Sen's framework provides, SHG would have to provide striking benefits to justify abandoning such fundamental rights as freedom of belief and conscience.

A different option would be to frame SHG in a manner akin to John Rawls's rethinking of justice as fairness in *Political Liberalism*. Confronted with a similar problem as Ruger—that institutions structured according to his conception of justice appear to allow belief systems that would unravel that arrangement over time—Rawls reconceptualized his principles as political rather than substantively moral (Hill 2000). Instead of one comprehensive doctrine among many, a political conception of justice as fairness provides an overlapping consensus among *reasonable* comprehensive doctrines, which helps secure its stability over time. Subsequent work on public reason has helped to define *reasonable* comprehensive doctrines and could provide a framework for the kinds of belief systems that should be tolerated within the capabilities approach (Sen 2004).

If Ruger (2011) were to present the public norm that underlies SHG as one that no reasonable comprehensive doctrine could reject, rather than as just another comprehensive doctrine, she would have a stronger justification for activities such as the redistribution of wealth required for health equity. This change would also move her position closer to Thomas Scanlon's version of contractualism. Although she rejects his views as being "impracticable," a contractualist justification of the public norm would make SHG a more feasible solution to health disparities. ■

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Internalized Public Moral Norms and Shared Sovereignty

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In her target article (2011) and in *Health and Social Justice* (2009), Jennifer Prah Ruger defends an original model of governance dubbed "shared health governance" (SHG). This model borrows elements from many other models of governance, and one may wonder what is the secret sauce that holds together these diverse ingredients. In response, Ruger would perhaps ultimately turn to public moral norms. My comments raise some concerns about the function and content of these norms in her model and their connection to her claims about shared sovereignty within SHG.

Let me first reconstruct Ruger's broader project, once it is stripped of its technicalities. In *Health and Social Justice*, she accomplishes at least two tasks. First, borrowing tools from moral philosophy, she elaborates a theory of justice suitable for health ethics, policy, and law. This theory belongs to a family of neo-Aristotelian theories of justice (along with Madison Powers and Ruth Faden's twin-aim theory of social justice [2006]), but elaborates more particularly on Amartya Sen's capabilities approach (a view Powers and Faden reject[1]). Ruger's contribution to theories of justice is focused on the ramifications of a health capabilities paradigm. In short, Ruger advocates the view that health capabilities are the indicators that serve to evaluate the justness and efficiency of health policy. The theory aims to enable individuals to reach a level of health sufficiency, and more generally

I do not wish to dwell on differences between Ruger's and Powers and Faden's theories, but it should be noted that Powers and Faden do not endorse the capabilities approach, though they also defend a neo-Aristotelian theory of social justice. The reasons they offer are complex (2006, 37–41). It will suffice to cite their clearest statement: "Our theory parts company with both Sen and Nussbaum insofar as we do not endorse the political or moral primacy of protecting and promoting functional capabilities over the aim of achieving actual functioning. We do not assume that the most basic aim of justice is captured fully by the emphasis on the capabilities of adults who are then free to develop or exercise those capabilities as they see fit. In many instances, and in the case of children especially, the best account of the positive aim of justice is more directly concerned with outcomes than with available choices. Often what someone can be is determined as much or more by factors that are external to what that individual can do for herself at any given moment" (2006, 192).

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to avert premature mortality and avoidable morbidity. The whole architecture rests on the neo-Aristotelian view that health is one major contributor to human flourishing that political activity needs to promote.

Her second task is more practical. She wishes to elaborate an action-guiding model of health governance—that is, a detailed framework for assigning responsibilities for health decisions at the individual and collective levels. Why is such a framework necessary? Here, Ruger suggests that the response to this question has to do with the problem of social cooperation. When each individual aims solely at maximizing her or his self-interest, lack of adequate social cooperation leads to suboptimal collective outcomes. To solve this problem, some propose to force individuals to cooperate with others by recourse to legal or social sanctions, or at least to use incentives that encourage cooperative behavior. Ruger disagrees. For her, these types of interventions are not sufficient to suitably motivate individuals and groups to act in conformity with the requirements of her theory of justice. Moreover, they are not normatively justified since they do not pay due respect to individual autonomy. Autonomy is best expressed through personal commitment to a norm one freely endorses, and not through obedience out of fear of coercion or for the sake of external motivators such as incentives or disincentives. Ruger's solution is to borrow tools from political and social sciences to elaborate her SHG—a model she believes to be normatively desirable and able to provide a better solution to the social cooperation problem than alternative models.

Within the SHG model, "internalized public moral norms" play a key role in solving the social cooperation problem. These are moral norms that govern the public sphere. When internalized, they function as internal motivators that enable individuals to freely act in conformity with the demands of justice. External legal and social sanctions and incentives might still be necessary, at least for those who are not committed to these public moral norms.

What is the content of public moral norms? Their content coincides with the demands set forth by Ruger's theory of social justice—the health capabilities paradigm. Examples include "the public moral norms of health equity," and a norm stating that each individual is entitled to an adequate level of "health sufficiency."

Now, it is not clear to me that internalized public moral norms can fulfill the function Ruger assigns to them. In other words, I am not convinced they can significantly help to solve the social cooperation problem. For instance, in this article Ruger mentions nonadherence to treatment as one case in which social sanctions are ineffective. Would internalized moral norms help with nonadherence to treatment and avoid its negative impact on individual and collective health? It is not clear that we should keep our expectations very high. The causes of nonadherence to treatment are complex and not fully elucidated, but if weakness of the will and myopic decision making (overly discounting future rewards) play a major role in explaining this phenomenon, being morally committed to doing one's fair share in order to advance individual and collective health will not be of much help to promote regular drug intake, for instance. Perhaps recourse to incentives or nudges will be more effective. My claim is not that commitments to public moral norms can play no role in fostering social cooperation; rather, it is that Ruger is vague about the magnitude of their expected impact and the particular problems for which they are likely to be most helpful.

There is a further worry with regard to public moral norms. Putting to the side the problem with their function, what about their content? As I read Ruger, their content is derived from the health capabilities paradigm. That is, it is exclusively based on a substantive neo-Aristotelian theory of justice. There is a tension between the role of moral theory in Ruger's work and the rhetoric of "shared sovereignty," which suggests a strong emphasis on citizens' input. Schematically, "shared sovereignty" can be read in three different ways.

On a strong reading, citizens share sovereignty in the sense of that they have a say as to which public moral norms should be adopted. This interpretation is ruled out by Ruger's defense of a substantive theory of justice and her rejection of a procedural one.

On a weaker reading, Ruger might claim that shared sovereignty simply means that through a public process of consensus building and value convergence, the moral norms set forward by her moral theory get specified into particular duties thanks to citizens' input and public deliberation. But her theory allows little room for rich specification (Richardson 1990). Take, for instance, the assignment of responsibility for health decisions. Ruger offers two criteria for dividing the moral labor as to who is responsible for what: one's position with regard to the possibility of fulfilling that duty and one's resources. Both criteria are entirely generated by her moral theory, and owe nothing to citizens' shared sovereignty. I conclude that the space left in Ruger's theory for the specification of duties is narrow.

On a yet weaker reading, Ruger argues that moral theory offers the best normative parameters within which collective decisions about particular health policies can be made. Hence, on this reading, public moral norms are not determined by the outcome of public deliberations (shared sovereignty), though health policy is, as long as it is consistent with the demands of moral theory. This is, I think, what she means in this article when she mentions that the content of the health constitution ought to be "consistent with and undergirded by the public moral norms." But in that case I do not see what distinguishes her theory from the other major neo-Aristotelian theory of social justice in health policy, that of Powers and Faden (2006, chapter 7), with respect to the role of moral theory.

I do not wish to make any claims in this commentary about whether more space for citizens' input is required in Ruger's theory. Instead, my aim is to simply point out that Ruger seems to fall short of her own ambitions to fully integrate moral theory, scientific expertise, and democratic procedures. In the final analysis, the connection between

her moral theory and her governance model needs further elaboration. ■

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Developing a Healthy Sense of Cooperation

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Traditionally, policymakers have thought of individuals as rational maximizers of their own self-interest, seeking to achieve the greatest possible benefit for themselves in any situation. Using this standard economic approach, the goal of policy is to find the right mix of regulatory carrots and sticks to align individual interests with socially optimal outcomes—with the proper incentive structure, individuals pursuing their own interest can contribute to the greater good as well.

Given this view, Ruger's (2011) call for a health care system grounded in voluntary compliance and cooperation in addition to self-interest may seem like wishful thinking. However, a growing body of research reveals that the actual motivations of individuals are far more complicated than those presumed in traditional economic theory. In fact, experiments suggest that more people are motivated by cooperative impulses than by self-interest (Benkler 2010). Moreover, cooperative impulses have been successfully utilized in a number of policy areas, including public health and patent review.

Building a cooperative system, however, requires careful planning: Cooperation has proven to be context specific, meaning that well-designed systems can encourage greater cooperation, while poorly designed ones can discourage it. Also, reliance on cooperative impulses may be misplaced when dealing with corporate entities rather than individuals. By looking to successful cooperative models, as Ruger suggests, policymakers can better understand how and when to utilize cooperative regulatory structures in the health care system.

In discussing cooperative systems, it is important to specify exactly what is meant by the term. Cooperative systems do not require total reliance on cooperation and voluntary compliance, nor do they ignore the important role that self-interest plays in human motivation. Rather, these systems reflect the understanding that self-interest is not the only means of motivating behavior, and are designed to ensure that appeals to self-interest do not undermine cooperative impulses. Cooperative systems are intended to inculcate individuals with the desire to participate because they are intrinsically motivated to do so, rather than because of external rewards or punishments.

While reliance on cooperation and voluntary compliance may seem misplaced from the viewpoint of traditional economics, in fact, we can see the presence of cooperative impulses everywhere we look. Few things are more derided than taxes, but our income tax system boasts a high level of voluntary compliance, much higher than standard economic models would predict given the low level of enforcement (Slemrod 1998). And the Internet has provided numerous examples of successful cooperative efforts that require significant investments of collaborators' time and energy for little or no financial gain, such as the online encyclopedia Wikipedia and the open-source operating system Linux.

Even in the business world, where self-interest would seemingly reign supreme, social psychologists argue that people are motivated by a number of factors other than money and prestige, including perceived competence at one's job, autonomy in one's actions, and interpersonal connections with one's coworkers (Ryan and Deci 2000). Thus, people can be inspired to work harder by creating an environment that causes them to more positively view their employer and coworkers.

Given its usefulness in motivating behavior, greater attention should be paid to methods of encouraging high levels of cooperation. Ruger is correct that "while regulations and laws are of great consequence to social cooperation, alone they are not enough; no government agency can micromanage and police everyone in every situation" (32), yet policymakers have an important role to play in shaping the conditions for cooperation to flourish. Benkler (2010) identifies a range of social dynamics that contribute to cooperation, including communication, efficacy, norms, trust,

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