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ORIGINAL RESEARCH

Norms in and between the philosophical ivory tower and public health practice: A heuristic model of translational ethics

Peter Schröder-Bäck[1], Claire van Duin[1], Caroline Brall[1,2], Beatrice Scholtes[1,3], FarhangTahzib[4], ElsMaeckelberghe[5]

[1]Department of International Health, School CAPHRI (Care and Public Health Research Institute), Maastricht University, The Netherlands;

[2]Health Ethics and Policy Lab, Department of Health Sciences and Technology, Swiss Federal Institute of Technology - ETH Zurich, Switzerland;

[3]Department of Public Health Sciences, University of Liege, Belgium;

[4]UK Faculty for Public Health, London, United Kingdom;

[5]University of Groningen, Institute for Medical Education, University Medical Center Groningen, The Netherlands.

Corresponding author: Peter Schröder-Bäck
Address: Maastricht University, PO Box 616, 6200 MD Maastricht, The Netherlands;
Email: peter.schroder@maastrichtuniversity.nl

Abstract

This paper draws attention to the translation of ethical norms between the theoretical discourses of philosophers and practical discourses in public health. It is suggested that five levels can be identified describing categories of a transferral process of ethical norms – a process we will refer hereto as "translational ethics". The aim of the described process is to generate understanding regarding how ethical norms come into public health policy documents and are eventually referred to in practice. Categorizing several levels can show how ethical-philosophical concepts such as norms are transforming in meaning and scope. By subdividing the model to five levels, it is suggested that ethical concepts reduce their "content thickness" and complexity and trade this in for practicability and potential consensus in public health discourses from level to level. The model presented here is illustrated by showing how the philosophical-ethical terms "autonomy", "dignity", and "justice" are used at different levels of the translation process, from Kant's and Rawls' theories (level 1) to, in this example, WHO reports and communications (levels 4 and 5). A central role is seen for what is called "applied ethics" (level 3).

Keywords: ethics, practice, public health, theory, translation.

Conflicts of interest: None.

Background

There is growing interest in public health ethics as a distinct discipline from clinical ethics and critical to consideration of population health issues (1). As highlighted by Michael Marmot there is an urgent need to create better understanding between philosophers, the health community and the real world (2). He has lamented, at times, the contemptuous approach of some philosophers, not considering real life concerns and not engaging with non-philosophers. These philosophers are often engaged in highly theoretical discussions, even in multidisciplinary gatherings. Such issues are relevant since public health prides itself in evidence based knowledge and there is a question as to why evidence often does not translate into public health practice. It has been suggested that evidence is generated within a deliberate exchange process between scientists and practitioners, and that it is essential to take values, resources and interests of the different parties into account (3). Consequently, consideration of ethical norms and values should be seen as a critical part of the translation process (4). This is more than just linking the philosophical ivory tower approach of academics with the practical world of practitioners but rather also appreciating the language, purpose and nature of philosophy and public health, and their essential roles for effective scholarship and practice.

To give an example, ethical norms, such as "autonomy" and "justice", are often mentioned in public health policy and practice discourses. When these normative concepts are used, public health practitioners probably understand them differently to – but not necessarily incompatibly with – philosophers. This presumed discrepancy leads to the question: How can one relate the ethical concepts in practice to their philosophical background theories? This paper provides a description of the potential pathway between the ivory tower and practice using case studies of some specific conceptual issues used in theoretical, policy and practical discourses.

Translation and Transferral

In medicine the term "translational research" or "translational medicine" is well established, generally referring to the translation of scientific research to clinical practice, a process often called "from bench to bedside" [e.g. (5)]. However, translation of knowledge does not only take place in sciences and medicine. Ethical concepts also undergo a translation– from philosophical theory to, in this example, public health policy and practice. In the following discussion we focus on the translation of philosophical work into public health practice.

The term "translational ethics" is relatively new. Even though ethical concepts are frequently "transferred" or "translated" – both etymologically meaning "to carry over" – between and across different domains, there is scarce academic scholarship regarding the issue (6-8). Unlike language translation it is not the name of the concept that is translated, but its specific content that is made applicable for practice: the meaning and scope of philosophical concepts is explained and made usable for – or "carried over" to – contexts of professional practice in a process that we can term "translation". The metaphor "translation" is also used as a reference for other areas of "translational research", as mentioned above, when one refers to the transferral of basic scientific knowledge (the laboratory "bench") to the more applicable and practical use of the knowledge (the clinical practice at the "bedside"). In this discourse, however, the concepts sometimes

change in scope and meaning so that we consider the term "translation" to be appropriate. This translational process is by no means meant to be a one-way street (6). Indeed practical discourses can initiate or inform developments in philosophical theory as well. However, in this paper – as a starting point – we focus on the translation of philosophical knowledge to public health practice.

Translational Processes

To give an example of the translational process, the concepts "autonomy" and "dignity" shall be mentioned. These concepts have been philosophically elaborated upon by the renowned eighteenth century philosopher Immanuel Kant. However, for him these concepts had a different meaning than they do for the public health practitioner who is, for example, considering the autonomy or dignity of a child and her parents who refuse immunization. Even without knowing the precise philosophical aspects of the concept of "autonomy", at least through common, every day or professional language, the physician possesses a normative understanding of the concept that usually derives from Kant's (and others') conception of it. A normative appreciation of autonomy may lead the physician to accept a patient's decision. Another example is how public health practitioners formulate in the context of childhood immunization that […] the impulse to maximize benefit for the highest number of people is counterbalanced by the Kantian threshold of a categorical imperative […] that preserves individual autonomy and emphasizes ideas such as informed consent" (9). However, this formulated Kantian "side constraint" may not be as readily accepted by a more theoretically informed philosophical argumentation, such as that offered by the philosopher and Kant scholar Onora O'Neill. In her argumentation, Kantian autonomy may even put moral obligations on parents to have their child immunized for the sake of protecting the autonomy of others (10). This is not to say – and not the question of this paper – that either Salmon and Omer or O'Neill are right in the interpretation of Kant. It is to demonstrate that the understanding of both is significantly different even though both relate back to Kant.

Indeed, autonomy is an ethical concept with a long standing philosophical tradition and strong and "content thick" background theories from which it has evolved (11). "Content thick" means the involvement of sophisticated philosophical substantiation and differentiation, perhaps including explicit consideration of other philosophical fields, such as from epistemology or metaphysics. Nevertheless, a public health practitioner is not (necessarily) aware of ethical theories behind this term when using it, even if he or she refers back to Kant explicitly, as the example of Salmon and Olmer (9) – who claim that Kantian autonomy is incompatible with involuntary immunization – shows. So, how does the practitioner come to use an ethical concept?

It is the thesis of this paper that ethical concepts move from the "philosophical ivory tower" to – in this case – public health "practice" (including policy making and research). This happens while practitioners have, or display, only common knowledge of the philosophical backgrounds of the ethical concepts they are normatively applying.

Thus we suggest that if we could reconstruct the patterns of translation of meaning of the term "autonomy" from Kant to the practitioners' use of this concept, we could help to facilitate communication among the stakeholders involved in the normative elaboration and development of public

health. The aim of this paper is thus to propose a heuristic model for discussion and to stimulate scholarship on the translation of ethical terms for practice.

Towards a Heuristic Model

The development of such a model draws on some assumptions of the philosophy and sociology of science in the tradition of Thomas Kuhn (12) and Ludwik Fleck (13). The concept held in common among these authors and underpinning the proposed model is that scientists and practitioners live and act in their respective paradigms and communities, which are partly constituent by their use of language. Thus, for members of one community to understand members of other communities, care needs to be taken to ensure that their lexicon is the same. Moreover, concepts should be made commensurable – meaning that the sense of a common concept or term is comparable in different discourses. However, this is not easy since the extension of concepts and their meanings can change. The model proposed here raises awareness of this challenge.

The "content thickness" of elaborated philosophical concepts is relevant for practice, for example, to achieve a differentiated and critical understanding of terms, similarly "content-thinness" has some virtues. "Content thin" concepts are more acceptable in pluralistic societies and policy making (because the concept could derive from and stand for many background theories and worldviews). Practitioners can agree on the normative concept first – and then elaborate upon what this means exactly by referring back to elaborations and theories of earlier levels of the translational process. It is the assumption of the model proposed here that normative concepts have legitimacy and specific roles in each of these communities – be it in the philosophical ivory tower or in practice. Yet, when "carrying over" or "handing over" the normative concept like a baton, even though the concept still looks the same, its meaning has often changed.

A Heuristic and Descriptive Model of Translational Ethics

The proposed model consists office levels. These levels range – analogous to the concept of "from bench to bedside" – from the philosophical ivory tower (Level One) to public health practice (Levels Four and Five). Normative concepts such as ethical principles are complex and "content thick" on a philosophical level and, in practice, are more "content thin". Thus, the model focuses upon the transformative journey that ethical concepts make from the ivory tower to practice.

In the following section we describe the different levels of the model by using different examples: the strongly related concepts of autonomy, dignity, and justice and specifications of these. We illustrate levels 4 and 5 using the example of the WHO report on "Health Systems Performance" from 2000 (14).

Level One: Abstract and ideal philosophical theory

The first level of the model refers to philosophical works that are often the foundation for normative ethical concepts. Using the examples of autonomy, dignity and justice, one can refer to the works of Immanuel Kant. In his discussion of these concepts, Kant already uses examples, such as the murderer at the door to whom one may not lie, even to protect an innocent friend– yet, they remain very abstract, often counterintuitive in the modern world. Kant's discussions would be too abstract and somewhat unconvincing if one were to apply them directly to public health practice.

Furthermore, he also includes complex and controversial metaphysical concepts in his argumentation– such as the claim that a person as "homo noumenon" bears human dignity (15) – that are unsuitable for public health practices, as we have argued elsewhere (16). In fact, theories at this level often integrate a rich and wide scholarship of other areas of philosophy – including ontology, epistemology and metaphysics.

John Rawls (in 1971) in his theory of justice as fairness (17), has also drawn on Kant's insights. Rawls' theory also remains abstract in many regards, for instance due to his use of hypothetical models such as the contractarian approach to justify his concept of justice and the difficulties associated with the applicability of the concept to everyday concrete problems. In fact, Rawls' account has been considered an "ideal" theory (18). Thus, we would consider this level as representing ideal theory; meaning that it abstracts from concrete real-world practice and conditions (7, p. 210). Similarly, Rawls is criticized by Amartya Sen for dealing with the design of "ideal" institutions (19, p. 15ff), as opposed to institutions that function in the real-world. Marmot has highlighted that non-philosophers are not familiar with complex philosophical concepts and that many think that "Rawls were to do with building sites" (2), given that the British English word for "screw anchor" is "rawl plug".

Level Two: Non-ideal theory for a field of practice

The second level covers ethical theories that are already more concrete with regard to the field of practice in question, and are developed based on empiric knowledge of that setting. Theorists build a theory for a concrete context referring to and basing it on Level One theories such as Rawls and Kant. Theorists from this level include figures such as health justice theorist Norman Daniels who developed a theory based on Rawls' basic ideas (20); or the philosopher Madison Powers and the bioethicist and public health researcher Ruth Faden, with their work on social justice (21). While developing, in their view, a sound theory of health justice, they also claim to develop a decided non-ideal theory. Powers and Faden (21) criticize Rawls' assumption of equality of persons in a hypothetical situation. Instead, they look at real world inequalities and work on criteria of why these inequalities matter. However, without Rawls' ideal theory of justice (and indirectly Kant's concept of dignity) their own theory would probably not have been developed. Despite this very theoretical difference between Levels One and Two, the intention to be more practical on Level Two and to try to deliver real world solutions for public health makes a significant difference. Yet, both Daniels and Powers and Fadens' theoretical approaches, explicitly draw on Level One theories, criticize them and dialectically develop their own, more accessible, Level Two theories for philosophers and practitioners.

Level Two academic scholarship is often made more practical by collaborations between philosophers and public health scientists (e.g. Daniels, Kennedy and Kawachi (22), Powers and Faden (21)). On Level Two, interdisciplinary perspectives and collaboration become more relevant. Here, the aim is, as O'Neill formulates it (23), to give more ethical substantial input to applied ethical debates, leading us to the next level.

Level Three: Applied ethics

Level Three represents what is often called "applied ethics", meaning that concepts and theories from previous levels are "applied" to concrete practical problems to receive

normative guidance – but this is also an area where normative convictions and judgements could be inductively connected to ethical theory. Level Three discourses are often initiated by practitioners. They look for interdisciplinary discourses with ethicists to find criteria or even solutions to moral questions. Public health practitioners at this level are positive about the powers (and limits) of philosophical ethics, as they are often already ethically informed or educated. Ethicists, when working on these issues – often in interdisciplinary teams or even commissions, like the Nuffield Council on Bioethics and its report on public health ethics (24) – try to use generally understandable references of ethical theories. At Level Three the works of applied ethics such as the influential work of philosophers Beauchamp and Childress (25) is very prevalent. In their four-principle approach for biomedical ethics, they also refer to "autonomy" and "justice". Beauchamp and Childress explain the background concepts of their principles such as "autonomy" and" justice" – making reference to Level Two and Level One theories and approaches. In the context of "autonomy" for instance, they combine Kantian ideas of autonomy and the related concept of dignity with other relevant philosophies (most notably the related concept of "liberty" of John Stuart Mill). Yet, they explain this overlap so broadly and generally that practitioners can understand and apply the principles. This might mean a loss of theoretical complexity and content thickness (even though Beauchamp and Childress would argue that they have a unifying background theory of coherentism and might claim their work to be on Level Two). For the sake of being interdisciplinary, pluralistically communicable, agreeable and helpful as tools and criteria for decision making this is understandable and in fact very helpful. Of course, as the example of Beauchamp and Childress shows, philosophers can work on different levels and levels should not be identified with persons. A good example is philosophers who engage in Level One scholarship but also write on applied ethics or work in interdisciplinary ethics commissions (such as e.g. Tom Beauchamp, a renowned Hume scholar).

Level Four: Applied ethics in practice

The normative concepts used at Level Four mainly refer to literature from Level Three. Authors of arguments using the terms "respect for dignity" or "autonomy" refer to the works of theorists such as Beauchamp and Childress. They understand these terms rudimentarily (in a philosophical sense). They are not (as) aware of the background theories. In this translation process the "content thickness" and depth of the norms are further lost, yet, these criteria help to make normative arguments around the acceptability of public health interventions. Representatives of these levels would be public health researchers or practitioners aware of moral problems. They are also aware of these being norms and concepts coming from a rich ethical discourse. Normative tools – including codes of conduct – that are established to guide practical conduct (1) arguably also belong to this level, or between Levels Three and Four.

The example we use to explain this level and Level Five is the use of ethical norms in a framework for health systems performance assessment developed for and used by the World Health Organization. The initial framework was developed by Christopher Murray and Julio Frenk and was improved and adopted for use in "The World Health Report 2000".

With their framework for health systems performance assessment, Murray and Frenk

aim to advise decision makers (26,27). In other words, their work should be of very practical use. Within their framework, they formulate "health system goals". The main goals are "health", "responsiveness" and "fair financing and financial risk protection". These goals are to be measured in health systems performance and efficiency assessments. "Responsiveness" has two dimensions. The second one is "client orientation", the first one, upon which we focus, is "respect for persons". Of the several sub-components, the first three explicitly use ethical norms and can be closely related to the philosophy of autonomy and dignity: "Respect for the dignity of the person" as the first sub-component forbids instrumentalisation of persons. As they formulate, it is important to show "respect for the autonomy of the individual to make choices about his/her own health. Individuals, when competent, or their agents, should have the right to choose what interventions they do and do not receive" (26). They further talk of "respect for confidentiality" (26). In referring to these ethical norms and applying them to their context, Murray and Frenk formulate precisely in the language of applied ethics and refer to 18 sources, many of which are works in applied ethics (Level Three), including Beauchamp and Childress.

The third goal "fair financing and financial risk protection" makes explicit reference to the concept of fairness (related to the concept of justice). Here they reference work by the philosopher Daniels and colleagues where they apply his theory to concrete health care issues (28). Here again it can be seen that normative arguments are clearly made, using ethical norms without going back to "content thick" theories of Level One.

Level 5: Reference to ethical-normative concepts in practice

On the final level, practitioners use ethical concepts as normative terms without making any reference to theories of ethics or applied ethics (Levels One -Three). No explicit elaboration of the normative concepts can be found at Level Four. At this point these concepts have only a rudimentary link with the concepts of Levels One and Two. Nevertheless, a certain normative essence is encapsulated.

To illustrate this, we look at how "The World Health Report 2000" was further condensed and "translated" for practice and the public by an accompanying message from the former WHO Director General, Gro Harlem Brundtland, and by the press release of the WHO. Gro Harlem Brundtland's statement opens the report as a "Message from the Director-General". Brundtland starts by asking two (of three) questions relating explicitly to ethical concepts "What makes for a good health system? What makes a health system fair?" She continues by saying that it is the task of the WHO and of such a report to help all stakeholders "to reach a balanced judgment" (29, p. vii). Moreover, she makes reference to values and norms we are already familiar with from Level Four, the framework paper by Murray and Frenk (26). She continues with stating the ethically relevant part: The goals of health systems "are concerned with fairness in the way people pay for health care, and with how systems respond to people's expectations with regard to how they are treated. Where health and responsiveness are concerned, achieving a high average level is not good enough: the goals of a health system must also include reducing inequalities in ways that improve the situation of the worst-off." According to these (normative, ethics based) considerations, health system performance is

measured to give policy-makers information to act on.

Additionally, the translational function of journalism is considered by formulating a press release. In this press release, there are direct quotes by the Director General but also by Murray, Frenk and others. The press release additionally refers to the ethical concepts and norms. It mentions "injustice" and treating with "respect". However, it also refers to the main categories and components of the performance index "responsiveness" and "fairness of financial contribution". The aspect of "responsiveness" based on the ethical norms is now concisely summarized as "respect for persons (including dignity, confidentiality and autonomy of individuals and families to decide about their own health)". In the press – e.g. in the New York Times (30)– the ethical concepts are even less prevalent. Formerly used foundational norms such as "respect" and "dignity" are not used any longer, only the term "fairness" related to the measurements. In other words, the explicit ethical norms are even further in the background. Yet, one could trace "fairness" back – translated through the levels – to Rawls' Level One explication.

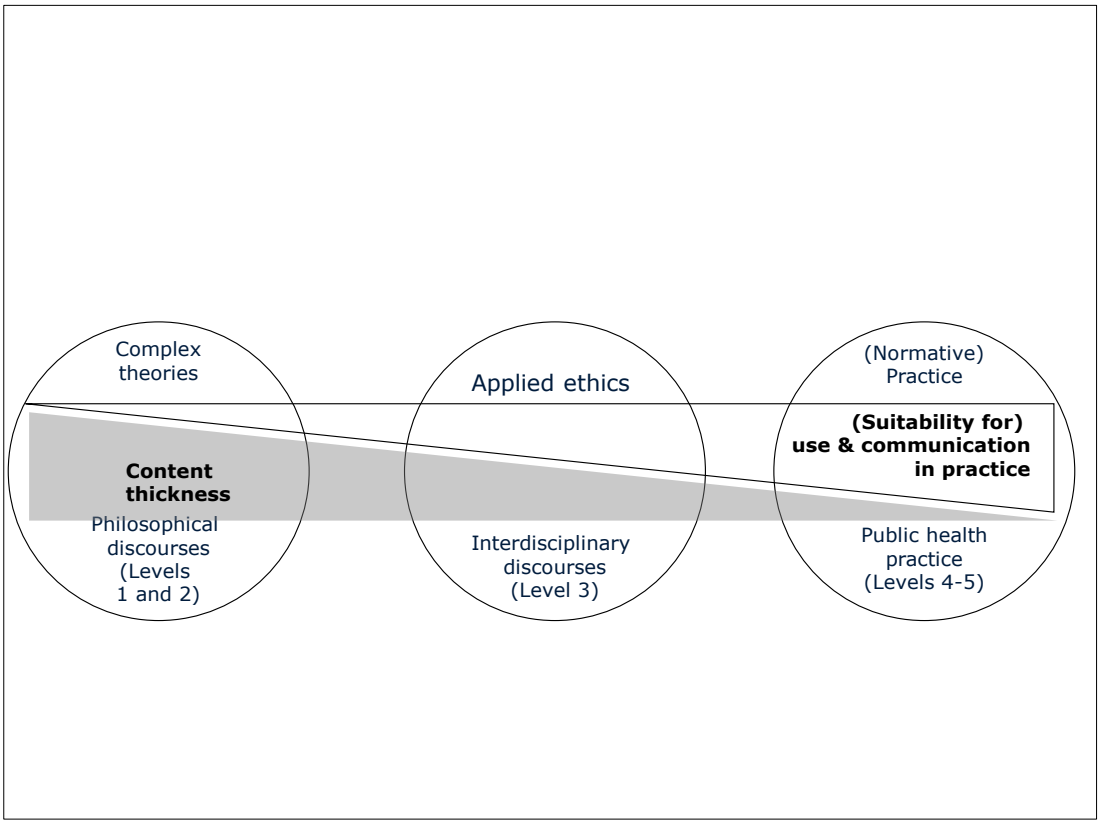
Discussion

Philosophers often develop their normative concepts and ideal theories without considering real world practice. Public health practitioners, on the other hand, often refer to normative ethical concepts without explaining their specific meaning or referring to underlying ethical theories (and possible normative ambiguities). In many cases, practitioners use these norms because they are "common sense" or belong to the "common morality", yet, in their normative explication they can generally be traced back to philosophical theories that substantiate the norms' normative content. This paper explores how these norms make their way into the language of practitioners (e.g. health policy documents). It is the thesis of this paper that there is a translational process in the background through which the norms in practices are *also* connected to (underlying, foundational) ethical theories. The paper proposes a model with several levels highlighting how this translational process occurs. The model is intended to heuristically describe how ethical norms are used (and translated) between scholarship (Levels One – Three) and practice (Levels Four and Five). Whereas in public health the use of schematic models is widely accepted, even though models are always a simplification and models like the 'policy action cycle' are by no means meant to be exhaustive or static, this seems less common in ethics. We are aware that the differentiation between the levels can be debated and concepts like "applied ethics" are contested in philosophy, yet we deem such a model *a heuristic starting point* for discourses aiming to *better connect philosophical theory to public health practice*. In this model we observe what we call the inverse relationship thesis which is visualized in Figure 1. On the one side (on Level One), there is content thickness and complex original philosophical thought with regard to theory building in the foreground. On the other side (Levels Four and Five) there is public health practice. Here the content thickness and complexity of the normative concepts proportionally decreases while there is an increase of applicability and suitability for practice. In other words, we formulate the thesis that there is an inverse relationship between content thicknesses and practicability. In public health practice there are also often inherent unsaid value judgements which are made around content "thickness" and "thinness" and their suitability to practice and the issue of practice

is important in terms of generating knowledge and interdisciplinary research and practice.

The developed model has several limitations that point in the direction of a need for further scholarship and development on this topic. The five levels have blurred boundaries and partly overlap (for example, the rich work of Beauchamp and Childress could be considered to be both Level Two and Three). Demarcations between these categories and levels are difficult to set. In fact, one could argue that there could be more or fewer categories and one would probably also find good reasons for these changes. Having five levels, however, also makes visible the central role of applied ethics as an intermediary and interface between the academic and the practical world. We believe that such a model helps raising awareness that different discourses on ethical norms are taking place and that a "translation" process exists. Awareness of this process is important to improve communication and ultimately to elaborate better arguments, consequently also improving public health practice.

Figure 1. The translational process of ethical norms: The relation of content thickness and suitability for use in practice



Lastly, we have suggested that there is a linear, top-down direction of travel from Level One to Level Five. Despite this not (necessarily or always) being a linear process – where levels can be jumped or individuals can work on several levels at the same time – the process works in several directions (6,31). It can work its way backwards – more practical levels inspiring more philosophical levels. And, of course, practical levels can request from multiple philosophical levels to reflect on implications of the use and meaning of normative concepts. For instance, discussions on the concept of autonomy in the philosophical levels can be prompted and inspired by problems arising on the work floor in the practical levels. To illustrate, certain groups can be encountered to whom autonomy and informed consent cannot be readily applied, such as young children or patients with Alzheimer`s disease. In such cases, it can be helpful to have discussions in the philosophical levels on the meaning and applicability of autonomy in different contexts (31).

Conclusion

There seem to be transferral or transformative processes, here referred to as translational processes, of ethical concepts from the "philosophical ivory tower" to public health practice – and vice versa. The model presented here describes that a norm reduces philosophical-theoretical "content thickness" and complexity to become more applicable in practice and, in the other direction, that norms from practice are connected to ethical theories. Awareness of these translational processes can ultimately help to improve the moral foundation of public health practice and critically inform practice of norms and values. More research would be helpful to validate this model, identify and discuss more examples of translational ethics as modelled here, and to investigate the relationships between the different levels. Furthermore, attention needs to be given to the practical consequences of our model.

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