

RESEARCH ARTICLE

# Justice in Healthcare: Welfare and Equal Opportunity

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**Abstract:** Public health crises, such as the current COVID-19 pandemic that the world is currently experiencing, highlight two undeniable truths, among others. One is the value of health and healthcare, which is necessary for our survival, well-being, and access to some of life's opportunities. The other is the scarcity of most healthcare resources. As everybody's healthcare needs will not be satisfied, misfortunes in the form of suffering, loss of opportunities, or death are bound to occur. In the face of such realities, the issue of justice in healthcare, which inquires into what makes healthcare resource allocations fair, becomes a serious moral concern. This essay critically examines two philosophical approaches to this issue: the *utilitarian approach*, which aims to promote our greatest overall welfare, and the *fair equality of opportunity approach*, which aims to promote equality in our access to life's normal range of opportunities. Despite their differences and challenges, it is shown that they can be combined to form a more comprehensive account of justice in healthcare and, consequently, serve as a practical moral framework for drafting or evaluating prioritization guidelines for allocating scarce healthcare resources in a COVID-19 pandemic.

**Keywords:** justice, healthcare, equality of opportunity, utilitarianism, pandemic, COVID-19

Two undeniable truths, among others, are highlighted in moments of a public health crisis, such as the COVID-19 pandemic that the world is currently experiencing. One is the value of health and healthcare. Good health and proper healthcare are necessary for our survival to maintain our well-being and access some of life's opportunities. The other is the scarcity of healthcare resources or the inability of available healthcare resources to satisfy our growing healthcare needs. This may be due to a lot of factors that include the growing population of humans; lack of technology to manufacture needed medicines and medical equipment; natural calamities such as typhoons, volcanic eruptions, and earthquakes; our deteriorating health conditions; environmental damages; and poor

allocation of such resources. In any case, due to this scarcity, there will always be some individuals whose healthcare needs will not be supplied or properly addressed. Given this, misfortunes are bound to occur. Some people will suffer (physically and mentally), lose opportunities in life (such as those related to work, career, social relationships, and self-enhancement), and even die. In the face of these realities, the issue of justice in healthcare, which inquires into how allocations of healthcare resources can be fair, becomes a serious moral concern.

This essay critically examines two dominant philosophical approaches to the said issue. The first is the *utilitarian approach*, which aims to promote the greatest overall welfare of all concerned individuals.

The second is the *fair equality of opportunity approach* (or simply the FEO approach), which aims to promote equality among concerned individuals in their access to life's normal range of opportunities. Despite their foundational differences and their respective challenges, it is argued that these two approaches can be combined to form a more comprehensive account of justice in healthcare. Specifically, it is maintained that the moral values of maximizing welfare and promoting equal opportunity are equally fundamental in promoting justice in healthcare. Consequently, it is also shown that the best balance of these two values will ensure the fairness of prioritization guidelines that may be drafted or adopted for distributing scarce healthcare resources in a COVID-19 pandemic.

The paper is divided into three main parts. The first elaborates on the moral relevance of healthcare resource allocation and provides an overview of the various theories of distributive justice. The second presents the fundamental contentions of the two approaches and examines some of their major challenges. The third illustrates how such approaches can combine to serve as a practical moral framework for drafting or evaluating prioritization guidelines for allocating scarce healthcare resources in a COVID-19 pandemic.

## Healthcare and Distributive Justice

Healthcare resources come in a variety of forms. Allen Buchanan (2009a) identified them as follows:

In the most inclusive sense, health-care resources are any goods or services that can reasonably be expected to have a positive effect on health. Thus, health-care resources include, but are not restricted to, medical resources. Furthermore, health-care goods and services are not limited to those that are produced by persons ordinarily recognized as health-care professionals, such as physicians and nurses. Health-care resources are not just medical drugs, procedures, and treatments; they are also the many resources used for pollution control, shelter, and food required for normal growth and functioning. (p. 38)

The allocation of these resources can be done on both macro and micro levels, distinguished according to

the level of decision-making authority and availability of the resources to be distributed (Buchanan, 2009a, p. 40). Boyd and Potter (1986, p. 197) defined macro-allocation in this context as involving “decisions about which services to provide to which groups,” and micro-allocation as involving “choices about which individual should benefit from the resources available.” Smith (2008) provided a more specific distinction:

While micro issues are often regarded as ‘patient selection issues’ or ‘choices among patients,’ regarding the resources available for specific kinds of health care services, macro issues are focused on highly political matters such as the amount to which a nation is devoting its health care resources to primary and preventive care—as opposed to new biotechnological medicine—as well as the budget percentages being expended by hospitals. (p. 28)

In accordance with these differentiations, a typical example of a macro-allocation of healthcare resources is how a government allocates a certain amount in its national budget to Medicare or healthcare vis-à-vis its fund allocation for other areas such as, among others, national defense and education. Concerning a micro-allocation of healthcare resources, a typical example is “a decision made by a particular physician when she decides to use the one available bed in her burn unit for Mr. Jones rather than for Ms. Smith” (Buchanan, 2009a, p. 40). Another example, still for the micro level, is the decision on who among a number of patients should be the recipient of the one available organ (say a kidney) for transplantation.

Why is the allocation of healthcare resources a serious moral concern? Amartya Sen (2002 p. 659) responded via the insights that he drew from the following remark by Thomas Browne, which goes: “The world... is not an inn, but a hospital.” For Sen, Browne’s comparison of the world to a hospital provides important insights, both positive and negative, about healthcare. On the one hand, Sen recognized its implied emphasis on the value of healthcare in our daily lives. As Sen (2002 p. 659) wrote, “illness of one kind or another is an important presence in the lives of a great many people.” On the other hand, Sen also thought that it can be taken to be implying a very optimistic view that sick people will always

have a place, and be taken care of, in a hospital. While agreeing with the first implication, Sen disagreed with the second one. As Sen (2002 p. 659) pointed out, “many of the people who are most ill in the world today get no treatment of their ailments, nor the use of effective means of prevention.” Sen’s insights drawn from Browne’s remark, in sum, highlight the fact that although good health is an extremely important feature of our lives, there is, however, a serious problem on how to meet the healthcare needs of everyone.

More specifically, the central problem with healthcare resources is the fact that they are scarce. As John Harris (2009, p. 375) remarked, “[S]carcity of resources for health is a permanent and inescapable condition.... Resources...are, after all, not infinite... then assuming expanding demand, scarcity is inevitable.” This scarcity inevitably leads to inequality in the allocation of resources as there will always be some individuals whose healthcare needs will not be satisfied. This, in turn, leads to misfortunes or will have undesirable consequences on our well-being, access to life’s opportunities, and survival. Harris (2009) described the situation well as follows:

The scarcity may be radical, where there are not enough resources to treat all in need, and the result is that some will be left untreated or die before their turn arrives. Scarcity may, on the other hand, be comparative, where patients have to be prioritized but the intention is that all will eventually be treated. However, in either case some will inevitably die or their condition irrevocably worsen before their turn comes round. (p. 375)

These consequences raise some serious ethical concerns, especially with regard to how healthcare resources are allocated. As regards the latter, the specific issue is when allocations of such resources can be said to be fair or morally justified. Philosophers refer to this issue as the issue of justice in healthcare, or sometimes more simply as the issue of just healthcare. The idea is that the undesirable consequences of unequal allocation of scarce healthcare resources are ethically justifiable only if this allocation is fair. A corollary issue concerns the prioritization principles should guide distributions of such kind. For instance, in allocating scarce organs for transplantation, the question of who should be prioritized among those

in need of such inevitably arises. Should it be those who can pay well for the organs, those who need the organs the most, or those who will benefit from the organ transplantation the most? (see Caufield & Ries, 2006, p. 2). A fair distribution of healthcare resources, in this regard, provides morally justifiable prioritization guidelines on how this distribution should be done.

The seriousness of the ethical issue of fairness in allocating healthcare resources can also be seen in the fact that this issue pervades the entire range of medical ethics. Buchanan (2009a) explained:

Virtually every significant problem in medical ethics includes ethical issues concerning the allocation of scarce resources or is shaped by allocation decisions that are subject to ethical evaluation. For example, in deciding whether to prolong the life of a severely disabled newborn, when doing so will involve great financial burdens (for her parents, the hospital, and the public coffers), the decision-maker—whether it be a parent, a court-appointed legal guardian, the physician, or a hospital administrator—is in effect choosing to allocate scarce resources to this particular baby rather than to someone else or something else. (p. 38)

Sen (2002) even went further in claiming that health plays a central role in establishing social justice. For Sen, it is not just medical ethics that is at stake in the issue of just healthcare but the more general area of social justice. Sen (2002) explained:

This is where health becomes a critical concern, making health equity central to the understanding of social justice.... First, health is among the most important conditions of human life and a critically significant constituent of human capabilities which we have reason to value. Any conception of social justice that accepts the need for a fair distribution as well as efficient formation of human capabilities cannot ignore the role of health in human life and the opportunities that persons, respectively, have to achieve good health—free from escapable illness, avoidable afflictions and premature mortality. Equity in the achievement and distribution of

health gets, thus, incorporated and embedded in a larger understanding of justice. (p. 660)

Now, “while health is a personal good, health care is a social good” (Silvers, 1988, p. 95). Healthcare resources, accordingly, are social goods necessary to promote the personal good of health. Being social goods, their allocation is thus subject to social policies and normative principles intended to establish justice in social distributions. What these normative principles are is the central topic in political morality called “distributive justice.” To properly handle the ethical concern about the fairness of healthcare resource allocations, I thus need to examine the different theories of distributive justice. These theories deal with the fair distribution of social goods, of which healthcare resources constitute a particular kind.

Theories of distributive justice can be presented in various ways. One is to treat them all, like what Sen (2002, p. 660) did, as making a claim about or advancing a certain type of equality, such as equality of resources, opportunity, and rights. For our purposes, however, I shall follow the one advanced by Robert Nozick (1993) in which these theories are classified in terms of whether they are end-result-oriented or means-oriented. In determining whether a distribution is fair, end-result-oriented theories examine the consequence or end result of the distribution, whether or not it conforms to a certain pattern deemed morally valuable. In contrast, means-oriented theories look at the process or means by which the distribution is done, whether or not it conforms to a certain fundamental moral principle. According to which aspect of the distribution they find morally valuable, its consequence or procedure, the end-result-oriented theories are also referred to as “consequentialist conceptions of justice,” whereas the means-oriented theories also as “procedural conceptions of justice” (Peter, 2001, p. 166).

The patterns on which the justice of a distribution is based, as advanced by the end-result theories of distributive justice, include considerations of equality, need, merit or achievement, effort, and maximal aggregate utility. Accordingly, the major end-result-oriented theories of distributive justice are as follows (see Evangelista & Mabaquiao, 2020, pp. 117–130):

1. *Egalitarianism*, which goes for equal distribution either of rights (thereby advancing

political egalitarianism) or socio-economic goods (thereby advancing economic egalitarianism). According to this theory, a fair distribution is when all concerned individuals get an equal share of the resources being distributed.

2. *Socialism* or *socialist justice*, which goes for distributions based on the individual needs of those involved in the distribution. According to this theory, a fair distribution is one in which the amount of what one gets from a distribution is in accordance with their needs. The greater one’s needs, the greater should be their share in the distribution.
3. *Capitalism* or *capitalist justice*, which goes for distributions based on the contributions of members of a group to the success of such group. According to this theory, a fair distribution is one in which the amount of what one gets from a distribution is in accordance with their contribution to the success of the relevant group (the group making the distribution). The greater one’s contributions to its success, the greater should be their share in the distribution.
4. *Justice based on fair opportunity*, which goes for distributions based on effort or the amount of work exerted. According to this theory, a fair distribution is one in which the amount of what one gets from a distribution is in accordance with their effort or exerted work to achieve the goal of a certain activity. The greater one’s effort to achieve the goal of the activity, the greater should be their share in the distribution.
5. *Utilitarianism* or *utilitarian justice*, which goes for distributions that maximize the aggregate welfare of involved parties. According to this theory, a fair distribution is one in which what one gets from a distribution is what one needs to get from it to promote the greatest aggregate welfare of their group or of all concerned individuals.

Needless to say, each of these theories of justice has its way of justifying its preferred pattern, along with reasons for rejecting the other theories. I can summarize their main contentions as follows. Egalitarianism argues that equal distributions guarantee respect for or promote equality of rights. Capitalism contends

that contribution-based distributions guarantee proportionality or balance between work outputs and rewards. Socialism argues that need-based distributions would correct natural inequalities or injustices brought about by a person's initial endowments in life. Justice based on fair opportunity argues that effort-based distributions guarantee that a person's benefits in a distribution are solely based on something they are responsible for and thus has equal opportunity to work. Utilitarianism contends that distributions aimed at maximizing the aggregate welfare of all involved parties guarantee impartiality in how these distributions are done.

Generally, the means-oriented theories of justice contend that imposing a certain pattern in the distribution (as what the end-result-oriented theories do) will lead to processes that violate certain fundamental moral principles, such as respect for moral rights and fairness (or objectivity) in the choice of distributive principles. There are two main theories under this group of theories.

The first is Robert Nozick's (1993) *libertarianism*, which claims that a distribution is fair if it does not violate any moral rights, more specifically property rights, in the processes of acquiring and transferring ownership of properties. For this theory, what is wrong with the end-result theories is that imposing a certain pattern to the distribution to ensure the desired result (that conforms to a certain pattern) will inevitably require redistribution of what people already have. Granting that what people initially have (prior to the distribution) are properties that they have acquired in morally correct ways, forcing them to redistribute their properties is tantamount to violating their property rights.

The second is John Rawls's (1993) theory of *justice as fairness*, which claims that distribution is fair if it conforms to principles chosen in a fair or unbiased manner. What this theory finds objectionable in end-result theories is that the choice of a pattern that will govern the distribution may be made in biased ways or ways that promote an individuals' self-interests or prejudices.

Both end-result and means-oriented theories are formulated on a general level to accommodate all sorts of resources or goods to be distributed. However, in consideration of the special nature of healthcare resources, some scholars think that any theory of just healthcare must address certain questions. In other

words, the application of the theories of distributive justice to the allocation of healthcare resources should address the special nature of healthcare resources. James Childress (1981) and Norman Daniels (2001, 1981) have identified two questions in this regard. The first concerns the special importance of healthcare resources, which inquires into their degree of importance relative to other social goods such as education, national defense, and environmental protection, and relative to their own kinds (that is, the degree of importance of one type of healthcare compared to other types of healthcare). The second concerns the principle of prioritization is when healthcare resources are scarce or are not enough to satisfy everyone's healthcare needs.

Accordingly, there are two related key questions that any theory of just healthcare must be able to explain: first, what accounts for the moral relevance of health and healthcare; second, what constitutes a just allocation of healthcare resources. In contemporary discussions of these questions, the focus is on two different responses. One is a welfare-based response, in which the moral relevance of healthcare and the justice of healthcare resource allocation are accounted for in terms of their welfare promotion. The other is an opportunity-based response, in which the moral relevance of healthcare and the justice of healthcare resource allocation are accounted for in terms of their promotion of equal opportunity. George Smith (2008) acknowledged the dominance of these two approaches in discussions concerning healthcare resource allocation:

The fundamental question raised in issues of health care resource allocation is, as seen: who decides what care is not worth the costs? The decision maker can be the patient, the physician or third parties (primarily private and governmental insurers). Two central approaches are considered normally: those oriented toward achieving the most productive use of the health resources and those designed to ensure equality of access to treatment through impartial or random selection for all suitable candidates. (p. 27)

The theory that embodies the welfare-based response is utilitarianism or the utilitarian approach to just healthcare, whereas the theory that embodies the

opportunity-based response is the FEO (fair equality of opportunity) approach to just healthcare. These two approaches are thus the dominant contemporary theories of just healthcare. As for the dominance of the utilitarian approach, Smith (2008, p. 1) attested, “essentially, all efforts to achieve justice in the distribution of health care resources are utilitarian in character and definition.” As for the dominance of the FEO approach, on the other hand, Gopal Sreevanisan (2007) attested:

In many civilized societies, universal access to health care—or, at least, to a decent minimum of health care—is regarded as a requirement of justice. Indeed, for many, its status as a requirement of justice may be fairly described as axiomatic. Still, even those who already subscribe to this consensus (as I do) may hope that a more articulate rationale can also be provided. One prominent rationale appeals to a principle of “equality of opportunity.” Its main idea is that good health is required to secure individuals in the share of opportunity, whatever it is exactly, that they are due under the principle of equality of opportunity. (p. 21)

Given their dominance in discussions involving the moral relevance of health and healthcare and the issue of just healthcare, I shall examine their main contentions as well as their challenges in the succeeding section.

### **The Utilitarian and FEO Approaches**

Following Richard Hare (2009, pp. 85–90), the best way to introduce utilitarianism is to explain its three fundamental elements, namely, consequentialism, welfarism, and aggregationism. First, utilitarianism is a form of consequentialism, for it determines the morality of an action based on the kind of consequences that the action produces. Consequentialism is one of three dominant normative ethical theories, the other two being deontology and virtue ethics. In contrast to consequentialism, deontology (or deontological ethics) determines the morality of an action based on the kind of rules that the action follows or violates. Deontological ethical theories differ in terms of the kind of rules that should form as the basis of moral

actions. For instance, the divine command theory takes such rules as divine rules or rules that express the will of God; the natural law theory as the laws of nature; Kantian categorical imperative as the laws of reason; and Rossian ethical theory as the moral rules embedded in our overriding prima facie duties. Virtue ethics, on the other hand, determines the morality of an action based on the character of the moral agent or the agent causing the morally evaluable actions. Classical virtue ethical theories include the ethical theories of Aristotle, Confucius, and the Buddha.

Consequentialism has various forms, of which utilitarianism is the most influential representative. Consequentialism is either hedonistic when pleasure is regarded as the only intrinsic good or non-hedonistic when the intrinsic good is understood as not referring to or solely to pleasure. Furthermore, it is either agent-relative (or egoistic) when the agent’s welfare is taken as the overriding good, or agent-relative (non-egoistic or impartial) when the maximum aggregate welfare is taken as the overriding good. Utilitarianism is an agent-relative form of consequentialism, which can either be hedonistic or non-hedonistic. In addition, utilitarianism is either act utilitarianism, when the utilitarian principle (i.e., the maximization of aggregate good or welfare) is directly applied to actions, or rule utilitarianism, when the said principle is applied to the rules that actions follow to determine the morality of the actions. The classic versions of utilitarianism were introduced by John Stuart Mill and Jeremy Bentham. Its influential contemporary proponents, on the other hand, include Richard Hare, Peter Singer, and J.J.C. Smart.

Second, utilitarianism is a welfarist theory because the consequences that it considers to be morally relevant are those that promote the welfare (or well-being) of persons. Welfare, in this context, generally means anything that a person finds beneficial or that improves the quality of their life. As Hare (2009, p. 85) explained, “we may define ‘welfare’ as the ‘obtaining to a high or at least reasonable degree of a quality of life which on the whole a person wants or prefers to have.’” Which kind of welfare is most fundamental, however, varies among proponents of utilitarianism. For some, it is the experience of pleasure; but for some, it is the fulfillment of desires, satisfaction of preferences, possession of power, among others.

Third, utilitarianism is an aggregationist theory because what it promotes is not just the welfare of agents (the doers of actions) or some selected recipients

of these actions but the maximum aggregate or sum total of welfare of all affected persons. As Mill (2004, pp. 197–198) explained, the “standard is not the agent’s own greatest happiness, but the greatest amount of happiness altogether”; “not the agent’s own happiness, but that of all concerned.” This feature of utilitarianism follows naturally from its being an impartial or agent-neutral form of consequentialism. As Mill (2004, p. 198) further explained, “As between his own happiness and that of others, utilitarianism requires him to be as strictly impartial as a disinterested and benevolent spectator.” The welfare of all affected persons is given equal consideration in the process of determining the net total of the welfare of these persons. This means that the agent is not in a privileged position. If the action that has the higher net total of welfare happens to be the one not beneficial to the agent, then the agent has the moral duty to sacrifice their personal welfare to promote the morally correct course of action.

Assuming, for explanatory convenience, that by welfare, I mean the experience of pleasure. Maximum aggregate happiness could be achieved through the following steps. First, I get the sum total of pleasures that an action brings to all affected persons. Second, I get the sum total of pains that the same action brings to the same persons. Third, I subtract the sum total of pains from the sum total of pleasures. What I get then is the net sum total of pleasures that the action brings to all affected persons. I do the same to the alternative action or actions. Afterward, I compare the net sum total of pleasures produced by the first action with the net sum total of pleasures produced by the alternative action or actions. Consequently, the action that produces the greatest net sum total of pleasures constitutes the morally good action.

Utilitarianism generally provides a practical way of resolving disagreements, so much so that it usually serves as a framework for decision making in the areas of economics, business, politics, and others. In particular, it serves as the framework for most strategic decision-making methods that include cost-benefit analysis, cost-effectiveness analysis, subjective expected utility analysis, and quality-adjusted life-years analysis (Smith 2008, pp. 2–3). Like the other ethical theories, however, utilitarianism also has its limitations. It has been argued, for instance, that maximizing aggregate good would sometimes lead to or even justify injustices and violations of rights. Another, as the aggregate good is what is of primary

importance, utilitarianism does not care whether each individual deserves to get what they receive from a distribution. So long as the overall welfare of the group is advanced, then it is morally fine for utilitarianism.

As regards the charge that utilitarianism sometimes leads to or justifies violations of rights, this is so because, as Buchanan (2009a, p. 43) explained, “a particular allocation... might maximize overall utility and yet be grossly unfair or unjust, which would violate the most fundamental rights of some individuals.” In this connection, Rawls (1971) argued that utilitarianism might justify slavery and serfdom if they can be shown to produce a higher balance of happiness. Now, as regards the charge that utilitarianism disregards or ignores the value of personal desert, Buchanan (2009a, p. 43) explained this as follows: “That one individual deserves some good, but another does not, is never itself a reason for the utilitarian to allocate the good to the former person; all that matters is how much utility can be gained.” Smith (2008, pp. 1–2) added that “not only is utilitarianism viewed as cold and calculating, it is seen as denying the individual of what is his due. The needs of those who are worse off are either ignored or neglected.”

In the specific area of healthcare, the utilitarian approach also encounters serious objections. Smith (2008, p. 2), for instance, pointed out that “because of the difficulty in calculating the net good deriving from a utilitarian approach to decision making, some have argued that this approach to health care decision making is not only unjust—but unfair.” Another problem with utilitarianism is that it allegedly may disfavor persons with lessened capacity to produce benefits to other persons due to their disease, disability, and old age. Jennifer Prah Ruger (2009), in this regard, critically reacted to the QALY (quality-adjusted life years) mode of analysis and decision making (which, as earlier noted, is utilitarian in essence): “QALYs disfavour individuals with a diminished capacity to benefit, people with disabilities, and older individuals with fewer years to live” (p. 23). Another is that utilitarianism does not justify a right to a decent minimum of health care for everyone. Those requiring more social resources but contributing less to social utility (such as the severely disabled newborns) will be excluded from such a right. Buchanan (2009b) provided a specific illustration for this point:

Consider, for example, the class of Down’s syndrome newborns. These retarded individuals, who

often suffer from various physical defects as well, require a large expenditure of social resources over a lifetime. And ... the contribution these individuals make to social utility is not large.... If this is so, then Utilitarianism will justify excluding these infants from even the most minimal health care provided to others as a matter of right. (p. 60)

Norman Daniels (2001), before introducing his FEO approach as an alternative to the utilitarian approach, likewise criticized utilitarianism for allegedly failing to explain the unique moral importance of healthcare adequately. This is due to his observation that illness and disability do not necessarily lead to unhappiness. Daniels (2001) wrote:

The fair equality of opportunity account does not use the impact of disease or disability on welfare (desire satisfaction, happiness, or utility) or utility as a basis for thinking about distributive justice. One might have thought, for example, that what was special about healthcare was that good health was important for happiness. But illness and disability may not lead to unhappiness, even if they restrict the range of opportunities open to an individual. Intuitively, then, there is something attractive about locating the moral importance of meeting healthcare needs in the more objective impact on opportunity than in the more subjective impact on happiness. (pp. 3–4)

The idea is that there may be people who, despite their sickness or disability, continue to lead happy and fulfilled lives. What is seemingly undeniable, however, is that due to their sickness or disability, “there is an objective loss in their range of capabilities and opportunities,” which is “captured by an appeal to a fair share of an opportunity range” (Daniels, 2001, p. 4). Given this, the moral significance of healthcare, which is intended to maintain good health, prevent and cure illness, and help disabled persons live a normal life, does not lie in promoting happiness or welfare but in something more fundamental. In Daniels’ (2001) perspective, this refers to a person’s access to life’s normal range of opportunities. Accordingly, access to such opportunities is what is necessarily impeded by the lack of good health as when one is sick or disabled.

This now leads me to examine the FEO approach developed and defended by Daniels (1981, 1985, 2001, 2009), which he advanced as an alternative to the utilitarian approach. This approach uses the framework of Rawls’ theory of distributive justice called *justice as fairness*. To better understand this approach, I need to look into the central tenets of Rawls’s theory and examine how Daniels built his theory from these. To recall, Rawls’ theory is means-oriented as it evaluates the justice of distribution, not in terms of whether the distribution results conform to a certain pattern but in terms of whether the process or procedure by which the distribution is done is fair. For Rawls, this fair procedure involves the unbiased choice of principles that will govern the distribution. More specifically, Rawls claimed that a certain distribution among members in a group is fair if its distributive principles, that is, the principles that govern such distribution, were chosen by the members impartially or objectively.

Rawls worked on the assumption that people are naturally inclined to promote their self-interests. In choosing distributive principles, this translates to a person’s natural tendency to prefer a criterion of justice that would benefit them in the end. As a remedy to this situation, Rawls used a mechanism or procedure, which he called the *original position* (following the tradition of the social contractarians), that would ensure the fairness or impartiality of the choice of distributive principles. In this procedure, imagine that people are under a condition called the *veil of ignorance*, where they forget or are ignorant of the particular characteristics of their lives, which are irrelevant to the issue (or point of negotiation) at hand. Such characteristics, if allowed to be factored in the decision, will only make the decision biased or self-serving. Depending on the situation, such characteristics may include social status, gender, religious affiliations, and position in the company.

The main idea is that if the distributive principles are chosen fairly, then the distribution that will follow will likewise be fair. In other words, for Rawls, what defines the fairness of a distribution is the fairness in which its governing principles are chosen. Rawls (1993, pp. 94–95), however, did not stop here. He proceeded to identify the distributive principles which he thinks will be chosen in the original position. For him, there are two such principles, which can conveniently be referred to as the *principles of equality* and *fair inequality*.

The principle of equality states that everyone should be equal in terms of having the primary social goods consisting of basic rights (like the rights to vote and to run for public office) and liberties (like the freedoms of speech and assembly). The principle of fair inequality, on the other hand, states that social and economic inequalities (such as differences in wealth, income, work position, and level of authority) should be arranged in ways that conform to two conditions. First is that these inequalities should be “attached to positions and offices open to all.” Second, such inequalities should be arranged in a way that will benefit everyone, especially the worse-off members of society (or that will be to the greatest benefit of the least advantaged members of society). The first condition is intended to provide equal opportunities for everyone to improve their lot in life, and for this reason, it is called the *principle of fair equality of opportunity*. The second condition is intended to safeguard the welfare of those who may not be able to compete well in society because of bad luck or poor initial endowments in life, and for this reason, it is called the *difference principle*.

Daniels, along with some other scholars (e.g., Smith, 2008, p. 21; Peter, 2001, p. 164), pointed out that Rawls failed to include healthcare as a primary social good. As Peter (2001, p. 164) wrote, “Rawls’ theory of justice as fairness has been the most influential theory of social justice put forward in this century. As already mentioned, however, it does not specifically address the issue of health.” As a consequence, Daniels (2001, p. 3) pointed out that Rawls is led to assume that people, after the veil of ignorance is lifted, are fully functional or are not suffering from a disease or disability over a normal life span. Simply, even if the needed social arrangements are already in place, people who are sick or disabled will still not have the same opportunities as those who are healthy. Thus, Daniels’ FEO approach is essentially an extension of Rawls’ theory of justice to the area of health and healthcare. In particular, it takes off from the first condition of Rawls’ second principle, referring to the principle of fair equality of opportunity. Under Rawls’ said principle, every person has a moral right to equal opportunity in terms of access to jobs and offices. However, a necessary condition for the people to exercise this right, from Daniel’s viewpoint, is the possession of good health. This implies that healthcare should be included among the primary social goods whose provision ought to be governed by Rawls’ two principles.

Daniels sees the central function of healthcare as that of maintaining and restoring normal functioning. Health is the absence of disease, and diseases (including deformities and disabilities) are deviations from the natural functional organization of a typical member of the human species. Disease and disability, by impairing normal functioning, restrict or narrow the range of opportunities open to individuals. Sick and disabled persons, thus, have less than the normal opportunity range in their society. According to Daniels (2001), a *range of opportunities* consists of life plans reasonable people would choose in a given society, depending on the society’s historical development, level of material wealth, technological development, and cultural features. By maintaining normal functioning, healthcare protects a person’s fair share of the normal range of opportunities. In Daniels’ (2001, p. 2) own words, “health care thus makes a distinct but limited contribution to the protection of equality of opportunity.... By maintaining normal functioning, healthcare protects an individual’s fair share of the normal range of opportunities (or plans of life) reasonable people would choose in a given society.” Gopal Sreenivasan (2007, p. 23) summed up the argument of the FEO approach as proceeding in two steps: “The first step takes us from a fair share of opportunity to a fair share of health; and the second step takes us from this fair share of health to a fair share of health care.”

The FEO approach, in sum, claims that a healthcare resource allocation is fair if it ensures that everyone involved can attain the normal opportunity range of their society. This, incidentally, also justifies the supposition that the right to healthcare is not just a legal right but a moral one as well. This moral right to healthcare is seen by Daniels (2009) as a special kind of right for functioning, as it were, as an *enabling right* in that it enables the exercise of the moral right to equal opportunity. Without the moral right to healthcare, the moral right to equal opportunity cannot be availed or properly exercised. It would be an empty kind of right.

Though advanced as an alternative to the utilitarian approach, the FEO approach, however, also has its share of challenges. One criticism against it, which has come to be called the “bottomless-pit worry,” contends that if society maintains or restores its citizens’ normal functioning, it could consume society’s resources. Charles Fried (1976) explained this worry as follows:

[I]f we commit ourselves to the notion that there is a right to whatever health care might be available, we do indeed get ourselves into a difficult situation where overall national expenditure on health must reach absurd proportions-absurd in the sense that far more is devoted to health at the expense of other important social goals than the population in general wants. Indeed, more is devoted to health than the population wants relative not only to important social goals-for example, education or housing-but relative to all the other things which people would like to have money left over to pay for. (p. 31)

However, this worry is answered by the qualification that the right to healthcare is not a right to all available healthcare resources but a right only to a decent minimum of healthcare. As Fried (1976, p. 29) explained, “to say that there is a right to health care does not imply a right to equal access, a right that whatever is available to any shall be available to all.” Nor does it mean for Fried (1976, p. 29) that “equal access to the best health care available.” In the case of Daniels (1981, p. 175; 2001, p. 5), he responded to this charge by noting that his theory of just healthcare is compatible with, and thus can be supplemented by, the *tiering system* as applied to healthcare. Daniels (2009, p. 369), in this connection, asked, “how equal must our rights to health care be? Specifically, must everyone receive exactly the same kinds of healthcare services and coverage, or is fairness in healthcare compatible with a “tiered” system?”

Daniels (2009) distinguished between a *basic tier* of health needs, which is intended to maintain or restore normal functioning, and a *supplementary tier* of health needs, which is intended to enhance normal conditions. Society, for Daniels, is only morally obligated to provide the basic tier of health needs of the people, as this suffices to guarantee the right to equal opportunity. The supplementary tier, which enhances health and is beyond what is required to maintain normal functioning, is optional for people who have the extra resources to avail of it. Daniels (2009, p. 368) clarified that “we are obliged to help others achieve normal functioning but we do not ‘owe’ each other whatever it takes to make us more beneficial or strong or completely happy.”

Because there are other important social goods besides healthcare resources, these resources are appropriately and reasonably limited by a government’s democratic decisions on how much to invest in these resources vis a vis other social goods such as national defense and education. Moreover, the right to healthcare is society-relative. It is dependent on various facts about the society, such as its level of technological development and social organization (Daniels 2001, p. 3). A healthcare system can protect opportunity only within the limits imposed by resource scarcity and technological development within a society. On the other hand, those who have the financial capacity to provide themselves the supplementary tier of health needs, say buy coverage for additional services for themselves or their families, are free to do so out of their own financial resources.

Another criticism raised against the FEO approach is that there may be contexts in which restoring the normal functioning of certain individuals could be disadvantageous to these individuals. If such were the case, then Daniels is mistaken in supposing that the primary function of healthcare is to restore a sick or disabled person’s normal functioning. Silvers (1988) cited the case of albinism among black people in Africa:

In Africa, far more than on any other continent, [albinism] is a lifelong curse.... As white-skinned men in black society, they are shunned and feared as the products of witchcraft... Should white Africans resident in Africa be turned black if this is the normal pigmentation of the members of their tribe? ... Let us suppose ... that we develop a series of relatively uncomplicated gene therapies so that neonates with albinism are enabled to produce the requisite enzymes or other factors related to skin-color that their type of albinism makes them lack. Does a just health establishment owe it to African infants with albinism to widely distribute this therapy ...? It is imaginable that such a policy would find opposition, on grounds of fairness .... For in those places, ... people with albinism are thought of as a model minority who are seen as being more intelligent and successful than their black brother and sisters.... Africans with albinism develop higher capabilities,

possibly as an adaptation to their physical limitations. It is hypothesized that their light-sensitive and deficient vision, and their sun-sensitive skin, restrict them to contemplative rather than active life styles, which encourage them to be more studious and which qualify them for more education and more respected and better remunerated careers. (pp. 118–120)

The main point of Silvers is that though there are certain opportunities open to black Africans that are not open to African albinos, the limited opportunities open to African albinos enable them to achieve certain successes desired by some black Africans. Silvers seemed to assume here that achievements bear significantly on equality of opportunity. However, it must be noted that Rawls's principle of fair equality of opportunity is about equality of *access* to basic life opportunities (e.g., jobs and offices). How people will fare in using their opportunities has no bearing on the value of the principle. The same will be true of Daniels's FEO approach. How people will use the healthcare resources that they have access to in advancing their careers, for instance, has no bearing on the value of the equal opportunity to such resources that they have been recipients to.

Finally, one serious objection to the FEO approach is that it does not seem right that considerations about welfare should give way to considerations about an opportunity in explaining the moral value of healthcare. Pain or suffering, disability, and death brought about by disease are objective misfortunes that are serious enough as considerations in providing healthcare. Lawrence Stern (1983) explained:

Death is important because it bars us from experiencing all earthly goods. The importance of disability and pain depends on their severity. But severe disability bars us from many goods, and pain – itself a form of disability when it is distracting enough – can completely blight in life and make a person welcome death. These facts are utterly sufficient to explain the specialness of health and health care. (p. 346)

Daniels (1981) claimed that illness and disability might not lead to unhappiness though they may

restrict an individual's range of opportunities. On this basis, he concluded that "intuitively, then, there is something attractive about locating the moral importance of meeting healthcare needs in the more objective impact on opportunity than in the more subjective impact on happiness" (Daniels, 1981, p. 169). In another context, Daniels (1981, p. 169) further noted that "some suffering, for example, some emotional suffering, though a cause for concern, does not obviously become a concern of justice." Although he recognized the fact that reducing pain and suffering is an important moral concern, it is not, from his perspective, what accounts for the special moral relevance of healthcare. His preference for opportunity to welfare in this regard seems to reduce to two reasons: (a) unhappiness (loss of welfare) is not necessarily the result of illness and disability, but a loss of opportunity and (b) although some forms of pain and suffering are not relevant for justice, all instances of loss of opportunity are.

However, Stern (1983) found it strange for someone to worry about a person's loss of opportunity when the person is experiencing severe pain due to their disease. In this situation, our immediate concern, for Stern, is to relieve the person of their suffering. Stern (1983) gave the following example:

Consider a child with strep throat whose parent does not take him to a doctor for lack of money. Suppose a rheumatic heart develops as a result. Does it make sense to say that justice requires us to worry about the child's loss of sports opportunity and possibly shortened life, but not about the pain and discomfort that attend the disease? (p. 349)

Furthermore, Stern (1983) contended that the experience of pain itself results in loss of opportunity: "It drains energy and attention, and for any such drain there is some conceivable activity we will perform less well. If the pain is severe enough, it will drive us below species-typical performance and thus narrow opportunity range compared to the normal" (p. 347). Given this, Stern believed that the minimization of avoidable pain and the avoidance of disability and early death are part of reasonable life plans. Put in the language of Daniels, this means that a significant part of life's normal range of opportunities are the opportunities to live a life free from avoidable pains

and disabilities and long enough to pursue other opportunities.

What I can derive from Stern's observations are: first, there are situations where welfare considerations override opportunity considerations (such as when patients are in severe pain); second, there are situations where welfare considerations significantly affect opportunity considerations (as a person in pain will most likely not perform well in his/her usual activities), which thus makes the promotion of welfare an important part of one's normal life plans. Although it may be granted that Daniels' FEO approach can handle well the other criticisms leveled against it, these points made by Stern also emphasize the need for the utilitarian welfarist approach.

These observations point to the conclusion that the value of welfare considerations is as fundamental as that of opportunity considerations. As they are not intrinsically mutually exclusive and one type of considerations affects the other (that is, the experience of pain may lead to loss of opportunity and loss of opportunity may lead to the experience of pain), the two approaches that promote each of these values can be combined to form a more comprehensive approach to just healthcare. In this way, each approach's weaknesses can be overcome using the other's strengths. For instance, the FEO's insistence on equal opportunity can prevent the violation of moral rights and disregard for personal desert to which the utilitarian approach is susceptible. It can likewise cover the alleged inability of the utilitarian approach to justify a moral right to a decent minimum of healthcare. On the other hand, the utilitarian approach proves to be the more practical approach to handle situations requiring immediate medical decisions in consideration not primarily of avoiding opportunity losses of patients but of alleviating patients' pains and sufferings.

### ***Prioritization Guidelines in a Pandemic***

The current pandemic, caused by COVID-19, has led to a public health crisis. The fast transmission of the virus has generated a large number of seriously ill patients whose healthcare needs cannot be satisfied by available healthcare resources. The capacity of existing health systems to take care of these patients has been overwhelmed, forcing them to ration medical resources, including hospital beds, ICU beds, ventilators, and medical services, as doctors and nurses are already becoming ill or quarantined.

Consequently, we are confronted with the issue of just healthcare. As Emanuel et al. (2020, p. 2049) wrote, "the rapidly growing imbalance between supply and demand for medical resources in many countries presents an inherently normative question: How can medical resources be allocated fairly during a Covid-19 pandemic?"

How then do the two approaches to just healthcare apply to the current pandemic? Or how are they relevant in dealing with the challenges of the pandemic? As general theories of just healthcare, they provide the moral framework for drafting or evaluating prioritization guidelines for allocating scarce healthcare resources in the pandemic. A fair distribution of healthcare resources naturally requires a fair set of prioritization guidelines. Being fair, they should not be, among others: (a) arbitrary (that is, they should not be based on personal interests) but based on some rational framework (that is, a framework that considers the common good); (b) biased to a particular group of people (say those who can pay more or those in power); (c) politically motivated (say they are used as means to get citizens' approval to certain government policies); and (d) solely driven by business considerations (say to earn profits from the situation—like those who took advantage of the situation to profit from the selling of alcohol, face masks, and others). One practical way to ensure the fairness of these guidelines is to examine whether they are aligned with the two approaches to just healthcare, or they can be shown to be maximizing welfare and promoting equal opportunity.

As a concrete illustration of how this can be done, let me examine a set of prioritization guidelines proposed by a group of medical doctors and academics (Emanuel et al., 2020; Aguilera, 2020) for the allocation of scarce healthcare resources in the current pandemic. Table 1 (Emanuel et al., 2020, p. 2052) summarizes the main points of these guidelines.

As shown in Table 1, Emanuel et al. (2020) identified four ethical values or moral directives they deem relevant to healthcare resource distributions in a pandemic, namely: (a) maximize benefits, (b) treat people equally, (c) promote and reward instrumental value, and (d) give priority to the worst off. Under each value are guiding principles and their applications to the COVID-19 pandemic. Aguilera's (2020) guidelines supplement those of Emanuel et al. (2020) by providing

**Table 1***Ethical Values to Guide Rationing of Absolutely Scarce Health Care Resources in a Covid-19 Pandemic*

<b>Ethical Values and Guiding Principles</b>	<b>Applications to Covid-19 Pandemic</b>
Maximize benefits	
Save the most lives	Receives the highest priority
Save the most life-years—maximize prognosis	Receives the highest priority
Treat people equally	
First-come, first-served	Should not be used
Random selection	Used for selecting among patients with similar prognosis
Promote and reward instrumental value (benefit others)	
Retrospective—priority to those who have made relevant contributions	Gives priority to research participants and health care workers when other factors such as maximizing benefits are equal
Prospective—priority to those who are likely to make relevant contributions	Gives priority to health care workers
Give priority to the worst off	
Sickest first	Used when it aligns with maximizing benefits
Youngest first	Used when it aligns with maximizing benefits such as preventing spread of the virus

Source: Emanuel et al., 2020

the specific ethical principles behind the ethical values or moral directives identified by Emanuel et al. Accordingly, Aguilera (2020) showed that the ethical value “maximize benefits” follows from the principle of social utility; “treat people equally” from the principle of equity; “give priority to the worst off” from the principle of social justice; and “promote and reward instrumental value” from the principle of social utility and principle of reciprocity. Given these, let me now examine how these guidelines are aligned with the two approaches to just healthcare.

First, the principle of social utility, where its moral directive is to maximize benefits, is clearly aligned with the utilitarian framework. Emanuel et al. (2020, p. 2052) acknowledged this themselves. Prioritizing the alternative course of action that will save more lives and the patient who will have most life-years after the treatment in the allocation of healthcare resources is definitely in accordance with the principle of maximizing aggregate welfare.

Second, the principle of equity with its moral directive to treat people equally is clearly aligned with the FEO approach. In deciding who among patients

with the same prognosis to give a scarce healthcare resource to in a pandemic, using the principle “first-come, first-served” is unfair. The idea is that because everyone is in the same condition, everyone should have an equal opportunity to the same scarce healthcare resource. The first-come, first-served basis will be based on contingent factors external to the health condition in consideration, including proximity of one’s residence to the hospital and a more efficient means of transportation to get to the hospital. Not everyone has access to these contingent factors; so, it will be unfair if they will be made as bases for prioritization. Emanuel et al. (2020) added that the first-come, first-served basis would just “encourage crowding and even violence during a period of social distancing is paramount” (p. 2053) and “people who get sick later on, perhaps because of their strict adherence to recommended public health measures, are excluded from treatment” (p. 2053). The fair way to handle this situation is through a random selection system (say, a lottery). Be this as it may, the point here is that sick people with the same prognosis should have an equal opportunity to avail of the scarce healthcare

resources, which is aligned with the objective of the FEO approach.

Third, the moral directive of promoting and rewarding instrumental value, specifically referring to the significant contributions made by health workers to the prevention of the pandemic, is for Aguilera (2020) follow from the principles of social utility and reciprocity. In so far as it follows the principle of social utility, it is clearly aligned with the utilitarian approach. However, in so far as it follows the principle of reciprocity, it is clearly aligned with the FEO approach.

Specifically, the retrospective feature of the guideline of giving priority to those who have made relevant contributions, such as the research participants (to the testing of vaccines) and healthcare workers who have risked their lives in the past, is justified by the principle of reciprocity. If they have given something to society, then it is but proper that society should repay them in some way, which, in this time of the pandemic, comes in the form of giving them priority to some healthcare resources. This can be taken as giving them back the opportunities that they lost when they risked their lives for the betterment of society, which is aligned with the objective of the FEO approach of promoting equal opportunity.

On the other hand, the prospective feature of the guideline of giving priority to those who are likely to make relevant contributions, such as the health workers in general, is clearly premised on maximizing benefits or welfare, which makes it aligned with the utilitarian approach. The idea is simply that health workers are those taking care of patients to save lives. Thus, the healthier health workers are, the more patients they will be able to take care of and the more lives they will be able to save. As Emanuel et al. (2020, p. 2053) explained, “if physicians and nurses are incapacitated, all patients—not just those with Covid-19 will suffer greater mortality and years of life lost.”

Fourth, the principle of social justice with a moral directive to prioritize the worst-off can be shown to be aligned with both utilitarian and FEO approaches. It tells in particular that the sickest and the youngest should be prioritized when this prioritization aligns with maximizing benefits. The idea behind the prioritization is that “the young, severely ill patients will often comprise many of those who are sick but could recover with treatment” (Emanuel et al., 2020, p. 2051) and “who will have lived the shortest lives if they die untreated” (Emanuel et al., 2020, p. 2051). Giving

them priority will maximize welfare in the sense that they will have more life-years after treatment, and at the same time will promote equal opportunity in the sense that the young will be given an opportunity to live a full life which older people, more or less, have already availed of. However, this should not be taken to mean that older people should not be given proper healthcare. Everyone, including older people, has the moral right to equal opportunity. The priority given to the youngest and sickest is premised on the assumption that they will be healthy enough after treatment to have more life-years. For if this is not the case, like if they do not respond well to treatment due to some other illness that they already have, then this particular guideline will not apply.

In sum, my analysis shows that these guidelines use both approaches in a balanced way. The first principle is aligned with the utilitarian approach, the second with the FEO approach, and the third and fourth with the combination of both approaches. I can safely conclude then that these prioritization guidelines are fair and morally justified.

Finally, for the implementation of these guidelines to be more effective, Emanuel et al. (2020) and Aguilera (2020) added supplementary directives, which can be summarized as follows. First, the guidelines should be transparent and readily available to everyone. Second, the guidelines should be open to revisions to accommodate new data and evidence. Third, the principles behind the guidelines should be applied to all COVID-19 and non-COVID-19 patients. Fourth, the principle of solidarity, which cultivates unity and cooperation among communities to fight the pandemic, should be promoted. This means that health institutions in communities with more resources must be willing to share some of their resources with those that have less. And fifth, there should be a separate committee in health systems or institutions, like a triage committee, to make decisions in morally challenging situations so as not to psychologically and emotionally burden healthcare workers.

## Conclusion

I have shown that the utilitarian and FEO approaches can be combined to form a more comprehensive account of justice in healthcare. The moral values of promoting the greatest welfare of all persons involved in a given situation and equality in their access to life's

opportunities—at least those within the normal range relative to one’s abilities and relevant social factors—are equally fundamental. Sickness and disability both result in suffering and opportunity loss. Moreover, suffering and opportunity loss significantly lead to one another. As such, both values are necessary to establish fairness in how healthcare resources are to be allocated. In a pandemic situation, health and government institutions are working together and trying their best to help the people face the challenges of the pandemic. Although health institutions usually focus on welfare considerations in caring for sick people, government institutions usually focus on opportunity considerations in providing resources needed for the people to access life’s basic opportunities or those necessary to lead a decent life. Other social institutions and some individual persons are likewise helping out, providing either welfare or opportunities, or both, to those seriously affected by the pandemic. Depending on the particular kind of healthcare resources and context in question, allocations of these resources along with their prioritization guidelines, to be fair, should thus strive for the best balance between the values of maximizing welfare and promoting equal opportunity. This may be a challenging task in certain situations, but it is necessary to establish justice in healthcare, especially in times of a pandemic.

### Declaration of ownership:

This report is my original work.

### Conflict of interest:

None.

### Ethical clearance:

This study was approved by the institution.

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