Shared Health Governance

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Abstract

In *Health and Social Justice* I developed the "health capability paradigm", a conception of justice and health in domestic societies. This idea undergirds an alternative framework of social cooperation I call "shared health governance" (SHG). SHG puts forth a set of moral responsibilities, motivational aspirations and institutional arrangements, and apportions roles for implementation in striving for health justice. I now develop further the SHG framework and explain its importance and implications for governing health domestically.

Introduction

Health and Social Justice 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 this social objective 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 assignment tend to be ad hoc, assessing 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.

Cooperation theory, however, offers both non-cooperative game theory and more cooperative game theory approaches, but in both, narrow self-interest is a chief motivation. Some have sought to merge game theory with ethics. These efforts, however, have focused primarily on formalizing social contract theory and demonstrating the rationality of acting morally in accord with particular agreed-upon principles through bargaining or negotiation (Gauthier 1986). The underlying premise here is still narrow self-interest. Few applications of game and social contract

theories in health and health care focus on distributing societal benefits for the wider common good.

In this article I take a broader view of health governance. To foster health justice, we must do more than design basic social institutions or extend game theory to ethics. To create conditions in which all have the ability to be healthy, the shared health governance model allocates responsibility, resources and sovereignty to national and state governments and institutions, non-governmental organizations, the private sector, communities, families, and individuals themselves. In this view of health governance, ethical commitments are fundamental. 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 than 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 where everyone has a say. 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 social cooperation needs more than just regulations and laws; no government agency can micro-manage 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 indispensable in 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. Most theories of cooperation, whether non-cooperative or cooperative, rest on the premise that cooperation or lack thereof involves strategic interactions among self-interested and rational individuals.

Non-cooperative game theory (NCGT) is a dead end for social cooperation in health even though it does not preclude cooperation. In NCGT, each player makes unilateral decisions driven by self-interest; cooperation can be achieved and maintained only if each player cannot do better on her own. While there are numerous game types in NCGT, the Prisoner's Dilemma (PD) is the most famous. 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 iterated PD games ("tit-for-tat"), 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 and norms (except maximizing one's own gains). Second, self-interest maximization trumps potential shared gains. Third, in NCGT each player makes her own decision, so there is no mutuality or shared deliberation. Fourth, classic NCGT games involve two players, so coalition building and group inclusion are absent, although group games have similar results (Bowles and Gintis 2008). Fifth, NCGT and the Prisoner's Dilemma specifically suggest that 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 (Fudenberg and Maskin 1986).

The second class of 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, on coordination conventions, 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 sub-groups) 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 and Sandler 2003).

Unlike SHG, CGT rests on self-interest maximization, and the point of cooperation for players is to achieve greater gains for oneself. A second difference is that 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, CGT is likely to exclude weak, vulnerable or marginalized groups. Unlike SHG, CGT places little or no emphasis on public moral norms; a CGT bargain holds only if it serves the parties' self-interest, not if it achieves an overarching social objective. Finally, in the CGT model there is a great deal of 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 gains). SHG is more closely aligned with cooperation models including other-regarding preferences leading to cooperation (Bowles and Gintis 2008).

A third general category of cooperation theory stems from the social contract theory 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 primarily 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. Social contractarianism also includes an element of power since parties to a contract must have the capacity to contribute to the interaction's social product 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 leaving certain groups – the severely disabled and other weak and vulnerable groups – outside the realm of justice. The success of the contract in securing cooperative interaction requires a "rationally acceptable" and "impartial" starting point and procedures (e.g., no coercion or deception) (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 at every decision point (Gauthier 1986). This means that following a course of action can be rational even if doing so means doing things that are suboptimal at the moment of action. Moral constraint on the pursuit of 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 contractarianism presents challenges about ensuring that parties make concessions to each other to achieve cooperation. It's difficult to see how social contractarianism might be implemented at the societal level.

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 "others 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 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 seeks 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 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 others' interests (Scanlon 1998). Thomas Nagel, among others, has criticized Scanlon's view for being impracticable, arguing that the construction of a set of principles no one can reasonably reject may be impossible (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 each person 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 which do impose greater burdens on others (e.g. paying 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 doctrine 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 (e.g., 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., Sigwick 1907; Broome 1991).

Utilitarianism contrasts with SHG in the 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 really 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 Sub-Optimal Outcomes in Health and Health Care

Self-interest 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 sub-optimal 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 therapeutic interests without internalizing system-wide effects. Geyman (2008) compiled an extensive collection of examples from the U.S. 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. 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, Tenet, a for-profit hospital chain, was found to have inflated operating room charges by more than 800% 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. Pfizer 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). Boston Scientific/Guidant 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, and their votes kept the drugs on the market (Harris and Berenson 2005). Of the 13 drugs withdrawn 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, use unauthorized service suppliers but bill at authorized supplier rates, among other tactics. Patients loan 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, 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 Botswanan 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.

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 (Rowland 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 users to cheaper parts of the health care 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 (non-experts) merely rubber-stamp those policies since they lack the knowledge and ability to understand complicated scientific and technological 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 policy-making and scientific advice is questionable (Fischer 2008). SHG maintains a middle view that recognizes both the essential roles 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.

Decentralized, civic participation models of governance include quite a few variants. Some are more problematic than others. 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 "control[ling] 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 undesirable features in a governance model: interest group competition in rule-making; rule-making 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 "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 ignored; "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.

More positive 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 holds 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 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 non-government 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 "dialogically, through a process of engagement and discussion among citizens" (Wendel 2001, 2000). Other versions of civic republicanism permits lawyers, as representatives of their clients, to pursue client interests, but stipulates 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 "pressur[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 below.

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, these 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 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 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 needed as an effective motivation and authoritative standard for everyone's action on health justice. Internalized public moral norms convey the shared values and goals of society and are indispensable for SHG's successful realization. The framework

needs to work out issues related to this premise: who frames the norm, situations of profound disagreement with the norm, requirements for adhering to it, and better understanding of how the norm is internalized and followed and what proportion of people need follow it. 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 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. They are found in the principles and their application as put forth in *Health and Social Justice*. This shared commitment can in turn lead to political obligations. Such ideas can be thought of as a set of political commitments that underpin a given regime's governing activities, shape the direction of institutional development, and propel action. Commitments serve as the organizing principle for integrating actions across subsystems. The actors then provide political power and legitimacy to a given regime, forming the bases of support for SHG. Institutions structure cohesion by guiding attention, providing authority, and directing information. No single decision accomplishes this, but simultaneous decisions together bring the SHG framework to fruition.

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 her fair share of resources. The implementation of this principle allocates resources based 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 declines relying solely on such mechanisms and places social norms and particularly public moral norms at the center of its framework. SHG recognizes that not only is it impossible to micro-manage all actors' health and health care behavior at all times, but it 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 about governance and the oscillation between ends of the central-local, expert-layperson, scientific-political, 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 takes hold and produces sub-optimal 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. 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

In *Health and Social Justice* I 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, I take this line of reasoning a step further, providing a theory for assigning responsibilities among the multitudes of institutions and actors (Ruger 2009a). A theory of health justice necessitates additional principles for distributing responsibility to ground the obligations of specific actors and institutions. The principles I have 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 assigns 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 necessitates a consensus on a shared authoritative standard (discussed below) 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 required to do. The process of reaching consensus on specific duties in turn demands that actors internalize the public moral norm of health equity, motivating them to act to reduce inequalities in health capabilities as efficiently as possible.

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 embraced principles. In the next section I will discuss 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 must differentiate between public and private norms. By public I mean 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." An example is the fairness norm known as the Golden Rule, which some have argued is engrained 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. In *Health and Social Justice,* however, I argued that not all moral norms are equally desirable. 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 which moral beliefs are permissible and which ought to be favored or disfavored. I agree 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 to apply social or even emotional sanctions for enforcement — on individuals failing to comply with medication instructions, for example, or on doctors recommending treatments to patients. Rather, we require a more profound commitment to both the individual and the common good, an understanding that we work together as a body to create the conditions for all to be healthy.

The autonomy (e.g., from self-interest) of the normative motivation under an SHG framework is important. Willingly living out the public moral norm is fundamental to achieving conditions for individual and population health. It is indispensable 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 provider recommendations for high quality, cost-effective care are illustrations. The internalized public moral norm also entails, 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 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 be insufficient motivation to act, and the wisdom and skills underpinning action will fail to develop over time.

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. This is the social commitment to health equity. Under this premise each individual and group will be committed to doing her or their fair share, including playing allocated roles, in creating these conditions. This joint or societal commitment is a fundamental 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 the public moral norm 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. SHG takes health functioning and health agency as central to human flourishing. 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. An extensive discussion of these points are beyond this article's scope; an examination of health capabilities vis-à-vis other capabilities can be found elsewhere (Ruger 2009b).

PST thus offers some intellectual resources that support a 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 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 approach of internalizing norms and behaviors, while more time-intensive, seems a sustainable way to promote health capabilities. One key is the norm's emerging to be viewed as legitimate and governing.

Division of Responsibility and Shared Responsibility

SHG requires individuals to take actions to improve their own health 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, I have argued for allocating the primary responsibility for efficiently reducing shortfall inequalities in central health capabilities to the State (federal government), because national governments have the political authority, resources, regulatory and re-distributive 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 which guarantees a universal comprehensive benefits package of medically necessary and medically appropriate goods and services, and which 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 the health equity norm 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 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 insure 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, 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 multi-step process, first to governmental and non-governmental institutions best positioned to make scientific decisions about such activity (e.g., the NIH, IOM, NSF), and then to entities such as universities and research institutes which 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 much 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 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 individuals 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 abstains from the traditional "motivation for responsibility" scholarship, which takes causation,

blameworthiness and guilt for harm as its 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 societal and self-regulation. While SHG brings the overarching political economic philosophy put forth in *Health and Social Justice*, SHG requires 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 responsibilities for creating a health society. The health constitution would set the framework and procedures informed by authoritative standards and principles, as set out in *Health and Social Justice*, as a foundation for assigning powers and obligations. 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 must be consistent with and undergirded by the public moral norms discussed above.

External and Internal Motivation: Failure to Commit, Positive Motivation, Social Sanctions, and Enforcement

The challenge is to get people to commit fully, share resources, and agree to be held collectively responsible. Thus individuals and groups can't internalize just any social norm; it must be a public moral norm. The normative principles stem from the health capability paradigm, which spells out the reasons for equity in social conditions for health; it explains why individuals and actors should see these 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 getting people to commit, in convincing them of the necessity of the joint enterprise. This task in many cases is possible through positive motivation (see below). There will also be a segment of the population that resists, and in these cases an effective system of sanctions, formal rules and even laws and regulation may be necessary to ensure that each actor is 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 that the health capability paradigm envisions. 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 and self- and societal understanding so that all 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 in the health sector produces sub-optimal outcomes for everyone. Redefining individuals' self-understanding and institutionalizing this common knowledge underlie 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 create a sense of dependence or co-dependence among individuals as parties to a social group. This approach appeals to the individualistic, rational side of persons and 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 so communitarian and allows a more central role for individualism. 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, like 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 US in the proportion of GDP spent on health care (OECD 2004), and both Germany and Switzerland have had more health care overutilization than the US (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 U.K. 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 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 or the patient taking an active role in her own care. 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, have 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. Rational choice theory, 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.

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