MPS 2018 Ethics Alive Winning Essay

Medical education goes far beyond merely educating students. The process of medical education also socialises students, introducing them into the society of fellow healthcare professionals. This socialisation may lead to a blunting of an individual's moral compass; as young professionals, they come to accept what would previously have been unacceptable to them. Even in an unflawed system this can be problematic, and is clearly more so in a flawed one.

Yesterday's leaders may have thought that they had solved the problems of inequality, or at least taken an important step in the right direction. How refreshing to see tomorrow's leaders, today's students, critically reassessing and commenting on where we are now. The importance of encouraging students to reflect on moral issues in medicine cannot be underestimated. It was for exactly this reason that Medical Protection became involved in supporting the annual University of the Witwatersrand's Medical Protection Society bioethics essay competition – now in its 10th year. It is with pleasure that I introduce Neo Ramagaga's winning essay, 'Witnessing injustice: What is the student's role in advocating for patients?'

Dr Graham Howarth, MB ChB, MMed (O&G), MPhil (Bioethics)
MPS, Head of Medical Services South Africa

Witnessing injustice: What is the student's role in advocating for patients?

N Ramagaga, MB BCh

Steve Biko Centre for Bioethics, Faculty of Health Sciences, University of the Witwatersrand, Johannesburg, South Africa

Corresponding author: *N Ramagaga (ramagaganeo@gmail.com)*

By the time they graduate, South African (SA) health sciences students are armed with all the necessary tools required to diagnose and treat patients. However, patient care is comprised of more than simply identifying and treating a combination of symptoms. A patient's state of health is determined by more than biological factors – the circumstances that they face outside the hospital setting directly affect their wellbeing as well. Identifying vulnerable patients and managing their health holistically should therefore be an integral part of health education. This will ensure a future in which SA healthcare professionals apply the biopsychosocial approach in patient care. The country's healthcare system is currently riddled with structural and systemic barriers that exist because of its tumultuous history. These barriers are yet to be rectified to provide healthcare that is equitable and accessible to all South Africans. This article deals with the role that the health sciences students of today play in identifying the various ways in which the current SA health system benefits certain demographics, while leaving others marginalised and without access to appropriate healthcare. The role that students can play in advocating for the rights of the patient who is denied equitable healthcare, and the skills required to do so, are also explored.

S Afr J Bioethics Law 2018;11(1):52-55. DOI:10.7196/SAJBL.2018.v11i1.646

The state of the healthcare system of any country is, inextricably, an indicator of the overall performance of the country [1] – it is one of the most important parameters that shows the separation between the First World and the Third. Yet a country like South Africa (SA) is able to boast First-World status to a certain extent, while at the same time, more than half of its population lives in dire poverty.[2] This article focuses on how the unequal and unjust distribution of basic healthcare services to people of colour in apartheid SA laid the foundation for these disparities, and has allowed whiteness to remain the definitive currency in receiving the best healthcare possible in SA, 24 years into our democracy. It first defines healthcare disparities in the context of the SA population, understanding the role that the government should play in protecting vulnerable patients, and exploring the role that medical students can play in protecting patients from being subjected to injustice.

Under apartheid rule, the black African, coloured and Indian populations of SA were all harshly discriminated against because they did not qualify as white citizens.[3] The term 'black' in this paper is therefore used to encompass all these racial groups.

The purpose of this article is *not* to point out that apartheid rule was unjust – that is a blatant blemish in SA history. Instead, it serves to underscore the facts that there exists severe health inequity between the different racial groups in SA, and that there has been very little change effected since the abolishment of apartheid rule to redress and to standardise the level of healthcare received by all South Africans – and that this is unjust.

Injustice in the context of healthcare

In exploring what justice means in the context of healthcare, author Norman Daniels[4] argues that critically answering three focal questions is a tool with which we can determine if health inequalities within a society are unjust:

(*i*) What is the special moral importance of health?
(*ii*) When are health inequalities unjust?
(*iii*) How can we meet health needs fairly when we can't meet them all?

In answering the above questions, Daniels puts forth a theory that states that firstly, health is of special moral importance because it affects the way in which people function and the opportunities that may become available to them because of their level of functioning. Secondly, Daniels argues that health inequalities are unjust when access to healthcare is unfairly distributed. Lastly, fairness in healthcare is attained when a fair process delineates a course of action that is legitimate, and is defined by unbiased, 'limit-setting' decisions.[4]

Thus injustice in the context of healthcare is defined as a state in which a patient is subjected to inadequate healthcare, either because the service is comparably inequitable, and/or because the lack of healthcare for said patient negatively affects their level of functioning, and therefore the opportunities that they are able to pursue.

History of healthcare in South Africa

In the 1960s, the average lifespan was approximately 65 years for white men and 72 for white women, but only 51 for black men and 59 for black women.[5] This was a direct result of the SA apartheid government's deregulation of public health, allowing the private health sector and those who had access to it – white South Africans – to flourish.[6] Under the Group Areas Act No. 41 of 1950,[7] black African people were forced to live in 'Bantustans' and were to essentially function independently of various governmental support structures.[8] Black people were severely marginalised, and were afforded little to no healthcare in these segregated areas. The few healthcare practitioners of colour available in the areas were heavily burdened with the immense patient load, and eventually, they could attend only to patients in dire need of medical attention.[9] This was not made any easier by the fact that the development of traditional SA medicine had suffered and dwindled under oppressive colonial pressures for many years before apartheid even began.[10] By the time of apartheid, traditional African medicine had become severely stigmatised, and the practice was then further marginalised by apartheid policy (the Witchcraft Suppression Act No. 3 of 1957[11] and the Witchcraft Suppression Amendment Act No. 3 of 1970[12] declared the practice of traditional African medicine unconstitutional, as it was believed that African healing had roots in dark magic/witchcraft).[10] Under these harrowing conditions, SA black people had neither Western nor traditional African medicine to turn to – increasing their burden of disease and resulting in their poor life expectancy statistics.

By 2009, 15 years into SA's democracy, the average life expectancy for white South Africans was 71,[13] while the life expectancy for the average South African was only 54.68.[14] With white South Africans constituting only 8% of the total SA population,[15] it was clear that even after the abolishment of apartheid, white South Africans still enjoyed a higher standard of healthcare than black South Africans. The evident disparity can be attributed to two very important factors, both heavily impacted by the socioeconomic realities of the country – the first being access to adequate healthcare, and the second being the differential burden of disease between black and white South Africans.

Inequities in healthcare access

Access to adequate healthcare in post-apartheid SA has been affected by various intersecting factors, but some of the most remarkable effects on healthcare access are best exemplified by the drastic inequality between the public and private healthcare sectors. Private healthcare, as their sole healthcare service, is used by only 14% of South Africans, yet it accounts for approximately 60% of national healthcare expenditure.[16] The private sector, which developed enormously under the apartheid regime, is not primary-healthcare centred, unlike the public sector.[6] It has been criticised because patient care is often augmented to include unnecessary procedures, leading to inflated costs for patients, and further increasing the exclusivity of the service.[17] Even with 28% of South Africans making use of both private and public healthcare services,[18] the free services provided by the public sector remain the only accessible option for the masses of South Africans who cannot afford private healthcare – resulting in the overburdening of an already under-resourced public healthcare system.[19]

Differential burden of disease

The World Health Organization (WHO) describes the relationship between health and socioeconomic factors as one of great interdependence.[20] The WHO details how factors such as one's income and social status, physical environment and education level all impact and are impacted by one's state of health,[20] thus perpetuating the cycle of poverty in the already poor, and helping to maintain the comforts of the privileged. Limited access to adequate healthcare since the end of apartheid rule has severely contributed to maintaining the burden of disease that was established due to the dire circumstances emanating from the time of the Group Areas Act.[7] This, coupled with the restrictions that were imposed upon black people in order to keep them economically and educationally disadvantaged, perpetuated the vicious and unjust cycle that is implicated in the differential burden of disease seen between white and black South Africans to this day.

It should be made clear, however, that the focus herein is on the inherent burden of disease of SA black peoples that are either a direct or indirect result of apartheid. This therefore excludes the disparities seen among racial groups that have a purely biological and/or genetic basis, e.g. oculocutaneous albinism type 2, which is fairly common among black Africans, but almost never affects whites,[21] or melanoma, which is prevalent among SA white women but almost never affects black African, coloured or Indian women.[22]

There are several ways in which the SA healthcare system has been unjust, particularly to black citizens. Firstly, the inability to access healthcare affects the normal functioning of patients, and infringes on their ability to acquire new opportunities, which, according to Daniels, is not only unjust but also immoral.[4] The differential burden of disease as seen between the white and black populations of SA reflects the inequity of healthcare among the different racial groups, which is also considered unjust under Daniels' theory.[4]

Post-apartheid strategies for reform

Since the end of apartheid, several measures have been put in place by post-apartheid administrations to advance health equity, which is defined as 'everyone having a fair opportunity to attain their full health potential without being disadvantaged from achieving this potential'.[23] With the appointment of Nelson Mandela as the president of the Republic in 1994, the new ruling party, the African National Congress (ANC), with technical support from the WHO and the United Nations Children's Fund (UNICEF), devised a National Health Plan that would ensure that healthcare in the country would no longer revolve around 'curative and private medicine', but would instead have a focus on primary healthcare and would 'change medical culture to provide the best care possible'.[24] Practically, this involved educating the public on issues of healthcare, as well as the building of many new clinics.[22,24] Addressing the social determinants of health also became a priority to the post-apartheid administration, as the relationship between socioeconomic factors and health was identified as a contributor to the burden of disease.[24]

However, the development of the primary-healthcare-centred public sector could only go so far, considering the severe shortage of healthcare workers available within the public sector.[16] In 2010, the WHO estimated that only 30% of all SA physicians were working in the public sector,[19] despite the fact that the public sector provides healthcare to more than 80% of the SA population.[19] A recently published study in the *South African Medical Journal* cited reasons such as the inadequacy of the working conditions and workplace security as directly affecting doctors' decisions to enter the private sector, or to leave SA entirely.[25] Nevertheless, despite the shortcomings of some elements of the National Health Plan, one of the most effective of the efforts at recompense was the introduction of certain standard protocols that would work to regulate the provision of healthcare,[22] which satisfies one of the conditions necessary to ensure justice in healthcare, according to Daniels' theory.[4]

The implementation of the National Health Insurance (NHI) is the SA government's latest large-scale method to advance health equity in the country. The government describes the NHI as 'a financing system that will make sure that all the citizens of SA (and legal long-term residents) are provided with essential healthcare, regardless of their employment status and ability to make a direct monetary contribution to the NHI Fund'.[30] This is a significant measure of redress on the SA government's part and, if successful, will definitely increase access to better healthcare for the multitudes, and will ultimately decrease the burden of disease in South Africans as a whole, but especially in black people, who have been more severely affected historically.

The role of students

Current SA health sciences students have the potential to effect a great deal of change in the country's healthcare system, if they are properly equipped with the necessary tools to do so during their schooling. A consequence of medical education, as seen all over the world, is the desensitisation to patients that many health sciences students seem to undergo due to the dominating biomedical model of healthcare, which 'attributes a key role to biological determinants in disease aetiology' and never goes further than viewing patients outside their physical symptoms.[26,28]

This emotional detachment from patients may impinge on the necessary ability of students, and so future doctors, to identify vulnerable people – who are defined as individuals whose human rights are more likely to be infringed upon, as a result of specific systemic barriers.[27] The type of vulnerability can be defined using either one or a combination of the following: cognitive, juridic, deferential, social, infrastructural, medical, or allocational.[27]

In the context of healthcare justice, students need to be equipped with a set of skills that will help them to identify vulnerable patients and treat them without further marginalising them. The course of treatment should take into account all of the intersecting factors that have led to the patient's vulnerability and/or state of ill health, and should not aggravate that state, but seek to protect the patient as far as possible.

This level of patient interaction and care would be best facilitated if the biopsychosocial model of healthcare were well ingrained in students, as opposed to taking the purely biomedical approach that is predominantly used in current medical practice.[28] The biopsychosocial model of health is simply defined as one that 'takes into account all relevant determinants of health and disease, and that supports the integration of biological, psychological and social factors in the assessment, prevention and treatment of diseases'.[28] Under this model of healthcare, students of the health sciences would have a wider scope to use to determine the aetiology of certain conditions and to understand why there exists a difference in the burden of disease among different SA racial groups. In understanding the nature of the condition, they would be better equipped to manage patients' health with long-term solutions, instead of merely alleviating the symptoms and not mitigating the actual problem.

Patient advocacy is also an important part of patient care that should be taught to SA medical students. Advocating for the rights of one's patient can be a crucial part of affording the patient equitable healthcare, especially if (s)he is unable to advocate for him- or herself.[29] However, there exists a fine line that ought not to be crossed, as inappropriate advocacy for one's patient could be perceived as paternalistic in nature, and could effectively strip the patient of their agency.[29] A key skill to be adopted by students would encompass both an understanding of when to appropriately advocate for one's patient, and the ability to discern when not to overstep the boundaries.

Conclusion

This article has explored the definition of healthcare injustice with the use of substantial examples within the context of SA healthcare. It has been shown that the disparities between the black and white populations of SA can essentially be reduced to two very important factors: unequal access to healthcare and the differential burden of disease – which are the results of the enduring effects of apartheid. It has also been noted that post-apartheid administrations have made some strides in an attempt to rectify what was thrown out of balance by apartheid policy and by colonial pressures even before that. The imminent implementation of the National Health Insurance is promising in that it will try to establish health equity in SA. The role that current health sciences students will one day have to play in protecting patients from being treated unjustly relies heavily upon the biopsychosocial model for the assessment, prevention and treatment of disease, as well as on patient advocacy.

Acknowledgements. Prof. Ames Dhai and Miss Lizeka Tandwa.

Author contributions. Sole author.

Funding. None.

Conflicts of interest. None.

1. Mokoena S. Health Status of Any Country Key Condition for its Economic Development – Cathy Dlamini. Pretoria: Parliament of the Republic of South Africa, June 2017. https://www.parliament.gov.za/news/health-status-any-country-key-condition-its-economic-development-cathy-dlamini (accessed 27 February 2018).
2. Magombeyi MT, Odhiambo NM. Poverty dynamics in South Africa: trends, policies and challenges. Socioeconomica 2015;4(8):333-348. https://doi.org/10.12803/sjseco.48140
3. South Africa. Population Registration Act. No. 30 of 1950. http://www.sahistory.org.za/sites/default/files/DC/leg19500807.028.020.030/leg19500707.028.020.030.pdf (accessed 24 March 2018).
4. Daniels N. Just Health: Meeting Health Needs Fairly. Cambridge: Cambridge University Press, 2007.
5. Horwitz S. Health and Health Care under Apartheid. Johannesburg: Adler Museum of Medicine, University of the Witwatersrand, 2009.
6. Price M. Health care as an instrument of Apartheid policy in South Africa. Health Pol Planning 1986;1(2):158-170 (abstract). https://doi.org/10.1093/heapol/1.2.158
7. South Africa. Group Areas Act No. 41 of 1950. http://www.sahistory.org.za/archive/group-areas-act%2C-act-no-41-of-1950 (accessed 29 June 2018).
8. Li V. South Africa's return to primary care: The struggles and strides of the primary health care system. J Glob Health 2014;4(1):10-14. http://www.ghjournal.org/south-africas-return-to-primary-care-the-struggles-and-strides-of-the-primary-health-care-system/ (accessed 21 February 2018).
9. Kautzky K, Tollman SM. A perspective on primary health care in South Africa. S Afr Health Rev 2008;2008(1):17-30. hdl.handle.net/10520/EJC35514 (accessed 27 February 2018).
10. Berger J, Hassim A, Heywood M, eds. Health & Democracy: A Guide to Human Rights, Health Law and Policy in Post-apartheid in South Africa. Cape Town: Siber Ink, 2007.
11. South Africa. Witchcraft Suppression Act No. 3 of 1957. http://www.justice.gov.za/legislation/acts/1957-003.pdf (accessed 29 June 2018)
12. South Africa. Witchcraft Suppression Amendment Act No. 50 of 1970. https://www.greengazette.co.za/acts/witchcraft-suppression-amendment-act_1970-050 (accessed 29 June 2018).
13. Vavi Z. How can we build on the World Cup success and mobilise our society to build a more egalitarian nation? Proceedings of Civil Society Conference, Boksburg, 27 October 2010. http://www.cosatu.org.za/show.php?ID=4170 (accessed 27 February 2018).
14. World Bank Group. Life Expectancy at Birth, Total (years). Washington, DC: World Bank Group, 2018. https://data.worldbank.org/indicator/SP.DYN.LE00.IN?end=2009&locations=ZA&start=200 (accessed 27 February 2018).
15. Statistics South Africa. Mid-year Population Estimates 2017. Pretoria: StatsSA, 2018. http://www.statssa.gov.za/publications/P0302/P03022017.pdf (accessed 27 February 2018).
16. Coovadia H, Jewkes R, Barron P, Sanders D, McIntyre D. The health and health system of South Africa: historical roots of current public health challenges. Lancet 2009;374(9692):817-834. https://doi.org/10.1016/S0140-6736(09)60951X
17. Francis K. Private Health Care and the Right to Health. Focus 67 – State and Nation. Johhanesburg: Helen Suzman Foundation, 2013.
18. Pretorius L. Does SA's private healthcare sector only serve 16% of the population? Africa Check, 2017. https://africacheck.org/reports/does-sas-private-healthcare-sector-only-provide-care-for-16-of-the-population/ (accessed 27 February 2018).
19. Keeton C. Bridging the gap in South Africa. Bull World Health Org 2010;88(11):803-804.
20. World Health Organization. Health Impact Assessment (HIA) – the Determinants of Health. Geneva: WHO, 2010. http://www.who.int/hia/evidence/doh/en/ (accessed 28 February 2018).
21. Manga P, Kerr R, Ramsay M, Kromberg J. Biology and genetics of oculocutaneous albinism and vitiligo – common pigmentation disorders in southern Africa. S Afr Med J 2013;103(12):984-988. https://doi.org/10.7196/SAMJ.7046
22. Ngassa Piotie P. Analysis: Is cancer a white people's disease in South Africa? Africa Check, 2017. https://africacheck.org/2017/12/05/analysis-cancer-white-peoples-disease-south-africa-legend/ (accessed 28 February 2018).
23. World Health Organization. Health Equity. Geneva: WHO, 2018. http://www.who.int/topics/health_equity/en/ (accessed 27 February 2018).
24. African National Congress. A National Health Plan for South Africa. Pretoria: ANC, 1994. http://www.anc.org.za/content/national-health-plan-south-africa (accessed 27 February 2018).
25. Van der Spuy ZM, Zabow T, Good A. Money isn't everything – CMSA doctor survey shows some noteworthy results. S Afr Med J 2017;107(1):550-551. https://doi.org/10.7196/SAMJ.2017.v107i7.12643
26. Cockerham WC. Medical Sociology. 14th ed. London: Routledge, 2017.
27. Kipnis K. Vulnerability in research subjects: A bioethical taxonomy (commissioned paper). Manoa: University of Hawaii, 2004.
28. Havelka M, Lucanin JD, Lucanin D. Biopsychosocial model – the integrated approach to health and disease. Collegium Antropolegicum 2009;33(2009); 303 -310. https://www.ncbi.nlm.nih.gov/pubmed/19408642 (accessed 28 February 2018)
29. Schwartz L. Is there an advocate in the house? The role of healthcare professionals in patient advocacy. Abstract. J Med Ethics 2002;28(1):37-40. https://doi.org/10.1136/jme.28.1.37
30. South Africa. Department of Health Green Paper: National Health Insurance in South Africa. Pretoria: NDoH, 2011.

Accepted 25 May 2018.