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I am by no means a professional ethicist in the sense of having had formal training in the discipline. My background, training, and practice are in health, beginning in personal care medicine and extending to concern for public health or, perhaps even better, population health. The differences between the individual and population focus are becoming increasingly blurred and many of the ethical concepts may apply to both as really they may be seen as two facets of caring for the public's health.

When I was a practicing academic physician, the ethics of health with which I was concerned were the ethics of medicine, and related primarily to the rules of conduct which guide interpersonal interaction. Classical medical ethics as I understood it, and given our fixation on Hippocratic principles, dealt with the physician/patient relationship, the determination of what was in the patient's best interest and the etiquette required of the virtuous physician. The ethics of care for the individual patient was critical and the ethics of maintaining quality of life, especially towards the end, was and continues to be a central concern. Now the field of medical or health ethics has expanded to become bioethics which embraces much of the above, but has broadened to include virtually all aspects of human life. We see attention being given increasingly to issues that touch the very origins and notion of life itself, such as the consequences of human genome mapping, the ethics of human stem cell research, and the complex issues surrounding possible cloning of humans.

But there still continues to be an appreciation of what I learned many years ago as the fundamental aspects of ethics as applied to health and the three essential principles to which we in health still adhere are autonomy, beneficence, and justice. In our original concentration on the individual, interaction with the patient was guided by autonomy, the physician's behavior was informed by the beneficence principle while justice was very much within the province of the wider society. When one comes to deal with population rather than individual health I believe that these still apply. As we will see, the autonomy of the group or population is still a relevant consideration, although the issues of beneficence and justice perhaps now assume greater importance. It is matters like the role of the beneficent state in providing those sanitary and social measures necessary for health that are being debated, as well as the theories of justice as

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applied to the provision and distribution of those measures. But if we are going to link health, ethics, and development, first we have to examine the relationships between health and development.

Over the past twenty years, I have been deeply interested in the relationship between health and development. My original and rather naïve concept was to see development as coterminous with economic growth and to examine solely the potential impact of health on such growth, and to a lesser extent the better understood reciprocal relationship. But I have seen the concepts and thinking in the field advance tremendously and there is now a broader view of development as many of the experts here have shown. But the pristine view of development as change or progress still remains valid, even as it is applied to the expanded concept of human development. I am now comfortable in accepting the view of human development as reflecting those changes in the human condition that allow the flowering of the human spirit and fulfillment of the human potential.

For this progress or change in the human condition to occur, there must be change or progress in certain fundamental capabilities or opportunities, or as Professor Amartya Sen would call them, “freedoms” - health being one of them and clearly such things as access to economic and educational resources being others. I must also not leave out a safe environment and access to basic rights and freedoms. No one now even thinks of development only in economic terms, and I am always fond of quoting Eric Williams, a former Prime Minister of Trinidad and Tobago, who was prescient enough many years ago to characterize development as “the face of man.”

There is now no debate that health at the individual or population level is important in its own right as something to be desired and appreciated for its intrinsic value, but we also accept that changes in health are critical, facilitatory or instrumental for progress in other capabilities or opportunities that constitute human development. It is the ethical aspects of these interrelationships that must concern us here. We must consider the ethical aspects of the relationship of health to other development capabilities, as well as how they in turn impact on the health of people. The rational reflection and dialogue that is very much a part of ethical discourse, although perhaps not sustained by empiricism should lead to the acceptance of certain principles that may hopefully inform conduct or policy decisions.

Perhaps the most defining moment in the ethics of modern public health occurred 22 years ago, and no who works in this field can forget the enthusiasm of that moment when the nations of the world embraced the call of *Health for All* as an expression of the need for social justice in health. Ethicists would have seen this as falling within the realm of deontic judgment and exemplifying a moral obligation of a general nature that devolved on the nations of the world. The differences or inequalities that existed between and within nations were held to be ethically unjust and should be reduced, and as the notion of equity in health took traction, efforts were made to define it.

This notion of equity in health and the ethics of it are of particular importance to us in the Americas, which has the dubious reputation of having the most unequal distribution of income which, as we shall see, is an important determinant of health. The definition of these inequities

in health and the policies needed to reduce them has become a major policy goal for us in the Pan American Health Organization and forms an important part of our technical work. There has been general acceptance of the Whitehead/Dahlgren interpretation of health inequity which implies those disparities that are avoidable, unnecessary and unfair. It is the unfairness of the health situation that is the critical issue, and we believe that this criterion is satisfied when the differences are avoidable, are outside the volition of the individual or group and it is possible to identify some responsible agent.

One of the first steps in identifying inequity is clearly to establish differences in health characteristics, and perhaps of equal importance their distribution. Thus, it is no longer good enough to speak of averages in countries, as this hides the differences between groups that may represent inequity. These differences may appear when data are disaggregated by economic or other measures of social class, by gender, race, or geography. It is clear, for example, that such classic indicators as infant mortality rates show great differences between and within countries, with the rich countries having the advantage. The infant mortality rate in the poorest of our countries in the Americas is about 70 per 1000 live births, and the lowest figure is about five in another country. The differences in maternal mortality are even greater with ratios differing by approximately a factor of 100 between countries of the Americas. It is a blot on our services that in one country four mothers die for every 1000 children born. The difference in health outcomes between indigenous and other population groups is striking, with the former being grossly disadvantaged.

But it is not sufficient to demonstrate health disparities and characterize them as inequities. It is crucial that we examine the determinants of health and the disparities or inequalities in those determinants if we are going to enact policies that correct inequities in health outcomes. We are recognizing that the determinants of health are almost identical with the capabilities or opportunities that make for human development, and the field of bioethics has grown to consider the aspect of fairness in relation to these determinants. Norman Daniels and his colleagues have challenged us to look not only at health outcomes, but as he puts it “to go farther upstream” where the determinants of health status and outcome have their effect.

The determinant that has engaged most of those interested in development is economic status. It has been known for ages that the wealthier are healthier, but the field of inquiry on the impact of health status on economic growth is relatively new. However, there is a growing body of data to support the thesis that the health of nations is indeed a major contributor to the wealth of nations, and the health of the public is an important social desideratum for both welfare and economic reasons.

The nature of the forward causality in the relationship of health to growth is complex, and there continues to be discussion on the appropriate metrics of health to be used and the extent to which the mechanisms operate principally at the household rather than at the aggregate population level. I will mention here only a few of the relevant issues. There is the historical evidence so well elaborated by Fogel who demonstrates that it was improvement in nutrition and health that was responsible for as much as 30% of the economic growth of Western Europe between 1790 and 1980. It has been pointed out several times with particular reference to Africa that those countries with the greatest disease burden are the poorest. Macroeconomic studies in

particular, demonstrate that investment in health can spur economic growth albeit with a lag interval. The factors by which this is mediated have not yet been entirely elucidated, but apart from the obvious enhanced capability of the healthy to be more productive, there may be a facilitatory or instrumental role of health in maximizing the investment in education, for example. Indeed, it has been suggested that much of the impact of investment in education on growth may be mediated through improved health. A demographic dividend that results from the growth of the productive sector of the population as child mortality and fertility rates fall in sequence may also make for enhanced economic growth provided the other infrastructural prerequisites are present. Conversely, a country with an unhealthy population is unlikely to attract investment and certainly an unhealthy environment or the deterioration of the environment is likely to render a destination unattractive for tourism, which has now become one of the world's fastest growing industries. At the national aggregate level, improved health will increase productivity, and by producing additional resources that may themselves contribute to improving the provision of the determinants of health, serve to create a virtuous circle.

Health services undoubtedly contribute to health outcomes, but the weight of that contribution is uncertain. While I do not in any way wish to diminish the importance of personal care medicine, these services may be of limited importance in terms of population health. Thus, there must be caution in advancing improved health care of the traditional curative type in advocating for health investment as a mechanism for enhancing growth. Unfortunately, this is a common mistake.

One cannot speak of health and economic growth without mentioning the other face of the coin, which is poverty, and the major thrust of all development efforts now is directed to the alleviation of poverty. Health contributes to poverty alleviation through enhancing economic growth, but to the extent that poverty is now regarded not only in reductionist economic terms, but as absence of those capabilities central to human development, then improvement in health will contribute directly and in its own right to poverty reduction. Deprivation of health, or the economic impact of an illness on a family at the margin, may drive it into a poverty trap from which escape is difficult if not impossible. In very few situations is the vulnerability that characterizes poverty so marked as it is in the field of health. Health is important for the maintenance of a people's autonomy, one of the fundamental ethical principles to which I alluded and whose absence is a hallmark of poverty.

The more difficult ethical issue which involves judgment of a moral value is related to the distribution of the determinants of health which, as we have said before are very much identical to the other capabilities of human development. Social and economic inequalities are inimical to good health, and this issue has been framed as one of justice within the framework of John Rawls' "Theory of Justice." I first read of this concept about 20 years ago, but recently it has been espoused more vigorously by Norman Daniels and his colleagues who have postulated that justice is indeed good for our health.

Rawls did not deal specifically with health, but proposed that a just society would provide equal basic liberties and equal opportunity for free and equal people. It is not a great leap to postulate that health would figure prominently in those basic liberties and equal opportunities. Justice would demand universal access to health services, but perhaps more

importantly, would posit fair distribution of the other determinants of health. In the context of the relationship of ethics to health and development, I will posit that inequalities in health would be associated with inequalities in the other capabilities and opportunities that characterize human development. There is such a close inter-relationship between these capabilities that it is impossible to conceive that there will be inequality in one and not to some degree in the others. Thus, in the just society, and one that is developing in the sense of seeing progress or positive change in the essential capabilities, there would be a minimum of inequality in them.

An important question is what is that minimum and how could it be ensured to the population. Rawls says that the just society would only permit those inequalities that worked to make the groups at the lower end of the scale fare as well as possible. Inequality was once thought to be essential for economic growth, but there is now good evidence that this is not so. Indeed, it is equality in access to critical assets such as land and those essential ingredients of human capital like health and education that is essential for economic growth. Of course, none of this is to deny the absolute need to have the correct macroeconomic framework for growth, but we have moved to the stage of seeing that framework as necessary but to be complemented by these other factors.

In spite of the moral arguments in relation to justice and health, it is debatable, and perhaps fatuous, to imagine that even the most beneficent state will be able to ensure the equitable distribution of all those sanitary and social measures necessary to ensure good health for all. Redistribution of income certainly is the most intractable. But there are some that can be more equitably distributed. This applies particularly to some essential basic services that do contribute to improving health, and one of the salutary lessons of the recent past is that the just state can and must assume the responsibility for the fair distribution of those services that have high positive externalities such as immunization and clean water, and which undoubtedly contribute to improving population health. Some of the services that are undoubtedly valuable, but are demand, rather than supply driven, such as family planning can also be better distributed through a conscious use of appropriate marketing techniques and improvement of the delivery capacity of the services themselves.

If we accept that population health is important for welfare reasons as well as for development, we must face the major ethical problem of how the state should allocate resources to achieve optimal population health and do minimal damage to the inevitable demand of the individual for access to the best care that modern technology can offer. Optimal quality care is being defined more and more as access to the fruits of modern technological imperatives. There is an inherent incompatibility in providing the best for some and a reasonable minimum for all—an incompatibility that is most evident when resources are scarce. But perhaps this goes beyond the field of ethics and is related more to politics and the extent to which power and authority to make the appropriate decisions is distributed and exercised in the society.

It is plausible to propose the ethical dimension of a beneficent state concerning itself with the provision of some interventions that we believe should be distributed equitably and are absolutely fundamental for development. But a difficult and almost intractable question relates to the provision of those global public health goods that are essential for the health of all and by definition escape the ambit of responsibility of any single state. In areas such as disease

surveillance and the control of massive epidemics no single state can be individually effective. The problem of the generation of the research knowledge to address the problems of the large numbers of the poor who simply cannot pay for them is becoming increasingly acute. These kinds of issues raise the ethical dimensions of population health to a global level where there are no effective mechanisms for addressing them.

Ethics will be most valuable when it leads us to some policy options or decisions, and in the context of this discussion it is fair to examine the possible posture of organizations like the IDB and other financial institutions in relation to health and development. The simple reply is that they should invest in producing better health, but the more difficult question is how. The usual concept is to target the major diseases that afflict the population in question. This is undoubtedly important, but one crucial part of the recipe is to strengthen the capacity of the state so that in its beneficent role it can assume the responsibility for the provision and distribution of the essential public health goods, and as I have said above, programs like providing safe water and the immunization of children fall into this category. But of equal if not greater importance is strengthening the capacity of the state to discharge its steering or regulatory role in ensuring that certain functions essential for the safeguarding and promotion of the public's health are discharged. I am pleased that recently the Pan American Health Organization, the IDB, and the World Bank agreed to a Shared Agenda for Health Development in the Americas. One of the intentions of our joint action is precisely to facilitate the efforts of our countries to so reform their health systems so that they do improve the health of their people. It makes good economic sense and it is ethically correct.

In summary, my thesis is that health is one of the fundamental capabilities that make for human development. Those capabilities are inextricably linked to one another, but more emphasis has been placed on the relationship between health and economic growth with more attention being placed recently on the forward causality. The ethics of the connection relate to the autonomy that is conferred on populations when they have the necessary capabilities—specifically in this case health and economic opportunity. Lack of this autonomy is the hallmark of poverty.

Inequity in health outcomes represent inequalities that are unfair, but it is critical to address not only the inequalities of health outcomes, but inequality in the determinants of such outcomes. The search for equity in health and in its determinants is cast in the context of social justice. A just society requires equality of access to the determinants of health, which include many of the capabilities that constitute human development.

The principle of beneficence is applied to the role of the state in ensuring the just distribution of the determinants of health that are linked to development. A major ethical dilemma is being faced by many countries that seek to balance the need for a just distribution of the determinants of health, particularly appropriate health care to the many, against the common demands of the few for quality care defined as access to all the advances driven by new technological imperatives. The issue of the ethics of the provision and distribution of global public health goods may not be resolved with the mechanisms currently available.

You will note that for reasons of time, I have studiously avoided trying to meld the concerns for the ethics of health and development with the complex issues of human rights.

One lesson for financial institutions is to seek an appropriate investment in health both for its welfare function, as well because it stimulates development. Such an approach can be justified on ethical grounds.