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Classical Distributive Justice and the European Healthcare System: Rethinking the Foundations of European Health Care in an Age of Crises

STÉPHANE BAUZON*
State University of Rome 'Tor Vergata' & Pontifical University 'Angelicum' of Rome, Rome, Italy

*Address correspondence to: Stéphane Bauzon, PhD, Pontifical University 'Angelicum,' Largo Angelicum, 1. Rome. 00184. Italy. E-mail: bauzon@juris.uniroma2.it

The state subvention and distribution of health care not only jeopardize the financial sustainability of the state, but also restrict without a conclusive rational basis the freedom of patients to decide how much health care and of what quality is worth what price. The dominant biopolitics of European health care supports a healthcare monopoly in the hands of the state and the medical profession, which health care should be (re)opened to the patient's authority to deal directly for better basic health care. In a world where it is impossible for all to receive equal access to the best of basic health care, one must critically examine the plausible scope of the authority of the state to limit access to better basic health care. Classical distributive justice affords a basis for re-examining the current European ideology of equality, human dignity, and solidarity that supports healthcare systems with unsustainable egalitarian concerns.

Keywords: *biopolitics, competition, distributive justice, monopoly of medical profession*

I. AN INTRODUCTION: CRUCIAL CONCEPTS ILL DEFINED

Over the last 75 years, there has been a complex development of the dominant vision of justice and of healthcare allocation in Europe (Agemben, 1995; Bauzon 2006, 2011; D'Agostino, 2011). The provision of health care and the state's capacity to finance health care involve two important issues

confronting contemporary Europe. It is as much of an illusion to believe that financing access to health care can be undertaken without financial limits as it is to believe that there can be equal access to the best of basic health care. The finitude of financial resources is a pressing issue in European countries whose economies are burdened by financial crises driven by over-commitments to social welfare. The finitude of our human nature forces us to recognize that no amount of health care can prevent us from eventually becoming sick and dying. Nor can it prevent us from being unequal. Financial limits require us to realize that rights to health care cannot ground absolute claims to healthcare support. The limits of finitude and those set by free human choice defeat any visions of equal access to health care. The illusion of equal health combined with an ever longer lifetime, as grounded in the idea of modern distributive justice (Rawls, 1971; Hellsten, 1998; Sen, 2011), confronts the issue of access to health care with abstract claims about human dignity, including claims to equal health care as integral to that dignity. Claims regarding equality also generate conflicting views regarding the implications of human dignity for the right to pursue one's own view of life and health care with one's own resources and network of social support. No two persons are ever equal in health or in social or natural resources. For a healthcare system to ensure equality in health care for all, the government would have to forbid persons from using after-tax resources to purchase better basic health care. Such prohibitions would in the end not be feasible and in any event involve a highly intricate and oppressive legal system with significant social and moral costs. But then there is the moral question of why one would be so interested in inputs, health care, rather than outputs, level of health. Why would one not focus, as cheaply as possible, on securing a basic level of health for as many as possible? (Nussbaum, 2011).

One is not obliged to do the impossible or the immoral. All cannot possibly have a legally established right to an equal amount of the best basic health care because there is not enough of the best of basic care to be given to everyone. The limit of talent is such that not all can receive the best of basic health care: for example, all cannot have access to the best of cardiovascular surgeons because their number is limited. Also, it is difficult to establish that the state has the moral authority to forbid persons with after-tax money to buy better basic health care. Such an egalitarianism would require a view of state sovereignty's absorbing all private possessions and liberties so that one could not act freely with one's resources and associates (Engelhardt, 1996, 375–411). The provision of all with equal health care is neither materially nor morally nor politically possible. The regnant ideology of human dignity, equality, and human rights makes it difficult to come to terms with the obvious: all cannot receive equal health care. The recent financial crises in Europe provide a heuristic that makes the obvious unavoidable.

Discussions about European state healthcare reform often run afoul of taboos of any critique of human dignity in European public healthcare

debates. Any critique or re-assessment of human rights, human dignity, and human equality has become taboo (Freud, 2004). These taboos also forbid any critical questions regarding the place of equality and prohibit a recognition of the difficulties with the reality of the *status quo*. The word "dignity" (overused by scholars of bioethics) in part reflects Immanuel Kant's claims regarding *Menschenwürde*, which is taken to imply treating all humans always as an end and never merely as a means (Kant, 1996). Today, matters are so sensitive that any political discussion about the healthcare system in Europe is perceived as threatening the egalitarian claims that have been integrated into the concept of "dignity" and have become core to the Western European ideology of welfare and healthcare provision. Kant was correct; human dignity as a right-making condition should not have a price! However, the general obligation not to use persons as means merely does not seem to exclude some buying better health care. All health care has a price. One must thus harmonize the abstract claims of human dignity with the realities of healthcare distribution. The puzzle remains that everybody is perceived as possessing an entitlement to (almost) free access to basic health care, even though resources are lacking to guarantee everyone the best of basic care. The nature of justice is a root puzzle (Sterba, 2004).

First, it is necessary to acknowledge that the role of the European states in the allocation of health care has increased significantly since the end of World War II (Saltzman and Dubois, 2004, 23–25). Most European constitutions have in some sense incorporated a fundamental right to health care (Sherrow, 2009). Nevertheless, in spite of the financial crises in Europe since 2008, most European citizens are not able or willing to rethink critically the role of the state in supporting health care, or to examine honestly the presumed grounds for linking equal access to health care with humans' equal dignity (Jacobson, 2007). Challenging the state's obligation to secure equal access is seen as a menace to the dominant, though nevertheless unfounded, egalitarian interpretation of human dignity. However, any view of equality in health lacks a general secular rational justification. Not all can have equal access to health, for some will be born blind, quadriplegic, and/or with a life expectancy of only a few years. No amount of health care will produce an equal outcome. The limits of the human condition set insurmountable boundaries within which healthcare allocation must be rethought. If all are provided an equal amount of health care or an equal amount of funds for the pursuit of health, some will have too much and others too little. At best, one can establish a fixed menu so as to forbid those who could purchase better basic care from doing so. Proposals of a rigid one-payer system are generally grounded in a robust endorsement of envy. Attitudes that focus on preventing some having more than others, rather than remedying as cheaply as possible the suffering of those who have too little, are grounded in a normalization of envy. It is only on the basis of envy that an opposition to the rich being able to buy better health care makes sense. Why, after all, should

one worry about a world in which some have more, instead of worrying about those who suffer because they have less? The result has been that a complex debate about justice in health care has emerged (Bayer et al., 2007; Buchanan, 2009; Palazzani, 2012; Pellegrino, 2002; Spagnolo et al., 2004).

Second, one must also address concerns about the fact that, if health care is available privately on the market, the demand for cheaper supply will increase. According to opponents of private health care, this demand for services would encourage ill-trained physicians to take advantage of the ignorance of the less affluent or simply those patients who might seek a better bargain. The risk that medical customers will purchase care from ill-trained providers can be met through certification processes and legal requirements of honest advertising. In what concerns medical competence, procedures of certification could minimize the medical risks. The financial risks involved in permitting privately financed health care are not a matter with which a state should concern itself. Moreover, just as with other markets (e.g., cars, insurance, or safety equipment), reports of customer satisfaction or testing results could secure as much information as needed in order to support rational decision-making in a private tier of health care. Moreover, although the continued ameliorization of morbidity and mortality risks depends on advances in the pharmaceutical and medical device industries, it is often difficult to discern which new pharmaceuticals are useful or useless (Even and Debré, 2012). However, as we have known for over a century and a half, the truth must be discerned through careful research (Bernard, 1984).

II. CHALLENGING THE ROLE OF EUROPEAN STATES IN ALLOCATING AND FINANCING HEALTH CARE

The idea that the state should be the primary provider of assistance to the poor and the sick is a result of the secularization in Europe, as occurred particularly in central Europe after 1803. In contrast, the Christian Gospel presents such assistance as a private or communal concern (Novak, 1993). In contrast, the Council of Europe's Convention on Human Rights and Biomedicine gives a basis for the provision of such services as a political obligation (Council of Europe, 1997, Ch. 1, Art. 3). In the EU, the social state has come to define health care as an essential public good. But this begs the question: is health care a matter that must be secured by public resources, and, if so, to what extent (Lefèvre, 2006)? Is the state obliged to provide only adequate basic health care? Does the state have the right (as far as it is able) to keep the wealthy and well-connected from privately securing better basic health care, given the fact that financial and human resources are never sufficient for securing the best of basic care for all? The question is the extent to which equality must become a public obsession imposed by law in a totalizing fashion.

The identification of the state with the idea of a public safety net was developed in modern philosophy, although it had been addressed already by Plato in the *Republic* (III. 405–410). Since Thomas Hobbes, it has been widely accepted that the state is to provide security to all its citizens, that is, protection against interference from other citizens. Beyond that, as early as the 17th century there was a prominent concern to regard medicine as integral to the health of the state (Castro, 1614). Today, the state has arrogated to itself the sole competence for protecting its constituents against the vicissitudes of life: for example, illness, unemployment, and other unfortunate occurrences. The notion of the state's obligation to maintain social peace has thus been extended beyond its original limitation to the protection of forbearance rights. It has been expanded to ensuring a range of claim rights now tied to the social envy that drives egalitarianism. Social peace today is taken to require protection from unequal opportunities for social inclusion and individual self-realization. The ideology of solidarity, human equality, and human dignity is invoked as the cement of public peace in a Europe ever more under centripetal force (Zucca, 2012).

With regard to health care, this extension of the state's role has been discussed under the heading of "biopolitics" by the French philosopher Michel Foucault (1963) and has been tied to complex developments in the understanding of health (Canguilhem, 2009). According to his analysis, since the mid-20th century the state has arrogated additional authority via a view of what should count as good or bad health so as to justify an account of who should get access to what kinds of health care (framed in terms of "institutional arrangements"). In the past, the state's medical competence and authority had been limited to protecting the safety of entire populations by preventing or combating epidemics of infectious disease. Now, the state has become the overseer of the allocation of health care. In 1963 Foucault stated:

> In the final analysis, when it is a question of these tertiary figures that must distribute the disease, medical experience and the doctor's supervision of social structures, the pathology of epidemics and that of the species are confronted by the same requirements: the definition of a political status for medicine and the constitution, at state level, of a medical consciousness whose constant task would be to provide information, supervision, and constraint, all of which "relate as much to the police as to the field of medicine proper." (Foucault, 1973, 26)

The phenomenon of state-supported healthcare security (Foucault's "biopolitics") has eroded not only the individual's sense of being in charge of his own health, but also the traditional role of the family. Contemporary society's lack of reserve when it comes to charging the state with the provision of health care indicates the extent to which the socialist commitment to state empowerment is still alive today.

III. BEYOND EQUALITY

The European Union cannot realize equality in health care. Public resources, and thus the quality of public basic health care, vary not only from one state to another, but even from one region of a state to another. In some wealthy European states, such as Germany,[1] Europe's financial crises have so far not significantly undermined the state's capacity to finance public health care. In poorer countries such as Greece, on the other hand, these crises—exacerbated by unwise policy decisions intended for their alleviation—have imposed severe financial limits on the state's ability to support its healthcare system.[2] In Italy, the healthcare system is controlled at a regional level. The financial situation between the rich region of Lombardy and the poorer region of Sicily has led to different levels of health care and different policies for reimbursing healthcare costs.[3] In many European countries, private insurance (financed by companies or individuals) is playing an ever more significant role in the support of health care. Tax deductions are available in many countries for private healthcare expenditures not refunded (mediately by state supported insurance or directly) by the state (or by the region as in Italy, for instance).

In some European states like France, the employer pays for the cost of healthcare coverage (Dutton, 2002, 2). In order to relieve the attendant burdens on the French labor market by reducing the cost of labor, there is an additional individual taxation directed to the support of the healthcare system. In most of the European countries, there is strong social support for the state's involvement with health care. For France, this was reflected in the 2012 presidential election: no candidate publicly questioned the role of the state in health care. Discussion remained limited to ways of reducing some costs. In general, one can say that the state's role in financing health care has been barely challenged in the European Union (Nauman, 2014). Nevertheless, despite the attempt to avoid inequality in access to health care, there is no equality in access to health care among Europeans in particular countries or even among areas of countries. Equality in health care is a myth, a misleading mirage. But again, one faces the question: why talk so much about equality? Would it not be much better to ask how one can most cheaply advantage those suffering from receiving poor health care rather than to worry about the well-off receiving better health care?

IV. CHALLENGING THE ROLE OF EUROPEAN STATES IN CONTROLLING THE SUPPLY OF HEALTH CARE

The medical profession, in Foucault's view, has allowed itself to become the instrument of biopolitics: "medicine becomes a task for the nation" (Foucault, 1973, 19). The monopoly of the medical profession, therefore, must also be

challenged. Karl Popper famously observed: "The medical profession was granted an effective monopoly over the right to practice on the assumption that it would be responsible for the standards of its members" (McIntyre and Popper, 1983, 24–31). Is it still legitimate today to leave this monopoly intact? More than thirty years after Popper wrote these words, is the time not ripe to re-evaluate this monopoly critically? We do not intend to discuss the (obvious) importance of having highly qualified (and even highly paid) physicians for specific specialized areas of competence. An obvious example is surgeons engaged with heart transplants. On the other hand, it is also well known that some surgeons are medically qualified, even if they do not hold any academic degree as a physician. One might think here of medics trained on the battlefield or the well-known case of Hamilton Naki.[4]

The point is heuristically to bring into question the contemporary, European ideological vision and its current biopolitics. This biopolitics has created the monopoly conveyed by the state to the medical profession. Should not patients, who are allowed to choose between physicians practicing in accord with the dominant established scientific paradigm and homeopaths, also be allowed to choose between low-cost medicine, regular medicine, and highly personalized medicine? The analogy to the state-supported monopoly of air-line companies might be useful in this regard. For a long time, the state (i.e., the taxpayers) used to pay for the deficit incurred by national airlines. Once the European air market was opened to competition, this was no longer the case. Would it be possible to do the same for the indebted European national health systems?

V. RETHINKING JUSTICE: RETURNING TO THE ROOTS

The modern political paradigm is centered around the concept of "power." The word "right" has returned to its old Latin sense of "power," as in the Latin *potestas*. This can be seen in the common expression: "I have the right (i.e., power) to do such or so." The assertion of a right is not just a forbearance right, but the forwarding of a claim right, to a power to have something realized, something given. The concept of dignity for its part has been set in dialectical relationship with right-claims, even though in a post-modern world after God there are no general grounds for grounding human rights (Engelhardt, 2014). The human rights discourse after World War II grew out of prior concerns with human dignity.[5] As a result, human dignity became independent of one's merits, unlike the general use of *dignitas* in Latin, which generally identified a status conveyed. Dignity has come to be used to affirm an abstract egalitarian notion of an innate status of humans. In summary, the modern dignity stands in stark contrast with the classical understanding of dignity, which tends to recognize the differences among human beings, including their differences of conveyed or accrued status.

Dignity in this classical sense is to be found in every Western European legal corpus before the Enlightenment. As a consequence, the notion of distributive justice, which lies at the roots of European jurisprudence, has been substantially altered. In health care this paradigm shift regarding the meaning of dignity has been engaged to accent the equality of the patient in health care. In the process, the state has been placed in the role of the primary protector of human egalitarian dignity—and in the process bound to biopolitics. On the one hand, the individual is given abstract human dignity, while at the same time the contemporary state overwhelms the individual with its care. This transformation is in deep contrast with classical understandings of distributive justice.

The cardinal principle of classical distributive justice is: "*ius suum cuique tribuendi*,"[6] which ultimately meant that everyone was to receive that amount of goods which he merited within a community. It is merit, not an abstract right, that is recognized. No concept of equality is to be found in classical distributive justice. On the contrary, distributive justice recognizes a hierarchy of citizens based on their merits. Merit was recognized to compass financial, social, and cultural capital. This sense of distributive justice took for granted that, if one is a rich person and knows how to acquire access to the best information, one is legitimately better off than other people who do not hold the requisite moral and financial capital. As a result, different members of the community (or the state, to use modern political terms) can be entitled to receive different proportions (from another member) of the common goods according to their merit in the community.

Classical distributive justice affirms an allocation of goods based on the merit of a person within his community, given the availability of common goods. This definition of classical distributive justice considers (1) the asymmetrical relationship of people in order (2) to balance what they should receive according to their personal merits, including their personal connections. The content of distributive justice in any community is a quest. There is no pre-conceived, proper, end-state distribution. As a process that attends to the common goods available and the merits of people understood in a broad fashion as encompassing the resources they possess, classical distributive justice cannot *a priori* determine what specific rights or goods particular specific people should have. For example, classical distributive justice does not tell us in what way common health goods should be shared.

As a theoretical perspective, distributive justice acknowledges the contingency of social norms with regard to the distribution of resources. As a consequence, it can be deemed "right" in one country to give "free" state-supported health care to everybody. On the contrary, in another country, it can be "right" to give no one "free" state-supported health care. The same can be said about the same country in different periods of its history. Classical distributive justice offers no determinate solution to the question of how to distribute health care. Among the consequences of this state of affairs

is that there is no *a priori* answer to the question of the proper role of the market in health care. In the end, classical distributive justice involves a tragedy,[7] because the distribution of common healthcare goods always involves a decision that is hard, provisional, and less than ideal.[8] Because classical distributive justice is able to come to terms with the fundamental inequalities that define the human condition, it can offer a heuristic for re-examining the allocation of health care in Europe and a means to break through Europe's contemporary established ideology.

VI. BEYOND SOLIDARITY AND EQUALITY

Facing human finitude will require Europeans to acknowledge that the best of basic health care cannot be guaranteed to all. This impossibility lies not simply in the great inequalities in resources in different European countries and regions of each country, but in the fact that there is not enough of the best of basic care to provide it for all. Beyond differences in resources, inequality is simply insurmountable. Equality in health care is impossible because of human freedom, which leads to different social and economic capital. Discourse regarding healthcare allocation is immersed in a vague and generally undefined and rationally unsecured claim regarding human equality and human dignity. Much of the discourse of human equality is tied to the hermeneutic of envy that focuses on those who have more rather than on those who have less and are suffering. Honestly facing this state of affairs will require a fundamental re-assessment of healthcare allocation and financing in Europe. One will need to reconsider the biopolitics that has given rigid monopolies in health care both to the healthcare professions and to the state. Classical distributive justice offers an opportunity for considering matters anew.

NOTES

1. As of 2012, the public German healthcare fund was estimated to end the 2013 fiscal year with a 23 billion euro surplus (Czuczka, 2012).

2. See "Greece's prescription for a healthcare crisis" (Faiola, 2014).

3. See "Growing differences between regional based healthcare service in Italy" (Inequality Watch, 2012).

4. Hamilton Naki was a black laboratory assistant whose surgical methods were employed by Christiaan Barnard during the first heart transplantation. Even if this point is controversial, it is a good emblematic example (Sliwa, 2009).

5. See, for example, the preamble to the United Nations' *Universal Declaration of Human Rights* ("Whereas recognition of the inherent dignity and of the equal and inalienable rights of all members of the human family is the foundation of freedom, justice and peace in the world . . .) and Article 1 ("All human beings are born free and equal in dignity and rights").

6. Ulpian in *Digest*, I.I.10. For further information about the philosophical history of this quotation, see Bauzon (2003). The usual translation "Justice is to *render* to every man his due" is criticized on pp. 167–176. In this book, it is argued that Ulpian's theory of distributive justice is perennial philosophy useful for our time.

7. In particular, one should consult Garrett Hardin's famous article "The tragedy of the commons" (Hardin, 1968).

8. Shakespeare's Hamlet is a metaphor that undermines the pursuit of a first best solution. Hamlet knows he wants to kill his uncle but does not know how best to do it.

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