

The Impact of Epidemics on the Principle of Equal Access to Health Services: The Case of COVID-19 in Algeria

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Abstract:

The right to health is a fundamental component of human existence, intrinsically linked to an individual's physical, mental, and social well-being. This study aims to highlight the impact of epidemics on the principle of equal access to health services, with a focus on constitutional and legal guarantees in Algeria. Epidemics reveal profound socio-economic and regional disparities in healthcare access and resource distribution. By analyzing the legal framework, including the Algerian Constitution and Law No. 18-11, alongside international human rights standards, the research highlights the critical gap between legal theory and practical reality. The COVID-19 pandemic in Algeria serves as a primary case study, demonstrating the maldistribution of medical resources between urban and rural areas, and its disproportionate impact on vulnerable populations. The paper concludes with strategic recommendations to strengthen health infrastructure, enforce equity monitoring mechanisms, and adapt legal policies to ensure non-discriminatory healthcare during future health emergencies.

Keywords: Health Equality; Epidemics; COVID-19; Algerian Law; Human Rights.

1. INTRODUCTION

Health is a fundamental component of human existence, intrinsically linked to an individual's physical, mental, and social well-being. It forms the foundation of personal welfare and the capacity to fully exercise other rights. Furthermore, health intersects with numerous aspects of life—including nutrition, education, the environment, and employment—making it a cornerstone for ensuring quality of life and social stability.

Given that health is a fundamental human right, international instruments have emphasized its importance. The Universal Declaration of Human Rights (1948) stipulates the right of every individual to a standard of living that ensures health and well-being, including food, housing, medical care, and social protection. Similarly, the International Covenant on Economic, Social and Cultural Rights (1966) affirms the right to enjoy the highest attainable standard of physical and mental health, obligating States to take necessary measures for disease prevention as well as maternal and child care. Additionally, the Convention on the Rights of the Child (1989) mandates the protection of children's health and the provision of preventive and curative medical care.

At the national level, Article 66 of the Algerian Constitution guarantees the right to health care for citizens. This includes free treatment, social insurance for medication and therapies, and the prevention of diseases and epidemics, with special attention given to vulnerable social groups. Furthermore, Law No. 18-11 on Health establishes the legal framework for the health system, outlining preventive, therapeutic, educational, and social measures to combat disease and improve public health and environmental conditions.

However, the spread of epidemics poses a significant challenge to the principle of equal access to health services. Epidemics reveal disparities in the distribution of resources and care among different social groups, raising questions regarding the effectiveness of legal and constitutional guarantees in achieving equity. Consequently, the primary research question of this study is: How do epidemics affect the principle of equal access to health services, and what role do constitutional and legal guarantees play in protecting this right and ensuring fair access for all citizens?

2. Section One: The Legal Framework for the Principle of Equal Access to Health

Services

The right to health is a fundamental human right, impacting physical, mental, and social well-being directly. It constitutes an essential pillar for quality of life and the exercise of other rights. Understanding this right requires an examination of its legal, constitutional, and international dimensions, which provide integrated protection through international charters, the Constitution, and national laws such as Law No. 18-11. This section aims to define the conceptual framework of the right to health and review the legal, constitutional, and international foundations that guarantee its exercise, paving the way for a discussion on the impact of epidemics on equal access to health services.

2.1 Subsection I: The Concept of Equality in the Right to Health

The right to health is a cornerstone of human life. It transcends the mere absence of disease or disability to encompass a state of complete physical, mental, and social well-being. This definition is affirmed by the World Health Organization (WHO), which states that health is "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity".

The principle of equality in the right to health serves as a mechanism to ensure access to health services for all individuals without discrimination. It implies that health care must be available to all citizens on an equal basis. However, it also allows for "positive discrimination" (affirmative action) to support the most socially and economically vulnerable groups, thereby achieving true equal opportunity in accessing services. Thus, the principle of equality in the right to health is not merely a theoretical slogan; it is a practical concept linked to social justice. It requires the organization of health resources and services in a manner that guarantees necessary care for everyone while promoting equitable distribution to those most in need. This approach achieves the objectives of constitutional and legal protection for this right.

At the national level, the principle of equality is embodied in the Algerian Constitution, particularly in Article 66, which enshrines the State's obligation to ensure health care for citizens including free treatment, social insurance, and disease prevention. Furthermore, Law No. 18-11 sets the legislative and regulatory framework for the practical application of this principle by defining the State's responsibilities in prevention, treatment, and the equitable distribution of health resources across all segments of

society.

2.2 Subsection II: The Legal and Constitutional Foundations of Health Equality

The principle of health equality is a core pillar of the right to health, supported by national legal norms and the State's international obligations. The Algerian Constitution, along with fundamental laws—foremost among them Law No. 18-11—establishes an integrated system aimed at ensuring equal access to health care without discrimination, while accounting for special social circumstances, such as those of the destitute.

The constitutional basis for this principle begins with Article 66, which stipulates that: "The State guarantees the prevention and control of epidemic and infectious diseases and works to provide conditions for treatment and health care for all citizens." This text implies that the Constitution goes beyond formal recognition of the right to health; it establishes a State obligation to provide equal health care to all citizens without discrimination, including vulnerable groups requiring special protection. Constitutional protection is further embodied in guarantees that enshrine equality in practice. The Constitution mandates that the State provide treatment to needy groups and guarantees free basic medical services. This constitutes a practical application of positive discrimination in favor of vulnerable groups within the broader principle of equal rights.

Legislatively, Law No. 18-11 translates these constitutional principles into practical rules. Article 1 states that "Health is a fundamental human right guaranteed by the State," emphasizing that realizing this right requires equal access to health services for the entire population, without discrimination based on gender, social status, or region. The law also establishes provisions for public health, disease prevention, epidemic control, and care for at-risk groups, reinforcing the social dimension of health equality.

Furthermore, constitutional oversight is pivotal in establishing the principle of equal rights. The Constitutional Council (and subsequently the Constitutional Court) plays a central role in monitoring the conformity of health laws and policies with the Constitution. Its mandate was expanded under the 2016 amendment to consider violations of fundamental rights and freedoms, including the right to health, whether through direct notification by authorities or referral from judicial bodies.

Algeria's international obligations also form part of the legal basis for health equality. By acceding to the International Covenant on Economic, Social and Cultural Rights (1966), Algeria is bound by Article 12, which recognizes the right of everyone to "the highest attainable standard of physical and mental health." This accession adds an international dimension to the principle of health equality, obliging the State to respect it in domestic legislation and practice.

In summary, the legal and constitutional foundations of health equality in Algeria are embodied in an integrated system comprising: Constitutional provisions: Recognizing health care as a public and free right. Organic laws: Primarily Law No. 18-11, translating equality into practical obligations. Constitutional control mechanisms: Represented by the Constitutional Council (now the Constitutional Court). International obligations: Enforcing respect for the principle of equal enjoyment of the right to health. These levels converge to establish justice in the distribution of health services and ensure equal access for all citizens, reinforcing the rule of law and human rights.

2.3 Subsection III: International Human Rights Standards Related to Equality in Health

The principle of equality and non-discrimination is a fundamental basis of the international human rights system and a prerequisite for the full realization of the right to health. International standards affirm that every individual, without discrimination, has the right to the highest attainable standard of physical and mental health. This is an immediate legal obligation for States, not subject to progressive realization or resource availability.

Article 12 of the International Covenant on Economic, Social and Cultural Rights (1966) requires States to take legislative and administrative measures to ensure equal access to health services. As stated in General Comment No. 14, non-discrimination is an essential, immediate obligation regardless of available resources. The Convention on the Elimination of All Forms of Discrimination against Women (CEDAW, 1979) reinforces this, mandating equal access to health care, particularly regarding reproductive health and maternity. Similarly, the Convention on the Rights of the Child (CRC, 1989) obliges States to reduce infant mortality and ensure access to health services without discrimination.

The Convention on the Rights of Persons with Disabilities (CRPD, 2006) includes parallel obligations to provide accessible, high-quality health services to persons with disabilities. Regarding migrants, the International Convention on the Protection of the Rights of All Migrant Workers (1990) affirms their right to emergency health care without discrimination based on legal status. At the comparative national level, the Egyptian Constitution of 2014 enshrines this principle in Article 18, stating that every citizen has the right to health and integrated health care, reflecting a commitment to international standards. Thus, international standards make equality in health access a binding legal and humanitarian duty.

3. Section Two: The Impact of Epidemics on Achieving the Principle of Equality in Access to Health Services

Epidemics are defined as the unusual or excessive spread of a disease within a community or geographic area over a specific period, exceeding normal incidence rates. In health jurisprudence, the term "epidemic" denotes a public health event requiring the immediate mobilization of resources. Legally, an epidemic represents a health emergency necessitating exceptional state measures for prevention, monitoring, and treatment. The World Health Organization defines an epidemic as "the spread of an infectious disease in a given community, or geographical area, at a rate that exceeds normal expectations, and calls for urgent action to curb its spread".

In the Algerian context, the concept constitutes a threat to national health security, as derived from Law No. 18-11, which enshrines in Article 16 the principle of State intervention to protect public health and control infectious diseases.

3.1 Subsection I: The Impact of Epidemics on the Distribution of Health Resources and Services

First: Resource Allocation Impact Epidemics deeply affect the distribution of health resources, imposing immense pressure on medical systems. The urgent need to respond to high infection rates leads to the diversion of financial and human resources toward specific areas at the expense of general health services. Public spending is redirected toward acquiring medicines, medical devices, and equipping hospitals, while primary care, vaccination, and prevention programs often decline. This disruption creates an imbalance in the equitable distribution of resources across sectors and social groups.

Furthermore, urban areas are often prioritized due to population density and existing infrastructure, while rural and remote areas suffer from equipment shortages and a lack of medical competencies, deepening the gap in access to health services.

3.2 Section Two: The Case of COVID-19 in Algeria as a Model

Emergence of the Virus Following the announcement of the novel coronavirus (COVID-19) in Wuhan, Hubei Province, China, in late December 2019, the World Health Organization (WHO) classified the outbreak as a global pandemic due to its rapid spread and transboundary nature. While Chinese authorities moved quickly to impose quarantine and isolation measures in the region, delays in the official announcement contributed to the virus's transmission to numerous countries, evolving into a global threat to international health security.

In Algeria, the first confirmed case was recorded on February 25, 2020. This was confirmed in an official statement by the Minister of Health, Population, and Hospital Reform, Abderrahmane Benbouzid, who announced via national media the infection of an Italian national arriving from the Lombardy region, one of Europe's most severely affected areas. The patient was immediately isolated at the accommodation base of an oil company in the Ouargla Province until the infection was confirmed. He was subsequently repatriated on a special flight on February 28, 2020, while quarantine measures were imposed on workers who had been in contact with him.

Rapid Spread Following the initial case, local transmission accelerated. On March 2, 2020, the Ministry of Health announced two new cases involving a mother and her daughter in the Blida Province. The virus was transmitted by a relative returning from France who had stayed in Algeria between February 14 and 21. Within days, the number of confirmed cases rose to five, establishing Blida as the first local epicenter of the virus in Algeria. Given the rapid rise in infections, the government imposed a total lockdown on the Blida Province on March 24, 2020, for one month as a proactive measure to curb the spread. However, delays in certain preventive measures and increased mobility prior to the lockdown facilitated the virus's rapid transmission to other provinces. By the end of 2020, the number of confirmed cases exceeded 99,000, distributed across various regions.

The COVID-19 pandemic exposed the fragility of Algeria's health infrastructure

and the disparities in the distribution of medical resources and services. Since the first cases in March 2020, health authorities were forced to redistribute assets to manage the crisis, leading to a concentration of resources in heavily affected provinces such as Blida, Algiers, and Oran. Conversely, provinces in the South and the High Plateaus (Hauts Plateaux) suffered from shortages in medical equipment and supplies.

It is evident that epidemics serve as a stress test for health systems' ability to uphold the principle of equality in resource distribution. Such crises reveal structural weaknesses, particularly regarding limited human and material resources and their maldistribution between urban and rural areas. The pandemic demonstrated that disparities in hospital equipment, shortages of intensive care units (ICUs), and weak diagnostic capabilities all contributed to undermining health equity, despite government efforts. Consequently, it can be argued that epidemics do not create inequality in service distribution so much as they expose and exacerbate it. This necessitates a revision of public health policies through the lens of equal opportunity to ensure equitable access to health resources under all circumstances.

3.3 Subsection II: Socio-Economic Disparities in Access to Health Care During Epidemics (Case Study: The COVID-19 Pandemic)

The principle of equal access to health care is central to health security, as affirmed by the WHO and national constitutions. However, epidemics-specifically COVID-19-have starkly revealed social and economic disparities in access to basic health services. These disparities and their negative impacts on health security and economic activity are highlighted in the following points:

1. Disparities in Access to Care and Services: Public Sector Inefficiency: Research indicates that a lack of oversight and administrative corruption in the public health system leads to failure, resulting in "inefficient or inadequate" service delivery. This deterioration disproportionately affects low-income individuals who are entirely dependent on this sector. High Cost of the Private Sector: Conversely, the cost of private hospitals and medical services is often prohibitive for low-income populations, creating a deep gap in the ability of individuals to seek treatment. Geographic Disparity (Rural vs. Urban): Research emphasizes the need for a "logical geographical distribution of medical institutions" to ensure service access in all areas, particularly marginalized rural villages. These areas often become "active hotspots" for epidemics, indicating that actual access to

services relies heavily on geographic location and regional development status.

2. Disparities in Prevention and Protection: Vaccines and Precautionary Measures: Although the WHO affirmed the individual's right to accessible vaccines at an appropriate cost, the lack of health security was partly due to the slow implementation of precautionary measures, such as the provision of affordable masks and vaccines. This resulted in unequal access to preventive means, especially during the early stages of the pandemic. Health Awareness (The Cultural Gap): There is a pressing need for "awareness caravans" in marginalized areas to educate populations on the importance of vaccination and preventive measures. This highlights a disparity in health literacy levels, a key factor affecting an individual's ability to protect themselves.

3. Disparities Affecting Vulnerable Groups (Socio-Economic Impact): Informal Sector and Poverty: Lockdowns and restrictions exposed the fragility of the informal workforce (e.g., day laborers, domestic workers). Many lost their jobs and suffered from poverty and unemployment, leaving them unable to afford necessary health services due to a lack of legal protection and social safety nets. Women and Youth: These groups were "most affected" by income inequality and job losses during the pandemic, particularly in the tourism sector, increasing their vulnerability to poverty and health insecurity. Medical Staff: Despite being the "first line of defense," healthcare workers were more susceptible to infection than other sectors. This illustrates how disparities in protection and support for staff can weaken the entire health system.

Statistical Evidence of Disparity: Official statistics from the Ministry of Health for 2020 indicate a marked disparity in health infrastructure distribution: Hospital Beds: Approximately 45% of hospital beds are concentrated in the North (Algiers, Oran, Constantine, Blida), compared to only 22% in the vast provinces of the Greater South (Tamanrasset, Adrar, Illizi, Tindouf). Medical Personnel: There are approximately 17 doctors per 10,000 inhabitants in the capital, compared to only 6 per 10,000 in some southern provinces.

Regarding COVID-19 infections, northern provinces recorded over 70% of total confirmed cases by the end of 2020. Meanwhile, interior regions suffered from a lack of detection and diagnostic tools, hindering accurate monitoring of the epidemiological situation and reducing opportunities for early intervention. These data reveal that the

pandemic deepened existing inequalities, making health equity a structural, rather than merely circumstantial, challenge.

3.4 Subsection III: Legal Policies and Measures to Promote Equality During Epidemics

First: The International Legal Framework. International human rights law, particularly the International Covenant on Economic, Social and Cultural Rights (1966), affirms the right of everyone to enjoy the highest attainable standard of physical and mental health without discrimination.

1. International Principles of Equality and Non-Discrimination Article 2 of the Covenant obliges States to guarantee rights without discrimination based on race, color, sex, language, religion, national/social origin, property, birth, or other status. Similarly, the WHO International Health Regulations (2005) emphasize that measures taken during epidemics must align with human dignity and fundamental freedoms and be applied in a non-discriminatory manner.

2. Legal Obligations of States International regulations oblige Member States to ensure transparency and fairness in resource distribution, prioritizing vulnerable groups such as women, children, the elderly, persons with disabilities, and refugees. Additionally, the Committee on Economic, Social and Cultural Rights (General Comment No. 14) affirms that the right to health includes four essential elements: Availability, Accessibility, Acceptability, and Quality (AAAQ), all of which must be provided on a basis of equality.

Second: Measures and Policies to Ensure Equality. In response to outbreaks like COVID-19 and Ebola, the WHO and Member States implemented policies to bridge gaps in healthcare access:

A. International Institutional Measures: 1. COVAX Initiative: Launched in 2020 (WHO, Gavi, UNICEF) to ensure equitable vaccine distribution, particularly for low- and middle-income countries. 2. Global Health Emergency Committee: Reviews policies to ensure emergency measures comply with principles of justice and non-discrimination. 3.

Technical Support Programs: The WHO provides technical and legal support to developing nations to strengthen their health systems.

B. National Measures Many countries adapted their health policies based on WHO recommendations: 1. Legislation: Enacting laws prohibiting discrimination in treatment or vaccination based on socio-economic status. 2. Social Protection: Launching urgent financial and food support programs for families affected by lockdowns. 3. Transparency: Publishing data on vaccine and medicine distribution to build public trust. 4. Gender Integration: Incorporating gender perspectives into pandemic response plans.

C. Challenges to Equality Despite efforts, gaps remain: Economic disparities between nations lead to the monopolization of medical resources by wealthy countries. Weak health infrastructure in developing nations. The spread of misinformation undermining trust in health systems. Lack of legal coordination between national and international institutions. Equality during pandemics is not merely a moral principle but a binding international legal obligation.

4. Conclusion

This study demonstrates that epidemics represent a true test of a State's commitment to the principle of equality in the right to health. While constitutional and legislative texts affirm this right, health crises reveal realistic challenges related to the equitable distribution of resources. The COVID-19 pandemic in Algeria highlighted that socio-economic and regional disparities constitute real obstacles to health equity. Residents of rural and vulnerable areas suffer from poor medical equipment and limited access to treatment compared to urban centers. However, the State made significant efforts through legal and regulatory measures to protect public health, ensure free treatment, and provide vaccines, thereby reinforcing the principle of equality despite the difficulties.

Recommendations:

1. Review the legislative framework to include specific provisions for health emergencies.
2. Establish a national mechanism to monitor health equity and resource disparities.
3. Increase investment in health infrastructure for rural and southern regions.
4. Expand prevention and awareness programs targeting vulnerable groups.

5. Strengthen public-private coordination during health crises.

Bibliography List

First: Books

National Council for Human Rights. *The Right to Health*. Cairo: National Council for Human Rights, 2018.

Second: Scientific Articles

Kandali, Mohamed. "The Right to Health in Algerian Law." *Journal of Policy and Law Notebooks*, University of Ouargla, Issue 06, January 2016.

Rital, Saleh. "Constitutional Protection of the Right to Health." *Journal of Legal and Political Research*, Saida University, Issue 10, 2018.

Youssef, Mohamed. "Health Justice in Light of Epidemic Crises." *Journal of Law and Society*, University of Algiers 1, Issue 5, 2022.

Khalid, H. et al. "The Impact of Epidemics on Health Systems and Resource Allocation." *Journal of Global Health*, Vol. 12, 2021.

Third: Official and International Documents

Committee on Economic, Social and Cultural Rights. General Comment No. 14. United Nations, Twenty-second Session.

World Health Organization. *Report on Epidemic Preparedness and Response*. Geneva, 2020.

Official Gazette of the Algerian Republic. Law No. 18-11 of July 2, 2018, relating to Health, Issue 46.

Fourth: University Theses

Barakahem, Abbasi. *The Impact of the COVID-19 Pandemic on Health Security in Algeria*. Master's Thesis, Kasdi Merbah University - Ouargla, 2021.

Aroual, Chaimaa & Chakakta, Soundous. *The Role of the World Health Organization in Combating Epidemics*. Master's Thesis, University of 8 May 1945 - Guelma, Faculty of Law and Political Science, 2024-2025.

Fifth: Electronic and Media Sources

Benbouzid, Abderrahmane. Television Statement, Algerian Television, News Bulletin, February 25, 2020.

Wikipedia. "COVID-19 Pandemic in Algeria." [Accessed April 8, 2021].

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Appendices:

Appendix No. 01: Number of COVID-19 cases in Algeria by gender (April 7, 2020).

Women	Men
42%	58%

Appendix No. 02: Monthly number of COVID-19 cases, deaths, and recoveries in Algeria (August and November 2020).

Period	Infection Cases	Death Cases	Recovery Cases
August	44,494	1,510	31,244
November	83,199	2,131	53,809

Appendix No. 03: Number of deaths attributed to COVID-19 in Algeria by age.

Age Group	Number of Deaths
Less than 1 year	0
5 to 14 years	2
15 to 24 years	1
25 to 49 years	3,415
50 to 59 years	1,411
More than 60 years	2,505

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Age Group	Number of Deaths
Unspecified	362