RIGHT TO HEALTHCARE: SUSTAINABILITY OF THE INSURANCE SYSTEM AND THE SITUATION IN THE CZECH REPUBLIC

Direito à saúde: sustentabilidade do sistema público de seguro-saúde e a situação na República Checa

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Abstract

The article deals with the question of right to healthcare as it is set by the Charter of Fundamental Rights and Freedoms of the Czech Republic and at the same time with the question of rationing in healthcare. Rationing in healthcare generally means a process realized by providing different levels of healthcare. In the Czech Republic, rationing in healthcare is rather based on a limitation of a treatment's payment from public health insurance which, however, does not fit the common definitions of rationing. By describing and explaining these crucial questions the article discusses the possibility to limit the constitutional right to healthcare covered by public health insurance in the Czech Republic and shows these possibilities which are based on provisions of the Act No. 48/1997 Sb., on public health insurance. More widely it questions whether the system of public health insurance in the Czech Republic is sustainable at all.

RESUMO

O artigo trata da questão do direito à saúde e de como ele é definido pela Carta dos Direitos e Liberdades Fundamentais da República Checa, e ao mesmo tempo da questão do racionamento na saúde. Racionamento na saúde geralmente significa um processo destinado a proporcionar diferentes níveis de cuidados de saúde. Na República Checa, o racionamento na área da saúde é baseado numa limitação de pagamento de um tratamento pelo seguro público de saúde que, no entanto, não se harmoniza com as definições usuais de racionamento. Ao descrever e explicar essas questões cruciais, o artigo discute as possibilidades de limitação do direito constitucional à saúde coberto por um seguro público de saúde na República Checa e mostra essas possibilidades baseadas nas disposições da Lei nº 48/1997 Sb. de planos públicos de seguro-saúde. Mais amplamente, questiona se o sistema público de seguro de saúde da República Checa é sustentável.

Key words

Healthcare, rationing, public health insurance

Palavras-chave

Direito à saúde, racionamento, seguro público de saúde.

Introduction
With an increasing quality of healthcare in general, there is the question of a possible conflict between the constitutionally protected right to healthcare and the sustainability of the insurance system in the Czech Republic which is based on public health insurance. Therefore the article will deal with the concept of rationing in healthcare which discusses the possibilities of limitation of healthcare provided on the basis of public health insurance.

In its first part the article will describe the basics of the Czech right to healthcare as it is set by the Charter of Fundamental Rights and Freedoms. In its following chapters it will then deal with the concept of rationing in healthcare itself. There are different approaches to rationing and those approaches will be discussed. Also the situation in the Czech Republic will be dealt with. This is important since there is a question whether the Czech approach to rationing in healthcare is rationing at all because it does not fit the common definition of rationing which will also be discussed in this article. In the Czech Republic the denial of a payment for a treatment from the public health insurance is normally a denial to all patients in a similar situation and not only to a particular patient needing the treatment.

The aim of this article is to discuss whether a sustainability of the Czech public health insurance system is possible and whether there are legal instruments which could lead to a limitation of healthcare covered by public health insurance.

**Right to healthcare¹**

In the Czech Republic, the right to healthcare is considered as one of the fundamental human rights and is mentioned in the Charter of Fundamental Rights and Freedoms which forms part of the country’s constitution. It is described in its Art. 31. This provision states that everybody has the right to protection of health. Citizens have also right to gratuitous healthcare and medical devices under conditions set by legislation on the basis of public health insurance².

Right to healthcare is also mentioned in the International Covenant on Economic, Social and Cultural Rights, specifically in its Art. 12 which recognizes the right to the best attainable level of health.

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¹ This Article was written with the Support by Czech Science Foundation Grant P408-12-1316 – Czech Health Law in European Context: Structural Analysis and Perspectives.
² See Art. 31 of the Resolution of the Presidium of the Czech National Assembly on Declaration of the Charter of Fundamental Rights and Freedoms as Part of the Constitutional Order of the Czech Republic No. 2/1993 Sb.
This right is one of the social rights according to the catalogue of human rights. It belongs to the so-called second generation of human rights. The Czech Charter of Fundamental Rights and Freedoms also categorizes this right as a social right. Because of this, it is only possible to demand the fulfilment of this right within the scope of the relevant legislation which sets the detailed rules. The Czech Constitutional Court decided that social rights do not have an unconditional character and it is possible to claim these rights only within the confines set by legislation. However, this legislation must not negate or invalidate these rights and their content\(^3\). The Constitutional Court also emphasized that the limitation of the right to healthcare is only possible by an act of Parliament and not by secondary legislation.

**Rationing in healthcare**

Rationing in healthcare might be seen as a process realized by providing different levels of healthcare. This process might lead to a refusal of care to a patient, although the care could potentially help him (however, provided that such care is not indispensable for him). Rationing is used when a healthcare service is provided only to some patients, selected on the basis of particular criteria, although it could also help other patients.\(^4\)

The most important question is that of rules for determining the extent of healthcare services paid from the public health insurance system. These rules deal with a possibility to pay for some method, medicinal product or medical device from the public health insurance system. To consider whether there are conditions for such payment, costs of a therapy are evaluated in relation to its benefits for a patient. This process is called cost-effectiveness analysis.

Cost-effectiveness analysis can be described as a basic instrument for rationing in healthcare. Financial resources of the healthcare system are always limited – that is the basic premise. This limitation means that it is not possible to pay all potentially beneficial healthcare for all patients because such healthcare is often very expensive. This problem might be partially solved by higher effectiveness of the healthcare system or minimization of defensive medicine\(^5\). Then better effectiveness of healthcare can be achieved.

\(^3\) Decision of the Constitutional Court of the Czech Republic from 23\(^{rd}\) March 2010, No. Pl. ÚS 8/07 or decision of the Constitutional Court of the Czech Republic from 23\(^{rd}\) April 2008, No. Pl. ÚS 2/08.

\(^4\) Herring, J. *Medical Law and Ethics*. Second Edition. Oxford : Oxford University Press, 2008, p. 52. For other definitions of rationing see e.g. Syrett, K. *Law, Legitimacy and the Rationing of Health Care. A Contextual and Comparative Perspective*. Cambridge : Cambridge University Press, 2007.

\(^5\) Brody, H., Cassel, C. K. „Rationing“ vs. defensive medicine? New approach is neither of the two. *Medical Ethics Advisor*, 2012, 28(7), p. 73.
Cost-effectiveness analysis can be seen as a tool which helps to find the optimal option how to provide healthcare. In this case optimal option means the most cost-efficient option which helps to save financial resources which can be used to help other patients. However, this tool may not represent a benefit for a particular patient.

A very well-known example is the case of Coby Howard from Oregon in the United States. Coby was a seven years old patient suffering with leukaemia. For this reason, in 1987, he needed bone marrow transplant. Until that time Coby has been treated within the scope of the Medicaid programme due to the financial situation of his family. The programme allowed him to undergo chemotherapy but this treatment was unsuccessful. However, the aim of the Medicaid programme was to help also other citizens of Oregon. Because of this aim it was not possible to cover the costs of bone marrow transplants from this programme and the programme stopped to cover them before Coby’s case turned up. A simple calculation was applied – about 1500 potential new patients whose healthcare could be covered by the Medicaid programme were simply more than some tens of patients suffering from leukaemia whose healthcare had been covered by the Medicaid programme until then. This cost-effectiveness analysis caused that Coby did not get this treatment and died. All this despite a huge social and media pressure whose consequence was that bone marrow transplant again began to be covered by the Medicaid programme.

Rationing in healthcare is very often confronted with such social and media pressure. This pressure is also being criticised in connection with the so called “identifiable” and “statistical” lives. Ubel states that while stricter rules for safety of motor vehicles (airbags, ESP etc.) or for the protection of environment protect the so-called “statistical” lives (anonymous people), rules for providing healthcare services protect an “identifiable” life of a particular person. He uses the example of a fifty-year old woman who needs urgent treatment and states that nobody would question the cost of such treatment in this case. On the other hand if somebody invented an expensive method to reduce the number of victims of traffic accidents, then, according to

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6 Medicaid programme is a social service which makes health insurance possible for people who need it – e.g. children, families with a low income etc. The programme is co-financed by the federal government and the individual states of the USA. Often it is being mixed up with the Medicare programme which constitutes health insurance for persons older than 65 years.

7 For further information on the Coby Howard case see e.g. Japnega, A. A Transplant for Coby: Oregon Boy’s Death Stirs Debate Over State Decision Not to Pay for High-Risk Treatments, Los Angeles Times, 28. 12. 1987, from www: http://articles.latimes.com/1987-12-28/news/vw-21384_1_marrow-transplant, quoted 03/10/2015 or Winslow, G. R. Watching Coby Howard Die: Ethics, Economics and Politics in the Allocation of Medical Care. Bioethics News. 1989, 8 (4), p. 14-26.
Ubel, everybody would question the price of this method. Therefore for people, an “identifiable” life is more important than a “statistical” life.9

This example is very much connected with the topic of rationing in healthcare. In such cases the media always inform about “identifiable” lives of particular patients who need highly specialized and expensive healthcare. Despite the fact that we value health significantly and consider the provision of healthcare a very specific service, it should not prevent us from rationalization of such services. In this connection Ubel states that if the society discusses how much should be invested in infrastructure or protection of environment (which should improve the life quality) it must also discuss how much should be invested in healthcare.9

The cost-effectiveness analysis has a high potential to influence the manner how rationing in healthcare would be accepted by the society. Rationing in healthcare influences not only the use of the latest medicine and treatments or very expensive methods as it was in the Coby Howard case. Therefore, a good example could be the issue of preventive examinations. How often should there be a preventive examination of a patient? For example how often should women undergo a mammography examination in order to prevent breast cancer – once in two or three years, or even every year? Here the cost-effectiveness analysis can give us the answer. The costs for an annual examination and number of cases where breast cancer was detected are compared. That means that the outcome is a number how many cases of breast cancer are detected in annual examinations or in examinations performed once in two years etc. This outcome results in information what is the cost of further “saved” lives by more frequent examinations. If these costs are too high (not enough cost-efficient), they are not (or should not be) paid from the available funds.

The problem of healthcare systems and of the human right to healthcare is that some of the resources are absolutely limited.10 Therefore some of the authors talk about rationing in healthcare only if the resources are really absolutely limited.11 Such resources are for example organs intended for donation for transplantation. In this case a higher quantity of money in the healthcare system does not mean a higher quantity of such organs.

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8 Ubel, P. A. Pricing Life. Why it’s time for Health Care Rationing. Massachusetts, MIT Press, 2001, p. 35. See also other authors, e.g.: Jenni, K. E., Loewenstein, G. Explaining the “identifiable victim” effect. Journal of Risk and Uncertainty, 1997, 14, p. 235-257. Schelling, T. C. Choice and Consequence: Prospectives of an Errant Economist. Cambridge : Harvard University Press, 1984.
9 Ibid, p. 35.
10 Here the word “resources” means not only financial resources but also available personnel or organs for transplantations.
11 Evans, R. W. Healthcare technology and the inevitability of resource allocation and rationing decisions. Journal of the American Medical Association, 1983, 249, p. 2208-2219.
Evans\textsuperscript{12} and other authors state that if the resources are not absolutely limited then the term rationing should not be used because then it is only an allocation of provided healthcare\textsuperscript{13}. On the one hand, allocation of provided healthcare means deciding about the type of the treatment, on the other hand rationing means choosing patients who will get a treatment which is limited only to a specific number of patients (while others will not get this treatment)\textsuperscript{14}. Many other authors refuse this theory, though. These authors consider allocation as rationing of a higher level\textsuperscript{15}.

All the above mentioned definitions bring us to further questions concerning the criteria for rationing in healthcare and its possibilities. With regard to the above mentioned, two types of explicit rationing will be discussed. These are rationing by exclusion and rationing by guideline\textsuperscript{16}. Rationing by exclusion is often described also as rationing by denial\textsuperscript{17}.

**Rationing in the Czech Republic**

Rationing in healthcare in the Czech Republic is closely connected with the question of public health insurance and the fundamental right to healthcare. If there is an acceptable ratio of costs to benefits, then a particular treatment or medicinal product becomes part of healthcare paid from the public health insurance. On the contrary, if the benefit for the patient is not acceptably proportional to costs (the benefit being not only saving patient’s life but also providing better life quality to the patient), then payment from the public health insurance is denied to all patients.

In this system in the Czech Republic it is necessary to question whether this method is rationing at all because it does not fit the definition of rationing mentioned before. The difference between the definitions of rationing and the described method used in the Czech Republic is that in the Czech Republic if payment from the public health insurance system is denied to somebody, then it is denied to all patients in a similar situation and not only to a particular

\textsuperscript{12} Ibid.
\textsuperscript{13} Ubel, P., Goold, S. “Rationing” Health Care. Not All Definitions are Created Equal. *Archives of Internal Medicine*, 1998, 158, p. 209-214.
\textsuperscript{14} Evans, R. Healthcare Technology and the Inevitability of Resource Allocation and Rationing Decisions. *Journal of the American Medical Association*, 1983, 249 (16), p. 2208-2219.
\textsuperscript{15} Ubel, P., Goold, S. “Rationing” Health Care. Not All Definitions are Created Equal. *Archives of Internal Medicine*, 1998, 158, p. 211.
\textsuperscript{16} Ham, C. Health Care Rationing. *British Medical Journal*, 1995, 310, p. 1483.
\textsuperscript{17} Syrett states in this connection that the first type is applied on higher decision making levels whether the second type is applied mostly at the level of healthcare services providers. See Syrett, K. *Law, Legitimacy and the Rationing of Health Care*. Cambridge: Cambridge University Press, p. 64.
patient needing the treatment. So is such a method really a process of rationing in healthcare in the Czech Republic? Theoretically, in such case the patient might pay for his treatment on his own, not getting any reimbursement from the public health insurance system. Is it still rationing in healthcare?

Here it is necessary to focus on the two definitions of rationing by exclusion and rationing by guideline and their use in the Czech Republic and also their relationship with the human right to healthcare according to Art. 31 of the Charter of Fundamental Rights and Freedoms.

Guidelines\(^{18}\) contain only professionally recommended procedures which should help doctors to decide about further treatment of a patient. Therefore these guidelines are neither primary nor secondary legislation but only recommendations of a professional association. These guidelines aim merely to ensure quality of provided healthcare services and compliance of provided healthcare services with medical knowledge through determination of best practice. However, these guidelines constitute a special method of rationing through determining the recommended treatment of particular diseases and determining an effective (and by that also ineffective) way to treat a disease. This means that their consequence might be exclusion of patients from provision of a particular healthcare service whose treatment is not considered effective enough in relation to its benefits\(^{19}\).

There is an evident difference between rationing by guideline which was described above and rationing by exclusion. In case of rationing by guideline it is primarily a decision of the doctor whether she will treat the patient in accordance with the non-binding guidelines or not. In case of rationing by exclusion it is the question of the payment (reimbursement) of a treatment from the health insurance system. Rationing by exclusion can be shown on the Coby Howard case and the Medicaid programme in Oregon. In that case only some basic core treatments were paid from the programme. Treatments which were not contained in the list were not paid by the programme. In such case they are inaccessible to all patients unless they are able to pay for them themselves\(^{20}\).

In this regard, the right to healthcare in the Czech Republic according to Art. 31 of the Charter of Fundamental Rights and Freedoms (that is right to payment of healthcare from the public health insurance) is often equated to the right to provision of healthcare. Granting or not

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\(^{18}\) In the Czech Republic there are guidelines of the Czech Medical Association of J. E. Purkyně which is a registered association of physicians. For information about this association see http://www.cls.cz/dalsi-odborne-projekty.

\(^{19}\) Syrett, K. Law, Legitimacy and the Rationing of Health Care, Cambridge: Cambridge University Press, p. 66.

\(^{20}\) Ibid, p. 64.
granting the payment for a treatment means creating categories of healthcare which either can or cannot be provided to a patient on the basis of funds from the public health insurance. Once a treatment falls among those paid from the public health insurance in accordance with Section 13 of the Act No. 48/1997 Sb., on public health insurance, then it must be provided to the relevant patient. For this process it is important to define whether a treatment will be paid from the public health insurance. This happens if the aim of the treatment is to improve or preserve patient’s state of health, if it fits his state of health and the purpose of the treatment, if it is safe for the patient and if it is in accordance with the latest knowledge of the medical science and there are proofs of its effectiveness regarding the purpose of its provision.

However, a participant on the system of public health insurance in the Czech Republic may also get payment from the public health insurance system in cases where such treatment is normally not covered by the public health insurance. That is the field of application of Section 16 of the Act No. 48/1997 Sb., on public health insurance. This provision of the act prescribes that a health insurance company shall also pay for treatment normally not covered from the public system if the following conditions are met:

- provision of such healthcare is the only possibility to treat the patient, and
- there is a previous consent of the health insurance company’s doctor (this condition does not apply in case of danger in delay).

Based on the above and contrary to all theoretical definitions of rationing in healthcare, in the public health insurance system in the Czech Republic rationing by exclusion does not legally apply in this type of cases.

It could be considered that an extraordinary payment according to Section 16 of the Act No. 48/1997 Sb., on public health insurance, might be granted only in case of life-saving treatments. However, that is not really the case. The aim of a treatment normally not covered by the public health insurance can be also preservation of patient’s state of health or moderation of his suffering. This aim is based on Section 2 Subsection 4 of the Act No. 372/2011 Sb., on healthcare services and conditions for their provision, which besides other things, states that provision of healthcare includes activities preserving patient’s state of health or moderation of his suffering. This provision allows the public health insurance system to cover also the so-called palliative care (care with the aim to moderate the patient’s suffering).

Generally, the fundamental right to healthcare in the Czech Republic comprises financial covering by the public health insurance of treatment, technically speaking, for each medicinal problem. If there is no such treatment already available, the patient has the right to get a
payment from the public health insurance system for a treatment which is normally not covered by this system. In such case a conflict of interests might arise. There might be a treatment which would help more patients but for one of them it is the only possible treatment, for the others it is a more expensive alternative to their current treatment. Most probably, the first patient would get a payment for this expensive treatment; the others would not get it. It would create differences in access to healthcare covered by the public health insurance.

An example could be a medicinal product which is covered by the public health insurance only in case of a specific indication, although it could be used also for other indications. For these further indications the medicinal product would be more expensive than a different one, but also effective treatment. Only because there is a cheaper and similarly effective medicinal product, the more expensive and more effective product is not covered by the public health insurance.

In this connection, there is a debate in the Czech Republic whether (and to which extent) it is possible to allow a regulation of the public health insurance system through rationing and at the same time not to allow the patient to pay treatments not covered by the health insurance system himself.

According to Section 11 Subsection 1 d) of the Act. No. 48/1997 Sb., on public health insurance, the patient has a right to get healthcare services paid by the insurance to the extent and under the conditions set by this act. For such services the provider is not allowed to require any payment from the patient. The question is whether the current legislation allows the patient to demand treatment exceeding the conditions for a payment from the public health insurance system. What happens if a patient refuses some treatment and wants a more expensive (but also more effective) treatment?

This question was decided by the Constitutional Court of the Czech Republic in its decision No. Pl. ÚS 14/02 from 4th July 2003. In its decision the Constitutional Court stated that the prohibition of a direct payment from the patient applies to gratuitous healthcare. However, the legislation does not prohibit payments for healthcare provided beyond the gratuitous healthcare. It is possible to get direct payments from patients for such healthcare. From this decision of the Constitutional Court it can be concluded that a specification of gratuitous healthcare covered by the public health insurance (specification by e.g. indication or the amount of the payment) is only a condition for provision of gratuitous healthcare and that it is

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21 Decision of the Constitutional Court of the Czech Republic from 4th July 2003, No. Pl. ÚS 14/02.
possible to request direct payments from the patients for healthcare provided beyond this specification of gratuitous healthcare.

There has been one more relevant decision of the Constitutional Court – decision from 20\textsuperscript{th} June 2013, No. Pl. ÚS 36/11. In this case the Constitutional Court dealt with the topic of possibility to pay for above-standard healthcare. Healthcare should have been divided into “standard” healthcare covered by the public health insurance and into “above-standard” healthcare where the patient would have to pay the difference between the costs of standard and above-standard healthcare. The Constitutional Court stated in its decision that the difference between standard and above-standard healthcare must not be in the suitability and effectiveness of a treatment. According to Czech legislation, the patients have a right to such healthcare which corresponds with the requirements of best practice and medicinal ethics\textsuperscript{22}.

A possible conclusion for the Czech system might be that in case there is a restriction for coverage of treatments or medicinal products by the public health insurance based on objective needs of patients and requirements of best practice and medicinal ethics, then a use of such treatment or medicinal product outside the scope of these restrictions shall be understood as provision of healthcare not covered by the public health insurance. As was mentioned above, if it is the only possible treatment, then it must be covered by the public health insurance. If it is only the patient who wants this particular treatment but there is another effective treatment covered by the public health insurance, then the patient must pay for his preferred alternative himself. The discussed restriction might be determined only by legislation.

To restrict a patient in getting coverage of provided (and beneficial for the patient’s health) healthcare by the public health insurance is only possible through legislation. This restriction shall then apply to all similar cases and the only possibility to breach these restrictions is if otherwise the patient would not get any healthcare. That means a limitation of the fundamental right to healthcare is only possible if it is set by legislation. On the other hand if it is unequivocally determined by the legislation, which healthcare provided to patients should be covered by the public health insurance, then it should not be considered to be against the law if the patient decides to choose a different, more expensive treatment and to pay the difference between the coverage by the public health insurance and the price of patient’s treatment. The patient must be informed of this alternative.

\textsuperscript{22} Decision of the Constitutional Court of the Czech Republic from 20\textsuperscript{th} June 2013, No. Pl. ÚS 36/11.
This opinion – that the patient shall have the right to pay for potentially beneficial healthcare even if he is not entitled to coverage of this healthcare by the public health insurance – is based on the fact that it cannot be possible to restrict the possible healthcare only to solutions covered by the public health insurance. Patients who do not meet the criteria to get coverage from the public health insurance for a treatment better than the one which is covered, should have the right to choose such not covered treatment and pay for it. But they should pay only the difference between the price of the treatment covered by the public health insurance and the price of the chosen treatment. They should not be excluded from the public health insurance system and forced to pay the whole costs of their preferred alternative.

In this connection it should be also mentioned that the provision of healthcare services is a question of private law because healthcare services are provided according to Section 2636 and following of the Act No. 89/2012 Sb., civil code. It is up to the contractual parties which healthcare they agree on. However, then a problem arises whether this solution is also covered by the public health insurance according to Art. 31 of the Charter of Fundamental Rights and Freedoms or not. If there is no coverage by the public health insurance, it does not mean that it could or should be possible to deny the patient his right arising out of the Art. 31 of the Charter of Fundamental Rights and Freedoms – i.e. the right to get healthcare covered by the public health insurance.

**Conclusion**

With a continuously increasing quality of healthcare, instruments and medicinal products (which leads to an increase of costs), the life expectancy lengthens due to a better ability of the system to detect illnesses. On the other hand there is the constitutionally guaranteed right to healthcare (Art. 31 of the Charter of Fundamental Rights and Freedoms).

Logically, there must be a limitation of this right because it is not possible to give everything necessary to all who need it. There must be an admissible limitation of this right which would be legal and legitimate at the same time. The article has shown that there are possibilities of the system to limit the constitutional right to healthcare. In the Czech Republic these possibilities are mainly based on limitation of payments from the public health insurance system and related legislation. This legislation determines to which extent and for which indication a particular treatment or medical device will be covered by public health insurance system and then these rules apply to all patients. The question, how sustainable this system is for the future, remains open.
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