Rich people live longer and healthier lives than the poor. In the past several decades, researchers have gained increasing insight into the robust and persistent relationship between social position and health, a pattern referred to as the social gradient in health. This gradient, and the inequalities it represents, holds across all fourteen major causes of death and most forms of mental disorder, persists into the upper reaches of socioeconomic strata, and is foreshadowed by social inequalities in children’s health and development. Differences in health between advantaged and disadvantaged groups are significant and growing. For many in public health, elucidating the causes of these health inequalities constitutes the field’s signal problem; remedying them, its moral purpose.

Public action to eliminate health inequalities commonly is justified on grounds of social justice. The recent report from the World Health Organization’s Commission on the Social Determinants of Health claims that “social injustice is killing people on a grand scale.” Against this backdrop of moral clarity, moral philosophers and bioethicists have begun to analyze the grounds on which health inequalities related to socioeconomic class and race/ethnicity might be deemed unjust and to articulate the goals of social justice in public health. Considerable attention has been devoted to examining why health should be subject to principles of justice and to determining when health inequalities are unjust. Such analyses address the “distributive” demands of justice in their attempts to answer two questions that preoccupy modern conceptions of distributive justice: Which goods should be subject to justice? How much of them should everyone have?

In this article, I examine a separate demand of justice that concerns the respect owed to socially disadvantaged groups and communities targeted by public health research and action for health promotion. Although some theories of justice incorporate respect for persons among their distributive goals or interpret distributive justice as an expression of equal respect, critics question whether distributive theories can secure this nonmaterial good. They argue that such theories neglect the social relations and institutional processes by which redistribution occurs and, in doing so, reproduce and reinforce the marginalized status of nondominant groups. Justice must, these critics contend, be concerned not only with distributing goods but also, and more fundamentally, ending relations of domination and establishing relations of equality.

This critique of distributive justice has particular salience for those engaged in the pursuit of a more equitable distribution of health. I explain why in the first section of the article, in which I show how redistributive policies to reduce health inequalities can reinforce nondominant groups’ subordinate status, inflicting...
what political philosopher Nancy Fraser calls harms of “misrecognition.” These harms, I argue, reveal a conflict between the distributive and the recognitional goals of justice. If this analysis is correct, it raises the question of how theories of social justice used to guide collective action to reduce health inequalities (a distributive goal) can also secure the respect and recognition owed to nondominant groups (a recognitional goal). I take up this question in the second section of the article, using Madison Powers and Ruth Faden’s theory of social justice, which I interpret as establishing a norm of “equal recognition” that safeguards against misrecognition. But, I argue, this norm needs further specification in order to make explicit the terms of inclusion of nondominant groups in the project of health equity, which I refer to as a requirement for participatory parity in health. I examine the meaning of this more fully specified norm in the third section of the article and point to promising models and movements in public health that illustrate what participatory parity in health might look like on the ground.

Health Equity and Harms of Misrecognition

The elimination, indeed even the reduction, of health inequities poses a significant policy challenge. As many have observed, initiatives to improve population health often produce or reproduce existing inequities in health. Health initiatives that rely on individual initiative and resources are the most likely to (re)produce health disparities because they leave intact entrenched socioeconomic inequalities. Take, for example, health education campaigns, which benefit individuals only when and if they become aware of and act on health-related information and are supported in changing their behavior. Similarly, biomedical advances typically benefit individuals only when and if they become aware of and have the resources to act on them by seeking medical advice and treatment.

In such cases, Link and Phelan explain, socioeconomic status functions as a “fundamental cause” of health inequalities, because resources such as money, knowledge, power, prestige, and social support work to the health advantage of better-off groups, even as risk and protective factors change dramatically from one historical period to the next. Socioeconomic resources exert their influence in two ways. At the behavioral level, these resources influence “whether individuals are aware of, have access to, can afford, and are supported in their efforts to engage in health-enhancing behaviors.” At the contextual level, these resources influence “access to broad contexts such as neighborhoods, social networks, and occupations that vary in their associated profiles of risk and protective factors.” For example, wealthier neighborhoods are better protected from criminal activity and noise, and occupations that require higher levels of education are typically safer, more stable, and accompanied by benefits such as healthcare and paid time off, workplace flexibility, and autonomy.

Health Equity

Improving the health of disadvantaged groups, then, requires population-based policies and interventions that act on the contexts in which people grow up, live, work, and play. Such initiatives may improve social and environmental conditions for health (e.g., fluoridating water, establishing public smoking bans, and mandating air bags in automobile design and lead abatement in old housing stock). Or,
policies may directly improve the socioeconomic status of vulnerable populations (e.g., Social Security and living wages). These initiatives seek to make health-beneficial resources and conditions more widely available to all groups and, when possible, unavoidable, such that health benefits are conferred to all, even in the absence of individual initiative and resources.\textsuperscript{21}

Yet, even population-based interventions can (re)produce health inequities.\textsuperscript{22,23} They, like their more individualistic counterparts, tend to benefit more advantaged groups first and disproportionately because better-off groups are better situated to benefit from improved conditions. And even when health initiatives do produce health gains among disadvantaged groups, as they often eventually do, these initiatives may increase relative disparities between better- and worse-off groups. Mechanic illustrates this phenomenon with the example of U.S. infant mortality. In 1950, black infant mortality was 64 percent higher than white infant mortality, with 43.9 deaths per thousand compared to a white rate of 26.8. By 1998 black infant mortality was 130 percent higher, with 13.8 deaths per thousand compared to a white rate of 6.0.\textsuperscript{24} Both groups made significant absolute health gains, but whites gained more.

In response, policy leaders often recommend an additional strategy that targets the particular needs and circumstances of disadvantaged groups.\textsuperscript{25} The goal is to tailor or “translate” population-based approaches into interventions that can better reach and impact disadvantaged groups.\textsuperscript{26} Link and Phelan describe the strategy as “contextualizing risk and protective factors,” such that the life circumstances and conditions that create barriers to behavioral change are eliminated.\textsuperscript{27} As an example of such an approach, interventions to reduce obesity would reduce the cost of and increase the availability of healthy foods, reduce the oversaturation and excessive advertising of fast food outlets in disadvantaged neighborhoods, improve access to safe and convenient places to exercise, and so on. Targeted interventions take a variety of forms but typically involve robust outreach programs and the provision of services and resources. As already noted, these interventions are deemed essential to the pursuit of health equity. “Health promotion efforts that are not targeted at the poor are likely to increase [socioeconomic] disparities, because they are used more readily by those with more resources to act on the information.”\textsuperscript{28}

Harms of Misrecognition

The call to target disadvantaged groups seeks to correct what many (including this author) view as an injustice—deep inequalities in health and the social determinants thereof. Yet, targeting disadvantaged groups risks inflicting an injustice of another sort—what political philosopher Nancy Fraser calls “misrecognition.”\textsuperscript{29} Fraser describes misrecognition as a form of disrespect expressed by “institutionalized patterns of cultural value” that create relations of subordination. Subordinated groups are treated as “inferior, excluded, wholly other, or simply invisible”\textsuperscript{30} and may be subject to shaming, demeaning stereotypes, harassment, assault and violence, and exclusion from deliberative forums and participation in public life.\textsuperscript{31} Misrecognition constitutes an injustice, Fraser argues, because it denies people the opportunity to interact and to engage as peers in social life.

My claim is not that agents of public health intend such harms. Rather, it is that the policy and practice of targeting disadvantaged groups takes place within and
is itself a part of a broader context of social relations and institutional processes that subordinate nondominant groups either by (1) heightening conceptions of them as deviant, thus denying their common humanity, or (2) imposing on them expectations of assimilation, thus denying their distinctive life experiences, traditions, and histories. Targeted policies risk reinforcing views of nondominant groups as deviant in two respects. The first relates to the meaning and value of health. Health in the modern era is seen as an achievement—"something people are supposed to work at." Add to this the fact that poor health habits and attributes such as smoking and obesity are stigmatized and despised. Against the backdrop of these social norms, disadvantaged groups' disproportionate incidence of poor health and unhealthy behaviors subjects them not only to (well-intended) targeting but also to scrutiny, blame, and disapproval. The ethical risk is that health will be viewed as just one more thing that “these people” have failed to achieve.

The second way in which the perception of deviance may be reinforced relates to the provision of additional resources and services. Targeted resources and services subject these groups to public resentment and hostility. The public provision of targeted resources, like any form of welfare, risks casting recipients as helpless or as “scroungers.” Moreover, the provision of resources and services, particularly when state funded, often also subjects these groups to demeaning intrusions into or the elimination of personal choices. Current policy debates over whether to prohibit welfare recipients from using food stamps to purchase soda (in an effort to reduce obesity in this population) are a case in point.

A second form of misrecognition occurs when dominant groups impose their values and expectations on nondominant groups. The most basic illustration of this is that health initiatives assume the preeminence of health as a value and a priority. Yet, health may or may not figure prominently among these groups’ values. This incongruity is suggested, for example, in studies of smoking, which indicate that for some groups of men it plays an important role in reinforcing ideals of masculinity. Other examples easily come to mind: culinary traditions may carry important cultural meaning that trumps health risks, corpulent body images may signal health and abundance, long work hours and unpaid domestic responsibilities may preclude relaxation and exercise, and so on. Health initiatives may serve and be experienced as tools of assimilation rather than as (welcomed) opportunities to improve their health.

Misrecognition in the form of ascribed similarity also can occur when researchers assume alignment between their and the targeted population’s assessments of barriers to health. Yet, researchers’ interpretations of barriers often differ from those of the targeted group. A study examining barriers to physical activity, for example, in which researchers hypothesized the salience of recreational facilities found instead that low-income urban women ranked physical security, street and sidewalk lighting and cleanliness, and gang violence as more important. Health research that fails to investigate and learn how community members view the problem fails to acknowledge their lived experience, renders them silent, and, in doing so, risks overlooking the real barriers to health.

The upshot is that such research actually may perpetuate health inequalities through the following chain of likely events. Interventions that fail to remedy barriers to health relevant to targeted groups are unlikely to yield improvements in their health. When public investments to improve the health of vulnerable
groups repeatedly fail, the results are, for reasons already described, likely to be blamed on poor people, not poor research and intervention design. This result reinforces the view that poor health and bad habits are the province of the poor and mark the disadvantaged as “inherently deficient . . . always needing more and more.”39 This perception can entrench or exacerbate stigmatization, discrimination, and social exclusion of these groups, all of which contribute to health disparities.40

This is not an argument against the pursuit of health equity. It is an illustration of critics’ concerns, noted in the introduction, that the pursuit of a fair distribution of goods may instead demean, marginalize, and oppress nondominant groups. It also raises a question about how a theory of social justice might guide the pursuit of a more equitable distribution of health (a distributive goal) while also securing the respect owed to minority and marginalized communities and groups (a recognitional goal). In the next section, I use Madison Powers and Ruth Faden’s theory of social justice, one of the best ethical resources currently available to agents of health equity, to examine the question.

Redistribution and Recognition in Public Health

Powers and Faden’s account of social justice is especially well suited for this investigation. Although theirs is a general theory of social justice, they take particular interest in its application to the health arena and to health inequalities. They argue that the moral foundation of public health is social justice, not a general obligation of beneficence to promote human health as is often (implicitly) assumed.41 Their account seeks to secure for all persons a sufficient level of the essential dimensions of well-being, which they identify as health, personal security, reasoning, respect, attachment, and self-determination.42 In addition, their criteria for determining what constitutes a “sufficient” level of well-being depend in an important way on whether social groups are subject to oppression and subordination. They characterize oppression and subordination as forms of domination that generate “systematic patterns of disadvantage,” which act as structural barriers to human well-being. Thus, they argue, social groups subject to systematic patterns of disadvantage are likely to suffer insufficiencies in well-being.43

But perhaps what makes their theory most apt for the current investigation is its view of justice as “an inherently remedial task,” one that must be responsive to constantly changing impediments to human well-being. “In a nonideal world, questions of justice emerge from the operation of the totality of social institutions, practices, and policies that both independently and in combination have the potential for profound and pervasive impact on human well-being.”44 Together these commitments suggest a theory that demands vigilant attention to shifting dynamics, including unanticipated ones, such as the possibility that (otherwise laudable) public health policies to remedy health inequities might instead reinforce the marginalized status of nondominant groups and perpetuate health inequities.

What resources does their theory possess to protect against such harms? The most important resource is their account of respect, one of the six essential dimensions of well-being that justice must secure. Powers and Faden designate respect as an explicit goal of justice, define it in terms that would identify misrecognition (as I have described it) as an injustice, and attribute special moral status to it. Respect
refers to the requirement to see others as a source of equal moral worth and to understand oneself as the moral equal of others. They refer to this as “recognition respect.” Recognition respect is flouted when people are oppressed or discriminated against on the basis of their skin color, gender, sexual orientation, class, and so on. To clarify the meaning of recognition respect, they distinguish it from appraisal respect, which refers to respect based on personal and social merit and achievement. In contrast, recognition respect “is owed to each of us as agents entitled to treatment worthy of members of the moral community.” The special status of recognition respect is built into Powers and Faden’s interpretation of what constitutes a sufficient level of it. Respect on their view is so essential to human flourishing that sufficiency in its case demands equality. For health and other dimensions, inequalities may be permissible. But, “respect has its value for any individual or group of individuals only when the social conditions that promote and sustain it are equal for all.”

The special moral status of recognition respect suggests, then, that in cases in which public health activity to improve the health of disadvantaged groups is suspected or shown to reinforce their subordination, presumably such activity would be deemed ethically impermissible. Powers and Faden themselves suggest this, saying that at the very least justice requires that “public health policies do not exacerbate [systematic disadvantage].” They illustrate this commitment when describing their own ethical assessment of a program that targeted poor pregnant women with HIV for treatment, which they and their colleagues rejected as morally impermissible because it would have heightened the disrespect and stigma these women suffered. They refer to such concerns as “nondistributional” considerations of justice, a description that supports some theorists’ contention that the recognition goals of justice must be separate from the distributive goals or must somehow otherwise be distinguished within a theory of justice.

If my interpretation of their account of recognition respect is correct, their theory provides considerable protection against harms of misrecognition. In effect, it establishes a norm of equal recognition that places ethical limits on the pursuit of health promotion and the reduction of health disparities. When collective action to achieve a fairer distribution of health and the social determinants thereof jeopardizes equal recognition, it would be deemed morally suspect if not impermissible. This interpretation raises a theoretical question of whether the essential dimensions of well-being are, in effect, lexically ordered, with priority assigned to recognition respect. This is not how Powers and Faden depict the matter. Yet, it is a plausible interpretation that seems compatible with the centrality accorded in their theory to ending relations of domination and oppression and securing equal respect for all persons.

For all of the protection their theory provides against harms of misrecognition (at least as I have interpreted it), I believe their account of equal recognition could be strengthened. The demand for equal recognition tells us that public health research and policy should be evaluated for potential harms of misrecognition. It tells us nothing about who should be involved in that evaluative process. In the absence of such guidance, the task is likely to be carried out by experts in the science and ethics of public health. Such experts may be vigilant and attentive in their moral assessments of proposed research and policy. They also may be well positioned to discredit harmful policies and stop them from being implemented.

But experts should not be the only participants in this process. The voices of the groups and communities targeted by research and action must also be included, because, as I have argued previously, leaving them out risks inflicting...
harm of misrecognition and perpetuating health disparities. Powers and Faden seem to agree up to a point: they say that the “voices and perspectives of those whose life experiences reflect the cumulative weight of multiple disadvantages” should be heard, but only when working out their theory’s implications in “concrete situations.” I would suggest, on the contrary, that those voices must be incorporated into the bedrock of any theory of justice fundamentally concerned with ending relations of domination and establishing relations of equality. One way to do this is to expand the meaning and requirements of equal recognition. Drawing on ideas advanced by political philosophers such as Fraser and Elizabeth Anderson, I propose that the norm of equal recognition be expanded to include the norm of participatory parity, which I frame in the following as a requirement for participatory parity in health.

Equal Recognition and Participatory Parity in Health

According to Fraser the goal of participatory parity is to ensure that all (adult) members of society can interact with one another as equal peers in public life. Participatory parity aims to preclude systematic discrimination, stigmatization, and social exclusion and to promote respectful interaction, reciprocal engagement, and equal opportunity for participation in social life. Similarly, Anderson prescribes a social order in which persons “stand in relations of equality,” where all are entitled to participate and to be heard and others have an obligation to listen and respond respectfully.

The Norm of Participatory Parity in Health

These commitments inform the norm of participatory parity in health in two ways. First, participatory parity in health has democratic intentions. It is concerned with the voices and decisionmaking power of nondominant groups. To that end, it requires the institutionalization of policies and practices that create opportunities for members of nondominant groups to participate in a meaningful way in the processes of public health research and action. Members of these communities are to be seen as agents, not simply recipients, of public health action. As agents, they have the potential to act as and be seen as effective, deliberative, and creative resources for social change, not simply victims or sources of pathology.

Second, participatory parity in health has transformative intentions. Transformative action seeks to remake the underlying social structures and processes that generate harms. As I have shown, those structures and processes should include the standard policy of targeting disadvantaged groups for health promotion. Transformed policy and practices would require that these targeted groups be involved upstream, engaged not only in evaluating already-formulated interventions for their appropriateness, acceptability, and potential harms but also in designing research and interventions. Members of these communities are to be seen as peers in the health equity enterprise. As peers, they are engaged in the formulation of the goals of public health research and policy.

The Practice of Participatory Parity in Health

Participation in health is not a novel idea, and in some places and by some measures participation has been institutionalized as a norm and a practice in
health and development contexts. The 1978 Declaration of Alma-Ata, sponsored by the World Health Organization, formalized the idea of participation as a “right and duty” of the people to be involved in planning and addressing their health needs.60 Nongovernment organizations working in developing countries, the World Bank, and many others heartily endorse community participation in health.61 The 2008 report from WHO’s Commission on the Social Determinants of Health includes participation as an essential element of health equity.62

In the United States, the American Public Health Association’s Code of Ethics includes a provision to work for the empowerment of disenfranchised groups.63 A review of moral considerations integral to U.S. public health includes public participation as a requirement of procedural justice.64 In addition, interest in community-based participation in health research has been growing markedly over the last 15 years. Philanthropies and the government via the Centers for Disease Control and the National Institutes of Health have created training and grant programs to support community-based participatory research (CBPR).65 A 2002 Institute of Medicine study included CBPR among eight new areas of training that public health professionals should receive.66

There is no question that participation in health has widespread appeal and acceptance as a principle of public health research and action. But whether such declarations, programs, and activities embody a commitment to participatory parity in health is a separate question, the answer to which turns on how participation is defined and what it looks like on the ground. The term “participation” is used in a variety of ways, not all of which capture the democratic or transformative intentions of participatory parity. Morgan describes a “definitional divide” that distinguishes between participation as a means to achieve project goals efficiently and effectively and participation as an end to empower the community to define the problem and create a locally controlled process to address it.67 The former adopts a utilitarian perspective wherein improved efficiency and effectiveness may be achieved via community collaboration with programs that are developed externally; the latter adopts an empowerment perspective focused on people-centered community development and social change.

Efficiency and effectiveness are important values in public policy and should always be welcomed. But participatory parity in health is about agency and shared power. It expresses a deep belief in people’s ability to assess their strengths and needs, express their views, set priorities, and act on them.68 An example of what participatory parity might look like in action took place in Bolivar County, Mississippi, during the late 1960s and 1970s against the backdrop of the civil rights movement and the U.S. war on poverty. The Tufts-Delta Health Center explicitly sought to be “an instrument of community development and social change.”69 In addition to medical and health education services and environmental programs to improve sanitation, water supplies, and housing, the Tufts-Delta Health Center had a community empowerment program that, through the creation of local health associations and the North Bolivar County Health Council, addressed financing and mortgages, education, transportation, and nutrition. The community identified these needs and in many cases ran the programs.

The Tufts-Delta Health Center approach was modeled on a pioneering South African program that invested in training, educating, and employing local residents and in these ways (among others) acted on the social determinants of health.70 Other examples abroad include the Comprehensive Rural Health Project
in India, which served as an inspiration for the 1978 International Conference on Primary Care at Alma Alta, out of which came the declaration noted previously. Unfortunately, in the United States, community health centers, of which Tufts-Delta was a groundbreaking model, have in the last three decades largely retreated to providing more traditional medical and public health services, although exceptions exist. The movement toward CBPR in U.S. public health research, however, reflects many of these same commitments, stressing collaboration with community members, equitable involvement in and shared control over all phases of research, mutual learning among partners, local capacity building, and social change.

These examples illustrate what participatory parity in health might look like in practice. No doubt, other possibilities exist. Participatory parity might look different in different communities and for different sorts of health problems and opportunities. The task of figuring out what sort of practices might fulfill this normative standard will need to be worked out through continued experimentation with participatory processes and dialogue and debate. This experimentation and debate will need to address other complex challenges, such as determining who exactly should be involved in participatory processes. I have not addressed very difficult questions about who represents any particular disadvantaged group. Such complexities do not, in my view, undermine the norm of participatory parity. Rather they simply demonstrate that the norm requires further elaboration, clarification, and specification. Much work lies ahead for theorists, practitioners, and the communities with whom they work.

Conclusion

In this article I have argued that the pursuit of a fair distribution of goods, in this case health and the social determinants thereof, must be constrained by a demand for equal recognition. Social justice requires it. To that end, I have argued for an account of equal recognition that makes explicit the terms of inclusion of non-dominant groups in the project of health equity. This norm of participatory parity in health creates an obligation to engage communities and groups in discussion and deliberation about the goals of public health research and policy and to involve them in the work itself.

This call for participatory parity may be subject to any number of objections. Some may object that a requirement for participatory parity in health places an unrealistic demand on agents of public health, perhaps noting challenges related to funding structures or reward structures within academic institutions. Others may object on the grounds that not all health challenges lend themselves to community participation. A very different sort of objection may issue from agents of public health who may wonder why an ethical argument for community participation needs to be made at all, because (as I have pointed out) community participation has long been viewed as a principle of public health and development action.

To the first category of critics, I would suggest that funding and reward structures need to be realigned so as to support participation and that clarifying and specifying the moral grounds for participation can help make the case for such change. To those who suggest that participation may be inappropriate under some circumstances, I would acknowledge the point. It might be that the...
urgent or lethal nature of some health threats precludes participatory parity. Still, it is worth noting that robust participatory methods sometimes can be done in advance, as a part of planning for health threats, as has been case for pandemic flu planning. To the last category of critics I would say that although community participation has long been acknowledged as principle and value of public health and development, it has not always been enacted or enacted in a way that demonstrates equal respect for those groups subject to targeting. As others have noted, attempts to engage the community may be carried out in ways that alienate and breed distrust among nondominant groups.76

Indeed, such examples underscore the importance of being very clear about why it is a moral imperative to engage disadvantaged groups in the broader project of health promotion and health equity. Participatory parity is necessary not only because it may improve the efficacy of health interventions for disadvantaged groups. Participatory parity can also begin to alter in a fundamental way how these groups are to be seen and treated—not as an undifferentiated “aggregation of the sick or potentially sick”77 or as a “population” on which to act.78 Rather, they should be seen as agents of change and peers in the health equity project. Their insights and stories must be heard if we are to make progress on social justice together.

Notes

24. See note 17, Mechanic 2002, at 50.
27. See note 21, Link, Phelan 2005, at 80.
29. See note 13, Fraser, Honneth 2003.
30. See note 13, Fraser, Honneth 2003, at 29.
31. See note 13, Fraser, Honneth 2003, at 18.
32. See note 13, Fraser, Honneth 2003, at 36.
34. See note 13, Fraser, Honneth 2003, at 65.
39. See note 13, Fraser, Honneth 2003, at 77.
41. See note 9, Powers, Faden 2006, at chapter 4.
42. See note 9, Powers, Faden 2006, at chapter 2
43. See note 9, Powers, Faden 2006, at 73.
44. See note 9, Powers, Faden 2006, at 5.
45. See note 9, Powers, Faden 2006, at 22.
46. See note 9, Powers, Faden 2006, at 23.
47. See note 9, Powers, Faden 2006, at 63.
49. See note 9, Powers, Faden 2006, at 23.
50. See note 9, Powers, Faden 2006, at viii.
51. See note 13, Fraser, Honneth 2003.
52. See note 14, Young 1990.
54. See note 9, Powers, Faden 2006, at 79.
55. See note 13, Fraser, Honneth 2003, at 36.
58. See note 13, Fraser, Honneth 2003, at 74.
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69. See note 57, Geiger 2002, at 1714.
72. See note 57, Geiger 2002, at 1716.
73. For example, see Codman Square Health Center in Dorchester/Boston, available at http://www.codman.org (last accessed 25 Jan 2011).
76. See note 68, Minkler, Pies 1997.
Fair Enough? Inviting Inequities in State Health Benefits
Jennifer Prah Ruger, Ph.D.

The Obama administration scored a political point in December with its bulletin on essential health benefits, appeasing critics of the Affordable Care Act (ACA) by giving states the right to determine what those benefits should be.1 The proposal is politically savvy. But is it fair?

The ACA stipulation that certain essential health benefits must be offered by health plans participating in the new state insurance exchanges is a huge step toward a more fair and equitable health care system. The 30 million uninsured Americans who have had limited or no access to care will be guaranteed at least some health care; for some, this could mean seeing a doctor for the first time in years.

Now, the policy outlined by the secretary of health and human services (HHS) gives states considerable flexibility in selecting benchmark plans to which all other health plans in that state must be “substantially equal.” Health plans will be allowed to change the makeup of specific benefits and set their own quantitative limits. So, for example, the number of psychologist visits permitted to a patient with depression or the number of hospital days provided after surgery can vary according to state. Some states may be more generous than others, and where one lives will be a key determinant of the benefits one receives. Moreover, the Department of Health and Human Services is “considering whether to allow substitution across the benefit categories,” which would mean that some “important services or benefits in particular categories” could be eliminated altogether. Thus, there will be no uniform standard for the quantity or quality of health care that must be provided.

But what if this policy means shoddy health care for some patients and top-of-the-line health care for others — a two-tiered system? And what if variations in quality lead to disability, dysfunction, complications, or premature death? Quite different outcomes can be achieved in a person with full access to high-quality health care and one who lacks such access, even if the two have the same health condition. Hypertension, for instance, affects almost 20% of the U.S. population, yet millions of Americans have
undiagnosed hypertension, and only 58% of patients receive appropriate treatment. And research shows that less than 3% of postmenopausal women with distal radial fractures received bone-density testing, and less than 25% received osteoporosis treatment within 6 months after their fracture occurred. Such gaps in care increase the risk of poor health outcomes.

Moreover, a state-by-state approach carries potential for discrimination against patients with rare, severe, or costly health conditions. Refsum’s disease, for instance, which is caused by a lack of the enzyme that breaks down phytanic acid, leads to skin disorders, loss of the sense of smell, night blindness, deafness, and heartbeat abnormalities that may result in sudden death. Neurologic, ophthalmologic, dermatologic, and generalist care are necessary for its diagnosis and evaluation. Treatment involves lifelong adherence to a strict special diet and close monitoring by clinicians; plasmapheresis and cochlear implants may be needed. Functioning and even survival could be compromised by a lack of access to high-quality care. Yet patients’ ability to obtain such care when they need it will probably vary according to state. Currently, a Medicaid patient in Mississippi, for example, is permitted only 12 physician visits per year, whereas a Medicaid patient in New York has “beneficiary-specific utilization thresholds” that are based on age, sex, clinical diagnosis, prescription drugs, and procedures. Although a uniform national benefits package might also omit rare or costly health conditions, it would at least avoid the troubling arbitrariness of state-based variation in coverage. And if it proved wanting, correcting one national package to ensure comprehensive coverage of high-quality services would be more efficient than attempting to revise dozens of different state plans.

I believe that the HHS proposal reflects an inadequate view of equality. A better approach would be to establish uniform standards so that all Americans would have access to the same high-quality goods and services. Such a policy could mean the difference between life and death, and it has been well tested and long debated. Indeed, this solution is grounded in the Aristotelian principles of vertical and horizontal equity. Vertical equity calls for different quantities and intensities of goods and services for persons with different needs. For example, patients with conjunctivitis and those with glaucoma need different treatments to restore normal ocular function. Horizontal equity demands that persons with the same needs receive the same treatment. Providing such persons disparate care — as might well happen under the flexible system established by HHS — represents horizontal inequity.

Those who object to the uniform-standards solution will counter that it ideally and naively seeks, as measures of fairness, the same health outcomes and the same amounts of care for everyone. In fact, however, it is based on the principle of proportionality — the notion that similar cases should be treated similarly and different cases differently, in proportion to their differences. Medical cases in which the health needs are the same are deemed alike; those in which the health needs are different are considered unalike. Such a solution would also require that health care be provided in keeping with medical necessity and medical appropriateness and that patients and their doctors — not state insurance exchanges, state governments, or private health plans — be the ones to make such assessments, within the scope of national standards.

Persons with the same health condition may require different amounts of care because of differences in severity or in their ability to improve their health with the available resources. Two patients may both have diverticular disease, for example, but one may simply have diverticulosis, which may be treatable with a dietary change or mild pain medication, while the other has diverticulitis, which might require surgery and colon resection. The principle of equal access I propose would call for differential provision of health care resources to achieve the same desired outcome for both patients — giving each what he or she needs to reach a medically determined level of functional health.

There is no perfect health care system. But setting a goal of equal access to high-quality, evidence-based care would be a step in the right direction. Unceasing effort to standardize comprehensive health coverage and reach a gold standard of care is essential to attaining this goal.

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Shared Health Governance
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Shared Health Governance

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Health and Social Justice (Ruger 2009a) advances a series of goals for domestic societies. It envisions societies in which all people can realize central health capabilities—to avoid premature death and escapable morbidity. While no society can guarantee good health, societies can, if they will, create the conditions—effective institutions, social systems, and practices—to support all members as they seek to achieve these central health capabilities.

This article continues this journey by considering who is responsible for various aspects of these social objectives and how societies might make this vision a reality. Societies differ significantly in the way in which they make decisions and take actions regarding health and health care. Some see governments as primarily responsible, setting up centralized national health systems. Others emphasize personal responsibility, relying heavily on the free market and individual choice, as in the United States and most developing countries. Scholarly discourse maps these trends, ranging from collective to individual responsibility, but the focus has tended to be more general than health care specific.

In health care particularly, efforts toward responsibility assessment and assignment tend to be ad hoc, judging the ethical behavior of individuals and particular institutions like managed care organizations, for-profit hospitals, or the medical profession (Wikler 2002; Buchanan 2009). This narrow approach diverts attention from the harder problem, mapping the interdependent and shifting roles of different actors in fostering health at both individual and societal levels. Individual and population health require shared responsibility, individual and collective. Social cooperation is essential.

Economic cooperation theory offers both noncooperative game theory and more cooperative game theory approaches, but in both, narrow self-interest is a chief motivation. Some have sought to merge the study of game theory with that of ethics. These efforts, however, have focused primarily on formalizing social contract theory and demonstrating the rationality of acting morally in accord with particular principles agreed upon through bargaining or negotiation (Gauthier 1986). The underlying premise here is still primarily narrow self-interest. Few applications of economic game and social contract theories in health and health care exist and focus on distributing societal responsibility and benefits for the wider common good and individual good simultaneously. Also, a growing body of research “eschews a narrow conception of rationality” altogether (Levitt and List 2008, 909).

This article takes a broad view of health governance. To create conditions in which all have the ability to be healthy, the shared health governance (SHG) model sets out allocations of responsibility, resources, and sovereignty to national and state governments and institutions, nongovernmental organizations (NGOs), the private sector, communities, families, and individuals themselves. In this view of health governance, ethical commitments are fundamental, in conjunction with institutions and policies. SHG focuses on the alignment between the common good and self-interest: It seeks societal conditions to achieve common and individual goods concurrently.

Shared health governance is a more normatively appealing and effective approach to governing health domestically as compared to existing alternatives. It asserts that as a society we’re all responsible for doing our fair share to seek health justice. Because health production at the individual and population levels demands resources and public environments that are beyond any one individual’s or group’s
ability to provide, it necessitates shared resources that are distributed fairly and efficiently. Because generating and distributing resources fairly and efficiently require the attention of us all—individuals, groups and institutions—we are all responsible for steering such efforts. While the government may assume the role of redistribution, regulation, and oversight, we all must govern ourselves to ensure wise use of scarce resources.

Health and health care decision making calls for input from both experts (e.g., medical professionals) and laypersons (e.g., patients). Thus SHG involves shared sovereignty—inclusive decision making and shared authority. But the corollary to this privilege is the obligation to make wise health decisions and take prudent health actions both for oneself and for society.

Mutual collective accountability is the coin of the realm in the SHG framework. Thus, consensus and congruence on values and goals are important among government, health providers, groups, and individuals, as is a shared understanding of objectives.

Finally, SHG recognizes that while regulations and laws are of great consequence to social cooperation, alone they are not enough; although monitoring is important, no government agency can micromanage and police everyone in every situation. Thus, SHG relies on a specific type of social norm—a public moral norm—and its correlative social sanctions as a motivation and authoritative standard for action. Internalized public moral norms convey society’s shared values and goals and are important to making shared health governance a reality.

THEORIES OF COOPERATION

An alternative model of social cooperation must situate itself within the contours of existing work in cooperation theory. Although an exhaustive review of the literature is beyond this article’s scope, most economic theories of cooperation, whether noncooperative or cooperative, rest on the premise of Homo economicus, that cooperation or lack thereof involves strategic interactions among self-interested and rational individuals (e.g., individual utility or payoff maximizing).

Economic noncooperative game theory (NCGT) is unappealing for social cooperation in health even though it does not preclude cooperation. In NCGT, each player makes unilateral decisions driven by self-interest; cooperation must be self-enforcing—achieved and maintained only if each player cannot do better on her or his own. The Prisoner’s Dilemma (PD) is a classic example. In the one-shot PD game, each player maximizes her own payoff according to the PD payoff matrix without regard to the other player, and defection becomes the dominant strategy for each player even though cooperation between players would yield a better final outcome. In indefinitely iterated PD games, using a “tit-for-tat” strategy, players are able to punish each other for defection in previous rounds, reputation matters, and there is a tendency toward cooperation.

There are contrasts between NCGT and a cooperation model such as SHG. For one, NCGT says little about values (except maximizing one’s own utility). Second, in NCGT each player makes her own decision, so there is no mutuality or shared deliberation. Third, classic NCGT games involve two players, so coalition building and group inclusion are absent, although group games have similar results (Bowles and Gintis 2008). Fourth, under certain circumstances people have an incentive to cheat or defect from cooperation in one-time interactions or in instances when they can elude punishment, potentially leading to “a sequence of successively higher order punishments” (Fudenberg and Maskin 1986, 538).

A second class of economic cooperation theories is cooperative game theory (CGT), which also presumes self-interested rationality. CGT can describe either cooperative or competitive environments. CGT concentrates on possibilities for agreement, as well as on outcomes resulting from player cooperation in different combinations. By contrast with NCGT, CGT places greater emphasis on coalition formation and on promising and threatening behavior (Aumann 2008). Common characteristics of CGT situations are participants who can achieve benefits (such as power or money) from cooperation but who are in conflict over the division of benefits since each desires the greatest share for herself (Lemaire 1984). Participants (all or as subgroups) negotiate, bargain, and form coalitions in pursuit of gains, and will not accept less benefit than what can be attained alone. The division of group benefits ultimately depends upon the relative power of participants. Players perceived as weak or of little value to the coalition may receive few if any benefits in the final allocation scheme (Lemaire 1984; Arce M. and Sandler 2003).

Unlike SHG, the bargaining and division of benefits under CGT are based at least in part on “layers” of power and marginal contribution, which means that CGT is unlikely to meet SHG’s goals of shared sovereignty or shared resources. For example, the distribution of gains from cooperation under CGT could exclude weak, vulnerable, or marginalized groups. Unlike SHG, CGT places little or no emphasis on public moral norms; a CGT bargain holds if it serves the parties’ self-interest, not if it achieves an overarching social objective. Finally, in the CGT model there is conflict among players over the division of benefits, reflecting a lack of congruence on values and goals (except the goal of maximizing one’s own utility or gains). SHG is more closely aligned with cooperation models including other-regarding preferences and social norms (Ullmann-Margalit 1977) leading to cooperation (Bowles and Gintis 2008). Moreover, additional work on cooperation theory and empirical social science research, particularly evolutionary game theory and biology and behavioral economics (Levitt and List 2008), provides empirical evidence of the role of morality in solving recurring social problems, consistent with SHG.

A third general category of cooperation theory stems from the social contract tradition. Social contractarianism is a major model and relates to CGT and bargaining theory. However, it assumes a “fundamental connection
between rationality and morality”—“moral norms ... are rationally acceptable ... if ... there is no feasible alternative arrangement where all parties concerned would be better off” (Verbeek and Morris 2010). Under social contractarianism, individuals are mainly self-interested; they don’t necessarily have regard for others’ well-being. A reasoned pursuit of self-interest leads to moral behavior, and moral norms are based on maximizing interests jointly. Social contractarianism theories presume that the initial bargaining position is characterized by scarcity or other cause for competition, and that social interaction and cooperation can produce gains (Cudd 2008). Social contractarianism also includes an element of power, since parties to a contract must have the capacity to contribute to the product of social interaction or at the very least pose a threat to it (Hartley 2009). In this sense, social contractarianism is similar to CGT and exhibits the same differences from an SHG model in potentially leaving certain groups—the severely disabled and other weak and vulnerable groups—outside the realm of justice. The contract requires a “rationally acceptable” and “impartial” starting point and procedures (e.g., no coercion or deception) to secure social cooperation (Gauthier 1986). Under social contractarianism, then, justice is possible where all those who are able to contribute benefit from the social contract.

In Morals by Agreement, David Gauthier discusses “constrained maximization,” in which players may actually do better in many situations by eschewing “straightforward” maximization and do not maximize self-interest (utility) at every decision point, given the expectation of cooperation from others (Gauthier 1986). Rationality can encompass individual decisions deemed suboptimal at the point of action. Moral constraint on pursuing self-interest is necessary because individuals can almost always do better by cheating in cooperative activities while others keep to the bargain (Gauthier 1986).

Because social contractarianism shares many features with CGT, its contrasts with SHG are similar. Gauthier’s version, however, does introduce an element of normative constraint on “straightforward” self-interest maximization that may be conducive to larger social interests. Moreover, the element of conditioning oneself to restrain self-interest for the sake of keeping an agreement is appealing, although, like SHG’s public moral norm internalization, likely difficult to implement in practice.

Social contractualism is another idea stemming from this tradition. Under contractualism, the rationality condition takes a slightly different twist: We must respect persons, which entails that moral principles be justifiable to each person. Individuals are thus motivated by a commitment to being able to justify their actions to others, rather than by self-interest (Scanlon 1998). The principle of persons having equal moral status grounds social contractualism. Moral behavior results from agreements that bind free and equal moral agents. Comparing social contractarianism and contractualism, the former describes a society in which individuals aim to maximize self-interest in bargaining or negotiating with others, whereas under contractualism, each individual pursues her interest by means justifiable to “other persons who have their own interests to pursue” (Ashford and Mulgan 2009).

Models of contractualism vary. Kantian forms seek principles expressing freedom and equality to which every agent would rationally agree (Rawls 1971). Though Rawls’s form also seeks principles to which everyone would agree, the focus is on political principles, not necessarily moral ones, and principles of justice are chosen by self-interested agents acting behind a veil of ignorance (Rawls 1971). Thomas Scanlon’s version of contractualism bases morality on mutual respect and looks for principles that “no one can reasonably reject” (as opposed to those on which everyone would agree) under free and voluntary conditions (Scanlon 1998). Scanlon does not propose a veil of ignorance; instead, individuals account for the interest of others through their own desire to justify themselves to everyone else. Scanlon places a more stringent criterion on how we live with others: The fact that a principle negatively affects oneself is insufficient reason for rejecting it. Individuals must rather ask how that principle affects others. In an interesting twist on the Pareto principle, Scanlon argues that the true test in assessing moral principles from the agent’s point of view is not whether a principle imposes a burden on the agent, but whether the alternatives would place a heavier burden on others; if so, the agent cannot reasonably reject the principle (Scanlon 1998). Under this view, both self-interest and respect for others motivate actors, who owe it to one another to promote each other’s interests (Scanlon 1998). Thomas Nagel, among others, has criticized Scanlon’s idea of principles no one can reasonably reject as impracticable, given the conflict of values in pluralist societies (Nagel 1991).

Contractualism actually shares some SHG elements. Like SHG, it requires individuals and groups to consider others in their moral calculations, and demands that persons promote others’ interests. Scanlon’s contractualism, in particular, rejects self-interest maximization with an emphasis on narrow individual rational agency. By focusing primarily on individuals as they relate to each other, however, contractualism, unlike SHG, does not provide adequate scope for aggregate or societal concerns. Moreover, unlike contractualism, SHG recognizes that there may be some actions that do impose greater burdens on others (e.g., requiring others to pay more for health insurance so the agent at hand has coverage) that are still justified as long as the sacrifice of others does not interfere with their own ability to ensure central health capabilities. Nor does it offer a sufficiently comprehensive approach to encompass shared sovereignty, shared responsibility, and shared resources.

A final category of social cooperation to assess in conjunction with SHG is utilitarianism. While there are many varieties of utilitarianism, some main features include grounding individuals’ moral status in happiness, desire fulfillment, and well-being, allowing interpersonal comparisons and aggregation of welfare and burdens, and an overall social goal of maximizing utility for all (aggregate utility), or in “average utilitarianism,” a goal of the highest average level of utility (e.g., Bentham 1961). Utilitarianism demands impartiality such that everyone’s utility is counted
equally in the aggregation scheme, although some have introduced equity weights to modify this requirement (e.g., Sidgwick 1907; Broome 1991).

Utilitarianism contrasts with SHG in this particular impartiality requirement because the SHG framework involves special efforts to include weak and vulnerable groups; utilitarianism does not give these groups special consideration. Moreover, the goal of maximizing overall utility does not address the distribution of utility. “Average utilitarianism” might mitigate this concern, but does not actually solve the problem of addressing those with the greatest needs. Utilitarianism, unlike SHG, lacks emphasis on individual agency or autonomy; collective interest may override individual interest. But utilitarianism does require actors to consider the impact of actions on others, because the goal is to maximize overall utility. Maximization of individual self-interest cannot be the coin of the realm; trade-offs among individuals are required, as in SHG.

SELF-INTEREST MAXIMIZATION AND SUBOPTIMAL OUTCOMES IN HEALTH AND HEALTH CARE

Self-interest (e.g., individual utility or payoff) maximization is at the heart of most theories of cooperation. From the perspective of social cooperation in health and health care, narrow self-interest maximization alone produces suboptimal results. In U.S. health care, there are examples of medical providers (doctors), drug and medical device businesses, insurance companies, and patients maximizing their own interests without internalizing system-wide effects. Geyman (2008) compiled an extensive collection of examples from the United States. Some doctors receive kickbacks from referrals, refer patients to medical facilities in which they have financial stakes, recommend and perform unnecessary procedures, and collect payments and gifts from hospitals and medical suppliers. In-depth studies of high-cost communities confirm many of these trends (Gawande 2009). Even doctors’ choice of specialties is affected by material concerns, as they avoid lower paying but crucial fields like family medicine, internal medicine, and pediatrics. Only about 10% of American medical students choose one of these fields for residency training (Pugno et al. 2005); meanwhile, 70% of the doctors in the United Kingdom and 50% in Canada are in primary care (Starfield 1994). A weak primary care base renders the U.S. system excessively specialized and inefficient (Geyman 2008).

Many for-profit entities boost profits by various means. For example, one for-profit hospital chain was found to have inflated operating room charges by more than 80% and collected fees more than 17 times that of public hospitals for blood tests (Benda 2003; Lagnado 2004). Diagnostic, screening, and imaging centers often have arrangements in which they charge discounted prices to doctors (e.g., $400 per scan, $850 per MRI), while doctors receive $2,300 from insurers for each MRI (Armstrong 2005). Such practices lead to overuse of needless services. Medical suppliers have been known to market and sell defective or unapproved medical devices. One supplier made and sold defective heart valves that caused 500 deaths. It paid civil penalties to avoid criminal charges, but then lobbied to ban future lawsuits against manufacturers of such devices (Palast 2002). Another company introduced a heart device (Prizm 2 DR) that malfunctioned in more than 33% of patients over a 19-month period, and failed to report to the U.S. Federal Drug Administration (FDA) the resulting 57 emergency surgeries and 12 deaths (Meier 2005; Finz 2003).

The FDA itself is not immune to these concerns. Many assert that its funding structure renders it vulnerable to conflict of interest. Half of the FDA’s budget for reviewing marketing applications comes from the drug industry (Willman 2000). Ten of 32 members of the FDA advisory committee deliberating Vioxx and Bextra withdrawal had conflicts of interest with drug companies (Harris and Berenson 2005). Of the 13 drugs removed from the market since 1997, at least 7 had been approved despite the objections of FDA safety reviewers (Mundy 2004).

Even the research and academic community faces concerns about integrity of research and reporting due to industry ties. For example, a 2000 New England Journal of Medicine article omitted some risks of Vioxx; all 13 authors were connected with the Vioxx maker Merck, through employment or other financial relationships (Bombardier et al. 2000). Suppression of damaging results also occurred in the case of the drug Synthroid (Rennie 1997) and a drug for thalassemia major (Baird et al. 2002).

Both providers and patients commit Medicaid and Medicare fraud. Providers bill for services not rendered, double-bill to both Medicaid/Medicare and to patients/private insurance, upcode, and use unauthorized service cards to others, deliberately receive duplicate or excessive services and/or supplies, and sell Medicaid/Medicare ID cards to others, deliberately receive duplicate or excessive services and/or supplies, and sell Medicaid/Medicare supplies to others (fraudguide.com).

Such corrosive behaviors are not unique to the American health care system. Health worker absenteeism, nepotistic hiring, medical supply theft, and corrupt procurement are significant problems in countries such as Uganda, Bosnia, Dominican Republic, Argentina, and Venezuela, just to name a few (Lewis 2006). Staffing shortages are sometimes further exacerbated by professional turf protection, where higher level professionals resist delegation of tasks to lower ones. One example is Botswana doctors resisting blood drawing by phlebotomists even in the face of staff shortage, thus hindering the scale-up of antiretroviral therapy (Swidler 2006). There are a number of structural factors contributing to these practices and they undermine health efforts and waste scarce public health resources.

The starkness of these examples does not necessarily represent universal behavior but serves to highlight the underlying importance of working within a framework of shared and individual goals simultaneously. The idea is not to deny or eliminate altogether self-interest as a human motivation; rather, it is to recognize it, align with shared goals, and create conditions (including institutions and policies that structure incentives) to reduce its...
negative, and enhance its positive, impact on health care and health.

MODELS OF GOVERNANCE

The most widely employed approach to rein in self-interest maximization in any field, including health and health care, is government regulation, although strong government is only one type of governance. This section contrasts SHG with different models of governance.

There are at least two major types of governance models: top-down, hierarchical models, and decentralized/civic participation models. Top-down, centralized, hierarchical governance is state-directed health system control, with the former Soviet Union (USSR) being a prominent and extreme example. The USSR federal Health Ministry in Moscow controlled medical education and training, health care facilities, personnel, and finances throughout the USSR, setting total health expenditures and allocating resources through annual and five-year plans. Regional and local health authorities operated under ministry budgets and rules, with little flexibility to address local needs (Roveland and Telyukov 1991). Another version of this top-down, government-mandated governance is the New Managerialist/New Public Management model. “Process-oriented” and “target-driven,” this model aims to reduce health service inefficiencies, close gaps, and reduce overlaps in services, with the goal of moving individuals “to cheaper parts” of the system (Rummery 2009, 1802). Both the centralized Soviet model and New Managerialism reflect the ideologies and goals of the center rather than local need. To different degrees, the top-down hierarchical nature of both models is contrary to SHG. Where the center dictates policies and procedures, there is little mutual collective accountability, little involvement of individuals and the community, and little effort to achieve the consensus or agreement sought by SHG and contractualist approaches. Resources are shared, but often in arbitrary and unproductive ways.

Two other examples of hierarchical governance models have been examined within the context of evolving European Union (EU) food safety regulation (Fischer 2008). One is technocratic governance, where technical experts dominate and make decisions. Politicians (nonexperts) rubber-stamp those policies since they lack the knowledge and ability to understand complicated scientific and technical issues. Public participation is unnecessary in the “production of scientific expertise” (Fischer 2008, 5). “Decisionist” governance takes the opposite approach, giving priority to political decision makers over scientific experts in the interest of clear accountability. Both these hierarchical models also run counter to SHG. While SHG respects scientific information and expertise, it differs from the technocratic model in understanding that political legitimacy involves normative reasoning and public deliberation. Political decisions are not purely scientific (Gutmann and Thompson 2002). And even scientific experts can disagree (Fischer 2008). The decisionist approach recognizes the political nature of policy decisions, but the effectiveness of strict separation between policymaking and scientific advice is questionable (Fischer 2008). SHG maintains a middle view that recognizes the essential roles both of proceduralism for public engagement and of epistemic values and standards for evaluating deliberative outcomes. While beyond this article’s scope to explore at greater length, SHG engages with elements of “epistemic proceduralism” (Estlund 2008) in its framework (Ruger 2010).

Decentralized, civic participation models of governance include quite a few variants. For example, another EU food safety regulation model is “reflexive” governance, which acknowledges that “facts are uncertain, values in dispute, stakes high and decisions urgent” (Fischer 2008, quoting Funtowicz and Ravetz 1993, 739). It seeks permanent, open lines of communication among experts, politicians, and the public, and attempts to “democratize” science by “controll[ing] scientists in expert committees” and presenting the views of laypersons (Fischer 2008, 6). This is contrary to the central role SHG gives to science; it also reflects an overly optimistic view of civil society, NGOs, and laypersons as key decision makers, ignoring the potential for laypersons to add inefficiency, irrationality, and incoherence to health policy decision making (Fischer 2008). The classic interest-group representation model is a version of civic participation, but one that underscores some undesirable features in a governance model: interest-group competition in rule-making; rulemaking based on log-rolling between agency and stakeholders; the treatment of agency officials as insiders and other stakeholders as outsiders; adversarial relationships among stakeholders; and government serving primarily as a “neutral and reactive arbiter among stakeholders” (Zabawa 2003, 379).

New localism and “local state entrepreneurialism” are additional examples of models that place heavy emphasis on civic participation. Citizens are asked to get involved in “every government directive” (Blakeley 2006, 139). These approaches may not empower citizens as much as expected. Constant citizen consultation can result in fatigue and disengagement. Citizens are pressed to work with government and the private sector, while entrenched inequalities in power and influence are not addressed; “professionalizing” citizen participation means that not all citizens are necessarily equally empowered. Participation as a governmental scheme may be a means of co-opting important citizens and “legitimizing domination,” instead of a strategy of empowerment (Blakeley 2006, 140). While new localism shares SHG’s focus on individual agency, SHG relies significantly more on the give and take between the established social order and individuals, and on an overarching framework of consensus on societal health goals. Moreover, in SHG, participation and consensus seek to recognize inequalities in power and influence.

Additional variants of decentralized, civic participation governance models exist that still differ from SHG but share some important elements. Co-governance combines “a strong state, extensive market economies, and a lively civil society” (Roiseland 2010, 140). Local governments share power and govern with actors like local businesses, civil
organizations, and neighboring cities, steering such efforts through “network management” or “metagovernance” (Roiseland 2010, 141). Like SHG, co-governance calls for collaboration among public, private, and civil actors within the public sector or within levels of government. However, co-governance lacks SHG’s emphasis on social norms, which helps hold cooperation together. Under co-governance, cooperation would be hard to maintain in difficult situations, as actors may cease cooperation if further collaboration produces no common gains. Accountability mechanisms are also weakened by the removal of decisions from elected institutions (Roiseland 2010).

Community governance and collaborative governance models both devolve governance to lower tiers of government, frequently the local and even institutional level. Under community governance, community representatives influence and specify policy, especially social welfare policy, to best serve local needs and to build capacity through youth and community consultation, local adaptation of externally specified services, and greater awareness of resource use (O’Toole et al. 2010). Collaborative governance emphasizes “problem-solving … information-sharing and deliberation among knowledgeable parties,” the “participation of interested and affected parties in all stages of the decision-making process,” and the “development of temporary rules subject to revisions” based on “continuous monitoring and evaluation” (Zabawa 2003, 378). Examples of applications of collaborative governance include the public–private partnerships to expand health coverage under the U.S. Health Insurance Flexibility and Accountability (HIFA) waiver, Seattle’s neighborhood planning program, and the U.S. Environmental Protection Agency (EPA) projects on watershed, Superfund, and environmental justice issues (Zabawa 2003; Neshkova 2010). Like SHG, collaborative governance emphasizes actors’ interdependence and accountability, with the government or a designated agency at the center. SHG, however, sees government as more than simply a “facilitator of multi-stakeholder negotiations” (Zabawa 2003, 378). It allocates more authority to government in the framework for mutual collective accountability, to enhance the legitimacy of both government and nongovernment actors. SHG also calls for a reorientation of underlying norms and motivations for authentic joint problem-solving.

The civic republican ideal envisions citizens connected in pursuit of the greater common good. One view of civic republicanism directs lawyers, for example, to identify the common good and to align their clients’ endeavors with social justice; thus, oddly, within this tradition lawyers don’t pursue only their clients’ interests. Preferences develop “di-rectly through a process of engagement and discussion among citizens” (Wendel 2001, 2000). Other versions of civic republicanism permit lawyers, as representatives of their clients, to pursue client interests, but stipulate that lawyers work toward the greater good of the system on their own time (Gordon 1988). Deliberation does not merely present extant preferences; participants must be ready to amend their preferences according to the public good. Civic republicanism emphasizes citizen deliberation and a pursuit of the public good (Wendel 2001).

Finally, another decentralized model of governance is the Boundary-Spanning Policy Regime (B-SPR), for unruly cross-sector problems primarily at the domestic national level (Jochim and May 2010). B-SPRs bridge multiple policy domains and encourage “integrative policies” by “pres-ur[ing]” actors in relevant domains to work “more or less in accord toward similar ends” (Jochim and May 2010, 307). The goal is to achieve greater policy cohesion and to make up for governance fragmentation. Examples of B-SPRs in the literature include community empowerment and pollution abatement in the 1960s and 1970s; in the 1980s and 1990s, drug criminalization, disability rights, and welfare responsibility; and in the 2000s, homeland security.

Civic republicanism, community and collaborative governance, and B-SPRs have features in common with SHG, but SHG places greater emphasis on meta-rules within a higher level structure assigning responsibility and stipulating authority for public and private actors in the joint collaboration in health, as discussed next.

**SHARED HEALTH GOVERNANCE**

The academic and policy work in social cooperation and governance helps illuminate efforts to organize collectively in health and health care. But despite progress in institutional design, many efforts have begun with a problematic orientation in health and health care: To found a theory of cooperation and governance on the “singular subject” theory of rational individualistic thinkers and actors. Entities, individuals or groups, are seen as isolated agents, even if they act collectively. On the other hand, a focus solely on the common good, overriding individual interests, is equally unsatisfactory. What’s required is the preservation of the methodological and normative importance of individuals, adding to it that of collectives as a whole.

A narrow lens cannot accommodate continual interactions of individuals and groups in a cascade of iterative and cumulative processes. Even the most basic health care example—the doctor–patient relationship—demonstrates the extensive “jointness” and “interaction” involved in health and health care. Producing an effective and efficient health system, and ultimately individual and population health, requires shared resources, shared sovereignty, and shared responsibility based on the specific functions and roles individuals and groups take on in this enterprise. Thus, rather than relying solely on individualistic rationality, SHG concentrates additionally on social rationality in an alternative view of health governance, which seeks to help us better understand how to effectuate principles of health and social justice.

The first basic premise of the SHG framework is a social scientific one: Multiple societal actors, public and private, engage in a joint enterprise that either by omission fails or by collective action succeeds in co-producing the conditions (including institutions and policies that structure incentives) for all to be healthy. SHG offers an
alternative set of fundamental assumptions for collective action in health and health care.

The second basic premise is both normative and social scientific: Approximating justice in health requires individual and group commitments to produce this social goal. A specific type of social norm—public moral norm—is put forth as an effective motivation and authoritative standard for individual and group action on health justice. Internalized public moral norms convey the shared values and goals of society and are key for SHG’s successful realization. The framework needs to work out issues related to this premise: Who frames the norms, situations of disagreement with the norms, requirements for adhering to them, and better understanding of how norms are internalized and followed and what proportion of people need follow them. Lessons from public health (e.g., vaccination) and environmental policy (e.g., recycling) are instructive here.

A third basic premise stresses that generating a shared commitment to an ideal or set of ideals can serve as the stimulus for attention and role fulfillment across governance subsystems (e.g., financing, organization, delivery of health care). The ideas constitutive of the shared commitment bind the subsystems together to achieve a common purpose. Illustrations of such ideas are found in the principles and care). The ideas constitutive of the shared commitment bind subsystems (e.g., financing, organization, delivery of health justice. Internalized public moral norms convey the shared values and goals of society and are key for SHG’s successful realization. The framework needs to work out issues related to this premise: Who frames the norms, situations of disagreement with the norms, requirements for adhering to them, and better understanding of how norms are internalized and followed and what proportion of people need follow them. Lessons from public health (e.g., vaccination) and environmental policy (e.g., recycling) are instructive here.

A fourth basic SHG premise is shared resources. Part of the social commitment to ensuring the conditions for all individuals to be healthy involves sharing individual and social resources. There are three components to this premise. The first is the commitment to contribute one’s fair share to the collective pot to fund the joint enterprise. The implementation of this principle involves progressive financing such that, on a sliding scale, wealthier individuals and groups pay a greater percentage based on the overall level of wealth. The second is on the receiving end and is the conviction that each individual is entitled to receive that person’s fair share of resources. The implementation of this principle allocates resources based, for example, on the criteria of health functioning and health agency needs. The third is the responsibility to use these shared resources wisely and parsimoniously and not to demand more than one’s fair share, based on bona fide needs as opposed to desires or preferences. We all share in the benefits that accrue to society from achieving justice in health, including a more healthy, stable, well-cared-for, productive population, as well as cost containment and reduction in disease risk. Thus, we all share in mobilizing and using the resources necessary to achieve this end.

A fifth premise comprises enforcement and social sanctions created to hold actors responsible, apportioned symmetrically according to the responsibilities attached to SHG functions and roles. While SHG includes a role for incentives and external motivation, it does not rely solely on such mechanisms and places both individual health agency and social norms (particularly public moral norms) as central to its framework. SHG recognizes that not only is it impossible to micromanage all actors’ health and health care behavior at all times, but such micromanagement may be less effective than social norm internalization. Internalized norms provide a shared authoritative standard by which individuals and groups can use their health agency to make more effective decisions for optimal individual and societal health.

A sixth premise involves shared sovereignty and constitutional commitments.

The extensive theorizing and empiricism about governance and the oscillation between ends of the central–local, expert–layperson, scientific–political, and procedural–substantive spectra demonstrate how frustratingly difficult it is to fine-tune institutional designs to get at improved health governance. And regardless of the intention to rein it in, self-interest maximization can take hold and produce suboptimal results in virtually every governance model. These models fall short of instilling a holistic sense of what is to be shared and mutual: (i) actions and goals, (ii) responsibility, (iii) resources, (iv) norms, and (v) sovereignty. An internalized and joint ethical commitment to ensure the conditions for all to be healthy undergirds SHG and serves as motivation to hold ourselves accountable for our respective roles and conduct. SHG does not deny or seek to eliminate altogether self-interest or individual “rationality”; rather, it aims to align it with shared goals through joint commitments. By jointly committing to this enterprise we accept our shared responsibility for health.

**GENERAL AND SPECIFIC DUTIES AT THE NATIONAL LEVEL: A RECAP OF HEALTH AND SOCIAL JUSTICE AND OTHER WORKS**

*Health and Social Justice* argued for a universal duty to reduce shortfall inequalities in central health capabilities as efficiently as possible and conceived of SHG as a governance model for achieving this general obligation. All individuals have obligations to each other, obligations discharged through our own actions and through public and private actors and institutions. Obligations of health justice are grounded in individuals as members of a cooperative joint venture to produce a health society. These duties involve creating and upholding conditions for all to be healthy. SHG rests on a robust sense of shared responsibility. Thus, we need public moral norm internalization and voluntary commitments to recognize and take ownership in this cooperative enterprise, ownership that applies both to our own actions and in holding institutions accountable. Political obligations follow from these duties.

In other works, this line of reasoning is taken a step further, providing a theory for assigning responsibilities among the multitudes of institutions and actors (Ruger 2009b). A theory of health justice necessitates additional principles for distributing responsibility to ground the obligations of specific actors and institutions. Principles
identified for allocating specific duties involve (i) functional and role-based requirements and (ii) voluntary commitments. Under the functional and role-based requirements principle, SHG dispenses functions and roles to those individuals and groups best situated by their positions and resources to fulfill them.

The voluntary commitments principle asserts that individuals and groups voluntarily embrace their role, share resources, and relinquish some autonomy through collective action to address health problems. This links with a consensus on a shared authoritative standard (discussed later) for specific duties so that specific actors and institutions will fulfill their obligations. In other words, specific actors and institutions intend to be bound by these obligations, with a clear understanding of what they are to do. The process of reaching consensus on specific duties in turn relates to actors internalizing public moral norms, for example, public moral norms of health equity, motivating them to act to reduce inequalities in health capabilities as efficiently as possible. Efforts to establish consensus, through for example incompletely theorized agreements, amidst pluralism, are critical (Ruger 2004; 2007).

Ethical commitments to this goal are key to motivating actors, both in sacrificing resources and autonomy and in discharging their duties. Voluntary commitments enhance individual liberty by appealing to individually agreed-upon and embraced principles. The next section discusses public moral norms as a shared authoritative standard for individual and collective behavior.

**PUBLIC MORAL NORMS AS A SHARED AUTHORITATIVE STANDARD**

The content of SHG’s social norms is an important focal point. To unpack this idea, we differentiate between public and private norms. Public, here, means applicable to the public sphere. So a public norm is a form of social norm since it applies to the social sphere, as opposed to applying only to our private spheres, but a public norm, in this view, has more political heft, concerning what we do as a society, with public resources in publicly created conditions. While it derives its content from the public and social, its internalization and application involve both public and private actors.

It is important to stress the morality of the norm. Norms of behavior can, in fact, be immoral, such as infanticide, rape, pillage, and corruption. A moral norm, by contrast, involves a deep shared conviction of its “rightness” or at the very least its lack of “wrongness.” An example is the fairness norm known as the Golden Rule, which some have argued is engrafted in human culture, having evolved with the human species (Binmore 2005). SHG therefore employs public moral norms in creating a standard for joint commitments and joint decision making. Health and Social Justice, argued, however, that not all moral norms are equally desirable for health and health care. There are even some moral norms whose fairness is debatable, such as absolutist libertarian or individualist theoretical approaches as applied to health and health care. The SHG project continues the journey embarked on in Health and Social Justice to set out for society as a public which moral ideas serve as guides and which ought to be favored or disfavored. I agree, in part, with Elizabeth Anderson in arguing that public moral norms autonomously motivate our behavior and do not necessarily require appeal to self-interest or even to the threat of social sanctions (Anderson 2000). In many individual decisions about health and health care, it will not be possible or even desirable to apply social or even emotional sanctions for enforcement—on individuals failing to comply with AIDS medication instructions, for example, or on doctors recommending treatments to patients. Rather, we require a more profound commitment to both the individual (building on self-regard as a human motivation) and the common good, an understanding that we work together as a body to create the conditions for all (including ourselves) to be healthy.

The autonomy of the normative motivation under an SHG framework is important. Willingly living out the public moral norm is important for achieving conditions for individual and population health. It is significant if we are to reach a steady state of enabling conditions. Millions of individual decisions to get vaccinated for H1N1 or to adhere to tuberculosis treatment regimens or to cover one’s mouth when one sneezes or wash one’s hands or to provide recommendations for high-quality, cost-effective care are illustrations. Internalized public moral norms also entail, like the Golden Rule, the recognition that we’re all hanging together in this enterprise: That we’re as likely to benefit from a society where all can be healthy as to contribute to it. Thus, the public moral norm incorporates interest for oneself (self-interest) in the context of society as well as interests for others. It links and aligns individual and society. While sanctions, incentives, and punishments can be helpful (e.g., in binding doctors to comply with standards for what they recommend to patients or regulating what providers can discuss with patients), without the autonomous effect of internalized norms on individuals embracing their responsibility for themselves and society, there will likely be insufficient motivation to act, and the wisdom and skills underpinning action will not develop over time. The claim is not that this type of norm is “all effective” but that it can assist in improving effectiveness. To achieve socially rational objectives we need socially informed individual judgments working at every turn.

**SOCIAL COMMITMENTS, SHARED GOALS, AND RESPECTIVE ROLES**

The third premise of SHG calls for a joint commitment among individuals and society to work together to secure the conditions for all to be healthy. Under this premise, individuals and groups will be committed to doing their fair share, including playing allocated roles, in creating these conditions. This joint or societal commitment is a key premise of the SHG framework. This feature shares the elements of self-understanding and identity with frameworks of collective agency and group membership put forward in social theory (e.g., Tuomela 1984; Gilbert 1989; Searle 1990).
The “We” in Health and Health Systems, A Nod to Plural Subject Theory

This third premise of SHG is conducive to theorization under “plural subject” theory (PST) (Gilbert 1989). PST explores the self-understanding of individuals in a group who view themselves and one another as a body of people jointly committed to a shared objective.

In the PST account, joint commitments create an external force that binds one to act or believe a certain way, counter to expected actions or beliefs absent the commitment. The joint commitment thus creates a binding rule, so to speak, that individuals follow even when the rule might conflict with short-term rational self-interest. Individuals are answerable, to others and to themselves, for violations.

The plural subjects in SHG are all of us. As plural subjects acting and in many cases working together, we create (or by omission or action fail to create) the conditions for all individuals (including ourselves) to be healthy. The PST understanding that “social groups” are “plural subjects” and that “plural subject phenomena” include “social rules and conventions, group languages, everyday agreements, collective beliefs and values, and genuinely collective emotions” (Gilbert 2003, 55) is highly relevant to SHG. Among the features stipulated by PST for joint commitments and plural subject-hood are: (i) open expression of willingness or “quasi-readiness” to do X together, where X connotes a belief or action (Gilbert 1989; Gilbert 2003); (ii) common knowledge among the plural subjects that others have expressed willingness to do X together (this constitutes an element of trust in the reciprocity of others’ behavior and is akin to the sociological notion of “consciousness of unity” (Schmitt 2003); and (iii) obligations binding plural members of the group together, such that “each party is answerable to all parties for any violation of the joint commitment” (Gilbert 2003, 49).

Under SHG, individuals need to express “readiness” to endow an individual or a group of individuals with decision-making power—forming a basic joint commitment to embrace public moral norms, for example, of health equity. Then individuals are politically obligated to uphold these decisions; political obligations flow from such commitments. SHG diverges a bit from PST, however, in the content of the moral imperative. PST does not distinguish between types of political obligations. Political obligations related to health under PST, for example, might not entail a significantly binding commitment as related to political obligations in other domains. However, under SHG, if political obligations related to health can be persuasively bolstered by moral considerations, they could entail a robust commitment as related to other types of commitments, for example, taking health functioning and health agency as central to human flourishing. An extensive discussion of these points are beyond this article’s scope; an examination of health capabilities vis-à-vis other capabilities (Ruger 2009a) and routes to consensus amidst pluralism (Ruger 2007) can be found elsewhere.

PST thus offers some intellectual resources that support an SHG view. Although PST cannot define what would constitute a fair share, nor what constitutes a reasonable definition of health justice, it can buttress the idea that individuals in a society have a political obligation to one another. This political obligation could involve supporting laws or norms that strive to foster, for example, health capabilities.

Another question is whether SHG could, at least temporarily, rely on a political obligation to inculcate certain norms and align behaviors with them. But even if individuals have a political obligation to do X, as theorized by PST, one must wonder how relevant this obligation is if individuals do not believe it to be legitimate, and if it is not enforced. The SHG framework of internalizing norms and behaviors, while more time-intensive, seems a sustainable approach. One key is the norm or set of norms emerging to be viewed as legitimate and governing.

DIVISION OF RESPONSIBILITY AND SHARED RESPONSIBILITY

SHG entails individuals taking actions to improve their own health, building on self-regard as a human motivation, as well as that of others, and encompasses duties to avoid harming others and the system as a whole. SHG parts company with the pure notion of collective belief in the sociological sense (that a belief can inhere in the social group without individuals in that group taking it on individually). Individual-level believing and thinking are a necessary part of the SHG framework, fundamental to the principle of responsibility allocation and responsibility division. SHG involves spontaneous convergence, since explicit agreements at every stage and every decision point are not possible. Specific responsibilities in the collective arrangement fall to those who, by their roles or resources, are best positioned to fulfill them.

Based on these principles, the primary responsibility for efficiently reducing shortfall inequalities in central health capabilities should be allocated to the state (federal government), because national governments have the political authority, resources, and regulatory and redistributive abilities to create health system infrastructures, including health care, public health, and other systems affecting health, like food, drug, consumer, and work safety. They are also in the best position to create and disseminate public goods necessary for sustaining central health capabilities. National duties include developing and maintaining a national health care and public health system that guarantees a universal comprehensive benefits package of medically necessary and medically appropriate goods and services, and that creates an environment that supports central health capabilities. National duties also involve delegating specific duties to specific actors based on these principles. Actors can be private or public, but SHG relies on empirical evidence as to the most cost-effective route to achieving desired ends. Actors also have a duty to inculcate norms—for example, of health equity—in their own spheres of influence.

Medical providers (the medical profession and hospitals, clinics, and other players) have duties to provide high-quality goods and services to patients as efficiently as possible. Private and public insurers have a duty to insure
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all citizens with a universal comprehensive benefits package of medically necessary and medically appropriate goods and services at the lowest possible costs. If these entities cannot fulfill this duty more efficiently than the state, then the state is to assume this duty. Empirical evidence from comparative health systems suggests that the national government is likely in the best position to insulate the population with efficiency, equity, and control over costs (e.g., Hussey and Anderson 2003; Reinhardt et al. 2004). Individuals and families have duties to promote their own health, fostered by self-interest, and we all (patients and other actors) owe each other a commitment to use our shared resources as wisely as possible. We also all share the duty to refrain from harming others and the system as a whole (e.g., through fraudulent claims or making imprudent health choices).

Finally, the state shall allocate the duties of research and education in a multistep process, first to governmental and nongovernmental institutions best positioned to make scientific decisions about such activity (e.g., the National Institutes of Health [NIH], Institute of Medicine [IOM], National Science Foundation [NSF]), and then to entities such as universities and research institutes that fulfill this duty by creating and disseminating knowledge.

SHARED RESPONSIBILITY, COLLECTIVE RESPONSIBILITY: A CAVEAT

Collective responsibility and shared responsibility have multiple meanings, and a point of clarification on their application in SHG is warranted. In SHG, individuals’ understanding of their roles leads them to take on the responsibility of doing their part successfully, pursuing specific goals to achieve together the overarching social aim. My use of “shared responsibility” thus has quite specific functional and role-based foundations and entails particular commitments, unlike broader, more existential notions of shared responsibility. In essence, my use of “shared responsibility” is a thin conception, linking explicit behavior and actions with values and attitudes to create conditions for all to be healthy. Existentialist responsibility has a more diffuse and general structure; as one scholar notes, “Even when there is seemingly nothing that one can do to prevent an evil in the world, one has a responsibility to distance oneself from that evil at the very least by not condoning it” (May 1992, 3). Under a SHG framework, actors can and must do something—they pursue their role-specific activities effectively.

Shared responsibility under SHG is thus more narrow and delimited. What SHG shares with the social existentialists, however, are two ideas: That both community membership and shared attitudes create responsibilities for all members (May 1992; Jaspers 2001; Smiley 2010), and that individuals and groups are responsible for “joint actions to which one contributes” (May 1992, 8). A change in attitude is necessary so individuals and groups see themselves as sharing responsibility for creating the conditions for all to be healthy, whether they do so by their own individual actions or those actions they share with groups and institutions. Ethical commitments to a shared goal, for example of health equity, serve as a focal point for responsibility; responsibility on the part of all parties for this joint endeavor is a basic premise for achieving the shared goal. This entails not just “group morality” but individual morality as well, preserving the methodological and normative importance of individual and adding to it that of collectives as a whole. Because SHG is designed positively to establish conditions in which all have the ability to be healthy, it differs from the traditional “motivation for responsibility” scholarship, which takes causation, blameworthiness, and guilt for harm as a point of departure. SHG is both an individual and group-based construct; both individuals and groups can have health agency, intentions, and goals.

SHARED SOVEREIGNTY AND CONSTITUTIONAL COMMITMENTS

A sixth basic feature of SHG is shared sovereignty. SHG depends on individuals and groups coming together to develop structures and procedures to make decisions, govern collectively, and set standards for self-regulation and societal regulation. While SHG brings in the overarching political economic philosophy put forth in Health and Social Justice, SHG employs a constitution of sorts to delineate the ends and means of health governance at the societal level. An SHG framework based on its own constitution will provide a structure for different institutions as they relate to each other (e.g., federal and state governments, civil society, and individuals). As a superstructure, a “health constitution” would delineate the respective actors (institutions, organizations, groups, individuals) in health governance and specify their respective duties and powers, thus allocating specific responsibilities for creating a health society. The health constitution would set the framework and procedures informed by authoritative standards and principles. Constitutional interpretation would then assess whether or not such duties have been fulfilled and whether actors are meeting their obligations to ensure conditions for all to be healthy. To date the different actors in the health system (e.g., providers and physicians, federal and state government, insurers, clinics and hospitals, and individuals themselves) have not known what their respective duties and powers are. It would be difficult and unfair to attempt to hold them accountable for unspecified responsibilities. The intent is to define effective institutional arrangements and divisions to bring about the conditions for a health society. This enterprise requires empirical research and evidence.

The health constitution is not a legal constitution, nor does it overreach in governing every aspect of society. It sets out meta-level rules for health, but it neither replaces nor competes with the legal “Constitution.” Rather, the two types of constitutionalism are complementary. The health constitution is constitutional in the sense of prescribing institutional arrangements and procedures and in assigning responsibilities and authorities to public and private actors. The principles set out in Health and Social Justice imply a correlative obligation that falls on society as a whole. As the institution that represents society at large, the
government will need to spearhead the effort to map a plan for all entities. Through the health constitution it will have the ultimate responsibility for making sure this societal obligation is met. The federal or national government has the regulatory, legislative, taxation, and distributive authority to oversee a just allocation of responsibility. The federal government has the authority and legitimacy to ensure the realization of important social goals. The health constitution specifies the obligations of different actors. It is to be consistent with and undergirded by the public moral norms discussed earlier.

EXTERNAL AND INTERNAL MOTIVATION: FAILURE TO COMMIT, POSITIVE MOTIVATION, SOCIAL SANCTIONS, AND ENFORCEMENT

The challenge is for people to commit, share resources, and agree to be held collectively responsible. Thus, individuals and groups can’t internalize just any social norm; it is a set of public moral norms. Normative principles are discussed and set forth, for example, in the health capability paradigm, which spells out the reasons for equity in health and explains why individuals and actors should see such norms as socially rational. It may very well be, for example, that many individuals, indeed most people in many societies, see health as an individual responsibility rather than a social obligation. In this case the heavy lifting is in people committing, in persuading and convincing them of the necessity of the joint enterprise. This task in many cases is possible through positive motivation (see later description). There will also be a segment of the population that resists, and, once institutions and procedures are put in place (as already described), in these cases an effective system of sanctions, formal rules, and even laws and regulation may be necessary to ensure that actors are fulfilling prescribed duties. Thus, this fifth basic premise of SHG involves primarily positive, but in some cases negative, motivation to commit to the joint enterprise. Even though numerous incentives and mechanisms of external motivation have been tried in virtually every health system worldwide, these efforts alone will not suffice to create the conditions approximating justice in health.

Drawing on what Gilbert calls “common knowledge,” the task of positive motivation is to generate common knowledge, self-understanding, and societal understanding so that individuals are clear about both the empirical evidence and the values: Individual and population health are inextricably linked, and improving our own health and that of others requires the shared commitment of us all. Health is a unique individual and social good, different from other types of private goods and requires a different magnitude of joint effort. Allowing self-interest maximization to run rampant throughout the health sector produces suboptimal outcomes for everyone. Redefining individuals’ self-understanding and institutionalizing this common knowledge underlies the SHG framework. As it stands, in many health systems, even those fully nationalized, actors see themselves as interacting with the system, either on the supply or demand side, in an individualized ad hoc capacity. What is needed is the understanding that together, we are the health business.

Still, “free rider” problems and failures to comply are omnipresent in health and health care. SHG, drawing on PST, can help address and minimize these concerns. One approach is to demonstrate dependence or co-dependence among individuals as parties to a social group. This approach appeals to the individualistic, rational side of persons and to social rationality, simultaneously, but it requires monitoring, sanctioning, and a sense of co-dependence to maintain stability (Hechter 1987).

REACTIONS AND OBJECTIONS

Reactions to the SHG model may come in a variety of forms, but I’d like to return just briefly to—and conclude with—a discussion of what SHG is not in relation to existing social phenomena.

First, SHG is not social solidarity. SHG is not nearly as communitarian and allows a more central role for individualism and self-regarding behavior. While examples of social solidarity in health systems exist—for example, in universal coverage in countries throughout the world—SHG is not just universal coverage, does not require a “common conscience” across life, and recognizes realistically that actors conflict considerably (rather than cohere) in the division of labor (Durkheim 1933). While social solidarity meets the SHG idea of shared resources, it is less focused on people governing themselves to use resources parsimoniously. Social solidarity also doesn’t emphasize individual action and individual responsibility and doesn’t embrace, to the extent in SHG, the opportunity to build a social system out of individual self- and other-regarding behavior. The Swiss and German systems, for instance, exhibit solidarity in the form of universal coverage (in Switzerland there is universal coverage and one-third of individuals receive government subsidies to purchase health insurance) (Herzlinger and Parsa-Parsi 2004), yet the Swiss system is second only to the United States in the proportion of gross domestic product (GDP) spent on health care (OECD 2004), and both Germany and Switzerland have had as much if not more health care overutilization than the United States (Weil 1994; Reinhardt 2004). Social solidarity is thus not quite enough to contain costs and use shared resources wisely, nor are occupational or interest group affiliations sufficient for solidarity in the health system; indeed, they (e.g., medical profession and health insurance industry) require greater governmental oversight. It further neglects to address many of the other elements of SHG, particularly those focused on responsibility, constitutionalism in health, and individual-level costs and benefits.

Second, SHG is not socialism. Socialist health systems are government funded and government run; the public sector controls both funding and service delivery. The United Kingdom and Cuba are examples. By contrast, one of SHG’s distinguishing features is an emphasis on individuals, private entities, and their actions, which are driven by
internalized norms promoting societal interests in addition to their own. A public system may not necessarily be inimical to SHG, though public funding and public service delivery cannot preclude active individual involvement in health decision making.

Third, SHG is not just stewardship. In a way, social solidarity and socialism can both be considered as manifestations of government stewardship: Government (with various degrees of democratic backing) decides to implement solidarity-based or socialist policies. As highly centralized and hierarchical health care systems show us, government directives and designs are not enough to ensure good health outcomes, and laws are not always sufficient to achieve health goals if popular norms oppose them. SHG would seek to address pressure points where self-interest maximization and/or social norms override government laws and projects. In Japan, for example, despite legislation to promote organ donation, rates of donation are low and have been falling since the mid-1990s. One barrier is the reluctance of family members to grant permission for organ removal from the deceased (Ishida and Toma 2004). Government action has not been able to overcome this normative opposition.

Fourth, SHG is not just enhanced autonomy, shared clinical decision making, or enlightened self-interest. SHG is more than consumer-directed medicine and the patient taking an active role in her own care with her physician or team of providers. Decisions should account for both individual and societal interests at every stage. Finally, following principles of “enlightened” self-interest or self-interest “rightly understood” (de Tocqueville 1863), while interesting in the abstract, has failed to curtail the emergence of the current dysfunctional American health care system. Relying on enlightened self-interest as a guiding principle leaves us without an overarching social objective toward which all have respective roles and responsibilities in the joint enterprise of a health society.

CONCLUSION

Achieving justice in health has eluded most nations. Economic rational choice theory based on Homo economicus, the dominant social theory of cooperation, has failed to ground an effective approach to health. Even when societies cooperate on a grand scale through national health policy and national health systems, they do so in vastly different and often inadequate ways. It is a daunting challenge to allocate responsibility, resources, and sovereignty to create conditions where all have the ability to be healthy. Some will object to SHG on the account that its conditions are too onerous and arguably implausible. Despite objections, shared health governance offers a promising new way forward.

REFERENCES


Ethics in American Health 1: Ethical Approaches to Health Policy

Jennifer Prah Ruger, PhD

I trace the evolution of ethical approaches to health policy in the United States and examine a number of critical unresolved issues pertaining to the current set of frameworks. Several themes emerge.

First, fair procedures claim more attention than substantive and procedural principles. Second, in the case of public deliberation, more focus has been placed on factors such as procedural mechanisms than on understanding how individuals and groups value different aspects of health and agree on health-related decisions.

Third, the nation needs workable frameworks to guide collective choices about valuable social ends and their trade-offs; purely procedural strategies are limited in illuminating overarching health policy and ethics questions. There is a need to integrate consequential and procedural approaches to health ethics and policy. (Am J Public Health. 2008;98:1751–1756. doi:10.2105/AJPH.2007.121343)

It is again time for a debate on health care reform in the United States. A major paradox of the American health care system is the existence of dramatic therapeutic gains alongside large discrepancies in access to quality care. The United States spends more than 14% of its gross domestic product on health care, yet more than 41 million Americans are uninsured. Efforts to achieve universal health insurance in the United States have never succeeded; the failure of the Clinton administration’s 1993–1994 health reform efforts illustrates the problem’s intractability. Explanations for policy failures typically focus on economic and political factors and the failure of different political parties and interest groups to strike a bargain on comprehensive reform.

In this article, I trace the evolution of ethical approaches to health policy and examine a number of critical unresolved issues pertaining to the current set of frameworks. In the companion to this article, I present an alternative framework, taking as its premise that an ethical vision resting on explicitly articulated values and norms is critical for health reform and that comprehensive reform requires a consensus on the public good, transcending self-interest and narrow agendas. What is needed for universal health reform is a moral vision underpinning collective action for universal coverage.

The companion article presents such a vision, offering an ethical paradigm to guide health sector reform that is part of an alternative approach to health and social justice. This paradigm calls for a reasonable consensus justified by appeal to a particular ethical vision of the good life. It envisions what I call shared health governance, in which individuals, providers, and institutions work together to enhance individuals’ health agency and create a social environment that enables all to be healthy.

**ETHICAL APPROACHES TO HEALTH POLICY**

Health policies reflect the ethical values that underlie them, yet few policy analyses have explicitly assessed these values. I examine five comprehensive, although not exhaustive, general categories of ethical strategies for addressing access, financing, benefits packages, and resource allocation. These categories form a collection of ethical approaches to health policy, each with advantages and disadvantages.

**Welfare Economic and Utilitarian Approaches**

The goal of utilitarian and welfare economic schemes is to maximize social utility or welfare; these schemes rely on economic techniques such as cost-effectiveness (CEA), cost-utility (CUA), and cost–benefit (CBA) analyses to translate costs and benefits into a cost-effectiveness or cost–benefit ratio. CUA, the primary method for evaluating health policy under a utilitarian ethic, values health status in terms of health preferences, desires, and utilities (numerical quantities representing the strength of a person’s desire for, or valuation of, an object or state of affairs). CUA’s quality-adjusted life-year index, which combines measures of quality of life and length of life, allows the utilities of different individuals and different interventions to be compared on a single quantitative scale.

CBA translates all benefits into monetary units through approaches such as cost of illness studies, in which health outcomes are assigned value via direct (medical and nonmedical expenses) and indirect (lost productivity measures) methods, and through willingness-to-pay and willingness-to-accept methodologies, which...
assess how individuals value risk reduction or acceptance (e.g., risks of disease or injury). CBA analysts also use contingent valuation surveys, in which people are asked to assign a monetary value to different outcomes, to assess valuation of various health states and associated risks.

Welfare economic techniques have notable drawbacks in their application to health policy. First, accounting for aggregate welfare without considering the distribution of benefits and burdens is problematic. CUA, CBA, and CEA tolerate significant inequalities while increasing total or average social utility. Although there have been attempts to incorporate a distributional ethic into utilitarianism, a Kantian or libertarian critique would challenge cross-person aggregation, arguing that individuals are ends who cannot be used instrumentally to assist other individuals.

Moreover, strict CEAs and quality-adjusted life-year indexes discriminate against people with a diminished capacity to benefit, such as disabled and older individuals, by assigning their health benefits comparatively less weight. Entrenched inequalities make interpersonal comparisons of utility on a single quantitative scale nearly impossible. Commensurate measures of utility cannot assess well-being in functional terms.

The extra-welfarist approach to health economics attempts to modify welfarism to include non-utility aspects of decisionmaking, however, and it is unclear how nonutility information and utility information are to be compared or even traded off in decisionmaking through an objective equation. How, for example, does it value the satisfaction derived from having access to care whether or not it is consumed (i.e., process utility)?

Although it includes health status in decisionmaking, the extra-welfarist approach does not give health status any special moral standing. Moreover, extra-welfarism shares the philosophical base of the utilitarian and welfarist approaches and thus has difficulty accommodating equity concerns. It applies many of the same conceptions about the social welfare equation, such as maximizing the health of the population and assessing the efficiency of trade-offs in asset allocation. Extra-welfarism thus is prone to many of the same criticisms that apply to the neo-classical economic model.

Equal Opportunity and Equal Welfare

Egalitarian theories typically stress equal access to certain goods but not “equal sharing of all possible social benefits.” John Rawls’s egalitarian theory of justice explains how rational agents behind an objective veil of ignorance would choose principles of justice that result in maximizing the minimum level of primary goods. Rawls did not directly apply his theory to health care (although he did include it in later works), but others have done so.

Norman Daniels employed Rawls’s theory to argue that health care is a right because it provides equality of opportunity. This account, labeled fair equality of opportunity (FEO), adopts the veil of ignorance concept to explain how people would choose allocations that ensure an age-relative normal opportunity range at each stage of life. Although he supports efforts “to eliminate or ameliorate . . . social factors that limit opportunity over and above discrimination,” Daniels does not go so far as Gerald Cohen’s “equal opportunity for welfare” and “equal access to advantage” approach, which expanded the Rawlsian view to support the rights of those disadvantaged by poor talents and skills as well as by disease or disability.

The FEO account does not distinguish among different types of health or health care, nor does it account adequately for health care costs or the trade-offs between health care and other social goods. Although Daniels and others have extended the FEO approach to include social determinants of health, many have criticized this expansion, asserting that reducing socioeconomic inequalities does not necessarily diminish health inequalities. This approach recommends that fair procedures (discussed later) be used to solve rationing problems in the health care realm. And although the FEO account has been extended to health care reform through the “benchmarks of fairness” approach, it is unclear how this extension helps eliminate critical and compelling barriers to health care reform, particularly costs, willingness to pay (e.g., individuals’ willingness to pay for others’ health care), value of public goods (e.g., goods from which no one can be excluded), resource allocation, and efficiency. This approach lacks concepts of opportunity costs and collective agreement for reform.

There is also nothing in the Rawlsian program more generally, or FEO more specifically, that
addresses the moral foundations of health insurance and its financing. Thus, although these issues are mentioned in the egalitarian framework, they are insufficiently justified, especially in contrast to the primary Rawlsian concerns of liberty and fair equality of opportunity. The trade-offs between efficiency and equity are complicated and require ethical reasoning for greater clarity. Ronald Green’s alternative to the FEO approach envisions instead an income-adjusted price system that enables consumers to set health care priorities.

A final major concern with the Rawlsian approach is its focus on means (resources) rather than ends and its failure to address human diversity. Even the proposal to expand the Rawlsian index of primary social goods or broaden the idea of equality of opportunity does not adequately address this shortcoming, because opportunity remains the primary social good and the main prescription entails the use of resources to counter opportunity disadvantages. Some theories of justice have attempted to address these concerns with equal resource accounts.

**Libertarian and Market-Based Approaches**

Libertarian theories stress equal access to rights with an emphasis on free-market-based or quasi-market-based solutions such as ex ante choices and advance contracting for health plans. Under libertarian philosophy, individual freedom and autonomy are the predominant societal values, and government’s role is to protect individual rights, especially property rights. This framework does not support a right to health or health care because efforts to guarantee such a right, along with being subject to regulation and oversight, could infringe on individual liberties by requiring people to pay taxes. A strict market-based approach would allow the more affluent and those with strong health care preferences to receive more and better care regardless of need or capability.

In another quasi-neoliberal approach, managed care, capped physician payments, quantity-based financial incentives, gatekeeping, and increased waiting periods are used to limit health care supply and demand. Although managed care has lowered health care prices in some settings, it has placed physicians in an unethical position, encouraging them to avoid diagnostic tests, hospitalizations, and expensive referrals that could benefit their patients.

The critiques of libertarianism stress that health care and health insurance markets do not support the conditions necessary for efficient market allocation. Even individuals with the right to make their own treatment decisions often defer to providers and are controlled by insurance companies, for reasons of information asymmetry, uncertain health risks, and benefit limits. Moreover, consumers do not necessarily pay the full cost or receive the full value of the goods and services they purchase. Also, market failures—such as the epidemic spread of communicable diseases, the failure to serve vulnerable populations, uncertainty, moral hazard (e.g., behaving imprudently when costs and consequences are not borne by the actor), adverse selection (e.g., when those most at risk are more likely than those less at risk to buy insurance), asymmetric information (e.g., when one party to a transaction has more or better information than another), and equity concerns—require public intervention in health care financing and, often, provision of health care.

**Deliberative Democratic Procedures**

Finally, democratic approaches, which “retreat to procedural justice,” employ open-ended processes, often legislative or randomized, to prioritize health care and health care recipients. These approaches are considered “fair” because citizens, as payers of insurance premiums and consumers of health care, are involved in democratic deliberation and decision-making. The “fairness of the rationales put forward [or] substantively just outcomes.”

However, these proposals have been criticized for failing to ensure the “rightness of the rationales put forward or substantively just outcomes.”

A number of criticisms of democratic procedures have emerged. Some argue, for example, that theories of just processes are never entirely culture free or universal. Some argue that the use of democratic procedures as a “last resort” in defining policy rests on a practical conception of these procedures that ignores deeper, more basic philosophical questions. These frameworks have failed to provide guidance on principles of justice, what the content of those principles should be, or how to evaluate the outcomes of such procedures.

Allocation theories resting on procedural justice alone view rationing decisions as just if they result from fair procedures. Thus, deliberative democratic approaches risk indeterminacy, a failure to reach resolution or effective outcomes. Furthermore, “majority preferences, no matter how well informed and fair, will sometimes eventuate in unjust outcomes.” Therefore, a purely or even primarily procedural mechanism could “return us to the same failures of justice that [already exist] in health care.”

**PROBLEMS WITH THE CURRENT SET OF FRAMEWORKS**

There are a number of problems associated with the existing ethics and health policy frameworks. First, the current frameworks, even those that include a focus on health status or expanded equality of opportunity, have typically justified health care as a special social good. Universal social justice concerns about health itself as an outcome (in consequentialist terms) have received less attention. More work must focus on the question of why health, as opposed to health care, has special moral importance in and of itself, not in terms of other goods or concepts such as opportunity or utility.

Second, more attention has been focused on the establishment...
of fair procedures for allocating resource claims than on development of substantive and procedural principles for prioritizing health-related goods and services. This imbalance stems, in part, from the way in which medical ethics has evolved. Establishing a right to health care has been a central thrust for decades and has channeled ethicists’ efforts into determining the content of this right. Still, there is little agreement on how and whether to specify such a right. The focus on democratic procedures as a way of distributing health care leaves scholars without a substantive moral theory of prioritization and resource allocation.

Third, there is a need for workable theoretical frameworks to guide collective choices about valuable social ends and their trade-offs, and these frameworks should address opportunity costs. It is clear that purely procedural strategies are limited in their application to deeper health policy and ethics questions. However, it is less clear which methodology might best elicit individual values for health states and incorporate them into a collective choice or whether this is the direction to pursue at all. Although there have been efforts to quantify equity concerns and include them in cost-utility models, such approaches still lack a deliberative component that enables groups to reach “reflective considered judgments.”

Fourth, there should be more of a focus on public reasoning (whereby society identifies, deliberates, examines, and makes a collective choice) than on formal quantitative, aggregative, or primarily purely procedural methods of deliberation and policy-making. To this point, there has not been as much emphasis on understanding how individuals and groups value different aspects of health and agency- or outcome-enhancing policies, or how they agree on decisions, as there has been on “accountability for reasonableness” (a fair process publicizing reasons and rationales for decision-making). Moreover, existing frameworks fail to ensure justice in rationing because they are indeterminate, often failing to reach resolution.

Finally, there are several more-specific concerns related to these frameworks, as follows.

1. The use of maximum benefits, utilities, or best outcomes as a basis for resource allocation confers lower priority to those who might benefit less from the use of a limited resource.
2. Paralyzing concerns that health care will become a “bottomless pit” in the face of empirical results demonstrating individuals’ interest in helping those in greatest need.
3. All benefits are not equal and cannot be evaluated according to a single metric (money in CBA and utilities in CUA). Improvements in health status, for example, cannot be measured in the same way as saving or extending life.
4. A reasonableness threshold has not been established. Aggregation techniques can produce results that defy clinical judgment, ranking life-saving treatments, for instance, below those that improve quality of life.
5. The indeterminacy of distributive principles for guiding resource allocation is especially problematic in pluralistic environments in which agreement cannot be reached regarding moral constraints on rationing.
6. In the scenario in which preferences would be used to allocate resources, there is still disagreement as to whose preferences should take priority: those of citizens, medical experts, patients, payers, regulators, or others. Research shows that those with particular health conditions and disabilities will modify their preferences to cope with their conditions; different preferences can result in underestimation or overestimation of treatment benefits.
7. Different methods of eliciting preferences, costs, and benefits (e.g., willingness-to-pay and willingness-to-accept methodologies, contingent valuation surveys, standard gamble, rating scales) produce different results.
8. Balancing the competing interests of population groups and individuals is challenging.
9. Numerous decisions about benefits packages remain unresolved, including whether to guarantee or mandate a benefits package, which services to include and exclude, whether to provide a floor or ceiling for benefits, and whether to guarantee a decent minimum, a basic benefits package, or a comprehensive benefits package.
10. Viewpoints vary about the factors to consider in resource allocation: prevalence and incidence of disease, effectiveness of particular treatments in improving quality of life and in extending and saving life, overall economic impact on society, medical necessity, costs, and applicable economic efficiency measures (e.g., CEA, CUA, CBA).
11. If open and democratic processes are used in determining resource allocation, the resulting decisions might or might not be just or consistent with clinical judgment; should they be accepted as a matter of procedural justice or be evaluated with respect to their substantive content?
12. Some theories (e.g., equality of opportunity, liberal theories) fail to address cost and efficiency adequately, ignoring scarcity, setting no limits, and failing to account for costs in their frameworks. Opportunity costs must be addressed.

The academic area of health ethics and policy is at a crossroads, oscillating between consequentialism and proceduralism, two dichotomous paradigmatic positions often deemed mutually exclusive. Consequentialists argue that we should assess health policies and laws according to their consequences; proceduralists believe...
that fair processes will yield fair decisions.

Thus far, neither end of the philosophical spectrum has prom-
ised or delivered a plausible solu-
tion, and attempts to incorporate both positions have been unsat-
sactory. As a result, the field is at
a standstill. Any movement for-
ward will necessarily involve ele-
ments of the consequentialist and
proceduralist frameworks in com-
bination.

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I argue that an ethical vision resting on explicitly articulated values and norms is critical to ensuring comprehensive health reform. Reform requires a consensus on the public good transcending self-interest and narrow agendas and underpinning collective action for universal coverage.

In what I call shared health governance, individuals, providers, and institutions all have essential roles in achieving health goals and work together to create a positive environment for health.

This ethical paradigm provides (1) reasoned consensus through a joint scientific and deliberative approach to judge the value of a health care intervention; (2) a method for achieving consensus that differs from aggregate tools such as a strict majority vote; (3) a particular action or aim, as when individuals have equal access to employment opportunities, and utility connotes desire or pleasure.

Second, this paradigm argues for valuing “central health capabilities” above those that are secondary. Agreement on such core health capabilities can provide guidance in prioritizing health care goods and services. This approach can help determine whether a particular medical intervention or technology merits a particular action or aim.

In this article, I offer an alternative approach to health system reform in the United States, which I call shared health governance, that is part of an alternative theory of health ethics. The basic ethical commitment to “human flourishing” underlies society’s obligation to maintain and improve health, under this paradigm. Public policy should focus on individuals’ ability to function. Health policy should support individuals’ health capabilities by enabling them to meet their health needs and by fostering what I call health agency (i.e., people’s ability to make health decisions and pursue health goals).

This ethic encompasses several key principles for health policy and reform. First, it assigns special moral importance to, what I call, health capability, a person’s ability to be healthy. This contrasts with the view that health care is special because of its impact on equality of opportunity and the utilitarian view that health care is important for maximizing social welfare. Equality of opportunity, for example, results from “a particular action or aim” for a particular goal (an action aimed at a particular goal).
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This ethical paradigm provides (1) reasoned consensus through a joint scientific and deliberative approach to judge the value of a health care intervention; (2) a method for achieving consensus that differs from aggregate tools such as a strict majority vote; (3) combined technical and ethical rationality for collective choice; (4) a joint clinical and economic approach combining efficiency with equity, but with economic solutions following and complementing clinical progress; and (5) protection for disabled individuals from discrimination. (Am J Public Health. 2008;98:1756–1763. doi:10.2105/AJPH.2007.121350)

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Second, this paradigm argues for valuing “central health capabilities” above those that are secondary. Agreement on such core health capabilities can provide guidance in prioritizing health care goods and services. This approach can help determine whether a particular medical intervention or technology merits societal resources.

Third, this paradigm proposes a joint scientific and deliberative approach to evaluating public health and health care interventions. It combines the evidence base of medicine and public health, expert opinions from health professionals, and input...
from individuals. Individuals, as change agents for their own behavior and for public policy at large, must be able to participate in deliberations and decision-making and must be informed of the risks, benefits, and costs of various health policy, prevention, and treatment options.

This view contrasts with paradigms in which health care decisions are made by consumers, physicians or public health experts, or third parties such as insurers alone, as well as with paradigms in which such decisions are made via strict algorithms, cost–benefit calculations, or shared decision-making within an informed consent model. In shared health governance, individuals, providers, and institutions work together to empower individuals and create a positive environment for all to be healthy.

This approach also differs from efforts to develop a decision-making process designed “to set fair limits on health care.” It calls for consensus on substantive principles and procedures of distribution and offers a method for achieving such consensus, one that places importance on the results (costs and effectiveness) of health policies and promotes collaborative problem solving.

Fourth, shared health governance argues for equal access to high-quality care and expanded health agency. Individuals, providers, and institutions should share responsibilities in achieving health goals. Fifth, shared health governance requires universal health insurance coverage via shared costs and risk pooling, with health care funded through community-rating and progressive financing.

Sixth, evaluations of health policies and technologies must consider costs. Every resource has an alternative use, so its expenditure represents an opportunity cost. Individuals and society must use resources parsimoniously by evaluating the efficiency of those resources. Finally, this paradigm aims to protect disabled people from discrimination while limiting exorbitantly costly care that would deprive others of health resources.

**EQUITABLE ACCESS TO HIGH-QUALITY HEALTH CARE**

Health systems must offer individuals the prerequisites for a healthy life. Many health determinants reside outside the health care system, but those that reside within should be distributed equitably and should conform to high-quality standards. Society, through the government, should guarantee equal access to appropriate preventive measures and high-quality treatments to the extent possible. The shared health governance paradigm evaluates the impact of health care on individuals’ health capability. It assesses health capability by examining health needs, health agency, and health norms.

This approach to equal access builds on Aristotle’s principle of just distribution, according to which like cases should be treated similarly and unlike cases differently, in proportion to their difference. This account is primarily based on need. It proposes measuring the quality of health care by its ability to address functional impairments arising from injury or illness.

This principle departs from approaches that emphasize a “decent minimum” or “adequate level” of care. It implies that people with the same health needs might require different levels of resources to ensure the same capability to achieve a given health state. The argument for a decent minimum or adequate level of health care typically asserts “a government obligation to meet the basic health needs of all citizens, at least an obligation to function as a last resort.” The result is generally 2 tiers of health care, one involving “enforced social coverage for basic and catastrophic health needs” and the other permitting “voluntary private coverage for other health needs and desires.”

Within the paradigm presented here, tiered health care is unjust because the reduced quality of the lower tier undermines some individuals’ health capability.

Adherence to this quality principle should reduce barriers to effective, efficient, and timely health care. Even if society guarantees equal access to high-quality health care, however, individuals must exercise their health agency to translate these resources into maximal levels of health functioning. Health agency includes health knowledge, effective decision-making in health matters, and self-management and self-regulation skills, among many important qualities.

**EQUITABLE AND EFFICIENT HEALTH FINANCING AND INSURANCE**

Universal health insurance coverage is important to this paradigm for several reasons. Lack of health insurance is one of the primary economic barriers to high-quality health care. Resource allocation should be based on medical necessity and appropriateness rather than ability to pay. In addition, the costs of health care can both
inhibit demand for necessary care and increase consumption of unnecessary care. Finally, the risk pooling inherent in insurance becomes central to health care financing as a result of the uncertainty of health needs, catastrophic medical care costs, individuals’ risk-averse nature, and the need to redistribute resources.21

Universal health insurance requires redistribution through taxation, and so individuals in societies providing this entitlement must voluntarily bear higher taxes to share these costs. Health policy should ensure provision of continuous universal health insurance, including all individuals at all times, regardless of changes in income, employment, or marital or health status. This goal is achievable through pooling risks and providing community-rated insurance premiums, sliding-scale prepayments, and progressive health care payments tied to income. Direct out-of-pocket expenses, which can impede individuals in seeking necessary health care and discriminate against the sick,29 are undesirable.

Financial arrangements affect access to care and health outcomes. For example, rates of health care use are more likely to be low among uninsured Americans than among privately insured individuals. In addition, those lacking insurance are more likely to experience inadequate care and adverse health outcomes and are less likely to have a usual source of care, to visit a physician, or to be hospitalized.

Lack of insurance and high costs also cause impoverishment. A study of uninsured Americans showed that medical payments drain savings and plunge people into debt. Seventy-nine percent of the participants in that study reported that they were unable to cover basic living expenses at some point while they were uninsured.30[42]

To distribute the health care burden equitably, governments must ensure that the financial risks of illness are spread fairly across the population. Health risks and costs are difficult to predict. Insurance collectively reduces financial risk; the larger the risk pool, the greater the redistribution from healthy to sick and from rich to poor. In general, public insurance tends to spread risk most efficiently and enhance equity, assuming that taxes are progressive.31 Private insurance pools risk to some extent but also segments risk to maximize profits. Regulation must ensure that private health insurers maximize the social benefits of risk pooling and include individuals with disabilities or preexisting conditions.

Health care financing must be efficient to allow wise use of limited resources. Wasted resources lead to important health needs being unmet. Administrative costs in the United States are wasteful, accounting for as much as 24% of total health care spending, in contrast to Canada’s 11%.32 To achieve both administrative and technical efficiency,33 the health system must minimize the costs of collecting and distributing revenue and loss of funds to corruption and fraud.

**A JOINT SCIENTIFIC AND DELIBERATIVE APPROACH**

**Reasoned Consensus Through Scientific and Deliberative Processes**

Shared health governance emphasizes deliberative public policy and reasoned consensus for setting values and priorities when policy choices are difficult. It is consistent with Aristotle’s argument for ethical as well as engineering forms of reasoning6 and contrasts with both a strictly technocratic or engineering approach and a strictly procedural approach to collective choice. As mentioned earlier, it differs from attempts to develop a decision-making process that sets “fair limits” on health care in that it promotes consensus on substantive—especially scientific—principles for distribution. It offers incompletely theorized agreements to achieve consensus, in contrast to aggregate tools such as strict majority votes.

Shared health governance particularly values the agency of individuals, who, as members of the public, should have a role in political, social, and economic choice.33 Participation and open dialogue are critical.

Public policy cannot result from narrow technical blueprints. Rather, it should emerge from a stepwise process that reflects the judgments of individuals and experts and incorporates scientific evidence to evaluate health policies, updated continually to reflect changes in medical knowledge, technology, and costs. New circumstances should lead to modifications of the ethical and scientific rules that form the basis for defining benefits packages, determining resource allocation, and constructing general guidelines. The underlying reasoning should be explicit and public and should include an appeals mechanism for reevaluating decisions.

**Combining Technical and Ethical Rationality**

The precise combination of technical and ethical rationalities in collective choice will vary. For example, decisionmaking at the national level requires participation by representative groups (legislatures or councils) and entails trade-offs between health and other social policies. Decisionmaking about a benefits package will focus more on broad categories at the middle level, and specific treatment decisions will engage patients and providers at the micro level. My goal here is not to specify procedures for every circumstance; however, I discuss certain substantive and procedural aspects of the process. Shared health governance emphasizes both clinical and economic analyses for evidence-based decisionmaking. The deliberative components of the process transcend the existing literature in that technical rationality, incomplete theorization, and partial ordering (e.g., allowing prioritization to take place among certain factors without ordering others) are used to establish consensus amid pluralism and wide disagreement.35

**Determining a Benefits Package**

What health goods and services should constitute a standard
benefits package guaranteed to all? Under this approach, goods and services that are “medically appropriate” (a term that encompasses medical necessity) to ensure central health capabilities would form the basis of a guaranteed benefits package. Society could then expand the package through reasoned consensus if so desired and resources allow. Thus, the government-guaranteed benefits package would cover appropriate and necessary care to prevent, diagnose, or treat illness, disease, injury, disability, or other medical conditions associated with avoidable morbidity or premature mortality.3,5

A major difference between this account and others is its requirement that goods and services be medically appropriate as well as medically necessary. Adding medical appropriateness and established clinical practice guidelines to the medical necessity standard introduces another level of science-based prioritization. Shared health governance gives authority back to physicians and patients, allowing them to make informed judgments about resource allocation on a category-by-category and case-by-case basis.

Not all health care is medically necessary or appropriate. Many advanced medical technologies are only marginally effective, extending life a few weeks or months, for example. Moreover, although millions of people in the world receive appropriately delivered, high-quality health care, many others undergo, overuse, or misuse health care services. According to some estimates, up to 30% of all US health care goes to waste through clinical practice inefficiencies.34 Eliminating inappropriate and unnecessary interventions is the first step to establishing equitable access to high-quality care and lowering costs.

Well-established, evidence-based clinical guidelines, continually updated and improved on the basis of new medical information, systematically bring together experience and evidence on various conditions and can guide treatment. However, clinical guidelines alone cannot reduce differences in health care quality, nor can they evaluate medical technologies. Although there is no perfect formula for determining whether interventions are appropriate and necessary, certain process components can combine in a workable health policy decisionmaking model.

At least one example of some of the elements of such a process exists. The Rand–UCLA (University of California, Los Angeles) appropriateness method35(p59) combines substantive criteria with procedural mechanisms that incorporate expert medical judgments, patient input, and scientific evidence to generate publicly available medical guidelines and standards for guiding policy decisions. Its three criteria for evaluating health interventions are (1) duration and degree of improvement, (2) likelihood of a beneficial outcome, and (3) associated risks. A multispecialty panel of physicians makes recommendations on medically appropriate procedures based on the criteria just mentioned and professional clinical practice guidelines. Patients have input after physicians assess an intervention’s effectiveness.

An intervention is deemed necessary if it is medically appropriate (expected medical benefit to the patient exceeds expected health risks)35 and if “withholding the procedure would be deleterious to the patient’s health.”36(p357) The process includes tallying of costs but not incorporation of costs into appropriateness rankings.35,37 As a means of protecting people with rare conditions, the process does not include a calculation of the number of individuals benefiting from the intervention.

Recommendations rest on up-to-date, published, evidence-based research.38 When evidence is incomplete or inconsistent, recommendations reflect the physician panel’s judgment. The process can help determine a benefits package and assists decisionmaking among individuals. For example, the panel might recommend a hysterectomy for women who have attempted alternative treatments (e.g., for pain or bleeding) without success but might not recommend the procedure for women with first-degree uterine prolapse that does not involve incontinence or pain.39 Or it might rule against postdischarge coronary angiography for myocardial infarction patients who do not have angina or have not undergone an exercise tolerance test.40 This process could be applied to new technologies, pharmaceuticals, and treatments as well as existing ones.

Protecting Individuals With Disabilities and Handling Difficult Cases

Some ethical theories focused on yielding the greatest net social benefit appear discriminatory.43–45 Critics charge these approaches with neglecting the individuals most in need, especially those with disabilities44,46–48 and those with rare conditions.49 Patients with severe disabilities must be protected from unfair discrimination; at the same time, however, society must allocate scarce resources as efficiently as possible. An
especially difficult issue is what some have called the “bottomless pit objection,” whereby individuals or small groups use large proportions of resources for unlimited periods.50,p4 Rawls’s “maximin” or difference principle and the fair equality of opportunity (FEO) account have encountered particular criticism.51 The “reasonable accommodation” principle outlined in the Americans with Disabilities Act and the Rehabilitation Act52,53 provides guidance here.

Reasonable accommodations are non-“fundamental” alterations that can be undertaken without causing “undue hardship” to a program (e.g., related to employment, public service, public accommodation, and telecommunication). The Americans with Disabilities Act defines undue hardship as “an action requiring significant difficulty or expense.”52 The Equal Employment Opportunity Commission assesses hardship by considering the “nature and cost” of the accommodation and the impact on the “overall financial resources” of the organization involved. The commission’s guidelines specifically disavow the use of cost–benefit techniques.54 Applying rigid cost–benefit analysis to interventions for the disabled would be discriminatory, some critics argue, because some individuals with disabilities would receive less objective benefits relative to costs than would individuals without disabilities.52

Several points require emphasis in analyzing how the Americans with Disabilities Act and the Rehabilitation Act could apply to resource allocations. First, when defining a benefits package, both private and public actors must not discriminate in assessing medical appropriateness and necessity. Second, these assessments should distinguish between the minimum level of functioning and a potentially achievable level, and the benefits package should target the potentially achievable level. This ensures that the weight assigned to health benefits for individuals with disabilities is equal to that assigned to benefits for individuals without disabilities.

Third, appropriateness and necessity criteria should not discriminate against individuals with rare conditions. That is, preventive measures or treatments that confer a large benefit on a few people should be included in a benefits package. One example would be timely treatment (within 24 hours of birth) for maple syrup urine disease, which affects 1 in 225,000 births.55 Fourth, clear examples of discrimination, such as limiting hospital days without considering condition severity, should be considered unethical because they exclude those with more-severe or -complicated primary and secondary conditions, reducing their ability to benefit fully from an intervention.

Fifth, benefits should not include extremely costly care that offers little improvement or is medically futile, including life support for permanently unconscious patients. Determining the appropriateness of medical care will help illuminate specific cases of medical futurity. If patients or their families have previously specified that patients wish to avoid futile care (e.g., through advance directives or do not resuscitate orders), their wishes should be met.56,p5

Finally, with respect to disabled individuals, who may receive reduced benefits relative to costs, this account weighs absolute harm in terms of functioning capability rather than through the use of a strict cost–benefit analysis.49 In operationalizing these ethical principles, however, it is appropriate to consider the absolute costs of certain treatment protocols and their effects on overall health system resources (as discussed subsequently).

Combining the principles of reasonable accommodation, medical appropriateness, and medical necessity will help society to clarify its obligations and will help obviate problems such as the “bottomless pit.”50,p4 Existing case law could reveal the rationale and application of such a standard. Eventually, however, decision-making in this area may be guided by a body of case law (as developed elsewhere)57,58 and policy case studies in health resource allocation.

Incorporating Efficiency Through Joint Clinical and Economic Solutions

Efficiency goals should, however, temper equality goals. Although it is consistent with the focus of welfare economics on efficiency, the shared health governance paradigm differs in that it applies efficiency principles to equity goals. Meeting the dual social obligations of equality and efficiency in health system reform requires both clinical and economic solutions. However, clinical input must drive this process to ensure that physicians and patients are the primary determinants of care.

Still, successful implementation of effective clinical solutions requires economic incentives. Empirical evidence suggests that economic tools can influence the behavior of patients, physicians, and planners. Several measures have encouraged cost consciousness and efficiency.

On the demand side, instruments such as copayment schemes and health insurance deductibles sensitize consumers to health care’s cost and deter consumption.59 On the supply side, price, budgetary, and salary incentives (prospective and capitated payment schemes, global budgets, competition,60 and utilization and management review systems) are used in attempts to reduce costs. In theory, these incentives force physicians and hospitals to provide only the most cost-effective care. In some cases, they actually shift the financial risk of health expenditures from insurers to providers. Payment mechanisms (e.g., diagnostic-related groups) and health financing and delivery institutions (e.g., health maintenance organizations and managed care organizations) have resulted from these efforts.61 However, whether these measures have actually reduced expenditures or improved efficiency is unclear.62,63

Such strategies could reduce the volume of health care provided. However, they frequently reduce levels of both inappropriate and appropriate care, resulting in deleterious health consequences, particularly for the poor and...
medically indigent, who often have the greatest health care needs and respond most sensitively to consumption-deterring incentives. Therefore, under this paradigm, economic solutions follow and complement clinical progress, not vice versa. Training physicians by rewarding appropriate care and penalizing inappropriate care should receive particular attention.

Fair health system reform must consider costs, and there are several methods of doing so. First, developing and implementing appropriateness guidelines will improve health care quality, reduce health care quantity, and decrease overall costs. Avoiding inappropriate coronary angiography after a myocardial infarction, for example, could save more than $700 million annually. Furthermore, using appropriateness guidelines should reduce cost-ineffective care.

One study focusing on post-myocardial infarction angiography, an expert panel’s appropriateness ratings were compared with cost-effectiveness ratings derived from a decision-analytic model. The clinical scenarios considered appropriate by the expert panel were more cost-effective (average of $27 000 per quality-adjusted life-year gained) than those deemed inappropriate (average of $54 000 per quality-adjusted life-year gained). Used in this manner, cost-effectiveness analysis can be helpful in comparing trade-offs between costs and effectiveness.

Second, efforts to further reduce inappropriate care should involve financial incentives based on quality rather than quantity. As information on inappropriate care accumulates, economists and health policy analysts can create policy instruments to reward appropriate care, necessary care, and risk adjustment. For example, health plans and hospitals could reap rewards for lower mortality in the case of certain procedures. Because it has been shown that financial incentives influence physicians and patients, efforts to motivate high-quality, appropriate care could be effective. Efforts are under way to pay providers for performance, although there are concerns with this approach.

Third, efforts to reduce health care costs are essential. In addition to economic incentives for influencing participants’ behavior, macro-level efficiency evaluations should inform guidelines for maximizing resource efficiency. Cost-minimization analysis is a form of efficiency evaluation that assumes a given objective (e.g., level of effectiveness) and searches for the least costly method of achieving it. One such analysis showed that although peripheral blood progenitor cell transplantation and autologous bone marrow transplantation are equally effective in treating Hodgkin’s and non-Hodgkin’s lymphoma, the latter costs $14 000 more than the former.

Cost-minimization analysis is being used in several medical fields, including obstetrics and gynecology, cancer therapy, stroke rehabilitation, and ambulatory anesthesia. It has also highlighted potential savings in pharmaceuticals. This approach differs from other efforts to address the efficiency–equity tradeoff.

Volume purchasing, restricted networks, and reductions in non-patient care costs could also reduce expenditures. Further work in this area could reveal ways to reduce total health care costs without compromising quality. Moreover, studies of cost differences between for-profit and non-profit providers and insurers offer evidence of cost reductions, as do studies of efforts to reduce costs near the end of life.

Finally, improved information systems could help standardize medicine and provide physicians and patients with the essential evidence base for appropriate and necessary care. Reporting of annual data on risk-adjusted mortality after coronary artery bypass graft surgery in New York, for example, resulted in a 41% decrease in mortality between 1989 and 1992. Streamlined data systems also help reduce unnecessary administrative costs.

**IMPROVED HEALTH SYSTEM EFFICIENCY OR MORE EXPENSIVE CARE**

The shared health governance paradigm does not propose a simple formula for answering complex questions; rather, it outlines several key ethical principles for guiding health care reform and policy. Although no method of health system reform can satisfy all ethical requirements, policies derived under this framework will more fairly distribute the benefits, burdens, and costs of ensuring equal access, providing universal and comprehensive coverage.

If greater health system efficiency is achieved but health care costs continue to rise, the American public must decide whether it is willing to spend more on health care. Most health economists find this stage of decisionmaking straightforward because they believe individuals should be free to spend what they like on goods they value highly, provided that waste is eliminated. Recent studies suggest that Americans’ willingness to pay for health care far exceeds current and even projected costs of medical goods and services. Although the shared health governance approach seeks to make more-efficient use of the existing level of health resources, it will not produce a flawlessly efficient health care system, given the number of organizational, institutional, and political obstacles likely to impede its implementation.

There will be reasonable objections to this paradigm. Some critics will argue that society is unable to afford such a generous plan and will demand more assurance of cost containment. Physicians might object, regarding clinical guidelines as “cookbook medicine” or a “liability,” even though such guidelines are designed to assist policy and clinical decisionmaking rather than replace clinical judgments. Despite these objections, this framework has many advantages and is perhaps our best hope for replacing the current system, with its exorbitant costs, widespread waste, and pervasive injustice.

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A wise man should consider that health is the greatest of human blessings.

—Hippocrates

Health

The Value at Stake

ERIKA BLACKSHER

Few dispute the need for health care reform in America. Two problems—access and cost—attract the most commentary, and for good reasons. The ranks of uninsured Americans, which have increased annually for the last six years, are likely to reach 50 million in this economic downturn, and health care expenditures are predicted to top $2.5 trillion in 2009. Both problems are unsustainable features of American health care. But these problems share company with a third that has gone largely overlooked. Our health system, if it can be so called, is not designed to produce health. Indeed, health care is but one determinant of health, and by some measures it is a relatively minor one. Despite the trillions spent on medical services, the United States ranks poorly on key measures of health. For example, according to 2004 World Health Association data, the United States ranks forty-sixth in average life expectancy out of 192 nations.

Addressing this gap in our national health reform debate requires a fundamental reorientation in our thinking about health care and its relationship to health. Reform needs to include measures that will help keep people healthy and better manage their illnesses should they fall ill. We should standardize insurance benefits, refocus services on primary care, reward the management and prevention of chronic disease, create information systems that track patient populations, expand community health centers. We should also assess (and act on) the health impact of policies in sectors other than health care, such as taxation, agriculture, housing, urban planning, transportation, and education. Such reforms will not only produce a healthier nation but also reduce the stark health inequalities that separate Americans who are better off from those who are worse off.

Health and Value

This perspective on health system reform turns on a value rarely identified, defined, or defended in explicit terms. That value is health itself. Health is thought to be a good in several respects. First, people may value health because it contributes directly to their sense of well-being; in this sense, it is an intrinsic good—a good that people enjoy for itself. But even if people do not consciously appreciate their health when they have it, losing it will make them aware that they rely on some level of it to pursue their interests and to act on their plans. Health, in this sense, is also an instrumental good that enables people to manage and control their lives. Health is also a collective social good that can contribute to a nation’s productivity and reduce absenteeism and health care costs.

Health may seem too simple an idea to define or too obvious a value to defend in a debate over health system reform. Questions abound, however, about how to define and produce it and how to balance it with other values. Is health an expansive idea that relates to human well-being, or a narrow idea that relates to bodily function? The World Health Organization defines health as “a state of complete physical, mental and social well-being and not

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controversies exist. But no matter how we measure health, the United States compares poorly to other wealthy countries and even to some middle- and low-income countries.

While we need not agree on a particular concept of health in order to agree that we are an unhealthy nation, how we conceive of health has implications for how we think about improving it. Because the biomedical conceptions of health rest on conceptions of disease and disability, they run the risk of channeling our collective attention and action toward medical services that respond to disease and disability—and away from broader social systems that prevent disease and promote health. Universal access to timely, high-quality primary care certainly would help to improve health outcomes and reduce health inequalities. But even with universal coverage, disparities in disease and injury will remain because it takes more than health care to ensure health. For example, medical services make a mere 10 to 15 percent contribution to reducing premature death. In addition, factors that contribute to health include health-related behaviors, genes, and social, economic, and environmental conditions.

The pursuit of health equity in this political culture will have to negotiate a number of American values likely to supply resistance. One source of resistance will be those who view such policies as an infringement on individual liberty. The precise meaning of liberty may take slightly different forms, depending on the different objections. Policies that ban products (such as trans fats) or that regulate activities (such as driving without a seat belt) may be said to interfere with individuals’ freedom of choice. Others may take aim at government programs and the taxes they entail, based on a principled rejection of the role of government, save its activities related to national defense, law enforcement, and judicial institutions that protect individual rights. These positions share a concern with what people are free from and may find common cause with a second plank of resistance to any robust health equity agenda—the view of health as individual responsibility. Individuals, not the state, are responsible for improving their health, and if they fail at that, it is individuals who must shoulder the consequences.

Of course, everyone knows of people who have managed, even against great odds, to change deeply ingrained ways of living and improve their health. But many people don’t manage that, and members of socially economically marginalized and minority groups are disproportionately among those who maintain poor health habits. This fact should cause us to rethink and reframe the question of responsibility and how we think about liberty. The significance of class and race for health habits does not suggest that members of socially disadvantaged groups are all choosing in lockstep; rather, it suggests that their choices are systematically constrained by living, learning, and working conditions that can limit people’s choices and perhaps the freedom expressed in those choices. Policies that remake these social conditions—for example, ensuring that everyone has a nearby grocery store that sells fresh produce, a primary care physician, a pharmacy, and safe venues for recreation and social gatherings—can enhance people’s freedom to make healthier choices. So some forms of collective action can enhance people’s liberty.

That these social conditions are often the product of widely endorsed public policies suggests that the call for personal responsibility should be accompanied by an awakening of our sense of shared responsibility. The idea is not foreign to U.S. political culture; indeed, it seems to be at the center of our new president’s philosophy. President Barack Obama has called for a “new era of responsibility” that makes demands not just of individuals, but also of families, communities, and society at large. This big tent conception of responsibility should be directed at promoting health for all.

***Policy Implications***

The social determinants of health are particularly salient in this era of chronic disease, whose causes can be traced to the conditions in which we grow up, live, learn, work, and play. Health habits related to diet, exercise, and tobacco use make an indisputable contribution to the onset and progression of chronic diseases and help explain some of the disproportionate disease burden among lower socioeconomic groups. But health habits do not explain all of it. Low socioeconomic status itself contributes to premature mortality and excess morbidity. Researchers do not yet know which markers of class exert the most profound influence on health, but low educational attainment, low-wage jobs, poor-quality housing, and polluted and dangerous neighborhoods, along with the stress and social isolation these experiences may induce, all plainly play a role. The vagaries associated with being
poor or near poor exact an especially heavy toll on the health and development of children, often with lifelong effects.

If the organizing principle of health reform is the production and the fair distribution of health, then we will need to rethink what a health system is. What might such a system look like and what sort of policies would it entail? Promising policies and programs have been recommended, and some are already being implemented in states and cities around the country. These interventions include measures aimed at several different levels. Some focus on neighborhood conditions: they seek to improve housing stock, create safe areas for exercise, and enhance the food supply (such as by banning trans fats and by supporting farmers’ markets, for example). Other interventions focus on at-risk families and children, by providing income supports, securing nutrition, and enriching educational environments and opportunities. Yet other possible interventions promote educational attainment and improve work conditions and benefits for adults. These measures cannot guarantee health for all. But they can promote a fair opportunity for health for all. And that is a very American value.