FEATURE

Applying the Health Justice Framework to Address Health and Health-care Inequities Experienced by Vulnerable and Marginalised Populations with Non-Communicable Diseases during and after Covid-19 in South Africa

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Introduction

Non-communicable diseases (NCDs) are increasing in South Africa, and are among the leading causes of death (StatsSA 2020). Vulnerable and marginalised groups (VMG) within the country have a greater NCD rate than advantaged populations (Di Cesare et al. 2013). In South Africa, vulnerable groups are that part of the population that experiences a higher risk of poverty and social exclusion than the general population (StatsSA 2018a).

The Covid-19 pandemic has disrupted health services, reduced access to health care and increased inequity, especially among VMG. South Africa has the highest number of Covid-19 cases in Africa, with more than 2.3 million registered cases and over 66,000 related deaths (Africa CDC 2021). The risk of severe illness and mortality among people infected with Covid-19 has been widely observed among people with co-morbidities, particularly NCDs (NICD 2021).

Covid-19 disproportionately affects VMG, particularly among people with a low income and of African descent (NICD 2021: 1; Shaw et al. 2021). Similarly, NCDs disproportionately affect VMG, thus increasing their risk of severe disease and mortality from Covid-19 (Di Cesare et al. 2013; Kushitor et al. 2021). These disadvantaged groups remain undiagnosed, untreated, and at greater risk of preventable complications (Kushitor et al. 2021). VMG often experience the simultaneous occurrence of more than one chronic disease, along with poor health and its outcomes, because of limited access to health care (Ataguba 2013; Ataguba, Akazili & McIntyre 2011). These are not recent occurrences but symptomatic of deeply rooted injustices that have existed for far too long. Although the South African government has tried to improve access to health care for these groups, health inequality persists.

Access to health care is a fundamental human right

recognised by the South African Constitution of 1996, the supreme law of the land. Section 27 of the Constitution guarantees the right of everyone to access health-care services, which in turn requires that the state take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of this right. Despite this guarantee, VMG with NCDs continue to have inadequate access to health care (Ataguba 2013; Ataguba, Akazili & McIntyre 2011). Although the government aims to address health reforms through the National Health Insurance (NHI) Bill, implementation has been delayed (South African Human Rights Commission [SAHRC] 2018).

Against that background, this article argues for the necessity of a comprehensive response that addresses the immediate needs of VMG, particularly in regard to NCDs during Covid-19, as well as the root problems that have caused persistent and long-lasting inequities. We draw on an emergent health justice framework (Benfer et al. 2020) and link it with human rights for eradicating health inequities experienced by VMG.

Health and health-care inequities

South Africa faces a quadruple burden of disease: HIV/AIDS and tuberculosis; high maternal, neonatal and child morbidity and mortality; high levels of violence and trauma; and the recent upsurge of NCDs (Michel et al. 2020). VMG are more likely to be diagnosed with chronic NCDs (such as diabetes mellitus, cardiovascular diseases, chronic lung disease, kidney and liver disease, and cancer) and multi-morbidity (the occurrence of two or more NCDs) (Biney, Amoateng & Ewemooje 2020; Kushitor et al. 2021). VMG include the unemployed, females, blacks, coloureds and Indians, the elderly and uneducated, and those living in extended households and at greater risk of developing NCDs; they have higher rates of multi-morbidity, which compounds their health status (Weimann, Dai & Oni 2016; Biney, Amoateng & Ewemooje 2020).

Health inequalities existed in the South African population before Covid-19 (Ataguba, Akazili & McIntyre 2011). South Africa remains one of the most economically unequal countries globally: advantaged groups can access health care via the private sector, while the poor rely on an under-resourced public sector (Michel et al. 2020). Health and health-care disparities among VMG are deeply rooted in the structures of apartheid and are thus based on a history of segregation and mistreatment by the health-care system (Coovadia et al. 2009). Only 9.9 per cent of blacks have medical insurance, compared to coloureds (17.1 per cent), Indians/Asians (52 per cent), and whites (72.9 per cent) (Stats-SA 2018b). Many VMG, predominantly black South Africans with NCDs, experience much worse health-care outcomes and barriers to care, probably as a result of factors such as unemployment, poverty and lack of medical aid. These data highlight the continuing violation of the right to health, and demonstrate a violation of closely linked and interdependent rights. These include the right to life, human dignity, and non-discrimination and equality.

Since VMG with NCDs are often uninsured, they rely on public health facilities (PHF) (Ataguba, Day & McIntyre 2015; Di Cesare et al. 2013), which poses many challenges. These include long waiting times; drug stock-outs; shortages of emergency transport; limited infection control; understaffing; and discriminatory staff attitudes towards vulnerable groups (SAHRC 2018; Michel et al. 2020). Such challenges are aggravated by unequal distribution of health resources (such as a lack of health facilities, health-care professionals, and inadequate recruitment), particularly in rural areas (Rispel 2015). The situation in PHF is exacerbated by underfunding, widespread corruption, mismanagement of funds, misconduct, and a lack of accountability (Rispel 2015).

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As a result, many VMG are forced to make use of multiple health systems to manage their chronic NCD conditions. For example, some studies report a greater prevalence of complementary and alternative medicine (CAM) usage for NCDs among individuals with a low socio-economic status, older women, rural dwellers, and persons with less education (Aboyade et al. 2016; Hughes et al. 2020). Using CAM may interfere with biomedical treatment, resulting in poor health outcomes or potentially adverse events. Thus, VMG are less likely to receive preventative health-care services for, and information about their chronic conditions.

The health needs of VMG with NCDs are complex and intersect with the economic and social conditions they experience. For example, reports on the social determinants of health have shown that these groups face inequalities, whether political, economic, environmental, social, or cultural, including deficient human rights and gender equality (Ataguba, Day & McIntyre 2015). VMG with NCDs experience more poverty and food insecurity, as well as lower employment rates, and have lower levels of education (Kushitor et al. 2021; Weimann, Dai & Oni 2016; Biney, Amoateng & Ewemooje 2020).

Given the pervasive health and health-care inequities that VMG with NCDs were already experiencing before Covid-19, it is not surprising that these injustices have increased as a result of the pandemic. VMG, particularly those with NCDs such as diabetes, heart and lung disease, hypertension, renal disease, and cancer, have experienced multiple forms of vulnerability. They are at an increased risk of becoming ill and facing critical outcomes (NICD 2021: 1). For example, during the pandemic, many cancer patients had no access to oncology services (Boikhutso et al. 2020). These VMG experience barriers to testing for Covid-19. They face poor outcomes because of their marginalisation and the persistent disadvantages imposed by structural inequities. Covid-19 mortality among the VMG may reflect their increased level of exposure to the virus, to the burden of co-morbidities, and to challenges in accessing health care (Hughes et al. 2021). Furthermore, VMG carry a disproportionate burden of the economic, social and health-related impacts of Covid-19, which distracts them from NCD self-care. Many VMG also disproportionately bear the effect of lockdowns and social distancing regulations, usually in settings where food insecurity and job scarcity influence access to health care.

During the lockdown, there was an interruption in essential health services, particularly in under-resourced settings where patients avoided accessing health facilities for follow-up and NCD prescription refills. PHF were overburdened with Covid-19 patients, limiting access to persons with NCDs. The inequalities plaguing disadvantaged groups with NCDs during the pandemic extended beyond poor health outcomes and impacted on all the social determinants of health, resulting in reduced access to health-care services and information and in unfavourable consequences.

South African VMG with NCDs experience a range of health injustices, which have worsened during the Covid-19 pandemic. Although biological factors, as well as individuals' risky behaviour, account for some of the health disparities, there is increasing evidence that many of the injustices can be linked to the social determinants of health (Ataguba, Akazili & McIntyre 2011).

These data highlight the continuing violation of the right to health, and demonstrate a violation of closely linked and interdependent rights.

Applying the health justice framework

Health justice is an emerging framework which uses law and policy to eliminate structural inequities that cause poor health outcomes and experiences (Benfer et al. 2020). This framework emphasises access to quality health care and engagement with social, economic, and environmental factors that affect the health and welfare of marginalised populations. Health justice builds upon the concept that social determinants of health are as vital to an individual's health as the health care he or she receives. These researchers have proposed using the health justice framework to develop and implement laws and policies that prevent or eradicate health disparities during and after the Covid-19 pandemic (Benfer et al. 2020).

The researchers suggest four interrelated principles for addressing inequities during and after the pandemic. First, laws and policies should address the effects of poverty and discrimination on the social determinants of health and look at how crises intensify these inequities for marginalised groups. Secondly, legal and policy responses mandating behaviours or conduct should be supplemented by legal protection and support in order to accelerate compliance without advancing social and economic inequities. Thirdly, laws and policies must respond to the immediate needs of marginalised populations, as well as to the root problems that have prompted longstanding injustices. Lastly, members of VMG must be involved and engaged throughout the development and implementation of interventions to address health justice (Benfer et al. 2020). Thus, the health-justice framework provides a solid basis for tackling the urgent needs of VMG with NCDs that have become apparent during the Covid-19 pandemic, as well as for addressing long-standing inequities.

To demonstrate the application of the health justice framework and principles, we describe how law and policy should respond to the health and health-care injustices experienced by VMG with NCDs during Covid-19 and beyond. We propose legal and policy considerations relating to health-care access and quality as social determinants of health that must be addressed to achieve health equity among these disadvantaged groups, with the right to health used as the foundation. South Africa's legal and policy framework on health is a combination of international and domestic obligations. Internationally, article 12 of the International Covenant on Economic, Social and Cultural Rights (ICESCR), with South Africa a state party, requires the government to recognise the right of everyone to the enjoyment of the highest attainable standard of health, including the prevention, treatment and control of epidemic, endemic, occupational and other diseases. Similarly, article 16 of the African Charter on Human and Peoples' Rights enshrines the right of every individual to enjoy the best attainable state of health. Domestically, section 27 of the Constitution guarantees the right of everyone to have access to health-care services.

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However, the ICESCR and the Constitution limit implementation of the right to health by requiring 'progressive realisation' within 'the availability of resources' of states. Thus, full realisation of the right to health cannot be achieved immediately but over time. The UN Committee on Economic, Social and Cultural Rights (CESCR) has established that there are minimum core obligations that states must implement; in doing so, states are required to prioritise the most vulnerable members of society (General Comment 3, CESCR). In interpreting article 12, the CESCR concludes that the limitations of progressive realisation and available resources do not detract from the obligation of states 'to take steps' which must be 'deliberate, concrete and targeted'. These steps include adopting legislation, ensuring that judicial remedies are available, and taking other appropriate administrative, financial, educational, and social measures (General Comment 3, CESCR).
In South Africa, the Constitutional Court has affirmed, in the Grootboom case [(2001) ZACC, 19], that socio-economic rights implementation imposes an obligation on

the state to (a.) take reasonable legislative and other measures; (b.) achieve progressive realisation; and (c.) do so within available resources. While 'reasonable legislative measures' require coordination between spheres of government and the provision of the necessary financial and human resources, 'progressive realisation' requires the state to take steps to ensure that the basic needs of all society are met effectively. What is more, the 'legal, administrative, operational financial hurdles should be examined and, where possible, lowered over time'.

Essentially, legal measures alone are insufficient to address the disparate impact of Covid-19 on VMG with NCDs. A combination of practical legal, administrative, and social interventions that prioritises the health needs of VMG with NCDs is needed. However, an essential first step is the development of appropriate and effective laws and policies to address the health needs of VMG with NCDs.

In its General Comment No. 14, the CESCR stipulates the core components of the right to health. These are availability, accessibility, acceptability and quality. We rely on these components in setting out the specific measures that South Africa should take to ensure that VMG with NCDs have access to health-care services during and after the pandemic.

Availability

Well-functioning PHFs must be available in sufficient numbers to cater for the needs of VMG with NCDs. These facilities must also have adequately trained medical and professional personnel, as well as Covid-19 medication and other essential drugs for treating NCDs. The rationing of basic health-care resources and specialised care such as renal dialysis and critical care for chronic NCDs that affect VMG must be addressed. For example, as reported, cancer patients were sent home to die because of a shortage of anti-cancer medicines and equipment failures at the PHF during the pandemic (Boikhutso et al. 2020). While public-private partnerships for chronic NCDs (including cancer) have been proposed (Ndungane 2021), the state bears the primary responsibility for ensuring that access to health care for VMG is prioritised, given the latter's heightened susceptibility.

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Accessibility

The element of accessibility requires an absence of discrimination at PHFs, and comprises four key components:

- Non-discrimination: Everyone, especially VMG with NCDs, must, in law and practice, be able to access health-care facilities without discrimination.

- Physical accessibility: Health-care facilities, medical services, and the underlying determinants of health, such as water and sanitation, must be within safe physical reach of VMG with NCDs. Data on Covid-19 in South Africa and other settings have shown that death was pronounced among certain VMG (those of African descent) (NICD 2021; Hughes et al. 2021), many of whom had chronic NCDs. This situation can be addressed by offering a range of health services in communities with low-income VMG with NCDs, such as home-testing and telehealth services. Furthermore, as vaccines become available, VMG with NCDs should be prioritised, given their higher vulnerability when exposed to the virus than those without NCDs.

- Economic accessibility: Health care must be affordable for all. Payment for health-care services must be based on equity, ensuring that publicly or privately provided services are also affordable for VMG. Those with NCDs must not be burdened with more health expenses than wealthier households. In particular, steps must be taken to ensure that the low-income status of VMG with NCDs is not a barrier to accessing life-saving health care, pending the rollout of the NHI.

- Information accessibility: VMG with NCDs should be given the opportunity to seek, receive and impart information on their health conditions. Given the widespread misinformation on preventing and treating Covid-19, including misinformation about vaccinations, specific steps must be taken to ensure that accurate and reliable medical information is accessible to VMG with NCDs. Long-lasting disparities in education that impair the ability of these groups to access health-care services and information should also be addressed, possibly by involving doctors and specialists from disadvantaged groups to communicate accurate information. As has been suggested by researchers (George et al. 2019), this would help address biases and lead to better health outcomes for VMG with NCDs.

> **Health care must be affordable for all.**

Quality

Health care must be scientifically and medically appropriate and of good quality, which requires the administration of services by skilled medical personnel and the provisioning of scientifically approved drugs, efficient hospital equipment, safe water and adequate sanitation. There is no doubt that poor environmental and housing conditions have negatively impacted the health disposition of VMG with NCDs during the Covid-19 pandemic. Many with low socio-economic status live in informal settlements, where pollution and a lack of potable water and sanitation make them vulnerable to contracting Covid-19 (Shaw et al. 2021).

Despite the government's best efforts to address the Covid-19 pandemic, it is anticipated that trends in NCDs will remain heightened in the aftermath of the pandemic and affect the achievement of the Sustainable Development Goal 3.4 target of reducing premature death. Therefore, adopting a rights-based approach to address health inequities in South Africa is a matter of urgency. The Law Trust Chair in Social Justice at Stellenbosch University, which, inter alia, monitors and implements Covid-19 policy responses, can play a significant role in compelling the government to prioritise health justice for VMG with NCDs during and beyond the pandemic.

Conclusion

The Covid-19 pandemic has disproportionately affected vulnerable and marginalised populations in South Africa. It has been devastating for these disadvantaged communities, and especially so for those with NCDs. The pandemic has exposed the long-standing and pervasive health and social inequities that VMG with chronic disease experience. Addressing these injustices is a crucial issue that demands broad consideration by policy-makers, legal professionals, and researchers.

The South African government must apply the health-justice framework that recognises core human rights principles on the right to health as a foundation for tackling increasing NCDs among VMG. The government should recognise that health extends beyond health systems. As such, laws and policies must be developed to ensure that VMG with NCDs can access essential resources such as food, water, transportation, and housing as fundamental human rights.

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