The MSF officials who take this stand against “rationing” also insist that MSF’s explicitly endorsed “patient selection” policy (as employed, for instance, in the Khayelitsha project described above) is not equivalent to “rationing”:

Within MSF’s programmes, the medical and social criteria applied to determine who needs antiretroviral therapy are employed not as rationing criteria but as good medical practice and public health practice. Medical criteria (clinical staging, CD4 count, and viral load) are employed to ensure that only people who need to be treated are treated; social criteria . . . are used as public health provisions to avoid providing antiretroviral therapy to patients with a high probability of non-adherence and in doing so promoting drug resistance.\(^{164}\)

However, based on a neutral definition of “rationing,” MSF’s “patient selection” policy is indeed a form of rationing. In economics, “rationing” refers to “any policy or practice that restricts consumption of goods.”\(^{165}\) The market rations goods by price. When demand exceeds supply for non-market goods like the ART dispensed by MSF, the consumption of the good is perforce restricted in some other way.\(^{166}\) Any policy that applies criteria to restrict the consumption of a good, however the criteria may be regarded or conceived of by those who apply them, amounts to rationing in this neutral sense.

Terminology aside, there is a point of principle lodged against MSF by its critics. While, of course, every possible measure must be taken toward hastening the arrival of the day when scarce resources like ART are universally accessible to those in need, that day is not yet here. And even if, per impossibile, every effort in its direction were to meet with perfect success, it would still not be here for at least a few years.\(^{167}\) In the interim the impossibility of offering ART to

\(^{163}\) Rony Zachariah et al., Do Aid Agencies Have an Ethical Duty To Comply with Researchers? A Response to Rennie, 6 DEVELOPING WORLD BIOETHICS 80 (2006).

\(^{164}\) Id.


\(^{166}\) Id.

\(^{167}\) See Rennie, supra note 159.
everyone who needs it would remain, and in the far-from-ideal actual world it will remain well into the foreseeable future. Fairness to people in need thus requires transparent, consistently applied policies for allocating ART, through processes of decision-making that offer accountability for reasonableness. The interests of people who need ART are poorly served by any organization that plays an important part in distributing ART among them, yet avoids the formulation and execution of policies for doing so fairly. Finally, learning more about the conceptions of fairness held by people in need is an elementary and crucial step toward developing any decision-making process, whether in government agencies or NGOs, that would be truly accountable to them.  

If it is correct to assert that the institutional culture of MSF, in many respects a laudable organization, is biased against formulating fair policies in a responsible manner, here is one way to diagnose its dysfunction. Fuller observes that “most people at headquarters have extensive field experience,” a background which makes them “extremely sympathetic” to the partial, relational perspective at the expense of the impartial, comparative perspective. But any sound rationing policy would have to be grounded in the comparative perspective. Over-representation of the relational perspective in deliberations about large-scale resource allocation would tend, inappropriately, to duplicate at the level of headquarters the psychological propensity of field staff to shy away from the comparative perspective. Even if a bias toward the relational perspective helps individual professionals in the field to cope (however imperfectly) with the role conflicts engendered by the problem of representation, the institutional leadership ought to correct for that bias in its own policy-making rather than take up the bias and amplify it into a systematic evasion of the problem of authority.

MSF is not an isolated example. On the whole, shortfalls in institutional accountability appear to be common among humanitarian aid organizations. Rarely do these groups consult beneficiaries in evaluating the impact of their efforts. In addition, another telling sign is the absence in the published literature of a significant body of evidence to assess, by any measure, the impact and cost-effectiveness of standard emergency interventions. These standard

168. Among the questions Rennie seeks to answer are: “What do affected community members find fair in regard to the allocation of this very scarce and vital medical resource? Do their conceptions of fairness in treatment access rationing differ from those of national or international authorities who will most likely have the greatest say in the matter?” Id. at 71-72.
169. Fuller, supra note 128, at 69.
interventions, which consume large amounts of aid money, include nutritional supplementation, measles vaccination, vitamin A supplementation, and anti-malarial bed-nets. Aid organizations, lacking an evidence base to assess the options for deploying possible interventions, are likely to persist in allocating their precious resources according to status quo policies around which they happened to build up their expertise and declared their organizational mandates, but which remain untested and unchallenged by systematic observation. The authors of a recent report on this subject recommend the creation of "an independent body or institutional mechanism" responsible for amassing the necessary evidence base and using it to advocate improvements in practice.

In sum, for any institutional program that undertakes to distribute basic necessities to the very poor, two fundamental ethical considerations are fairness and cost-effectiveness. Most humanitarian aid organizations, however admirable their motivations and however heroic their exertions in the field, seem to stand in need of marked improvement on both counts. A necessary component of taking each consideration seriously is consultation with intended beneficiaries.

B. Research Organizations

Growing attention in bioethics focuses on a cluster of questions about the ethics of international medical research. One way to frame these questions is to start with what we might call the "domestic" ethics of medical research with human participants and see what happens when we extend it to the context of

For three out of six common emergency interventions, no published impact-assessment studies appeared, while the other three were the subject of nine, fifteen, and sixteen impact-assessment studies, respectively. With respect to cost-effectiveness, only one economic-evaluation study was published on each of only three interventions out of six. Duffield et al., supra, at 842-43.

172. Duffield et al., supra note 171, at 843.
173. Id.
174. Id.
175. Evidence and explanations for a prevailing lack of accountability in philanthropy, the genre of which humanitarian aid is a species, are offered in Editorial, The Business of Giving, ECONOMIST, Feb. 25, 2006, at 3-5.
177. See, e.g., ETHICAL ISSUES IN INTERNATIONAL BIOMEDICAL RESEARCH: A CASEBOOK (James V. Lavery et al. eds., 2007); RUTH MACKLIN, DOUBLE STANDARDS IN MEDICAL RESEARCH IN DEVELOPING COUNTRIES (2004).
This Section addresses research sponsored by organizations in affluent countries to study scientific questions of import for poor populations, meaning that the social value of answering the questions under study lies in their relevance to the needs of the poor.

Among several core duties of any medical researcher working with human participants are duties to respect the participants and not to harm them in the course of the study. One question raised by the disparities in wealth, health, and health care that pervade the context of international research is whether researchers also owe various kinds of benefits to impoverished participants. We can think of the benefits in question as radiating outward in several directions from the uncontested core duties.

It is uncontroversial that researchers have a duty to provide basic medical care pertaining directly to the interaction between the medical condition under study and the intervention that the study is testing, at least for as long as the participant is enrolled in the study. But for impoverished participants whose society offers them little or no other source of medical care, do researchers also have a duty to treat conditions other than the one under study? If so, which ones and to what extent? This is the problem of ancillary care, and it calls for much further inquiry.

While ancillary care is primarily a matter of what should happen during an individual's study participation, another problem that needs further inquiry is what, if any, benefits participants should receive after the study (post-trial benefits).

Most centrally, if the evidence shows that participants who receive the intervention under study have benefited from it, do researchers have a duty to continue treatment for impoverished participants who have no way...
of securing access to it when the study ends? If so, for how long?

Before we take up the question of obligations to provide such benefits, an issue that calls for some comment is "undue influence."\footnote{181} For research in low-resource settings, one might worry that in the prevailing absence of adequate medical care, the offer of ancillary care or post-trial benefits could lead people to participate in research when, in the absence of such benefits and all else being equal, they would otherwise decline. However, it has been argued that the influence of such incentives is "undue" only if it actually distorts people's judgment to the point that they make choices harmful to their interests.\footnote{182} Since no research protocol that poses excessive risks or burdens to participants ought to pass independent review, a properly reviewed study should already be such that a prudent person could reasonably choose to participate in it, whatever the additional benefits or lack thereof.\footnote{183} The general form of this point is that many safeguards ought to be in place throughout the research process—from study design, through independent review, to the monitoring of participants' safety and well-being, to follow-up as needed after their participation—to assure that risks and burdens are not excessive. If any protective concern should be intensified by gaping disparities of wealth between prospective participants and the researchers who ask them to take part, it is the concern to minimize the risks and burdens of the research. When that concern receives the attention it is due, there should be no residual worry that benefits otherwise indicated by ethical considerations—especially benefits owed to participants—are somehow ethically suspect.\footnote{184}

Returning to the topic at hand, one way to argue for some duty to provide ancillary care or post-trial benefits might be to invoke global justice.\footnote{185} When medical research in severely impoverished populations is sponsored by agencies in wealthy countries, it may seem that research sponsors, if not scientists themselves, have an obligation of justice to provide such further benefits, as a gesture toward redressing the vast resource inequalities that their very presence

\footnote{181} The U.S. federal regulations governing research with human subjects address this topic under the heading of informed consent. 45 C.F.R. § 46.116 (2006) ("An investigator shall seek... informed] consent only under circumstances that provide the prospective subject... opportunity to consider whether or not to participate and that minimize the possibility of coercion or undue influence.")

\footnote{182} Ezekiel J. Emanuel, Ending Concerns About Undue Inducement, 32 J.L. MED. & ETHICS 100, 101 (2004).

\footnote{183} Id. at 104.

\footnote{184} A kindred set of worries involves research in low-resource settings that is undertaken not for the benefit of the poor, but in order to develop treatments for people in the affluent world. There are important reasons to question the ethical legitimacy of recruiting members of medically deprived populations to participate in such research, even if risks and dangers are minimized and the actual risk/benefit profile would in itself make participation reasonable. See Jennifer S. Hawkins, Justice and Placebo Controls, 32 SOC. THEORY & PRACT. 467 (2006).

\footnote{185} See generally Alex John London, Justice and the Human Development Approach to International Research, HASTINGS CENTER REP., Jan.-Feb. 2005, at 24 (arguing that global justice is the key to a comprehensive re-conception of the ethics of international research).
in the host country makes embarrassingly obvious. But appeals to global justice might just as well support a policy of curtailing further benefits: Scientifically valid clinical research on questions important to poor populations is urgently needed, and resources for conducting such research are limited (especially when a commercial profit motive is absent). Arguably, so far as global justice is concerned, scientists and research sponsors ought to focus their resources on doing research and leave social welfare to others.\textsuperscript{186}

As a supplement or alternative to invoking global justice, it is illuminating to examine researchers’ and sponsors’ obligations to research participants through the lens of institutional ethics. To begin with, consider more closely the relationship between researchers and their institutional sponsors, and the relationship of both to research participants. Scientists who conduct medical research in low-resource settings are acting, in part, in the role of agents representing their sponsors. Producing generalizable knowledge through scientific inquiry is typically the sponsor’s chief objective in funding the researcher’s work. At the same time, the social value of the expected scientific results supplies part of the ethical rationale for researchers’ coming into medically intimate contact with participants.\textsuperscript{187} Even when sponsors and researchers intend the social value of their scientific results to accrue mainly to the poor, the way in which they expect this to come about is through the generalizability of their results to populations beyond the one immediately under study. Thus the researchers, not only in pursuing their own projects, but also by acting on behalf of their sponsors, are asking participants to take on the risks and burdens of research \textit{in the service of other people}. It is this feature of any researcher-participant relationship that engenders the researcher’s distinctive professional obligation not to disregard the participant’s well-being.\textsuperscript{188} Since the sponsoring institution is a party to putting the researcher (as its representative and agent) in this situation, the sponsoring institution is also, in some sense, a party to the obligations that arise from the researcher’s professional relationship with participants.

In the context of research with participants in low-resource settings, due regard for their well-being raises the problem of responding to at least some aspects of their medical needs, which, in more comfortable circumstances, the researcher could simply address through referral to existing services. A case in point is the question of providing post-trial access in ART trials for impoverished study participants who have benefited from ART during the study, but cannot

\textsuperscript{186} At most, on this view, global justice requires researchers to propose scientific questions whose answers will have value for poor populations, to conduct scientifically valid research, to publicize their results, and perhaps to press for the incorporation of their findings into equitable national and global health policy.


\textsuperscript{188} Maria Merritt, \textit{Moral Conflict in Clinical Trials}, 115 ETHICS 306, 312, 322 (2005).
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afford to secure access to it afterward. Recent policy guidance from the NIH encourages sponsored researchers who foresee these circumstances to coordinate plans ahead of time with host-country agencies, so that trial participants can secure ART through local treatment sites supported by international aid programs like the Global Fund.\(^{189}\) This policy guidance seems to be a good-faith attempt to treat the Global Fund and similar programs as “existing services,” to the end of acknowledging researchers’ professional obligation not to disregard the well-being of their participants. Researchers’ home organizations (for example, their university institutional review boards) and other sponsoring agencies might well like to encourage compliance with the NIH policy guidance on post-trial ART, as a solution to one instance of the “problem of representation.”\(^{190}\) Such encouragement is a convenient and low-cost expression of institutional support for researchers who feel obligated to assure participants of post-trial ART. It relieves researchers of worries about incurring this professional obligation in the absence of an institutionally endorsed means of fulfilling it.

But even if the NIH policy guidance for post-trial ART does solve the problem of representation, it does so only at the cost of exacerbating the “problem of authority.”\(^{191}\) What raises the problem of authority is a severe shortage of ART, which requires rationing among those in urgent need. This same shortage is what originally made the host country a good candidate for international aid from programs like the Global Fund.\(^{192}\) To pursue special arrangements as encouraged by the NIH policy guidance could be, in effect, to request that ART trial participants be offered special priority for access to ART at the expense of other similarly needy compatriots.\(^{193}\) But legitimate justifications for rationing the resources of international aid programs in low-resource settings must extend beyond special relationships like the researcher-participant relationship. As we saw above, the reasons given for the priorities set in rationing must be justifiable even to the people who lose out.\(^{194}\) It is of questionable legitimacy to appeal to the special researcher-participant relationship to justify asking research participants’ similarly needy compatriots, who may not have had the opportunity to participate in ART trials, to postpone or give up their own chance at access to ART in deference to participants.\(^{195}\) More generally, as a rule, no foreign research sponsor has legitimate authority to direct

190. THOMPSON, supra note 125.
191. Id.
192. See Rosen et al., supra note 165.
194. See supra note 89 and accompanying text.
195. Merritt & Grady, supra note 193.
the allocation of scarce resources within the host country.

On the other side, host-country authorities responsible for setting priorities, who are ideally supposed to represent the entire constituency of people who need ART as regarded from an impartial perspective, may be tempted by the attractions of hosting externally sponsored research to short-circuit the deliberative process unfairly. While it is possible that ART trial participants as a group might be assigned priority in ART rationing through a fair deliberative process, it can hardly be taken for granted that this would be the outcome of an actual deliberative process, and in any given setting there may be no such process or fairly decided set of priorities yet in place.

A promising alternative is to re-conceptualize any obligation to assure participants of post-trial care, such that the obligation includes off-setting the local health-system impacts of providing such care. This would modify the content of researchers’ professional obligations, and the content of their sponsors’ supporting institutional policy, to register the complexities of institutional ethics for research in low-resource settings. A sponsor ought to set policy informed by the professional obligations that researchers incur while acting as its agents, but a sponsor also ought to be constrained by boundaries proper to its relationship with other institutions, such as international aid agencies and the government of the host country.

CONCLUSION

As population-level bioethics rightly gains currency, critical reflection on the obligations of individuals, both as ordinary persons and as the occupants of institutional roles, continues to be warranted. Considering the actions open to individuals from the standpoint of their foreseeable impact on the health of the world’s poor, what emerges is the importance of consultation and partnership with intended beneficiaries, together with concern to mitigate the consequences for others who may also be affected.

The tacit assumption in the background of this discussion has been that the affluent, in aggregate, still care too little about the poor. It does not follow,

196. This is a slight modification of a suggestion originally made by Henry S. Richardson. Richardson, supra note 179 (manuscript at 2) (“If those who sponsor and carry out medical research have a responsibility to provide ART to trial participants, this can be conceived as an obligation to take the steps necessary to increase the overall availability of ART and skilled personnel in the country or countries hosting the research, if only for the benefit of their trial participants. By so conceiving it, we may sidestep the difficult issues that would arise if trial participants were to be seen as competing with their co-nationals for priority in access to a fixed supply of anti-retrovirals or medical professionals.”).

197. In the case of post-trial ART, one means of satisfying both demands is for the research sponsor to negotiate parallel funding mechanisms, through partnerships with private donors and NGOs. See, e.g., Jintanat Ananworanich et al., Creation of a Drug Fund for Post-Clinical Trial Access to Antiretrovirals, 364 LANCET 101 (2004).
however, that simply caring more would be better. Clumsy attention can be worse than none at all. An insidious impediment to making our attention properly sensitive is indulgence (even if unwitting) in fantasy that portrays the poor as passive victims awaiting rescue, where we as benefactors play the starring role. We, the affluent, will do better to consider in a spirit of self-effacement the kind and degree of assistance we owe to the poor. Ideally, the aid and scientific research that we sponsor should proceed hand-in-hand with in-country training of professionals, incentives to keep trained professionals there, and context-specific health-systems operations research, all directed toward the goal of building self-sufficient health-system capacity on a scale commensurate with the size of populations in need. 198 This is part of what it would take not only to meet the needs of the poor, but also to raise and hold global standards of living above poverty.

198. NUFFIELD COUNCIL ON BIOETHICS, supra note 120; LYNN. P. FREEDMAN ET AL., UN MILLENNIUM PROJECT TASK FORCE ON CHILD HEALTH & MATERNAL HEALTH, WHO’S GOT THE POWER? TRANSFORMING HEALTH SYSTEMS FOR WOMEN AND CHILDREN 22 (2005); Brian W. Simpson, If We Don’t Do it, Then Who? JOHNS HOPKINS PUB. HEALTH MAG., Spring 2006, at 24.