

Public Health or Clinical Ethics: Thinking beyond Borders

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Most work in medical ethics across the last twenty-five years has centered on the ethics of clinical medicine. Even work on health and justice has, in the main, been concerned with the just distribution of (access to) clinical care for individual patients. By contrast, the ethics of public health has been widely neglected. This neglect is surprising, given that public health interventions are often the most effective (and most cost-effective) means of improving health in rich and poor societies alike.

In this essay I explore two sources of contemporary neglect of public health ethics. One source of neglect is that contemporary medical ethics has been preoccupied—in my view damagingly preoccupied—with the autonomy of individual patients. Yet individual autonomy can hardly be a guiding ethical principle for public health measures, since many of them must be uniform and compulsory if they are to be effective. A second source of neglect is that contemporary political philosophy has been preoccupied—in my view damagingly preoccupied—with the requirements for justice *within* states or societies, and (until very recently) has hardly discussed justice across borders. Yet public health problems often cross borders, and public health interventions have to measure up to the problems they address.

An ethically adequate approach to health questions needs to look beyond the clinical context, and beyond the boundaries of states and health care systems. Health ethics must cover more than clinical ethics; accounts of

health and justice must cover more than the just distribution of clinical care within health care systems.

INDIVIDUAL AUTONOMY AND PUBLIC HEALTH

Contemporary medical ethics emerged in rich societies, in particular in the United States, during the 1970s. Unsurprisingly, it took for granted the medical practices and institutions of such societies. The new medical ethics addressed ethical problems that were typical of professionalized, hospital-based clinical practice that could provide expensive, high-tech medical interventions. Traditional one-to-one, long-term physician-patient relationships, based on patient trust and physician beneficence, did not fit well into the new clinical settings, which deployed large teams of professionals in the care of individual patients. The new medical ethics advocated an end to all forms of medical paternalism, in favor of what is now usually called patient autonomy.¹

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¹ Tom L. Beauchamp and James F. Childress, *Principles of Biomedical Ethics* (New York: Oxford University Press, 1979), became a standard text placing individual autonomy at the heart of medical ethics. Consistent opposition was voiced from an early date by Daniel Callahan, "Autonomy: A Moral Good, Not a Moral Obsession," *Hastings Center Report* 14 (1984), pp. 40–42, and "Can the Moral Commons Survive Autonomy?" *Hastings Center Report* 26 (1996), pp. 41–42.

The various conceptions of individual autonomy deployed in medical ethics view it as a predicate of individual persons. Autonomous patients are independent agents who decide for themselves whether they will accept or refuse treatment; professionals are to respect patients' autonomy and undertake treatment only on the basis of informed consent. Compulsion and coercion are always unacceptable in clinical practice. The new medical ethics had relatively little to say about public health, where interventions are often (and sometimes necessarily) compulsory.²

Even in clinical practice, unqualified demands to respect individual autonomy proved problematic. As sociologists and anthropologists of medicine have long pointed out, the individualistic frameworks within which conceptions of individual autonomy can most easily be thought of as central to medical ethics correspond poorly with the realities of clinical practice. Professionals are linked in complex institutional networks; patients come encumbered with family and other responsibilities.

Nor was individualism the only problem. Since ill health so often limits individual independence in minor and major ways, it was harder to build respect for individual autonomy into medical practice than into most other areas of life. Children and the senile, the comatose and the confused, the cognitively impaired and the mentally disturbed, and all of us when we are feeling ill and frail, have reduced or no capacity for individual autonomy.

Showing what it takes to support patient autonomy and professional respect for that autonomy amid—almost despite—the realities of limited capacities proved hard work. The social and medical realities were typically reconciled with individual independ-

ence by relying on minimal interpretations of individual or personal autonomy that reduced it to requirements to institute and respect informed consent procedures.³ In cases where capacities to give and refuse consent were impaired, medical ethicists looked for more inclusive or accessible ways for patients with limited capacities for individual autonomy to give and refuse consent. Patients nevertheless seldom experience medical care as an arena for individual autonomy or independence. This is hardly surprising: if individual autonomy is reduced to respect for informed consent procedures, it amounts only to freedom to refuse what others offer. Patients who are offered only the standard treatment for their disease may (even if consent and refusal of consent are within their capacities) feel that their choices were pretty limited, that they had little scope for any robust expression of individual autonomy.

In consequence the forms of autonomy discussed in contemporary medical ethics had very little to do with the Kantian conception of autonomy, whose pedigree was nevertheless frequently but misleadingly invoked.⁴ Unlike individual autonomy, Kantian autonomy is predicated of principles, rather than of persons. It demands that

² Even discussions of health and justice have often been more concerned with the just distribution or allocation of clinical care to individuals, rather than with public health. See Norman Daniels, *Just Health Care* (Cambridge: Cambridge University Press, 1985).

³ Tom L. Beauchamp and Ruth R. Faden, in collaboration with Nancy M. P. King, *A History and Theory of Informed Consent* (New York: Oxford University Press, 1986).

⁴ For some of the differences see Thomas E. Hill, Jr., "The Kantian Conception of Autonomy," in *Dignity and Practical Reason in Kant's Moral Theory* (Ithaca: Cornell University Press, 1992); and Onora O'Neill, *Autonomy and Trust in Bioethics* (Cambridge: Cambridge University Press, 2002).

action be based on principles that can be adopted by all. It therefore demands that we reject principles such as those of injuring or coercing, of manipulating or deceiving, of extorting or false promising, of oppressing or victimizing, and the like, whose universal adoption would *at least sometimes* be expressed in like action, so *at least sometimes* prevent others from adopting like principles. Such principles cannot be universalized.

Proponents of Kantian and individual autonomy converge in regarding compulsion, and the coercive sanctions by which it is achieved, as generally wrong. The advocates of individual autonomy generally take a Millian view of the limits of acceptable coercion, which argues that it is permissible to coerce individuals only to prevent them from harming others. Kant and proponents of Kantian autonomy argue more broadly that human societies need public authorities with power to compel individuals to act in order to support a larger scheme designed to limit restrictions on freedom. They advocate an approach that does not give automatic priority to individual autonomy, and a framework within which some public health measures may—and others may not—legitimately be compulsory, and backed by coercive sanctions if necessary.

COMPULSION IN CLINICAL MEDICINE AND PUBLIC HEALTH

If the ethically acceptable practice of medicine prohibits compulsion of individuals, except in narrowly drawn circumstances, it is clear enough why contemporary medical ethics has little to say about public health. Yet since public health measures are particularly effective ways of improving health, particularly (but not only) in poorer societies, this silence has striking results. Reading in med-

ical ethics one could be forgiven for thinking that health interventions and improvements are the preserve of medical systems and the medically qualified, that they always require individual consent, and that the very health interventions most likely to be most effective in poorer and richer societies are not ethically acceptable. The fact that aspects of clinical practice rest on forms of compulsion, and so ultimately on the possible use of coercion, is simply overlooked.

I am personally skeptical of attempts to make individual autonomy the central value of medical ethics. However, here I do not want to say more about my underlying reasons for this skepticism, but rather to look more closely at ways in which a focus on individual autonomy can marginalize and even undermine adequate consideration of public health ethics, and also distort discussions of justice and health care. The basic reason why contemporary medical ethics has so little to say about public health is, in my view, that its focus on individual autonomy suggests that *all* compulsion for the sake of health is wrong. Yet many public health measures have to be compulsory if they are to be effective, and all compulsion ultimately relies on sanctions, hence on the possible use of some sorts of coercion. If we start from the assumption that individual autonomy is the key to medical ethics, and that all compulsion and all coercion are wrong, public health measures are unavoidably suspect.

In fact, some sorts of compulsion are basic even to clinical medicine, as practiced in all parts of the world. Most obviously, the costs of health care are usually funded in part, or even entirely, out of taxation, which is compulsory and whose collection ultimately rests on the use of coercive sanctions. However, this compulsion is perceived as “external” to medical practice. Secondly, the practice of clinical

medicine is heavily controlled by legislation and regulation, and these are ultimately enforced by coercive sanctions. The controls within health-care systems bear in the first instance on professionals rather than on patients, and are generally seen as acceptable conditions of professional certification and employment rather than as threats to professional autonomy (nobody is forced to practice medicine). Equally, institutional certification, inspection, and quality control also are compulsory, but again are generally viewed as acceptable conditions for being permitted—sometimes even funded—to practice medicine. By contrast, the health-care systems and policies of rich societies limit compulsion of patients to emergency and exceptional measures, such as detention of those whose illness may endanger others, quarantine, vaccination (in some cases), or notification of certain diseases. (In the vaccination case some rich societies, including Germany and the United Kingdom, have allowed individual autonomy to trump public health concerns, and some communities in both societies now hover on the edge of measles epidemics).

The need for compulsion, however, and the possibility of coercion, is evident in the area of public health. Some public health measures have to be compulsory because variation in provision to suit individual preferences is not technically feasible. For example, standards for public goods such as air and water quality, food safety and waste disposal, and road and building safety have to be imposed. Because they are organizationally external to the health-care system, their imposition is not seen as violating demands for individual consent and autonomy that have been so prevalent within medical ethics.

By contrast, we can allow some variability in the standards to which consumer goods are produced. Yet here too we accept some

compulsion in setting uniform safety standards, because we know that individuals cannot judge the safety of complex products themselves. Only in marginal cases where the effects of individual consumption are wholly on that individual, and where consumption is optional—high-tar cigarettes, safety helmets for cyclists—may we sometimes think it enough to warn and educate. Even in these cases there is constant debate as to whether health education and health promotion, which preserve individual autonomy and avoid compulsion (at least for adults) are enough.

Evidently, then, public health policies are often imposed, and imposed for good reasons. They are imposed on populations and groups at common risk—that is why they can be so effective. So it is not surprising that they have been so largely exempted from demands that individual autonomy be built into health provision. Yet this is often obscured because mainstream writing in medical ethics has ignored public health requirements. They are often seen as external to medicine, perhaps because they are the responsibility not of medical practitioners or ministries of health, but of other agencies and ministries. During recent decades a concentration on autonomy in medical ethics, combined with the assumption that public health can properly be separated from provision of clinical care, has distracted us from thinking as broadly or as well as we might about health ethics, and in particular about the ethics of public health.⁵

⁵ I leave aside the question of whether processes of democratic legitimation could show that some compulsion is acceptable, though we would probably not judge health and safety standards and requirements acceptable if they inflicted or permitted serious harms, however strongly they were endorsed by a democratic process.

HEALTH, JUSTICE, AND BOUNDARIES

A focus on clinical medicine has (rather surprisingly) been extended into many discussions of health and justice, which often focus mainly on the just distribution of individual (access to) clinical care.⁶ If health provision consisted entirely of clinical provision, it could in principle be based on voluntary, consensual relationships between patients and physicians that respect individual patient autonomy (however conceived). The good to be distributed could not then be health care itself (let alone health!), but rather access to health care or opportunity for health care. This way of thinking preserves the view that health measures are the province of clinical medicine, and that compulsion is unacceptable outside narrowly defined areas.

Discussions of health and justice that focus on the distribution of (access to) clinical care marginalize public health in two ways. Like medical ethics that focuses on clinical medicine, they tend to leave public health measures out of the picture. They also usually marginalize public health by taking existing boundaries—whether the boundaries of states or the (often coinciding) boundaries of health care delivery systems—as fixing the *scope* of justice.

In taking this view of the scope of justice, discussions of health and justice follow the statist focus of most contemporary conceptions of justice. They view questions about just health care, medical rationing, and medical resource allocation as internal to states and health-care delivery systems. Health economists and health policy analysts typically focus on (just) health-care provision within boundaries, and bracket ill health beyond boundaries. The huge health problems of poorer parts of the

world, for which public health interventions are often of decisive importance, are then seen as matters for development programs and development studies, rather than as part and parcel either of mainstream theories of justice or of mainstream medical ethics.⁷

The common neglect of ill health beyond borders reflects well-entrenched features of contemporary political philosophy, which has typically confined questions of distributive justice within societies, and viewed transborder justice (at best) as a secondary matter. The conceptions of justice most favored in developed societies have often been statist—they have assumed that states are the primary agents of justice, and that justice is primarily “domestic.” These claims may seem surprising in view of the fact that some prominent contemporary conceptions of justice have explicitly repudiated the view that justice is state-centered. For example, John Rawls, whose philosophical approach has been so widely followed in writing on justice in welfare and health-care provision, insists that the locus of justice is not the state but the “bounded society.” In my view, the supposed difference between states and bounded societies is less robust and less convincing than Rawls claims. For he thinks of a “bounded society” as a socie-

⁶ Daniels, *Just Health Care*; Dan W. Brock, Allen Buchanan, Norman Daniels, and Daniel Wikler, *From Chance to Choice: Genetics and Justice* (Cambridge: Cambridge University Press, 2000).

⁷ The scene may be changing. Recent literature on health inequalities is not confined to inequalities within states, and connections between normative reasoning and health inequalities are being drawn more frequently. See some of the papers in David A. Leon and Gill Walt, eds., *Poverty, Inequality and Health: An International Perspective* (Oxford: Oxford University Press, 2001); and in Sudhir Anand, Fabienne Peter, and Amartya Sen, eds., *Health, Ethics, Equity* (Oxford: Clarendon Press, forthcoming).

ty that is politically organized, that protects its territory and its boundaries, and that excludes outsiders.⁸

The costs of assuming that the context of justice, including that of justice that bears on health, must be either a “bounded society” or a state are high. In failing to look beyond boundaries we fail to take into account the fact that boundaries are now multiply porous. Health problems travel across boundaries not only because diseases travel, but also because the mirror image of a global configuration of social and economic power is a global configuration of poverty and ill health. Work in political philosophy that assumes that boundaries can define and separate discrete domains of justice is increasingly unrealistic.

Yet looking beyond boundaries in building an account of justice, including health justice, is not simple. Adopting a wholly abstract or moral cosmopolitanism ostensibly takes the moral standing of all individuals in all societies equally seriously—but often at the expense of moving thinking about justice remarkably far from the realities of power and the capabilities for effective action. Such thinking is likely to identify at most certain targets or ideals: for example, an ideally just distribution of resources, or of health care. Further lines of argument to show *who* ought to do or provide *what* for *whom*, and specifically *who* ought to do *what* to protect or restore *whose* health, are then remarkably hard to identify. Knowing that some distribution (equal, maximin, or whatever) of resources, or of health care, would be *ideally* just does not take us far toward knowing *who* should do *what* for *whom* in order to work toward that distribution.

Nor can approaches to justice that assign priority to “bounded societies” or states get very far by pointing out that states construct international institutions, such as the United

Nations and the WHO. If states are the primary global actors, they may be able to secure some forms of international justice, but “domestic” justice will remain the primary focus and the primary locus of any legitimate use of force. Political philosophy that starts with states is therefore unlikely to offer a full account of global or cosmopolitan justice, in which any boundaries have to be justified rather than presupposed. Any political philosophy that assigns basic moral standing to societies (or to other bounded entities such as nations, peoples, or states) will be hard-pressed to justify a more cosmopolitan conception of justice, including health justice. As we know all too well (in this respect realists in international relations are not wrong), states and other bounded entities usually pursue self-interest in constructing and supporting international institutions.

In my view, we need to be both more practical and more philosophically rigorous if we are to identify norms for health policy that can guide action without marginalizing public health, and without assuming arbitrarily that justice is to be pursued primarily within borders. To do so we need to engage as fully with political philosophy as we do with (medical) ethics, and to set aside—or rather relegate to their proper context—exaggerated views of the importance of individual autonomy. In starting with political philosophy, we must make it explicit that just health provi-

⁸ Rawls’s reasons for thinking that such societies are not states is, I suspect, that he adopted a realist conception of the state, consequently assumed that state action would be irredeemably self-interested, and thus that states provide an inadequate basis for thinking about justice beyond borders. But not all conceptions of the state are realist. See Onora O’Neill, “Political Liberalism and Public Reason: A Critical Notice of John Rawls, *Political Liberalism*,” *Philosophical Review* 106, no. 3 (1997), pp. 411–28; Andrew Kuper, “Rawlsian Global Justice: Beyond the Law of Peoples to a Cosmopolitan Law of Persons,” *Political Theory* 28, no. 5 (2000), pp. 640–74.

sion has to be based on a reasoned view of the limits of justified compulsion, and hence of the limits of permissible coercion, not only in transferring resources (whether within or across borders) but also in maintaining and enforcing public health policies.

NORMS FOR HEALTH POLICIES

Norms for health policies could be approached by a number of types of argument. To many writers it has seemed most plausible to derive them from an account—complete or partial, subjective or objective—of the good. Such accounts are hard to establish, but supposedly can provide a strong anchor for normative reasoning, and thereby for health ethics and health justice, including public health ethics. I am skeptical on various counts. Some brief reminders will have to stand in for long and complex arguments.

First, it is worth recalling the standard difficulties with subjective conceptions of the good, such as those preferred by utilitarians or more narrowly by those whose approach to health ethics is based on some measure of experienced health (for example, the Quality Adjusted Life Years measure). Subjective measures of the goodness of outcomes are problematic, in matters of health as elsewhere, because each person experiences benefit and harm, including good or ill health, in a certain light. The problems of adaptive preference (in health debates: the “contented invalid”) and of expensive tastes (in health debates: the “worried well”) are ubiquitous. Aggregating with elastic units of account cannot lead to reliable conclusions, even if the units are purportedly worth attending to.

If health norms are to be derived from a conception of the good, it had better be from an objective conception of the good, measurable in objective units and providing

a basis for objective judgments of aggregate and comparative good. It is easier to wish for an objective account of the good than to find one. Broadly speaking, few philosophers now expect to find an objective account of the good, complete with a standard unit of account, for measuring and comparing differing goods. Most contemporary accounts of the good are pluralistic: they claim that a good life includes a plurality of goods, but that we lack any common metric for ranking their goodness. For example, in *Women and Human Development*, Martha Nussbaum proposes a rich, pluralistic conception of the good.⁹

Without a common metric for aggregating goods and comparing different bundles of goods, however, a conception of the good cannot shape public policy, including health policy. The reason is simple. Just as a shopping list—a list of heterogeneous goods that cannot be measured, ranked, or compared in terms of any common unit—does not tell us which purchases should have priority, so a pluralistic account of the objectively good without a common metric does not tell us which policies or interventions should have priority. These problems are not overcome either by confining discussion to “basic” goods (which still need to be ranked or compared if we are to draw normative implications), or by treating public discussion and collective decision-making as a source of normative justification. The philosophical demands of arguments that define basic goods or demonstrate how and when political legitimation provides normative justification are formidable.

Another way of reaching action-guiding health norms would be to ask what ought to

⁹ Martha C. Nussbaum, *Women and Human Development: The Capabilities Approach* (New York: Cambridge University Press, 2000).

be done, rather than what results ought to be achieved. A favored way of doing this across the last fifty, and especially the last thirty years, has been to look at action from the recipient's point of view and to propose an account of rights.¹⁰ A common problem with rights-based approaches is that rights are usually identified using highly ambiguous substantive phrases such as "right to life" or "right to health," "right to development" and "right to work," "right to equal opportunity" and "right to access," as well as latterly "right to know" and "right not to know." Most of these phrases have multiple interpretations: they cannot be disambiguated without sorting out *who* has to do *what* for *whom*—in short by specifying which *obligations* correspond to various more specific interpretations of each supposed right. Taking rights as basic to ethics, including health ethics, does not get close enough to the action.

Theories of rights generally assume that there is a single answer to the question "Who should ensure that rights are respected," and that the correct answer is that this is the task of states. Yet some states are either unwilling or incompetent, or both. Rogue states are not going to secure justice or just health care for their citizens, let alone for the citizens of other states; weak and failing states cannot secure justice or health care for their citizens, let alone for the citizens of other states. States of either sort sometimes make it hard for other agents or agencies to step into the breach, but weak states sometimes allow them to do so.¹¹

My own view is that if we want to establish intellectually robust norms for health policies it would be preferable to start from a systematic account of obligations rather than of rights. One rather simple reason why this is preferable is that a focus on required action, rather than on entitlements to receive, makes it easier to spot incoherence. For example, it is easy and rather fetching (and regrettably

common) to talk about a universal "right to health," but plain enough when one considers *who* has to do *what* for *whom* that universal health cannot be provided, so that there can be no such right. Even the notion of a universal "right to health care," while not glaringly incoherent, is multiply ambiguous and may or may not be compatible with other equally important—or more important—obligations in particular cases and circumstances. It is easier to judge the coherence of proposed sets of obligations than of proposed sets of rights, because requirements for action are more explicit when we start with obligations.

This is not the place to show how fundamental principles of obligation can be derived from underlying conceptions of action or of practical reason. I simply state that in my view a promising route for doing this goes by way of a minimalist Kantian conception of reason and action that can establish (for example) basic obligations to reject coercion and deception, victimization and oppression, and to assist others in permissible forms of action—hence specifically to support others' health. These obligations are, of course, not fully specific: but it is clearer *who* holds the obligations than it is when obligations are derived from accounts of the good or of rights. Some obligations fall directly on *all* agents; others fall indirectly on *all* agents in the form of obligations

¹⁰ Typically rights are justified by reference to well known public documents such as the UN Universal Declaration of Human Rights of 1948. As justifications such arguments from authority are pretty unconvincing. See James Griffin, "Discrepancies between the Best Philosophical Account of Human Rights and the International Law of Human Rights," Presidential Address, *Proceedings of the Aristotelian Society* 101, no. 1 (2000), pp. 1–28.

¹¹ For a significant example, see A. Bhuiya, R. Chowdhury, and A. Mushtaque, "Do Poverty Alleviation Programmes Reduce Inequities in Health? The Bangladesh Experience," in Leon and Walt, *Poverty, Inequality, and Health*.

to support the construction and maintenance of effective practices and institutions that allocate obligations to identifiable agents and agencies. The need for an internally coherent allocation of obligations, including transborder obligations, is more explicit, hence more readily addressed, than it is in rights-based accounts of justice.

Just health policies and practices cannot be identified without relying on the core arguments of political philosophy. It would, for example, be quite arbitrary to assume that health policies can do entirely without compulsion, and the possibility of coercion. On the contrary, any society and any world that seeks to limit coercion will have to permit some coercion—for example the forms of coercion needed to enforce just laws. Considered abstractly, coercion may be wrong, but it does not follow that actual health policies can all be optional. Considered abstractly, deception may be wrong, but it does not follow that actual health policies can require total transparency. Under real world conditions of communication, elements of deception—for example, those that we think of as silence or tact—may be necessary components of any reliable culture that seeks to limit deception and to support agents who seek to judge where to place and where to refuse their trust. Where excessive demands for total disclosure are made, such as those to which we gesture in invoking supposed ideals of complete transparency or openness, we may end up with a public culture which makes it harder rather than easier to distinguish true from false, trustworthy from untrustworthy, significant from trivial.¹²

This is particularly evident in providing health information, where excessive disclosure by health providers (often in the name of supporting some version of patient

autonomy!) may overwhelm rather than support patients' abilities to judge for themselves. Still less can we assume that obligations to assist or support others can be owed to all others: nobody can help all others in all ways on all occasions. Each of these caveats also applies to policies that affect health: here too we are unlikely to be able to avoid all coercion and all deception, let alone to provide maximal health care for all.

Since total compliance and comprehensive provision are never feasible, we need to choose among less-than-ideal policies, including less-than-ideal health policies. Health policy choices can never be made in isolation from other practical and ethical goals and requirements. A demand that we be totally dedicated to others' health is not achievable; even a demand that we always give priority to health improvements over other action is unachievable. Health care needs time and resources, and giving unconditional priority to the demands of health and health care would be self-defeating since it would undercut capabilities to provide health care. But it is reasonable to make some judgments about the health interventions most needed in particular times and places, and about the ways in which these can be most effectively supported. In my view, these are always likely to include the construction and the maintenance of institutions and practices that support public health, simply because these interventions are known to produce effective health improvements for large numbers, often at low cost.

This does not mean that there will be general agreement about the range of medical policies that fall under public health

¹² Onora O'Neill, *A Question of Trust: The BBC Reith Lectures 2002* (Cambridge: Cambridge University Press, 2002).

provision. In the developed world, for example, views differ on whether prenatal provision and provision for substance abusers should be classified as public health provision or individual, refusable treatment. Both are often classified as medical treatment of individuals, even where individuals who refuse treatment inflict huge costs on others. Those who are less convinced of the primacy of individual autonomy may view prenatal and family planning care and vaccination programs, whose full benefit to communities requires full compliance, as matters of public health rather than of individual choice.

WHO SHOULD ACT?

Who should do or provide *what* for *whom* for the sake of better public health? Who are the agents of justice, and specifically the agents of public health provision? In my view, accounts of obligations offer a clear general answer to this question: basic obligations fall on *all* agents, and *all* institutions. These obligations are then made more specific and concrete by constructing institutions and cultures that embody coherent and effective allocations of obligations, and by developing the necessary capabilities. A realistic process for instituting health policies begins from the *actual* configuration of agents and institutions and their capabilities.

The most effective agents of justice may therefore be different bodies and different institutions in different situations. In some situations an international institution, or a certain sort of nongovernmental organization (NGO), or a religious group, a women's group, or even a multinational corporation (MNC) may be able to take an effective role in improving public health, and contribute thereby to just health poli-

cies. Given the dire level of public health provision in many parts of the world, I do not think we should be too fastidious in insisting that specific types of institutions should take on specific obligations to support public health. In a politically and economically well-ordered society it might be quite wrong for a women's group to take control of a sewage scheme, or for an MNC to provide health education, or for a religious group to take control of food provision, or for an NGO to provide family planning programs—and doubly wrong if there is any element of compulsion, backed by coercion, in the way in which they proceed. I believe that in many poor or politically disorganized societies it is too rigid to assume that all interventions can or will be initiated and directed in a well-ordered way by the central authorities.

These thoughts have implications for any account of the part that rich societies ought to play in supporting public health in poorer societies. Since obligations of justice fall on all, there is no reason to think that rich societies and institutions are systematically exempt from basic obligations to those who are far away, or beyond various sorts of borders. But since abilities to act effectively may have varied configurations, there is also no reason to assume that one type of intervention will generally be the most effective, or that states may work only with other states and their governments. Often richer states and institutions located in richer states will be able to act only in partnership with state and nonstate institutions within a poorer society. Again, there is no reason to assume that the only partners with whom they may cooperate, or whom they may fund, must be of any one sort. Assistance and funds may reasonably be provided to any group or institution that can use them effectively and

accountably to improve public health without doing injustice. In saying this I am not arguing for lack of accountability, or for across the board permission to coerce: evidently just health policies, like all other just policies, should not proceed by compulsion

when it is avoidable. Equally, however, they have no reason to assign such priority to demands for individual independence and autonomy that they impede or fail to support action that is indispensable for basic public health.