Introduction

Life expectancy improved dramatically worldwide during the 20th century as a result of
major expansion of the world economy and spectacular progress in science, medicine and
technology. However, the grim reality in the first decade of new millennium is that
human life, health and security remain under severe threat - but now from the adverse
effects of inexorably widening disparities in wealth and health within and between
nations that marginalize the lives of billions of people.

The challenge of achieving improved health for a greater proportion of the world's
population is one of the most pressing problems of our time and is starkly illustrated by
the threat of infectious diseases.¹

Increasing global instability and threats from the growing gulf between the world's haves
and have-nots call for a new balance of values and new ways of thinking and acting that
transcend national boundaries and recognize that public health, even in the most
privileged nations, is closely linked to health and disease in impoverished countries.

This is the backdrop to the issues under discussion and I shall endeavor to provide some
answers to the questions posed for this session by the conference organizers.
Discussion

What values are deeply embedded in the most important global health policies and programs?

It would seem to me that the most highly prized values that we hold in the modern western world are succinctly listed as individualism, respect for a narrow conception of human rights, consumerism based on market ideology, the legitimacy of bureaucratic/corporate control over professionals, and faith in direct scientific solutions to health problems despite these being related to dysfunctional complex social systems.

The prominence given to individualism and to respect for human rights (albeit a narrow interpretation of this concept) is relatively new in human history and has become a dominant feature of life only in the past 50 years. Our narrow interests in only civil and political rights also overshadow interest in social, economic and cultural rights, and our desire for competition and dominance eclipses cooperation and partnerships.

The ideology of bureaucracy has led to growth in numbers and power of managers over professionals. A concomitant rise to dominance of a consumerist market ideology has resulted in incremental commercialization of all aspects of life – including professional and academic life. The ability to create lines of control has given managers considerable power over the work of professionals.

Because we seem to be more interested in advancing knowledge than in using such knowledge, unless it is commercially profitable, we encourage and support the pursuit of scientific progress over social progress.

How do values, more than ethics, function as important rhetorical devices for global health decision makers?

The spread of market values and the growth of bureaucracy especially within the context of complex social institutions like hospitals and universities are transforming them into organizations that resemble corporations, intent on pursuing their financial goals with less interest in the non-economic aspects of the lives of those they should be serving. These institutional forces tend to eclipse the ideology of professionalism, weaken ideals and impede rather than facilitate the rational and ethical behavior that could improve global health. Sadly the central purposes of important social institutions, like universities and health care systems, are being greatly undermined by excessive emphasis on bureaucratic and market values that over-shadow the pursuit of knowledge or fair access to care. Highly individualistic social values and the power of market ideology are reflected in the way in which medical care is organized and delivered.

Within western societies the values of self-determination, civil and political rights, and free trade are generally ranked above socioeconomic rights, government control over health care services and civic duties. This radically individualistic perspective, most evident within the American value system, combined with the deeply rooted preference...
of Americans for involvement in voluntary community organizations that emphasize the duties of charity and philanthropy rather than faith in “politics” or “government,” encourages personal choice and self-interest over solidarity and the common good. As a result, public accountability through the democratic process is eclipsed by the progressive accumulation of power by private corporations that have been freed from accountability by “deregulation.” The result is resistance to national health insurance or universal access system in the USA. This is justified by concealing narrow motives behind smokescreens and through “window dressing” that obfuscate the real purpose of many official activities.

Regrettably medicine is becoming increasingly privatized and commercialized in many other countries, even in South Africa, with associated adverse effects on the poor and on the sustainability of medical education.

The Universal Declaration of Human Rights defines all rights, including socio-economic rights, as inalienable and interdependent. Failure to achieve socio-economic rights is to a considerable extent the result of powerful upstream forces that control the global economy. It has been argued that by locking into place the ‘rights and freedoms of capital (or large property owners)’ through progressive institutionalization of the new constitutionalism (as reflected in such international agreements as the North America Free Trade Alliance [NAFTA] and the World Trade Organization [WTO], as well as legal and institutional changes in macroeconomic policy, the rights and freedoms of millions of individuals are sacrificed for the benefit of the wealthy.

The arms trade has similar effects. Amnesty International has recently accused the G8 countries (the United States, the United Kingdom, Germany, Canada, Italy, France, Russia and Japan) of undermining their commitments to poverty reduction, stability and human rights with irresponsible arms exports to some of the world’s poorest and most conflict-ridden countries. The claim has also been made that the trade in arms perpetuates, worsens and legitimizes the systematic abuse of human rights all over the world.

The recent focus on the conflict of interest between arms trading and health in relation to medical publishing is sobering.

Paul Farmer has made a powerful statement: ‘Human rights violations are not accidents; they are not random in distribution or effect. Rights violations are, rather, symptoms of deeper pathologies of power and are linked intimately to the social conditions that so often determine who will suffer abuse and who will be shielded from harm.’ Recent violations of civil and political rights by the nation that has championed these most vociferously in the past exposes the pathologies pf power.

The Global Fund, the generosity of the Bill and Melinda Gates Foundation and of many individuals and organizations exemplify the commitment to voluntarily improving the lives of the less fortunate. However, such attitudes result in linear and vertical approaches to health problems rather than approaches that acknowledge the complex systems within which health is embedded and the need for an integrated horizontal approach to health care. Despite the shortcomings of these values they achieve the highest global profile.
The preference for advancing knowledge over the use of knowledge with wisdom leads to science and innovation being seen as the best solutions to global health problems even though there may be more appropriate social solutions: The spectrum of the ‘Gates Grand Challenges’ illustrates this point. Ann-Emmanuelle Birn has eloquently described the shortcomings of such an approach that fails to take into consideration the social determinants of health.  

“At the heart of scientific medicine, there is a mystery and a paradox. The mystery is the mystery of knowledge, that product of a community of minds, unique to humans, in which sense experience is pooled. This marks a huge gap between humankind and all other animals. The paradox is that the success of scientific medicine has been based upon a biological approach to human disease that elides this gap. Some of the discontent with medicine, despite its extraordinary success, may be explained by this paradox.”

Where do our values come into conflict with the local values of the intended beneficiaries of global health programs?

Before asking this question we need to ask if we know anything about local values in the regions in which we claim to be interested. If we do is there any evidence that we use this knowledge constructively? If we do not have this knowledge then why is this so? Are we disinterested? Do we assume that their local values are the same as ours? Do we assume that our values are universal rather than local? In general terms we can answer that we tend to consider our value system as universal and as the model for all. Not only are we incapable of understanding other value systems but we wish to impose our values on others.

One example of the narrow focus of our interests is illustrated by frenzied activities to provide widespread access to antiretroviral drugs with minimal attention to the provision of food and to the prevention of avoidable deaths from easily treatable conditions in children. More people die every day from malnutrition and preventable childhood diseases than from AIDS – and one wonders if anyone has asked local populations to rank their priorities before embarking on an antiretroviral treatment program. Developing and providing new drugs are more attractive to us than wise use of the knowledge and resources we already have. There is no shortage of food in the world - only a lack of will to distribute unused food optimally. Deborah Frank’s presentation to the US House of Representatives about hunger and malnutrition in children in the US is an indictment of that society. How is it possible for children in the wealthiest nation on earth to be malnourished?

Do values change from an unfolding developmental process in global health?

While values can change with time, they tend to do so slowly and to a limited extent. For example the shift from paternalistic practices in medicine to respect for patient autonomy has taken place slowly and to varying extents in different societies. Within bioethics the 30 year focus on individual autonomy is now also being supplemented by an understanding of the need for an ethics of public health to enable us to deal rationally
with infectious disease threats – although this discourse is in a nascent state.\textsuperscript{20} There have also been shifts within other fields of study indicating that it is possible to bridge local moral experience with global insights.

For example, in the field of economics it is at last being acknowledged that poverty cannot be reduced merely through economic growth, and that built into the process of economic growth are such practices as unfair trade that ensure that economic growth does not benefit all;\textsuperscript{21} and that rather than trickling down resources are predominantly funneled upwards towards the wealthy.\textsuperscript{22}

Within philosophy there has been a shift away from only theoretical considerations towards applied ethics as a scholarly endeavor. While scholars continue to pursue theory, for example through development of broad cosmopolitan theories of justice\textsuperscript{23, 24} there has also been movement towards more pragmatic work on non-ideal theories that could contribute to narrowing injustice.

Within development studies there is a gradual shift in focus away from the myth of sustainable development to the idea that what is needed is the development of sustainability.

\textbf{What conflicts in values exist between programs at the global level?}

One of the major problems with foreign development aid (even for health) is that it is focused on direct provision of financial aid rather than on providing the capacity-building support that could reduce dependence and increase self-sufficiency. It is now evident that efforts to address serious global problems are both dominated and thwarted by a conception of development that focuses predominantly on economic growth. Even worse is the extent to which so called development aid is turned to the advantage of donor countries and to arming despotic rulers intent on maintaining control over their countries’ natural resources so as to enrich themselves and remain in power.\textsuperscript{25, 26}

Another problem lies in the way we seek solutions to problems through what is called a ‘linear’ approach that seeks direct answers to specific problem without taking sufficient cognizance of the fact that all specific problems are embedded within complex systems in which positive and negative feedbacks occur in response to changes and with consequent effects that may differ significantly from outcomes envisaged within a linear approach. Systems approaches potentially offer more meaningful progress but have not been adequately addressed.

\textit{Do we need consensus? If so, then to what degree do we need this? If not, how do we manage multiple values, especially in the context of new public-private partnerships for global health?}

While there is indeed a need for consensus, it is realistic to acknowledge that consensus within systems that host communities with pluralities of values is often superficial, and
that there will be a need to manage multiple values through deliberation and cooperation without insisting on dominant paradigms.27

How do we bridge local moral experiences with global health policies?

Against a backdrop of ideologically driven discourses on growth, free trade and security, increasing health disparities between rich and poor between and within countries, and evidence of flaws in the economic conception of development, new ideas and forces for development are urgently required.

A new model for development is required that transcends the North–South dichotomy and goes beyond a narrow conception of development as an economic process. This would entail a shift towards a new metaphor that emphasizes that all countries are to some extent underdeveloped and what is needed is to develop sustainability, rather than sustain development.28 This new paradigm of development would abandon four flawed assumptions lying behind previous approaches: (i) that developing countries’ problems are entirely internal; (ii) that developed countries are an example to be globally emulated; (iii) that the role of developed countries in promoting development is defined by altruism; and (iv) that the poor lack the potential to improve their own lives significantly.

One of the features of this new paradigm is explicit inclusion of the ethical challenge of effectively addressing the upstream forces that contribute to widening disparities in global health. It would be hard to deny that the vast numbers of global poor and their lower life expectancy represent a clear and significant injustice. One way to analyse this injustice is through the lens of global distributive justice – for example, in terms of an obligation to redistribute resources from rich countries to poor countries. If, against the background of the above scenario, we can agree that this is an ethical solution, then the challenge becomes to determine how to pursue this goal.

The example set by the US National Institutes of Health through its Fogarty International Center program for capacity building in international research ethics in developing countries29 30 illustrates how local and international moral experiences can be bridged and enriched in an era in which international collaborative research is expanding rapidly, and cross-cultural understanding is being promoted.31

Grappling with and understanding diversity in scholarly ways could allow progress to be made in finding rational and agreed-to common ground. Making such progress will require acknowledgement that research does not take place in a vacuum but rather in a world with wide disparities in which much research on vulnerable people has never been applied for their benefit. The need to link moral progress to scientific progress should become a high priority. Progress could then be made towards narrowing the gap between local moral experiences and global health policies by coupling research to improvements in health through a broader conception of the standard of care associated with research, and by linking research to development through partnerships and strategic alliances that could promote sustainability.32
Perhaps the recent shift away from the neo-liberal and human rights frameworks to a right-based development approach offers some ideas.

First we must ask if such a shift is indeed taking place or if it is an illusion created to make it seem that such changes is taking place! The concept of Human Rights has become the modern civilizing standard to which all should aspire and attain. However, in an era characterized by widening disparities in health and human rights across the world, and despite spectacular advances in biotechnology, it is necessary to reflect on the extent to which human rights considerations are selectively considered for the benefit of the most privileged people. This certainly seems to be the case in the new South Africa where, despite all the attention given to human rights before the political transition in 1994, the previously highly acclaimed right-to-development program gave way to neo-liberal policies that have enriched many but have left 40% of South Africans poorer than in the apartheid era.

South Africa’s shameful lack of attention to gross human rights abuses in Myanmar, Iran and Zimbabwe is another example of how parochial political considerations can eclipse attempts to address human rights issues.

In such an era it is also necessary to ask whether, when we speak about human rights, we are concerned about the rights of the 1 billion people who live so well and who have so much to look forward to from the benefits of further scientific progress or the rights of the 4 billion people who live under miserable conditions?

We should ask this question for many reasons. Firstly, the disparities between the lives of people who fall into these two categories have been constantly widening over the past 30 years and there is little evidence that this pattern will be reversed. Secondly, abuse of power has been a significant force in contributing to wide disparities in human lives and to gross violations of human rights. Thirdly, there is little to suggest that the new power that will be available in the biotechnology era will be used more wisely than other forms of power have been used in the past.

Global economic processes have extracted material and human resources from many poor countries, eroded the value of their currencies and placed their economies at the mercy of such unaccountable organizations as the International Monetary Fund and the World Bank. Massive deprivation of citizens of poor nations has also been promoted through the sale of arms to corrupt leaders, enabling them to accumulate vast wealth and to wage wars of ethnic conflict, with devastating social effects.

What will happen in the era of biotechnology to improve the lives of the poor? Will advances in plant, animal or human genetic engineering enable major pharmaceutical and agrochemical companies to produce cheaper drugs and food and will the sentiments expressed in the Universal Declaration of the Human Genome be respected - as optimistically suggested by some? Alternatively will the insistence on intellectual property rights and reduction in the biological diversity of agricultural products disrupt the economies of poor nations and ensure that food prices continue to rise and malnutrition aggravated? Is it possible that genetic data from some groups of people will be exploited for economic benefit, or even more horrifyingly, to develop weapons
for genocidal purposes? If drugs for malaria, tuberculosis, many tropical diseases and HIV/AIDS have not been made available to billions in poor countries (let alone food!) is it likely that the poor will benefit from advances in biotechnology?

“The progress of history rests on the battle for supremacy of competing ideas. The power and wealth of western countries give them a dominant role in shaping the international public discourse. This is a privileged position they have earned, and the rest of us have little claim to object….This imbalance of voice in the international discourse has built up a dangerous sense of resentment by the silent majority of the world’s people.” 39  Sadly, as noted by Human Rights Watch in their latest report, the USA can no longer provide credible leadership in advancing human rights.40

**Indications of failure to make the paradigm shift required for meaningful progress**

When the CIOMS research ethics guidelines were being updated in the early 2000s participants in the process who lived in developing countries argued for inclusion of a preamble describing the global context within which research was being conducted. A draft preamble was submitted at the final meeting when changes were being discussed but this was not included in the final 2002 version of the guidelines. One wonders why not and why no explanation was provide for this omission?

The Global Fund has been an innovative and exciting approach to acquiring the funds needed to address pressing health issues in the developing world. However, the limited success in raising the required resources illustrates the lack of meaningful support by wealthy nations for this ambitious endeavor. 41

The idea of setting Millennium Development Goals is another example of an attempt to reduce avoidable suffering and early deaths but when these goals were not being reached the goal posts were subtly changed to make it appear that they were! 42

Repeated failure of health care reform in the US reveals the difficulty in changing an expensive and inefficient way of providing health care. This ongoing failure of a wealthy nation to set an example of caring for its citizens erodes the concept of medicine as a valued, caring social endeavor. 43

Those with deep insight recognize that poverty can only be effectively addressed by recognizing that poverty and human rights abuses are related to the structural violence built into modes of living that favor some over others, and that it is essential to modify the upstream forces, including trade rules, that sustain poverty and disadvantage poor nations.44 Failure of the DOHA round of trade negotiations exemplifies the difficulty in achieving this goal. 45

Reference has already been made to the limited scope of the Grand Challenges funded by the Gates Foundation.15 Failure to pay attention to the upstream forces that profoundly influence health reduces the credibility of serious scholars who claim to be concerned about human health? 46
Thomas Page’s shift from a focus on ‘World Poverty and Human Rights’ \(^{10}\) to a Private-Public Partnership for new drugs that will sustain profits for Pharma is an example of how even a serious philosopher can change the direction of work because of lack of political support for an approach that has a long term and ‘out of the box’ perspective to a more speedy and effective means of correcting social injustices within the framework of mainstream thinking.\(^{47}\)

**Conclusions**

Given the scenario painted above I can only conclude that the prognosis for improving global health is poor. Whatever changes are taking place in how we think and act are grossly insufficient to make significant progress towards changing the status quo. This also applies to our approach to the energy crisis and environmental challenges. We seem to be fooled by what Soros has called ‘a window dressing agenda’ in a ‘feel-good society’.\(^{48}\) Wallenstein’s perspective of the world being in a ‘state of unstable equilibrium’ rings true.\(^{49}\) Galbraith cautioned against the complacency of the wealthy many years ago.\(^{50}\)

A global agenda must extend beyond the rhetoric of universal human rights to include greater attention to duties, social justice and interdependence. While it may be unrealistic to expect that it is possible to find commonality in our approaches to such issues in a highly diverse world, health and ethics provide a framework within which such an agenda could be developed and promoted across borders and cultures.\(^{51}\)

We have suggested that the relatively new interdisciplinary field of bioethics, when expanded in scope to embrace widely shared foundational values has the potential to make valuable contributions to improving global health by providing the space for such a discussion to occur.\(^{52}\) Others have also argued that ‘ethical claims have the power to motivate, to delineate principles, duties and responsibilities, and to hold global and national actors responsible for achieving common goals’.\(^{53}\)

Our vision, explicated in detail elsewhere, offers a way forward for global health reform.\(^{49}\) We have proposed that peaceful and beneficial use of new knowledge and power could be promoted through a *set of values* that combines genuine respect for the dignity of all people with a desire to promote human development beyond the notion of development conceived within the narrow, individualistic ‘economic’ model of human flourishing. Such values include meaningful respect for human life, human rights, equity, freedom, democracy, environmental sustainability, and solidarity. Foremost among these, however, is solidarity because without this we ignore distant indignities, violations of human rights, inequities, deprivation of freedom, undemocratic regimes, and environmental damage with potential adverse effects on future generations.

We argue that bioethics needs to adapt to global realities through an expanded discourse that goes beyond the micro-level of interpersonal relationships and individual health to include ethical considerations that impact on health at the level of institutions and international relations. A framework that combines understanding of global
interdependence with enlightened long-term self-interest has the potential to produce a broad spectrum of beneficial outcomes. An extended public debate, promoted by building capacity for this process through a multi-disciplinary approach to ethics in education and daily life, could be a significant driving force for such social change.

Extending the discourse in this way could promote the new mindset needed to improve health and deal with threats to health globally. That mindset requires a realization that health, human rights, economic opportunities, good governance, peace and development are all intimately linked within a complex, interdependent world. The challenge for scholars in the 21st century is to explore these links, to understand their implications and to develop processes that can harness economic growth to human development, narrow global disparities in health and promote peaceful coexistence.

Developing a global state of mind about the world and our place in it is perhaps the most crucial element in the development of an ethic for global health. Achieving this requires some understanding of the world as an unstable complex system. It also requires balancing the value of individual goods and social goods, and avoidance of harm to weak/poor nations through economic and other forms of exploitation that frustrate the achievement of human rights and well-being. Achieving widespread access to such public goods as education, basic subsistence needs and employment requires collective action, including financing, to make sure they are produced, and good governance to ensure their optimum distribution and use.

Striking a balance between optimism and pessimism about globalization, solidarity and progress will require a platform for dialogue among stakeholders, and a space where people can share different views about globalization. A broader conception of bioethics offers such a space. Our vision for promoting an ethic for global health also features the development of capacity and commitment to a broader discourse on ethics propagated through centers regionally and globally networked in growing and supportive North-South partnerships.

The emergence of a multi-faceted social movement ‘globalization from below’ illustrates additional pathways to constructive change. In arguing that it is both desirable and necessary to develop a global mindset in health ethics, we suggest that this change need not be based merely on altruism. As an example consider long-term self-interest and mutual interdependence in the face of emerging new infectious diseases and microbial antibiotic resistance.

Constructing new ways of achieving economic redistribution is the key to resolving many global problems. If wealthy people progressively care less for the lives of those whom they relegate to living under inhumane conditions, the lives of the wealthy will become more meaningless and inhuman to the underprivileged masses. The global trap in which neither rich nor poor care if millions of the members of the other group die is the recipe for ongoing conflict and unnecessary loss of life on a grand scale. While economic equality is an impossible goal, narrowing of the current gap is surely well within our grasp.
It is a welcome sign that credible scholars are now acknowledging the downside of conventional economic theory and its adverse impact on the design and implementation of global rules tend to favor already rich countries. The proposal that there is a need to reinvent the business of foreign aid and to develop a global social contract is to be welcomed.  

While it is satisfying to believe that there is a glimmer of hope that such progress is possible, cognizance should be taken of the skepticism of those who ask such questions as: `Is there any possibility of a global bioethics in the face of respect for diversity and multi-culturalism? Can ‘rationality’ overcome contrasting moral and other perspectives on the good life? If we cannot agree across time and within relatively homogeneous populations on many ethical dilemmas (for example the culture wars in the USA) what hope is there that we may achieve any ‘thick’ consensus on complex global health issues? Are we standing in the `ruins of attempts at global bioethics?`
References

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