Global Public Health
Vol. 5, No. 2, March 2010, 115–121

Routledge
Taylor & Francis Group

INTRODUCTION

Values and moral experience in global health: Bridging the local and the global

Over the past several decades, political conflicts, economic volatility and large-scale cultural and social changes, have strongly influenced not only the global health problem and solution frameworks, but also the very way we conceive of global health as a public good. As politicians, business people and cultural elites employ the language of global health to shape discourse and policies focused on displaced and migratory peoples, they have, perhaps unwittingly, broadened the classic public health agenda. As a consequence, that agenda now includes violence and its traumatic consequences, the health (and mental health) impact of natural and social catastrophes, other health-related problems from obesity to substance abuse, and the effect of pharmaceutical and digital technology innovations not previously considered to be core public health issues. They expand and reformulate the traditional spheres of public health, and challenge classic public health values.

As a result, debates shaping global health research, ethics, policy and programmes have developed along two parallel tracks. One can be characterised as a neo-liberal approach combining economics (liberalisation of trade and financing; public–private partnerships; cost-effectiveness analysis), disease-specific and biotech programmes and security concerns. The other has focused on human rights, social justice and equity frameworks with a broader, more inclusive model of the determinants of health. This perspective calls for a transformation of the current fractured system of global health governance into a transparent and accountable system better equipped to address the world's global health agendas. The latter approach embraces public health as one of the essential features of a new moral commitment to remake the world, similar to the environmental/climate change movement. In fact, in 2002, the American Public Health Association explicitly affirmed in their professional code of ethics, *Principles of the ethical practice of public health*, that the pursuit of public health is an 'inherently moral' obligation.[1]

Very recently, the two approaches appear to be converging around a *values focus* to bolster arguments in favour of increased resource allocation for global health programmes. Values embodied by individual behaviours are often rooted in cultural interests or shaped by hegemonic norms that, at times, appear to be so natural as to be invisible. Similarly, values are so central to political life, policy-makers freely admit that political discourse that appropriates the values debate builds political support, consequently driving policy goals. Although for different reasons, values in these two spheres are often unclear and not well articulated. For the political realm, the result is that values are neither consistently applied nor shared across diverse policy sectors. What is new, however, is an emerging recognition that the 'social context' of values must be explored before we can begin to understand the meaning of any value, whether personal, political or invoked directly in reference to global

ISSN 1744-1692 print/ISSN 1744-1706 online

DOI: 10.1080/17441690903484201
http://www.informaworld.com

health. Where is the values debate in global health headed, and what can public health, the social sciences and the humanities contribute to the discussion?

Background

Global health values are under-theorised and lack concise definitions. To address this issue, the authors jointly convened a workshop entitled, 'Values and moral experiences in global health: Bridging the local and the global', held in May 2007 at Harvard University. The conference was co-sponsored with support from Harvard, Boston and Northwestern Universities. Drawing on an interdisciplinary and international group of scholars and practitioners, this workshop explored the emerging values discourse as it relates to global health priority-setting, policy, governance, practice and research. The workshop posed several broad questions: What values are deeply embedded in the most important global health policies and programmes? How do we combine moral philosophy, applied (empirical) bioethics, economics and public health, and engage people in the high-income countries to improve the health of people in resource-poor settings? How do we change this engagement from a charitable/humanitarian value to a fundamental shared value that withstands the inevitable periodic global economic downturns? How do we balance multiple, often conflicting, values to find consensus for setting priorities in global health policy and research agenda? How do we translate insights from highly specific, local cultural contexts into theoretical frameworks for effective global health governance that transcend local boundaries? Participants explored the relevance of political, ethical and economic theories to global health governance, or offered assessments of specific global-acting entities, such as the UN agencies, World Bank and World Health Organisation (WHO). The articles to follow, in this Special Issue of *Global Public Health*, while based on workshop presentations, represent the product of new working groups assembled afterward to reflect new thinking informed by the debates and discussions at the workshop.

Moral experiences, religion and global health values

Values can be situated in two spheres: first, actual moral experiences of people in their local worlds whose practices regarding what really matters can, and often do, diverge from their ethical aspirations; and second, lay aspirations and more disciplined professional articulations of ethical responsibilities. Emmanuel Levinas argued that ethics should precede all acts, as an affirmation first of the suffering of others, after which analysis and action can follow (Bernasconi and Wood 1998). Further, suffering in and of itself is ethically useless, and its moral utility is the recognition of responsibility by those around the sufferer. While Levinas was an ethicist who explicitly built his ethical approach out of religious commitments, the origins of American bioethics include important contributions by religionists who explicitly avoid religious language and metaphors. More recently, however, practicing public health professionals have drawn upon liberation theology and social justice frameworks to raise awareness and financial support for global health initiatives. For example, Paul Farmer and Jim Kim, in their work in Haiti, Peru and Rwanda, clearly recognise the connection between political structures and health inequities and, therefore, focus their efforts on political will to improve health. Others, like former

US Senator and physician Bill Frist, use evangelicalism and the prosperity ministries to attempt to reduce health inequalities through the ideology of individual responsibility and sheer determination. The essays presented here, focus on the implication for global health of values animated by individual and local commitment but routinised by institutionalisation through macro-level health policies (see the articles by Feierman *et al.* and Yang *et al.*).

Values in global health governance

Values are deeply embedded in the most important global health policies and programmes, even when the dialogue is highly pragmatic or political. Yet, we do not understand how values, beyond narrowly defined ethics, function as important rhetorical devices for global health decision makers. For example, what were the deep value commitments of Halfdan Mahler in 1979, when as the secretary general of the United Nations at Alma Ata, he pressed for an emphasis on primary healthcare and an institutional commitment to Healthcare for All by the year 2000? His Scandinavian background and familiarity with the building of a social democratic welfare state clearly influenced his emphasis on health and social equity. But, did the deeper values of his Lutheran religious traditions or his own personal biography transform an idea into a commitment? Many public health policy-makers today seem comfortable with the idea of a 'right to healthcare' but less comfortable with the idea of a 'right to health'. Amongst those who have made the commitment to a right to health, to what extent is it liberation theology and commitment to religious values that undergird their passions for the human rights and health domain? When the international values that shape global intervention conflict with the local values of the intended beneficiaries of global health programmes, no clear pathway exists to address or resolve that conflict. We posed several questions to be addressed by the workshop participants: Do values change as a result of an unfolding developmental process in global health? What conflicts in values exist between programme donors and recipients at the global level? Who decides? Do we need consensus? If so, to what degree? If not, how do we manage a plurality of values, especially in the context of the new public–private partnership paradigm for funding global health initiatives? And, how do we bridge local moral experiences with global health policies?

Two of the articles published in this Special Issue respond directly to these questions: Benatar *et al.* and Yang *et al.* These authors agree that global health programmes have failed to deliver better primary healthcare in resource-poor countries for three central reasons: a vertical rather than a combined vertical–horizontal system to reducing disease; a traditional disease control model that ignores the broader social and cultural determinants of health; and the increasing inequity in access to health resources. Benatar *et al.* argue that existing values in global health reflect the growth of global capitalism and a narrow commitment to scientific solutions delivered through large-scale programmes. They advocate a new set of values that emphasise sustainability and global distributive justice. Yang *et al.*, offer an original analysis of the concept of sustainability in global health, arguing that the current donor-driven approach will never reach sustainability because the narrow focus on disease control and inconsistent funding can have the paradoxical effect of sustaining the disease itself, rather than developing the broader assets and capabilities

essential to preventing future outbreaks. They believe major opportunities exist right now to provide the right health services at the right prices where they are needed most.

Ethics and priority-setting in global health research

Awareness of the ethical challenges of conducting global health research in resource-poor settings emerged most famously in 1997, with the controversy over the use of a placebo-controlled study design in a clinical intervention to prevent perinatal HIV transmission in developing countries (Angell 1997). The controversy sparked a decade of debate and research by bioethicists, public health practitioners, biomedical researchers and social scientists, that focused primarily on the technicalities of health research study design, the compliance in resource-poor settings with international research regulations and the appropriateness of western normative research ethics for health research in the developing world. The debate about global health research is now moving beyond the technical and regulatory questions of study design to a reconsideration of the possibilities for health research itself as a means to achieve more equity through 'needs-driven' research. What constitutes a need? Who will define it? Who should prioritise it and based on what principles and values? What will be the role of the humanities and social sciences in this emerging debate? Global health research is a collaborative, multisectoral and multidisciplinary effort; how can we move forward in this interdisciplinary endeavour when multiple, often conflicting, sets of principles compete in defining social value and how to achieve social justice through global health research? Do we describe the social value of global health research from an individual or aggregate (and which aggregate) level? Can we build principles based on a conglomerate of evidence and arguments from ethnographic, empirical and philosophical/theoretical data?

In response to these questions, IJsselmuiden *et al.* focus on the principles of global justice and solidarity to argue for a new era in the ethics of international health research. They suggest that research must be more responsive to local health systems and must strive to enhance local capacity through equitable collaboration, and they envision new approaches in the research review process to prompt funders from the north to consider the inclusion of local priorities as a condition for funding. Finally, they argue that researchers have an obligation to conduct research promoting health equity and linking results with future local development. In contrast, Stewart and Sewankambo examine the process of global health research itself as a socially embedded activity. Their analysis of therapeutic misconception reveals that local expectations of research benefits are infinitely more complex than previously thought, while motivations for participating in research suggest an intricate calculus of responsibilities between researcher, participant and community. By studying the cultural value and social impact of global health research from the lived experience of the research participant, rather than from the operational perspective of the researchers, a more meaningful understanding of the social value of global health research should emerge.

Economic valuations in global health

Measurement is a core concern for economists, and they strive to measure the value of health in economic theory. On a national or global scale, the value of health can

be assessed in financial terms (gross domestic product). At the individual level, the value of an individual's health can be assessed by calculating their total projected lifetime earning, which contrasts to assigning a cost to the extension of healthy years of life and the reduction of years lived with disability due to ill-health. A third approach to measuring the value of health, recognises that health status might be defined, acted on, rejected or narrated in quite distinct ways. For example, as an abstract normative principle in times of non-crisis, as a more 'objective' or concrete assessment in times of crisis, or as a moral tale, explanation or regret when reflecting on or narrating the event. Moral positions on violence and trauma are often experienced in this manner. However, if we assign value to health, we must find common ground for answering these questions: How do we measure the value of health? Who decides? How do we scale it? To whom is health valuable and for what purpose? How is new health-related value created and distributed? And, how do we connect the analytical and social justice advocacy approaches to measuring value in global health?

McGahan and Keusch address such issues, reminding us that the concept of value or valuations in economics can represent something different than the concept of value in global health advocacy. They argue that we have the knowledge and technology to prevent or treat most diseases, but why, they ask, do those who need these resources most have the least access? The answer, they suggest, lies in understanding the interplay between the moral content we assign to equitable access to health resources and the reality of shortages in local healthcare markets. Markets are the most common way of assigning value, but they do fail, as indicated by the inability of the 1994 TRIPS agreement to significantly improve pharmaceutical innovation. Four other mechanisms for assigning market value to health, and the importance of the market mechanism for improving local access to healthcare resources, are discussed. The imperative, they conclude, is to use the method of economic valuation best suited to stimulating product and service development, which will then reduce scarcity at the local level.

Anthropology as a bridge between the local and the global in global health

Because two of the organisers of this Special Issue are anthropologists, we firmly believe that an empirically based ethnographic approach can effectively bridge local narratives of health with the cosmopolitan global health values that shape macro-level health policies. For example, transparency and accountability have emerged as key values in the formulation and implementation of global health policy. These values require a more direct and intimate relationship between those who control global health assets and those whose lives are shaped by the distribution of resources. For instance, community advisory boards act as translators between the language of research protocols and the idioms that resonate with the community as well as relay local concerns back to investigators. This facilitates more efficient and effective health research, but it also raises local expectations of the power of community opinions to influence globally financed health interventions. This site of local–global interface can be a litmus test of the true worth of transparency and accountability as essential values for the funders and practitioners of global health. Feierman *et al.* argue that the production of contextualised ethnographic knowledge about local experiences of global health programmes (kinship, technologies, sources of power

and authority) can enhance the success of those programmes. Equally important, but often overlooked, is how that new content and knowledge moves or 'flows' amongst global health actors and defines the contours of the local–global interface. More than a lack of ethnographic description and analysis, Feierman *et al.* argue that the absence of a deep understanding of social action at all levels in the practice of global health is a serious barrier to effective programme implementation at the local level.

New approaches in global health practice

Two papers exemplify new directions in global health practice: Kim *et al.* and Palamountain *et al.* Kim *et al.* begin by arguing that twenty-first century global health programmes must shift from a series of individual, disease-centric programmes to a coordinated system of fully functioning healthcare delivery programmes. They describe the newly formed Harvard Global Health Delivery Project, a partnership between the Harvard Medical and Business Schools, as a strategic road map towards the creation of a systematic framework for innovation in the infrastructure of global care-delivery programmes. When we apply the core business value of profitability to the core global health value of maximising health in resource-poor settings, Kim *et al.* argue that we address one of the greatest constraints in medicine today – the delivery of healthcare. It is essential, they urge, to foster more effective partnerships between academic institutions, NGO's, private entities and the public sector in order to deliver real value through the effective delivery of healthcare in resource-poor settings. Sharing a similar vision, a group of biomedical, business and social science researchers at Northwestern University are combining industry, donors and academia to narrow the gap between supply and demand for HIV/AIDS diagnostics. Palamountain *et al.* argue that the university is uniquely positioned to catalyse a new type of partnership, between non-profit global health donors and commercial diagnostic companies, that builds on the efficiency and creativity of the private sector, reduces industry risk by guaranteeing a low margin, high volume financial opportunity, and provides medical goods to resource-constrained populations.

The papers in this collection reflect the serious treatment of values in global health and the sources, frameworks and larger implications of global health. Far from comprehensive, this collection unearths some of the more challenging of global health's theoretical underpinnings. It suggests, by developing a robust, multi-disciplinary discourse on values, that global health, like biomedicine itself, displays a striking inadequacy in the construction and deconstruction of theories of meaning, experience and practice.

In sum, these papers represent the beginning of a new dialogue, that must take place among the broad range of stakeholders and participants in the ongoing global health revolution, and not a definitive statement of what is known and accepted.

Note

1. *Principles of the Ethical Practice of Public Health, Version 2.2*, 2002, Public Health Leadership Society, APHA.

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