DOI: 10.29302/Pangeea 25.15

# BIOETHICS OF EQUITY. INEQUITIES AND SOCIAL JUSTICE IN ACCESS TO MEDICAL TREATMENT

*Assoc. prof. PhD. MONICA ANGELA BARA, assoc. prof. PhD. ANCA IULIA BUGNARIU*
*"1 Decembre 1918" University of Alba Iulia, Romania*

***ABSTRACT:*** *Equitable access to healthcare is a central issue in contemporary bioethics and public health policy. Fundamental ethical principles, such as respect for autonomy, beneficence, non-maleficence, and justice, are often challenged by structural inequalities that affect vulnerable groups. This theoretical paper analyzes, from a bioethical and deontological perspective, the relationship between social justice and access to medical treatment, with an emphasis on the tension between equity and efficiency in the distribution of resources. Relevant ethical models (utilitarian, egalitarian, needs-based) and international regulatory frameworks on the right to health are discussed. At the same time, it highlights the role of healthcare professionals in promoting equity and preventing discrimination, including in relation to disadvantaged socio-economic groups or ethnic minorities. The paper proposes a critical reflection on the moral responsibility of health systems and physicians in reducing medical inequalities, arguing for the need for an ethic of solidarity in clinical practice and public policy.*

***Keywords:*** *bioethics; social justice; health equity; medical ethics; solidarity; moral responsibility; access to medical treatment; health inequalities.*

## Introduction

Fair access to healthcare services is one of the most complex ethical and social challenges facing contemporary healthcare systems. In a global context marked by rapid technological advances but also persistent socio-economic disparities, health inequalities often reflect the limits of applying the bioethical principle of justice (Beauchamp & Childress, 2019). Although the right to health is recognized as a fundamental human right, differences in access to healthcare remain significant both between and within countries, affecting vulnerable groups, low-income individuals, ethnic minorities, rural populations, and patients with chronic diseases (World Health Organization [WHO], 2023).

Bioethics, as a normative discipline, proposes a framework for analyzing the moral evaluation of these inequalities, providing conceptual tools for understanding the tension between equity, efficiency, and social justice. Traditionally, the principle of justice, along with patient autonomy, beneficence, and non-maleficence, is at the center of bioethical reflection (Beauchamp & Childress, 2019). In public health, however, the application of justice requires a distributive approach: how limited resources are allocated and to what extent the health system responds to the needs of the most disadvantaged (Daniels, 2008).

In modern theories of justice, there are several models relevant to the interpretation of equity in health. The utilitarian approach advocates maximizing collective benefits and the health of the population as a whole, even if it sometimes sacrifices individual equity (Mill, 1863/2001). In contrast, the egalitarian model promotes the uniform distribution of resources and treatment opportunities, considering health to be a basic social good (Rawls, 1999). An alternative perspective, proposed by Amartya Sen (2009) and Martha Nussbaum (2011), is that of capabilities, which shifts the focus from resources to the actual freedom of individuals to achieve their health potential. This view provides a solid ethical basis for health policies geared toward the real and contextual needs of patients.

At the European level, comparative analysis of health policies highlights persistent inequalities in access to treatment, particularly between countries in the west and east of the continent (European Commission, 2023). In Romania, inequalities are amplified by structural factors such as underfunding of the system, unequal distribution of medical staff, and cultural and economic barriers affecting certain groups, including Roma communities and rural populations (Vlădescu et al., 2021). Thus, although the legal framework guarantees universal access to healthcare services, in practice there are significant discrepancies between stated ethical principles and social reality.

From a deontological perspective, healthcare professionals have a dual moral responsibility: to the individual patient and to the community. Contemporary medical ethics require doctors to become not only service providers but also promoters of equity, capable of recognizing and reducing the barriers that perpetuate inequalities (Rumbold et al., 2017). This responsibility derives from the fundamental values of the medical profession: respect for human dignity, solidarity, and social justice.

Therefore, this paper aims to analyze, from a theoretical and bioethical perspective, the relationship between medical inequalities and the principle of justice, exploring the moral foundations of equitable distribution of healthcare. It will be argued that an ethic of solidarity, based on the recognition of the needs of the most vulnerable, can contribute to reorienting medical practices and policies towards true bioethics of equity.

## 1. Theoretical foundations of justice in bioethics

Justice, as a fundamental principle of bioethics, refers to how benefits and burdens are distributed within the healthcare system and the moral criteria that guide this distribution. In the classical conception formulated by Beauchamp and Childress (2019), the principle of justice implies "equal treatment of equals" and the equitable distribution of resources, considering the real needs of patients and not just economic or administrative criteria.

In bioethics, this principle is not only of theoretical significance but also represents a normative benchmark for clinical decisions and public health policies.

There are several normative models through which justice in health can be understood and applied. Each offers a distinct perspective on equity and the allocation of medical resources.

***The utilitarian model***. The utilitarian model, based on the philosophy of Jeremy Bentham and John Stuart Mill, argues that moral actions and policies are those that maximize the general good or collective happiness (Mill, 1863/2001). In the context of health, this implies orienting decisions toward maximizing the health of the population, even if certain individual groups may be disadvantaged. From a bioethical perspective, the utilitarian approach is effective in managing limited resources, but risks neglecting the rights and needs of the most vulnerable patients (Persad, Wertheimer, & Emanuel, 2009).

***The egalitarian model.*** In contrast, the egalitarian model, developed by John Rawls, promotes the idea that justice is based on equal opportunities and the protection of the most disadvantaged members of society (Rawls, 1971/1999). The "difference" principle, formulated by Rawls, states that inequalities are acceptable only if they lead to an improvement in the situation of the most disadvantaged. In health, this principle translates into guaranteeing equal access to essential medical services, regardless of an individual's socioeconomic status (Daniels, 2008). Thus, equity becomes a condition of justice, not a secondary result.

***Model based on needs and vulnerabilities***. Another important model in equity bioethics is the needs and vulnerabilities model, according to which resources should be distributed according to the severity of problems and the reduced capacity of some individuals to meet their basic needs (Powers & Faden, 2006). This model reflects a solidarity-based approach, recognizing that not all inequalities are morally acceptable and that certain groups, such as patients with chronic diseases, the elderly, or minorities, require priority protection.

***Capability model.*** The capabilities approach, proposed by Amartya Sen (2009) and further developed by Martha Nussbaum (2011), extends the understanding of justice beyond the distribution of material resources. It focuses on the real freedom of individuals to lead healthy, dignified, and autonomous lives. In this sense, equity in health means ensuring the conditions that allow all people to reach their biological and social potential, not just formal access to medical services.

This model is increasingly used in the ethical analysis of global health policies, as it is compatible with the concept of the "right to health" promoted by the World Health Organization (WHO, 2023).

***Distributive justice in bioethics***. Distributive justice occupies a central place in medical ethics, as medical resources, whether treatments, organs for transplantation, or public funds, are limited. Distribution principles must balance fairness, efficiency, and respect for human dignity (Daniels, 2008). In practice, this translates into dilemmas such as: who receives treatment when resources are insufficient? What criteria are ethically legitimate, the severity of the disease, the chances of success, age, or social contribution?

The answers to these questions depend on the cultural context and the dominant values of society. However, most ethical and deontological systems converge on the idea that medical justice cannot be reduced to a calculation of costs and benefits but must consider the principle of universal human dignity (European Bioethics Committee, 2020). Thus, modern bioethics promotes a balance between the principle of utilitarian efficiency and that of protecting the vulnerable, in the spirit of social solidarity.

***The ethics of solidarity as the foundation of fairness.*** In recent decades, the concept of solidarity has become a complementary principle of justice in bioethics. It emphasizes the collective responsibility to support individuals and communities at risk (Prainsack & Buyx, 2017). In this sense, solidarity is not only a moral virtue, but also a guiding criterion for public health policies. It implies the recognition that health is not a private good, but a common good that depends on cooperation and mutual care among members of society.

By integrating the principles of justice, equity, and solidarity, contemporary bioethics offers a complex normative framework capable of responding to the ethical challenges of current medical practice. Understanding these theoretical foundations is essential for formulating medical policies and decisions that respect the dignity and rights of all patients, contributing to the construction of a culture of equity in health.

## 2. Inequalities in access to medical treatment

Inequalities in access to medical treatment are a major ethical, social, and political problem, with direct implications for the fundamental right to health. According to the World Health Organization (WHO, 2023), health inequity refers to "avoidable, unjust, and systematic differences in health status between different population groups." These differences stem from structural, economic, geographical, cultural, and institutional factors that determine unequal access to medical services, medicines, technologies, and qualified personnel.

***Determinants of health inequalities.*** Social determinants of health have been identified as the main source of health inequalities. According to the WHO Commission on Social Determinants of Health (WHO, 2023), income, education, occupational status, living environment, and access to health infrastructure have a decisive influence on individuals' ability to obtain adequate care. People with low incomes often face direct financial barriers, such as co-payments, transportation costs, or lack of health insurance, as well as indirect barriers, such as lack of information or trust in medical institutions (Solar & Irwin, 2010).

In addition, ethnicity and gender play a significant role in perpetuating inequalities. European studies show that ethnic minorities, including Roma populations, face systemic discrimination in accessing healthcare services, including denial of treatment, stigmatising attitudes, or a lack of culturally trained medical staff (European Union Agency for Fundamental Rights [FRA], 2022). Women from disadvantaged backgrounds are also more exposed to reproductive health risks due to a lack of accessible family planning services and health education (European Public Health Alliance, 2021).

***Inequalities in a global and European context.*** Globally, the differences between high-income and low-income countries are evident. Developed countries have stable healthcare funding, advanced technologies, and sufficient staff, while low- and middle-income countries face chronic underfunding, shortages of essential medicines, and poor infrastructure (Daniels, 2008). These imbalances are exacerbated by the globalization of the pharmaceutical industry, which favors wealthy markets and leaves poor regions dependent on international support programs (Gostin & Meier, 2018).

In Europe, inequalities exist not only between countries, but also within them. The State of Health in the EU report (European Commission, 2023) highlights significant differences between Western and Eastern European countries in terms of both life expectancy and access to treatment. In Central and Eastern Europe, access to healthcare is limited by factors such as insufficient funding of the public system, institutional corruption, and migration of medical staff.

***Medical inequalities in Romania: a bioethical perspective.*** Romania offers a relevant example of the tension between declared ethical principles, universality and equity, and the social reality of the healthcare system. Although the Constitution and Law No. 95/2006 on health reform guarantee access to basic healthcare services for all citizens, multiple reports show that actual access is unequal (Vlădescu et al., 2021).

Geographical disparities are evident: rural areas, where approximately 45% of Romania's population lives, have a density of family doctors that is almost three times lower than in urban areas (National Institute of Statistics, 2024). In addition, rural patients are more exposed to indirect costs and delays in diagnosis, leading to higher mortality for treatable conditions (World Bank, 2022).

In addition to geographical differences, there are inequalities related to socio-economic status and ethnicity. Roma communities, for example, face double vulnerability: structural poverty and systematic discrimination. According to an FRA report (2022), over 30% of Roma in Romania stated that they do not have access to primary healthcare when they need it, citing lack of documents, communication barriers, and negative attitudes of medical staff.

These realities raise essential questions from a bioethical perspective: to what extent does the healthcare system respect the principle of distributive justice and the moral obligation to protect vulnerable people? As Daniels (2008) points out, a fair healthcare system must provide "access to a range of services that everyone needs equally in order to maintain normal life functions." In Romania's case, achieving this ideal requires not only administrative reforms, but also a moral paradigm shift, moving from a bureaucratic view of health to an ethic of solidarity and social equity.

***The moral dimension of inequities.*** Beyond statistics, health inequalities are a matter of moral justice. They affect human dignity and contravene the bioethical principle of non-discrimination. Lack of equal access to treatment is not just an administrative deficiency, but a form of social injustice that perpetuates suffering and exclusion (Sen, 2009). Contemporary bioethics emphasizes that reducing inequalities is not just a matter of efficiency, but a moral duty of the state and health professionals (Nussbaum, 2011; Prainsack & Buyx, 2017).

In this sense, promoting equity in health involves recognizing structural vulnerabilities and implementing public policies based on the principles of solidarity, justice, and respect for the dignity of everyone. Only in this way can a medical system be built that truly responds to the bioethical imperatives of the 21st century.

## 3. Bioethics of fairness and moral responsibility

The principle of justice, in a bioethical sense, cannot be understood separately from the moral responsibility of healthcare professionals and the moral obligations of healthcare systems. Equity in healthcare involves not only the fair distribution of resources, but also a moral attitude of solidarity, compassion, and respect for human dignity. In a profound sense, the bioethics of equity involves a shift from an ethic of individual obligation to an ethic of collective responsibility (Prainsack & Buyx, 2017).

***The moral responsibility of healthcare professionals.*** As a moral agent, doctors have a dual responsibility: to individual patients and to the community. Modern codes of ethics, including the Code of Ethics of the Romanian College of Physicians (2016), state that doctors must treat all patients "without discrimination, with respect for the dignity and values of each person." From this perspective, fairness is not just an abstract principle, but a concrete professional duty.

Beauchamp and Childress (2019) emphasize that the principle of justice applies directly to everyday clinical decisions: prioritizing patients according to urgency, recommending expensive treatments, or involvement in medical research. In each of these situations, the physician must balance individual interests with the common good, avoiding favoring patients based on social status, ethnicity or influence.

The moral responsibility of professionals also extends to combating the social determinants of inequality. As Ruger (2010) states, doctors cannot be mere executors of an unequal system but must actively participate in reforming the structures that cause suffering and exclusion. This means civic engagement, advocacy for patients' rights, and the promotion of equitable public policies.

***Medical ethics and the principle of non-discrimination.*** Modern medical ethics is closely linked to the principle of non-discrimination, recognized both in international law and in applied bioethics. Article 3 of the Universal Declaration on Bioethics and Human Rights (UNESCO, 2005) stipulates that "the interests and welfare of the individual must prevail over the sole interest of society or science," and Article 10 provides for the equality of all human beings in dignity and rights.

In medical practice, this principle imposes a moral obligation to avoid any form of discrimination based on sex, age, ethnicity, sexual orientation, disability, or socioeconomic status. However, recent studies show that implicit bias remains a reality in many healthcare systems, affecting the quality of care provided to vulnerable patients (Chapman et al., 2013). From a bioethical perspective, ongoing ethical training and critical reflection on one's own biases are essential tools for reducing these inequities.

***The ethics of solidarity in medical practice***. Solidarity is the central concept linking bioethics of equity to moral responsibility. It goes beyond the notion of individual compassion, representing a collective attitude aimed at protecting the most vulnerable members of society (Prainsack & Buyx, 2017). In the medical field, solidarity manifests itself through interdisciplinary cooperation, mutual support among professionals, but also through the defense of the interests of patients who cannot claim their rights on their own.

According to Nussbaum (2011), solidarity implies "the recognition of common humanity" and the moral obligation to support the development of everyone’s capabilities. In the context of medical care, this means that doctors should not limit themselves to treating the disease, but should approach the patient in a holistic manner, considering their living conditions and socio-economic vulnerabilities.

Solidarity can also be understood as an institutional expression of justice. Public health policies based on solidarity, such as joint financing through proportional contributions or guaranteeing universal access to essential medicines, are concrete forms of implementing the bioethics of equity (Daniels, 2008).

***The moral dimension of institutional decisions***. In a broader context, moral responsibility extends to health institutions and policies. According to Daniels (2008), health equity cannot be achieved through ethical individual behavior alone but requires a fair institutional framework. Decisions on resource allocation, setting therapeutic priorities, or regulating access to medical innovations must be evaluated considering fundamental bioethical principles.

This perspective implies a collective moral responsibility: society has a duty to create conditions in which every person has a real chance to reach their health potential (Sen, 2009). Thus, the bioethics of equity transcends the boundaries of clinical medicine, becoming an instrument of moral reflection on public policy and social justice.

## 4. Reflections and directions for action

Promoting equity in health is not just a technical-administrative issue, but a fundamental social ethical issue that involves the moral responsibility of doctors, institutions, and society. Bioethics of equity provides a solid theoretical framework for analyzing and correcting structural imbalances that affect access to healthcare, transforming the principle of justice into an operational value of the healthcare system.

***From principles to practice equity as a moral and political obligation***. As Daniels (2008) points out, health justice should be seen not only as an abstract ideal, but as a practical obligation of public policy. Implementing equity requires that decisions on funding, planning, and resource allocation be transparent, participatory, and oriented toward the real needs of the population. In this sense, integrating bioethical principles into the governance of the healthcare system beneficence, non-maleficence, autonomy, and justice is essential for strengthening public trust in healthcare institutions (Beauchamp & Childress, 2019).

At the same time, equity cannot be achieved in the absence of collective responsibility. As Sen (2009) points out, social justice involves the concerted action of all actors (state, professionals, communities, and patients) in reducing avoidable suffering and expanding the real freedom of individuals. In this context, public policies must include compensation mechanisms for vulnerable groups, such as subsidizing treatments for rare diseases, expanding the rural medical network, or providing cultural translation services for ethnic minorities.

***Ethical education and continuing professional development.*** One of the key areas of action in promoting equity is the ethical education of healthcare professionals. In many healthcare systems, including Romania, ethics is treated as a marginal theoretical discipline with no immediate practical application (Ruger, 2010). However, studies show that continuing education in bioethics and intercultural communication contributes to reducing implicit discrimination and improving the doctor-patient relationship (Chapman et al., 2013).

In addition to technical skills, medical education should include moral and reflective skills that enable future professionals to recognize and critically address inequalities in the system. In this regard, integrating the principles of solidarity and social justice into the university curriculum can contribute to the formation of an institutional culture of moral responsibility (Prainsack & Buyx, 2017).

***Public policies oriented towards social justice***. At the macro level, health equity depends on the institutional and political structure of the healthcare system. Public institutions must adopt policies based on data and ethical assessments, not just economic criteria. As Nussbaum (2011) states, a just state is one that creates "conditions for human capabilities," allowing everyone to achieve a healthy and dignified life.

For Romania and other countries in Central and Eastern Europe, priority areas should include:

- increasing public funding for health and preventive programs.
- reducing rural-urban disparities by stimulating the professional mobility of doctors.
- combating systemic discrimination in access to treatment.
- developing partnerships between the public sector, NGOs, and local communities to improve access to basic health services.

These measures are not merely administrative reforms, but practical manifestations of an ethic of solidarity, in which health is treated as a common good, not a commodity (Gostin & Meier, 2018).

***The ethics of solidarity as the foundation of health policies***. Solidarity, in the bioethical sense, offers a moral alternative to the neoliberal paradigm of efficiency and competition. It involves recognizing human interdependence and assuming shared responsibility for the well-being of all (Prainsack & Buyx, 2017). In health, this translates into the equitable redistribution of resources and constant support for disadvantaged groups.

Therefore, public policies should be built on the principle of active solidarity, which combines distributive justice with democratic citizen participation. This means involving patients and communities in decision-making, transparency in the allocation of funds, and an institutional culture based on mutual respect.

Bioethics of equity calls for a reconceptualization of the relationship between medicine, morality, and social justice. It reminds us that medicine is not only a science, but also a moral act. In a world marked by persistent inequalities, the application of bioethical principles, justice, solidarity, dignity, and respect becomes an essential condition for the sustainability of health systems.

True health reform cannot be merely institutional but must also be axiological: it begins with the recognition that every life has the same moral value and that access to treatment is not a privilege, but an expression of justice. Only through such an understanding can the bioethics of equity become not just a theoretical ideal, but a living practice of solidarity and humanity.

## Conclusions

Bioethical analysis of inequalities in access to medical treatment reveals a profound moral dimension of contemporary health systems. Equity is not simply an indicator of administrative performance, but an expression of social justice and human dignity. In a world where economic, geographic, and cultural differences continue to determine survival rates and quality of life, the bioethics of equity provides an indispensable normative framework for the moral reorientation of medicine and public policy.

The fundamental principles of bioethics autonomy, beneficence, non-maleficence, and justice take on increased relevance when interpreted through the lens of solidarity. As Beauchamp and Childress (2019) point out, bioethical justice cannot be reduced to a formal distribution of resources, but must ensure a morally equitable distribution, oriented towards the needs of the most vulnerable. In the same vein, Sen (2009) and Nussbaum (2011) argue that health is an essential condition of human freedom, and justice involves creating conditions that enable individuals to achieve their fundamental capabilities.

The paper showed that moral responsibility belongs equally to professionals, institutions, and the community. Doctors, as moral agents, are called upon not only to treat illness, but also to recognize and combat the social determinants of suffering (Ruger, 2010). At the same time, the state and health institutions have a moral obligation to ensure the structural conditions for equity: adequate funding, universal access, ethical education, and policies based on solidarity (Daniels, 2008).

It has also been pointed out that medical inequalities in Romania and Eastern Europe reflect a crisis of distributive justice, a gap between stated ethical principles and institutional practices. In this context, the bioethics of equity becomes not only a theoretical field, but also an instrument of social criticism and a call for moral transformation. Its implementation requires a twofold change:

1. *at the individual level, by cultivating empathy, moral reflexivity, and professional conscience.*
2. *at the institutional level, through public policies focused on solidarity, transparency, and democratic participation.*

Essentially, bioethics of equity invites us to rethink medicine as a moral practice of solidarity. True justice in health does not consist solely in equalizing resources, but in recognizing the equal value of every human life. Only by embracing this perspective can we build a healthcare system that not only treats disease but also repairs inequalities, thus reaffirming the moral mission of medicine as a profession dedicated to humanity.

## References

1. American Medical Association. (2021). *Ethics in telemedicine*. AMA.
2. Beauchamp, T. L., & Childress, J. F. (2019). *Principles of biomedical ethics* (8th ed.). Oxford University Press.
3. Chapman, E. N., Kaatz, A., & Carnes, M. (2013). *Physicians and implicit bias: How doctors may unwittingly perpetuate health care disparities*. Journal of General Internal Medicine, 28(11), 1504–1510. https://doi.org/10.1007/s11606-013-2441-1
4. Colegiul Medicilor din România. (2016). *Codul deontologic al medicului. București:* CMR.
5. Daniels, N. (2008). *Just health: Meeting health needs fairly*. Cambridge University Press.
6. European Commission. (2023). *State of Health in the EU: Romania – Country Health Profile 2023*. Publications Office of the European Union.
7. Gostin, L. O., & Meier, B. M. (2018). *Global health law*. Harvard University Press.
8. Greenhalgh, T., Wherton, J., Shaw, S., & Morrison, C. (2020). *Video consultations for COVID-19*. BMJ, 368, m998. https://doi.org/10.1136/bmj.m998
9. Mackenzie, C., & Stoljar, N. (Eds.). (2000). *Relational autonomy: Feminist perspectives on autonomy, agency, and the social self.* Oxford University Press.
10. Mill, J. S. (2001). *Utilitarianism*. Hackett Publishing. (Original work published 1863).
11. Nussbaum, M. C. (2011). *Creating capabilities: The human development approach*. Harvard University Press.
12. Pellegrino, E. D., & Thomasma, D. C. (1993). *The virtues in medical practice*. Oxford University Press.
13. Persad, G., Wertheimer, A., & Emanuel, E. J. (2009). *Principles for allocation of scarce medical interventions*. The Lancet, 373(9661), 423–431. https://doi.org/10.1016/S0140-6736(09)60137-9
14. Prainsack, B., & Buyx, A. (2017). *Solidarity in biomedicine and beyond*. Cambridge University Press.
15. Rawls, J. (1999). *A theory of justice* (Rev. ed.). Harvard University Press. (Original work published 1971).
16. Ruger, J. P. (2010). *Health and social justice*. Oxford University Press.
17. Rumbold, B. E., Baker, R., Ferraz, O. L. M., & Wilson, J. (2017). *Universal health coverage, priority setting, and the human right to health*. Oxford University Press.
18. Sen, A. (2009). *The idea of justice*. Harvard University Press.
19. Tronto, J. C. (1993). *Moral boundaries: A political argument for an ethic of care*. Routledge.

20. United Nations Educational, Scientific and Cultural Organization. (2005*). Universal Declaration on Bioethics and Human Rights.* UNESCO Publishing.
21. Vlădescu, C., Scîntee, S. G., Olsavszky, V., & Hernández-Quevedo, C. (2021). *Health system review: Romania*. World Health Organization, Regional Office for Europe.
22. World Health Organization. (2021). *Risk communication and community engagement (RCCE) action plan guidance: COVID-19 preparedness & response*. WHO.
23. World Health Organization. (2023). *Health equity and its social determinants: Global report 2023.* WHO Press.