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RESPONSIBILITY – IN PUBLIC HEALTH

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Responsibility⁷⁴ is a fundamental value for all decisions and actions in all phases of life and all sectors of society. Responsibility is a key benchmark for ethical behaviour. The following contribution concentrates on the responsibility of Actors in health, especially public health.

Every year, eight million children die before they reach the age of five. More than 300,000 women die in pregnancy or childbirth and more than four million people die of AIDS, malaria, and tuberculosis.⁷⁵

On the one hand, global health would appear to be a permanently irresolvable issue: an immutable pending debt. On the other, it reveals a complexity and variance that makes it a moving target.

I will first present some empirical facts about global health. I will argue for a multiple strategy with a nuanced and context-specific solution. Secondly, I will outline possible responsible agents that should tackle global health. Because of partial compliance and practical obstacles to putting ideal theories into practice, I will consider a non-ideal approach.

⁷⁴ This article is republished with the permission of the author given 11th April, 2016. Original title: Law and Global Health: Current Legal Issues Volume 16 edited by Freeman, Hawkes, and Bennett (2014) Chp.17 "Adding Nonideal Agents to Work Out a Pending Debt" by F. Luna pp.295-307. By permission of Oxford University Press.

⁷⁵ L. Gostin et al, 'National and Global Responsibilities for Health' Bulletin of the World Health Organization (2010) 88: 719.

I will defend the need to consider a plurality of responsible agents to ameliorate global health. Finally, I will analyse a real case and show how this proposal based on multiple strategies and various responsible agents is feasible and the best response.

8.1 Why is Global Health a Moving Target?

Basic and fundamental public health policies can solve part of the problem of global health. However, these are structural modifications like sanitation, drinkable water, or a working electric system. Most of the developing countries are indebted to their inhabitants owing to the absence of such infrastructure. In addition to this public health infrastructure that is lacking in most developing countries, specific illnesses still present particular challenges (for example malaria, river blindness, Chagas, or dengue), some of which, the so-called neglected diseases, are infectious and strongly related to poverty, climate, and living conditions. In what follows I will focus on those diseases. Let me enumerate some of the challenges these diseases present and why their control or cure can be considered so complex.

A first challenge is the lack of an available cure for many of these illnesses and the ineffectiveness of existing treatments; many drugs also have side-effects or patients have built up a resistance to those drugs, making them less effective. Research is crucial. However, as these are the illnesses of the poorest, pharmaceutical companies show little interest in conducting research. This lack of interest is an enormous obstacle. Some solutions may come from a theoretical and innovative framework like the Health Impact Fund (HIF) proposed by Pogge and Hollis to incentivize pharmaceutical firms.⁷⁶ It seeks to promote research in relevant

⁷⁶ A. Hollis and T. Pogge, *The Health Impact Fund: Making New Medicines Accessible for All* (Incentives for Global Health, 2008).

illnesses (for example those killing a large number of persons) in order to develop and make drugs available at cost. It is based on a complex scheme of rewards depending on the impact the new drug has on the health of the people. Although this proposal is creative, interesting, and has the correct ethical insight, it is still very hard to implement. Less structural but supposedly more feasible alternatives are public-private partnerships (PPPs) with the leadership of international intergovernmental organisations, such as the World Health Organization (WHO), or non-governmental organizations (NGOs). But such partnerships can be more restrictive and sometimes difficult to achieve.⁷⁷

A second challenge, once a cure or a possible medicine has been found, is the difficulty of deciding how this cure should be distributed, given that the poverty context can add further obstacles. Making the new drug or treatment accessible in hospitals is not without problems in itself. Hospitals need the resources to buy the drug and make it available to those in need. When the product is connected to an agency, such as the WHO, prior agreements can be made to implement price reductions or have the drug distributed cost free.⁷⁸ When this is not the case, the state will have to buy it and endorse the universal policy of providing the drugs to those patients. Should this not happen, NGOs can provide the treatment or help the population. But there is a long, steep, and winding road from the success of finding a new efficacious drug or treatment to the effective treatment of the population.

A quite different third challenge shows that some treatments cannot be reduced to a pill or a short treatment provided during hospitalization or a visit to the clinic. Many of these diseases have no ‘magic bullets’: just providing the drug does not necessarily mean the problem is over.

⁷⁷ Care should be taken about the drive of private partners to foster private interests and not public health.

⁷⁸ As will be explained in section 8.3, this was the case with ivermectin for onchocerciasis, which was donated by Merck.

Treatment may not be easy to adhere to or effective. For example, some cures can take months and are difficult to follow up on and enforce. Consider Chagas disease, this is a chronic disease that causes irreversible cardiovascular, gastrointestinal, and neurological problems and occurs in adult life. By the time the symptoms appear, it is too late to cure. An effective treatment exists for children with Chagas disease but it has to be taken daily for one month. The medication has side-effects. As there are no symptoms of the disease, the child appears to be healthy, making it difficult to ensure adherence to the full course of treatment. Another case is the treatment of tuberculosis, which takes even longer and generates high drop-out rates. This poses a serious threat to public health as it is extremely contagious, especially in the case of large families living together in small rooms in large overpopulated cities.

The opposite situation is that of people living in rural or inaccessible areas. A lack of transport could mean hours of walking to reach the nearest village or hospital; no electricity means medicines cannot be kept cold. Thus, dealing with these circumstances calls for other strategies, other approaches. But as we can see, it is far from simple. If measures are going to be implemented as a public health policy, they should be carefully studied and this implies a different kind of research. How to achieve adherence or the effectiveness of treatment? Who is to fund this kind of research? No new drugs are involved. This public health research or implementation research poses new and different problems.

The availability of drugs or treatments in hospitals is one of the challenges, but as mentioned previously, countless obstacles can give rise to other problems: treatment and provision alone does not suffice. Most illnesses are not merely 'biomedical'; there are psycho-social components in resilience and recuperation. In the case of the infectious diseases of poverty, these factors are even more relevant. Poverty itself largely explains why the elimination of these diseases is so complex. Different

social determinants of health play a significant role.⁷⁹ Illness in these deprived economies is more devastating than in other societies, where labour laws protect the workers. The poorest of the poor are almost certainly the informal workers without any social protection. They depend on what they can produce and have a hand-to-mouth existence. These situations are so complex that it is hard to find a feasible answer.

Another fundamental issue for a cure is an accurate diagnosis to avoid overtreatment or under treatment. But again, if we cannot access the physician or clinic easily, how can we manage the diagnosis? The ‘standard way’ to solve medical problems (reaching a clinic, being tested, and receiving an accurate diagnosis and treatment) will not follow. One example of this kind of situation arises with malaria. An effective treatment of malaria involves training and working directly with the communities or households. That implies a shift in the usual biomedical Western paradigm and illustrates how difficult it is not only to make the established drug available but also to provide for its effective use.

Hence, even if we can solve the second challenge of obtaining the resources, finding the desired cure, and making it available in hospitals or clinics, the target will move as it will not be easy to deliver the drugs efficaciously to many of the people that need them the most.

Fourth, a set of problems is related to the prevention and eradication of the causes of these illnesses. A number of these diseases have to do with climate and vectors such as insects. Chagas disease is transmitted by an insect that can be hosted in dogs and chickens. It is very hard to make people understand that bringing the pet dog into the house can pose a serious threat, that it should not enter, not to mention sleep in the

⁷⁹ For example, many of the people that fall sick are generally weak and suffer from bad health: they may not be able to rest and eat nutritious food for a quick recovery. The simple fact of ‘not eating enough food’ can hinder a proper absorption of the medication without incurring side-effects. Rest is a luxury they cannot access. In addition, just being sick introduces a vicious circle because illness generates more poverty. Not only is money spent on the cure but the illness also stops them from working.

house. Here again, it is not merely a question of introducing a cure or a drug. But the daunting task of changing life styles and educating the community so that they can modify their habits and customs. This goes well beyond the biomedical realm.

Some of the prevention tools are as simple and commonsensical as bed-nets, insect traps, or insecticides to prevent infected mosquito bites and to fight against the vectors of these illnesses. However, before these devices can be implemented as a public health policy by a poor government, they must be shown to be efficacious and relevant. One of the problems is that these studies are not very common and do not follow 'standard procedures'. Even though some manufacturers may find it profitable, they are not in the business of conducting the research trials (specific cluster randomized trials) that should be designed and put into practice.⁸⁰ Again, once their role in prevention and usefulness has been proven, a second step will be to provide these devices and educate the people in prevention behaviours.

Fifth, there are even more complex issues involving neighbouring nations. This challenge is related to the mobility of people and migrations. Frontiers are permeable and negatively affect a country that has made efforts to eradicate one of the vectors and the illness (for example Chagas) resulting from seasonal migrant workers. Consequently, the vector and the disease will return year after year. Solving these kinds of problems signifies a regional rather than state policy that can be exceedingly difficult to implement.

In addition it is crucial to develop surveillance systems to gather and share data. And there is a further need to install strategic responses at

⁸⁰ For example, a first study in the Gambia showed a 63% reduction in child mortality owing to the use of bed-nets with insecticides, but when replicated with a design of cluster randomization in three countries, it found a 20% reduction in malaria. Hence, the final study showed a lower impact than the first. On the whole, however, it also demonstrated that this was an effective tool to implement as a public health policy.

global, regional, national, and local levels if changes are to be sustained⁸¹—another front of action.

The complexities described so far show conditions that are far from ideal and why one answer alone does not follow. So many and diverse obstacles are involved that multilevel answers have to be tackled. So many and diverse are these challenges that we are witness to a moving target. Once a cure is found, there is the provision issue, and when the isolation or adherence problems are overcome to achieve the effective cure, all these other peri-health issues regarding vectors, hosts, and regional strategies move it to a new level. Once again, the scenario changes because of new obstacles. Most of the answers in themselves prove partial and ineffective. But this partiality is not just a building-block system where the solution can be found in a step-by-step construction. It is not clear in these cases whether partial solutions will ultimately solve the problem. In most situations there is no lineal progress; this implies the need for a set of different approaches. That same partial solution may modify the problem and create a new one. Merely taking one step can give the impression of having implemented a policy without having resolved it, thus worsening the situation, discouraging and fostering a negative reaction towards the problem. A useful analogy for the situation is the incorrect use of an antibiotic.⁸² Not only can an incorrect dosage or early abandonment not cure, but it may generate a resistance, as well as the subjective feeling that the medicine did not work.

Hence, without a systematic, coordinated, and efficient approach by different agents, stakeholders, and the community and the ‘political will’ at the national and international levels to implement changes, global health will still lag behind, conceived as a mere utopia. Social policies,

⁸¹ World Health Organization (WHO), Special Programme for Research and Training in Tropical Diseases (TDR), *Global Report for Research on Infectious Diseases of Poverty* (Geneva: WHO/TDR, 2012) 32.

⁸² I am grateful to Julieta Arosteguy for her comments and her suggestion of this analogy.

human health (biomedical and public health), veterinary, environmental, and wildlife management expertise should join to formulate innovative and suitable strategies.

8.2 Who are the Responsible Agents?

Do the challenges and obstacles presented in the previous section imply that nothing can be done? I do not believe so. However, we must acknowledge challenges if we are to overcome them. As was said previously, the issues are very complex and, in consequence, we should seek out complex and diversified ways to solve them with different non-traditional tools. The primary goal is to ameliorate global health. In this section I will identify some of the responsible agents in political theory in order to evaluate their possible role in global health.

In recent years, a strong debate has emerged in the theoretical arena regarding ideal and non-ideal theories, their relationship, merits, and problems.⁸³ These considerations are increasingly relevant to bioethics and the field of global health. Ethical and political theories designing institutions and attributing responsibilities assume an ideal world where people comply with their responsibilities and ethical requirements. The first and fundamental feature of an ideal theory is that it assumes 'strict compliance'. According to Rawls, an ideal theory presupposes that: '(Nearly) everyone strictly complies with... the principles of justice'.⁸⁴ The second feature is that it assumes favorable circumstances. These

⁸³ J. Simmons, 'Ideal and Non-ideal Theory' (2010) *Philosophy and Public Affairs* 38: 5. Z. Stemplowska and A. Swift, 'Ideal and Non-ideal Theory' in D. Estlund (ed), *Oxford Handbook of Political Philosophy* (Oxford: OUP, 2012). A. Hamlin and Z. Stemplowska, 'Theory, Ideal Theory and the Theory of Ideals' *Political Studies Review* (2012) 10: 48.

⁸⁴ John Rawls was the first to introduce the distinction between ideal and non-ideal theories regarding his own Theory of Justice, but his proposal can be applied broadly. J. Rawls, *Justice as Fairness: A Restatement*, (Cambridge, MA: Harvard University Press, 2001) 13.

include ‘historical, economic, and social conditions, such as economic means, education, or the main skills to run a democratic regime’.⁸⁵ Even if strict compliance can be distinguished from the moral compliance of a saint or a hero and even if Rawls is not considering the ‘best possible circumstances’, the situation seeking global health (the conditions described in the first part of this chapter) are far from strict non-heroic compliance or normal socio-economic contingencies.⁸⁶ Hence, I argue that the answer will not be found in ideal theories. A non-ideal approach, by contrast, will suggest how to deal with noncompliance and unfavourable conditions.⁸⁷

In an imperfect world with extreme conditions and scarcity, where the ideal responsible agents do not comply, a non-ideal strategy should be designed. And this can be justified until fairer and more feasible conditions for justice and ideal agents’ actions are in effect. The ideal theory may still have a place: it can take the role of a target or aspiration.⁸⁸ It may identify the objective at which to aim; it may help non-ideal theories to become transitional theories, hence pursuing new ways of thinking. And this applies not only to principles and institutions but to responsible agents. Instead of only considering ideal responsible agents, a pluralistic non-ideal approach may be better— researchers, states in-

⁸⁵ Rawls, *Justice as Fairness* (n 84) 47.

⁸⁶ It can be argued whether ideal theories are applicable to more ‘normal’ situations because in the real world, people do not generally comply with their obligations. Aside from this controversy, it is clear that in very scarce resource settings where global health is not achieved, conditions are unmistakably far from ideal.

⁸⁷ Rawls and others explain that it comprises such topics as theory of punishment, doctrines of just war, and various ways of approving unjust regimes; Stemplowska and Swift, ‘Ideal and Non-ideal Theory’ (n 83) 2. I think we can apply this non-ideal approach more broadly to unfavorable situations and non-compliance.

⁸⁸ There is also a debate regarding this interaction. I think that the ideal theory might not be a prerequisite but should be on the horizon. A possible role is to guide non-ideal strategies. See Stemplowska and Swift, ‘Ideal and Non-ideal Theory’ (n 83).

volved, rich states, and international corporations should have a role until the ideal responsible agent or agents can comply.

8.2.1 Ideal Agents and Compliance

In ideal theories, who are the responsible agents? Philosophers such as Peter Singer target individual responsibility: each affluent person has a moral obligation.⁸⁹ In Singer's view, we ought to exercise our duty to assist the needy. This is currently quite easy. The world has changed and we can now use the internet to help distant persons. It is also true that if each person is committed to global health or global poverty, more possibilities and help will become available. This would also mean a wider exercise of values such as solidarity through moral obligations. Moreover, if the suffering of others, even distant and unknown individuals, truly mattered and a moral obligation to help others was felt, the world would be better and fairer. Civil society and every individual can become fundamental actors in a profound change. However, no matter how easy and achievable this proposal may seem, Singer had to reduce the amount of money to be given due to the refusal to help and noncompliance. Hence, it is difficult to meet Singer's proposal. But even more problematic is that even if individual help is needed and desirable; 'general' and harmonized policies performed by collectives⁹⁰ may be a better fit for sustainable global changes in health.

⁸⁹ Singer is mainly considering affluent people from developed countries. See P. Singer, 'Famine, affluence and Morality' *Philosophy and Public Affairs* (1972) 1(3): 229.

⁹⁰ It should be acknowledged that responsibility, as a moral concept, is typically attributed to individuals. People speak of the causal responsibility of moral agents for harm in the world and blame them for causing harm. It is based on the assumption that actions begin with intentions and moral blameworthiness requires the existence of intention. Nonetheless, it is also true that, in practice, groups are blamed and that people have emotional reactions to groups, such as anger, resentment, or moral indignation. Therefore, it can be argued that even if, in the strict sense, responsibility is attributed to individual persons, in a subsidiary sense the notion of collective responsibility as an intellectual construct is also used.

Philosophical positions, such as Thomas Pogge's, could be applied. For him, not only citizens from the rich countries—that is, individuals—but also elites from scarce resource countries and global institutions—that is, collectives—are morally responsible for the extreme condition of the global poor. This proposal also appeals to human rights, which is another interesting perspective worth pursuing.⁹¹

Human rights provide an important answer. However, while the human rights framework discourse and documents have mainly focused on the recipients, a relevant question is who should be responsible for providing them?⁹² In this area, there are different analyses about the proper agents of justice. For example, 'traditional' or 'orthodox' interpretations hold each national state responsible for its citizens' access to health care.

Health obligations are typically carried out by national states. States, as primary agents, should care for their people. Access to health care could be developed through public hospitals and policies and national state policies are the best suited to do so. For example, when Gostin et al.⁹³ propose a Joint Learning Initiative on National and Global Responsibilities for Health, one of the proposals they outline is governments' obligations to their inhabitants and they define what these essential health services and goods are. They explain that the World Health Organization estimates an annual cost of US\$40 per person to cover these essential health services. In 2001 in Abuja, Nigeria, African heads of

⁹¹ Regarding the human rights framework, the Universal Declaration of Human Rights, Art 25; the International Covenant on Economic, Social and Cultural Rights, Art 12; the Convention on the Rights of the Child; and the Convention on the Elimination of All Forms of Discrimination Against Women—among other human rights texts—all speak of the right to enjoy the highest attainable standard of physical and mental health. This includes medical care, treatment, and control of epidemic and endemic diseases, besides other issues.

⁹² O. O'Neill, 'Agents of Justice' in T. Pogge (ed), *Global Justice* (Oxford: Blackwell, 2001) 189.

⁹³ L. Gostin et al, 'National and Global Responsibilities for Health' (n 75).

state pledged to devote at least 15 percent of their national budget to the health sector. Yet, in 2007, the average per capita allocation was US\$34, an average of 9.6 percent of the budget.

Can we infer that weak and poor states found this too difficult to achieve? There are at least two interpretations of this situation. The first and more benevolent one can be found in O'Neill's words:

*Weak states may simply lack the resources, human, material, and organizational, to do very much to secure or improve justice within their boundaries . . . They may fail to represent the interests of their citizens adequately in international fora and may agree to damaging or unsupportable treaties or loans. They may lack the capabilities to end or prevent rebellions and forms of feudalism.*⁹⁴

This may be true of the situation of some poor states. But there can also be a second less charitable interpretation suggesting that many of these states do not make the necessary investments and, regrettably, money is instead spent on corruption, wars, or unwise endeavors. However, even if the role and responsibility of these inefficient or corrupt governments is condemnable, the fate of the people suffering under them should be highlighted so that they are not punished even further. States as primary agents of justice can fail and, in fact, many of them do. And because of this, non-ideal strategies can enter the picture. Thus, these reprehensible cases should not be ignored, however, other ways to end the detrimental consequences of the actions of such governments should be determined.

Another issue to consider is the responsibility of other states as bearers of global health obligations. These states vary in their ability to provide aid without suffering unreasonably high costs for their own popula-

⁹⁴ O'Neill, 'Agents of Justice' (n 18) 197.

tion's quality of life and well-being.⁹⁵ That is, global health obligations increase in proportion to the agent's capacity to assist. The more resources they have, the larger funding commitments they can achieve. Therefore, rich European countries, for example, would seem to have a stronger duty to assist. Gostin et al, in exploring the responsibilities of all governments for the world's poor, also point out that high-income countries have not come close to fulfilling their pledges made in 1970 to spend 0.7 percent of their gross national product per annum on Official Development Assistance. Four decades later their average contribution stands at 0.31 percent. From a human rights positive law perspective, the United Nations Charter aims at international cooperation for the solution of economic, social, cultural, or humanitarian international problems. Articles 55 and 56 explicitly establish international cooperation, among other duties to health, as 'an obligation of all states'. In the same vein, international, interstate or intergovernmental agencies or programs such as the World Health Organization and UNAIDS can also be held responsible. They belong to the United Nations system and were created for this and similar purposes. The constitution of the World Health Organization, for example, as the coordinating authority on international public health, states as its objective 'the attainment by all people of the highest possible level of health'.

8.2.2 A Non-Ideal Approach

In an ideal ethical and political theory, states can be held responsible for the health of their people and richer states for international cooperation with disadvantaged countries. In an ideal theory, human rights agents are the responsible actors. This is also reflected in the international system of human rights through positive law.⁹⁶ However, due to

⁹⁵ Lowry and Schuklenk also point this out. C. Lowry and U. Schuklenk, 'Two models in Global Health Ethics' *Public Health Ethics* (2009) 2(3): 276.

⁹⁶ Including interstate organizations, such as the World Health Organization responsible for public health as its mission.

the failures of poor states and a lack of general compliance of those ideal agents (we have just pointed out the partial or lack of compliance of poor states to their citizens and the partial or non-compliance of richer states), we should think of non-ideal strategies as a sort of bridge.⁹⁷ These new strategies, then, should focus on a combination of agents (in addition to the previous ones) working together towards global health.

When discussing agents of justice, Onora O'Neill argues for a plurality of agents. She explains that primary agents (generally the national states) can construct other agents or agencies with specific competences, and they can assign powers or build institutions with certain powers and capacities to act. Secondary agents are thought to contribute to justice mainly by meeting the demands of primary agents, most evidently by conforming to any legal requirements they establish.⁹⁸ O'Neill holds international non-governmental organizations and, especially, transnational or multinational companies or corporations responsible. Regarding international non-governmental organizations, she argues that their typical mission is to contribute to specific transformations of states, governments, and policies—quite often to a single issue or objective.⁹⁹

In response to the question of how transnational or multinational corporations could be concerned with justice, except insofar as justice requires conformity to law, O'Neill argues that what matters is what transnational or multinational corporations or companies can or cannot do: the capabilities they can or cannot develop.¹⁰⁰ She claims capabilities

⁹⁷ I will provide some non-ideal strategies. I will consider specifically the cases of states without the capacities to achieve global health. However, for other failures of poor states due to corruption or unwillingness to do the right thing, other strategies might be designed, such as the empowerment of citizens or international monitoring institutions.

⁹⁸ O'Neill, 'Agents of Justice' (n 92) 189.

⁹⁹ They may contribute to justice precisely because the states are too weak; they can act opportunistically and secure an unusual degree of access to some key players. O'Neill, 'Agents of Justice' (n 92) 199.

¹⁰⁰ She takes this concept from Amartya Sen. She says an agent's capabilities are not to be identified with their individual capacities or with their aggregate pow-

are more important than motivations: ‘... It is more important to consider the capabilities, rather than the (supposed) motivations of transnational companies.’ Many transnational companies are evidently capable of throwing their considerable weight in the direction either of greater justice, of the status quo, or of greater injustice. ‘Corporate power can be used to support or strengthen reasonably just states. Equally, they can accept the status quo, fall in with local elites and with patterns of injustice, and keep powers to keep things as they are—or indeed to make them more unjust.’¹⁰¹

I believe these considerations regarding the capabilities of certain agents can be more defensible and stronger from a non-ideal approach than from an ideal perspective as O’Neill attempts.¹⁰² What in the ideal system can be deemed as beneficent,¹⁰³ and where no strong responsibility is felt; in a non-ideal strategy these agents can be held responsible. Efforts are needed to complement partial compliance and failures, and a minimum standard should be established from which to move forward. A non-ideal strategy also leaves aside the debate regarding human rights agents and the extent of their obligations,¹⁰⁴ introducing an independent and complementary layer of analysis and responsibility. However, I believe that to hold agents responsible, we should not only consider their

er. An agent or agency, considered in the abstract, may have various capacities or abilities to act. Capabilities are, instead, the specific capabilities of agents and agencies in specific situations rather than the abstract capacities or their aggregate power.

¹⁰¹ O’Neill, ‘Agents of Justice’ (n 92) 201.

¹⁰² Although I endorsed O’Neill’s proposal in a previous paper, I now think that her ideas can be better defended from a non-ideal perspective. F. Luna, ‘Pobreza en el mundo: obligaciones individuales, institucionales y Derechos Humanos’ *Revista Latinoamericana de Filosofia* (2007) XXXIII(2): 293.

¹⁰³ Although the classic idea is that for-profit corporations obtain benefits for their stockholders, is maximizing stockholders’ benefits the sole legitimate purpose of corporations? There are arguments for a stronger obligation of beneficence from a stakeholder’s perspective. E.R. Freeman *Strategic Management: A Stakeholder Approach* (London: Pitman, 1984).

¹⁰⁴ M. Freeman, *Human Rights* (Cambridge: Polity Press, 2011) 81.

capabilities—as O'Neill proposes—but also whether they are related in some relevant way to these populations and can make a reasonable difference without harming or destroying themselves. This is the case with major pharmaceutical companies regarding global health or of international companies based or working substantially in these lower resource countries. In addition, we can endorse the rescue principle—a non-ideal approach—to justify such obligations. Timothy Scanlon, for example, says: 'If you are presented with a situation in which you can prevent something very bad from happening or alleviate someone's dire plight, by making only a slight (or even moderate) sacrifice, then it would be wrong not to do so.'¹⁰⁵

Although Scanlon is considering persons and reasons, this principle can easily be applied to corporations. Undoubtedly, the previous situation is so bad that providing medicines for some pharmaceutical companies is, at best, a slight sacrifice. Note that, for example, companies—especially major pharmaceutical ones—do have a policy of corporate social initiatives on which they spend millions of dollars to promote education, the sponsorship of art programs, etc.¹⁰⁶ Directing those funds or part of them to rescuing people from devastating preventable illnesses seems a slight sacrifice.

An additional and interesting argument is given by Thomas Dunfee,¹⁰⁷ regarding the role-based obligation of the pharmaceutical companies. He argues for a mandatory obligation to devote substantial resources towards rescuing victims of catastrophes.¹⁰⁸ He provides a strin-

¹⁰⁵ T.M. Scanlon, *What We Owe to Each Other* (Cambridge: Belknap Press of Harvard University Press, 1998) 224.

¹⁰⁶ T. Dunfee, 'Do Firms with Unique Competencies for Rescuing Victims of Human Catastrophes Have Special Obligations? Corporate Responsibility and the AIDS Catastrophe in Sub-Saharan Africa' *Business Ethics Quarterly* (2006) 16(2): 200.

¹⁰⁷ Dunfee, 'Firms with Unique Competencies' (n 106).

¹⁰⁸ 'The minimum amount that firms should devote to rescue is the largest sum of their most recent year's investment in social initiatives, their five-year trend,

gent definition of catastrophe and points to firms that possess ‘unique competencies’ for rescue. His position might be narrower than mine, as he attributes obligations only to very specific pharmaceutical firms due to the ‘uniqueness competency’ criterion. However, we are both proposing a similar trend. Dunfee makes a case for some specific big pharmaceutical corporations in the Sub-Saharan Africa AIDS catastrophe, but I believe his arguments are easily applicable to some of the situations depicted earlier.

Hence, within this framework, not only should the usual ideal agents be responsible, but transnational and pharmaceutical corporations should also be committed to the improvement of health, for example by developing better health habits among their employees, promoting pro-health policies through their advertising strategies, supporting local hospitals or local efforts to provide better access to health, using their resources (their fleet of trucks and logistics) to distribute medicines or other health devices,¹⁰⁹ and so on. Therefore, from a non-ideal perspective, pharmaceutical companies and even transnational corporations can be held responsible.

8.3 Is It Feasible? A Case

If a plurality of responsible agents can address different needs, a dynamic and flexible answer will be obtained. It is not just one agent but a multiplicity of them with different and appropriate levels of responsibilities.¹¹⁰ Each of them can reinforce the other’s action.

their industry’s average or the national average.’ Dunfee, ‘Firms with Unique Competencies’ (n 106) 185.

¹⁰⁹ Coca Cola has delivered AIDS testing kits to hospitals in Nigeria, billboards for awareness campaigns in Kenya. Dunfee, ‘Firms with Unique Competencies’ (n 106) 189.

304

¹¹⁰ How to decide levels of responsibilities in this case is a relevant and important issue but goes beyond the scope of this chapter.

Let us consider a case: River blindness, or onchocerciasis, is a disease, transmitted by Simulium blackflies living near streams. It is endemic in more than thirty countries in Africa. Gradual progression to blindness often occurs in infected individuals and in the more forested central and eastern African regions; debilitating, itching, and disfiguring skin lesions are the primary symptoms.¹¹¹

Recalling the 1970s, the Director of Tropical Disease Research (TDR), a department of the WHO, said:¹¹²

*The two drugs we had for onchocerciasis at the time were notorious poisons. We were really desperately looking for a new drug. When we visited the major drug companies, it was clear they were not interested in this disease. No one was screening any compounds. We thought that perhaps there was a compound on the shelf that had not been discovered. The strategy put forward was to open a compound-screening network . . . We asked the industry to give us compounds to test and we would give them the results. We offered this free of charge and confidentially. We had thousands of compounds sent through small animal screens in the broader network.*¹¹³

In July 1978, scientists at the pharmaceutical company Merck, who had been researching ivermectin for several years, sent the compound to the TDR-supported drug screening facility at James Cook University in Australia. Such screening was regarded by scientists as the best predictor of how a compound would act against human onchocerciasis. Results showed the drug was ‘highly effective’ against the microfilariae, or in-

¹¹¹ World Health Organization-Tropical Disease Research, ‘Making a Difference. 30 Years of Research and Capacity Building in Tropical Diseases’ (Geneva: WHO, 2007) 39–40.

¹¹² Dr Lucas, director of TDR at that time.

¹¹³ WHO-TDR, ‘Making a Difference’ (n 111) 12–13 (emphasis added).

fant larvae of the parasite, although it did not, in fact, seem to kill the adult worm.¹¹⁴

In analysing this case, we should first note a typical situation: ineffective drugs and the need for research. In addition, drug companies were not interested in that disease. However, WHO-TDR, an intergovernmental organization, acting as a responsible agent of justice, begins the interaction and research in ‘non-interesting’ compounds with drug companies to develop a suitable drug; it also created a compound screening network. This first action was biomedical.

Because of the good results obtained through the drug research, Merck had been negotiating with development and donor agencies over the purchase of ivermectin, but had received little response. TDR and WHO officials came ready to drive a hard bargain over pricing for developing countries.¹¹⁵ Finally, in 1986, Merck offered to donate the drug. Large-scale trials were launched to determine the safety and effectiveness of mass drug administration. Since then ivermectin (mectizan) has reached some 60 million of the 100 million people at risk in endemic areas in sub-Saharan Africa.

Continuing with the analysis of the case, another obstacle should be outlined—the difficulties of making the drug available. There was no interest or money on the part of poor states, or of donor agencies, to pay for the drugs. Millions of poor people were at stake and could not afford the drug. However, this time, Merck, acting as a responsible agent with strong capabilities—as the owner of the compound—acknowledged its responsibility and offered the drug at no cost. It provided the drug to the population at risk for more than twenty years.¹¹⁶ Considering the arguments that claim that pharmaceutical companies should not be burdened,

¹¹⁴ WHO-TDR, ‘Making a Difference’ (n 111) 12.

¹¹⁵ WHO-TDR, ‘Making a Difference’ (n 111) 12–13.

¹¹⁶ Consider that in most cases the production of the drug in itself is not expensive, unlike the discovery process and the procurement of a patent through clinical trials and regulatory agencies requirements.

and that their only goal is to maximize profits; it is interesting to point out that giving this drug cost free to the population in need for such a long time was no threat to the survival or profits of the company. On the contrary, Merck is proud of its corporate responsibility as can be seen on its website, where the Merck Mectizan Donation Program is outlined as one of the longest and more successful public/private collaborations in the world.¹¹⁷

Given the non-ideal approach I follow, which shows the lack of capabilities and failures of ideal agents and the difficulties in providing the drug, Merck (acting as a pharmaceutical company with an effective drug for a devastating illness) has a moral obligation to provide it. Merck can reduce the price to make it available or, as in this case, provide the drug at no cost. Merck, like many of the leading pharmaceutical companies, has the means to do so.¹¹⁸ These corporations can make a substantial change in global health amelioration and their action does not seem to endanger their companies.

During the 1990s, results indicated that a combined strategy of vector control plus drug treatment would reduce the projected timeline to bring onchocerciasis under control and eliminate onchocerciasis as a public health problem in the Onchocerciasis Control Program in West Africa (OCP) region. However, the actual interruption in disease transmission might not be feasible in many hyper-endemic areas. In such areas, annual ivermectin treatment would have to be sustained almost indefinitely. This posed a significant challenge to disease control:¹¹⁹

Eleven West African States, together with the World Bank, the Food and Agriculture Organization of the United States (FAO), the United Nations Devel-

¹¹⁷ See <<http://www.merckresponsibility.com>> which deals with corporate responsibility and the role and programs of this company.

¹¹⁸ Not only because of the high profits that most pharmaceutical companies obtain, but also because they already devote substantial funds to corporate social activities.

¹¹⁹ WHO-TDR, 'Making a Difference' (n 111) 40–1.

opment Programme (UNDP), and the WHO embarked on one of the largest and most comprehensive vertical vector control operations against onchocerciasis in West Africa. An area of about 1,300,000 km, with more than 50,000 km of rivers, was covered by the operation. The success of this intervention was due in large part to the enormous information infrastructure. . . . This drew on hydrology/seasonal river flows, information on vector habitats, parasite mapping, and information on population levels of infection and blindness.¹²⁰⁴⁶

Here again, multiple agents interacted in order to solve the challenge. Many African countries acted responsibly as primary agents of justice. Note the necessary level of coordination whereby eleven countries acted together. The action of each single country acting alone did not suffice; regional efforts had to be achieved (with the challenges this implied). Note also the action of stewardship and harmonization of United Nations international agencies, responding to their mandate and responsibilities. Also consider the different expertise involved (environmental, biological, veterinary, medical) working together. The drug or narrow biomedical knowledge was not enough.

Even though a substantial amelioration was achieved, obstacles persisted: the actual field distribution of the drug was still limited. Getting the drug to the people who needed it in remote areas year after year was a significant challenge. Some 80 percent of the population at risk of onchocerciasis lives outside of West Africa. In these other African regions, the disease exhibited different features and control presented different challenges.¹²¹

In 1994, a new framework for ‘community-directed treatment’ (ComDT) put communities directly in charge of ivermectin administration and health services were developed to provide the necessary training. This effort called for a different kind of research. It was demon-

¹²⁰ WHO-TDR, ‘Global Report for research on infectious diseases of poverty’ (Geneva, 2012) 32.

¹²¹ WHO-TDR, ‘Making a Difference’ (n 111) 40–1.

strated that ComDT has been feasible and effective and has led to greater treatment coverage since 1996.¹²²

Again note how the strategy to make the drug available changed in light of this final challenge. Another kind of research was needed and new responsible agents appeared: the narrow biomedical approach was not enough. The people themselves and the communities were also responsible agents. In this case, they had to be trained and—

mostly—empowered in order to obtain efficacious results.¹²³ As the main agents in this case caution:

*The picture has never been all rosy. Serious problems were encountered in sustaining drug distribution when wars and instability struck various endemic countries. In October 2001, a detailed review of the African Programme of Onchocerciasis Control (APOC) and OCP experiences with onchocerciasis control concluded that while onchocerciasis was well under control as a public health problem in the 11 original OCP countries, it could not be eradicated using the currently available tools. The development of a drug that can kill or sterilize the adult onchocercal worm living inside infected individuals remains a top priority. Disease transmission cannot be permanently interrupted with ivermectin, and so annual treatment must continue for an indeterminate length of time, placing a considerable burden on health systems.*⁵⁰

¹²² ComDT was adopted by OCP as its ivermectin delivery strategy and became the backbone of APOC operations in 1996. By 2007, ComDT had succeeded in extending the annual ivermectin coverage to more than 45 million people in Africa, out of an ultimate target population for treatment of approximately 70 million, in collaboration with APOC and local research institutions.

¹²³ Even if we can appeal to the responsibility of the community, it is not the same situation as that in which international corporations have the means to make a change. Here we need to empower the populations and work closely with the communities, which are isolated, often illiterate, and have very few resources. Hence, a very different level of responsibility exists. 50 WHO-TDR, 'Making a Difference' (n 111) 73.

Hence, even if many goals were achieved, river blindness as a health problem has not yet been resolved. New strategies and new research are pending. But we should also note that all this progress would not have been possible had we only targeted one particular agent (be it the national state, the pharmaceutical companies, the wealthy countries, or the actions of international agencies).

8.4 Conclusion

Global health presents itself as an immutable debt and as a moving target with a cluster of different challenges. Following ethics and political philosophy proposals, the states and the international human rights architecture are ideal agents of justice. However, because global health presents a combination of very little compliance by ‘ideal’ responsible agents and manifold obstacles exist, I argued for a joint effort appealing to the responsibility of multiple agents and actors aiming for a transitional strategy. Within this strategy, secondary agents of justice—in O’Neill’s proposal—can be identified as responsible agents. This implies holding various institutions, pharmaceutical companies, and even transnational corporations responsible. Finally, I presented a real case where many different agents (intergovernmental agencies, states, international corporations, among others) interacted to fight onchocerciasis in Africa. Instead of defending a simple monistic answer, I consider a pluralistic and diversified view to be far richer and more constructive.