GLOBAL HEALTH IN THE TIME OF COVID-19 AND BEYOND: WHAT'S JUSTICE GOT TO DO WITH IT?

(Working Paper)

by

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ABSTRACT

The authors are three members of the Independent Resource Group for Global Health Justice (https://www.irg-ghj.org/). The group comprises philosophers and other related specialists from around the world who have come together to support the global response to COVID-19, to contribute in the urgent task of making visible issues of global health justice, and to facilitate global public deliberation on the profound ethical choices facing the world. In this brief article, the three authors explain the distinctive philosophical contributions that we aspire to provide.[i]

INTRODUCTION

Plagues and pandemics are not new but today they spread more rapidly than ever before. COVID-19 raises countless ethical questions for individuals, for governments, and for the international community. For example, governments ask how to weigh considerations of public health against considerations of economic stability and individual liberty; individuals ask how to weigh compliance with public health mandates against their own financial and caretaking responsibilities; states ask whether taxpayer-funded investments in vaccine development entitle their citizens to priority receiving vaccinations. These questions are already receiving extensive debate in both scholarly venues and public media, with the conversation often focusing on concepts such as autonomy, rights, and solidarity. We aim to add further value to these debates by drawing on our expertise in global justice. Below we explain some ways in which our contributions may enrich deliberation about these urgent but complex issues.

1. OUR REFLECTIONS CENTER ON JUSTICE

The value we propose to add does not consist primarily in offering new direct answers to specific ethical questions such as those above. We do not aspire to run an ethical advice column. In most cases, specific questions must be addressed in context and it is not possible to give a general answer that works in the same way in all countries. For instance, the issues that a government must consider when enacting public health measures to prevent the spread of the infection must be influenced, not only by how widely the pathogen is circulating, and by the economic resources the country has to cope with the financial costs of such measures, but also by the conditions within the country. In an extremely impoverished country, where most of the population depend on informal jobs, measures such as stringent lockdown or shelter in place may be ethically unjustifiable because the consequences for already disadvantaged populations might be as devastating as the pandemic or even more so, in both short and longer term. The fact that, in other contexts, such

measures are highly effective in preventing uncontrolled infections that rapidly overwhelm health services does not mean that it is ethically acceptable to apply the same measures in contexts that are economically and politically more fragile.

Governments implement public health policies that often oppose consequentialist to deontological approaches, sometimes prioritizing the protection of health on a large scale over the rights of individual citizens. We acknowledge the indispensability of moral values such as collective wellbeing, personal autonomy, care, and solidarity but our own work is committed to making visible questions of justice in its many dimensions. We are especially concerned with disparities among groups in the health impacts of pandemics and in the benefits and burdens resulting from various policies and practices intended to address pandemics. We aim to use a social justice lens not merely to study the most pressing ethical quandaries posed by the pandemic but also to investigate how the appearance of those quandaries may signal the existence of other types of injustice that are less frequently noticed. We wish, as well, to look beyond medical models of disease toward the political economy of the social determinants of health. The inequitable impacts of the pandemic resemble skin eruptions indicating that larger social systems may be infected by injustice. These systemic injustices may be regarded as "pre-existing conditions" for pandemic inequities. They not only generate many of the health disparities manifested in the COVID-19 pandemic; they are likely also to shape future disease outbreaks.

2. WE INVESTIGATE INJUSTICES LYING BENEATH THE SURFACE

Many disparities in health and disease stem from what Iris Marion Young has called structural injustices.[ii] Young describes structural injustices as

> " […] social processes (that) put large groups of persons under systematic threat of domination or deprivation of the means to develop and exercise their capacities, at the same that these processes enable others to dominate or to have a wide range of opportunities for developing and exercising opportunities available to them (2011:52)."

Structural injustices occur when everyday and normalized social practices systematically position some to suffer the threat of domination or deprivation while enabling others to dominate or flourish. Structural injustices are not reducible to the conduct of individual agents, nor do they result from intentional institutional planning. Instead, structural injustice characterizes many nested networks of constraints and opportunities that emerge unplanned from complex patterns of social interaction.

Multiple structural injustices underlie the disparate impacts of the COVID-19 pandemic. For example, empirical evidence from various countries indicates that racialized populations appear to be more heavily affected by COVID-19, in part because they typically live in more economically disadvantaged neighborhoods. Moreover, the containment measures imposed by public health authorities reveal racialized divisions in the labor market. While specific socio-economic categories of the population adapt to home-office work without financial loss, others lose their jobs or take up jobs considered essential but less well paid, which exposes them to more significant infection risks. In Canada, for example, health care aides often come from immigrant, racialized

populations or are individuals awaiting permanent residency. In other countries too, the higher number of cases reported in disadvantaged neighborhoods with an immigrant background indicates the urgency of addressing race as one of the most critical social determinants of health. In the wake of the Black Lives Matter movement, which has drawn worldwide public attention to the pervasive issues of structural racism in the United States (and elsewhere), increasing numbers of researchers assert that racism must be considered a public health issue.

Gender analyses also reveal underlying structural injustices. Several reports have shown that the pandemic has disproportionately affected women and girls in at least four respects: 1) loss of employment (formal and informal), 2) increased burden of care obligations, 3) higher risk of sexual and domestic violence, and 4) restricted access to sexual and reproductive health. Although in physiological terms, men seem to develop more severe COVID-19, women experience more risks and costs associated with the public health measures intended to limit the spread of the disease. On-line work and education policies have been fundamental in many countries in lowering the R rate but these policies have also put millions of women and girls at risk because in many parts of the world the home is not a safer place for women and children. The pandemic shines a new light on structural gender injustices and provides even more reasons for addressing these.

Young notes that it is difficult to assign moral or political responsibility for structural injustices. First, it is often impossible to trace any individual's causal contribution to particular harms and, even when that is possible, the causal contribution made by most individuals is miniscule in the overall picture. Second, many people who contribute causally to structural injustice do not intend to do so. Third, even when people are aware that their actions contribute to injustice, they often lack realistic alternatives and so are constrained or even "forced" by their circumstances. For these reasons, moral responsibility for harms disproportionately affecting particular social groups cannot be captured by the traditional liability model of responsibility. Recognizing that the pandemic is shaped by structural injustices requires acknowledging that responsibility for addressing these injustices extends beyond our leaders and that its scope goes far beyond applying band-aids to immediate health disparities. If we do not address the structural injustices underlying the disparate impacts of the pandemic, they will continue to reproduce health disparities and ensure that the next pandemic is characterized by the same inequities as the present one.

3. WE TAKE A BROAD VIEW.

We look not only at injustices in health systems, broadly construed, but also at the ways in which these systems are connected with injustices embedded in the social arrangements that organize systems such as food production, transportation, natural resource utilization, our relation to the environment, and care work. We offer two examples, one on the domestic and the other at the global level.

At the domestic level, it is widely reported that a disproportionate number of COVID-19 deaths have occurred in care homes. The fact that this high mortality rate has occurred in several countries, such as the US, Canada, Spain, and Sweden, may be taken to suggest that it results from "natural" vulnerabilities related to age and disability. However, further analysis reveals that it is also linked with injustices of several kinds. Philosophers of disability have argued that the high mortality in long term facilities is related to austerity measures and the normalized neglect and indifference in

which the elderly and people with disabilities live.[iii] In the United States, nearly 40% deaths have occurred in care homes, with the deaths sometimes attributed to lack of government oversight. Even more fundamental than lack of oversight may be the fact that most nursing and care homes in the US are not provided as public goods but instead are run for profit. To maximize profit, they depend on the most precarious workers many of whom are migrant women. As feminist bioethicists have pointed out, such workers earn low wages, work long hours a day and have no support to demand labor rights.[iv]

One issue receiving extensive attention around the world is that of access to vaccines against COVID-19. Despite the efforts of the WHO and Gavi (the Vaccine Alliance) to foster international cooperation by creating COVAX to facilitate worldwide access to vaccines, the initiative appears to be a failure. Among the ethical questions emerging in connection with vaccine distribution are: 1) Are the citizens of countries that have financed the COVID-19 vaccines development with their taxes morally entitled to demand priority in access to vaccines? This question is closely related to the *vaccine nationalism* issue to which members of the IRG-GHJ group are giving special attention.[v] 2) Should the intellectual property rights on vaccines and other drugs necessary to attend this pandemic be enforced or not, a question that has also been addressed by members of our group.[vi] 3) Is it ethically acceptable to accumulate vaccines in order to incentivize vaccine tourism, as the US is doing right now, while other countries have no hope of receiving vaccines until next year?[vii] Addressing such questions of distributive justice is certainly urgent but it is also crucial to investigate the justice of the context in which these distributive questions arise. Why are rich countries able to stockpile vast hoards of vaccine which they must then be persuaded to share, appealing to considerations such as charity or even the self-interest of preventing "their" diseases from infecting "us"? During this pandemic, extraordinary efforts have been made to facilitate scientific collaboration between universities, research centers and the private sector but the world still depends on Big Pharma's business model to access not only vaccines but also therapeutic alternatives for COVID-19. If the whole enterprise of vaccine research and development is embedded in the technoscientific capitalist complex, then it should come as no surprise to learn that there are many obstacles for vaccine equity. One reason health inequities continue to reproduce over time is the persistence of knowledge and technological dependency and epistemological injustice on a global scale. Some voices are not heard nor even invited to the table to discuss global public health issues, let alone considered as valuable sources of knowledge.[viii]And this is the result of a normalized set of oppressive and exclusionary practices than hinder scientific research and innovation in the Global South.[ix]

4. WE TAKE A HISTORICAL VIEW.

We ask whether present health/disease inequities may have roots in past injustices and in many cases, we find an inescapable historical dimension. For example, in the United States, economic inequality between social groups in the context of confinement can be traced back to the origins of slavery. In Montreal, the tragedy of an Innu man found dead in a portable toilet on one of the coldest nights in January because he was fleeing police during a COVID-19 curfew is a consequence of Canadian colonialism. Indigenous Peoples still suffer from poor health and living conditions directly linked to historical injustice. Because of gender discrimination built into the fabric of our societies, more women have lost precarious jobs and are more heavily affected by the combination of work and family duties in the context of confinement measures.

The research and development processes of the new COVID-19 vaccines has been financed, in part, with public funds contributed by economically and politically powerful countries, such as the US, UK, Germany, China and Russia. But why are countries so divergent in their ability to produce vaccines? Why are some so wealthy and "developed," while others are poor and still "developing"? There is no simple answer to these questions but the neocolonial after-effects of Euro-American colonialism affect global health prospects even today. After WWII, many formerly colonized peoples achieved sovereignty but much of the global epistemic structure established under colonialism remained in place. The immense wealth and prestige of centuries-old universities in former colonial powers often enabled them to build on and maintain their earlier epistemic advantages in the post-colonial world. Today, they receive the bulk of Western research funding and continue to operate as major centers of knowledge production, leading advances in virology, immunology, and other scientific fields. Such research is often shaped by the interest of corporate funders and many argue that some diseases do not receive adequate research attention because they tend not to affect the populations of the most affluent countries or undermine their national health security. The history of tropical and neglected diseases illustrates clearly the issues of inequities in global health research and we ask why these epistemic injustices continue to exist despite several decades of attention.

5. WE TAKE A FUTURE-ORIENTED VIEW

If a backward-looking analysis of the origins of structural injustices points in the direction of past injustices, how should forward-looking perspectives be projected into the future? It is arguable that the pandemic raises questions not only of international justice but also of inter-generational justice. We should consider both reparations for historical injustices and additionally design better pandemic preparedness plans for the future.

Many public health researchers argue that historical injustices must be redressed through economic measures to reduce the wealth gap between social groups to ensure equal opportunities for future generations[x]. The "baby-bond" or reparation policies for Indigenous Peoples are crucial examples of what needs to be done. We support the call from feminist thinkers and economists to "de-commodify" human resources and labor, "democratize" workplaces[xi], de-carbonize the economy, and "de-colonize" inequalities both at the national and international levels. These are starting points that we believe essential to addressing the pervasive injustices revealed by the pandemic. Social inequalities (among class, gender and race), economic disparities among countries (exacerbated in the race for vaccines and essential drugs), and global environmental inequities are all bad for people's health. We, along with many members of our research group, intend to guide thinking and hope to contribute to the development of more equitable socio-economic responses and more sustainable environmental alternatives guided by social, international, and global health justice principles.

The issue of vaccine equity provides one example. The current global scarcity of the vaccine highlights the need to rethink the financing model for research and development of pharmaceutical products. Science and technology systems in formerly colonized countries need sufficient support to respond to local needs and interests. It is not enough to provide justifications for sharing vaccines with "developing" countries, even on grounds of reparative justice. They will only need

more handouts in the next pandemic. Instead, we should aim for a profound scientific and intellectual global democratization. Although it is true that funders now do pay attention to previously neglected diseases, the funding still goes mainly to partners in the global North. Funding mechanisms are established by the global funders in such a way that the PI is typically from a Northern country or the funds are released to the Northern partners. Also there is a very narrow focus on what counts as capacity strengthening. For example, capacity strengthening is not only the ability to collect data or write research grants but also includes capacities in mastering new technologies and eventually developing new technologies and leading innovations at the cutting edge of science in their home countries.

The crises caused by this pandemic expose fundamental flaws in our international order which generate and maintain health disparities on a massive scale. Recent developments in theories of global justice argue for moral obligations and international institutions upholding duties of mutual humanitarian assistance, not based on charity, but in the name of universal human rights. Some might object to cosmopolitan ideals because they regard nation-states as having the right to close borders in the name of national interest. A major challenge awaiting our generation will be to overcome the dilemma between the securitization of health in the name of national interest (or health nationalism) and the pursuit of the ideal of global health for all. There is no doubt that our interdisciplinary research efforts need to focus on the development of feasible models of global governance of public health compelling all countries towards greater international transparency, accountability, information sharing, and distribution of resources to develop means of prevention, adaptation, and mitigation for future crises to come.

6. WE SEEK AN INTEGRATED VIEW

We three authors have diverse ancestries and citizenships and each of our first languages is different. Members of our research group come from an even wider variety of countries and continents. Our cooperation enables us to incorporate a range of diverse perspectives on the ethical questions raised by the present pandemic and to contextualize those questions within a more comprehensive understanding of global health justice. By situating our discussions in this more inclusive global context, we aim to contribute not only to addressing particular ethical issues arising immediately from COVID-19 but also to tackling the new pandemics looming on today's horizon. In the early days of the pandemic, it was often said that we were all in the same boat but that metaphor was seriously misleading. Even if we are all facing the same storm, our boats differ widely in comfort and even seaworthiness. We authors intend that our philosophical work should illuminate the ways in which pandemics are not simply natural disasters that affect everyone equally but instead are rooted in underlying injustices that then they typically exacerbate. Mitigating those injustices would reduce the likelihood that pandemics would occur and, when they do occur, would enable us to deal with them more fairly as well as more effectively. By cutting through the dense tangle of interconnections between COVID-19 and global health injustice, we aspire to illuminate more comprehensive as well as attainable visions of universal health justice.

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[ii] See Iris Marion Young, *Responsibility for Justice*, Oxford: Oxford University Press (2011).
[iii] See Shelley Lynn Tremain, "The Horrors of the Nursing Home Industrial Complex in Canada", *World Institute on Disability*, COVID Blog, August 5 (2020) https://wid.org/2020/08/05/covid-blog-the-horrors-of-the-nursing-home-industrial-complex-in-canada/ ; S. L. Tremain, "Covid-19 and the Naturalization of Vulnerability", *Biopolitical Philosophy*, April 1 (2020) https://biopoliticalphilosophy.com/2020/04/01/covid-19-and-the-naturalization-of-vulnerability/
[iv] Lisa Eckenwiler, "A Global Ecological Ethic for Human Health Resources", *Bioethical Inquiry*, 17, 575-580 (2020) https://link.springer.com/article/10.1007/s11673-020-10039-2
[v] See for instance Arnab Acharya, Sanjay Reddy, "Hoarding is Undermining a Key Effort to Vaccinate the Global Poor", *Barron's*, January 29 (2021) https://www.barrons.com/articles/hoarding-is-undermining-a-key-effort-to-vaccinate-the-global-poor-51611882933
[vi] Gabriela Arguedas-Ramírez, "Hay que replantear la propiedad intelectual en situación de pandemia", *Washington Post*, January 5, 2021. https://www.washingtonpost.com/es/post-opinion/2021/01/05/vacunas-covid-19-america-latina-propiedad-intelectual/"
[vii] https://www.thehastingscenter.org/instead-of-vaccine-passports-lets-push-for-global-justice-in-vaccine-access/
[viii] Rebecca Tsosie, R., "Indigenous peoples and epistemic injustice: Science, ethics, and human rights", *Wash. L. Rev.*, 87, 1133 (2012); Nancy Tuana "The speculum of ignorance: The women's health movement and epistemologies of ignorance", *Hypatia*, 21(3), 1–19 (2006).
[ix] Daniel Reidpath and Pacale Allotey, "The problem of 'trickle-down science' from the Global North to the Global South" BMJ Global Health, 4, 1-4 (2019). doi:10.1136/bmjgh-2019-001719; Ali Murad Büyüm, Cordelia Kenney, Andrea Koris, Laura Mkumba , Yadurshini Raveendran, "Decolonising global health: if not now, when?" BMJ Global Health 2020;5:e003394. doi:10.1136/bmjgh-2020-003394; Seye Abimbola, et al. (2021) Addressing power asymmetries in global health: Imperatives in the wake of the COVID-19 pandemic. PLoS Med 18(4): e1003604. https://doi.org/10.1371/journal.pmed.1003604
[x] W.A. Jr. Darity and A.K. Mullen, *From Here to Equality: Reparations for Black Americans in the Twenty-First Century*. UNC Press Books (2020).
[xi] Isabelle Ferreras, Dominique Méda, Julie Battilana et al., "Work: Democratize, Decommodify, Remediate", May 16, *Le Monde* (2020) https://democratizingwork.org/. I. Ferreras, D. Méda, J. Battilana (co-eds), *Le Manifeste Travail. Démocratiser, Démarchandiser, Dépolluer*, Paris, Seuil (2020).