

PUBLIC HEALTH ETHICAL PERSPECTIVES ON THE VALUES OF THE EUROPEAN COMMISSION'S WHITE PAPER "TOGETHER FOR HEALTH"

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SUMMARY

Background: In 2007 the European Commission issued the White Paper: "Together for Health". Considered the EU Health Strategy for the years 2008–2013, it offers the cornerstones for setting priorities in EU health actions.

Objectives: The public health framework offered in this strategy is explicitly built on shared values – including the overarching values of universality, access to good quality care, equity and solidarity that reacted to certain health care challenges within the EU. This article analyses the Health Strategy via its ethical scope and considers implications for future health policy making.

Methods: The Health Strategy and related documents are scrutinised to explore how the mentioned values are defined and enfolded. Additionally, scientific databases are searched for critical discussions of the value base of the Health Strategy. The results are discussed and reasoned from a public health ethical perspective.

Results: The Health Strategy is barely documented and discussed in the scientific literature. Furthermore, no attention was given to the value base of the Health Strategy. Our analysis shows that the mentioned values are particularly focussed on health care in general rather than on public health in particular. Besides this, the given values of the Health Strategy are redundant.

Conclusions: An additional consideration of consequentialist public health ethics values would normatively strengthen a population-based health approach of EU health policy making.

Key words: ethics, European Union, health policy, values, health strategy

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INTRODUCTION

In 2007, the Commission of the European Communities issued the White Paper "Together for Health: A Strategic Approach for the EU 2008–2013" hailed since as the EU Health Strategy (HS). As a strategic document, it establishes a coherent framework (1) presenting the cornerstones of EU health programmes and is a text setting priorities at EU level.

The HS is explicitly based on values. The aim of this paper is to include a public health ethical perspective on the HS and to analyse and categorise the values it explicitly contains. An ethical assessment can help to disclose normative implications and show where challenges and shortcomings of the value-framework might exist. This is important as to reason ethically is helpful to make justified and sound judgements in the policy arena. Furthermore, being ethically explicit concerning values is good for consistency, coherence, clarity and robustness during further discussion of decisions in the health domain of the European Commission.

The "Council Conclusions On Common Values And Principles In European Union Health Systems" (2) seem to offer a foundation for the HS. Yet, the Council Conclusions need to be contextually scrutinised as the EU presently and historically has had only limited competence in the field of health. It is now insinuated that the values of the Council Conclusions – at the forefront the values: equity, universality, access to good quality care and solidarity – are foundational for the whole European Commission's HS, despite the HS mentioning that the Commission will work on a self-standing "Statement on fundamental health values" in the future. However, these Council's values are mainly mentioned when authors make reference to the value base of the HS (3, 4) and health values of the EU in general. Thus, these values are conceived as being central to the Commission and EU health values.

Yet, it must be acknowledged that the body of norms and values of the EU is wide and encompassing from a public health ethics point of view. It is reason enough to focus on the pivotal document of the HS and to discuss some issues to which the EU

and the European Commission in particular could be responsive to in future policy papers.

MATERIALS AND METHODS

Theoretical Framework

For an ethical analysis aiming to deliver a foundation to discuss normative-ethical implications of the HS, a so-called *coherentist approach* has been chosen (5). This stems from the assumption that coherence is a central feature of ethical reasoning, and ethical reasoning should be based on a variety of plausible norms and values. Importantly, these value-based criteria have to be specified to attain a concrete, normative meaning (5, 6).

In coherentist approaches it is assumed that different traditional ethical schools of thought can highlight values and normative aspects valid for further analysis. Main categories for traditional ethical approaches are rights-based approaches and consequentialist approaches.

Rights-based approaches are often based on deontological traditions and the assumption that human dignity is of central value. Current rights-based approaches of political philosophy relate often to the influential justice approach of John Rawls (7). Rawls' liberal justice concept claims that persons have rights to fair equality of opportunity. Norman Daniels transferred Rawls' approach to health and specifies it in such a way that health (defined as normal species functioning) contributes to the opportunity range of persons. Thus, people have rights to receive appropriate health care and live in environments in which social determinants of health are distributed in a fair way (8).

In *consequentialist approaches* actions are judged for their outcome and overall produced value (9). The critical question is: do actions successfully pursue a good (e.g. human happiness) that they maximise? The most common and elaborated consequentialist theory is utilitarianism. The basic principle of utilitarianism is to maximise utility for the largest number of people possible. This is suitably a very influential theoretical base in public health (10), even though utility and health are not identical concepts. In this context, a consequentialist principle like health maximisation could be formulated. It focuses specifically on health and transports the utilitarian assumption that this shall be maximised (as long as health maximisation is not endangering the maximisation of the overall utility of people). Another influential and traditional consequentialist principle in the health setting is *do no harm* (5).

Ethical coherentism now proposes that none of these theories are fundamentally superior to any other, but all deliver (and elaborate on) important moral insights. Nevertheless, their norms do weigh *prima facie* the same and need to be plausibly enfolded and specified in a given setting. When they are contextualised and specified they develop their normative weight and power (5, 6).

To conclude, in the field of public health, policies and actions must be designed to recognise human dignity and accept a principle of justice. Simultaneously, public health has to strive for a maximised population health outcome. This asserts that health is a desired positive consequence of policies and action that is

maximised in a population with given side constraints based on rights and justice (11).

Data Collection and Analysis

To explore the issue of what comprises the ethical anatomy of the HS, the values and referenced documents will be examined. Questions for exploration include the following: What values are brought forward? How are they exactly defined? How do they relate to each other? How are they normatively enfolded?

These values will be categorised within the above mentioned framework to show what ethical theoretical background they are derived and substantiated from. The following section involves examining the normative implication of the values that are identified and what relationship and meaning can be derived. Principal focus will be on the four values of the Council Conclusions highlighted in the HS as they are overarching and are reiterated and referred to explicitly in discussions as pivotal EU health values (3).

Furthermore, it will be systematically reviewed as to whether ethical criticism of the HS values is already given in scientific literature. Searches involve the BELIT (the most comprehensive database dealing with ethical issues of health). Search terms included "Health Strategy", "Together for Health", "Council Conclusions", "Com (2007) 630" and "2006/C 146/01". The additional inclusion of Google Scholar ensured a wide research scope¹. The terms "Together for Health: A Strategic Approach for the EU 2008–2013" and "Council Conclusions On Common Values And Principles In European Union Health Systems" were used to identify relevant publications. Further snowball sampling was applied to ensure an adequate literature review.

RESULTS

The following section is structured with reference to the values as listed in the HS (Table 1). The intention here is to present the values and their meaning as explicitly documented in the HS. This is achieved by analysis of principle 1 which is elaborated in the staff working document of the HS (12). Documents that are specifically referenced in the formulation of the HS values are sought to attain a broad scope and to extend a valid discussion. The focus remains at the level and context of the HS specifically, and is in line with the assumption that the HS is the leading policy text that will be a practical tool for policy makers of the European Community. Finally, criticism retrieved from the literature of the HS value-base will be presented.

The Values of the Council Conclusions

In exhibiting its value base, the HS makes its first reference to the overarching values of equity, universality, access to good quality of care and solidarity. They derive from the "Council Conclusions On Common Values And Principles In European Health Systems" (hereinafter CC) (1), yet are included and given a central locus by the Commission in the HS.

The CC recalls these four values in its text after stating that the Council of the European Union considers "that health systems

¹See: <http://scholar.google.nl>

Table 1. Explicitly discussed health values in principle 1 of the Health Strategy (1)

Locus in the HS	Values explicitly mentioned in the HS	Source of values where HS draws explicitly on other essential EU policy documents
Principle 1: A strategy based on shared health values	Universality, access to good quality care, equity and solidarity	Council Conclusions on Common Values and Principles in European Union Health Systems (2)
	Gender equality	Council Conclusions on Women's Health (13)
	Citizens' right of access to preventive health care, right to benefit from medical treatment	Charter of Fundamental Rights (14)
	Citizens' empowerment/health literacy	(No referenced policy document)
	Reducing inequities in health	(No referenced policy document)
	Scientific evidence	(No referenced policy document)

are a central part of Europe's high levels of social protection and make a major contribution to social cohesion and social justice" (11). Thus, values of social cohesion and social justice are named as an important endeavour and value of the European Union in general. This is repeated in the Staff Working Document (12), yet human dignity is added when saying that the EC "supports social justice and respect for human dignity" (12). These can therefore be identified as central important values for EU policy in general.

The CC explains only very briefly what the four values mean. It details that *Universality* "means that no-one is barred access to health care". *Solidarity* "is closely linked to the financial arrangement of our national health systems and the need to ensure accessibility to all". *Equity* "relates to equal access according to need, regardless of ethnicity, gender, age, social status or ability to pay. EU health systems also aim to reduce the gap in health inequalities, which is a concern of EU Member States; closely linked to this is the work in the Member States' systems on the prevention of illness and disease by, inter alia, through promotion of healthy lifestyles". It is added that health systems should be "patient-centred and responsive to individual need". *Access to good quality of care* is not further defined, yet indirectly linked to the HS's other value topic of "scientific evidence" that shall ensure good quality (see below)².

Gender Dimension

In the HS reference is made to the "Council Conclusions on Women's Health" (13). Here it is mentioned that the Council "has also invited to take into account and integrate the gender dimension". It is stressed that men and women are equal and that this gender equality should be pursued in all policy fields, yet women's health is still an "area of concern".

Charter of Fundamental Rights

The HS refers to the Charter of Fundamental Rights of the EU (hereinafter Charter) (14) that came into force in 2009. The Charter's values mentioned explicitly in the HS are citizens' right of access to preventive health care and the right to benefit from medical treatment. These rights stem from the same Charter in

Article 35 that is entitled Health care. This article together with Art. 168 of the Treaty of the European Union (TFEU) clarifies that the Commission lacks the authority to rule into national health care systems. Furthermore, the interpretation and application of EU health values would remain critical as the Member States set the framework for public health policies and practices. Thus, all EU citizens may have the same right under the Charter but the transformation of the right into practice differs substantially and depends, inter alia, on the resources that can be allocated. The specification and implementation of the values mentioned in the HS ultimately depend on the specific governance of national health systems.

Additionally, the Charter grounds and reflects very foundational values such as equality, solidarity, democracy, rule of law, freedom, security, and justice in its preamble. These are then referred to in later articles of the Charter in different contexts.

Citizens' Empowerment

Citizens' empowerment as a value, reflects that health care "is becoming increasingly patient-centred and individualised". Furthermore, it supports that patients are "becoming an active subject rather than a mere object of health care". Thus, the EU "must take citizens' and patients' rights as a key starting point". This points in the direction of the value of health literacy which is defined in the HS as the "ability to read, filter and understand health information in order to form sound judgements" (1).

Reducing Inequities in Health

Reducing inequities in health is a further value of the HS. Inequities are defined in the HS as inequalities in health that are avoidable and unfair. Even though life expectancy in Europe has risen, "major inequities in health exist between and within Member States and regions as well as globally" (1).

The Staff Working Document adds that inequities should be challenged so that a vision is "worked towards ... where all European citizens have an equal opportunity to enjoy a high level of health care regardless of where they live or their social status" (12). Health gaps should also be challenged because "they

²There are further 'operating principles' in the CC. Yet, they are methodologically 'beneath' the overarching values. As they are not explicitly reflected in the HS's 'principle 1', they shall not further be scrutinised here.

contribute to undesirable pressure on the social and economic development of the EU as whole and hinder its integration and competitiveness” (12).

Scientific Evidence

Considering scientific evidence as a value, the HS details that “health policy must be based on the best scientific evidence derived from sound data and information, and relevant research” (1). The Commission is “in a unique position to assemble comparable data from the Member States and regions and must answer calls for better information and more transparent policy making including a system of indicators covering all levels (national and subnational)” (1).

Criticism from the Literature

The search terms in BELIT (21.7.2011) (using previously specified phrases, identifying “everywhere” as a location and limiting to English literature) retrieved zero documents related to the HS or CC. The search in Google Scholar for the term “Together for Health: A Strategic Approach for the EU 2008–2013” recovered 192 papers and documents, 180 of these were written in English or at least written with an English abstract. Snowball sampling led to no further results. Most of the 180 appraised English papers and documents only mention the HS in the context of related research or policy activities, e.g. global health (15) or ageing (16). However, these papers do not critically discuss the HS itself. Other papers merely present the HS, with broach to its principles (17). Nevertheless, no paper was found that explicitly sets out to ethically scrutinise the HS. The only ethical paper found that makes explicit reference to the HS does not refer to its values. It only mentions that the HS focuses on prevention (18).

Additional search criteria included the phrase “council conclusions on common values and principles in European union health systems”. In total 32 papers and documents were found, 27 of which were written in English. None of these retrieved discusses the values from an ethical stance. Most of the papers were already found in the previous search and caused overlap.

Value-related discussion can only be found in papers that discuss and appraise the HS in general (3, 4). One further paper was found that discusses EU policies with health values before the HS was issued (19).

From these papers, Birt (4) argues in a response to McCarthy (3) that the HS’s principle 3, health in all policies, is not realised. „The EC seeks to support Europe’s industries: hence, if DG Sanco” were to propose policies that “might challenge the interests of the alcohol and food industries, those directorates general seeking to promote European products across the world could be expected to block these.” Birt concludes, “perhaps the health in all policies Treaty obligation can never be all that it appears to be” (4). This is especially apparent for Birt with regard to the agriculture and food policy of the EC that is in direct conflict with fighting (risk factors for) cardiovascular diseases in the EU that are the principal killer of European populations. Birt criticises that the EC does not make any reference to this problem.

Similarly, Koivusalo had said while making explicit reference to health values that seem to anticipate the CC that “rather than ensuring that Member States will have scope and space for main-

taining universal services, solidarity, and healthy public policies [...] European health policies seem to be on their way to becoming more of a means of serving the priorities of other policy sectors and the perceived competitiveness of the European economy.” (19). Additionally, he is concerned that “the basis of understanding health policies in the European Union is related to the very individualised and behaviour-based model. While policy influences are recognised, they are seen only as means of guiding individual lifestyle and choice” (19). In conclusion, the quoted authors focus mainly on the unsuccessfully realised health in all policies approach of the EC that is in implicit tension to health values.

DISCUSSION

Categorisation of the Values

How are the four overarching values related to each other and to the fundamental values in the EU? In moral philosophy, *equity* is a concept closely related to justice (a general value of the EU) and could be understood as an equivalent concept of justice in the context of health (20). Justice strives in most of its conception for equity i.e. that inequities are unjust. Often, justice and equity are even considered to be synonymous concepts. In the above cited documents (1, 12) it also becomes clear that equity is used as a concept to promote justice. The Staff Working Document even uses a conception that is reminiscent of Daniels’ justice approach (8).

The other three overarching values can be conceptualised as specifications of equity (and of social justice). *Access to good quality of care* and *universality* can be seen as a reiteration of the core demands of equity and justice. In fact, both are quite similar. Justice approaches in health care often demand nothing more than universal access to good quality care. Whereas the anchor for the level of care made available is a concept of health. This is viewed by Daniels as “species typical functioning” (8), thus excluding certain demands such as cosmetic surgery.

Solidarity is a concept common in sociological discourses but is rarely employed in liberal normative ethics. There is no convincing systematic normative development and specification existing in the health ethics realm. This is namely because normative questions of solidarity in health (care) are often discussed as normative questions of equity or justice, respectively. In ethical justice theories, solidarity is seen as a characteristic that describes the willingness of members of communities to be committed to the principle of justice (21) or to each other. This is certainly an important value. However, in this case solidarity has no added value for normative ethical argumentations (22). As we look at the concept of solidarity in other definitions in ethics, it contains elements of supererogation. This forces it beyond the realm of policy making and not extending justice discussions (23). In liberal ethical discourses the concepts of justice or equity are rather used to describe what we owe to each other. This is actually redundant with the definition of solidarity in the CC as solidarity reflects “the need to ensure accessibility to all” (2), and is a conceptualisation in a normative sense reminiscent if not identical to those other three overarching values.

It could be argued that equity (or justice) is a broader and all encompassing value. The remaining overarching values includ-

ing the main points raised in the Charter are specifications and merely provide a contextualised interpretation thereof. They focus on certain aspects and perspectives of equity; still they do not represent new or significant complementary value aspects. Also, we see that the value of reducing inequities in health might be a starting point for a new context but not a new value. Gender equality aspects emphasise that a special attention shall be given to women; however, this can purely act as a specification or an additional reminder of equity. Normatively it does not offer a distinct perspective and neither do other rights that claim access to health services for all. A presupposition that women's health currently needs more attention is correctly based on given scientific evidence. However, conceptually it should not be excluded that it could also be men's health in the gender context that needs special attention in current and prospective circumstances. To reduce gender aspects in health to specially support women would conceptually be a shortcoming from a general justice perspective. *Citizens' empowerment* can be related to the mentioned values and health literacy is seen by many as a criterion of social justice and equity in itself (24).

To summarise, by virtue of the proposed ethical perspectives the overarching value *equity* is a concept closely related to justice. Other values of the HS can be seen as specifications of equity for the health (care) realm, hence supporting the values of equity and justice.

Furthermore it can be stated that the mentioned values clearly seem to stem from the tradition of rights-based approaches (and seem to be coherently connected). Nevertheless, genuine consequentialist public health ethics values that would add another ethical tradition and complementary schools of thought (such as *do no harm*, or *health maximisation*) are missing. One could argue that these norms are referenced in EU law documents (e.g. Charter Article 3.1. "Everyone has the right to respect for his or her physical and mental integrity" or in The Treaty of the European Union "protection and improvement of human health" (Art. 6 TFEU). However, this is neither to be confused with the ethical points (e.g. improvement is more relative than maximisation or right to protection is not to be identified with the consequentialist *do no harm*) nor are these Charter and TFEU values made explicit as values in the foreground of the HS. Rather, the afore mentioned CC values are at the centre, and this level is being discussed in this paper: with the HS as a leading policy document in its own right. If these Charter and TFEU values would have been understood as central health values for the EU, they should have been explicitly reiterated by the Commission in the HS.

As a consequence of the above, it appears that the HS has a clearly rights-based orientation. Furthermore, it appears to be determined on a level of basic values (e.g. universal access to good quality care or gender could be seen as a specification of equity). However, neither aspect is surprising from a policy document of the EU. Rights are a core concept of policy making and reference to other policy documents and concepts is a common approach in policy formulation.

Nevertheless, the chosen variety of values and norms could from a systematic ethical point of view only also be said to appear arbitrary. This is namely because the overlap is neither made explicit nor discussed. One has to wonder if the plausibility of the values and norms was ever scrutinised in the policy formulating

process. If we look only at the four values of the CC they already appear somewhat redundant.

If one talked of overarching values, human dignity, equity or justice could be the one overarching value from which more specific norms and values could be deduced. The given remaining values in the HS could then be conceived as specifications of these. Even more, from a wider and coherentist public health ethics point of view, justice or equity and the consequentialist principles *health maximisation* and/or *do no harm* could be overarching values. A value such as *health maximisation* would have an added value as it would give a normative foundation of not only looking for equality (that could also be reached on a low level) but to spread as much health as possible.

To conclude, the presented values of principle 1 of the HS does not have an added value from an ethical perspective but perhaps more in terms of political symbolism. Here, values to guide issues and questions of cross-border health care are made foundational for the whole European Commission's HS; or are at least often seen to be so and are then reiterated accordingly. If values should be brought to the forefront of the HS to guide good policy making in health care and public health, then it should rather be values from different categories. Consequentialism with its derivative of *health maximisation* or the classical *do no harm* might be seen as an essential normative perspective on public health (25) with an added value. Yet, one has to be aware that taking these public health values seriously could have far-reaching consequences for decision making.

The Criticism from the Literature: Health Care Values vs. Health in All Policies

Without *health maximisation* and *do no harm* in the HS, one could argue that there is a missing link between the focus on health in all policies (principle 3) and the health values (principle 1). This is true conceptually within the HS as a normative non-correspondence, which one should not expect from a coherent policy document.

Rather, the HS values emphasise the care domain that becomes important when people are already sick and are in need of classic health care. Once ill, (so the HS's values insinuate) at least the repairing of ill health should be organised equitably, universally, in good quality, and commonly financed.

However, the HS with its focussed health care values leaves one conceptual loophole: the promotion of individual health literacy could be read as the backdoor for health policy making. Yet, the responsibility for healthy living and its burden would then be shifted towards the individuals – as Koivusalo had already observed. This might be the trial in the HS values to square the circle: health literacy and self-responsibility are identified as the EC responsibility to promote in the HS, rather than healthy environments. However, this does not follow a value of *health maximisation* or *do no harm* (this might be deliberately excluded). Rather, here it manifests what could be considered as the EU health value paradox: the values are mainly supporting an equitable repair service. The European Commission has limited competence in this arena and is governed mainly under Member State regulation. The EU is therefore limited in its ability to provide an encompassing, preventive and promoting public health approach.

One could provocatively ask: What is a value based HS morally worth if it does not explicitly subscribe to public health ethics values such as *do no harm* and *maximise health* that would fully support health in all policies? Principally, one must not forget that health is not the only dimension for policy making. Here the strong ambiguity for the European Commission becomes most apparent: health is even seen instrumental to wealth (HS, principle 2) and an aim of the EU is to secure and improve wealth. Here the European Commission is caught in a dilemma between economic and social values. From an ethical point of view, a theory of well-being is needed on a more general level for good policy making. Health is but one dimension of well-being and thus only one dimension for a truly encompassing value of social justice (20, 21). A value theory would be needed here to explain this and the place of the health values in a comprehensive and coherent policy approach.

CONCLUSIONS

The HS is explicitly built on values. From an ethical point of view the explicit incorporation of values is highly welcome. However, questions remain as to whether the values appear to be superfluous and too health care focused for a document that is an umbrella for the wider public health domain. Norms of public health ethics such as *health maximisation* and *do no harm* should be rather explicitly and centrally included in an ethically meaningful and comprehensive (Public) Health Strategy. By not including such elements, the HS leaves normative loopholes for unhealthy policies. The HS strengthens a way out of this problem by stressing health literacy and behaviour change, as individuals are to make healthy choices themselves. However, the justice related question as to whether people can really be empowered to make healthy choices and obtain understandable health information is not addressed.

The HS foresees taking further action to develop and then adopt a further and broader "statement on fundamental health values" (1). From an ethical viewpoint it would be most welcome if such a framework would render the different values more coherently to include more public health ethics values and to clarify the normative stances and their relations to each other. Furthermore, strategies of how to deal with conflicting values and norms could be covered in such a statement.

Conflict of interest

None declared

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