Social Justice, Health Care and the Poor

DIONISIO M. MIRANDA, SVD

A good number of philosophers who have turned their attention to the question of social justice have at times despaired of ever rationalizing the concept fully. But whether it is soluble or not, the issue of social justice continues to be unavoidable. I would like to discuss the subject in three parts: the first will take a look at the discussion of justice in the West with particular reference to bioethics. The second will present various ways of understanding social justice in bioethics. The third will reflect on their implications for social justice and health care for the poor in the Philippine context.

I. The Western Tradition

In this section I will briefly discuss: (1) the development of justice and bioethics in Catholic Moral Theology; (2) some recent developments, and (3) the plurality of views of social justice.

Catholic Moral Theology

Insofar as life and health issues are concerned, Catholic Moral Theology has developed three frameworks. First, the fifth commandment of the Decalogue ("Thou shalt not kill"); second, the virtue of justice ("to each his due") and, finally, various principles proposed by experts in the field of Moral Theology (e.g. M. Vidal).

---

* Fr. Dionisio M. Miranda, SVD, is a professor of Moral and Pastoral Theology at Divine Word Seminary, Tagaytay, Philippines.

• *PHILIPPINIANA SACRA*, Vol. XXX, No. 88 (Jan.-April, 1995) 113-127

Aquinas approached what we know as bioethics today through the virtue of justice. Following Aristotle in Book V of the Nicomachean Ethics, St Thomas pointed out two groups of vices opposed to commutative justice: involuntary exchange (II-II,qq.64-76) and voluntary exchange (II-II,qq.77-78). He divided the former into yet two other groups: factual injury and verbal injury. It was in factual injury that he refered to homicide, mutilation, flagellation and imprisonment. He dedicated one whole question to suicide, together with the death penalty. Other problems were only summarily discussed in one single *quaestio* (q.65).

It was this format of justice that the Thomistic Renaissance (16th-17th c.) followed consistently. A minor variation can be found in Lugo, who classified injuries into four types (with respect to the body, to honor, to reputation, and to fortune or riches). It was against the goods of the body that he discussed the usual themes, adding those of rape and adultery.

The framework can still be used to approach some current problems in bioethics today. Commutative justice, as fair exchange, could refer to services demanded from the medical sector and paid for by its beneficiaries. Retributive justice, as the restitution of what is due, has applications which range from capital punishment to malpractice compensation. Distributive justice, as politically regulated sharing of social benefits and burdens, has clear implications in health-care systems, both directly and indirectly.

Recent Developments in the West

Of the two significant developments which Veatch cites as having emerged in recent times, the first comes out from Liberal Political Philosophy. The movement emphasizes love for individual liberty or autonomy: self-determination is the highest and most decisive principle of medical decision-making. Its companion theme is equality: respect for persons implies justice as well. In essence, the perspective is that of natural rights: man is endowed with rights, not duties, obligations or interests. This focus is totally new.

The other development comes from the Patient's Rights Movement. The movement is against paternalism and consequentialism as found in traditional medicine. On issues of abortion, terminal illness,

research and so on it emphasizes the patient's right to consent or refuse treatment. Some examples are *A Patient's Bill of Medical Rights* (American Hospital Association, 1973), *The AMA Principles of Medical Ethics* (1980), or the *UN Declaration of Human Rights*. They see two types of rights, namely, *liberty rights* —negatively the right to non-interference, or positively the right to conduct one's life as one wants except when it infringes on others—, and *entitlement rights* —right to claim from someone the resources needed to exercise an option—, such as the right to health care.

Both movements are symptomatic of what is happening in the field of Western bioethics in general. Authors observe that the Western tradition finds itself in flux due to the many important questions it is forced to ask itself: (a) Should the field of medicine be defined in more restrictive senses —corporality and corporal life— or more inclusive ones —life sciences and health care? How does this affect its agents (personal-professional as against social-institutional)?; (b) Where is the proper location of bioethics as a topic within special ethics, what its consequent framework and inner methodology?; (c) What is the relationship between philosophy and theology or between ethical reason and religious faith?; (d) How are reason and faith related to scientific data and methods?, and so on; (e) What are the relative advantages of a thought-shift from right-wrong to good-bad, e.g., right to life vs. the value of life, right to die vs. obligation to live, needs vs. rights, love vs. justice?

In brief, representatives of the "exclusive view" believe that bioethics should concern itself only with issues which bear on medical practice and services. Others with a more "inclusive view" believe otherwise: that bioethics would be too restricted if limited to the goals, scope and content of medical ethics. Insofar as our subject is concerned, the exclusive view would leave out the whole question of social justice, whereas the inclusive view would find it intrinsic to bioethics.

Pluralism in Social Justice

Hume observed that distribution of benefits becomes an instance of justice only when the wanted or needed goods or services are moderately scarce compared to their demand. In conditions of abundance the question is pointless; in conditions of extreme scarcity other questions come to the fore.

In the case of bioethics it is evident that we live in a world of "sub-optimal alternatives" with perplexing issues: Medical resources are always finite; needs are not always satiable; should risks be borne collectively or individually?; and so on. In terms of social justice the problem is usually simplified in terms of the criteria for resource allocation: (a) In ordinary circumstances, how should one distribute medical resources —manpower, skills, technology— democratically? (b) In emergency situations, "who should live when not all have to die?"

The notion of social justice is difficult to define. The Greeks used only one word *dike* to signify not only "just" but also "equal." This is not unlike translating "justice" in Filipino by both *katarungan* and *katuwiran*, which are not the same. Indeed it is not just the concept of justice that is disputed but also that of society, since the community may be viewed either as an abstract collectivity or as an aggregation of distinct individuals.

From a formal viewpoint, however, we can conceive of social or distributive justice in the following formula: (Feinberg)

$$\frac{\text{A's portion}}{\text{B's portion}} = \frac{\text{A's possession of relevant characteristic X}}{\text{B's possession of relevant characteristic X}}$$

The problem comes in defining the content of the variable X. For "meritarians" X = skill or virtue, or even hereditary class, labor, or past contribution. For egalitarians X = need. Some would simply say that X depends on the benefit or burden to be distributed and in which context, giving rise to either libertarian, egalitarian or utilitarian proposals.

II. Social Justice and Health Care

Outka makes the problem of distribution more specific by formulating five different concepts of social justice. How does each of them apply to health-care?

To Each According to his Merit or Desert

Proponents argue that just as behaviour must be graded on the criteria of effort or results (as in exam performance), benefits should also be deserved. They point out that getting something for nothing is

unjust. This is particularly true where health crises are *deserved* because they are due to drugs, alcohol, tobacco, obesity, careless vehicular accidents, and the like.

Critics counter, at a general level, that the criterion of effort is not always fair, that differences in innate ability and talent create differences in required effort. In short, some people can achieve more with less effort. Further, one must note the difference in circumstances: e.g., some people cannot find work despite seriously trying it. Thus no matter how important, the idea of merit does not exhaust the meaning of equality and hence of justice, since it focuses only on differential behaviour rather than on the differential conditions of persons.

Applied more specifically to health care, the criterion of deserts is not fully adequate to determine policies governing a system of health care. Many health crises occur for reasons beyond the sufferer's control or power to predict. They strike indiscriminately and afflict the just and unjust, the virtuous and the wicked, the industrious and the slothful alike. No right-minded person will argue that a newly born child "deserves" his/her haemophilia or the tumor affecting his/her spine. No one can be so callous as to believe that anyone at all merits leukaemia, genetic defects, Pinatubo or random violence.

To Each According to his Societal Contribution

Proponents are confident that this approach gives the concepts of public interest, common good, the welfare of the community, or the greatest good of the greatest number, the moral primacy due to them. With the criterion of social benefit, favoritism is avoided, unlike where the criterion is need or deserts.

Critics object that no person should be considered as merely a means or instrument, e.g., for the social good. All of us are equally worthy as human beings. Second, the canon of social productiveness fails. Health crises occur more frequently to those whose comparative contribution to the general welfare is less, e.g., the aged, the disabled, the children. Third, even if we could devise a list of socially and economically relevant criteria —e.g., age, sex, marital status, number of dependents, income, educational background, occupation, past performance, future potential, etc.— their application to the problem of allocation would be extremely problematic. Should a family man

always have priority over an unmarried artist? Productive people often need help when they are least productive; should those who provided for their families be penalized for their efforts? Fourth, the subjectivity in such factors include the danger of embodying majority value judgements which discriminate against nonconformists and dissidents ("unproductive" beggars do not have a weaker right to life!).

In fact, Ramsey asserts, the criterion itself is a mistake insofar as health is concerned. Every human being has an equal right to live. The value of survival, which is basic to all other values, cannot be compared with another value like another person's social worth. Apart from a focused social situation (e.g. competition between a private citizen and a general for protection), how does one arrive at a judgment of the greater or lesser societal worth of a person?

To Each According to his Contribution in Satisfying Whatever is Freely Desired by Others in the Open Marketplace of Supply and Demand.

Proponents argue that money is a causally necessary condition for receiving medical treatment. Why should the rich ill and the poor ill be treated equally? Let people pursue what they desire or dispose of themselves without coercion; let the laws of supply and demand prevail. For, as with other things, medical care is neither a right nor a privilege but a service offered by HCP to consumers who wish and decide freely to purchase it.

To begin with, so the critics say, the reasons why people do not have the same incomes cannot be the same reasons for receiving medical treatment. Further, health cannot be treated like any other commodity; medication is not merely one option among consumer items like TV sets. Second, alternative goods and services are not always available in this "health market." It is the physician who controls its laws: he/she decides about diagnosis, treatment, hospitalization, number of return visits, etc. About all of these things the patient-consumer is often totally ignorant and without any possibility of choice. Third, health-care providers ignore the fact that they are themselves supported by others in general ways —e.g., by taxpayers who make research and innovative technology possible— and in particular ways, e.g., by researchers who are paid less.

To Each According to One's Essential Needs

Proponents hold that, preventive medicine aside, the proper ground of distribution or receipt of medical care is ill health. It is a true need, and it is an essential need. Much ill health is fortuitously distributed by a kind of "natural lottery" or arbitrary "*kapalaran*." Granting that some crises are deserved because due to "sin" or preventable because due to moral evil, others are due quite simply to human finitude. While we can somehow predict and provide for the future scarcity of certain needs —e.g. food and shelter— we cannot always predict nor control the onset of health crises.

"Questions of social justice arise just because people are unequal in ways they can do very little to change and... only by attending to these inequalities can one be said to be giving their interests equal consideration." (Benn) As Outka puts it, true equality does not only involve generic endowments as a human existent but also extends to needs. Needs being unequal, treatment must also be unequal; different interests must be treated in different ways.

Ayn Rand protests that the criterion rewards a defect. People who achieve are cursed for their accomplishments; they are forced to pay for the weak, incompetent, and diseased. The virtuous —the "non-zero"— is penalized, while the parasite —the "zero"— is rewarded.

Similar Treatment for Similar Cases

Proponents formulate the principle thus: "Like cases are to be treated alike and different cases treated differently in direct proportion to the differences between them." (Feinberg) The equality or inequality must not be arbitrary; the similarity or dissimilarity must be "relevant" to the issue. Hence, all things being equal, people should be treated equally. This criterion, though formal, is comprehensive, consistent, and universalizable, truly equal and impartial. It is blind to considerations of social class or geographical location or finances.

Opponents advance several arguments. First, "relevance" is itself dependent on too many other criteria —e.g. the purpose of a legislation, the basis of an award, the reason for the burden. Some differential treatments are obvious to common-sense, for instance, exempting an ambulance from speed laws. But others which refer to basic attitudes, like merit and need in the distribution of wealth

throughout a community, are inherently controversial. Second, applicable as this may be to active intervention, is it applicable as well to non-intervention? Non-intervention means the possible exclusion of entire classes of cases from a priority list.

The most serious critique is that, granting the principle of equal access, there simply are times when it is physically impossible to treat all who are in need. On such occasions justice may be better served if one discriminates by categories of illness, for example, rather than between rich ill and poor sick. This means, for instance, (a) that all persons with a certain rare, non-communicable disease would not receive priority where the costs are inordinate, the prospects for rehabilitation remote, and for the sake of equalized benefits to many more; (b) that patients may be randomly selected when one must decide between claimants for a medical treatment unavailable to all; (c) that "comprehensive benefits" to which persons should have equal access are subject to practical restrictions which will vary from society to society depending on resources at a given time.

Overall, the Christian or humanist will readily sympathize with Outka's proposal for agape, with its corresponding emphases on the value of the individual, the criterion of need, the call to more attention to social questions in medical ethics, and so on. What he proposes as practical criteria —random choice, first-come, first-served, etc.— are acceptable insofar as they are less discriminatory than others. One can further agree with him when he says that the approaches by way of merit, contribution or market are less relevant when the focus is on critical care as opposed to preventive care.

Indeed my own opinion is that, given not only the scarcity but dearth of resources in a country like the Philippines, the only meaningful choice that government has, insofar as social justice is concerned, is that of preventive care. It is fully justified by essential need and rendered fair by the criterion of similar treatment.

III. Justice, Bioethics and Philippine Culture

I would like to develop this section in three stages: (1) the notion of justice in Philippine health culture; (2) the advocacy of justice in the Philippine health context; and (3) differential justice and health care, also in the Philippine context.

The Notion of Justice in Philippine Health Culture

Just as there are plural views in the notion of social justice in the West there are also various views of it in the Philippine culture. These have not been thematized sufficiently, and this is but a preliminary attempt to address this problem.

a) In one strand of indigenous animism there is no way to justify notions such as the one of social justice; at least on the religious or spiritual level. For in this view there is no intrinsic connection between the spiritual and the moral: one's status in the after-life is not determined by acts in present-life; misfortune and disease do not depend on either the spirits' or human beings' moral behavior. Moral ambiguity governs the world of both spirits and human beings.

b) In another strand, misfortune is the direct result of some immoral behavior. Like punishment, it is the result either of "immanent justice" or of "supernatural justice." In this view, for example, illness results from deviation from social norms as well as sin. Like *karma*, one does evil to oneself; one causes one's own suffering. Even *sumpa* (curse) follows the violation of strict family values. Retribution is due to *pagkukuland* (social deficit): one fails in fulfilling obligations to friends and relatives.

In brief, if one "deserves" one's illness and if it results from the violation of the social value of reciprocity or balance, one would also loose his good social standing and qualification for benefits when appealing for relief. Through propitiation, however, he regains good standing in the social corpus and is then qualified to seek its benefits and support. The justification of social justice is set in a different and wider context, namely, the notion of solidarity. In fact it points to an attitude without which the discussion of social justice is meaningless, and that is our common humanity. Before need and before merit or anything else we are bound to each other simply because we are humans. And since we are bound to each other we are also bound to help each other. In more theoretical terms, social justice is based on secular humanism.

c) From the secular point of view, the theme of humanism finds form in the core values of the culture. In my own opinion, justice in general can be subsumed in the value of *Kabutihang-loob* (Beneficence). In this context, *kabutihang-loob* means the will to do the

objectively good, and to do so not only in an occasional and incidental way but as an integral value of one's social role and/or profession. It is the good "due from oneself," a debt to one's own humanity, as it were. In contrast with Western justice as "what is due to another" the emphasis in Philippine culture is the righteousness "due from oneself." Hence it is a value in the sense of virtue rather than value in the sense of norm.

Kabutihang-loob is more a matter of personal righteousness than of objective justice. In part that is why it is so readily conflated with another core value: *Kagandahang-loob* (Benevolence). The corresponding shift from social justice to social solidarity makes the issue of social justice intensely problematic. But no more problematic than that of the Western thought. As Outka and others demonstrate, social justice ultimately slides away from the strict notions of justice to more fundamental assumptions about the human condition itself. If the philosophy of secular humanism of the local culture fails, this is no different from the failure of Western ethics itself to find rational bases for social justice. It is at this point that one must introduce the question of religion, of Christianity, and of the relationship between justice and charity.

The Advocacy of Justice in Philippine Health Context.

The moralization of a particular field of human life consists in its rationalization. In the health field the morality of issues raised lies in their rationality. As far as actual trends in the Philippines are concerned, two different points of view seem to be represented, one accenting *katarungan* and the other accenting *katwiran*. The difference between them is not unlike the difference between liberty rights and entitlement rights, noted earlier. In fact, whereas the West tends to emphasize liberty rights, the emphasis in the East is on entitlement rights. In any case the two compete with one another but also complement each other.

a) *Kabutihan-loob*: Accent on *katarungan*. The advocacy of justice in health care has been justified in different ways, some quite specific —e.g., taking the perspective of consumer protection—, others quite broad —e.g., the national health picture. Cause groups criticize the decision and delivery systems as elitist, authoritarian and paternalist. Their counter-proposal is the democratization of health. Health-care

would be empowerment —in the sense of enlightenment, participation and organization for their health interests. The struggle would be to create alternative policies regarding information systems, meaningfulness of choice, and substantive remedies. Measures of success would be significant impact, e.g., on occupational safety, patient's rights, drug policy and others.

On the nonmedical side justice would include other issues such as graft and corruption, incompetent political appointees in health institutions, low wages of health professionals and workers, decline in quality of medical and nursing education, serious deterioration of health care facilities, excessive control of multinational drug companies and medical suppliers, better health education especially regarding environmental and sanitation problems, etc. All this demands political will.

b) *Kabutihang-loob*: Accent on *katuwiran*. The appeal to political will has also been made in the alternative sense of "political caring," (which seems like, but is not the same as political charity). It is a *kabutihang-loob* where the accent is not on justice in the objective sense but on the subjective righteousness of the political leadership. In the case of health policies, the issue is not a matter of unjust structures and relationships in the first place but rather an issue of "governmental" in the sense of "paternal" responsibility —criticized precisely by the preceding view. The call is not so much to citizens to fight for their rights, as to officials to become more responsible toward people's needs. Appeals are made not to social justice in the strict sense, but to equity or social solidarity, as in "preferential allocation of resources toward promoting the health of the majority poor." In the ideal of "health for all," "service" should become the "guiding principle in the health care system." The accent in the socio-political approaches of certain NGOs, seems to be more on the "social" than on the "political" dimensions.

Justice, Charity and the Philippine Context

In *Pagkamakabuhay* I contend that the concept of "third world" is in need of further specification in order to apply to the Philippine context. To understand the state of health-care in the Philippines adequately one must see it as composed of a first, second and third world. Those familiar with the situation and the statistics do not need a detailed elaboration of how those worlds differ among themselves.

For purposes of social justice, however, one can see how in each and all the three worlds the three-fold traditional notion of justice —commutative, retributive, and distributive— exists and apply. At the same time it becomes clear that they do not apply with equal weight in all three worlds; and, finally, that they apply to the three worlds in reverse proportion.

a) In the first world of Philippine health care, which compares with conditions in the first world elsewhere, it is only right that a fair exchange should exist between medical service and financial remuneration —commutative justice. Should the client not be satisfied or be injured in the process he has the right to get relief, satisfaction or compensation —retributive justice. For the *ethos* of this first world is in fact dominated by these forms of justice.

The issue of distributive justice, however, is problematic. If and insofar as the rich contribute to the health-care systems, whether directly or indirectly, they have an equal right as anyone else to share in its benefits as well. However, in the regressive system of the Philippines the fact is that the burden of taxation lies more heavily with the poor than with the rich. More bluntly, it is the poor who pay for the medical services of the rich when these are attended in government institutions. To the extent that, for instance, the Heart, Kidney and Lung Centers are government institutions, should not their services be *primarily for* and not just *also for* the poor? Otherwise, here as elsewhere in an unjustly structured society, it is the poor who give their lives for the rich!

b) In contrast with the designed hospitals and sophisticated services of the first world, the second world of Philippine health is a melange of complicated systems of health care policies, institutions and relationships. It is modern and traditional, systematic and disorganized, efficient and ineffective, legal and illegal, orthodox and charlatan, scientific and primitive, private but also socialized.

There are complex issues of ethics here, complicated further by the processes of modernization and technological advance. And yet sophistication does not automatically translate to greater medical morality; abundance does not necessarily ensure greater justice. Despite the numerical sufficiency of graduates, the level of medical humanism has not risen. The distribution of medical personnel does not correspond to demographic logic or needs but rather to economic and social criteria.

How do the traditional divisions of justice apply to this second world? Commutative justice, as fair exchange, would refer to services demanded from the medical sector and paid for by its beneficiaries (in some places more fairly than in others). Retributive justice, as the restitution of what is due, has applications which range from capital punishment to malpractice compensation —often more rarely than usually. Distributive justice, as regulated sharing of social benefits and obligations, has clear implications for health insurance —sometimes directly but more commonly indirectly. For the second world citizens these are rights which are guaranteed by the Constitution. But their rights, moralists will say, are often more formal than substantive rights. In other words, although they are set in black and white, they are mostly the stuff of dreams or of mere rhetoric. As with most middle groups, such rights exist in the limbo of liberty and entitlement, and such social possibilities stand forever halfway between availability and affordability.

c) If there is need to emphasize the theme of justice in bioethics, this becomes more evident in the third world of Philippine health-care. Despite its importance, it must move beyond the justice of micro-social relationships, beyond the social justice within a system of deprivation, towards a social justice on behalf of the whole itself.

At the macro-level health-care in the third Philippine world must mean "societal," i.e., public or primarily community health-care. Government and middle-level institutions will express their social conscience towards it in policies of social good, regulation and preferential distribution, of primarily preventive —but also of critical— care. Those choices are not easy, decided as they often are on the basis of sheer political power, something that those of the third world hardly have. It is futile for the individual health-care worker to think of one's moral responsibility as exclusively personal; the moral responsibility belongs to the whole of society in general.

A review of macroethical principles should examine the norms derived from theories which presuppose a different context and thus a different set of emphases. Given the urgency and magnitude of the problems of this third world the problems will then be seen in a different key. They are choices between production of food vs. production of nonessential goods; family choice of number of children vs. population control; budgetary allocations for health care vs. debt servicing; the interests of health-care multinationals vs. the demands of national

health, etc. They are not only non-medical but pre-medical and hence just as critically significant.

Conclusion

More could be said of poverty and its relationship to health-care before we grasp the seriousness of the problem. However, let me bring this discussion to a conclusion with two sets of comments.

1. First, despite the complexity of the problem of social justice, health-care and the poor, we must seek even general approaches to the practical problems encountered daily. For example, how can we arrange the five approaches to social justice discussed previously?

• Given the variety of justifications for criteria of social distribution of medical and health resources and services, Rescher would seem to propose a compromise list of five factors, grouped into two sets and followed sequentially: (a) The medical criteria refer to the relative likelihood of success as well as life expectancy; (b) The non-medical criteria would be the following: family dependence, future contributions, and past services rendered:

• A second proposal would also divide Outka's alternatives into two sets, also to be followed sequentially: (a) The first set of criteria would consider the situation under the titles of essential needs and similar treatment; (b) The second set would then proceed to consider the criteria of merit, contribution and demand.

• My proposal consists of three steps of discernment: (a) Like Outka, the primary criteria would be needs in general together with similarity of treatment; (b) These, however, must be applied with different emphases, corresponding to the triple context of health-care in the Philippines. For the first world the stress would be on curative care and commutative justice. For the second world it would be on both the curative and preventive care, whichever is more urgent, as well as commutative and distributive justice, whichever is more applicable. For the third world the accent would be on preventive care and distributive justice; (c) Having observed these steps one could then introduce other criteria suggested by the authors, such as first-come, first-served, random choice and similar ones.

2. Second, what does this discussion tell us about bioethical responsibility in general? (Cf. Marchall and Marchall).

Rudlf Virchow, a 19th century pathologist, defined physicians as the "natural attorneys of the poor" and argued that "social problems should largely be solved by them." In essence, if the objective of the healing professions is *to promote health*, many medical problems require nonmedical solutions. Activities such as social action, political pressure, and redistribution of income lie well within the bounds of health care, since its concern is the identification of all factors, social as well as personal, that contribute to ill health. In that sense working for a better health is not the sole responsibility of medical institutions or medical personnel.

If the objective of the professions is *to cure disease*, then physicians will have fulfilled their responsibility through the delivery of medical care services. For medical care is disease oriented and dependent on techniques and technology broadly defined as medical or surgical in nature.

However, the treatment of disease is not an isolated activity, and it is not enough to identify a bacterial cause. One must also look at the social and economic environment that critically affect health. Those who are concerned with health must also be concerned with poverty, while recognizing that in themselves health programs offer no solution to the basic problem of poverty. Better health palliates and empowers, but it does not garantee a cure.

Unfortunately most ethical discussions today zero in more on medical care issues than on health care. Virchow's challenge is an integral part of the 2500 year tradition of Western medicine. Dubos summed it up by viewing it as a dichotomy between the healing god, Aesculapius, and Hygeia, the goddess of health.

References: Feinberg, Joel, "Justice" in *Encyclopedia of Bioethics.* (ed.) Warren Reich. (New York: The Free Press. 1978); Marchall C. and Marchall C.P., "Poverty and Heath" in *Ibidem*; Miranda, Dionisio, *Pagkamakabuhay. Prolegomena for Bioethics from a Filipino-Christian Perspective.* (Manila: Logos Publications, 1994); Outka, Gene, "Social Justice and Equal Access to Health Care" pp. 373-395 in *Bioethics*, (ed) Thomas Shannon. (New York: Paulist Press, 1976); Vidal, Marciano, *Moral de Actitudes*, II. (Madrid: PS Editorial, 1978).