*Review Paper*

# Existence Of Unequal Treatment in Healthcare: An Indicator for The Violation of Healthcare Bioethical Principles

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**ABSTRACT**

Despite decades of existence of universal declaration of human rights, all goals and principles that aim to respect human rights have not been fully esteemed and achieved in many nations. For instance, global discrimination continues to appear almost in all sectors, and it is still a grave problem that deserves optimal attention. Worldwide numerous people do not get what they deserve due to certain kinds of discrimination. In healthcare sectors unequal treatment exists and it reduces the quality of life for many people. In 2002, the United Nations under the leadership of Kofi Annan launched a Global health initiative. Global health has been regarded as a collection of problems, but also, a field of study and practice concerned with improving health of all people and achieving health equity worldwide through addressing transnational problems. It could be possible to optimize the health status of the world's population via synergizing healthcare bioethical principles with global health initiative but also with other commitments. Could such be achieved if unequal treatment continues to exist in healthcare sectors? Some indicators that violate healthcare bioethical principles have been described in various contexts. It is truism that the existence of unequal treatment in healthcare settings also indicates the violation of healthcare bioethical principles. However, no researchers have addressed unequal treatment as an indicator for violation of healthcare bioethical principles. Unequal treatment happens at all levels of healthcare sectors. This synthesis article describes how unequal treatment is an indicator for violation of healthcare bioethical principles at Micro-level, Meso-level, and Macro-level of healthcare sectors.

**Keywords:** Bioethics, Discrimination, Healthcare, Healthcare Sectors, Human Rights, Unequal Treatment in Healthcare, Violation of Healthcare Bioethical Principles

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## Introduction

On 10th December 1948 in Paris/France, United Nations (UN) in its 183rd plenary meeting adopted fundamental universal declaration of human rights. Following such declaration other numerous conferences that aimed to promote optimal existence of human rights for all people in all countries, continents, regions, and sectors have been taking place. For instance, in conference held from 14th June to 25th June 1993 in Vienna/Austria culminated into affirming that all states should fulfil their obligations with respect to the principles of human rights. It likewise reaffirmed that, human rights are the birth right of all human beings and highlighted that international cooperation in the field of human rights is essential for the full achievement of the purposes of the UN [1-2].

Moreover, from 31st August to 8th September 2001 in Durban, South Africa a World Conference against Racism, Racial Discrimination, Xenophobia and Related Intolerance was held. In such conference, an address was made that *"People in all parts of the world continue to suffer daily from racism, racial discrimination, xenophobia and related intolerance. They are looking to the United Nations and its Member States to lead the way forward and help them to have the conditions for a better life, a decent life, and one free of discrimination"* [3].

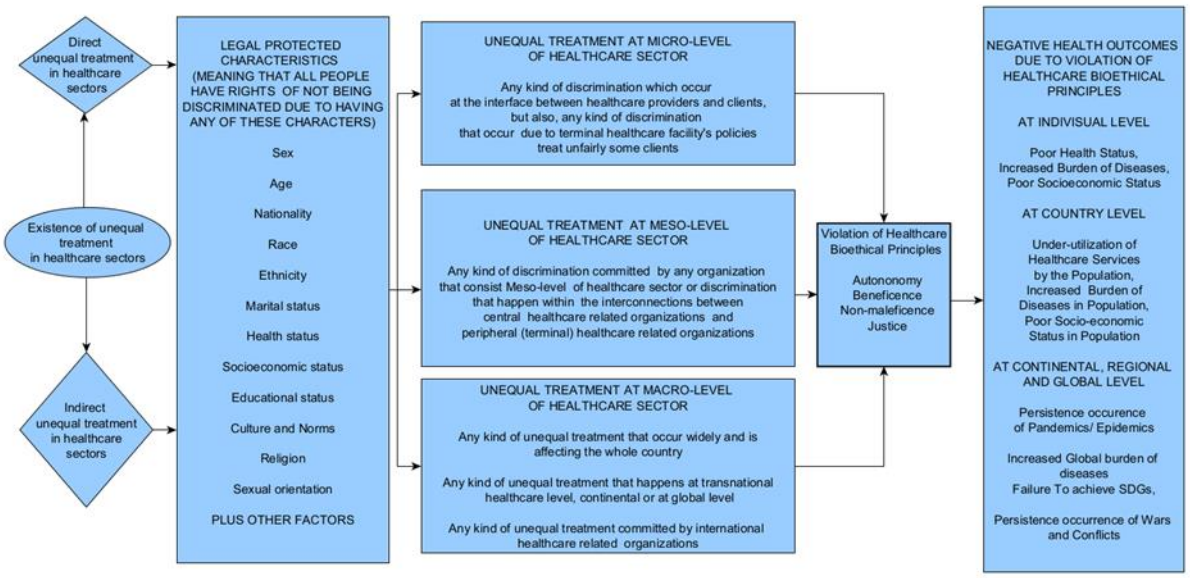
However, despite all those conferences and declarations related to human rights, all principles related to respecting human rights have not been fully attained and appreciated in many Worlds' nations. For instance, just one year following Vienna conference a profound failure for protecting human rights appeared as evidenced by the genocide which happened in Rwanda in 1994 and it occurred despite the presence of UN peace keeping troops there [4]. But also, many more wars and conflicts leading to deaths and compromises for the health of many people have been happening in many Worlds' nations, in fact some are still going on! These are painful facts as it has been known for many years that, *"the right to health is a fundamental part of our human rights and of our understanding of a life in dignity"* [5]. Globally discrimination continues to appear almost in all sectors, and it is a grave problem that still deserves optimal attentions. Truly, worldwide thousands and thousands of people do not get what they deserve and worked for due to certain kinds of discrimination. In healthcare sectors, unequal treatment exists, and, in many ways, it affects negatively the quality of life for many people [6-7]. Mainly, people entitled socially disadvantaged face great burden of healthcare discrimination in both developing and developed countries. A survey done from France in 2020 by a group of investigators concluded that *"discrimination within the healthcare settings may present a barrier to healthcare for people that are socially disadvantaged due to gender, immigration, race/ethnicity, or religion"* [8].

Worldwide various ambitions that aim to eradicate unequal treatment in healthcare sectors have been taken. For instance, on 27th June 2017 UN related agencies issued a statement for ending discrimination in healthcare settings to serve as one of the compasses for guiding people and nations to achieve sustainable development goals (SDGs) by 2030 [7,9]. In 2002, United Nations under the leadership of Kofi Annan launched global health initiative. Global health has been regarded as a collection of problems but also, a field of study and practice concerned with improving health for all people in all nations by endorsing wellness and removing avoidable diseases, disabilities, and deaths [10]. Thus, its main goal is to ensure equitable availability and accessibility of healthcare services for all people devoid of any type of discrimination. Moreover, on 19th October 2005 United Nations Educational, Scientific and Cultural Organization (UNESCO) issued Universal Declaration on Bioethics and Human Rights [11-12]. The main scope of this declaration is *"to address ethical issues related to medicine, life sciences and associated technologies as applied to human beings, taking into account their social, legal and environmental dimensions"* [11]. Article 10 of this declaration affirms that *"the fundamental equality of all human beings in dignity and rights is to be respected so that they are treated justly and equitably"* [11]. Furthermore, article 11 of this declaration stresses that *"No individual or group should be discriminated against or stigmatized on any grounds, in violation of human dignity, human rights and fundamental freedoms"* [11]. All these initiatives, commitments and declarations seem to be synergy to leave none behind ambition proclaimed in sustainable development goals (SDGs). But could all these be achieved if unequal treatment continues to exist in healthcare sectors? Existence of healthcare bioethical principles could have resulted into eradication or minimization of unequal treatment that have existed in healthcare sectors in many countries for many years, because these principles could have empowered all healthcare concerned stakeholders to respect the dignity of all human beings.

Yet, in many countries' unequal treatment in healthcare settings still exists. In fact, some countries have ignored it, thus, it is a grave problem that deserves optimal attentions. In 2017 United Nation Development Group released a statement on zero discrimination in healthcare settings and strongly affirms that different forms of discrimination in healthcare sector exist. Among those forms include physical and verbal abuse; breaches of confidentiality; barriers in accessing services

as third party authorization requirements; denial of, or failure to provide adequate health care; violations of autonomy and bodily integrity; and compulsory detention [9]. Indicators for the violation of healthcare bioethical principles have been described in various contexts. It is truism that existence of unequal treatment in healthcare sectors also indicates the violation of healthcare bioethical principles. However, there are no published studies that have considered existence of unequal treatment in healthcare sectors as an indicator for the violation of healthcare bioethical principles. Unequal treatment happens at all levels of healthcare sectors (Micro, Meso and Macro healthcare sectors). Direct and indirect unequal treatment happens at all these levels as it is shown in Figure 1. Direct unequal treatment in healthcare settings takes place when certain client (patient), or a group of clients, are cared less favourably than another client or group of clients due to their background or certain personal status. While indirect unequal treatment in healthcare sectors occur anytime when certain rules, policies, regulations, or arrangements that must be applicable equally to every client are put in place, nevertheless such put some clients at unfair detriment. The goal of this synthesis and review article is to indicate how existence of unequal treatment violates healthcare bioethical principles at Micro-level, Meso-level, and Macro-level of healthcare sectors. Possible factors leading to existence of unequal treatment in healthcare sectors are also discussed.

*Figure 1: Framework for the occurrence of unequal treatment at Micro-level, Meso-level and Macro-level of healthcare sectors, violation of healthcare bioethical principles and some of its negative impacts to the health.*




## 1. Possible factors leading to existence of unequal treatment in healthcare sectors.

It is very essential to reaffirm all 30 fundamental principles of Universal Declaration of Human Rights. The first of those 30 fundamental principles proclaim that *"all human beings are born free and equal in dignity and rights. They are endowed with reason and conscience and should act towards one another in a spirit of brotherhood"* [11]. Every human being of any origin and background may need a support at certain points of his or her life. Intuitively, in the current modern world, no one is immune to all diseases and injuries. We share problems; thus, we must combine our efforts in order to solve them without any kind of discrimination.

Through experience, I have recognized that blood save lives of many patients who have confirmed blood transfusion indications. Unaccountably, I have visited blood bank room, I have collected blood from blood bank room, and I have transfused blood to many patients after their informed consents. Apart from checking for presence of infections and performing blood grouping and cross matching in order to make sure that donor's blood matches with recipient blood, while carrying out all these, I have never seen, the consideration of questions like: who donated blood? Was the

donor a rich or a poor person? Was the donor a white or black person? Was the donor an educated or a non-educated person? Was the donor a male or a female, Was the donor coming from certain religion? Was the donor coming from certain country? Was the donor of certain race, tribe or ethnicity? Etc. All these indicate that, life of any person can be saved by the contributions provided by any person of whatever the background! In case blood is to be used for saving life; a blood of black person could be used to save life of white person and vice versa, the blood of poor person could be used to save life of rich person and vice versa, the blood of non-educated person could be used to save life of educated person and vice versa etc. But the question is, why does this world continue to have some people who discriminate others? We are all endowed with reason and conscience, and we should act towards one another in a spirit of brotherhood. Thus, as of the facts, nobody is entitled to any kind of discrimination at all.

However, worldwide different types of discrimination still occur almost in all fields because of number of factors. Possessing so termed protected characteristic means that all people have full rights of not being treated less auspiciously or subjected to unfair disadvantage by reason of that characteristic. Among the protected characteristics include sex, age, nationality, race, ethnicity, marital status, health status, educational status, religion, sexual, orientation socioeconomic status etc. According to United Nation Development Group statement on zero discrimination in healthcare settings released in 2017 all people must have access to quality health care services provided in timely manners without any kind of discrimination [13]. However, numerous literatures indicate that, worldwide the tragedies of discrimination still occur unacceptably in all fields including healthcare related fields.

Unfair provision of healthcare services to voluminous clients has been reported for many years. And for many decades numerous researchers and experts have turned their interests in searching the likely risk factors leading to existence of unequal treatment in healthcare sectors. Yet, unfortunately most of their answers are incomplete, insufficient, and inconsistent because they have not specifically considered existence of unequal treatment from different angles of healthcare provision sectors. Intuitively, risk factors leading to unequal treatment at Micro-level, Meso-level, and Macro-level of healthcare sectors are different. Likewise, risk factors leading to occurrence of direct, indirect and other forms of discrimination at different levels of healthcare sectors also differ. Probably without broad and thorough understanding risk factors that lead to healthcare discrimination, globally the tragedies of healthcare unequal treatment will continue to occur, due to lack of sufficient knowledge about the risk factors leading to its occurrence, and due to lack of effective and efficient strategies for addressing it. From literature review and conceptual experiential approach, the possible factors leading to healthcare discrimination are shown in Table 1.

**Table 1: Some possible factors leading to unequal treatment at micro, meso and macro levels of healthcare sectors.**

| Possible Factors | Some key remarks and comments |
|---|---|
| **Some possible factors leading to unequal treatment at Micro-level of healthcare sector** | |
| **Possession of certain protected characteristics by the clients** | • Among the protected characteristics, racial and ethnicity have been the commonly studied variables with regard to unequal treatment in healthcare especially in the United State of America (USA).<br>• In 1999, the congress of USA ordered Institute of Medicine (IOM) to investigate extent and cause of racial and ethnic disparities in healthcare for the purpose of developing the frameworks for eliminating it(14,15).<br>• In 2003 IOM published a report entitled Unequal Treatment: Confronting Racial and Ethnic Disparities in Healthcare. Evidence from such report and |

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| | studies suggest that "racial and ethnic minorities tend to receive a lower quality of healthcare than non-minorities"(14,16).<br>• Several groups of minorities have been negatively affected by the tragedy of healthcare discrimination in USA. But empirical evidence affirms that for many years African Americans have been the mostly affected group due to their race(17) |
| **Hypocritic and incomplete healthcare related education system** | Non-integrative healthcare related education system is synonymy of such system. Some of its features are:<br>• Health related Schools/Universities with such system do not align their goals and working principles with $SDG_s$ [(especially, SDG1(End poverty in all of its forms), SDG2 (end hunger everywhere in all of its forms), SDG 3 (Ensure healthy lives and wellbeing), SDG4 ensure quality education)] plus other SDGs<br>• It focuses mostly on medical aspects.<br>• It does not highly consider all other social determinants of health to be crucial.<br>• It does not offer enough time for healthcare bioethics; thus, some students graduate without knowing how to respect the health and the dignity of every patient.<br>• More theoretical oriented and less practical sessions<br>• It does not train students to adopt evidence-based decision-making approach while they start providing healthcare services to their clients in future.<br>• Passing exams-oriented teaching approach instead of community oriented and problems oriented (solving) teaching approaches is more predominant in such system.<br>• It does not support students to plan for their future career including specializations.<br>• Discrimination done either intentional or nonintentional by some healthcare professionals trained in such system is one of the worst outcomes from all these.<br>• Violation of healthcare bioethical principles by such system is marked by poor health status for the people who are in catchment area of which such system operates. |
| **Inadequate knowledge about the principles of human rights for some health care providers** | Some characters of those healthcare providers are:<br>• Misunderstanding of the meaning of human rights<br>• In-application of the principles of human rights<br>• Healthcare providers who have these features may discriminate their clients due to not knowing that health is fundamental human rights.<br>• Sometimes they do not care about the dignity of their clients.<br>• Violation of healthcare bioethical principles by those healthcare professionals is marked by poor health status of the people surrounding healthcare facilities of which they work |
| **Misuse of position and feel of superiority by some healthcare providers** | Some characters of those healthcare providers are:<br>• Some tend to favor paternalism.<br>• High rate of absenteeism.<br>• Likely they adopt non-interprofessional collaboration practices.<br>• Non-patient centered care behaviors.<br>• Some discriminate their clients physical or by verbal abuse.<br>• Violation of healthcare bioethical principles by those healthcare professionals is marked by poor health status of the people surrounding healthcare facilities of which they work. |

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| **Inadequate love for life by some healthcare providers** | Some characters of those healthcare providers are:<br>• They do not follow principles of empathy and compassionate in their healthcare practices.<br>• They do not care to restore functioning capacities (physiological and social) for all patients as quickly as possible.<br>• They do not value the life of all patients equally.<br>• Their levels of job satisfaction are about money they gain rather than abilities to make their clients feel better (cured).<br>• Violation of healthcare bioethical principles by those healthcare professionals is marked by poor health status of the people surrounding healthcare facilities of which they work. |
| **Inadequate patriotism for some Healthcare providers** | Some characters of those healthcare professionals are:<br>• Non-goals-oriented healthcare provision approaches<br>• Some do not align their healthcare practices with healthcare facilities', communities', and country' health related visions and goals.<br>• Violation of healthcare bioethical principles by those healthcare professionals is marked by poor health status of the people surrounding healthcare facilities of which they work |
| **Inadequate passion to the field of healthcare by some healthcare providers** | Some characters of those healthcare professionals are:<br>• They do not involve in further advancing their field to the high level.<br>• No search for up to dated information related to their field,<br>• Unlikely to attend continuous medical education and scientific healthcare conferences.<br>• The likelihood for the violation the principle of veracity is high.<br>• Violation of healthcare bioethical principles by those healthcare professionals is marked by poor health status of the people surrounding healthcare facilities of which they work |
| **Corruption adopted by some healthcare providers** | • Corruption exists in health care settings in different forms [14].<br>• For instance, certain healthcare providers working in government healthcare settings (which offer free of charge health services) could force some of their clients to go to buy medicine from private pharmacy due to bribes they received from such Pharmacy.<br>• Corruption in healthcare sectors violate all principles of healthcare bioethics.<br>• Violation of healthcare bioethical principles by those healthcare professionals is marked by poor health status of the people surrounding the healthcare facilities of which they work |
| **Misuse of cellphones by some healthcare providers** | • Sometimes healthcare providers adopt behaviors of misusing cellphones while managing their patients.<br>• Among those behaviors include, picking phone call in the middle of history and physical examination, improper time of using social medias.<br>• That result into mistrust and at the same time some patients are discriminated, neglected and healthcare bioethical principles are violated |
| **Some possible factors leading to unequal treatment at Meso-level of healthcare sectors** | |
| **Corruption and stealing healthcare facility's properties** | • In his paper Emily H. Glynn [14] reveals different forms of corruption that exist healthcare sector<br>• Among those forms include:<br>1) Improper financial relationship (government officials, payers, suppliers, and providers may involve in this form of corruption)<br>2) Theft and diversion (government officials, payers, Suppliers, and providers may involve in this form of corruption) |

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| | 3) Absenteeism (government officials and providers may involve in this form of corruption)<br>4) Counterfeit medical supplies (government officials and suppliers may involve in this form of corruption)<br>• Corruption violates all healthcare bioethical principles.<br>• Such violation is often marked by unacceptable poor health status of disadvantaged people who live in catchment area of the healthcare facilities in which corruption often occur |
| **Non-goals-oriented healthcare provision approaches** | Some features of non-goals-oriented healthcare provision approaches are:<br>• Healthcare policies are not well oriented with the country's vision.<br>• Healthcare policies and working principles are not well aligned with WHO pillars of strength.<br>• Healthcare Policies and working principles are not aligned with SDGs.<br>• Violation of healthcare bioethical principles due to such approaches is marked by unacceptable poor health status of disadvantaged people of which such approaches are applied |
| **Some possible factors leading to unequal treatment at Macro-level of healthcare sector** | |
| **Weak countries' Healthcare systems related factors** | • Such weakness leads to discrimination linked to deficiencies in education and regulation, informal employment, and poor working conditions.<br>• Tendencies of making generalized policies that aim to tackle various diseases.<br>• Healthcare providers also face discrimination(9) (for instance delay of salary payment, different payments but same job and working hours) due to such weak healthcare system |
| **Possession of certain protected characteristics by the clients** | • Immigrant, racial and ethnicity have been the commonly studied variable with regard to unequal treatment in healthcare.<br>• In France national representative cross section survey done in 2020 of which 21761 participant immigrants were enrolled, it was found that *"reporting discrimination within healthcare and reporting foregone care in the past 12 months were generally highest among women, immigrants from Africa or Overseas France, and Muslims"* [8]. |
| **Negative past–present history of a country, of the world and Conflict between countries** | • For instance, slavery trade caused many Africans people to find themselves in other continents and they are often discriminated because of their race(17), skin etc. In fact, evidence suggests that they are among the minority group which receive unfair healthcare services in many countries.<br>• Negative past history of many counties contributes to persistence of poverty which is among the main cause of discrimination in many fields including healthcare settings.<br>• Some international healthcare organizations also discriminate some countries which have negative past history |

**2. Unequal treatment at Micro-level of healthcare sector and violation of Healthcare Bioethical Principles**

The clients come to the health facilities to seek for support because they are ill (thus need for cure) or they need substantial information that could promote their health and prevent certain diseases. The main goal of healthcare professionals should be to make all clients feel better via provision of timely effective and efficient healthcare services. Accurate relationship between healthcare professionals and clients is the cardinal strategy for achieving that goal. Instead of establishing such relationships some healthcare professionals do commit certain categories of discrimination against their clients. Any kind of discrimination that happens at the interface between healthcare providers and clients, but also, between terminal healthcare facilities' policies and clients should be considered as unequal treatment at Micro-level of healthcare sector. Direct and indirect discrimination exists at Micro-level of healthcare sector.

Direct unequal treatment exists at micro-level of healthcare sector because some clients are not managed fairly compared to others. Examples given below are cases and situations that describe direct discrimination that occur in healthcare setting.

Firstly, as observation of me, some hospitalized patients with chronic diseases in many healthcare facilities face a direct discrimination. With standard practices, all hospitalized patients in any healthcare facility must be reviewed and monitored frequently on daily basis. However, in many hospitals, healthcare providers do not review and reassess some chronic patients who have been hospitalized for many days because of the presumption that they know much about those patients. But such omission of review of chronically admitted patients is very dangerous. In fact, that is a direct healthcare discrimination because in such cases healthcare providers are not considering all patients to be equally important. Psychological problems may occur to those patients due to such discrimination.

Another example is about absenteeism behaviours of some healthcare professionals. Unless formal permitted by certain authorities, there should not be an excuse of not attending to the clients by any healthcare providers who are employed in certain healthcare facility. No deliberate multiple self-given permissions of being absent for assigned working area is to be allowed in any healthcare facility in all worlds' nations. Timely availability and accessibility to healthcare services to any clients should be respected human rights all the time [13]. Yet, in some countries absenteeism of healthcare providers leading to non-timely provision of healthcare services has been the chronic demeanour for many years. For instance, a recent study on cost of corruption in Uganda accounts different forms of corruption that negatively affect healthcare services provision to some Ugandans. Absenteeism is among those forms and in fact each year about 495 billion Uganda Shillings (UGX) of state budget is wasted for salaries payments to the healthcare providers who are often absent [18]. Any healthcare providers or healthcare facilities that allow existence of absenteeism should consider themselves as direct discriminators for their clients. At any time, all patients are equally important, and they have rights of being managed in timely manners. Disrespecting this principle by any healthcare providers or healthcare facilities indicates direct discrimination which is a prominent indicator for the violation of healthcare bioethical principles.

Another example is related to some healthcare providers who provide the comprehensive healthcare services to some clients and leave others. It has become mandatory that, all healthcare providers should provide curative measures, preventive measures and health promotion information to all clients at any time of encounter. Some patients do receive all those services, but others are left. Those who are left are directly discriminated by their healthcare providers because they deserve those services. This should also be considered at the healthcare facility level in which some of its departments provide comprehensive healthcare services while others do not.

Otherwise, indirect unequal treatment exists at micro-level of healthcare sectors because often healthcare providers and healthcare facilities make certain decisions or policies that permit provision of care for all patients equally, yet there are biased to some patients either due to the severity of their diseases, age, sex, gender, race, disability, sexuality, pregnancy or caring responsibilities etc. Some policies and situations leading to indirect discrimination at Micro-level of healthcare sector are given below:

When a policy exists and proclaims that all patients who are to be referred from lower to higher levels healthcare settings for continuous management of their diseases should themselves pay transport fee all the time. Such kind of policy is too broad, and it favours some patients (if any) but leaves others. Probably rich patients would benefit in terms of using their money for taking care of their health in timely manners. But poor patients would get a serious trouble of impoverishment; in fact, some would opt to sell their properties in order to tackle transport issues and sometimes their diseases become more severe because of not being treated timely. Indirectly such policy has discriminated poor patients because of considering all patients as if they are socioeconomically equal. In fact, these kinds of policies are in place in many countries, but they cause severe harm to poor patients unacceptably.

The second example is for healthcare providers who do not adopt principles of triage, because they think that all patients are sick equally and then make a decision of treating them equally by

following order of patients' arrival. Doing this all the time is very dangerous due to high likelihood of discriminating severely ill patients who may need emergency care.

Any kind of discrimination that happens at micro level of healthcare sector violates healthcare bioethical principles and such discrimination adds extra burden of problems to the already health problems of which the client may possess. Principle of autonomy is violated likely because in case of discrimination the clients do not get rights of self-determination. Principle of justice is violated possibly because healthcare providers who discriminate their clients would not fairly and equitably distribute scare resources to them. The principle of beneficence and non-maleficence are violated because any healthcare providers who discriminate their clients may cause psychological harm to such clients and such psychological harm may act as stimuli for stress responses. Any kind of stress primarily disturbs the equilibrium between external and internal environment of the body. Four main hormones involving in stress responses are: catecholamine; fight and flights hormones (epinephrine, norepinephrine), cortisol, thyroid hormone, and Corticotropin releasing hormone. Most of the time, these hormones are released for adaptive purposes. Likely, in case of excessive and prolonged release of these hormones dangerous outcomes occur. For instance, excessive release of catecholamine may cause high blood pressure that would result into haemorrhagic stroke due to rupture of blood vessels in the brain.

Catecholamine hormones may also play roles of inducing fighting behaviours in which some clients fight against healthcare providers. In fact, cases have been reported whereby healthcare providers were killed by their clients. one of the typical published cases is found in paper entitled *"the crisis of patient-physician trust and bioethics: lessons and inspirations from China"* [19]. Accordingly, such paper narrates that, in major Hospital in Southern Inland China, a 38-year-old educated male who had been suffering from leukaemia and was treated by 67-year-old physician using innovative treatment regime combining biomedical intervention with traditional Chinese remedies for leukaemia. Patient was impoverished by paying for such treatment and he anticipated absolute cure, but later his condition deteriorated which provoked him to stab the physician 46 times! The physician died immediately due to those stabs. The patient directly cerebrated the victory for having killed such physician, however, one month later; the patient was convicted of murder and sentenced to death. The type of leukaemia of which such patient was suffering from is not indicated in such paper. A commonly known fact is that some types of leukaemia are very aggressive and sometimes to provide the cure is not possible. It is not clear whether the physician provided possible prognostic information to such patient prior to initiation and while managing him.

With regard to prognostic information, the principle of veracity is often violated because most healthcare professionals do not tell the truth about the prognosis of many diseases to their clients. Prognostic information of many diseases is often concealed for many patients. Somehow, healthcare professionals are right because sometimes it is hard to assess accurately or relatively approximate the prognosis of several diseases of many patients due to limited resources that have been in existed for many years in some healthcare facilities. Health information management system of most countries also does not provide an option for capturing and documenting prognostic data. In fact, there has not been existence of ideal strategies for truth telling with regard to the prognosis of many diseases in all Worlds' hospitals, even in famous one. Have clinical bioethicists and other healthcare stakeholders addressed negative outcomes associated with such lack? Is it of good ethical practices to communicate possible prognostic information to any patient in all circumstances? Lack of supporting strategies for truth talking about the prognostic information for many diseases, sometimes is the factor leading to negative outcomes to some patients, patient's family, and healthcare providers. According to this case from China if a physician did not tell truth about the likelihood outcomes from his interventions, no doubt, such may assert that, lack of veracity was the striking factor which led to the death of both patient and physician and families of the deceased may have also faced problems. Another factor would have been impoverishment.

All patients visit healthcare facility with anticipation of getting better or are cured of their diseases but sometimes such anticipation is not attained because of the diseases type and severity, and socioeconomic status of the patient. Impoverishment exacerbates the situation. For instance, after death of certain patient, family members of deceased person struggle to clear bills for the healthcare

facility of which patient was being cared from. Sometimes, for instance in private surgical field, reoperation is needed due to complications of which the patient did not have influence for their occurrence. Some healthcare facilities recharge patients for such operation even when they have not been or when recently discharged from such facility. Truly these are types of healthcare discrimination which must be addressed. Thus, where applicable, like in most private healthcare settings. Should patients pay with regard to the positive outcomes of their anticipation? Should there be an agreed and legal designed discount in case negative outcomes occur? There are no clear answers to these questions but what is known is that in private (and in some governments) healthcare settings a full payment must be made all the time no matter the outcomes of interventions.

The worst outcomes from all these are well known and they include severe and prolonged stress responses that lead to mental health problems such as anxiety and depression to some concerned people. Immune system of those people may also become weak due to such stress responses, thus they become more prone to infections. Besides that, discrimination leads to insufficient utilization of healthcare services (curative, promotion and prevention services) thus increased burden of diseases in various communities, and poor socioeconomic status have been reported [20]. Not to forget dangerous harm of which some patients or their family members would cause to healthcare professionals as this case from China indicate.

## 3. Unequal treatment at meso-level of healthcare sector and violation of healthcare bioethical principles

In any country the critical obligations of providing effective, efficient, appropriate, powerful, equitable and accessible healthcare services could be achieved via adopting six pillars of strengthen of World Health Organization (WHO). The Six pillars of WHO strength are: 1) Governance: management and accountability, 2) Finances: funding availability and allocation, 3) Service Delivery: accessibility, affordability, and acceptability, 4) Human resources: recruitment, retention, development and deployment), 5) Information systems: data quality, analysis, dissemination, and use, 6) Medicine and supplies: accessibility, quality, efficacy, and cost effectiveness. It is not bad to add healthcare bioethics as the 7$^{th}$ pillar.

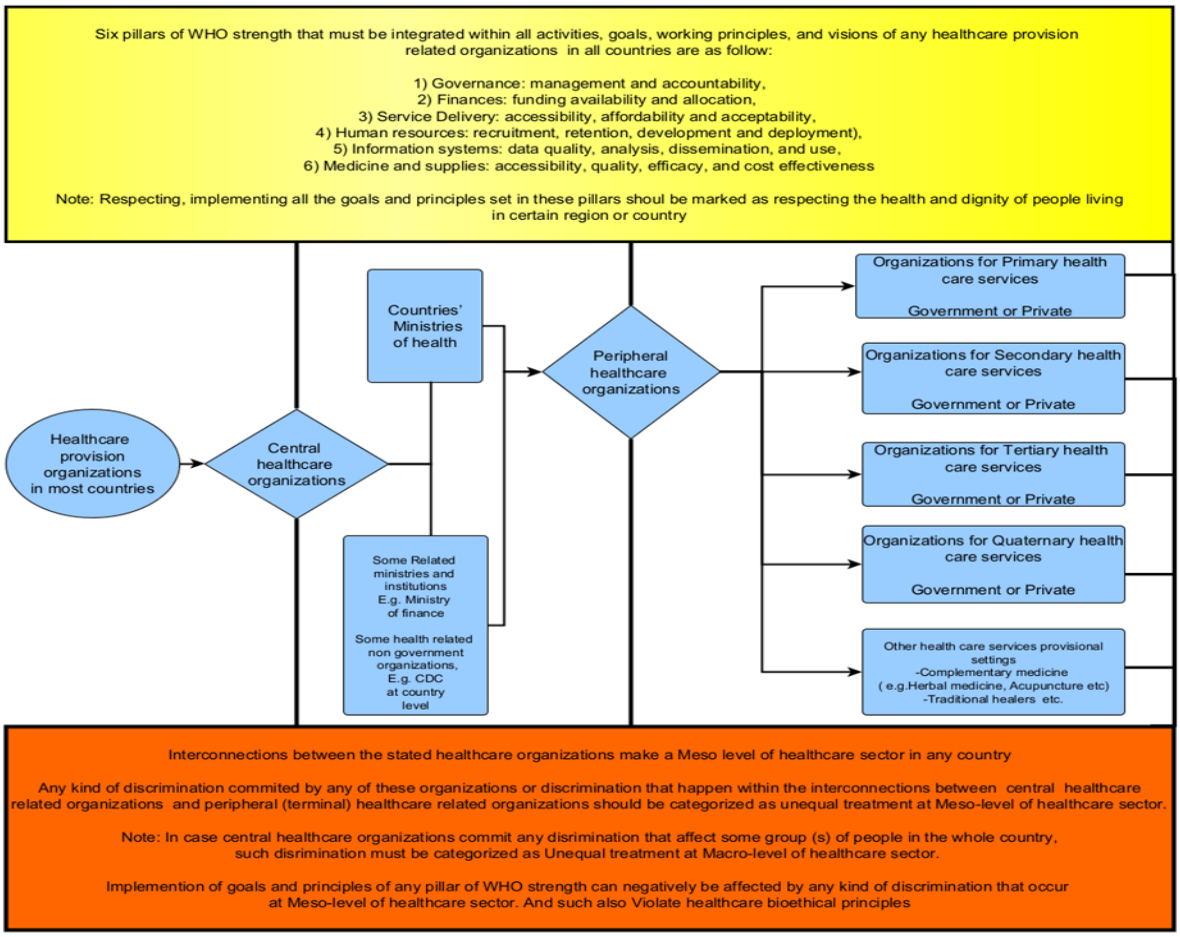
The main goal of these pillars is to ensure attainment of optimal health status for all people in all countries, without any kind of discrimination. In order to achieve anticipated outcomes from these pillars, there must stronger interconnections between concerned central healthcare organizations with peripheral healthcare organizations, and between peripheral organizations with clients.

Figure 2 shows a general framework of interconnections between healthcare related organizations which form meso level of healthcare sector within any country. Each of these organizations must have the mandate for implementing and respecting the principles set in WHO pillars of strength. Excellent coordination, collaboration, monitoring, and distribution of all items and services set in these pillars would favour optimal provision of healthcare services to many people who need them in most countries. However, in many countries remarkable feebleness is of self-evident in terms respecting principles and goals of WHO pillars. Intentional and nonintentional discrimination against some clients is among the prominent factors leading to such feebleness. Any discrimination committed by any organization that consist of Meso-level of health care sector or any kind of discrimination that happens within the interconnections between central and peripheral (terminal) healthcare related organizations should be categorized as Unequal treatment at Meso-level of healthcare sector. Note: if central healthcare organizations commit certain kind of discrimination and it is widely affecting some people in the whole country, such discrimination turns into Unequal treatment at Macro-level of healthcare sector.

Unequal treatment negatively affects all healthcare services provision at Meso-level of healthcare sector and because of that all principles and goals of WHO pillars are not achieved which is profound indicator for the violation of healthcare bioethical principles. In many countries different forms of healthcare sector related corruption done by government officials, healthcare providers and others [20] negatively hinders achievement the goals of WHO pillars. For instance, in Uganda estimated annual total cost of bribery in healthcare sector is nearly UGX 670 billion of which if eradicated would allow 25% saving of government spending on health. Firmly in Uganda

*"corruption hinders access to vital services, worsening poverty and increasing inequality. Access to essential services across the country is often dependent on the ability to pay a bribe to the public servants who act as informal gatekeepers"* [18]. Existence of high rate of corruption in healthcare sector increases the likelihood of inequitable and inaccessibility of healthcare services because of injustice and other factors. Likely vulnerable people are negatively affected by any form of corruption that occur in healthcare sector [21]. Non-goals-oriented healthcare provision approach is another factor that negatively hinders accomplishment goals of WHO pillars and violate healthcare bioethical principles. A striking example suggesting that; is continuous existence of inequitable distribution of health workers in many countries. Strength of many health facilities of same level is often different; that exist even when epidemiology of diseases seems to be homogenously distributed in many countries. All these indicate healthcare discrimination, and they happen despite WHO organization proclamation that the availability of health workers is crucial for healthcare provision, and they must equitably be distributed and accessible by the population [22]. Healthcare providers are also discriminated at this level. Nonalignment of policies and working principles of meso level with other ambitions such as SDGs also indicate healthcare discrimination.

*Figure 2: A general framework of interconnections between healthcare related organizations that form meso level of healthcare sector and their relation to WHO pillars of strength in any country.*




## 4. Unequal treatment at macro-level of healthcare sectors and violation of healthcare bioethical principles

For many centuries, ensuring optimal health status for all people has been the core obligations for many worlds' nations because of the fact that, presence of optimal health status of population would support any country to achieve all its ambitions. Optimal health status of population is the primary key of development in any country. Worldwide numerous strategies have been confirmed to be the core keys for improving health status of many people. By $1960_s$ it became clear that, the

solely provisions of curative measures are not enough for improving health status of many countries' population [23-25]. No other splendid ambition has ever been made by global healthcare stakeholders than opting to achieve health for all by 2000. In 1978 Alma Ata conference affirmed the principles of primary healthcare and were regarded as core strategies for achieving health for all in many nations by 2000. In 1986 Ottawa conference decreed principles of health promotion to be respect in all nations. In December 2000 United Nations and representative leaders of all worlds' nations and states proclaimed Millennium development goals which were to be achieved in 2015. Moreover, on 25th September 2015 all Worlds' nations adopted agenda to achieve Sustainable Development Goals by 2030. Outcomes from these ambitions have been diverse in many countries.

Cuba has been ranked as an excellent country that have respected and achieved agenda for supporting its people. Such excellent outcomes did not happen as miracle. It is because of serious determinations of Cuba. For instance, Cuba allots 27.5% of its national budget to health sector, among all world's countries Cuba is ranked as the first country that have eliminated Mother to Child HIV and Syphilis transmission and it has also eliminated other numerous diseases, prenatal care in Cuba exceeds 95% and institutional delivery is 99,9%(26), plus other achievements. No doubt other countries can attain optimal health status for their population like Cuba in case rights for health and the dignity of human being is full considered and respected all the time. That may only become true, if all actions that aim to improve health status of population in many countries are allowed to go hand in hand with all strategies that aim to eradicate unequal treatment that has existed in health care sector for countless years. Respecting healthcare bioethical principles can also serve as synergy to actions that are being used to improve health status of people in many countries.

Various ambitions that aim to improve health status of global populations have been fashionably launched during globalization era which has some proven positive opportunities for many people but also, with extra negative health related problems. Among the benefits of globalization include, easy transfer of technologies, easy dissemination of scientific evidence including healthcare related information, easy sharing of development activities and opportunities etc. Otherwise, evidence put forward that, numerous health related problems including deadly infectious pandemics/epidemics occurred and caused unacceptable burden because of globalization. For instance, between 1918-1920 Spanish flu led to deaths of about 17-100 million people globally, since its beginning in 1981 to present HIV/AIDS epidemic has killed about 42 million people globally and as of April 2023 Covid19 that just started in 2019 has led to deaths of about 6.9-28.3 million people worldwide.

With continuous troubles for fighting numerous diseases and need for attaining of optimal health status for all people, no single country can ensure long lasting health status of its populations by working in solitary manners. Strong and active partnerships should be established between countries and international healthcare related organizations such as: WHO, Centres for disease control and prevention (CDC) etc. But also, strong, and active partnerships must be established between countries themselves in order to accomplish maximal health status of their populations. Achieving all these would result into the formation of durable Macro-level of healthcare sector. Respecting ethical and global bioethical principles is among the powerful strategies that can support to achieve all these.

As an obligation, each country must fairly provide healthcare services to its entire people without any kind of discrimination. It should be an obligation for all worlds' countries to work together in well and coordinated manners in order to maximize health status of global populations without any kind of discrimination. All international healthcare related organizations must freely be immune of any kind of discrimination while giving support to any world country. If any kind of unequal treatment penetrates in any of these frameworks of healthcare provision at this level, such kind of discrimination should be termed as unequal treatment at macro level of healthcare sector.

Direct and indirect unequal treatment at macro-level of healthcare sector exists in both developed and developing countries because healthcare systems of all these countries do not fairly and equally provide healthcare services to their populations. In USA, for many years, African Americans have suffered unacceptably in terms of accessing healthcare services due to existence of racial and ethnic Health Care Disparities [17]. In recent cross-sectional survey done in USA, 21% of the 2137

enrolled participants revealed to have experienced healthcare discrimination. In such survey 72% of those who reported facing healthcare discrimination have experienced it more than once. Investigators of this survey concluded that discrimination in the USA health care system appear to be more common than previously recognized and deserve considerable attention [16]. Unequal treatment negatively affecting Canada's Healthcare Systems also exists. Racism is the most prominent factor leading to unequal treatment in Canada. Indigenous Canadian people greatly face the tragedy of unequal treatment and because of that, they often experience lower health outcomes than non-Indigenous people and such is exacerbated by lack of access to quality health care and lower socio-economic status [27]. Unequal treatment also exists in developing countries because of chronic existence of inequitable healthcare services provision. Thus, of these facts it is clear that, many countries and healthcare related organizations frequently commit different types of healthcare discrimination and truly all those negatively impact healthcare bioethical principles. Likely most of them commit indirect unequal treatment via making policies which seem to treat all people equally but otherwise such policies unfairly treat some disadvantaged people. Examples given bellow demonstrate some of the situations and policies in which countries and healthcare related organizations commit indirect unequal treatment.

Evidence suggests that non-communicable diseases ($NCD_s$) have become a serious global public health problem. World health organization (WHO) estimates that worldwide every year 41 million people are killed by $NCD_s$, representing 74% of all deaths. Globally $NCD_s$ kill prematurely about 17 million people before age 70. $NCD_s$' tragedy is great in low- and middle-income countries because 86% of reported premature deaths and about 77% deaths caused by $NCD_s$ are from these countries.

Non-communicable diseases consist of the spectrum of diseases such as cancers, cardiovascular diseases, mental health disorders, injuries and genetic diseases etc. People who are affected by these diseases have different socioeconomic status. The severity of these diseases also differs from one patient to another. However, few countries and international healthcare related organizations have formed policies that aim to tackle each type of non-communicable disease individually. Most countries have formed generalized policy for tackling non-communicable diseases. However, probably fewer sick patients benefit from those generalized policies. While those who are very sick mostly die quickly and those who survive remain with permanent disabilities; yet most of them would survive and live with improved quality of life in case the policy favouring them to get appropriate care was in place and provided in timely manners. Absolutely, with regard to $NCD_s$ indirect unequal treatment leads to the violation of healthcare bioethical principles. No manifest of justice when people are not treated equally. Premature deaths probably indicate serious harm linked to some policies and non-respecting the principle of beneficence.

To be specific, globally mental health disorders have become one of the common serious public health problems. In 2019 WHO estimated that 1 in 8 people live with mental health disorder and that about 970 million people were living with mental health disorders. It has become mandatory for each country to have policies that address mental health problems. Many countries have complied with such mandate. However, ways in which policies for tacking mental health problems are made seem to be erroneous in nature because they generalize mental health disorders. Mental health disorders are in different spectrums. The severity of mental health disorders differs from one patient to another. But also, people with mental health problems have diverse socioeconomic status. Making generalized policy for supporting all patients with mental health problems equally is a serious mistake; in fact, it is profound indirect discrimination of which various healthcare policy makers have committed globally.

The truth and evidence are clear, while moving in any streets, or markets of most countries' cities, towns and commercial centres, you see people with severe chronic mental health problems in miserable look of health status. Such people do not have shelters, no sources of food and nutrition, no one cares about their health, yet according to scientific evidence most (if not all) people in this world are at risks of suffering from mental health problems! These people are also human beings. Their rights for health must also be respected. Surely, globally, mental health problems are still neglected issues and the system for tackling them is still poor at all. It does not need extra knowledge and efforts for anyone to declare that homeless people with severe chronic mental

health have been neglected and discriminated by countries, continental and global mental healthcare system.

As long as we continue to see people with severe chronic mental health problems in various commercial centres', towns and cities' dustbins while struggling to get what to eat from those dustbins, sleeping nowhere, it will continue to be of self-evident that, globally the system for tackling mental health problems is poor. In fact, such will continue to be considered as discrimination at all and most people would constantly bear in their mind that, all fields (such as Social work fields, Psychiatric fields, Religious fields, Community leaders fields, Research fields, Academic fields, Public health fields, Various policy makers fields, Journalists fields etc.) entitled to tackle and address the tragedy faced by severe chronic mental sick people, as if there are in existence but non-functional at all or partial functioning!

Until now, there is no clear definition of life; however available evidence suggests that life is maintained by the interactions between biotic and abiotic factors. Biotic refers to living things while abiotic refers to non-living things. Scientific evidence shows that any kind of life is possible due to proper existence of two environments namely internal and external environments. The significant of internal environment on life was demonstrated by two famous physiologists, Claude Bernard (1813-1878) and Walter Cannon (1871-1945), Claude firstly used the term milieu Intérieur and later Cannon coined the term Homeostasis. Homeostasis refers to the mechanism in which living organisms maintain internal stability while adjusting to changing external environment. Apart from viruses all types of life need homeostasis. Any disturbance for homeostasis mechanism may lead to disorders or deaths of affected organisms. Progressively dangerous factor which has appeared to disturb all variables that regulate homeostasis is abnormal climate change.

Human activities contributed to existence of abnormal climate change. Some worlds' regions, countries, continents (such as Africa though it contributed less to the occurrence of abnormal climate change) are more vulnerable to the negative impact of abnormal climate change. All variables that would be used to maintain lives and wellbeing of many people have been negatively affected by abnormal climate change. For instance, abnormal climate change has been among the prominent factors leading to the occurrence of food insecurity in many parts of the world. That has resulted into chronic existence of inadequate food and nutrition intake, thus giving undernutrition a higher rank of still being the most dangerous medical condition in many countries.

Climate change mitigation and climate adaptation are critical concepts that discuss how to slowdown the occurrence of abnormal climate change and supports people to be resilient to the negative impact associated with abnormal climate change. Until now, there is significant feebleness regarding to implementing all principles and goals agreed on how to tackle abnormal climate change and its associated negative impacts worldwide. Deny of giving and delay in giving agreed contributions for tacking negative impact associated with abnormal climate change by some concerned stakeholders indicate such feebleness. The worst outcomes from such is poor health status for affected people especially minorities. Abnormal climate change is extra stressor for some continents and countries that are already harassed with food insecurity, high poverty levels, communicable diseases such as HIV/AIDs pandemic, tuberculosis and possibly Covid19 pandemic and non-communicable diseases have exacerbated the situation.

Health is fundamental human rights. As long as there is no optimal adaptation to the negative impacts associated with abnormal climate change, no affirmation should be made by any authorities that, globally healthcare and human rights for health are being respected. Because it is of self-evident that, progressively and negatively abnormal climate change continues to affect human health at unacceptable levels. However, climate adaptation strategies are still suboptimal in nature. Numerous people would bear in their mind that, the violation of human rights with respect to health is still more prevalent worldwide because of such suboptimal adaptation to the abnormal climate change. In fact, such must be described as unequal treatment at macro level of health care sector which have been or being done by various global communities and international organizations.

**Conclusions**

This synthesis article addressed various aspects related to existence of unequal treatment in healthcare sectors. The main goal of this article has been to describe how existence of unequal treatment violates healthcare bioethical principles at micro-level, meso-level, and macro-level of healthcare sectors. Great considerations have been made in terms of linking the discussed facts to fundamental universal declaration of human rights and universal declaration of bioethics and human rights. As genuine facts, unequal treatment still exit in all levels of healthcare sectors in both developed and developing countries. However, significant considerations for addressing it have only been taken in developed countries. Moreover, most of the UN Agencies have taken various ambitions that aim to ensure zero discrimination in healthcare sectors. However, they narrowly seem to have only considered direct healthcare discrimination that occur at micro-level of health care sector and left all others. Furthermore, healthcare bioethical principles have not been marked as powerful strategies that would be used in eradicating unequal treatment that have been in existence in healthcare sector for many years. In all countries, further considerations are needed in terms of addressing healthcare discrimination broadly from all possible angles related to healthcare sectors. To achieve such task a great pact of prominence should be dedicated to broadening the scope of healthcare bioethics and empower entirely people to respect all of its principles optimally. Rightly, without using healthcare bioethical principles as powerful weapon for fighting any kind of discrimination that occur in healthcare sector by all healthcare stakeholders, healthcare discrimination will continue to occur. People entitled socially disadvantage face countless burden of discrimination, yet entirely they consist of the group of people that actual need unlimited support from all healthcare system levels. What remains unknown is how to eliminate or eradicate such discrimination? New ethical strategies should be designed to support to eliminate or eradicate such discrimination which continues to exist in healthcare sectors.

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