The Focus on Health Capability and Role of States in Ruger's Global Health Justice Framework

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In "Global Health Justice and Governance," Jennifer Prah Ruger (2012) presents a compelling framework for evaluating and reforming the standing global health system. The framework is in many ways an extension of Ruger's health capability paradigm and work on domestic health governance, most fully articulated in her recent book *Health and Social Justice* (2009), to the global order. The two components of Ruger's framework are provincial globalism (PG) and shared health governance (SHG). Provincial globalism is a theory of global health justice that can be coupled with various models specifying means through which actors in the global health system can meet the theory's demands and realize its ends. Shared health governance is one such model, and the one that Ruger argues should be chosen.

PG is a health capability approach to global health justice. For Ruger and other capability theorists, flourishing is an aim shared by all persons that social institutions ought to promote, and the flourishing of persons involves their possession of capabilities. Capabilities are, roughly, freedoms understood as real opportunities to achieve functionings—living, moving around, reading, writing, expressing oneself, and so on—that one values. Ruger's (2012) health capability approach focuses on the capabilities involved in being and remaining healthy, and the "central health capabilities" in particular. The central health capabilities are those without which further capabilities, and thus flourishing, cannot be realized. Ruger's two central health capabilities are the capabilities to avert premature mortality and to escape morbidity. The familiar thought here is that remaining alive and meeting some basic threshold of healthiness are preconditions for anything else we might wish to do. PG holds that the focal variable or, in Amartya Sen's terms, "primary informational base" (Sen 1993) for assessing the justness and efficiency of global health policy is the possession of health capabilities and particularly the central health capabilities by all living persons (Ruger 2012). We have a general duty to address threats to and reduce the extent to which individuals anywhere fall short of possessing the central health capabilities. Although this captures, in large part, the global aspect of PG, the theory is provincial in that it assigns special responsibilities to co-nationals and states for achieving domestic health goals. A multilevel system of roles and responsibilities for individuals, states, nongovernmental organizations (NGOs), international health organizations, and global institutions must be implemented to bring about and maintain a just global health system.

Shared health governance is a model of global health governance that can operationalize provincial globalism. SHG rests on the premise that domestic and global actors in the global health system will voluntarily cooperate in achieving global health justice (Ruger 2012). Individual, group, and national self-interest are typically regarded as the primary motivations for international cooperation in global health. Ruger believes that we can transform the global health system into one in which individuals and institutions in the global health architecture are genuinely committed to fulfilling the core health interests of all human beings. As the first step in this process, she recommends setting up a Global Institute of Health and Medicine (GIHM), a global NGO in which scientific and technical experts cooperate to provide knowledge and advice on health policy to these actors. Second, a Global Health Constitution (GHC) should be developed and agreed upon that delineates clear responsibilities for each of the actors mentioned. States bear primary responsibility for meeting domestic health objectives for both practical and moral reasons (Ruger 2012). They are uniquely situated to develop and maintain efficient and equitable health systems with political legitimacy, even when significant ability and responsibility to provide aid rests with nonstate actors. All actors involved in global health governance would be given evidence-based role and responsibility assignments suited to their functions and the needs of individuals.

One concern regarding PG that bears on its role in justifying and informing the recommendations set out in SHG is that it may rely on commitments that will not achieve widespread acceptance among theorists. There is deep disagreement between theorists over what the correct criterion is for morally assessing and comparing alternative health policies and institutions. Ruger (2012) holds that PG is committed to moral principles that are universally shared in their content and, although to a lesser extent, in their justifiability. Yet there is a real question as to whether those who don't share in her commitment to health capabilities as the fundamental criterion for evaluating health policies and institutions will be on board with her approach. Other theorists, for instance, give this role to the fulfillment of (health-related) human rights, or particular specifications

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of welfare. The fact that few if any would deny that health capabilities are valuable, even intrinsically valuable, does little to reassure us that they will agree to the central evaluative role that PG gives to health capabilities.

Ruger is aware of this concern, but it's not entirely clear how she means to respond to it. She states that she is committed to the possibility of achieving an overlapping consensus in her theory at all levels—individual, local, national, and global—but that an overlapping consensus doesn't require unanimity (2012). Nonetheless, it does seem that Ruger will want to achieve a consensus broad enough to include theorists of global health justice with foundational commitments other than her own—many of whom, like herself, have been and remain involved in important organizations and projects for global health reform. This is especially important insofar as PG is intended to justify and inform the implementation of SHG, which itself requires widespread agreement among domestic and global health actors to health-related norms to achieve its goals. It would be useful to articulate more clearly how this might be accomplished.

A separate but related concern applies to the commitment of PG to cosmopolitan individualism, which holds that individual human beings are the ultimate units of moral concern. Ruger holds that PG accepts this commitment, but at various points suggests that PG and SHG give a fixed place to respect for the sovereignty of states. For instance, she writes that "borders and states (nations) . . . have moral significance, because self-determination guarantees respect for the collective agency of peoples and mutual respect among states (nations) in a system of state sovereignty" (39–40), "SHG intrinsically respects self determination" (48), and "No world government, bilateral trading partner, multilateral institution, wealthy donor country or foundation can or should coerce another country to ensure [access to quality health care without regard to ability to pay] for its people" (48). A cosmopolitan theory, however, can give only a contingent standing to state sovereignty—a policy of respecting state sovereignty is only morally justified insofar as it promotes the interests of individuals weighted equally. Ruger makes a strong practical case against intervening directly in the internal affairs of states for the sake of the health of their members in general unless intervention is requested. Perhaps cosmopolitans and theorists who give a fundamental moral status to states could come to an agreement regarding state sovereignty and global health that would be ratified in the GHC. For the sake of avoiding controversy and possibly undermining its own commitment to state sovereignty, it seems to me that PG can and should remain neutral on the question of what entities are ultimate units of moral concern.

Lastly, I want to raise an important issue regarding the relationship between global health inequity and other problems of global injustice. An expansive literature involves arguments to the effect that rich, developed countries are engaged in unjust practices that harm the global poor. A few examples of these practices that have received sustained attention are the imposition of the TRIPS-inspired global patent regime (Pogge 2009), the recognition of resource and borrowing privileges for autocratic political leaders (Pogge 2004, 2008; Wenar 2008), and the failure to prevent or, all the worse, the encouragement of illicit financial flows from the global south to the global north (Kar and Curcio 2011). These and other problems are argued to play a large role, individually and taken together, in the persistence of global poverty. It is an easy step to the further conclusion that these problems are directly tied to the inability or, in some cases, unwillingness of at least some developing country governments to secure the central health capabilities of their political subjects.

Ruger and other capability theorists, largely in response to Rawlsians like Norman Daniels and colleagues (Daniels 1985; Daniels, Kennedy, and Kawachi 2000), argue that health justice cannot be achieved as a byproduct of justice (Sen 2000; Ruger 2004, 2009); that is, through a just distribution of social determinants of health such as social primary goods. Steering clear of the resourcist-capability theorist debate in which this point is made, health policy actors will still need ways of assessing the effects of unjust practices outside the realm of health care provision on global health equity. They may even be well poised to attract public attention to these practices and to collaborate with those working to end them. It is doubtful that responsibilities for achieving global health justice can be fairly assigned to domestic and global health actors without taking these practices and their effects into account in some fashion. Including mechanisms and procedures for doing so in SHG would not require us to relinquish Ruger's suggested commitment to central health capabilities as the focal variable for assessing global health justice. It would, however, require us to loosen Ruger's commitment to the proposition that states bear primary responsibility for domestic health objectives, which in any case is threatened by a number of other empirical points that could be made. For instance, rich countries can achieve vastly higher health gains with their marginal health dollars in poor countries than at home, gains poor countries could not be expected to make with their own financial resources. Additionally, the creation and implementation of a system of global health governance, which Ruger believes to be important for improving domestic health outcomes, will depend most on commitment and investment from rich countries for the foreseeable future. ■

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Building a Global Health Ethic Without Doing Further Violence

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Health has been called the first wealth, and global health justice and governance call us to consider how justly and ethically to share this wealth. In formulating a proper political theory for global health, health professionals have a central role to play. First, they have a well-established code of ethics based on the Hippocratic oath: *primum non nocere*, to first do no harm, and in some versions, to keep from injustice. Second, the application of this code in the contemporary context calls for engagement at a larger scale, in line with the World Health Organization's definition of health as "not merely the absence of disease or infirmity" (World Health Organization 1946). Third, if we were to translate doing no harm as first avoiding violence, we must consider Johan Galtung's (1969) notion of structural violence, which observes that unjust social structures cause greater harm to people than any form of direct violence. Along this logic, increasing emphases on prevention give health professionals a capacity and duty to protect from injustice. Amid changing conditions, keeping with original principles can be a useful guide for action. Physicians, then, who have a negative duty not to harm and a positive duty to promote health, must pay attention to the larger social and cultural forces that determine who will fall ill in the first place and who will be provided relief.

When health professionals work for optimal health care delivery, they are working against violence and participating in the struggle for peace (Arya and Santa Barbara 2008). This struggle for peace itself must not entail its own form of aggression through an imposition of our own political agendas, cultural assumptions, and worldview (Barnett and Weiss 2008). To be adequate, any answer must recognize that caring well is at the heart of justice and that therefore political theory will be judged in significant part on how effectively it fosters caring well. Such caring arises from a basic sense of responsibility for how one applies or makes use of the great gift bestowed by many contributors through the entire course of one's training to be a clinician of whatever stripe. Thus, it is seen, for example, that physicians should not be involved in police or intelligence interrogations of prisoners (Young 2006). Similarly, the American Psychiatric Association (2008, 4) declares that a psychiatrist should not participate in a legally authorized execution. We acknowledge that not all physicians agree. One, for example, maintains that when acting as an interrogator he is "not a physician at all" (Allhoff 2006). Further he weighs national security as a higher duty than caring well. We submit that in order to be considered sound, a political theory should clearly exclude this violent view.

We discover, furthermore, that caring well is often the most effective antidote to violence (Gilligan and Lee 2004; Lee and Gilligan 2005). To achieve the justice it fundamentally seeks, the judiciary, for example, in the criminal arena must also care well. It has a fundamental responsibility toward the defendants with whom it deals, as well as toward those defendants' victims. In pronouncing a sentence the judge unavoidably becomes involved in violence on behalf of the state. It is a complex interpretive act setting in motion a well-organized kind of violence (Cover 1986). Fyodor Dostoevsky offers a more literary version of the same reality through a story told in *The Brothers Karamazov* by the

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