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REFLECTIVE SOLIDARITY AS TO PROVINCIAL GLOBALISM AND SHARED HEALTH GOVERNANCE

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Abstract. There is a special need for solidarity at the global level to address global health disparities. Ter Meulen argues that solidarity must complement justice, and is, in fact, more fundamental than justice to the arrangement of health care practices. We argue that PG/SHG, though a theory of justice, is fundamentally synergistic with solidarity. We relate PG/SHG to Jodi Dean's conceptual work on reflective solidarity, contrasted with conventional solidarity, as an approach to transnational solidarity that dovetails with PG/SHG. We argue that PG/SHG meets both the need for solidarity at the global level and the need for solidarity within theories of the arrangement of health care practices.

Keywords: solidarity, justice, reflective solidarity, health capability, health capability paradigm, provincial globalism, shared health governance, global health governance, plural subject theory.

There is a special need for solidarity at the global level to address global health disparities. Without solidarity, remote violations of rights and distant health inequities are too easily ignored.[1] This is evidenced by the persistence of the large gap in global health expenditures, the migration of skilled healthcare workers from low-income to high-income countries, exploitation of the poor by private pharmaceutical and research interests,[2] and ineffectiveness in the donor-driven international aid agenda.[3] The result is a consistent health disparity between the "haves" and the "have-nots." As greater emphasis is placed on the self, a preference for individual freedom and individual rights grounded in autonomy replaces the value found in social context and drives alienation of, and thus a lack of concern for, the "other."[4] Conventional solidarity, with its emphasis on group or national identity, is itself often criticized for perpetuating this "us versus them" mentality,[5] and is therefore insufficient to address global health disparities. Only the

[1] Benatar [2003].

[2] Harmon [2006].

[3] Ibidem; Ruger [2015].

[4] Harmon [2006].

[5] Meulen ter [2015].

global social context can "vindicate the value" of solidarity.[6] Global, transnational solidarity, not simply "new types of national solidarity,"[7] are needed if we are to meet the challenge of addressing global health disparities. Provincial globalism and shared health governance (PG/SHG) is a theory of global health justice and governance which seeks to provide a standard for global health judgments for global social progress.

It is in this context that the relationship between solidarity and provincial globalism and shared health governance (PG/SHG) is considered. How, if at all, does PG/SHG incorporate and promote solidarity within the global social context? Ter Meulen, in the conclusion of his recent article on solidarity and justice in health care, raises a fundamental concern regarding theories of justice. He writes,

> The increased emphasis on the concept of justice to analyze distributions of benefits and burdens in health and social care has the risk of a diminishing of attention for the personal bonds and commitments on the level of care practices. This may result in an impoverishment of the relations in health care which are fundamentally based on benevolence and commitment to the well-being of the other.[8]

According to ter Meulen, solidarity must therefore "be regarded as an important corrective to arrangements of health care practices that are based on a just distribution of goods only."[9] He does not mean that solidarity ought to replace justice, but that it must complement justice, and is, in fact, more fundamental than justice to the arrangement of health care practices.

We argue that PG/SHG, though a theory of justice, is fundamentally synergistic with solidarity. To be sure, we do not mean conventional solidarity, but relate PG/SHG instead to Jodi Dean's conceptual work on reflective solidarity as an approach to transnational solidarity that dovetails with PG/SHG. PG/SHG should be seen as a theoretical model for the arrangement of global health care practices consistent with ter Meulen's view that solidarity must complement justice in such theories. PG/SHG therefore meets both the need for solidarity at the global level and the need for solidarity within theories of the arrangement of health care practices.

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[6] Harmon [2006] p. 218.

[7] Houtepen, Meulen ter [2000] p. 329.

[8] Meulen ter [2015] p. 18.

[9] Ibidem.

In *Solidarity of Strangers*, Dean contrasts conventional and reflective solidarity.[10] Conventional solidarity is built around a community's "common interests and concerns"[11] such as particular traditions and values. Conventional solidarity has effectively motivated the development of universal health coverage schemes in many Western industrialized nations. However, insofar as a community with conventional solidarity aims to bring outsiders into its circle, it aims to persuade these outsiders to adopt its particular traditions, values, interests, and concerns. Communities with conventional solidarity, therefore, either remain isolated from the individuals or groups they cannot convert or discourage and repress the differences inherent in those individuals or groups they do convert. This is what critics mean by conventional solidarity's lack of concern for the "other." Emphasizing in-group similarity necessarily perpetuates a divide between "us" and "them," or minimizes the traditions and values of the other. Reflective solidarity, on the other hand, "provides a form of consideration of the other where the other is considered a member despite, indeed because of, her difference."[12] Reflective solidarity collapses the divide between "us" and "them" by acknowledging that community members "are always insiders and outsiders…[and] are always situated in a variety of differing groups all of which play a role in the development of our individual identities."[13] As we argue below, this conception of solidarity, and not conventional solidarity, is consistent with PG/SHG.

PG/SHG is not nearly as communitarian as conventional solidarity. Rather, PG/SHG permits a greater degree of individual expression and self-regarding behavior. Though conventional solidarity in health systems does exist—in many countries that boast universal health coverage, for instance—PG/SHG cannot be reduced simply to universal coverage, does not require global citizens to develop a "common conscience," and realistically expects that actors will sometimes disagree substantially about means and ends. Conventional solidarity also discounts the role of individual action and individual responsibility and therefore departs from PG/SHG around the opportunity to construct a social system from individual self- and other-regarding behavior.[14]

Rather, PG/SHG embodies elements of reflective solidarity. A central focus of PG/SHG and of solidarity is positive freedom (freedom to develop oneself),

[10] Dean [1996].

[11] Ibidem, p. 18.

[12] Ibidem, p. 30.

[13] Ibidem, p. 34.

[14] Ruger [2011].

whereas many theories of justice tend to focus on negative freedom (freedom from interference by others).[15] The normative basis of PG/SHG—the health capability paradigm (HCP)—also emphasizes positive freedom in its adoption of health capability as the central variable for determining whether health policy is just and efficient.[16] Health capability is defined as the confidence and ability to effectively achieve optimal health within the constraints of one's biology and genetics, proximal and wider socio-political and economic environment, and access to public health and systems of health care. People do not only desire good health, but also the ability to obtain it. Thus, the HCP places value on both health functioning and health agency as targets for social policy and evolution. Health agency is the ability to obtain and use health-related information, understanding, and skills to promote health and develop habits and conditions for avoiding morbidity and mortality as much as possible within the constraints described above. Health agency is therefore not simply autonomy about one's health or health-related decisions. Health agency is simultaneously a more positive concept closely related to personal development and maintenance and a concept that acknowledges the interdependency and codependency of individuals. At its core, the HCP captures the reality that individual choices do not take place in a vacuum.[17] For this reason, health capability necessarily requires the analysis of societal factors that interact with and influence individual health capabilities. Health capability is not merely a collection of individual knowledge, skills, and habits; it is additionally a collection of external situations and conditions that permit the achievement of optimal health, including material realities, health service quality and availability, social norms and networks, and the impact of group memberships. By focusing on health agency, the HCP is fundamentally concerned with an individual's ability to develop oneself, and with its focus on both the internal and external factors that affect health agency, views the individual as firmly embedded in a social context.[18]

The idea that individuals are firmly embedded in a social context is developed further in PG/SHG. PG/SHG employs Plural Subject Theory (PST) to conceptualize different categories of "subjecthood" that individuals everywhere experience, which subsequently result in the ethical commitments we make and obligations we assume.[19] PST is concerned with the self-understanding of individ-

[15] Houtepen, Meulen ter [2000].

[16] Ruger [2010a].

[17] Ruger [2012].

[18] Ruger [2010b].

[19] Ruger [2012].

uals who see themselves and others as a social collective committed to the achievement of a common objective. Every individual is a plural subject in PG/SHG. As plural subjects who frequently act and work together (or fail to act), we create the conditions for all individuals including ourselves to achieve optimal health. The PST recognition 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"[20] is integral to PG/SHG.[21] PST acknowledges that all human beings are simultaneously individuals and community members at both a domestic and global level. For instance, in the domestic and global health contexts, individuals are plural subjects in at least three categories: (i) ourselves and our individual endeavors; (ii) our nation; and (iii) our world. This approach enables balancing our justified partiality toward fellow citizens (our national subjecthood) with our partiality toward foreigners (our global subjecthood). Even if our global partiality is not as strong from an associative or identity perspective, it can and should be quite strong in terms of our commitment to health equity and the domestic and global levels. Understanding both motivations and striking a balance between them requires assuming roles and responsibilities that incorporate both moral motivations simultaneously. In fact, these moral motivations can be compatible, rather than mutually antagonistic. Applying PST to health issues calls for a common subjecthood aimed at the co-creation of a healthy society.[22] PST applied to health, therefore, requires mutual understanding of shared problems and joint commitments to solving them, but without ignoring the reality that individual subjects and their differences exist.

PST therefore captures an important aspect of solidarity best understood within Dean's conception of reflective solidarity. Harmon argues that, "Solidarity recognizes that individuals are naturally and irrevocably embedded in social contexts; they are in a state of interrelationship or interconnectedness with individuals, groups and society."[23] Others, following Jaeggi,[24] stress that solidarity is "based on the mutual relatedness and fundamental interdependency of individuals" and quote Marx ("the existence of the other is not the limitation but the precondition of my own freedom") to underline the "fundamental social

[20] Gilbert in: Schmitt [2003] p. 55.

[21] Ruger [2011].

[22] Ruger [2012].

[23] Harmon [2006] p. 218.

[24] Jaeggi in: Meulen ter, Arts, Muffels [2001].

embeddedness of individuals."[25] PST acknowledges that the conditions necessary for individual health are created by and within communities. While theories of justice can be criticized for focusing on freedom from interference by others, PG/SHG, with its grounding in PST, views individual freedom as conditional on relationships with others. This notion of solidarity also addresses objections to conventional solidarity that are concerned with perpetuating an "us versus them" mentality that reduces our desire to help those in outside communities. Solidarity in PG/SHG does not aim for the development of overly strong national and group identities. While it recognizes the legitimacy of partiality toward fellow citizens, PST requires that we balance our domestic subjecthood with our global subjecthood, thus recognizing a need to fulfill obligations to foreigners who may appear very different from us. Instead, solidarity in PG/SHG emphasizes the "fundamental social embeddedness of individuals"[26] and requires recognition of the fact that interrelationships with other individuals, groups, and societies are necessary for individual freedom and the achievement of health capabilities, not their limitation. This is what Jodi Dean calls reflective solidarity as opposed to conventional solidarity. In reflective solidarity, "We recognize [the other] in her difference, yet understand this difference as part of the very meaning to be one of 'us'…"[27]

In conclusion, conventional solidarity is built around "common interests, concerns, and struggles" and group identities, which can promote a counter-productive "us against them" mentality.[28] Reflective solidarity and the plural subject components of PG/SHG, however, views "the other" as indispensable to the individual self and her pursuit of freedom and health capabilities. Moreover, the exercise of health agency rests partially on external conditions such as social norms, networks, and capital, the influences of group membership, and material circumstances. That is to say, in the pursuit of health-related ends individuals require emotional and instrumental support from friends and family, communities in which social norms are developed and social assistance is offered, the opportunity for work, safe and sufficient housing, adequate sanitation, and food security, among others.[29] These things are only possible within a community. Reflective solidarity captures this reality. PST similarly conceives individual freedom as

[25] Houtepen, Meulen ter [2000] p. 335.

[26] Ibidem.

[27] Dean [1996] p. 39.

[28] Meulen ter [2015].

[29] Ruger [2010b].

predicated on relationships with others. There are at least three levels of individual subjecthood: ourselves, our state, and our world. Our obligations to each level are inextricably linked. Within conventional solidarity, these obligations are often considered mutually antagonistic; within reflective solidarity, they are mutually, and necessarily, compatible.

There is both a critical need for solidarity within the global social context, so that remote violations of rights and distant health inequities may be addressed and, as ter Meulen argues, a need for solidarity to ground theories of justice about the arrangements of health care practices. PG/SHG addresses both of these needs by grounding its global theory of justice in plural subject theory and the health capability paradigm, each synergistic with reflective solidarity, thus avoiding the pitfalls of conventional solidarity and ensuring an "important corrective to arrangements of health care practices that are based on a just distribution of goods only."[30]

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