Critical Public Health Ethics and Canada's Role in Global Health

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ABSTRACT

This commentary introduces *critical public health ethics* as an innovative lens for considering Canada's role in global health. Arising from the relatively young field of public health ethics, this analytic perspective sheds light on questions regarding public health policy, research and practice that often remain shaded from view because of traditional ways of thinking about public health. The advantage of a critical public health ethics lens is illustrated through the example of Canada's role in scaling up access to HIV treatments in developing countries.

MeSH terms: Public health; ethics; HIV; justice

La traduction du résumé se trouve à la fin de l'article.

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Public health practitioners, researchers and policy-makers approach global health issues according to their different (explicit or implicit) conceptual perspectives. However, these various perspectives are not politically neutral. Our different conceptual underpinnings lead us, knowingly or not, to ask certain questions and exclude others, which consequently lead to certain public health programs, research results and policy solutions at the exclusion of others. This commentary introduces a lens called *critical public health ethics* which helps to consider public health questions regarding Canada's role in global health that are often shaded from view.

Critical public health ethics

Critical public health ethics is a kind of analysis emerging from the relatively young field of public health ethics.¹ The related discipline of bioethics has grown tremendously since its inception after the atrocities of Nazi medical experimentation in World War II. To date, however, bioethicists have focussed largely on individualistic issues related to researcher/subject and health care provider/patient relationships.² It is only in the last decade that ethical concerns in public health have received a surge of attention fuelled by recognition that many issues raised in public health are insufficiently served by principles like autonomy and beneficence which have contributed so much to clinical ethics.³⁻¹³

To help define the field, Callahan and Jennings¹ described a four-part typology of public health ethics analyses, one of which is critical public health ethics. Critical public health ethics describes an approach to judging rightness and wrongness that is practically oriented toward real-life problems, but brings larger social values and historical trends to bear. It understands dilemmas not only as the result of behaviours of disease organisms and individuals, but also as resulting from institutional arrangements and prevailing structures of social power. Critical public health ethics is concerned with global health equity and power relations between rich and poor countries that impact on health. The example of HIV treatment scale-up can illustrate the kinds of questions raised by this lens.

Scale-up of HIV treatments

Canada has played a central role in advocating for the scale-up of HIV treatments for people living with HIV in developing countries through our role in the creation of and ongoing support to the Global Fund to Fight AIDS, TB and Malaria. This commitment was solidified in May 2004 when the Government of Canada rescued the WHO 3x5 Strategy by funding one third of their budget.

However, HIV treatment scale-up is a complex issue which raises many questions about the rightness and wrongness of different approaches from both ethical and public health perspectives.^{14,15} For instance, debate is ongoing with regard to the relative value of treatment efforts compared to other approaches. Should we scale up HIV treatments in developing countries despite the potential negative impact of viral resistance? Should we be investing in expensive HIV treatments when many people do not even have access to basic nutrition and clean water? Is it wiser to invest in treatment or prevention to stem the tide of HIV/AIDS? Should we focus on existing strategies or invest in future prevention technologies like vaccines and microbicides?

Refocussing the questions

These are all legitimate questions, but our preoccupation with this level of enquiry often precludes engagement with questions related to the framing of these concerns in the first place. A critical public health ethics lens prompts us to question the taken-for-granted and think about the ways in which power relations are represented in these concerns. Such an approach would lead us to enquire as to why we are starting with these kinds of questions. Are not all of these initiatives essential? Why, then, are we beginning our discussion at the level of choosing between essential services?

The starting premise for the questions posed above is that there are insufficient resources to undertake all of these efforts simultaneously. A critical public health ethics approach would encourage us to challenge this starting position, suggesting instead that we acknowledge that all of these components are essential for a comprehensive response to HIV/AIDS and redirect our attention to claims that such a

comprehensive response is unaffordable. Labonte et al. call this “interrogating scarcity”.¹⁶

In other words, why are we not challenging this notion that resources are so scarce? Why are we not asking more questions, such as:

- Why is it not better known that the cost of a meaningful global response to HIV (and TB and malaria for that matter) is well within our reach?¹⁷
- Why are we not identifying that this supposed scarcity stems from the behaviours of rich countries, including Canada, in terms of past and present policies related to development assistance, trade and debt?^{18,19}
- Why are we not, as Canadian public health practitioners, researchers and policy-makers, questioning the actions of our national representatives at the International Monetary Fund, World Bank and World Trade Organization regarding international policies that are having detrimental effects on global public health?²⁰

A common response to this line of reasoning is that such proposals are unrealistic and impractical in the real world. However, others might argue that these are exactly the *real world* issues that require attention in order to effect significant change. To reject this kind of thinking as unrealistic is to capitulate to “TINA”, or “There Is No Alternative”, an ideological stance that this commentary is attempting to transcend. On the contrary, there are alternatives to the current state of affairs. A crucial starting point for advocacy among public health professionals is the ability to conceive of the kinds of questions that will allow us to reach the alternative answers that are currently eclipsed by traditional thinking about what is and is not realistic and worthy of consideration.

Development of HIV resistance

Returning to the example of HIV treatments, one can focus on the issue with viral resistance. Concern has been raised that scale-up of HIV treatments in developing countries could result in skyrocketing rates of viral resistance in the longer term. However, if the real concern is limiting viral resistance, one might argue that an important part of the solution would be to discontinue the use of HIV treatments

in North America and Europe where development of resistance to all classes of HIV drugs is most advanced. Clearly, this strategy would be outrageous.

Yet, dialogue continues as to whether fear of resistance is a sufficient reason to preclude scale-up of treatment to the other 95% of people with HIV who live in the developing world. A critical public health ethics approach would prompt us to ask how it is morally feasible to propose that people in developing countries may be less deserving of treatment than people living with HIV in the rich world, especially when it is the policies of affluent nations that have partially created the poverty in the Global South that has fuelled the epidemic.^{10,11} Indeed, what is it about the race, gender or market value of people living in developing countries that allows us to live so easily with our disinterest in their lives and our impact on them through our behaviours and policies?

Again, a traditional defense might contend that health divides between people in rich and poor countries are *simply a matter of harsh realities* or that *this is just the way it is*. However, such an approach dismisses the fact that the current state of global inequity is not a natural occurrence. On the contrary, our richness and their poorness are intimately linked. A critical public health ethics lens requires that we interrogate this interconnectedness for the kinds of ethical obligations to which they give rise. The political philosopher, Thomas Pogge, encourages us to move beyond moral inquiries regarding *distributional aspects* of justice (e.g., how best to allocate limited resources). While these are important concerns, Pogge argues that we have focussed on this perspective to the exclusion of *relational aspects* of justice, which are concerned not merely with outcomes, but also with the extent to which our actions are responsible for the outcomes. The greater the causal relationship between our actions and the harms suffered, the greater our obligation to help.²¹

Remembering our social justice roots

Such arguments may not be easy to hear, but these sorts of social justice appeals have served as the backbone of the public health movement since its inception. Indeed, one may reflect upon the seminal 1976 paper, *Public Health as Social Justice*, in which

Beauchamp called for attention to the incompatibilities between market justice and social justice.²² The argument proposed here continues this line of reasoning and is expanded to include the 2005 realities of gross global health inequities in the context of economic globalization.

Often, these questions are felt to be better suited for the realms of political science or philosophy, but the profound public health implications of these issues require that we join forces with such disciplines in raising these concerns. A critical public health ethics lens is one mechanism for bridging our multidisciplinary perspectives and bolstering the integrity of Canada's contribution to global health.

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RÉSUMÉ

Nous présentons ici la question cruciale de l'éthique en santé publique comme un prisme novateur à travers lequel envisager le rôle du Canada en santé mondiale. Née du domaine relativement nouveau de l'éthique en santé publique, cette perspective analytique éclaire des questions de politiques, de recherche et de pratique en santé publique qui restent souvent dans l'ombre en raison des modes de pensée traditionnels sur la santé publique. L'avantage d'un prisme critique de l'éthique en santé publique est illustré par l'exemple du rôle du Canada dans l'élargissement de l'accès aux traitements contre le VIH dans les pays en développement.

ERRATUM

Re: Sahai VS, Ward MS, Zmijowskyj T, Rowe BH. Quantifying the iceberg effect for injury: Using comprehensive community health data. *Can J Public Health* 2005;96(5):328-32.

In Table II in the above article, the total number is listed as 98,656,800. This should read 9,865,600.