Focus: current issues in medical ethics

Human rights and distributive justice in health care delivery

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This paper was first presented at the Annual Meeting of the American Society of Society of Christian Ethics, Toronto School of Theology, Toronto, Ontario in January 1977. Robert Shelton aims to focus on the concept of 'right to health care,' its related principle, 'distributive justice' in an attempt to suggest 'where we are' at present and where we perhaps ought to be heading. The paper is divided into three parts, which in their turn explore the moral grounds, the US general public's policy and the part justice and government are likely to play in the development and distribution of health care. He concludes by highlighting 'omissions', an intentional one of his own and the other a major gap in the literature.

Introduction

Three years ago, I prepared a paper for a Regional Meeting of the American Academy of Religion, in which I noted that some significant social dimensions were receiving inadequate treatment in the developing field of medical ethics. Ethical issues in health care delivery systems were my concern, and I argued that they were a proper and necessary field of study for Christian social ethicists. Although there was a considerable literature regarding these issues from the work of sociologists, health care personnel, political scientists, legal scholars and economists, those persons trained in philosophical and theological ethics had devoted most of their attention to other problems in medicine and bioethics. This situation had led Albert Jonsen to write that the thesis of a 'right to health care' was '... more a political slogan than a philosophical truth'. He considered 'its further definition and argumentation' as an 'indispensable task for medical ethicists'. It was his judgement that medical ethics had become a 'public ethic,' and he called for (in what has now become a widely quoted statement), '... the formulation of a 'coherent conceptual framework' for ethical analysis and debate'.

Just after my paper was completed, the mail

brought the Spring, 1974 issue of the *Journal of Religious Ethics*, with Gene Outka's excellent article on 'Social Justice and Equal Access to Health Care'. It was, to my knowledge, the first systematic effort to apply basic ethical criteria in an analysis of a specific type of health care delivery system. Outka observed at the conclusion of his essay:

'Those committed to self-conscious moral and religious reflection about subjects in medicine have concentrated, perhaps unduly, on issues about care of individual patients (as death approaches, for instance). Those issues plainly warrant the most careful consideration. One would like to see in addition, however, more attention paid to social questions in medical ethics'.²

Since that time, the literature has steadily expanded. Basic issues have come to be more clearly identified, and forms of analysis have been both proposed and applied. My own study during this time included a sabbatical leave in Great Britain to look into their National Health programme and to inquire into ethical issues in that system. It is now clear that consideration of systems for delivery of health care constitutes an emerging agenda in social ethics. More precisely, the notions of human rights and distributive justice are seen as essential to the national debate. This paper, then, will focus on the elusive concept of a 'right to health care' and its related principle, 'distributive justice,' in an attempt to suggest 'where we are' at this point in the discussion and state some propositions for the growing agenda.

The paper will present the following points:

- (1) The proposition that health care is a right to be claimed on moral grounds is gaining increasingly convincing support.
- (2) Although there is no clear sense in which it can at present be stated that there is a legal right to health care in the United States, it is clear that there is a developing 'public policy' to assure delivery of health care to those who need it.
- (3) The moral right to health care is best claimed in terms of equal opportunity and access. Justice requires a distribution of opportunity for care, and government is the appropriate instrument to guarantee equality of distribution.

The concluding 'Postscript' makes two comments: one, regarding an intentional omission on my part,

the other, a near-omission which I find in the literature.

In approaching these points, I borrow a sort of methodology from Joseph Fletcher. In his *Situation Ethics*, you remember, he had a 'hero', a cab-driver, and a 'co-hero', the father in *The Rainmaker*, who stated some plain truths on the issues of good, right and principles. I, too, have a 'hero' – a construction foreman who was working on a Health Centre building which I visited in London. When he learned that I was studying Britain's health system, he volunteered to me that it was 'the best in the world'. Why, I wanted to know, did he believe that? 'It's simple', he said, 'anyone who needs help gets it.' My 'co-hero' is a social theologian in one of London's universities, who had a simple response upon learning that I was interested in ethical issues: 'We solved the ethical problem long ago', referring to the social and parliamentary decision to assure basic health care to every person. 'Our problems now are administrative, political, economic – not ethical.' They had decided everyone had a right to health care. The only issues centred around how best to deliver it.³ Both of them, the labour foreman and the academician, were certain that 'we Americans' had not yet solved the basic issue – does everyone have a right to health care?

Support for the moral right to health care

In 1970, Rosemary Stevens wrote in her impressive historical study of American medicine, "Health care as a 'right' has ceased to have a useful meaning. Does it imply a constitutional right, a moral right, a right for specified benefits under an insurance contract? In today's political context the answers are for practical purposes immaterial."⁴ A short time later, Renee Fox was taking note of ethical trends in American medicine, with a rather different observation: 'Increasingly, health is being defined as a universal human right, rather than as a privilege, a sign of grace, or an aleatory consequence of good fortune.'⁵ Although not commenting on political relevance, Fox did see this trend as having significance for culture and society.

It may be said, in response to Stevens, that there appears to be little *direct* basis for claiming health care as a constitutional right. William Blackstone has shown that the equal protection and minimum welfare concerns of the Constitution may have application to the issue, but any Court announcement regarding a constitutional right to health care would rest upon 'the slenderest of reeds.' 'The most that could be said', his study concludes, 'is that there are sound moral and constitutional grounds for the legislative creation of a right to health care and a corresponding health care delivery system to provide a remedy for any such *right-claim*.'⁶ I shall return later to the question of a legal right to health care. The weight of Blackstone's essay, however, is

on the side of recognition of health care as a moral right, which I take to be what Fox means in terms of 'a universal human right'.

There is a growing agreement that human beings do have a 'right' to health care. Definitions of 'right' set aside for the moment, we do find a wealth of such assertions. The studies toward a 'Responsible Society', under the World Council of Churches two decades ago, affirmed a 'decent and healthy life' as being due to each person out of respect to the human personality.⁷ James Nelson has asserted health care as a human right, drawing on the philosophical and theological traditions that 'a right is a power reserved to the person such that he can morally demand it of others that it not be interfered with or taken from him.' It is Nelson's position that Christians have claimed, in various ways, that 'human rights are based upon God's humanising intention for persons.'⁸

The extent to which the 'right to health care' taken seriously outside the United States is demonstrated in a Symposium on Human Rights in Health organised by the CIBA Foundation in 1973. The Symposium organisers chose four 'fundamental human rights in health as the minimum at which mankind should aim.' The four thus identified are safe drinking water, sufficient food, protection against communicable disease and access to the means of controlling fertility. These four were seen as interlinked, leading to a fifth which, in a wider sense, covers the others: 'the right to have within reach at least some form of health care.' The published volume is the result of some fundamental ethical assumptions being accepted and affirmed, although not carefully analysed and defined, by technicians, planners and scientific theoreticians. They set out to explore the practical implications of adopting the above determinants of health as universal human rights. The implications were pursued in the areas of funding, human and material resources, and management needs.⁹ What would take, they asked, to fulfil these human 'birthrights' in poor and underdeveloped countries? The symposium did not include professional ethicists. There is a wide array of ethical assumptions inherent in the writings, although one contributor recognised that symposium participants had fallen short in consideration of 'biological and ethical background to human rights.' His own conviction that human right is but the corollary of 'a species-wide obligation'¹⁰ is suggestive of the ethical principle of social solidarity, and is an example of varying levels of assumptions working through the study.

The notions of rights in regard to health have been presented in such an array as to become confusing at times; one helpful attempt to sort them out is offered in Ruth Macklin's insistence that appeals to rights and duties must be grounded in theory of justice, in a 'general moral theory', or else be backed up by a sound methodology which

'specifies how anyone – in principle – can discover the existence of such rights and know what to do when two or more legitimate rights conflict.' 'The existence and nature of human rights are matters for moral decision.'¹¹ rather than empirical or *a priori* discovery. One of the strongest possibilities for such grounding in moral theory, according to Macklin, is John Rawls' *Theory of Justice*. A commendable attempt to apply that theory has been contributed by Ronald Green, and I shall return to it shortly. It is sufficient at this point to record Green's conclusion that 'contract reasoning gives independent rational support to the assertion common today, that health care is a basic right of all persons regardless of income.'¹²

I have not attempted to make an extensive case for a particular concept of health care rights. I have, rather, concluded that the notions to which I have alluded, among others, are sufficiently compelling to be worthy of support. There is no question that contrary positions have been stated and are in fact operative in the United States at present.¹³ The considerable disarray in which the health care institutions find themselves across the country is at least partially due to our societal indecision on this matter. It remains clear that a preponderant portion of our health care delivery operates from systems which assume that care to be a commodity to be bought and sold, rather than a right to be claimed, guaranteed and protected. That we do have such a mixed situation, as compared to certain other countries, is, of course, related to the fact that there is no legal right to health care clearly established for all persons in our society.

'Public policy' and the delivery of health care

In a legal sense, a right is like a ticket that can be cashed in by its holder if he meets the terms of the contract represented by the ticket – that is, the 'conditions specified by the right'.⁶ As Blackstone has shown, there is little basis for viewing any present entitlements to health care in that light. Whereas the ethical stance in Great Britain is also codified into law and public policy, the most that can be said for the United States is that there is a developing public policy which assures delivery of health care to those who need it.

Our situation is described concisely by Edward Sparer:

A legal right to medical care may be said to exist when two conditions are met: (1) there exists a definable duty on the part of ascertainable medical care providers to give medical care to particular persons (or persons in general); (2) the persons who are the beneficiaries of the duty have a legal remedy which they can use to enforce performance of the duty, or collect damages for failure to perform. Without these conditions, one may request medical care. One may offer to purchase it. One may always

claim that a moral obligation on the part of a provider exists. But one does not have a legal right to medical care.¹⁴

One can only draw the conclusion, with Sparer, that in the United States the general public has no legal right to medical care. Those who have private contracts may have legal rights under those contracts. For some, certain circumstances may entitle them to limited care. Many of us are left without any legal rights. Sparer illustrates the 'elusiveness' of the legal right by posing an extreme circumstance in which a person may have a medical emergency, facing the possibility of serious, perhaps mortal, damage without immediate care, and is brought to a hospital having a staff of qualified personnel. He suggests that 'if ever there was an occasion for a "legal right" to care, this would be it.'¹⁴ He then asks if the hospital and staff must give care. My 'hero', back at the construction site in London, would quickly answer for *his* situation, 'of course'. Sparer answers: 'it all depends.' He illustrates from several types and levels of law, common law, federal and state statutory duties, federal tax-exemption, private contracts, and publicly financed care, just how complicated and unlikely the legal 'right' may be.

We are led beyond the strictly legal question by Sparer's different analysis of 'congressional action and inaction'. Here, he says, a public policy can be gleaned: rather than there being a record of opposition to government-assured medical care, 'governmental action is taken where it is necessary to assure the delivery of good medical care to those who will not otherwise receive it.'¹⁴ On the basis of recent legislation, Sparer goes even further in describing public policy:

Current national public policy is to promote equal access to comprehensive quality care for all Americans; to use public financing insofar as is necessary to achieve that goal; to reorganise the health care system insofar as it is inconsistent with the achievement of that goal at a reasonable cost; to accomplish the planning for that goal under consumer (not professional) dominated agencies.¹⁴

Sparer concludes his illuminating essay with the recognition that certain social conditions are required in order to have the legal right, conditions which are actually goals of the current policy. He offers some specific steps to be achieved toward a 'broad public right to good medical care.'

Within the realm of existing and proposed law and public policy, Blackstone finds the most hope for needed change and realisation of rights in the 'Health Security' programme. This proposal came from the Committee of One Hundred for National Health Insurance, and was sponsored by Senator Edward Kennedy and Representatives Martha Griffiths and James Corman. The language of

rights is used by Representative Corman in advocating a 'basic proposition that health care is a right, not a luxury, and that the way to attain this right is through a financing mechanism whereby leverage is used to bring about a reordering of priorities, a strengthening of resources, and a restructuring of services.'⁸ The Health Security approach, it is argued, will overcome inequalities in the distribution of health care. It is the meaning of equality in care and its distribution to which we now must turn.

Justice and government – their roles in the distribution of care

Since Outka's thoughtful statement of the problem, there is growing agreement that equal access is the central issue for a just distribution of health care. Of known systems available, Outka was most positive toward the prepaid practice systems of Health Maintenance Organisations. Former Congressman William Roy, who was the primary author of federal legislation underwriting developments of HMO's throughout the country, agrees that access is one of the three main problems (along with availability and continuity) in relating resources to needs.¹⁵

Definitional debate in the last five years has clarified that there is little meaning in the term 'right to health', in the sense that one might claim entitlement to collective resources in order to fulfil the right. On the other hand, there are clear operational meanings in the term, 'right to health care', and more recent debate has centered on what level of health care may be claimed within this right. Two approaches to this issue from the recent publication by the Research Group on Ethics and Health Policy² are particularly cogent in this regard: Ronald Green's analysis of Rawls' *Theory of Justice* and Robert Veatch's beginning of a construction of theory for just distribution of health care.

Green observes that the highly important and much-debated work by John Rawls¹⁶ does not discuss health care, in spite of the fact that Rawls' object of inquiry is social justice. Green is convinced, however, that there are significant implications in Rawls' views for health care policy. One may refer to the essay for the details of Green's analysis; his conclusions which inform our considerations are as follows:

- 1) Parties in the contract theory perspective would opt for a principle of equal access to health care – to the most extensive health services the society allows.
- 2) The theory seems to rule out direct income-based distributions of health care.
- 3) Basic preventive and therapeutic services have priority over expensive, high quality care and 'costly, esoteric research.' Basic services should be 'rapidly

brought within reach of every member of society. The society's 'basic structure' would determine what portions of its total resources would go directly to health care, as compared with other aspects of a just society which influence the health of its members.

- 4) There is not a demand for repudiation of free market mechanisms: political intervention in the free market is necessary, however, for assurance of progressive rates on health care and proper training and distribution of health care personnel. It is the government's job, Green concludes, to attract competent personnel to these occupationally attractive professions, even 'without especially high wages.

In each of these matters, Green has used the distinguishing aspects of Rawls' contract theory – 'the device of the original position, the identification of instances where maximum reasoning is appropriate, and the focus on the basic structure . . .'¹²

Veatch's essay is devoted to a beginning of the construction of 'a theory of justice – a theory of distribution – for health care delivery.' Veatch proposes an egalitarian theory as an alternative to a utilitarian approach. The basic premise is that every human being has an equal claim, insofar as health goes. Working from the principle 'that justice requires that everyone get the resources needed to be healthy', he develops stages of explication and qualification of the principle. His final statement regarding rights and justice in care is: 'Justice requires everyone has a claim to health care needed to provide an opportunity for a level of health equal, as far as possible, to other persons' health. In consideration of the principle for funding, he extends the egalitarian principle, to add that justice also 'requires equality as the ordering principle for funding of health care.' The principle is stated in such a way that those who are most ill have priority insofar as their health can be improved, and any may reject the care if it is not desired. It also takes into account the pragmatic necessity to include the wealthy along with the poor as a way of protecting the quality of the system while at the same time promoting equality. Veatch applies his principles to various proposals for health insurance and their funding, and finds 'remarkable differences in the national health insurance proposals viewed from the perspective of egalitarian justice.'¹⁷ He apparently finds none that fit the criteria well, rather, he ends the essay with a call for exploring the claims of justice within the 'coming National Health Insurance debate.'

I find little with which to quarrel in Veatch's commendable effort to 'begin' a theory. He has taken account of most of the issues which have been outlined in this paper. He opts for an egalitarian principle for justice's sake, recognising that what is 'right', on the basis of efficiency or utility, may sometimes be different from what is just. His statements on equality in funding not only recognise

the necessity for government as instrument for guarantee of just distribution of costs, but also acknowledges the need to separate provision of service from payment for the service.

One further note, as we reflect on theories of distributive justice. Several writers have examined the various conceptions of social justice for their applicability to health care rights: rights based on merit or desert, on societal contributions, on market contribution, on need, or on similar treatment for similar cases. (This particular list is that developed by Outka.) To the extent that we can say that a movement toward theory is in process (one stage of which is codified by Veatch), we can also say that there is general agreement that the concept most basic is 'to each according to needs'; in secondary position is 'similar treatment for similar cases.' The second is an important principle, as is obvious in the Veatch formulation, but one which must give way to dissimilar treatment in cases of individual need.

Our analysis has been devoted primarily to the work of philosophical and theological ethicists. It is interesting to note, in passing, a formulation similar to the above but in the somewhat different jargon of the sociologist, David Mechanic:

In sum, the right to health care means that government will assure each person a reasonable level of health services and take steps to insure that the entitlement can be exchanged for services in the medical marketplace. Further, it means that when rationing processes are imposed, as they inevitably will have to be, the rules for rationing are applied fairly on the basis of reasonable categorisation and are neither frivolous nor discriminatory. This does not imply that everyone has the exact right to the same services, just as public education does not imply that children who differ in their capacities and needs must be given identical attention in every instance. The actual scope of entitlement at any given point must be an issue for public discussion and political consideration and is not solely a matter for the professional community.¹⁸

The 'public discussion and political consideration' referred to by Mechanic is suggestive of the arena identified by Albert Jonsen and Lewis Butler as that of 'public ethics'. Public ethics is a 'sub-set' of, or a move beyond, social ethics. It is the application of the general principles of social ethics to the particular, pressing matters of decision in public policy. Jonsen and Butler suggest a detailed method for public ethics which includes three tasks:

- 1) Articulation of relevant moral principles in the policy problem;
- 2) Elucidation of proposed policy options in light of relevant moral principles;
- 3) Displaying ranked order of moral options for policy choice.¹⁹ I see these as an elaboration of method implied in Veatch's construction of theory.

A fascinating approach to the just distribution of health care is suggested by Maurice King in his proposals for 'interventions' in personal health care by way of 'packages': collections of interventions and the technical resources necessary to apply the medical interventions in a given time and location. King was describing an approach to cultures different from our own, and our limitations do not allow us to pursue the details of his proposal. What is important for this discussion is his description of 'packaging' interventions for the improvement of health care, and the connection he draws between these packages and the notion of rights. The symposium in which he was participating was not in a position, he felt, to specify what human rights in health care shall be; they could, however, 'go a useful distance towards deciding what they should look like, which will be at least something towards promoting their fulfilment.' King suggested that packages (national health care programmes) will in many countries come first, 'it seems likely that we shall have to proceed from packages to rights, and not vice-versa, because it is only as packages that rights can be manipulated.'²⁰

At this point, we seem directed back toward some of the observations of Ruth Macklin regarding the language of rights. By her analysis, it is not strange that a World Health Organisation representative in Indonesia would see the question of rights as having relevance only in achieved programmatic terms. Claims about human rights are really used to 'incite' persons to programmes of moral reform, to urge changes in a direction to which the moral community has become sensitive. As such, it may well be that right claims are not objective truths about the moral order, but legitimate expectations about the social order from persons who experience that order.¹¹

Can we, then, speak responsibly of a right to health care? Yes, we can. We have a growing community of understanding that human beings do have a proper moral claim to a basic, 'decent' level of health care. This is a right, not in a strict legal sense, certainly not politically codified into the economic structure, but a condition of public policy emerging with increasing force and clarity. We even have a developing theory of distributive justice, from which we may move into the arena of public decisions and participate with responsibility and credibility.

Perhaps we are closer to the time when we can answer as quickly as did my English acquaintance, 'anyone who needs help gets it.' Perhaps, we can soon say the basic ethical question is settled, and move on to the administrative and political issues of facilitating our ethical agreement.

Postscript

Two comments must be made before concluding;

one has to do with an intentional omission of my own; the other refers to a major gap which I find in the literature.

First, it may well be argued that the discussion of health care apart from the larger realm of state control of allocation and distribution of resources, is an anomaly. As Charles Fried has put it:

For as long as our society considers that inequality of wealth and income are morally acceptable – acceptable in the sense that the system that produces these inequalities is in itself not morally suspect – it is anomalous to carve out a sector like health care and say that *there* equality must reign.²⁰

I think that I would like to be able to say that what Fried implies is wrong, that we *can* carve out areas and direct our energies toward gaining equality in those areas without attacking the whole 'system'. At the same time, I am nagged by the realisation that became clear to me while observing the national health programmes of Scandinavia and Great Britain, that there is a close correlation between the forms through which they deliver their health care and other aspects of their economic and political systems, just as there is in our own mixed economic and political system. That is a matter for another, perhaps more extensive, study. But the fact remains that the principles of equal access and distributive justice are matters which have increasing clarity and applicability in the public forum, even at the risk of being 'sectors' carved out of the larger problem.

Second, this is a paper originally presented to a Society of Christian Ethics, and yet most of the literature to which I have referred has drawn on the philosophical resources of our religious and secular traditions, rather than the sources of Scripture, and the record of disciplined Christian communities. With the exception of Outka's reliance on the Agape concept, Nelson's work with rather general theological formulations, the use of the Biblical understanding of covenant by William F May,²¹ and Tittmuss' gift relationship in the work of both May and Peter Singer,²² I find in the literature a minimum of careful development of the resources of the faith community (as opposed to the purely rational, philosophical part of our tradition).²⁴

This disturbs me. Perhaps there are others which I have overlooked; if so, there is room for them, and I shall welcome this correction in my survey. It may be that the work of Birch and Rasmussen in applying their *Bible and Ethics* approach to world hunger²³ will be a model for similar efforts in health care delivery. Outka's Agape studies may re-emerge with more extensive applications. Finally, a careful examination of Richard Tittmuss' assessment of the American system may produce some fresh understandings when viewed in the light of a theology of grace or an 'ethic of gift'.

References and notes

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- ²Outka, Gene (1974). Social justice and equal access to health care. *The Journal of Religious Ethics*, 2, p. 29. Reprinted in Veatch and Branson (1976), *Ethics and Health Policy*.
- ³It should be noted that he was the only ethicist with whom I talked who thought that the remaining problems – administrative, political and economic, were somehow beyond or apart from ethics. Others saw serious ethical issues remaining in the procedures for distribution of care.
- ⁴Stevens, Rosemary (1971). *American Medicine and Public Interest*. New Haven. Yale University Press. p. 536.
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- ⁶Blackstone, William T (1976). On health care as a legal right: an exploration of legal and moral grounds. *Georgia Law Review*, 10, 2, pp. 409, 410, 416.
- ⁷Muelder, Walter G (1959). *Foundations of the Responsible Society*. New York. Abingdon Press.
- ⁸Nelson, James B (1973). *Human Medicine: ethical perspectives on new medical issues*. Minneapolis. Augsburg Publishing House. pp. 182–183. (This book, familiar to many American readers, was recently reviewed positively in the *Journal of Medical Ethics* (1976), 2, 3. London. The Society for the Study of Medical Ethics.)
- ⁹Elliot, Katherine and Knight, Julie (Eds) (1974). *Human Rights in Health*. Ciba Foundation Symposium 23 (New Series). Amsterdam, London and New York. Associated Scientific Publishers (Elsevier). p. 2.
- ¹⁰King, Maurice (1974). Personal health care: the quest for a human right. *Human Rights in Health*, op. cit., pp. 241, 228, 238.
- ¹¹Macklin, Ruth (1976). Moral concerns and appeals to rights and duties. *The Hastings Center Report*, 6, 5, pp. 31–38.
- ¹²Green, Ronald (1976). Health care and justice in contract theory perspective in *Ethics and Health Policy*. (Ed) Veatch, R M and Branson, R. Cambridge, Mass. Ballinger Publishing Co. pp. 111–124.
- ¹³Sade, Robert M (1971). Medical care as a right: a refutation. *The New England Journal of Medicine*, 285, 23, p. 1289; a favourite example of an opposing view to be found throughout the literature is the short article quoted above. Sade argued the individualistic economic theory that one's skill is one's property, to place at the disposal of others on the market, and that medical care is neither a right nor a privilege, but rather a service to be sold by the physician and purchased by the public. The *Journal's* editor later remarked that he was distressed by the amount of mail he received from physicians in support of Sade's position. (See Ingelfinger, F J (1972). Rights of authors and of patients. *The New England Journal of Medicine*, 286, 9, pp. 486–487.)

- ¹⁴Sparer, Edward V (1976). The legal right to health care: public policy and equal access. *The Hastings Center Report*, 6, 5, pp. 39-40, 43, 45.
- ¹⁵Roy, William R (1972). *The Proposed Health Maintenance Organisation Act of 1972*. Washington DC. The Science and Health Communications Group Inc. pp. 7-8.
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- ¹⁸Mechanic, David (1976). Rationing health care: public policy and the medical marketplace. *The Hastings Center Report*, 6, 1, p. 36.
- ¹⁹Jonsen, Albert R and Butler, Lewis H (1975). Public ethics and policy making. *The Hastings Center Report*, 5, 4, p. 22.
- ²⁰Fried, Charles, (1976). Equality and rights in medical care. *The Hastings Center Report*, 6, 1, p. 32.
- ²¹May, William F (1975). Code, covenant, contract and philanthropy. *The Hastings Center Report*, 5, 6, pp. 29-38. Although May's focus is more on the professional relationship of the physician to the patient, his discussion of covenant does have larger social dimensions.
- ²²Singer, Peter (1976). Freedom and utilities in the distribution of health care. in *Ethics and Health Policy*, *op. cit.*, pp. 175-193.
- ²³Birch, Bruce and Rasmussen, Larry (1976). *Bible and Ethics in the Christian Life*. Minneapolis. Augsburg Publishing House. The authors have a study of world hunger in process, to be published by Westminster Press.
- ²⁴Since this paper was presented in January, 1977, additional literature has appeared which demonstrates some further examination on biblical and theological grounds. An example is an unpublished doctoral dissertation by Earl Edward Shelp, from the Southern Baptist Theological Seminary, in 1976, 'An Inquiry into Christian Ethical Sanctions for the "Right to Health Care".' Although the study does not address the problem of distributive justice, it is especially helpful in its exploration of biblical concepts of man, health and well being, and, particularly in its treatment of the concept of community.