

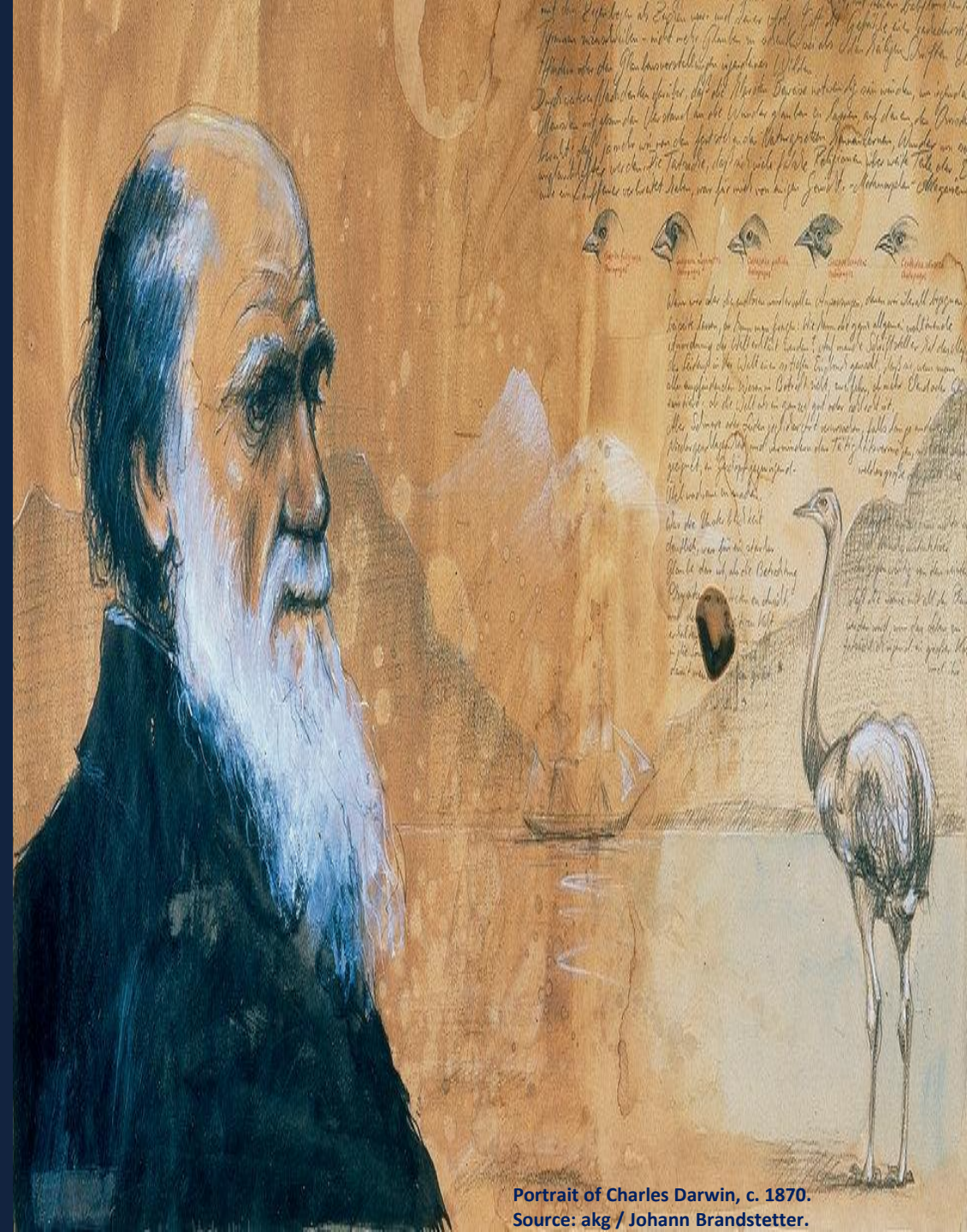
Survival of the fittest?

Beliefs in “Social Darwinism” and attitudes towards fair healthcare access



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Updated version · August 2026



Portrait of Charles Darwin, c. 1870.
Source: [akg](#) / [Johann Brandstetter](#).

Research gap & puzzle

Priority setting has always been an ethically demanding aspect of healthcare. What is ultimately at stake is not a good or a service, but the value assigned to human life in a specific time, place and context.

■ What is established

Healthcare faces resource scarcity, so mechanisms are needed that (re)distribute rewards and burdens alike in ethically defensible ways.

■ What is contested

“Ethically defensible” has no settled content. Who is deserving and who is undeserving? When legitimate vulnerability exists, when should society compensate it and when not?

■ Gap 1 - empirical

There appear to be no empirical studies on explicit attitudes towards meritocratic access to healthcare.

■ Gap 2 - theoretical

No research or theory appears to connect distributive justice principles in healthcare to beliefs in SD, or to SD-ideology more broadly.

■ The puzzle

SD can be read as a belief-system: a synthesis of ideas about how benefits and burdens ought to be allocated. Thus, it should also structure attitudes towards fair access.

How should we decide - and who gets a say?

- Empirical data, such as healthcare stakeholders' attitudes towards a normative issue, need to be clearly contextualised by explicit normative-ethical theories (Salloch et al. 2014).
- The normative and the empirical in biomedical research should be integrated far better than they currently are (Sugarman et al. 2009; Wangmo & Provoost 2017).
- Surveys can unearth cleavages in values, beliefs, attitudes and preferences between social, economic, political and other groups.
- The public is both able to identify and to understand issues in healthcare spending and medical investment policies (Kaplan & Connelly 2021). It should therefore have a say in shaping questions of medical resource rationing.

■ Why this matters here

Attitudes towards healthcare access are not merely opinions. They are the observable trace of underlying distributive-justice principles.

If those principles can be measured, normative theory gains an empirical counterpart, and priority setting gains a democratic one.

This study therefore treats a philosophical dispute as an empirically testable one.

Access to healthcare

- Medical needs arise from individual bad luck, but also from systematic and asymmetric socio-economic conditions: poor housing, poor diets, hard manual labour, or unhealthy behaviour such as excessive alcohol consumption or regular smoking.
- Accessibility can be improved directly on the supply side. On the demand side, however, access is fundamentally tied to medical need and to coverage.
- Coverage is a pivotal column of accessibility and is closely linked to access through the income gradient in health.
- The widespread call for universal coverage ties access to equality and to an egalitarian notion of social justice, but also unavoidably to the rationing of scarce resources.

“Do these disparities reflect an autonomous right of people to live for today and disregard the future? Or does health inequality reflect a systemic inequity so that to compare ‘lifestyle’ with choosing a pair of flares or a striped shirt is wrong because health inequalities engage deeper issues of citizenship?”

“Social Darwinism” - the Victorian root

“... mankind being governed by natural laws shared by animals, in a world in which scarce resources were acquired through greater mental and physical effort (or in the case of thrift, abstinence from present pleasures), and in which the most ‘fit’, ‘desirable’ or ‘valuable’ members of society, the most ‘useful’ or productive, survived or ought to survive.”

Claeys 2000, p. 235

■ Where it led

Misinterpretations of Darwinism rooted in racism and chauvinism were implemented as segregation and eugenics across Europe, the USA and South Africa, and culminated in the Holocaust.

■ Where it persists

“Biological determinism” (that race is genetically inherited) and “racial essentialism” (that group-based biology maps onto basic social behaviours) remain driving factors of social inequalities — including those in health (Byrd & Hughey 2015, p. 8).

“Social Darwinism” - the modern form

- On the intellectual front, thinkers spearheaded by Friedrich Hayek challenged the assumptions underlying the 20th-century Keynesian welfare state, proposing that the state be retrenched in favour of “free” markets trading virtually all goods and services as private resources.

“... the process of natural selection prevailed to balance human procreation as weak, unfit elements could not adapt, and, therefore, were prevented from reproduction. The mindset favored Capitalism and enabled the wealthy to justify any means, however treacherous, to amass fortunes.”

Banks 2007, p. 179

■ The object of this study: a “modern” SD

Less liberal, individualistic, eugenic and racialised than SD in the past — yet still reductionist and biologically over-determined, while under-socialised (see Drouard 2015).

SD as a belief-system: seven assumptions

- 1 Competition between persons, kinships, groups and populations is the primary mechanism that shapes society.
- 2 Hierarchies are determined solely by capability and by those traits that further fitness and competitiveness.
- 3 Capabilities and traits are distributed across humanity according to a natural order.
- 4 Kin- and group-selection can result in cooperation only among homogeneous people.
- 5 Inequality is the natural result of asymmetrically distributed capabilities and traits.
- 6 The costs that vulnerabilities impose on a population can be minimised by enforcing competition and hierarchy.
- 7 Benefits and burdens should be distributed conditional on rank in the social hierarchy and on fitness.

Distributive justice - merit

Three correlative principles are relevant for health: distribution by contribution, by effort, and by traditional hierarchy or entitlement. All three require one group to judge another group's contributions, efforts or needs. This study singles out contribution-based (meritocratic) justice.

■ The case against merit

In its pure form meritocracy would produce a genetic lottery and install an overly competitive spirit in society; family ties, luck and inequality determine success in reality (Bell 1972).

■ Merit as justification

Merit-based justice serves as an important justification for the existing socio-economic order and for existing inequality — ultimately, for the status quo (McCoy & Major 2007; Son Hing et al. 2011).

■ Merit and mobility

Meritocracy does not deliver equality of opportunity, which manifests as asymmetric mobility between social classes (e.g. Breen & Goldthorpe 1999).

■ Inequality and belief

Income inequality and belief in meritocracy go hand in hand: citizens of more unequal societies believe in merit more strongly, not less (Mijs 2021).

■ Merit as a health determinant

In the USA, dominant meritocratic beliefs continue to be a negative determinant of health in the African-American population (Kwate & Meyer 2010).

■ Why healthcare is special

Healthcare is one of the last spheres where the use of merit is both contested and limited by mechanisms built during the emergence of the welfare state.

Distributive justice - equality

- “Equality of what?” dominated the second half of the 20th century: equality of welfare, of resources, or of capabilities.
- One egalitarian position: government must guarantee access to needed healthcare so that no citizen’s finances affect that access, even where this means levelling down, because inequality reduction outweighs the lost health and welfare of some (Hughes 2020).
- Luck-egalitarianism mitigates the effects of “brute luck” only. “Option luck”, resting on free and reasonable choice, creates no additional entitlement to redistributed resources, so the human being is portrayed as a responsible agent.
- But precisely this sensitivity to responsibility has been used to extend anti-egalitarian reforms, making aspects of basic healthcare conditional on merit and compliance.
- Equality-of-opportunity is a pre-condition of both luck- and outcome-egalitarianism: unequal opportunities belong to the sphere of brute luck.

“Equal access to health care for those in equal need of health care.” — the working definition adopted here: equal opportunity for access to healthcare.

Why health is not an ordinary commodity

Seven corollaries underscore the nature of health as a universal human right that the welfare state should protect.

■ 1 Not ordinary

Health is inseparable from moralities and ethics.

■ 2 Normatively special

It levels the playing field and enables equal opportunity for every other endeavour, including the pursuit of wealth.

■ 3 Market failure

Healthcare and health insurance markets are prone to moral hazard, monopolisation, adverse and risk selection, free-riding and the assurance problem.

■ 4 No Pareto-optimality

Real markets, without complete property rights, full information and perfect competition, cannot attain it. Thus, public intervention is a responsibility, not just an option.

■ 5 Efficiency is not automatic

Increasing private provision cannot automatically be associated with efficiency gains.

■ 6 A solidarity good

Good population health produces large positive externalities; a society in good collective health exceeds the satisfaction of one in poor health.

■ 7 A normative public good

Public health ethics, health equity and distributive justice must enter any thoughtful discussion of health policy. All of which evoke normative principles.

... and what meritocrats argue instead

■ Need, met by charity

Meritocrats invoke need-based prioritisation but close the gap between need and access by appealing to empathy and altruism rather than to institutions, structure or society. This reinforces social hierarchy.

■ Public floor, private top

The state should provide a public good while permitting unrestricted private supplements. Yet supplemental private insurance is clearly associated with income, class and socio-economic inequality.

■ Autonomy over equality

Personal autonomy is held to overrule societal egalitarian justice. Extensive readings of autonomy leave people to fend for themselves, which is a renaissance of SD by another name.

■ Rational self-interest

Humans are modelled as self-interested actors cooperating only to maximise gains. But people display innate dispositions to behave pro-socially, altruistically and reciprocally.

■ Two systems, two treatments of need

- Meritocratic: basic care bounded by a cost-effectiveness sufficiency threshold; waiting times calculated from costs and contributions.
- Egalitarian: equal priority to receive equal healthcare at equal levels of medical need.

“Social Darwinism” & distribution

“... two distinct, and frequently competing, fairness claims arise out of the imperatives of human nature and the nature of human society as a collective survival enterprise: (1) basic needs (or distributive equity) and (2) merit (giving every person his/her due).”

Corning 2005, p. 444

■ Competition and brittle hierarchy

SD builds on perpetual competition and on the establishment of brittle dominance hierarchies with asymmetric resource distributions (Cummins 2015).

■ Policy, not accident

Inequality of access in the USA did not arise randomly: it is rooted in long-term welfare and policy making that carries the assumptions of SD (Jones & Kantarjian 2015).

■ A system-justifying belief

In the USA SD is a widespread system-justification belief that portrays inequality as inevitable and even desirable, while welfare is unwanted (Rudman & Saud 2020).

■ The tension in one line

There is inherent tension between the idea of health as a social right and of health as a private good.

Why SD-beliefs and meritocracy travel together

Meritocratic thinking reflects SD-beliefs because meritocracies ...



quantify social rankings in very materialist and stratified terms



rely on the continuous transformation, multiplication and (re)distribution of resources



hinge on the idea of “fair” competition between people, groups and populations



are structured as hierarchical societies reproducing stratification from socio-economic asymmetry

The extension proposed here



SD

Distributes by social ranking. Rewards or punishes the social outcome of behaviour. Incorporates existing inequality and stabilises asymmetries along social, cultural and ethnic lines.



Meritocracy

Distributes by merit. Remunerates or penalises the economic product of behaviour. Alters inequality, reproducing asymmetries along economic and materialist lines.

The crucial link: SD believes in asymmetrical hierarchy; meritocracy is oblivious to asymmetry. Egalitarian justice, by contrast, pursues both the compensation of asymmetry and the replacement of hierarchy by equality.

Expectations

■ Main expectation

Stronger beliefs in SD correspond to greater support for meritocratic access to healthcare and to weaker endorsement of egalitarian access.

■ Institutional trust

Trust in democratic, judicial and welfare institutions reflects background and procedural justice — expected to align with egalitarian attitudes.

■ Political ideology

Persons on the right hold stronger SD-beliefs and favour meritocracy; the opposite for the left.

■ Risk perception

Elevated perceived risk from the pandemic is expected to be positively linked to equality and negatively to meritocracy.

■ Vulnerability

Poor health or chronic conditions favour egalitarian access — via self-interest, reciprocity, and altruism/empathy.

■ Group identity

Expected to correlate positively with egalitarian and negatively with meritocratic attitudes.

■ Perceived social rank

Expected to correlate positively with meritocratic and negatively with egalitarian justice attitudes.

Data & measurement

- Cross-section of the Austrian Corona Panel Project, wave 32 (20–29 May 2022). Respondents quota-sampled on age, gender, region, municipality size and education, mirroring the Austrian resident population (Kittel et al. 2020; Kittel et al. 2021).
- **Two outcomes — “How fair or unfair would you consider it if the following groups were given priority in public healthcare?”**
 - Equality: “All people get equal access”
 - Merit: “People who earn more and therefore pay higher contributions”
 - Both 5-point Likert, neutral midpoint, plus “I do not know” and “N/A”

■ Primary predictor — SD-beliefs

Polychoric principal component analysis of two 5-point Likert items: “There is deserving and undeserving life” and “Policies that protect the vulnerable in society contradict the natural order”. Index range –4.1 (very weak) to +1.6 (very strong); Pearson’s $r = 0.98$ with an additive alternative index.

■ Six covariate blocks

- Institutional trust (PCA)
- Left–right self-placement (0–10)
- Perceived COVID risk to economy and public health (PPCA)
- Medical conditions; self-assessed health
- Group identity: town, province, nation (PPCA)
- Gender, migration background, household income deciles, age, education (ISCED 1–5)

Estimation strategy

■ Multiple imputation (MICE)

Chained equations based on augmented regressions, with demographic and political sample weights. 25 pilot imputations, two weighted post-OLS tests at $CV = 0.05$, 25 further imputations estimated as required.

■ Resulting sample

N = 1,557 respondents; 39,336 observations across M = 50 imputations.
Complete-case sample after listwise deletion: N = 786.

■ Power & missingness

F-tests at the 5% level suggest required sample sizes of 387 (equality) and 779 (merit) at 80% power; achieved power with N = 1,557 is 1.00. Little's χ^2 supports MCAR with covariate-dependent missingness ($p = 0.99$).

■ Two weighted robust OLS models

one per outcome, with the PPCA predictor and all covariates

■ Two ordered Probit models

sample-weighted; outcomes collapsed to three values around the neutral midpoint

■ Two SUR models, two equations each

complete vs. imputed data -> model comparison

■ AIPW with weighted NLS

double-robust potential-outcome means

■ Generalised ordered Logit

complete, non-imputed sample with sample weights

Distributions of outcomes and predictor



Equality is the majority position

74% of the imputed sample agrees with equal access to healthcare for everybody.

Merit is a minority position

20% exhibit support for meritocratic access to healthcare.

Deserving and undeserving life

31% somewhat or completely agree with distinguishing human life as worthy/deserving and unworthy/undeserving.

A “natural order”

A smaller minority of 16% expresses belief in a natural order that should not be counteracted by policies protecting the vulnerable.

Figure 1: Distributions of outcome & predictor variables, with demographic & political sample weights. ACPP May 2022 (N = 1,557, imputed M = 50).

Predictive margins — OLS

Predictive Margins with 95% CIs

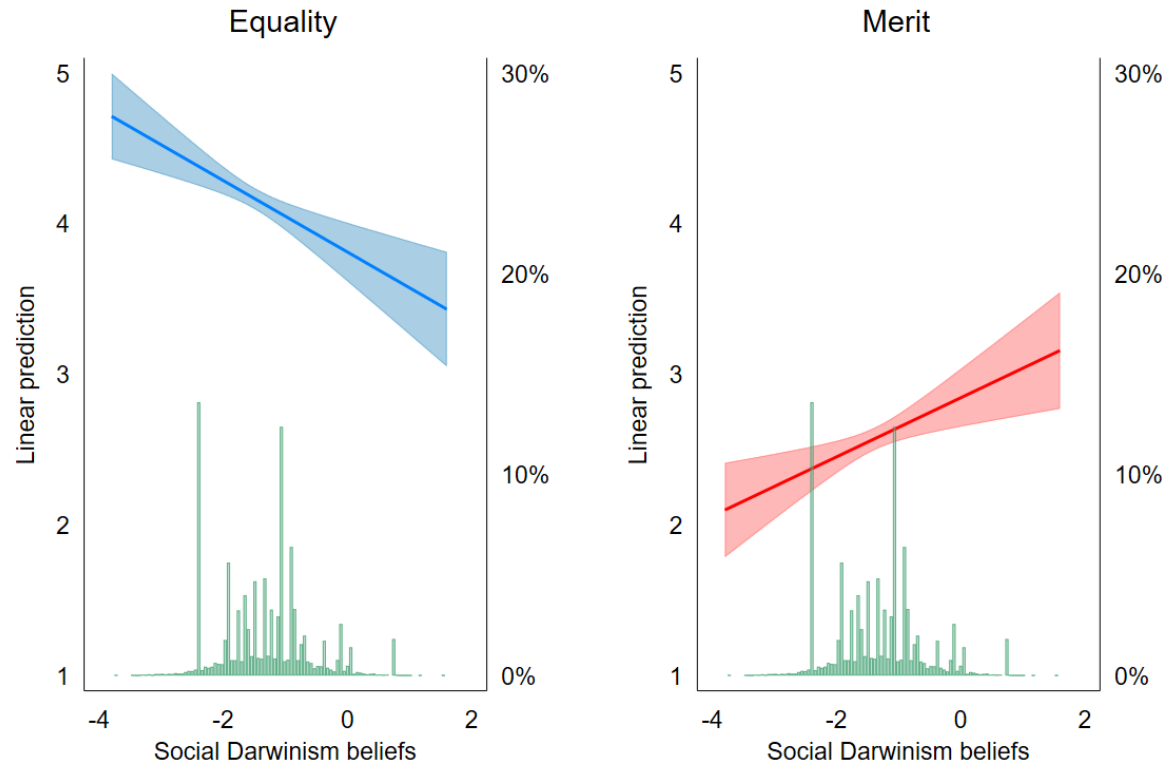


Figure 2: Predictive margins of equality & merit attitudes with 95% CIs; added is the MICE-distribution of SD-beliefs in %, covariates as observed. Multiple-imputation estimates of OLS regression models, including auxiliary covariates, robust VCE, with demographic & political sample weights. ACPP May 2022 (N = 1,557, M = 50).

■ The central finding

The more a person believes in SD, the less they stand by equal access to healthcare and the more they support merit-based access.

■ Both slopes, one mechanism

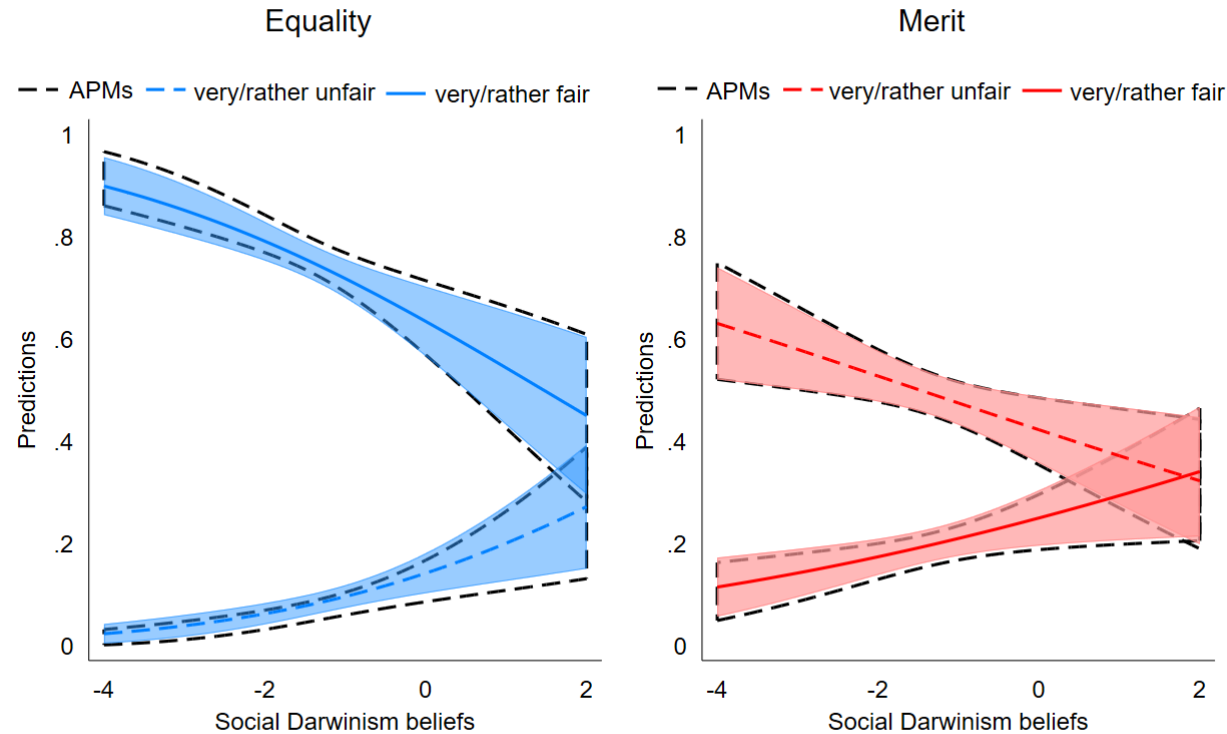
The two curves move in opposite directions across the same predictor. SD does not simply depress egalitarianism; it substitutes one justice principle for another.

■ Model fit

Both the OLS and the ordered Probit models feature good levels of fit.

Adjusted predictions — ordered Probit

Combined Margins Results with 95% CIs



APMs = Adjusted Predictions at the Means, otherwise: APRs = Adjusted Predictions at Representative values

■ Likert structure respected

Collapsing the outcomes to three ordered values around the neutral midpoint reproduces the linear result.

■ Equality

Overall seen as fair, but the probability of judging it fair declines as SD-beliefs strengthen.

■ Merit

Exhibits low-level approval overall, yet approval rises consistently with SD-beliefs.

Fig. 3: Adjusted Predictions at Representative values (APRs) & Adjusted Predictions at the Means (APMs) of very/rather unfair & very/rather fair equality & merit attitudes with 95% CIs. Multiple-imputation estimates of ordered Probit regression models, including auxiliary covariates, unconditional VCE, with demographic & political sample weights. ACPM May 2022 (N = 1,557, M = 50).

Two covariates stand out

■ Left–right ideology — as expected

Ideological leaning correlates significantly and negatively with support for egalitarian access, and significantly and positively with meritocratic attitudes.

People further right favour meritocracy but dislike equality; the opposite holds for those further left.

■ Why the ideology result makes sense

Right-wing parties frequently promote the importance of social hierarchy, competitive capitalism and meritocracy (Solt et al. 2016).

■ Institutional trust — against expectation

People who are more trusting in democratic and state institutions display higher support for merit-based access and lower backing of egalitarian fairness.

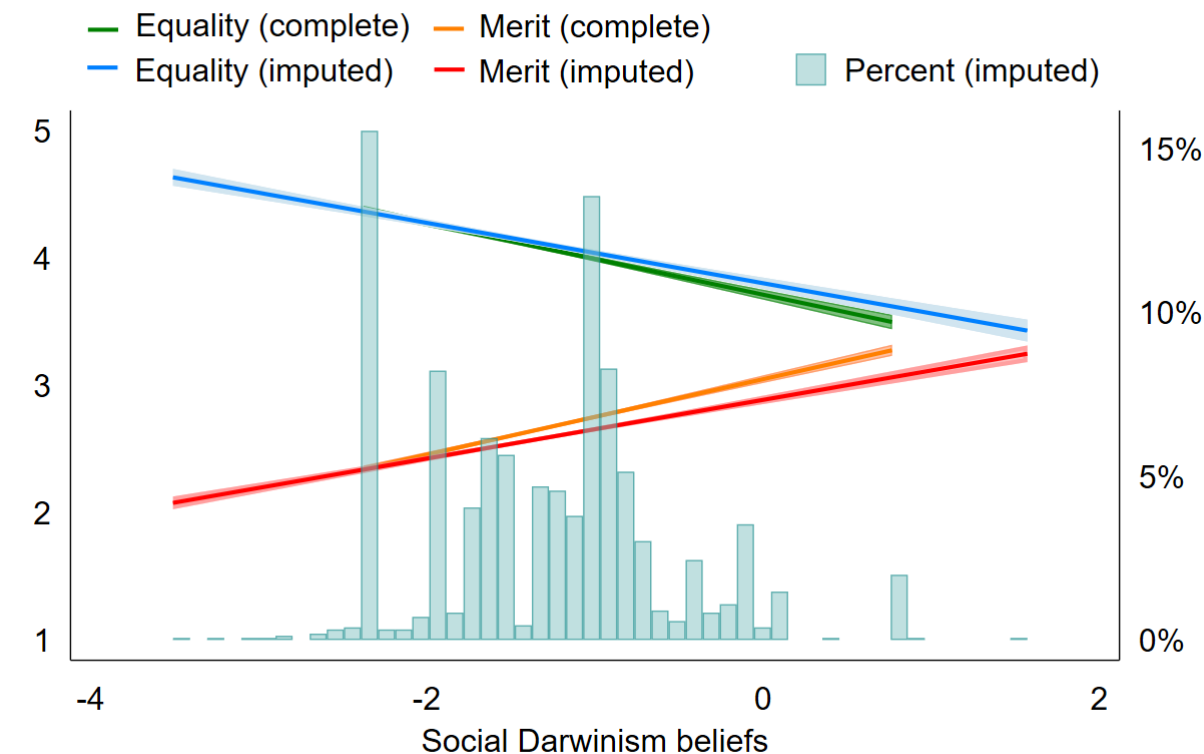
This is the opposite of the pattern anticipated from a Rawlsian reading of background and procedural justice.

■ An open question

Does institutional trust here capture confidence in the fairness of institutions — or satisfaction with the status quo that those institutions currently produce?

Robustness - seemingly unrelated regression

Linear predictions with 95% CIs - based on SUR equations



Complete vs. imputed

MICE evidently approximates a more normal distribution of SD-beliefs, producing more outliers. Yet, Cook’s distance shows no systematic outlier error in the imputed sample.

Direction of the small biases

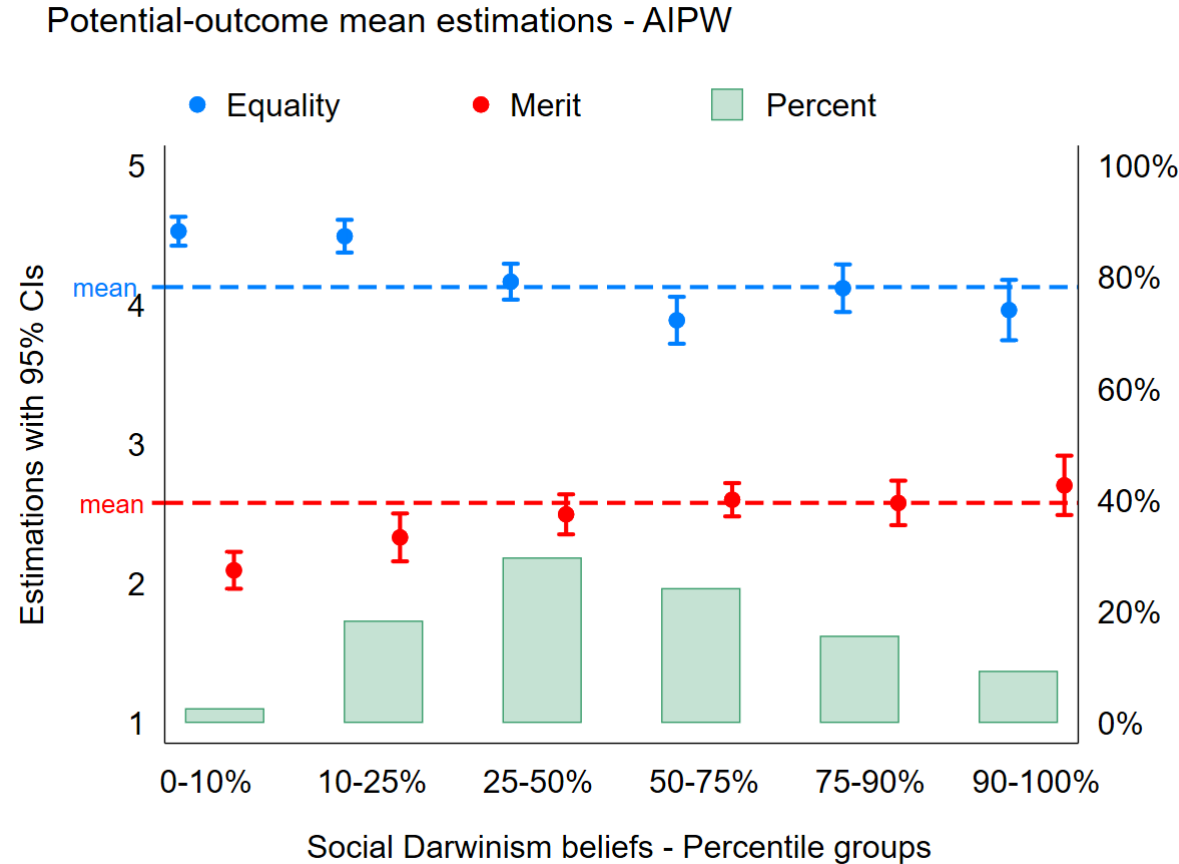
The imputed prediction slightly overestimates the SD–equality correlation and slightly underestimates the SD–merit association.

Verdict

Predictions from the complete-data models and from the MICE regressions are consistent.

Figure 4: Linear predictions of equality & merit with 95% CIs; added is the MICE-distribution of SD-beliefs in %. Seemingly unrelated regression (SUR) models with 2 equations, including auxiliary covariates, with demographic & political sample weights. ACP May 2022 (complete N = 786 / imputed N = 1,557, M = 50).

Potential-outcome means via AIPW



■ A double-robust check

AIPW with weighted nonlinear least squares estimates potential-outcome means across six SD percentile groups.

■ Equality declines monotonically

Support falls from the lowest to the highest SD percentile group, crossing below the sample mean.

■ Merit rises monotonically

Support climbs steadily across the same groups. The widest gap sits at the extremes of the SD distribution.

Figure 5: Potential-outcome means (POMs) with 95% CIs, estimated through augmented inverse-probability weighting (AIPW). SD-beliefs split into six percentile groups from lowest to highest. Includes auxiliary covariates, cluster-robust VCE. ACPP May 2022 (N = 1,557, imputed M = 50).

Four properties of the nexus

Inertia

Meritocracy fosters and reproduces social hierarchies which in fact rely partially on merit — yet considerably on the inheritance of various types of capital.

Inefficiency

SD delivers a pre-text for meritocracy through the ideals of competition and competitiveness, which ought to maximise fitness.

Inconsistency

It demands individualism and liberty in some spheres, while imposing strict sanctions and norms in other affairs of life and other domains of society.

Inequality

SD and meritocracy ignore asymmetric opportunities but insist on differential outcomes.

■ The paradox

Meritocracy cannot maximise efficiency and represent equity without severe egalitarian interventions. A society would have to eliminate brute luck to warrant the claim that merit is independent of privilege and social rank because equality-of-opportunity is the cornerstone of social mobility.

Why people who believe in SD also back merit

■ Prospect of upward mobility

Many poor people reject redistribution because they hope that they, or their kin, may ascend the social hierarchy. SD conveys that fitness can be improved through kin-selection — which is precisely the belief in advancing one's own kin.

■ Respect upwards, disdain downwards

SD builds on perpetual competition and brittle dominance hierarchies (Cummins 2015). “Social Darwinists” have respect for ranks above them and disdain for ranks below.

■ Group structure and cooperation

Populations are composed of kin and of groups; both determine population structure. As SD also fosters between-group competition, more groups and higher segregation may lower a population's overall cooperation.

■ The status-quo mechanism

Social classes maintain the status quo through ideological justifications of inequality and through dehumanising judgments of the groups below them. Humans accept inequality imposed from above and defend their own rank against those beneath.

Policy implications

- Meritocratic ideas have been installed in many domains of the welfare state (Sachweh 2016). Welfare retrenchment, privatisation, marketisation and commodification are the tools of a meritocratic-competitive policy paradigm.
- Expanding the role of private health insurance and of out-of-pocket payments tends to have a negative effect on health equity (Bambra et al. 2014).
- Decades of that paradigm substantially undermined public health and public healthcare infrastructure, reducing many countries' capacity, preparedness and resilience to confront COVID-19 (Navarro 2020).
- The pandemic further exposed the defects and inequalities caused and inflated by neoliberal policy paradigms (Cardona 2021).

Evolutionarily learnt “cooperative mutualism, competition between the same or different species, and strategies to enhance fitness” may lead to nationalist responses and a lack of global solidarity.

Pacaol 2021

■ What policy makers ought to realise

1. Human groups rely on distinct modes of reciprocity to establish cooperative behaviour.
2. Those modes shape not only behaviour within and between groups, but welfare systems, healthcare systems and public policy.
3. Sustained academic criticism of the neoliberal agenda is not ideology but an evidence-based concern about false assumptions regarding human coexistence, including faulty SD and the ideation of “fair” meritocracy.

Limitations & outlook

■ Limitation 1 - the case

Austria represents a particular welfare regime: social insurance, mandatory social security contributions, statutory health insurance. The sample is therefore only indicatively generalisable.

■ Limitation 2 - the timing

Data collection in May 2022 fell in a period of recovery from most COVID-19 infections in Austria and much of Europe, which may have shaped responses.

■ Strengths

Methodological rigour through multiple imputation, four estimator families, explicit power and missingness analysis — combined with holistic reasoning that links general and biomedical ethics to sociological justice theory.

■ Open extension

Entitlement as a third correlative principle. Hierarchy-based access is theorised but not yet fully modelled.

What this study establishes

1 Beliefs in SD are significantly associated with attitudes towards fair healthcare access.

The association survives multiple imputation, ordered Probit specification, SUR model comparison and double-robust AIPW estimation.

2 The association is directional, not merely negative.

Strong SD-beliefs raise support for contribution-based justice and lower endorsement of egalitarian access, so that one principle substitutes for the other.

3 Ethics needs an empirical counterpart.

“Darwinist sciences” ground their claims in empirical study. Biomedical ethics should not become less philosophically reasoned, but it has much to gain from evidence-and-value-based dialogue.

Healthcare stakeholders may be advised not to underestimate the potential and attraction of the relationship between beliefs in SD and meritocratic justice.

Summary

■ Background

“Social Darwinism” (SD) is embedded in political, social and economic belief-systems — welfare chauvinism, authoritarianism, extreme neoliberalism.

COVID-19 made scarcity in healthcare, and the trade-offs between health equity and other standards, unusually salient.

■ Methods

Austrian Corona Panel Project, cross-section of May 2022 (wave 32).

SD measured via two survey items: ‘deserving and undeserving life’ and ‘policies contradicting the natural order’.

Access criteria captured by one survey item per priority-setting principle.

■ Results

Beliefs in SD are significantly associated with attitudes towards fair healthcare access.

Strong SD-beliefs → more support for contribution-based (meritocratic) justice.

Strong SD-beliefs → less endorsement of egalitarian access.

■ Conclusions

General and biomedical ethics, and social justice theory, should be tied far more closely to quantitative empirical social science.

SD deserves recognition as an underlying mechanism behind acceptance of health inequality.

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