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REVIEW PAPER

Rights or solidarity? In search of international justice in healthcare

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Abstract

Background: There are two models for legitimizing the redistribution: an entitlement-based model and one based on solidarity. In both cases we are dealing with moral obligation; however, not imperative. In the legal model, one often refers to s.c. imperfect duty, while in the solidarity model we are dealing with a moral duty based on values. I defend the idea of justifying redistribution by referring to the principle of solidarity combined with the idea of sustainable development.
Material and methods: This a philosophical paper in healthcare ethic.
Results: The result of the discussion is my proposal to combine categories of sustainable development and solidarity to provide justofication for the global redistribution of healtcare resources.
Conclusions: Solidarity is a pragmatic and proactive relationship, flexible and open to the various beliefs and motivations of the cooperating parties. Therefore, the language of solidarity is more universal and promising in the work of building a global health system in which developing countries can feel safe and treated fairly, rather than a language that speaks of entitlements, obligations and charity. Building a climate of trust and pursuing socially responsible sustainable development policies do not require strong theories of justice or other rigid legal or ethical doctrines. Such doctrines can even be harmful. Meanwhile, the discourse relating to solidarity, trust-building and cooperation to achieve realistic and reasonable goals at the transnational public health level is relatively undoctrinaire, and instead flexible and open to a variety of interpretations. In the realities of international politics and cooperation, these are serious advantages.
Keywords: justice, healthcare, redistribution, solidarity

Introduction

The purpose of this article is to contribute to the debate regarding the principle of legitimizing the provision of healthcare resources to poorer countries by wealthier countries. There are two basic models for legitimizing the redistribution of healthcare resources: an entitlement-based model (human rights and the right to minimum health care) and one based on solidarity. In both cases we are dealing with moral obligation, although not a moral

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imperative. In the legal model, one often refers to so-called imperfect duty, while in the solidarity model we are dealing with a moral duty based on the virtues and values of those called to action. In this article, I will defend the idea of justifying redistribution by referring to the principle of solidarity combined with the idea of sustainable development. Solidarity is an ethical ideal that presupposes joint activity, i.e. cooperation, while the right to receive support is realized indirectly and in effect ceded to public institutions. Sustainability is an imperative dictated by prudence. Both solidarity and sustainability are categories that go beyond the opposition of selfish and altruistic action.

Beyond the charity model

In the field of public health ethics, the issue of equitable redistribution of public funds for health services – both nationally and globally – is crucial. One of the widely debated issues is the nature and scale of the obligations of rich Western countries to developing countries. In this context, the question arises as to the legal and ethical basis for the diversion of funds from national budgets for the medical purposes of the populations of less developed countries and regions of the world. This question is crucial in this regard. When richer countries have an interest in supporting the countries of the global South, then it is right that this interest justifies engaging in redistribution. However, if the benefits cannot, even in the long term, be pointed out, another justification is necessary. Probably most of us feel that supporting the poorer is right and even morally necessary, but we differ on how it should be understood and what principles of redistribution should be adopted when they are not defined in terms of entitlements, as is the case for the insured citizens of a country where public health budget exists.

With regard to areas such as infectious disease prevention, the interest is mutual: investing resources in preventing epidemics in Africa or Asia simultaneously protects Western societies. The case is different, however, with financial transfers whose sole, or in any case overriding, purpose is simply to help those in need in developing countries. These are transfers that are wholly or partially (i.e. in some areas) altruistic and therefore inexplicable in the narrow perspective of rational management of national resources and the logic of costs and effects. In order for them to be serious and sustainable, public health doctrines and, consequently, the laws of rich Western countries must use moral justification, based on plausible moral ideas rather than emotions. The concept of sustainable development, based on social responsibility and principally opposed to great social inequalities, either local or global, appeals to the notion of justice and to prudence, obliging us to

avoid risky and uncontrollable situations; these include serious deficits and inequalities in access to critical goods, including health benefits. Sustainable development, based on a balance of environmental, social and economic factors, is in the common interest of all humanity, and the related policies are something to which their beneficiaries are entitled, both in local and global systems of social justice. Thus, it is possible to speak of a universal human solidarity reinforced by a shared global fate and global threats. This means that the practice of solidarity is the basis of sustainable development. Still, the driving force behind solidarity-based practices is the time-honoured and essentially conservative idea of the duty to help one's neighbour in need. There is a certain dissonance and inconsistency here, stemming from the popular conviction that the motivation for action can be either self-interest or the ideal of selfless, altruistic doing good. Perhaps one should go beyond this opposition, bearing in mind that actions can have mixed motivation and not at all be based on separating one's own benefit (for example, the national benefit) from that of another (for example, another nation).

The very phrase 'providing help' – so strongly associated with an attitude of altruism – can be controversial, as activity referred to in this way (or similarly, for example, referred to as 'support') is regarded as entirely voluntary and always praiseworthy, reducing relations with recipients of 'help' to the level of donors and beneficiaries of charity. As a result of discussions concerning the concepts of classical liberalism and libertarianism, the social and political consensus has long been established that reducing international aid to the category of charity is wrong and harmful, not least because it deprives the beneficiaries of all rights to criticize and express dissatisfaction with the scope and form of the aid they receive. This does not mean that charity is wrong in itself, but only that, as the dominant pattern of providing support, it has a condescending quality to it and perpetuates inequality, placing the beneficiaries in a subordinate position and even in the position of never grateful enough and insolvent debtors. In addition, charity is always more or less fragmentary and offers no guarantee of continuity or lasting security for the beneficiaries' needs. Therefore, the social policies of Western countries, especially so-called welfare states, are looking for a more secure doctrinal basis for themselves, in the sense of both legal and ethical doctrine. The matter is not settled, however. We are still not sure whether the category of charity and activities subordinated to the logic of charity in principle and over the long term serve the good of the needy, or whether they limit the development of the real entitlements of economically weaker individuals and communities, leaving too much in the field of public policies to the whims of goodwill. In order to answer these questions and formulate an international consensus on the doctrinal foundations of financial and technological

transfers from rich countries to developing countries, it is necessary to adopt some resolution on how collective and institutional obligations are born and what the limits of the obligation to take care of other people's welfare are, i.e., according to what criteria its scope should be determined. The simplest and most popular answer to these questions appeals to the notion of solidarity (one should bring help, because this is what natural solidarity with the weaker requires) and the notion of satisfying minimum needs (by drawing a line between minimal and supra-maximal actions, we make it possible for a greater number of those in need to benefit from the always limited resources and ensure that they are used sparingly).

Hassoun vs. Hausman

An expression of how lively the discussion is regarding these issues is Daniel Hausman's very interesting polemic [1] with Nicole Hassoun, the author of the book *Global Health Impact: Extending Access to Essential Medicines* [2], featured in the special issue of Developing World Bioethics published on 22.06.2022. In her book, Hassoun defends the model of global redistribution in health care based on the obligation to ensure a minimum quality of life for all people. The basis of redistribution is thus a universal entitlement to minimal medical care. Hausman, on the other hand, points out the paradoxes inherent in this position, while referring to the ethical concept of imperfect duties, which derives from the work of Immanuel Kant and is rooted in the traditions of Roman law (*lex imperfecta*). Ultimately, Hausman defends the position that the global redistribution of healthcare resources belongs precisely to imperfect duties, that is, duties that can be fulfilled indirectly, but through others – for example, dedicated state institutions – with no sanctions for failure to fulfill such duties [3]. I think a compromise between both positions is possible.

Hausman is right when he points to the statistical dimension of medical needs. Disease prevention, such as vaccination against COVID-19, has such a huge impact on the well-being of society that one can speak of an elementary interest that society has in taking advantage of available means of preventing diseases that cause a statistically large number of deaths. However, if the threat of death from an unfavourable epidemiological situation, for example, from an infectious disease epidemic, means a risk of death for one in a thousand, it can hardly be said that the use of a preventive procedure (e.g., vaccination) in this case is the safeguarding of a person's minimum health needs. If the right to minimum health care is a human right, and therefore an individual right, then it would not be easy to justify international aid for disease prevention in a given country using this category. It appears, however,

that the source of moral obligation in this case is the collective, not individuals taken in isolation, just as the responsibility for providing assistance rests with the collective and its institutions, not with individuals.

Nicole Hassoun derives the right to minimal medical care from the more general right to a minimally good life. Unfortunately, as Daniel Hausman points out, quality of life is largely left to the subjective judgment of each individual. Many people who are seriously ill and deprived of medical care for various reasons may think they have a good life and even consider themselves happy. Nevertheless, in the vast majority of cases, a serious and painful illness makes a person unhappy, and it is reasonable to accept as a rough generalization that this or that illness excludes a minimally good life in many cases. It does not follow from the fact that a certain number of people with serious parasitic diseases are happy that we do not have a moral obligation to share with developing countries the medical means to treat them. And arguably, we also have this obligation in the case of those parasitic diseases that are so chronic that they are rarely the main cause of the patient's death. On the other hand, Hausman's observation that what we might define as minimal medical care in many cases constitutes less than we would like to provide for the people whose fate we really care about also seems correct. So there is a certain harshness in 'redistributive minimalism' that does not correspond to the fundamental intention behind acts of solidarity, including international solidarity. Minimalism in providing aid has its rationale in increasing the number of beneficiaries while maintaining the same pool of resources, which is always insufficient to meet all needs. At the same time, however, minimalism reveals a fundamental reluctance to engage in aid, which appears as a kind of 'necessary evil.' However, is helping really something we should avoid and always fulfill only minimally? Probably not – the rationale for helping is generosity rather than stinginess, as well as a sense of solidarity rather than a moral imperative to save, capable of affecting us strongly enough to overcome our selfishness.

Towards solidarity

In their programmatic article *The Place of Solidarity in Public Health Ethics* [4], Angus Dawson and Bruce Jennings advocate overcoming traditional liberal individualism in public health ethics and taking as a starting point a vision of the individual as a being in all aspects of his or her life, practices and socialized activity. The expression of this change of point of view in public health ethics should be to give an entirely new prominence to the hitherto undervalued category of solidarity. In the concept of solidarity they present, the metaphor of 'standing by' plays a key role. This concept can be

understood in a variety of ways, but the authors are concerned with the creation of a natural community of action in the face of an emerging problem and the resulting task to deal with it. As they write, 'If I am healthy and you are sick, the appropriate response is not one merely of pity or even sympathy by me toward you, but rather seeing that there is a connection between us' [4:77].

I agree with this position. Solidarity is not based on interest or calculation or emotion but is in itself a proactive attitude in which other people's problems are recognized with one's own simply because other people are important and matter. A goal-oriented and straightforward or direct attitude towards another whose difficulties and needs become a challenge and a call to action is meant to replace a deliberative attitude towards a stranger who, on the basis of some justification, should be included in some system of mutual concern and justice. The concept of solidarity as a basis for action for the good of those who cannot reciprocate the benefits received treats the attitude of solidarity as a self-evident good that does not require justification. Such a justification could be the religious idea of mercy, the idea of brotherhood, or the idea of a shared human condition Each of these, like the appeal to emotion and the capacity for empathy, is particularistic in nature and thus unsuitable for universal application as the basis of a global system of benefit distribution.

Peter G.N. West-Oram and Alena Buyx [5:213] define solidarity as an "enacted commitment to carry 'costs' (financial, social, emotional, or otherwise) to assist others with whom a person or persons recognize similarity in a relevant respect," emphasizing that recognition of similarity is different from empathy. Like most authors who write about solidarity, they link it to the community based on the similarity that all people share. We act together for common goals and support each other because we are alike – this is how the argument for solidarity as a driver of global public health can be summarized. West-Oram and Buyx realize the inverse relationship between the cohesive force of solidarity and the size of the group within which solidarity is supposed to motivate action. At the pan-human level, this force is still small. It may, however, gradually increase. However, what makes the category of solidarity remain useful in spite of everything is the local and 'projective' nature of any action resulting from a sense and attitude of solidarity. For our actions are never (except perhaps at the UN or WHO level [6]) addressed to all people, but to some group that becomes close to us precisely because we begin to engage with these people and serve their welfare.

Redistribution of healthcare resources internationally cannot be based solely on goodwill or arbitrarily granted entitlements. The obligations of rich countries to countries and regions in need of support should not be

arbitrary and adopted unilaterally. If we are to take redistribution seriously, all stakeholders must be treated in just such a serious and respectful manner. If the basis for cooperation is solidarity and social responsibility within the framework of a global policy of sustainable development, those responsible for health care in the donor country and in the beneficiary country must treat each other as partners, working together with the single goal of improving the health of a particular community. The direction of the flow of funds is only one of the considerations that must be taken into account here. Under conditions of solidarity, joint action is triggered not by an interest, but by a need and an appeal for help in solving a problem.

Of course, solidarity is grounded in certain real links between the interacting parties, in commitments made, as well as in interests and benefits. In an international system of cooperation based on the shared ideals of sustainability and solidarity, there is no need to maintain a separation between action based on interest and altruistic action. Nor is there a need to value them. Evaluating the attitudes of cooperating parties does not have to presuppose a calculation of proportions between what is driven by interest, by a propensity for charity or by respect for rights to minimum health care.

Conclusion

Solidarity is a pragmatic and proactive relationship, flexible and open to the various beliefs and motivations of the cooperating parties. Therefore, the language of solidarity is more universal and promising in the work of building a global health system in which developing countries can feel safe and treated fairly, rather than a language that speaks of entitlements, obligations and charity. Building a climate of trust and pursuing socially responsible sustainable development policies do not require strong theories of justice or other rigid legal or ethical doctrines. Such doctrines can even be harmful. Yet we know in advance that not all cooperating parties will be able to share these doctrines. Meanwhile, the discourse relating to solidarity, trust-building and cooperation to achieve realistic and reasonable goals at the transnational public health level is relatively undoctrinaire, and instead flexible and open to a variety of interpretations. In the realities of international politics and cooperation, these are serious advantages.

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