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From health inequalities to equitable health equality: ethical governance in healthcare empowers equity as social justice

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ABSTRACT

Global millennium healthcare ambition to attain equitable health equality as a prelude to achieving health for all is challenged by increasing health inequalities. First, diversity in the contemporary world is emerging as the unreckoned determinant of health inequalities, and second, the healthcare intervention modalities to subdue health inequalities amidst diversity and attain equitable health equality are not yet sufficiently articulated to help. Thus, the objective of this research is to illustratively demonstrate an innovative healthcare intervention framework to subdue health inequalities amidst diversity, that is, how ethical governance in healthcare empowers equitable intervention against diversity with the impetus of social justice to minimize health inequalities and attain equitable health equality. This healthcare intervention mechanism informs context-sensitive healthcare efforts to ensure that all the people in need communities and individuals are given equal opportunities to have what it takes to be healthy.

KEY WORDS: health inequalities, health equality, health equity, ethical governance in healthcare, equitable health equality, social justice in healthcare.

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INTRODUCTION

Health is one of the universal human rights and aspirations rated a basic human need that everybody should enjoy [1, 2]. To this effect, the Global Healthcare Taskforce established the millennium ambition to attain *equitable health equality* as a prelude to achieving *health for all*, the ambition they further emphasized that it is "leaving no one behind" [3]. This ambition was again underscored in the *Sustainable Development Goals* with the universal intention "to assure human rights to health for all at all ages" (Goal #3) [4]. The multidimensional struggle towards the realization of this ambition is not achieving much, and health inequalities among and across the peoples of the world are instead increasing: between the global North-South societies [5]; across European countries [6]; within the Global South [7]; and with Indigenous peoples [8], just to name but these few.

To begin, the main causes of this failure are perceived at both the micro and macro levels of healthcare. At the micro level, the distinction between the concepts *equity* and *equality* in healthcare are not well established to help healthcare professionals practically apply them as complements to attain *equitable health equality*. As this weakness impedes or distorts strategic healthcare intervention processes amid diversity, inequalities instead increase [9]. We are talking of health inequalities referring to the *unfair* and *avoidable* health disparities that result from systematic differences in key health determinants between groups of people from different social settings [10, 11]. These are health differences resulting from socially determined circumstances and behaviour that can be detected, managed and avoided [12].

Thus, unlike other health disparities that might be biologically defined, we distinguish health inequalities by the fact of their being *avoidable* and *unfair* because we have great control over them. For example, we may not have control over any health disparities that come with aging because they are biologically defined, but

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we have managerial control over the diversity that defines the functionality of various social determinants of health. We need to apply an equitable healthcare intervention strategy to overcome diversity and assure health for all; otherwise we risk increasing health inequalities. This is one of the reasons for which the prevalence of health inequalities also infers failure to avoid or to overcome the *avoidable* disparities that infringe the *fairness* of human rights to health and wellbeing [13]. At the macro level, both the political and professional *governing* structures of the healthcare systems do not coherently harmonize various determinant of health to galvanize healthcare intervention processes towards the realization of this ambition. Given that various determinants of health are the individual factors that influence human health amidst diverse healthcare needs across the populations, we must harmonize these determinants to satisfy 1) the diversity that characterizes various healthcare needs of the populations, and 2) the universality of human rights to health for all. Therefore, while recognizing this harmonization process as indispensable and central in healthcare intervention amidst diversity, we classify *governance*[1] as the structural determinant of healthcare, and its harmonization responsibility as the main aspect of *ethical governance in healthcare*.

To this effect, healthcare stakeholders, partners and policymakers must exploit the impetus of ethical governance in healthcare to subdue health inequalities and attain *equitable health equality* to assure human rights to *health for all*. But how can they exploit the impetus of *ethical governance in healthcare* to subdue *health inequalities* to attain *equitable health equality*? Our main objective in this article is to demonstrate an innovative healthcare approach against health inequalities amidst diversity: how the insight from ethical governance in healthcare could guide the healthcare intervention process to overcome health inequalities and attain equitable health equality. It is, therefore, clear that while the key theme of this research – equitable health equality – is a novel millennium concept that is not yet extensively developed in the scientific literature, both the conceptual and theoretical framings of the research are innovative.

Thus, we used a *thematic-based research* procedure in which we identify, extract, analyse, incorporate, and harmonize themes relevant to the research question [14]. Also, as necessitated by these novel characteristics, we will adopt a step-by-step illustrative demonstration to clearly show how ethical governance in healthcare supports equity with the impetus of social justice to confront diversity and give equal healthcare opportunity to all those in need. Though these illustrations and demonstrations will be prototypical, they will underscore the importance of context-sensitive intervention as an aspect of the pragmatic interdisciplinary perspective of applied ethics that enforces equity in healthcare. As such, this article constitutes the ideal guide for the calibration, distribution, and application of the available healthcare resources, especially as the fundamental analysis of healthcare intervention.

[1] We are talking of *governance* referring to the notion of the World Bank as the utilization of the institutional power to determine the distribution and use of resources for the benefit of the whole society without discrimination.

OPERATIONALIZATION

EQUITY IN HEALTHCARE TO MINIMIZE HEALTH INEQUALITIES

Ever since the early 1980s when the knowledge about health inequalities came to light [15], this healthcare disparity among and across the populations of the world had been increasing. Many people are thus tempted to believe that we only have to accept these inequalities and live with them. Proponents of this school of thought often associate health inequalities only with the socio-economic health factors, thereby attributing them to some people in the same way income is directly assigned and indexed to individuals [16]. They often forget that we determine, evaluate, and target health inequalities from the prevailing bio-socio-environmental factors that vary from one context to another, the reason for which these inequalities are avoidable [11, 17]. That notwithstanding, the WHO holds to the millennium ambition to attain equitable health equality and give everyone equal opportunity to be healthy, thus calling for equitable healthcare to minimize health differences between people or groups of people [18]. The initiation of this ambition instigated questions within the scientific community because identifying, targeting, and redressing health inequalities involve interdisciplinary normative judgment that applied science alone cannot determine [19]. As such, there has been a critical re-examination of the causal interconnections that lead to health inequalities, thereby opening up for collaborative interdisciplinary context-sensitive efforts. We need interdisciplinary context-sensitive knowledge in healthcare to determine how health inequalities are experienced under different contexts, especially by the vulnerable [16].

This knowledge facilitates the implementation of the equitable healthcare intervention process to overcome diversity. Equitable healthcare intervention is a recommended procedure to fight health inequalities because health inequalities unexpectedly increase or result from less strategic healthcare intervention models *vis-à-vis* diversity. When the calibration and the distribution of healthcare resources and services amidst diversity or in a situation of health inequalities are based on equality (equal distribution), there is a great risk of instead increasing health inequalities by disfavouring the worst-off populations. Equal distribution of the resources and services will render the situation of the better-off group excessively positive, while that of the worst-off group worsens, thereby increasing the inequality gap [9]. As the better-off group is comparatively over-rewarded,

judging from the difference in their healthcare *needs*, the worse-off group is relatively under-rewarded, and their health records become more negative. The outcome can be even more drastic if more resources are invested in the better-off society/populations than on their worst-off counterparts. We apply an imaginary scenario (Blue and Orange societies in Figure 1 below) to demonstrate the consequences of an ideal situation in which stakeholders used an equal healthcare intervention process in a situation characterized by health inequalities.

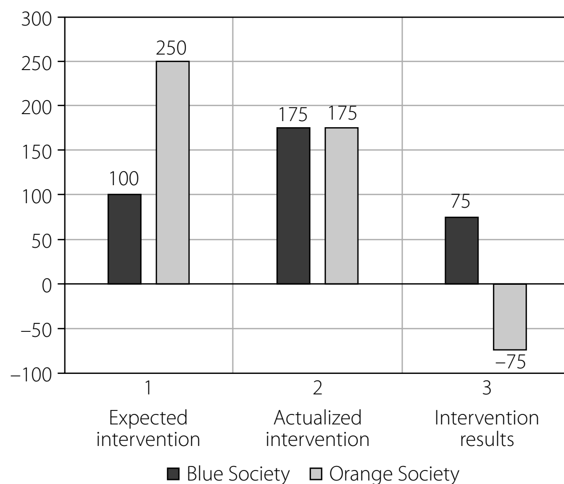


FIGURE 1. Equality in healthcare intervention

Y axis = Value. When reading it for morbidity, each spacing equates to 50 cases. When reading it for intervention, each spacing is valued at US$ 50M, henceforth written simply as $.

X axis = intervention categories (sections).

Blue bars indicate the amount/value of the intervention resources for 'Blue Society'.

Orange bars indicate the amount/value of the intervention resources for 'Orange Society'.

Figure 1. We imagine two societies manifesting health inequalities in their morbidity cases. The Blue Society has the morbidity of 100 cases, and the Orange Society has the morbidity of 250 cases. Estimating that $1 could cure one case, health stakeholders are entitled to intervention resources worth $350. As the 'expected intervention' (section 1 of the X-axis), $100 could go to Blue Society for its 100 cases and $250 to the Orange Society for its 250 cases. But based on **justice**, stakeholders agreed on equal intervention worth $175 to each of the two societies (section 2 of the X-axis). This move is in perfect accord with justice as a measure that satisfies equality. In the light of our explanation above, we see that the Blue Society is unjustly over-rewarded by +$75 because it needs $100, but justice gives $175. In the same way, the Orange Society is unjustly under-rewarded by –$75 because it needs $250, but justice gives $175 (section 3 of the X-axis). At the end of the intervention, the Blue Society has the pending excess of +$75 (superfluous) while the Orange Society is still at –$75 (deficit). This situation still maintains health inequalities of 150 cases between the two societies because the Blue Society has enough to cure any 75 cases that arise while the Orange Society still has 75 cases in need of resources to cure. The situation of the worst-off (Orange Society) risks becoming chronic and more endemic. With equal healthcare intervention as an act of justice, the problem of health inequalities is not solved, nor is the targeted illness eliminated.

The inequality gap could increase wider if the Blue Society were awarded more resources than Orange Society. As a practical example, during the era of the Millennium Development Goals, while 58.45% of malaria cases in sub-Saharan Africa (SSA) were being recorded in the Western part, 61.07% of antimalarial funding and research was instead directed to the Eastern part. Consequently, within that period of 2000 to 2016 malaria became holoendemic in many countries in the Western part with enormous increases in malaria comorbidities and deaths as compared to countries in the Eastern part [20, 21]. For example, Niger recorded a 13,058 malaria death increase and Tanzania recorded a 19,335 malaria death decrease. While this disequilibrium widens the health inequality gap across countries, it also complicates the fight against malaria in that part of the world. Though it however favours the populations of many countries in the eastern part of SSA, it safeguards malaria in a larger part of SSA, thereby maintaining the position of SSA as the epicentre of the global malaria burden [22]. Thus, from the pragmatic perspective of applied ethics, healthcare justice should be moderated with the philosophy of fairness through equitable healthcare intervention so that all the people are given an equal healthcare opportunity. We can better and rapidly minimize health inequalities with equity in healthcare intervention (equitable input amidst diversity) to obtain equitable equality (equal healthcare opportunity) in outcome. Unlike the case of equality in healthcare intervention demonstrated above (Figure 1), the operationalization of the equity in healthcare intervention is based on healthcare *need*. In equitable healthcare intervention, we calibrate the distribution of the available resources and design the intervention strategy according to the gradient of *need* as enforced by the ethics of care and of human rights to health [11]. This dimension takes us to the idea of social justice in healthcare, which is based on distributive justice (the fair allocation of resources) to satisfy the health needs of a wider population. It yields more in qualitative than quantitative units by helping to improve the quality-adjusted life years (QALYs) of the populations. Equitable healthcare intervention aims not only at preventing inequalities, but also at preventing or mitigating the resulting effects of health inequalities [9].

As such, it helps to attain *equitable health equality* as a prelude to achieving *health for all* (Figure 2).

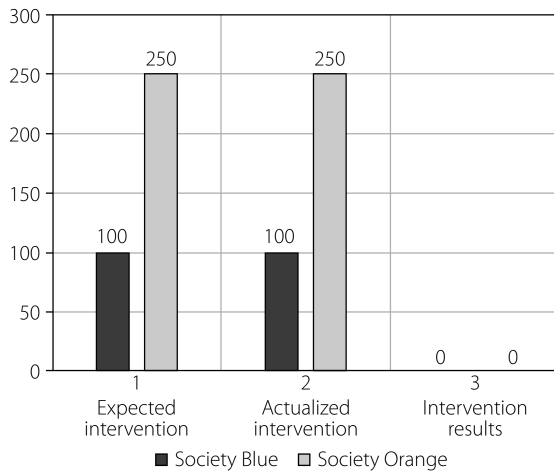
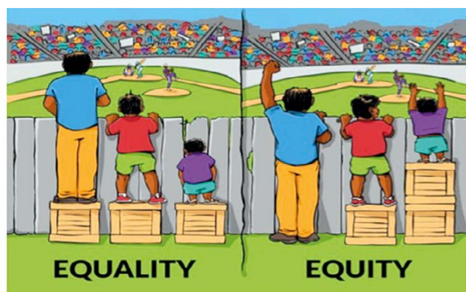


FIGURE 2. Equity in healthcare intervention

All the referencing and readings in Figure 2 are the same as in Figure 1 above.

Figure 2. As already explained in Figure 1, the Blue Society expects $100 to cure its 100 cases (expected intervention), and they gave them the amount they needed (actualized intervention). In the same way, the Orange Society needs 250$ to cure all its 250 cases (expected intervention), and they gave them the amount they needed (actualized intervention). This is equitable healthcare intervention, and it is 'need' that has determined the intervention process/amount. The Blue Society does not feel cheated since the amount given is the amount they needed/expected, though smaller than that of the Orange Society. All the cases are eliminated to zero (intervention results) because the two beneficiary societies are justly rewarded.

Here, we diagrammatically illustrate the difference between 'equality' and 'equity' in the distribution of (health) resources with the artistic work of Augus Maguire (Figure 3).



Reproduced with thanks from Interaction Institute for Social Change | Artist: Angus Maguire. Original available from interactioninstitute.org and madewithangus.com

FIGURE 3. Diagrammatic illustration of 'equality' and 'equity'[2]

[2] We have this image thanks to the online publication by Rachel Kwiatkowska in 2016: https://www.healthknowledge.org.uk/public-health-textbook/medical-sociology-policy-economics/4c-equality-equity-policy/balancing-equity-efficiency (Accessed on 10/06/2019). Permission to reuse the image was granted by its publisher Healthknowledge - phast (enquiries@phast.org.uk), signed by Dr Catherine Brogan – PHAST CIC (catherine.brogan@phast.org.uk).

Figure 3. With equality, the available resources (footstools) are equally distributed, despite the visible inequalities (height differences). With that method, the inequalities are not redressed, nor is equality in the outcome achieved (for all spectators to watch the game). The worst-off (the shortest) spectator cannot watch (enjoy) the game like others. On the contrary, with equity, the available resources (footstools) are distributed equitably according to need. Equity simultaneously redresses the inequalities (height differences) and achieves equality in the outcome for all spectators (to watch the game) including the worst-off (the shortest) spectator. When we reflect this analogy in the concept of health inequalities, the latter scenario sheds light on the achievement of the equitable health equality through health equity.

FROM HEALTH INEQUALITIES TO EQUITABLE HEALTH EQUALITY: ETHICAL GOVERNANCE IN HEALTHCARE AS SOCIAL JUSTICE IN HEALTHCARE

Among the many recurring complications in global healthcare, there have always been difficulties in the harmonization and contextualization of the universal healthcare theories to implement context-sensitive healthcare interventions in a world characterized by diversity. Many people within the scientific communities have long had serious disagreements over the call to tailor health policies, politics and practice to suit contextual health realities [23]. Then, there came a time when these differences and disagreements generated some unpredicted professional complications that corrupted healthcare systems, ruined practical healthcare efficiency, and distorted pathways to achieving expected healthcare results. This situation necessitated the practical inculcation and enforcement of ethical theories and virtues in the healthcare domain to harmonize differences and regulate healthcare interventions [24, 25]. This idea gained wide endorsement from many health stakeholders and policymakers who believed that the link between theoretical healthcare knowledge and practical healthcare intervention is better discerned and understood with ethical governance in healthcare. Generally, ethical governance takes conscience and behaviour beyond the role of law [25] with the practice of *reflective equilibrium.* Reflective equilibrium facilitates the acquisition of context-sensitive knowledge, thereby enabling the proper application of various principles [25, 26]. Though the process of reflective equilibrium *per se* may require common acceptance, the disposition of ethical governance in healthcare uses mainly that process to assure rigorous testing and refinement of context-sensitive facts and data. Ethical governance in healthcare has no established definition other than the embodiment of the ethical decision-making processes in healthcare that satisfy the interests of the community served and that of stakeholders involved [27]. It upholds various

principles of the pragmatic interdisciplinary ethics with the axiom that theories and principles are useless unless they enhance action, practice, and experience [28]. Ethical governance in healthcare comes into play when each leading authority (political or professional) involved at any stage of the healthcare intervention process organizes various determinants to satisfy diversity according to contextual healthcare needs. While the insight from ethical governance in healthcare is enforced by the respect for human rights to health, it also instructs healthcare stakeholders and partners to respect various stages of the healthcare intervention processes. It invigorates the analytical capacity of health professionals with the autoregulatory system of applied ethics to exploit the ethical values embedded in necessary ethical dispositions of efficient management: 1) ethical enquiry that lures professionals into seeking context-sensitive knowledge through investigative question-answer processes; 2) ethical deliberation that encourages authorities to listen to colleagues/subordinates and seek collaborative and interdisciplinary engagements; 3) ethical regulation that necessitates honesty, integrity, respect, responsibility, trustworthiness and concern for others in all actions and decision-making; 4) ethical supervision where authorities exercise personal responsibilities with the sole aim of solving the problems in question; 5) ethical interaction where relations prioritize altruism and respect for others. This impetus goes further to answer context-sensitive questions to equalize intervention with contextual healthcare realities [24, 29]. Among many such questions are the following: What are the categories of the determinants of health inequalities in the society in question? Which health services do they need? What factors can possibly deter or enhance the intervention process? This investigative healthcare intervention procedure produces context-sensitive information that satisfies the hetero-regulatory stem of applied ethics. Thence, the two systems, autoregulatory and hetero-regulatory, complement one another to render the intervention process equitably efficient as an aspect of social justice. As mentioned above, governance as systems or individuals has the structuralizing responsibility to ensure the effectiveness of this ethical process in the domain of healthcare: the WHO has the global responsibility; regional organizations have continental responsibility; Ministries of Health have national responsibilities; heads of hospitals and healthcare units have the responsibility towards their workers and patients, etc. For example, when COVID-19 was declared an epidemic, the *European Commission-backed Access to COVID-19 Tools (ACT) Accelerator* was launched. In its responsibility as the structural determinant of healthcare, it established a framework for the equitable intervention and distribution of COVID-19 vaccines and therapeutics. This initiative was immediately endorsed during the G7 summit of June 2020, supported by the G20 states involved in the development of COVID-19 countermeasures [30]. While it is obvious that this mission set by the G7 might not have been easy, we believe it greatly contributed to subduing COVID-19 in less than four years despite its magnitude. That notwithstanding, the global call for healthcare systems to attain equitable health equality remains challenging, given that "equity is not the same as equality" [11]. Nonetheless, this call remains a measurable strategy to fight health inequalities and influence the health lives of the least advantaged populations. Thus, as the highest global healthcare authority, "WHO must play a central role in planning and coordinating the implementation of the equitable frameworks" (p. 2463). Any governing system that promotes equitable access to healthcare measures envisaging equitable health equality needs to earn the confidence of the international community [30]. Equitable health equality signifies the situation in which the calibration of the available healthcare resources and the distribution of the healthcare services among and across the populations are based on the degree of healthcare need. While the intervention (the calibration and distribution) mechanism is equitable (according to need), the outcome is the equal healthcare opportunity it gives to the populations in need (Figure 4). That is, when we determine the distribution process of the available resources and services from people's healthcare needs, the outcomes provide equal health opportunities to all the populations [31].

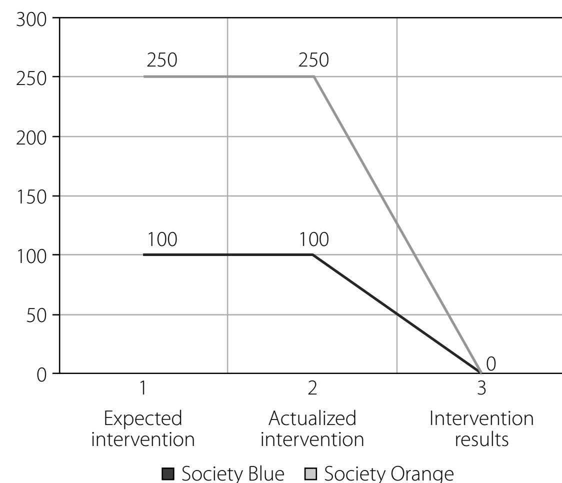


FIGURE 4. Equitable health equality

All the referencing and readings in Figure 4 are the same as in Figure 1 above.

Figure 4. With equitable healthcare intervention where the allocation of the intervention resources is according to need (expected), the two societies have obtained equal results (outcome). Thus, the graphs of the Blue Society and the Orange Society have finally converged to a common point of value 0 (intervention results). While we base the intervention strategy on equity (need), the outcome is equal (equality) as all the cases identified in these societies

are eliminated, bringing the two societies to equality at 0. This is 'equitable health equality', and it would not be possible with equal healthcare intervention. Acknowledging that no such perfection can ever be reached in healthcare, this example is only a prototype signifying that in equitable health equality, all countries record changes.

It thus goes without saying that we need the unconditional provision of "equal access for equal need" [32] to attain equitable health equality. That is, we need to provide equal access to healthcare services to people with equal healthcare needs, and unequal access to healthcare services to those with unequal healthcare needs. We refer to the former as horizontal equity because it "implies equal treatment or satisfaction for equal needs"; and to the latter as vertical equity, which "implies that individuals with unequal needs should be treated unequally [not as discrimination] according to their differential needs" [33]. From another perspective, we look at the horizontal equity as the equal treatment of equals compromised by fair outcomes, and at the vertical equity as the unequal but fair treatment of the 'unequals' compromised by a fair process [34]. When we apply equity in healthcare intervention (Figures 2 and 4), we provide fair treatment in the distribution of the available resources, and get equal outcomes in the elimination of the disease, thereby giving equal opportunity to all the citizens to be healthy. Nonetheless, we still have some confusion on the practical reality of the notion of *equal access for equal need*. We use the term *access* with reference to the opportunity or the ease with which people or communities can get appropriate healthcare services in proportion to their need [35]. But the phrase "equal access for equal need" (p. 655) entails "the ability to secure a specified set of healthcare services, at a specified level of quality, subject to a specified maximum level of personal inconvenience and cost, while in possession of a specified amount of information" [32]. The overriding position of the term *specified* in this notion signals the unavoidable process of contextualization when designing and implementing healthcare policies to capture the specific determinants of health inequalities in the specific regions/locations/countries to help stakeholders address specific healthcare needs. This is another area where the insight from ethical governance in healthcare becomes primordial in the process of healthcare intervention. It inspires and supports stakeholders to detect and direct the available resources to the populations that direly need them, when they direly need them, and in the quantity they direly need.

DISCUSSION

All national and international healthcare systems always wish to achieve health efficiency and health equity. While health equity aims at minimizing the avoidable health differences among the populations with the available resources, we achieve health efficiency when we use the available health resources to maximize the health of the populations. The main objective of these two healthcare qualities is to give the disadvantaged and vulnerable populations equal opportunity to be healthy [36]. The insight from the intervention procedure initiated with ethical governance in healthcare suggests that we apply an equitable intervention process to confront contextual diversities and obtain health efficiency. This type of the healthcare intervention process brings the rationale of social justice into healthcare to impact the vulnerable and attain equitable health equality.

The infusion of the rationale of social justice in the distribution of healthcare intervention services is not only meant to treat illnesses but also to enforce healthcare against factors that influence and shape human health, thereby envisaging equitable health equality [37]. As health equity means equal opportunity for all the populations to be healthy, equity in healthcare refers to the proportionate intervention process in which everyone is granted fair opportunities to be healthy [11]. But when the contextual diversity that defines various health determinants, as well as the healthcare needs of the populations, emerged as a determining factor of healthcare, the fact of fairness become a factor of the distribution mechanism of various healthcare resources to benefit the disadvantaged and the vulnerable [37]. While the practical enforcement of *fairness* in healthcare intervention modified the concept of *justice* beyond what others call *traditional justice* [38], their blend goes beyond the normative standards of *fairness* into the ethical concerns about human rights to health and wellbeing [11]. The combination of equity, fairness, and justice takes us closer to the socio-political philosophy of John Rawls. First, John Rawls wished that we should make justice the central virtue of all human interactions and interventions [39]. We are talking of justice here referring to "the quality according to which goods are justly distributed equally" by giving to each their due according to the law [38]. John Rawls later emphasized that we should shape our social systems in a way that the practice of justice should benefit the most vulnerable, thereby instigating the concept of social justice. However, from the socio-political perspective, he further instructed stakeholders to design fair social policies to favour the disadvantaged [39]. According to him, the notion of social justice, which he also called *fairness*, refers to the act of giving each member of the society fair treatment and equal opportunities [40]. The insertion of Rawls' dimension of social justice into healthcare aligns with the human capability theory propounded by the Nobel Prize Laureate economist Amartya Sen. According to his human capability theory, stakeholders are expected to design health policies in such a way as to give the vulnerable populations maximum opportunity to achieve good health and avert escapable morbidity and

preventable mortality [10, 41]. According to Lee Anne Bell [42], social justice is both a "goal" and a "process". As a goal, it refers to "full and equitable participation of people from all social identity groups in a society that is mutually shaped to meet their needs" (p. 3). As a process to attain these goals, it is "democratic and participatory, respectful of human diversity and group differences" (p. 3). The practice of social justice creates "a world in which the distribution of resources is equitable and ecologically sustainable, and all members […] are treated with respect […] and are interdependent" (p. 3). Instead of taking social justice as minimizing the importance of justice, social justice simply complements the principle-based healthcare emphasis with empathy-based approaches that favour the vulnerable and minimizes the inequality gap. Considering health inequalities as the main elements that characterize the gap between the health situation of the best-off and worst-off groups or populations, social justice in healthcare intensifies the need for the ethics of care and of human rights to health. 1) These two perspectives of applied ethics emphasize that we should always allocate more healthcare services and resources to people with the greatest health needs and fewest capabilities to give them equal healthcare opportunities [11]. 2) They support the insight of distributive social justice that emphasizes the equitable allocation of healthcare resources amidst diversity to minimize the adverse effects of inequalities [34]. These dimensions underscore the pragmatic interdisciplinary impetus of applied ethics embedded in the theory of ethical governance in healthcare. As demonstrated above, the pragmatic interdisciplinary perspective of applied ethics enforces ethical governance in healthcare and enables health stakeholders to generate, incorporate and disseminate interdisciplinary health knowledge needed to fight health inequalities. The fight against health inequalities is no longer the sole responsibility of biomedicine or biomedical sciences. It needs the practical engagement of various multi-sectoral global actions of social justice to address health inequalities and move towards equitable health equality [5]. This is partly because the proper management of human health requires varied knowledge [43, 44], and partly because most aspects of health inequalities have varied/diverse causes and manifestations [16, 18]. The insight from ethical governance in healthcare mobilizes both global and local healthcare stakeholders, governments, and policymakers to always strive to collect enough information about contextual health realities. As such, they will be able to inform fair healthcare policies and equitable intervention strategies so to target and minimize health inequalities. To this effect, the best healthcare outcome is not only determined at the intermediary (micro) level by counting the number of people treated but at the community (macro) level by evaluating the general improvement in the QALYs of the populations. Thus, when fighting health inequalities to attain equitable health equality and achieve *health for all*, health stakeholders and partners should strive for optimum health efficiency [34]. In other words, healthcare *governance* must proficiently calibrate and distribute the available healthcare resources and services envisaging the best outcome for the populations. It assumes the context-sensitive role as the structural determinant of healthcare that harmonizes healthcare engagements and informs healthcare interventions to target the diversity that defines healthcare needs and minimizes the inequality gap. While we refer to this process as ethical governance in healthcare, we are talking of *governance* referring to the utilization of the institutional power to determine the distribution and use of resources for the benefit of the citizenry without discrimination. We achieve this standard when hierarchy has successively mobilized the healthcare system with efficient healthcare policies and regulations to equitably intervene and protect the health of the vulnerable.

CONCLUSIONS

We have established equitable health equality as the healthcare scenario where health inequalities are minimized with equitable healthcare intervention to ensure and assure equal healthcare opportunities to all the people in need. According to the exigencies of ethical governance in healthcare, this process requires committed contextualization engagements (contextual inquiries, deliberations, etc.) so as to harmonize and channel various healthcare intervention resources and services towards the peoples in need. However, the realization of equitable health equality is not yet a global reality, and the Global South caries the greatest impact of health inequalities. For example, in the twenty-first century, children in Africa are still more than 15 times more likely to die before their fifth anniversary than their age mates in the western world [5]. Even within Africa (SSA in particular), they are still recording a high degree of health inequalities across countries, especially with the increasing malaria morbidity/mortality inequalities [20, 45]. Nonetheless, our prototypical illustrations in this article have demonstrated how the insight from ethical governance in healthcare can lead healthcare interventions to attain equitable health equality and satisfy human rights to *health for all*. The time to boost this enforcement and attain this global healthcare ambition is now. We acknowledge that various demonstrations and illustrations in this article might be too idealistic as compared to the realities around us. But we know that various healthcare stakeholders and partners need such a prototypical guide from which to adapt their context-sensitive intervention processes to subdue health inequalities. It is through theoretical knowledge of this calibre that professionals gain proactive ideas that complement technoscientific practices and nourish actions endowed with energy and significance [46]. This article is pioneering in demonstrating

how healthcare intervention could use health equity to convert health inequalities into equitable health equality and move towards achieving *health for all*.

DISCLOSURE

The authors report no conflict of interest.

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AUTHORS' CONTRIBUTIONS

CBD, RD prepared research concept and design of the publication. CBD collected data. CBD analysed and interpreted data. CBD, RD prepared the first draft of the article. RD critically revised it. All authors approved the final text of the publication.