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Discrimination in Ensuring the Nation's Public Health

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Abstract. The author in article analyzes the legal nature discrimination in the public health sector by defining its essence and identifying the categories of individuals belonging to discriminated groups within the healthcare system.

The article examines issues the discrimination in national healthcare, particularly institutional and structural discrimination. It is noted that institutional discrimination is typically manifested in the restricted access of certain groups to state healthcare policies through discriminatory regulations or indirect limitations. An example of this is an order issued by the Ministry of Health of Ukraine, which grants the right to use assisted reproductive technologies exclusively to married couples, thereby placing individuals in civil marriages at a disadvantage.

Structural discrimination encompasses the stigmatization certain groups, such as the elderly, children, and women, which results in unequal access to medical services due to gender, age, and ethnic barriers. In analyzing the impact of discrimination in healthcare services, the article highlights issues such as ageism, gender discrimination, and racial inequality, all of which negatively affect the accessibility and quality healthcare for vulnerable populations.

The article further emphasizes that gender discrimination significantly impacts access to healthcare services, treatment quality, and women's overall health. This often manifests in inadequate attention to women's health issues and structural barriers that limit their ability to receive necessary medical care. Additionally, the consequences of the COVID-19 pandemic for women, who have been disproportionately affected in the healthcare sector, are discussed.

It is also noted that national and racial minorities face a significant issue of distrust toward both medical personnel and the healthcare system as a whole. Medical distrust is conceptualized as a broad term encompassing both a general lack of confidence in medical institutions and skepticism specific to certain diseases or medical contexts. This phenomenon is particularly critical, as it weakens the patient-doctor relationship, ultimately undermining the principle of parity in healthcare interactions.

Keywords: discrimination, legal regulation, public health, medical law, national minorities, age discrimination, racial stigmatization, patient distrust in medicine.

Introduction

Public health is a crucial factor in the humanity survival and the advancement in future civilization. It plays a fundamental role in societal development, contributing to its positive ontological existence and influencing various social issues. In particular, public health is inextricably linked to economic well-being, demographic trends, and the quality life for future generations.

The urgency in a scientific legal analysis of public health at the national level arises from several pressing challenges in contemporary society. These

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include environmental issues, economic difficulties related to ensuring equal access to effective medical services, global transformations in the digital and technological spheres, and the military circumstances in which the Ukrainian people currently find themselves. The increasing levels of environmental pollution–particularly due to the use of military weapons and equipment–the destruction of natural ecosystems, the inadequate infrastructure of medical institutions, and the widespread incidence of severe injuries among both civilians and military personnel all underscore the need for robust legal regulation aimed at protecting and improving public health in Ukraine.

One of the most pressing issues in the field of public health is discrimination, which should be viewed as a violation of the social order governing human life and community. It constitutes a restriction or infringement of the fundamental human right to life and health and serves as a devaluing factor that negatively impacts the overall well-being nation. In jurisprudence, discrimination as a legal concept and phenomenon has been studied only superficially. This issue is often examined primarily in the violations context of the right to medical services. However, theoretical legal doctrine suggests that this understanding is insufficient. Therefore, a comprehensive analysis of discrimination in public health at the national level remains a critical and necessary area.

Literature Review

The issue of public health has already been examined by scholars in the fields of medicine, medical law, administrative law, and civil law. Various aspects of reproductive health as a public health component have been explored in the works of M. Blikhar, I. Zharovska, B. Shandy, and O. Zayats [1]. Issues related to the protection of children's and adolescents' health have been addressed by L. Jennings, A. S. George, and T. Jacobs [2]. The role of public organizations in the public health field has been analyzed in the studies of L. Muntyan [3]. Additionally, from the perspective of constitutionalism, public health has been examined by A. Silenko [4].

Despite the considerable attention, the scientific community, the study of public health, a comprehensive and systematic legal analysis of this issue remains insufficient. In particular, the manifestations of discrimination as a destructive social and legal phenomenon in the context of public health have not been thoroughly explored. Therefore, the purpose of this study is to analyze the legal public health nature through the lens of discrimination, highlighting its implications as a factor that undermines both social equity and legal protections.

Purpose

The purpose of this scientific article is to analyze the legal nature of discrimination in the public health sector at the national level by defining its essence and identifying the categories individuals who belong to discriminated groups within the healthcare system.

Methodology

In order to achieve the purpose of the study, it is appropriate to use an intercomplex methodological approach that allows for the multidisciplinary use of principles, knowledge and concepts to determine convincing conclusions. Since the issue studied in this article is a complex problem and concerns aspects of medicine, sociology, social science and law, it is appropriate to use a balanced approach to their combination, which allows taking into account the complexity of the public health problem and its impact on various spheres of the nation's life.

Additionally, a synergistic methodological approach is utilized, enabling the incorporation of the best achievements of legal science and practice. This approach facilitates the assimilation of legal information, the formation comprehensive understanding research subject, and the identification key trends in its development within the dynamic and unpredictable legal and political landscape.

Results and Discussion

Discrimination in ensuring public health at the national level manifests in various forms and is primarily linked two key legal gaps.

The first is institutional discrimination, which has a state-normative nature and involves the oppression, restriction, or denial of access for certain individuals or groups–those possessing characteristics subject to discrimination–to the formation and implementation of state health policy. Discri-

mination may take a regulated form, explicitly embedded in legal norms and regulations, or it may be unregulated and indirect, where existing laws do not explicitly indicate unequal treatment but nonetheless create conditions that place individuals or groups in a disadvantaged position compared to the majority or a reference group. This form of discrimination is often systemic and global, reflecting structural deficiencies not only in the healthcare sector but also in state governance and policymaking.

A clear example of this issue can be found in contemporary legal practice. The Order of the Ministry of Health in Ukraine "On Approval of the Procedure for the Application of Assisted Reproductive Technologies in Ukraine" [5], dated September 9, 2013, No. 787, grants the right to use such technologies only to spouses or single women. This provision effectively excludes individuals in civil partnerships from accessing assisted reproductive technologies, placing them in a disadvantaged and discriminatory position. According to Article 21 of the Family Code of Ukraine, a spousal relationship is defined as a legal union between a man and a woman, officially registered with the State Civil Registry Office [6]. This legal limitation demonstrates how institutional discrimination can restrict access to medical services based on marital status.

The second major form of discrimination is structural discrimination, which relates to the stigmatization of specific groups. This type of discrimination is often associated with structural racism, a concept defined as the systemic structuring opportunities and the value attribution based on race, leading to the unfair disadvantage of certain individuals and communities while privileging others [7]. However, we argue that structural discrimination extends beyond racial factors, encompassing a broader spectrum of marginalized social groups. These include women, the elderly, individuals with disabilities, LGBTQ+ persons, and economically disadvantaged populations, all of whom face barriers in accessing equitable healthcare services.

Discrimination in healthcare is defined as negative actions or a lack of consideration toward an individual or group based on preconceived notions about their identity. Importantly, individuals do not need to belong to a marginalized group to experience discrimination; rather, discrimination can occur based on perceived group membership. Moreover, the existence of discrimination does not necessarily require direct harm; a group may be considered discriminated against if it consistently receives lower-quality healthcare services than another group solely due to factors such as race, ethnicity, gender, disability, social class, socioeconomic status, sexual orientation, gender identity, primary language spoken, or place of residence.

Discrimination can affect any individual, regardless of age, sex, social or economic status, physical condition, or other personal characteristics. While anyone may become a target of discriminatory devaluation, certain groups are particularly vulnerable to systematic discrimination within the healthcare sector. For example, recent research indicates that white men are twice as likely to receive excellent or good end-of-life healthcare, followed by white women (with a score of 1.75 points), whereas Black men and Black women are the least likely to receive adequate medical care in geriatric healthcare facilities [8].

Defining discriminated groups in more detail. The first group subject to discrimination in healthcare consists of the elderly and young children.

Strategies for sustainable development–both at the national level and globally–link progressive societal development to key factors such as public health. Notably, the Sustainable Development Goals (SDGs) emphasize the need for comprehensive global improvements in this area. Goal 3 specifically underscores the importance of ensuring a healthy lifestyle and well-being for all individuals, regardless of age. A critical focus of this goal is age-based discrimination in medicine, which is particularly prevalent. Issues of praxeological significance often arise at the two age extremes–early childhood and old age. Goal 3.2 highlights the necessity of reducing early childhood mortality, while Goal 3.7 stresses the importance of access to reproductive healthcare. Additionally, Goal 3.9 seeks to mitigate negative environmental impacts on health. However, while these components explicitly address children's health, the SDGs do not specifically reference the elderly or their unique healthcare needs. Despite this omission, several indirect indicators within Goal 3 pertain to aging populations. For instance, the strategy to reduce premature mortality from non-communicable diseases includes the most prevalent conditions affecting older individuals, such as

cardiovascular diseases, cancer, diabetes, and chronic respiratory illnesses. Furthermore, mental health preservation–including efforts to combat dementia and Alzheimer's disease–is essential for ensuring well-being in old age. Goal 3.8 further reinforces this need by emphasizing universal health coverage for all individuals, including older persons.

Despite the legal frameworks aimed at ensuring equitable healthcare, ageism in medical services remains a significant public health challenge, particularly in geriatric medicine. In practice, ageism manifests in multiple forms of discrimination, affecting the ethical provision of care. These range from "micro" issues, such as paternalistic medical attitudes and therapeutic nihilism, to "macro" systemic barriers, including delayed or inaccessible medical treatment and exclusion from clinical research trials [9].

In non-crisis situations, age is already a determining factor in the routine allocation of hemodialysis machines, scarce organ transplants, and elective surgeries. However, during the COVID-19 pandemic, age played an even more significant role in medical decision-making. Consider the following examples: in Italy, the Italian Society of Anesthesia, Analgesia, Resuscitation, and Intensive Care (SIAARTI) recommended setting an age limit for admission to intensive care units (ICUs) [10]. Similarly, in Spain, some healthcare institutions proposed denying artificial lung ventilation to patients over 80 years old while using the frailty scale as a criterion for patients aged 70 to 80 [11].

The second group facing systemic discrimination in healthcare is women, particularly in the context of reproductive health. The most prevalent form of discrimination in this regard is gender-based discrimination, which significantly affects access to medical services, the quality of treatment, and women's overall health.

Gender discrimination often manifests as insufficient attention to women's health issues, along with structural barriers that limit women's ability to access necessary medical care. Women frequently encounter obstacles in accessing reproductive health services, including contraception, abortion, and pregnancy care. In many countries, legal or societal restrictions make these services difficult to obtain, negatively impacting women's health outcomes. Additionally, medical research often neglects physiological differences between men and women, leading to less effective diagnosis and treatment for female patients.

The most significant gender disparities tend to widen during periods of military conflict, political instability, and legal crises. Scientific research has highlighted that the COVID-19 pandemic disproportionately affected women in various ways. Studies have demonstrated its impact in areas such as: disruptions in women's medical treatments [12]; failures in reproductive health services [13]; an increase in gender-based violence against women and girls [14]; higher levels of coercion for women to receive vaccinations [15].

Furthermore, experts argue that in countries with high levels of structural sexism–pervasive across domestic, social, and public life–women were significantly less likely to seek preventive healthcare services [16].

The Third Group is National and Racial Minorities. Discrimination against national and racial minorities in healthcare is a multidimensional phenomenon that reflects deep-seated structural inequalities and systemic biases within the healthcare system. It manifests not only through direct barriers to accessing medical services but also via latent mechanisms of social exclusion that heighten the vulnerability of these groups. Language barriers, cultural misalignment in medical practices, and economic instability contribute to a complex system of exclusion, wherein ethnic identity becomes a determinant of medical marginalization.

In addition to facing institutional discrimination, this group also struggles with medical distrust, which affects their engagement with healthcare services. Medical distrust is a broad term encompassing both a general lack of confidence in the healthcare system and specific concerns related to particular diseases or medical contexts. This issue is particularly critical, as it weakens the patient-doctor relationship, disrupts parity in medical interactions, and ultimately compromises healthcare outcomes.

Empirical research and field studies conducted by leading experts in the United States underscore the significance of this problem. California Department of Family Medicine has found that racial and ethnic background is strongly associated with levels of medical distrust. Specifically, non-Hispanic Black and Latino adults exhibit critically reduced

levels of trust in healthcare institutions–up to 73 %–compared to white non-Hispanic adults. Researchers report that this mistrust often escalates to alarming levels, leading some individuals to completely avoid seeking medical care, even in cases of acute health issues [17].

The roots of medical distrust among racial and ethnic minorities are multifactorial, stemming from both historical injustices and contemporary instances of medical negligence. Many minority communities remain deeply aware of past medical abuses, including unethical experimentation and systemic medical violence, which further reinforce their skepticism toward healthcare institutions.

The medical distrust present within these communities must be effectively addressed, as these groups are more likely to engage in behaviors detrimental to their health due to this mistrust. These behaviors include poor health management, low adherence to medical appointments and recommendations, reduced utilization of healthcare services, and decreased participation in preventive care programs [18].

Racial and ethnic disparities in healthcare can be attributed to multiple factors, including the role of healthcare providers themselves in perpetuating these inequalities. Previous research has demonstrated that general practitioners often exhibit implicit or explicit biases toward patients of ethnic and racial minority backgrounds. Although these biases contribute to unintentional discrimination, they have been found to directly influence medical decision-making, thereby exacerbating disparities in healthcare access and treatment outcomes [19].

The interaction between healthcare professionals and patients of diverse ethnic and racial backgrounds is shaped not only by sociocultural influences but also by deeply ingrained cultural perceptions of medicine and health. This raises critical legal and ethical questions regarding how prejudices impact the quality of healthcare services and how these disparities are reflected in patient outcomes.

As a social institution, medicine is not immune to cultural stereotypes and biases, which may unintentionally influence healthcare professionals' attitudes and practices. Addressing this issue requires not only education and training for medical practitioners but also systemic reforms aimed at promoting cultural competence and eliminating discrimination in healthcare settings.

The categorization of vulnerable groups in the healthcare sector, as presented in this study, is reinforced by the scientific perspectives of numerous experts, who have demonstrated that historically marginalized communities continue to bear a disproportionate burden of disease and experience significant healthcare disparities [20; 21].

Conclusions

The legal nature of discrimination in the public health sector is characterized by a dual structure: 1. Institutional discrimination, which is state-normative in nature and involves oppression, restrictions, or the exclusion of certain individuals or groups–based on discriminatory characteristics–from participating in the formation and implementation of state health policies. 2. Structural discrimination, which manifests in the stigmatization of specific social groups, further deepening inequalities in healthcare access and treatment.

This study has demonstrated a clear correlation between discrimination and health outcomes, with disparities strongly influenced by race, ethnicity, gender, and age. These systemic inequalities not only hinder access to quality healthcare but also contribute to broader social and legal challenges that require urgent policy interventions and legal reforms.

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Дискримінація у сфері забезпечення громадського здоров'я нації

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Анотація. Авторка статті здійснила аналіз правової природи дискримінації у сфері громадського здоров'я нації через встановлення її сутності та виокремлення категорій суб'єктів, які належать до дискримінованих груп осіб у сфері охорони здоров'я.

У статті розглянуто проблеми дискримінації у сфері охорони здоров'я нації, зокрема інституційну та структурну дискримінацію. Констатовано, що інституційна дискримінація зазвичай виражається в обмеженні доступу окремих груп до державної політики у сфері охорони здоров'я через дискримінаційні норми або непрямі обмеження. Прикладом цього є Наказ Міністерства охорони здоров'я України, який визначає право на використання допоміжних репродуктивних технологій лише для подружжя, що ставить осіб у громадському шлюбі в нерівне становище.

Структурна дискримінація охоплює стигматизацію окремих груп, таких як люди похилого віку, діти та жінки, що пов'язано з нерівним доступом до медичних послуг, а також гендерними, віковими та етнічними бар'єрами. Аналізуючи вплив дискримінації у сфері медичних послуг, підкреслено проблеми, зокрема ейджизму, гендерної дискримінації та расової нерівності, що негативно позначаються на доступності та якості медичних послуг для вразливих груп.

Констатовано, що гендерна дискримінація значно впливає на доступ до медичних послуг, якість лікування та загальний рівень здоров'я жінок. Часто вона проявляється у недостатній увазі до жіночих проблем у сфері охорони здоров'я, а також у структурних бар'єрах, що обмежують можливості жінок отримати потрібну медичну допомогу. Також обговорюються наслідки пандемії для жінок, які зазнали значного негативного впливу в галузі охорони здоров'я.

Узагальнено, що в групі національних та расових меншин спостерігається проблема недовіри пацієнтів як до медичного персоналу, так і до всієї системи охорони здоров'я. Медичну недовіру позиціоновано як загальний термін, який охоплює як загальне почуття недовіри до медичної установи загалом, так і недовіру, специфічну до однієї хвороби чи контексту. Вона має істотне значення, оскільки руйнує зв'язок між пацієнтом та лікарем, усуває паритетність таких відносин у сфері охорони здоров'я.

Ключові слова: дискримінація, правове регулювання, громадське здоров'я, медичне право, національні меншини, вікова дискримінація, расова стигматизація, медична недовіра пацієнта.