



**AUTHOR:**  
Solomon Benatar<sup>1,2</sup>

**AFFILIATIONS:**  
<sup>1</sup>Emeritus Professor of Medicine and Senior Scholar, University of Cape Town, Cape Town, South Africa  
<sup>2</sup>Adjunct Professor, Dalla Lana School of Public Health, University of Toronto, Toronto, Ontario, Canada

**CORRESPONDENCE TO:**  
Solomon Benatar

**EMAIL:**  
solomon.benatar@uct.ac.za

**HOW TO CITE:**  
Benatar S. More eyes on COVID-19: Perspectives from Ethics: The most powerful health-promoting forces in COVID-19 are social. *S Afr J Sci.* 2020;116(7/8), Art. #8492, 2 pages. <https://doi.org/10.17159/sajs.2020/8492>

**ARTICLE INCLUDES:**  
 Peer review  
 Supplementary material

**KEYWORDS:**  
COVID-19, South Africa, social sciences, humanities, ethics, social determinants of health

**PUBLISHED:**  
29 July 2020

## More eyes on COVID-19: Perspectives from Ethics

# The most powerful health-promoting forces in COVID-19 are social

As the COVID-19 pandemic rages through the world, all aspects of life globally are being disrupted by mounting death rates<sup>1</sup> and governments' responses. The first ethical lesson has been the realisation that the increasing instability of the world, characterised by diverging trajectories<sup>2</sup> of health and well-being, with a minority (25%) benefitting from spectacular human development and progress, and a majority (75%) suffering from inadequate human and social development, is amplified in South Africa as a failing state, with its even wider disparities and continuing, pervasive poverty, hunger, unemployment and heavy burden of disease.

The second lesson relates to the complexity of the challenge for the government and people of a middle-income country seeking a balance between efforts to: (1) mitigate and control the pandemic for long enough to prepare already inadequate overall health facilities to save as many lives as possible, and (2) prevent severe damage to our fragile and crumbling economy in order to avoid deaths from starvation and other neglected health needs.

Our politicians, who are abandoning their moral legacy (like those in another retrogressing country<sup>3</sup>), are not well equipped to take difficult evolving decisions as the pandemic unfolds, without support from a range of available scholars in science, the humanities and medicine. Knowledge of the science<sup>4</sup> and dynamics of socio-political-economic influences on health and disease are crucial to the wise use of knowledge to improve the lives and health of people at both individual and population levels.

Despite these shortcomings, some admirable attempts are being made to utilise both our well-funded private and poorly funded public health-care sectors to face the immediate challenges. The spirit in which the best and most committed of our health professionals are working, embraces high standards of evidence-based medical practice. Although less adequately taught in our medical schools, the ethics of clinical duties of care and the art of medicine are also manifest, having been nurtured during many decades of clinical experience in caring for the world's largest proportions of patients with both HIV/Aids and tuberculosis.<sup>5</sup> Inspiring confidence, trust and measured hope are important in everyday health-care practices, and of special importance during public health emergencies. These are best achieved through the application of knowledge with clear, unambiguous communication across diverse barriers by coordinated health-care teams, with empathic understanding of the contextual nature of personal suffering and appreciation of the uniqueness of each person with respect for patient autonomy.

A significant ethical challenge highlighted by the pandemic, is the failure to openly acknowledge a weakness of the popular notion of a 'right'. Conceptually a 'right' can only be considered as one side of a coin, the other being a co-relative 'responsibility'. Rights cannot be met without identifiable and accountable bearers of responsibilities with the ability to do so. The relevance of this at the level of the easing of lockdown restrictions is that national public cooperation is needed to ensure that all are aware, for example, that 'your right not to be infected by me requires me to wear a mask, sanitise and respect social distancing, and my right not to be infected by you requires that you do the same'. By imposing some rigid and poorly conceived rules that provoke frustration and anger, our government is regrettably losing a crucial opportunity to enable all its people to embrace an ethics of good character and responsibility that could contribute to solidarity and social capital. At a higher level, achieving the 'right to health care for all' implies a societal responsibility. Despite success in ensuring equitable access to treatment for HIV/Aids, universal access to broader health-care needs and rights remains an important unfulfilled societal responsibility<sup>6</sup> with implications that extend to considerations of the global political economy.

In addition to all the above, it should be noted that a public health lens enables us to 'see' that the most powerful health-promoting forces are social. Their effect on health is exemplified by the improved living conditions and use of sanatoria during the 19th century resulting in a ten-fold reduction in mortality from tuberculosis long before effective drug treatment was developed to complete the cycle towards the potential of curing almost all patients with this disease.<sup>7</sup> It has been estimated that social forces, even in a wealthy country like Canada, account for 50% of the causal factors impeding good health. This proportion is much greater in Africa, disadvantaged by a legacy of previous exploitation<sup>8</sup> that continues through internal and external processes<sup>9</sup>.

Extension of the interpersonal health ethics discourse since the 2003 SARS epidemic, to include public health ethics, has enabled careful examination of tensions between individual rights and the common good (e.g. quarantine), as well as the evaluation of arguments about how best to balance these conflicting, but mutually valued, ethical perspectives.<sup>10</sup> Greater attention to social justice involves transparent and accountable processes for the allocation of limited health-care resources.<sup>11</sup>

A study of public health lessons from the SARS and Ebola epidemics revealed the ill-preparedness of the World Health Organization and the global community for large/sustained disease outbreaks.<sup>12</sup> Seven themes that were identified as *ethical lessons stemming from such moral failures* and requiring rectification, are also of crucial importance in South Africa. These include recognition that: health systems are fragile and need strengthening to prevent and mitigate future epidemics and pandemics; there is a need for improved surveillance/response capacities and improved communication and community engagement to build trust; effective and rapid response requires leadership at international, national and local levels; and market-based systems do not cater adequately for neglected diseases.<sup>13</sup>



The impact of both the pandemic and of governments' responses, that most profoundly affect the poor majority in our country and globally, are amplified by a multifaceted complex global/planetary crisis<sup>14</sup> within an ecological system stretched to the limits where multiple tipping points<sup>15</sup> into chaos threaten the future of us all. These insights also help to clarify what striving ethically for health means in the world in which the COVID-19 pandemic has emerged and spread so dramatically. This context<sup>16</sup> comprises a multitude of upstream crises that generate considerations of the ethics of the global political economy, international trade, development aid and the creation of crippling debts, and of cruel industrial animal farming<sup>17</sup> and wet markets with their implications for our humanity and our ecosystem. Such problems are aggravated within an energy-intensive market civilisation, driven by belief in endless economic growth, consumerism, the profit motive and free-riding on the environment, with damaging effects on health, especially in low- and middle-income countries.<sup>18</sup>

All the above should be viewed through framings<sup>19</sup> that reveal the ethical dilemmas and power relations<sup>20</sup> relevant to population health and well-being (the socio-political underpinnings<sup>21</sup> of which have previously been identified), and the need for a paradigm shift<sup>22</sup> from a competitive anthropocentric focus towards a cooperative ecological perspective on all aspects of life and health. This agenda for a 'new normal' in a post COVID-19 world could be advanced globally and locally through education and public discourse to foster widespread construction of a more collaborative concept of global health ethics as the rationale for mutual caring<sup>23</sup>, in a country and a planet in the throes of entropy<sup>24</sup>.

Innovative social action to facilitate sustainable survival<sup>25</sup> is potentially feasible, given human imagination, ingenuity, determination and global political will by those with a vision for the future.

## References

1. Johns Hopkins University. Maps: Tracking global cases [webpage on the Internet]. c2020 [updated daily; cited 2020 Jun 08]. Available from: <https://coronavirus.jhu.edu/data>
2. Labonté R, Schrecker T. The state of global health in a radically unequal world: Patterns and prospects. In: Benatar S, Brock G, editors. *Global health and global health ethics*. Cambridge: Cambridge University Press; 2011. p. 24–36. <https://doi.org/10.1017/CBO9780511984792.003>
3. Packer G. We are living in a failed state. *The Atlantic*. 2020 June; Ideas [cited 2020 Jun 08]. Available from: <https://www.theatlantic.com/magazine/archive/2020/06/underlying-conditions/610261/>
4. Abdool Karim SS. The South African response to the pandemic. *N Engl J Med*. 2020;382, e95. <https://10.1056/NEJMc2014960>
5. Mayosi BM, Benatar SR. Health and health care in South Africa – 20 Years after Mandela. *N Engl J Med*. 2014;371:1344–1353. <https://10.1056/NEJMs1405012>
6. Benatar S, Gill S. Universal access to healthcare: The case of South Africa in the comparative global context of the Late Anthropocene era. *Int J Health Policy Manag*. 2020 In press. <https://10.34172/ijhpm.2020.28>
7. Benatar SR, Upshur R. Tuberculosis and poverty: What could (and should) be done? *Int J Tuberc Lung Dis*. 2010;14(10):1215–1221.
8. Caplan G. *The betrayal of Africa*. Toronto: Anansi Press; 2008.
9. Stop the bleeding campaign – Africa [webpage on the Internet]. c2015 [cited 2020 Jun 08]. Available from: <https://www.globaltaxjustice.org/en/latest/stop-bleeding-campaign-africa-2015>
10. Singer PA, Benatar SR, Bernstein M, Daar AS, Dickens BM, MacRae SK, et al. Ethics and SARS: Lessons from Toronto. *BMJ*. 2003;327:1342. <https://doi.org/10.1136/bmj.327.7427.1342>
11. Benatar SR, Ashcroft R. International perspectives on resource allocation. In: Quah SR, editor. *International encyclopedia of public health*. 2nd ed. Waltham, MA: Academic Press; 2017. p. 316–321. <https://doi.org/10.1016/B978-0-12-803678-5.00380-5>
12. Smith MJ, Upshur REG. Ebola and Learning Lessons from Moral Failures: Who Cares about Ethics? *Public Health Ethics*. 2015;8(3):305–318. <https://doi.org/10.1093/phe/phv028>
13. Haffajee RL, Mello MM. Thinking globally, acting locally — The U.S. response to Covid-19. *N Engl J Med*. 2020;382, e75. <https://10.1056/NEJMp2006740>
14. Gill SR, Benatar SR. Reflections on the political economy of planetary health. *Rev Int Polit Econ*. 2020;27(1):167–190. <https://doi.org/10.1080/09692290.2019.1607769>
15. Pearce F. As climate change worsens, a cascade of tipping points looms. *Yale Environment 360*. 2019 December 05 [cited 2020 Jun 08]. Available from: <https://e360.yale.edu/features/as-climate-changes-worsens-a-cascade-of-tipping-points-looms>
16. Benatar S, Brock G, editors. *Global health and global health ethics*. Cambridge: Cambridge University Press; 2011. <https://doi.org/10.1017/CBO9780511984792>
17. Benatar D. Our cruel treatment of animals led to the coronavirus. *The New York Times*. 2020 April 13; Opinion [cited 2020 Jun 08]. Available from: <https://www.nytimes.com/2020/04/13/opinion/animal-cruelty-coronavirus.html?referrerSource=articleShare>
18. Gill S. Globalization, market civilization and disciplinary neoliberalism. In: Hovden E, Keene E, editors. *The globalization of liberalism*. Millennium Series. London: Palgrave Macmillan; 2002. [https://doi.org/10.1057/9780230519381\\_7](https://doi.org/10.1057/9780230519381_7)
19. Pogge TW. *World poverty and human rights*. 2nd ed. Cambridge: Polity Press; 2008.
20. Benatar S, Upshur R, Gill S. Understanding the relationship between ethics, neoliberalism and power as a step towards improving the health of people and our planet. *Anthropocene Rev*. 2018;5(2):155–176. <https://doi.org/10.1177/2053019618760934>
21. Baudot J, editor. *Building a world community: Globalisation and the common good*. Copenhagen / Seattle, WA: Royal Danish Ministry of Foreign Affairs / University of Washington Press; 2001.
22. Benatar SR, Gill S, Bakker I. Making progress in global health: The need for new paradigms. *Int Affairs*. 2009;85:347–371. <https://doi.org/10.1111/j.1468-2346.2009.00797.x>
23. Benatar SR, Daar AS, Singer PA. Global health ethics: The rationale for mutual caring. *Int Affairs*. 2003;79:107–138. <http://doi.org/10.1111/1468-2346.00298>
24. Sandy MA. *The Sixth Extinction: An unnatural history*. The AAG Review of Books. 2017;5(3):159–161. <https://10.1080/2325548X.2017.1315239>
25. Bensimon CM, Benatar SR. Developing sustainability: A new metaphor for progress. *Theor Med Bioeth*. 2006;27(1):59–79. <https://10.1007/s11017-005-5754-1>