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Jasper Doomen

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Distributing Health

Jasper Doomen, Leiden University

The advent of ever more elaborate means to continue people's lives and to improve their quality of life has led to increasingly pressing questions with regard to the distribution of those means. Ruger (2012b) presents a model to answer such questions. This proves to be quite constructive when administrative matters are involved; Ruger qualifies the nation state as the central actor (Ruger 2006, 1001; 2012a, 682; 2012b).

The basic challenge, however, is what this justice looks like. This is properly presented by the author by asking what a universal consensus on health would be and which distributive principles would be involved (Ruger 2012b). A major issue that must be addressed is the basis of the claim to health. Ruger states: "The PG [provincial globalism] approach embodies social goods less amenable to material 'distribution,' such as norms, health agency development, and ethical engagement" (Ruger 2012b, 39).

The main question, however, is *what* such directives entail. In answering this question, circular arguments like the following must be avoided: "A just system of global health governance is required for achieving and maintaining global health justice" (Ruger 2012b, 42).

There are various ways to approach the issue. It is clear from the outset that Ruger would dismiss equality of opportunity (as she pleads government intervention) as well as equality of welfare (since material "distribution" is deemed insufficient). It may, incidentally, be argued that the author disqualifies equality of welfare too simply, since, given the way she presents her argument, it would not—being contrasted with perspectives that do stress norms and ethical engagement—qualify as an ethical viewpoint at all. The capabilities approach (e.g., Anand 2005, *passim*) is not accepted, either (Ruger 2006, 999, 1000). The most likely remaining model of distribution is equality of resources (Dworkin 2000, 69, 311–318). In order to complete her account, the author will have to choose one of these alternatives or provide one of her own.

Given what she says, Ruger would incorporate moral imperatives into the complemented account, yet it is incumbent on her to indicate what would make it a moral one in the first place. So when she says "SHG [shared health governance] rests on the premise that actors in the global health system will genuinely aim to achieve global health justice as opposed to pursuing self-interest or national interest alone" (Ruger 2012b, 42), one wonders whether this premise is merely an assumption (or postulate), or rather a statement that can be supported. It will not, in any event, suffice to say that "What we owe others stems from our common humanity and the centrality of health capability as a fundamental human interest, not consent to hypothetical choices" (Ruger 2012b, 38), especially if this is supported by a statement that can be explained with an appeal to self-interest: "People value health over nearly all other aspects of life when it matters most: when they are at the brink of losing it" (Ruger 2012b, 38).

To conclude, Ruger manages to analyze a number of health policy matters and to provide significant solutions, but she needs to supplement the analysis with a viewpoint—whether it be a moral one or not—that indicates on what basis health distribution is to be realized.

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Address correspondence to Jasper Doomen, Law Department, Postbus 9500, Leiden University, Leiden 2300, Netherlands. E-mail: jasperdoomen@yahoo.com