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RESOURCE ALLOCATION AND BIOETHICS: EGALITARIANISM V. PRIORITIZATION

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Abstract:

Resource allocation, a debate among bioethicists, is an argument that manages to transverse many issues in fields both in and outside bioethics, fields such as: economics, culture, gender, religion, law, etc. Creating debate among utilitarianism and deontology is extremely easy as the aforementioned fields all have a certain discourse as to what is preferable. Not to mention the issues that arise sporadically, and purposefully (according to those who wish to systematize their reflections on the medical world) with the issues found in the epistemology and logic of ethics (of course). Due to this, the parallel between the allocation of resources in the medical world and resource allocation is profound. In the following paragraphs I will attempt develop on the question: "what common practices and analysis towards health care resource allocation have ethically better foundations than the counter-practices?"; and then understand how there is a disconnect with resource allocation and the principles of healthcare.

Keywords: Bioethics; Egalitarianism; Prioritization; Deontology; Utilitarianism; Practical Philosophy

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1. Part 1 - Introduction

When this question of: "what common practices and analysis towards health care resource allocation have ethically better foundations than the counter-practices?" arises from three factors. The first being the difference between CBA (cost-benefit analysis) and CEA (cost-effectiveness analysis), which are: "Cost-benefit analysis (CBA) attempts to weigh gains in health against other ways of increasing welfare. CBA computes the benefits and costs using a common denominator (usually money), allowing the comparison of health benefits with other kinds of benefits, such as education and highways, to permit a reasoned decision on where funds should be spent." (Wilkler and Marchand, 2009, 352)

And "CEA, unlike CBA, is designed to permit prioritization among health-related benefits only. Like CBA, it requires that diverse goods be quantified in comparable units; but in CEA they are units of health benefit." (Wilkler, and Marchand, 2009, 353).
Secondly: "The most widely used general unit of measure of medical benefit, the quality-adjusted life year (QALY), discounts life years compromised by symptoms and functional limitations, as does the disability-adjusted life year (DALY), a measure used by the World Health Organization (WHO) in its Global Burden of Disease surveys." (Wilkler and Marchand, 2009, 353) A better explanation between the two can be seen from the article Deciding Between Patients, where DALY is described as:

"Arneson and Nord (1999) have observed: [The DALY approach] seems to be that the healthier the person, the more valuable their life is to themselves and to society and the greater their claim on restricted healthcare resources to have their life extended. . . . A valuation of human beings according to their functional capacity is in sharp contrast to the humanistic values laid down in the Declaration of Human Rights "recognition of the inherent dignity and of the equal and inalienable rights of all members of the human family is the foundation." Arneson and Nord conclude that "The DALY approach . . . presupposes that life years of disabled people are worth less than life years of people without disabilities."" And QALY, which can be seen as interested in the "Greater Need

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for Health Care"..."Need is often defined in terms of the capacity of the patient to benefit, with the implication being that the greater the capacity to benefit, the greater the need. On this view, the degree of need is the same as the degree of capacity to benefit measured in life years or quality-adjusted life years (QALYs) to be gained from treatment. The greater the number of years of good-quality life that can be gained from treatment, so the argument goes, the greater the need (Williams 1985) . Is the degree of need for health care equated in any way to the capacity to benefit from it, where capacity to benefit is measured in terms of quality and quantity of life? The degree of need for health care has at least three dimensions: the urgency, intensity, or importance of the need; the amount of whatever it is that is needed; and the capacity of the individual to benefit from what she needs." (Harris, 2009, 339)

The following anecdote follows, and is clear in its simplicity of the difference in allocations of resources:

If A needs a drink and B would like a drink, then they have different degrees of need. If A desires 10 drinks to be satisfied and B is happy with 2 drinks, they are expressing different degrees in the second sense. If A desires 10 drinks every day ad infinitum and B says is happy with 2 drinks for a week, they express difference in what they claim they need. If A gets 10 drinks but is unsatisfied and B gets 2 drinks and is satisfied it not certain to say that A has more need than B because the need is more urgent, intense, important, or based on amount; or to say that B has more need because the capacity to be satisfied is more.

We see then, that there need for clarification in the field of allocation. On one hand, you have the different metrics of economic benefit to think about, i.e. CBA and CEA; second, there is the issue of QALY and DALY; the difference if life should be measured as how one spends it qualitatively or not? For, what is that quality? and finally, third, there is the issue over what constitutes need in the shadow of these two previous issues.

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Thus, we are landed to understand that the levels of ambiguity in resource allocation are extremely high. For the sake of this paper, it is important to stress to the difference between CBA and CEA. Philosophically speaking, one can be inclined to think that cost-effectiveness is a better method for health care, being that it sees the person as the end of a certain goal, as Kant details in his Categorical Imperative, whereas cost-benefit analysis sees the economics and the abilities to make money, as the final goal. As well, the business side of health care was not mentioned in the Hippocratic Oath. Now of course, there is the argument that if CBA is used properly, then there is more money for more patients, and while this speculation is interesting to consider, it is still speculation. Conversely, if CBA functions to think of itself as a method that is best for the patients, it then works in the methods of CEA, making its goals different from the inherent goals of CBA, so there seems to be an understanding that any discussion of what is best for the patients in general is thus closer to CEA than it is to CBA, which even if we do not take the Kant's Categorical Imperative can function as a utilitarian ethic as well , as it is about a doctor being a doctor and not an economist. As for the difference between QALY and DALY forms of analysis, for as mentioned above, DALY "presupposes that life years of disabled people are worth less than life years of people without disabilities." Considering the subjective attitude of what constitutes a disability, for as we have seen before in the medical world, and the general world as well, what was once a disability is no longer seen as such.

Thus, to have an open attitude towards disabilities allows for open access to medical care and does not allow a sliding of definitions so that people who exhibit certain "disabilities" are not taken care of. Examples of such issues in the past, and while these examples of generally accepted "disabilities" did not exclusively be a part of the bioethical world, they did permeate society to a general degree, which by inclusion, means that in the medical world, similar attitudes were shared. That being said, such examples of "disabilities" in the past were" homosexuality, being a girl, left-handedness, Downs-syndrome, autism, darker complexion, etc. you get the idea. If not, it is this:

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when we decide whose disability is less acceptable than others, then we are living in a biased view. And should there, and of course there will, be any issue of decisions to be made in understanding the differences of which disabilities should take priorities over the other, then we can reference of CEA approach.

Now, the third and final issue with resource allocation is the question of need, and: who should get what they need? This is a hard to question to answer, but I think that a merging of the two previous selected attitudes that have been chosen based on proximity to ethical views in Philosophy and understanding fallacies in human definitions of disabilities, a combination of CEA and QALY analysis, would be the most beneficial. This is because it sees what the best and most effective unbiased opinion is, that being said, it is utilitarian and objective. However, it should be noted that utilitarianism reflects the Kantian principle of people as ends and not means, so the reflection of both ethical fields serves very much to its potential. However, to better encompass these fields, these three needs we are to concern ourselves with, we need to use an umbrella term and find that terms opposition. For this we can use the arguments between “egalitarianism” and “prioritization”. “Setting priorities in health resource allocation to promote equity among the more and the less fortunate requires a choice between “egalitarian” and “prioritarian” goals. Egalitarians want equality; “prioritarianism” merely favors giving some degree of priority to the worse-off. The former aim at narrowing health gaps; the latter seek to improve the lot of those closer to the bottom (Parfit, 1991).” (Wilkler and Marchand, 2009, 358)

Part 2 - Method, Assumptions & Predictions

The method of the article will revolve around an analysis of Egalitarian and Prioritarian ethical views in the issue of allocation of resources. I will look at the inherent philosophical value in both camps by logical superiority by objective value in regard to the ethical schools of deontology and utilitarianism.

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In the spirit of practical philosophy this article will also consider very practical issues found in health care allocation. These practical issues will be divided into 3 sections: 1) The argument of cost-benefit analysis vs. cost-effective analysis; 2) QALY (quality-adjusted life year) vs. DALY (disability-adjusted life year), the two schools of allocation resource; and 3) using real world cases to support the practicality and realistic endeavours of these two forms of analysis.

The aim of this paper then, is not necessarily to find the best philosophical fit, but to find the best practical fit found by philosophical inquiry. For if one were to think in purely philosophical terms, then perhaps the whole idea of CBA vs. CEA would be rendered moot and QALY vs. DALY analysis would be seen as a tautology, thus collaboratively forming completely ideas and manners on how to approach this issue. While it is not my intention to say that pure philosophical inquiry could gain important ground on this issue, for the purposes of this work, we will be practical.

Assumptions are: 1) cost-benefit analysis is ethically weaker that cost-effective analysis in deontological principle; 2) Egalitarianism is an ethical umbrella for prioritarianism, given priority works towards deontological and utilitarian ends.

This article is heavily aided by works found in the book: A Companions Guide to Bioethics 2nd. Edition.

Part 3 – Egalitarianism

Egalitarianism asks us to decide what is best in the long run, not what is best in moment, in this sense, it is more objective. It allows a macro approach, to philosophizing within the bioethical world, so that definitions and methods are understood in a horizontal manner, that being, there are values that transverse culture, religion, economics, etc., better than does prioritization which has more difficulty in being shared as universal methods, thus egalitarianism is better at understanding the issue of what need is. As well, along logical and literal lines egalitarianism can encompass prioritarian values, whereas this cannot happen the other way around. We

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will explore these three benefits of egalitarianism now. Again, those being: objectivity, universality, and logical superiority as opposed to prioritization, which can be seen as logically inferior in definition by the goals themselves of bioethics, subjective, and not easily shared knowledge.

What are the goals of bioethics? “First, its goal is not the development of, or adherence to, a code or set of precepts, but a better understanding of the issues. Second, it is prepared to ask deep philosophical questions about the nature of ethics, the value of life, what it is to be a person, the significance of being human. Third, it embraces issues of public policy and the direction and control of science. In all these senses, bioethics is a novel and distinct field of inquiry.” (Kuhse and Singer, 2009, 4)

We can see that giving priority means to reference that priority to some construct of what is the priority of something. That is, methods of inquiry by prioritization, are founded on what is valued by the person making the priority. This is a complex method to use as its mission is itself. That is, the priority is to maintain the priority. However, the priority of egalitarianism, is equality. Now as well, equality can also fall prey to previously determined methods of inquiry, but it is not necessarily so; as equality is a discussion of values over a long period of time and for a large amount of people, whereas priority deals with the immediate. Thus ethically, priority is a most basic method of utilitarianism, and egalitarianism is both seen as a utility and as a goal of deontology. As said by Kasper Lippert-Rasmussen in his book Deontology, Responsibility, and Equality in the chapter titled Equality and Responsibility: “The most plausible versions of egalitarianism all agree that in the case of preventable inequalities: (I) it is in itself bad if some people are worse off than others through no responsibility of their own. (I) does not imply that it is in itself bad that some are worse off.” (Lippert-Rasmussen, 2003, 330). He further states that there are two forms of egalitarianism, that of “responsibility-denying egalitarians. They believe that no one is ever responsible for being worse off.”; and second the: “responsibility-affirming egalitarians - believe that to some extent some people are responsible for being worse off.”

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We can see again, that this is of the issue of QALY vs. DALY initiatives, and as well, sufficiently so of both CBA vs. CEA, where prioritization is either cost-benefit, or cost-effectiveness, but of equality, CEA is necessarily a part of the methods egalitarianism. However, now again, we come to idea of what need is, and from the point of view of priority, who is worse off, but who is worse off does not necessarily mean that they need what is their priority. Let us look at the example that was mentioned above, that off the two different beer drinking men from the point of view of a prioritization list and a egalitarian. The man A wants 10 pints of beer every day, ad infinitum. The man B wants 2 pints per week, with no mention of continuing this action ad infinitum. Now, the priority for both is that they get their beer, but certainly there is inequality at play. And due to their differences in need, man A will get the beer he needs opposed to man B who can live without such things. Now we know that this level of alcohol consumption is bad for man A, but he is worse off if he does not get it compared to man B. If they both get what they want, then they both operate as on priority and equality. But if then we question about true equality, and that is about both men being happy, which according to man A, is not the issue, it is the issue of getting enough beer. For an egalitarian, the question of their equality is then seen giving them both what they want, but what if there is a number of limited beers? Well then, certainly there needs to have something be done so that both are satisfied. But upon the goals of bioethics asking questions of a deeper meaning, if an egalitarian ask, “what makes these men equal?” The answer then, could be that both men want to be satisfied, and then we ask, “how can we satisfy both these men?” Prioritization does not do this inherently.

In the case of “Baby Theresa”: The priority here, of the parents was the other children, and in this they were thinking as well of the equality of life, of which their child Theresa would not have one, so they efficiently used both priority and equality to attempt to give life to others. Now, the priority of the state was the law, which was not about equality, but a principle. Here we see that prioritization can fit into a egalitarian method, but not necessarily so; and conversely, if equality is shown in priority, then it is

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of itself, so that meaning equality has a higher logical and definitive structure, that can encompass priority, but this cannot be the other way around. Thus, priority restricts questions and possibility of methodology, which is against the goals of bioethicist.

Because of the subjectivity of need, or the subjectivity of who is worse off, equality is in itself a better form of prioritizing than the method of priority mentioned in the book. That being said, the definition of priority in the book, again, is: “merely favor giving some form of priority to the worse off.” Then on a practical level: “Whenever priorities between patients are set, the appropriate decision-maker would need to have immediate access to a wealth of personal information about all the individuals involved which would include their family details, sexual habits, lifestyle choices, diet, domicile, work, deciding between patient’s genetic constitution, income levels, and much besides.

A real question is: would we want to live in a society that routinely gathered, stored, and had instant access to such comprehensive personal information?”” (Harris, 2009, 346-347). So, as we can see then, that the worse off, in this scenario, was “Baby Theresa”, as she was certainly going to die, but through a method of equality, it would have been said that the others are worse off. What prioritization does is assume equality so that all may be then categorized. Egalitarianism sees the world as unequal, but then works to create balance. Thus, prioritization assumes a truth, whereas egalitarianism works to find the truth.

Thus, we can see, that logically speaking prioritization assumes a conclusion based on an ambiguous premise, which is based on the assumption: equality exists. First, from the statement above of access to information, personal history, database access, etc., that can be found in prioritarianism is a task that requires massive amounts of information, leading to more subjective decisions. Second, as before, priority leads to specific cases and does not add to the practice and understanding of bioethics. Finally, egalitarianism finds a premise and makes the best conclusion based on bioethical goals; this is ironic because egalitarianism is working better to real priority that prioritarianism

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is Therefore is case sensitive and not universal in approach. Which are otherwise expressed by egalitarianism, that being: logical superior, objective, and universal.

Part 4 – Prioritarianism

But how does prioritization work? Well in fact, it is hard to understand equality and how to best suit the needs of equality without understanding certain priorities. "How should ethical judgments in health resource allocation take into account broader issues of social justice? Much of the literature on the subject focuses, understandably, on how best to weigh competing needs of individuals needing care or protection. We expect people to be treated according to what they need and what can be done for them, and not according to who they are or how well they have done in life. In practice, deviations from these precepts nearly always favor the better-off (Tudor Hart's "Inverse Care Law" – see Hart 1971) , and are generally viewed as moral flaws in health systems." (Wilkler and Marchand, 2009, 357) That some people and their priorities are worth more than others is the closest it gets to the dilemma. That is to say, while egalitarianism offers a better perspective to understanding how the world is not equal, inherently, the best form to manage these inequalities is to understand equity and thus understand allocation by priority. "For some, any significant disparities in health between rich and poor (and those coinciding with other social boundaries, such as race and ethnicity) are an offense to justice, and narrowing these gaps should be accepted as a national priority (Marchand et al. 1998) " (Wilkler and Marchand, 2009, 357) We then see that egalitarianism plays a useful role, but not without the understanding on the ground, which is pure utilitarianism. So this to my begs the question: for those then who cannot get health care, how is reallocation mandated? One common answer is that of macro-allocation.

To understand the macro, we need to take into account historical practices and influences in the medical practice. Doctors should have the best intentions - from ancient times, such as we can see in the Hippocratic Oath. As well, many ethical

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conversations came from religious practices and customs. Thus, giving credence to the practices of doctors and their understanding of their patients' needs. One such case is of John Gregory. This work on the sympathies is both a perspective of equality and priority, but its understanding of application is directly used then as a method of priority. As here we see that the sympathies are arising from the senses, and are not objectively aimed certitudes, but instead are closer the ethical approach of utilitarianism. Of which, the best in the moment is taken into consideration, apart from detached long lasting ethical values.

Furthermore, in the method of prioritization, which shares attitudes with egalitarianism we can read: "The straightforward-application model. The ethical theory is the starting-point, and we apply the theory to the case at hand in order to reach a conclusion about what should be done." (Rachels, 2009, 15) Continuing are a list of principles in which we can see how this method of prioritization is easily compared to virtues found in egalitarianism. Those being: "that people are moral equals – that no one's welfare is more important than anyone else's; that personal autonomy, the freedom of each individual to control his or her own life, is especially important; that people should always be treated as ends in themselves, and never as mere means; that personal relationships, especially kinship, confer upon people special rights and responsibilities with regard to other people; that a person's intention, in performing a given action, is relevant to determining whether the action is right; that we may not do evil that good may come; and that what is "natural" is good and what is "unnatural" is bad." (Kuhse and Singer, 2009, 19) Each item on this list can be rationally assessed; it need not be judged simply on its intuitive appeal. But such assessments quickly take one into the more abstract matters of ethical theory, which in itself is not an issue, but there is a difference happening here in that while both egalitarianism and priority both share many of the same values, without a perspective of the immediate, then egalitarianism struggles to understand what is necessary. We can see this is the following quote: "At the level of principle there are challenges to the universal validity of the principles of

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autonomy, individualism, and secularism. These principles, which are generally regarded as being at the heart of Western bioethics, have been challenged at several points by non-Western cultures still proud of their communal relations and spiritualistic ethos." (Gbadegesin, 2009, 28) So while, there is a sense of cultural differences, the spirit of equality has an interest in preserving certain principles to show cultural understandings.

However, this can be problematic in the case of the Yoruba. The following showcases some of the issues with a purely egalitarian or prioritized attitude. "At the level of rules, the rationality of a procedure or belief is differently conceived and derives from what principles and values are upheld as sound. The Yoruba accident victim, who objects to amputation of both legs on the ground that it is better to die than to live without legs, may be operating on the principle that "death is better than (a perceived) loss of dignity." This would make sense in a culture in which such a principle is widely accepted." (Gbadegesin, 2009, 28). Here demonstrated is a difficult position to behold, so, should we allow the equality of culture to pervade? And for the Yoruba to die in what we would consider unnecessary death. Or do we make a priority of their suffering and work to curb this mentality, or is it a priority that their loss of dignity is worse, to them, than it is to live without legs? It is well summarized in the following quote: "Finally, on the level of practice, there are challenges to the Western focus on high-profile biomedical technology which seems to be the driving force of bioethics in the West. This is simply a matter of aiming one's theoretical focus on society's most pressing practical issues." (Gbadegesin, 2009, 28)

From these previous explanations we can see that prioritization has a benefit in its upholding of egalitarian principles, and that the two are closely intertwined, so much so, that one might make the assertion that the two are different sides of the same coin. But, if we are to know which one works better, we need to understand which one would inherently include the other as if it was the only method used.

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5. Conclusions

"Measurement of the quality of life involves further challenges along these lines. The value assigned to a state of health such as mild arthritis or blindness varies according to whether the respondent has experienced these conditions. Healthy people may not be able to imagine what it is like to live with a given disability or symptom…. A satisfactory measure of the relative value of health states for individuals may require combining objective and subjective evaluations, a task which has not yet been successfully undertaken in health measurement." (Wilkler and Marchand, 2009, 354) From these we can see that there is an obvious dilemma in which approach we should use, as both objective and subjective matters are taken into account, but once again, which form can use the other inherently. The answer still, is egalitarianism. For was having a better objective attitude raises the ability to subjectively think, not the other way around. As well, another issue of concern is the universality and the depth of the approach, from this following quote, it is implicit that the best method then is to understand the maximization of the method. "How should measures of health-related quality of life be used in allocating healthcare resources?

One option, as mentioned above, is maximization of the total sum of units' society's allocation of resources for health of health-related quality of life; indeed, it is widely assumed that this is the point of the measurement. There are, however, alternative principles of allocation which use these same measures, and defenders of maximization must answer some important ethical challenges." (Wilkler and Marchand, 2009, 355) When maximization is taken into consideration, then best method is again egalitarianism, for it allows a universal approach, whereas we saw before that taking a priority level of understanding we are left with a milieu of information to have to digest. To understand better this inherence of method from egalitarianism to priority, let us look at the following quote: "If we are concerned only about the highest total amount of health benefits, rather than about their distribution among individuals, a patient in

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severe distress might lose out in competition for health funds to a number of patients in much better condition, providing that the aggregate gain in health-related quality of life of the latter group was greater. In the extreme case, a person with a life-threatening, treatable condition would be allowed to die so that others could enjoy relief from mild discomfort." (Wilkler and Marchand, 2009, 355) This is utilitarianism in action, that is, it is the lowest ethical standard, not necessarily the worst it should be noted, but it is the easiest to accomplish, but the most controversial to cultural norms, but however through this practice, which is itself priority oriented, the questions then begin to form about the equal nature of doing such things, of which it is much easier to prove the egalitarian point of view from such an example as mentioned above, than to prove that something contrapositive to the example as being priority based. That meaning, that once again egalitarianism is a much more encompassing field, it will be ready to provide the methods for many different scenarios and interpretations.

Now, we have retracted to some of our previous material and need to once again understand that those methods of CEA vs. CBT, and QALY vs. DALY all reflect very much on the methods one wishes to accomplish and implement. That is, it is when following an egalitarian method, CEA is used, as it is patient driven and not monetarily driven, which priority can be as well, but is not necessarily so. As far as QALY vs. DALY goes, priority does to what brings about equality, which is a much more inherently universal subject than that of priority, so then in understanding how to give quality of life understanding to decisions we know that our method must be more holistic and serve, according to the bioethical goals, to the betterment of the field itself and not the priority of another field, such as to what is economically beneficial, or culturally beneficial, politically beneficial, etc. That is saying so, that priority makes its methods include more methods to base its information on, which egalitarianism does as well, but to a degree in which incorporation of other disciplines is for the purpose of equality and not for their purpose themselves. In conclusion, it seems that egalitarianism is a better functioning method to understand the question: who gets what and why? Than is

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prioritization, as it is better logical available and sound, due to the higher lack of subjective interpretations. Finally, it is more objective in its holistic approach.

References:

Arneson, T. and Nord, E. (1999). The value of DALY life: problems with ethics and validity of disability adjusted life years. British Medical Journal 319: 1423–5

Gbadegesin, Segun (2009) 'Culture and Bioethics', in Wiley, John (ed.) A Companion to Bioethics, Oxford, Blackwell Publishing)

Harris, John (2009), 'Deciding Between Patients', in Wiley, John (ed.) A Companion to Bioethics, Oxford, Blackwell Publishing)

Kraus, Kateryna and Kraus, Natalia (2013), in Dictionary of Economic Terms, Poltava national technical university named after Y. Kondratyuk)

Kuhse, Helga and Singer, Peter (2009) 'What Is Bioethics? A Historical Introduction', in Wiley, John (ed.) A Companion to Bioethics, Oxford, Blackwell Publishing)

Lippert-Rasmussen, Kasper, (2003), Deontology, Responsibility, and Equality, Copenhagen, University of Copenhagen

Marchand, S., Wikler, D., and Landesman, B. (1998). Class, health, and justice. Milbank Quarterly 76/3: 449–68.

Parfit, David, (1991), 'Equality or Priority?', The Londey Lecture, University of Kansas

Rachels, James (2009) 'Ethical Theory and Bioethics', in Wiley, John (ed.) A Companion to Bioethics, Oxford, Blackwell Publishing

Stein, Mark S., (2012), 'A Utilitarian Approach to Justice in Health Care', Medicine and Social Justice: Essays on the Distribution of Health Care, Oxford University

Wilkler, Daniel and Marchand, Sarah (2009), 'Society's Allocation of Resources for Health', in Wiley, John (ed.) A Companion to Bioethics, Oxford, Blackwell Publishing

Williams, A. (1985). Economics of coronary artery bypass grafting. British Medical Journal 291: 326–9.

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ISSN 1842 – 6638 (print)

“The Hippocratic Oath Today.” PBS, Public Broadcasting Service,

www.pbs.org/wgbh/nova/body/hippocratic-oath-today.html.