ADDRESSING PUBLIC PRIVATE SECTOR INEQUALITIES

PROFESSOR EMERITUS YOSUF VERIAVA

HEALTH INEQUALITY AND INEQUITY

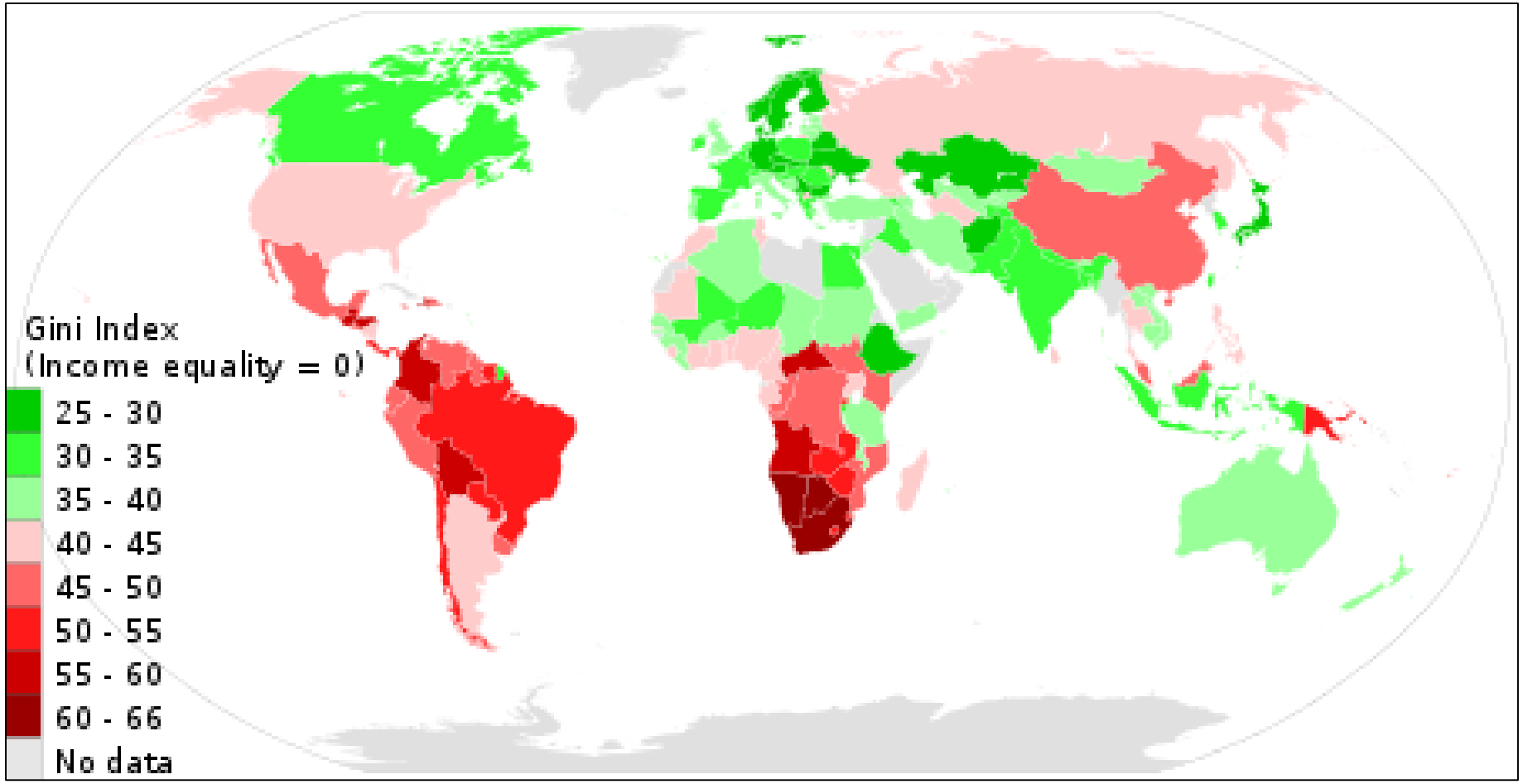
Disparity: Is there a difference in the health status rates between population groups?

*Inequality: R*efers primarily to the condition of being unequal, and it tends to relate to things that can be expressed in numbers (quantitative).

*Inequity: I*n its main sense, is a close synonym of *injustice* and *unfairness*, so it usually relates to more qualitative matters.

Gini Coefficients

(South Africa approximately 63%)



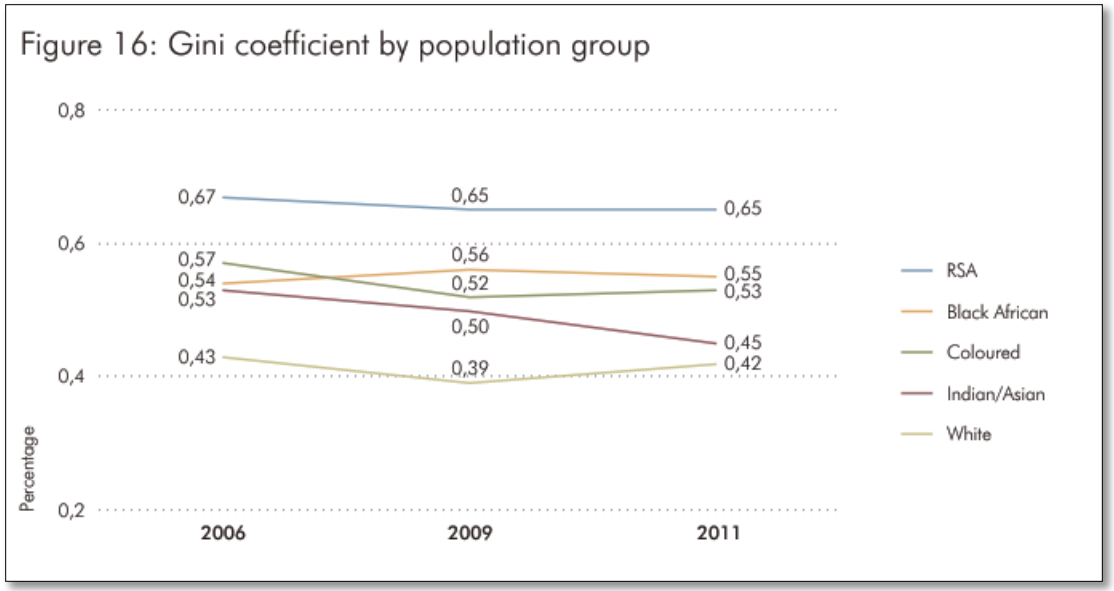
Gini index measures the extent to which the distribution of income (or, in some cases, consumption expenditure) among individuals or households within an economy deviates from a perfectly equal distribution. Thus a Gini index of 0 represents perfect equality, while an index of 100 implies perfect inequality.

Countries' income inequality (2014) according to their Gini coefficients measured in percent: red = high, green = low inequality.

Source: https://en.wikipedia.org/wiki/List_of_countries_by_income_equality

GINI COEFFICIENT – STATISTICS SA

- The Gini coefficient for the country as a whole decreased slightly from 0.67 in 2006 to 0.65 in 2009. There was no change from 2009 to 2011. The scores reflect the high levels of inequality that persists in SA.



Poverty trend in SA – Statistics South Africa, www.statssa.gov.za

“While we have made some progress in reducing poverty, poverty is still pervasive and we have made insufficient progress in reducing inequality. Millions of people remain unemployed and many working households live close to the poverty line.

NPC NDP

HEALTH INEQUITIES

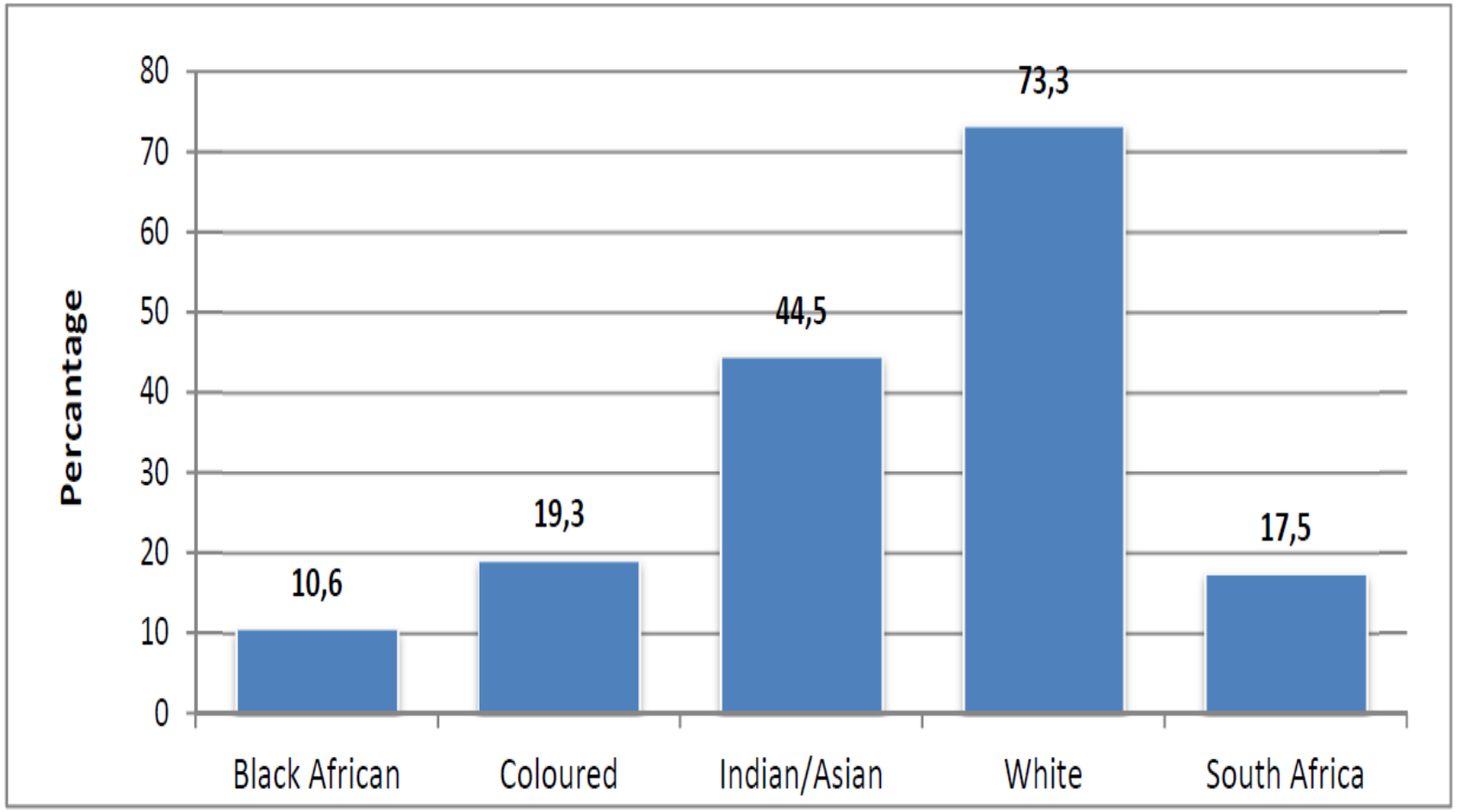
- *Marked differences in rates of diseases and mortality between races, reflecting racial differences in the access to basic household living conditions and other determinants of health.*

- *Substantial inequities in health between provinces and also within provinces*

- *Differences in health status indices between the rich/middle class and poor individuals.*

- *Difference of access to tertiary/quaternary services related to differences between the public and private sectors, between urban and rural, between academic and non academic hospitals.*

POPULATION WITH A FORM OF MEDICAL COVER (% COVERED BY RACE)



Source: GHS 2015 (STATSSA)

KEY ASPECTS OF THE RIGHT TO HEALTH CARE

- The right to health is an inclusive right
- The right to health contains freedoms
- The right to health contains entitlements
- Health services, goods and facilities must be provided to all without any discrimination
- All services, goods and facilities must be available, accessible, acceptable and of good quality.

- WHO.

HEALTH DOMAINS

- Health services
  - Individualistic between health professional and patients
- Social and other Determinants of Health
  - Population/Communities
- Life style
  - Individual behavior

EXPENDITURE ON HEALTH: 8.7% OF GDP.
SOUTH AFRICA SPENDS MORE ON HEALTH
THAN ANY OTHER AFRICAN COUNTRY

HEALTH INEQUALITY AND INEQUITY

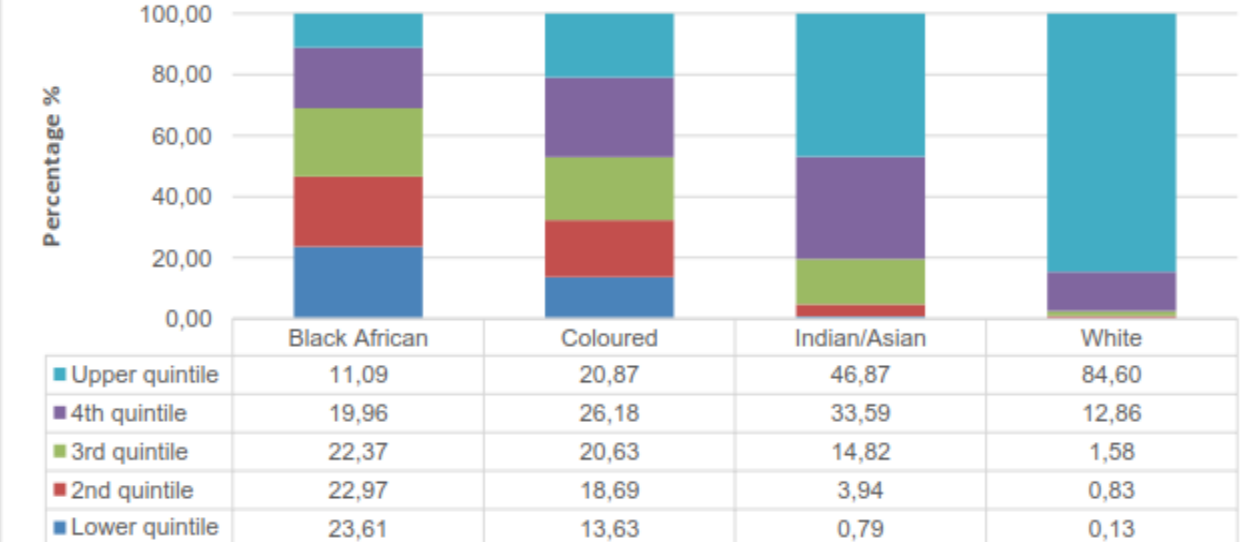
- The annual per capita healthcare expenditure is approximately as disparate as R1 200 in the public sector serving 84% of the population, and R12 000 in the private sector for 16% of the population.

Thus the split in health care spending between public and private is unfair, no matter how one defines fairness.

HEALTH INEQUITIES REFLECT DIFFERENCES IN HEALTH OUTCOMES

EXPENDITURE AND INCOME QUINTILES

Figure 3.5: Percentage distribution of households by expenditure per capita quintiles and population group of the household head



	Black African	Coloured	Indian/Asian	White
Upper quintile	11,09	20,87	46,87	84,60
4th quintile	19,96	26,18	33,59	12,86
3rd quintile	22,37	20,63	14,82	1,58
2nd quintile	22,97	18,69	3,94	0,83
Lower quintile	23,61	13,63	0,79	0,13

The income per capita quintiles have the following values:

- Upper quintile: R71 479 and above
- 4th quintile: R28 092 – R71 478
- 3rd quintile: R13 819 – R28 091
- 2nd quintile: R6 486 - R13 818
- Lower quintile: Up to R6 485

Living conditions of households in SA – Statistics South Africa 2014/2015, www.statssa.gov.za

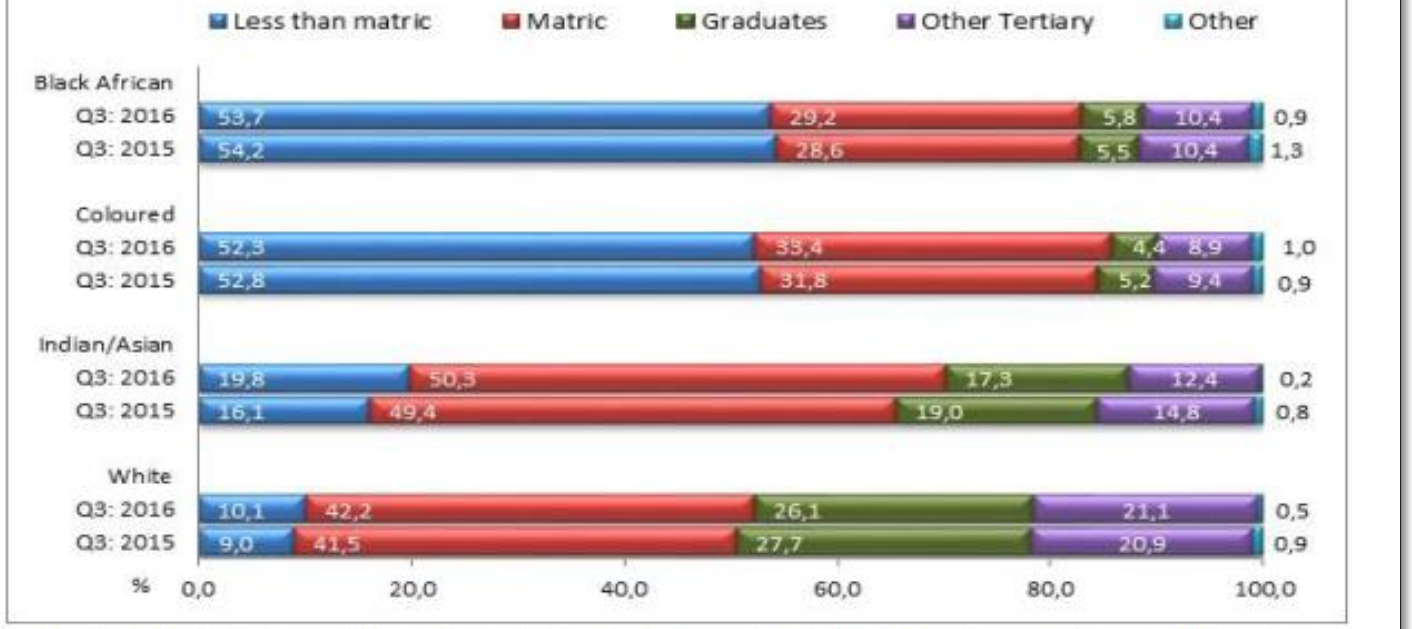
EDUCATION

EDUCATION EMPOWERS PEOPLE TO DEFINE THEIR IDENTITY, TAKE CONTROL OF THEIR LIVES, RAISE HEALTHY FAMILIES, TAKE PART CONFIDENTLY IN DEVELOPING A SOCIETY, AND PLAY AN EFFECTIVE ROLE IN THE POLITICS AND GOVERNANCE OF THEIR COMMUNITIES.

NPC NDP

SHARE OF EMPLOYED PERSONS BY EDUCATION AND POPULATION GROUP, Q3 2015 AND Q3 2016

Figure 7: Share of employed persons by education and population group, Q3: 2015 and Q3: 2016



Note: 'Graduate' includes post-higher diploma, bachelor's degree, post-graduate diploma, honours degree and higher degree. Values for 'Other' are not shown on the graph.

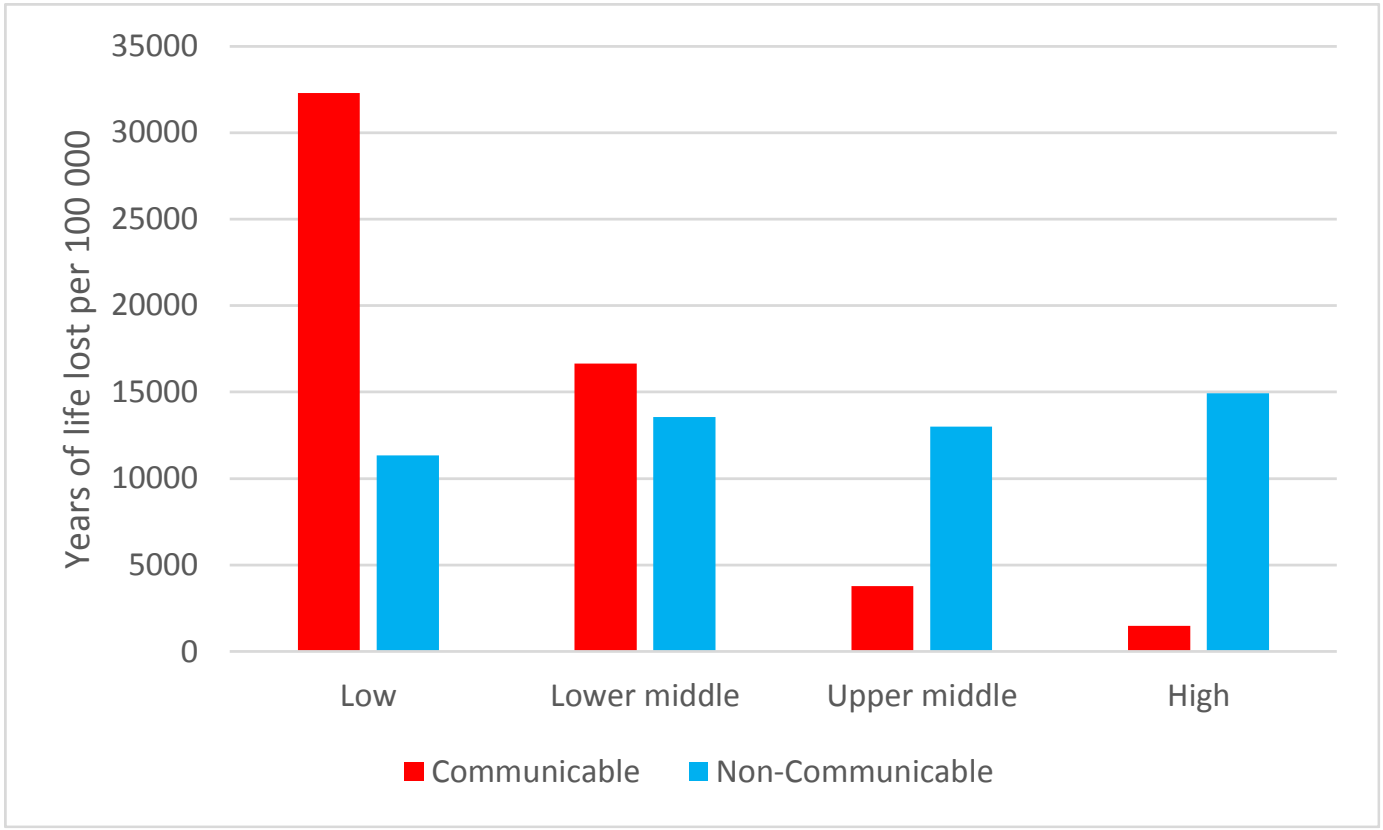
DIFFERENTIAL IMPACT OF EDUCATION ON HEALTH

- Linear negative relationship exists between mortality, fair/poor health and years of schooling.

- Positive impact on health (e.g. functional limitations and obesity) once individuals have obtained education beyond a high school degree.

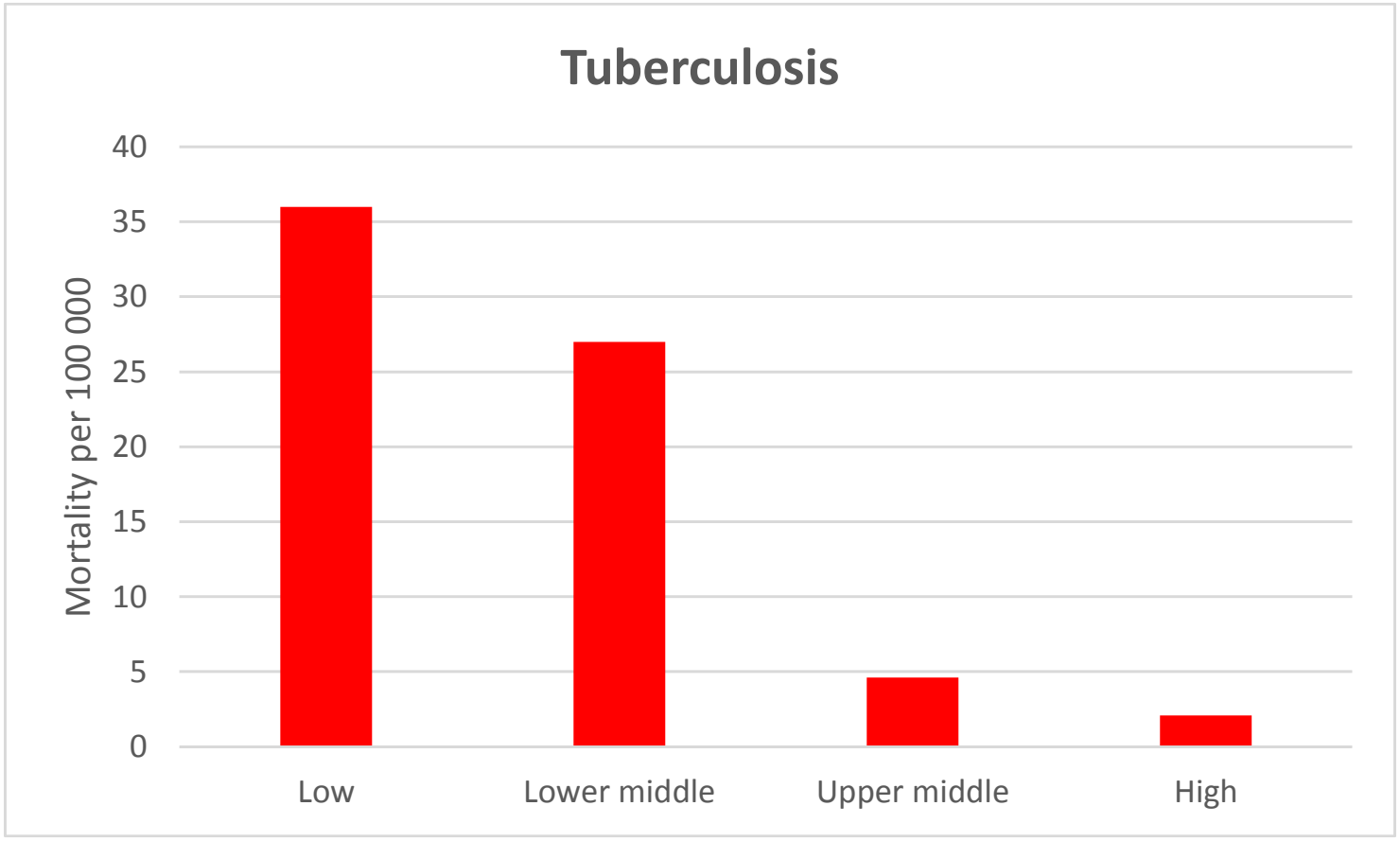
    - Cutler DM; Lleras-Muney (2007)

YEARS OF LIFE LOST PER 100 000 POPULATION BY INCOME GROUP - 2012



Source: World Health Statistics Report 2015.

TB MORTALITY RATE PER 100 000 POPULATION BY INCOME GROUP – 2013



Source: World Health Statistics Report 2015.

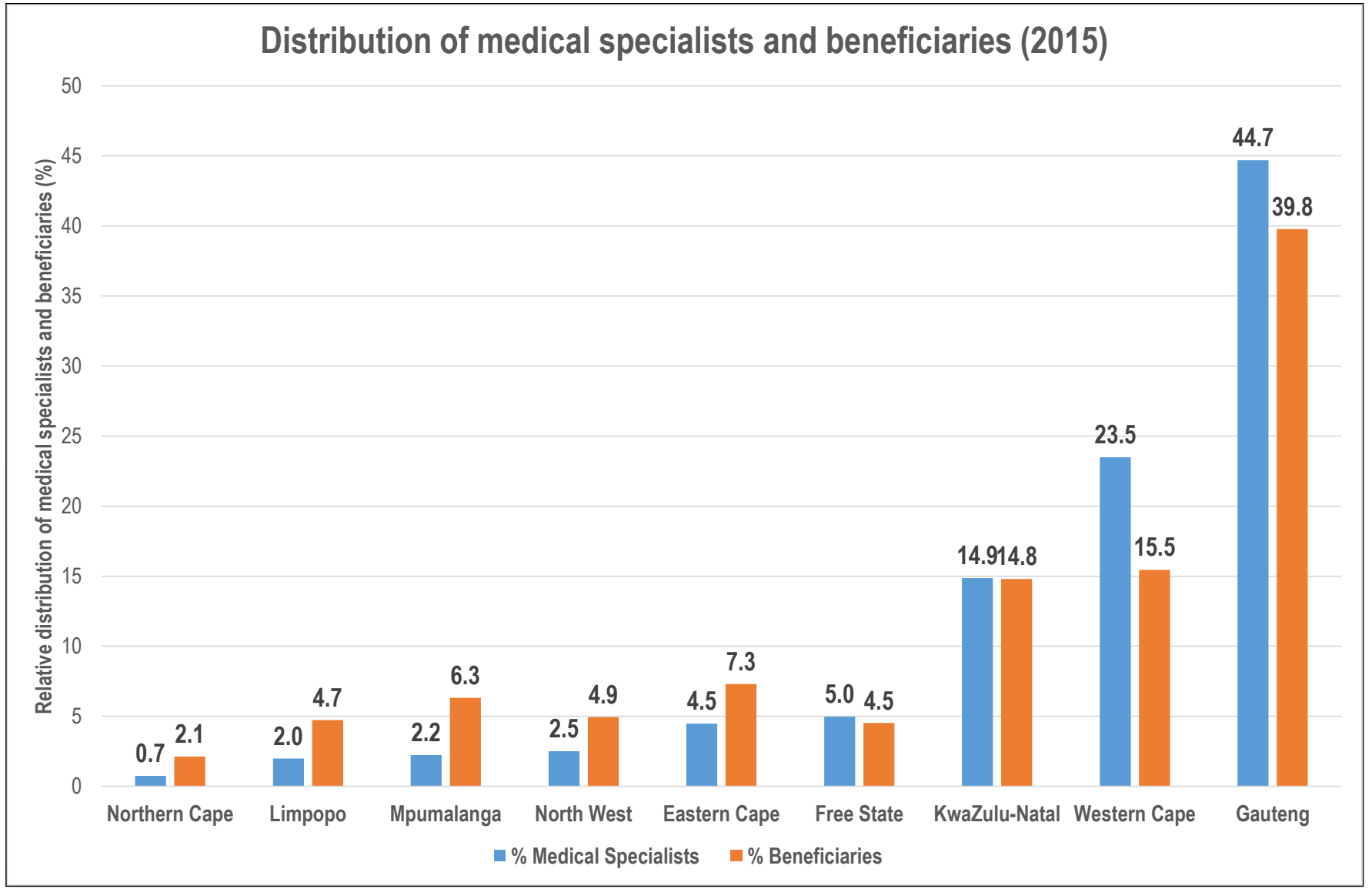
Health inequality between provinces

(Hospital beds: Public versus Public)

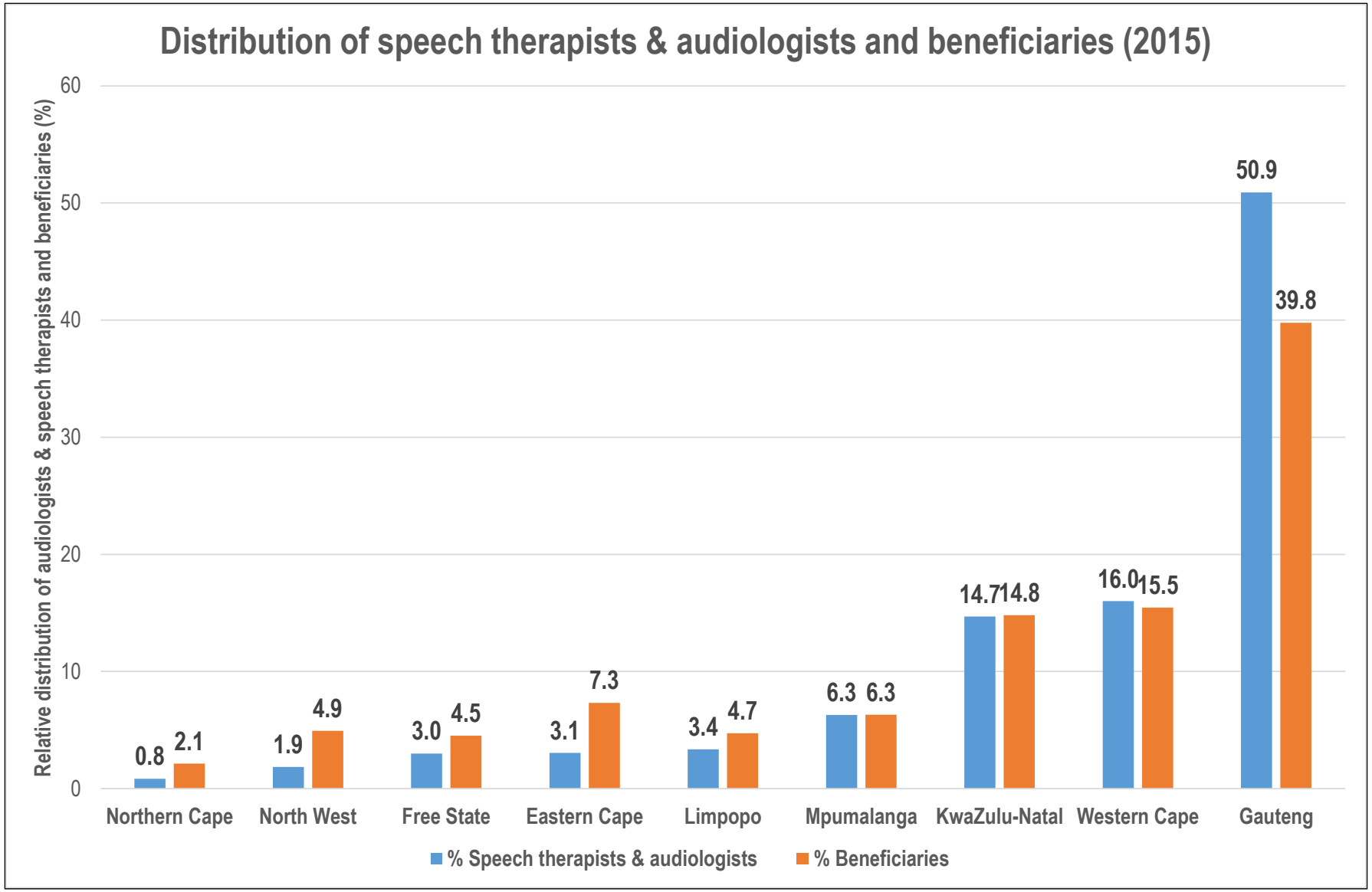
Total number of hospital beds in South Africa in 2014			
Province	**Public hospital beds**	**Private hospitals beds**	**Total hospital beds**
Eastern Cape	13 200	1 723	14 923
Free State	4 798	2 337	7 135
Gauteng	16 656	14 278	30 934
KwaZulu-Natal	22 048	4 514	26 562
Limpopo	7 745	600	8 345
Mpumalanga	4 745	1 252	5 997
North West	5 132	1 685	6 817
Northern Cape	1 523	293	1 816
Western Cape	12 241	4 385	16 626
South Africa	85 362	31 067	119 155

Source: https://en.wikipedia.org/wiki/Healthcare_in_South_Africa

Note: Could not verify the numbers with the NDoH. One can use the numbers to calculate ratios per 1 000 beneficiaries in the public versus private, but there is also an overlap of resources created by the state as DSP.


Distribution of medical specialists and beneficiaries (2015)
Relative distribution of medical specialists and beneficiaries (%)
50
45
40
35
30
25
20
15
10
5
0
0.7
2.1
2.0
4.7
2.2
6.3
2.5
4.9
4.5
7.3
5.0
4.5
14.9
14.8
23.5
15.5
44.7
39.8
Northern Cape
Limpopo
Mpumalanga
North West
Eastern Cape
Free State
KwaZulu-Natal
Western Cape
Gauteng
% Medical Specialists
% Beneficiaries

Healthcare resources: Private sector 2015



MAJOR PRIVATE HOSPITAL GROUPS FINACIAL INFORMATION (2012)

	REVENUE (R million)	PROFIT
NETCARE	25,174	2,004
LIFE HEALTH CARE	10,973	2,412
MEDICLINIC	21,986	2,177

PUBLIC PRIVATE SECTOR CHALLENGES

- *The mismatch of resources in the public and private health sectors, and the inefficiencies in the use of available resources, has contributed to the very poor health status of South Africans.*

LEVEL OF SATISFACTION – PUBLIC VERSUS PRIVATE HEALTH CARE INSTITUTIONS

	PUBLIC	PRIVATE
VERY SATISFIED	57.6%	91%
VERY UNSATIFIED	6.1%	0.5%

ADDRESSING INEQUITY

- Constitutional Imperative (The Right to Health Care)
- National Development Plan
  - Integrated approach towards addressing the Social,Economic, Educational and Environmental Determinants of Health
- Human Rights Commission
- South Africa a signatory to the UN Sustainable Development Goals

SECTION 27 OF THE CONSTITUTION OF RSA

- ***EVERYONE HAS THE RIGHT TO HAVE ACCESS*** *TO:*
  - *Health care services, including reproductive health care*
  - *Sufficient food and water and*
  - *Social security including if they are unable to support themselves and their dependants, appropriate social assistance*

- ***THE STATE MUST TAKE REASONABLE LEGISLATIVE AND OTHER MEASURES, WITHIN ITS AVAILABLE RESOURCES TO ACHIEVE THE PROGRESSIVE REALISATION OF EACH OF THESE RIGHTS***

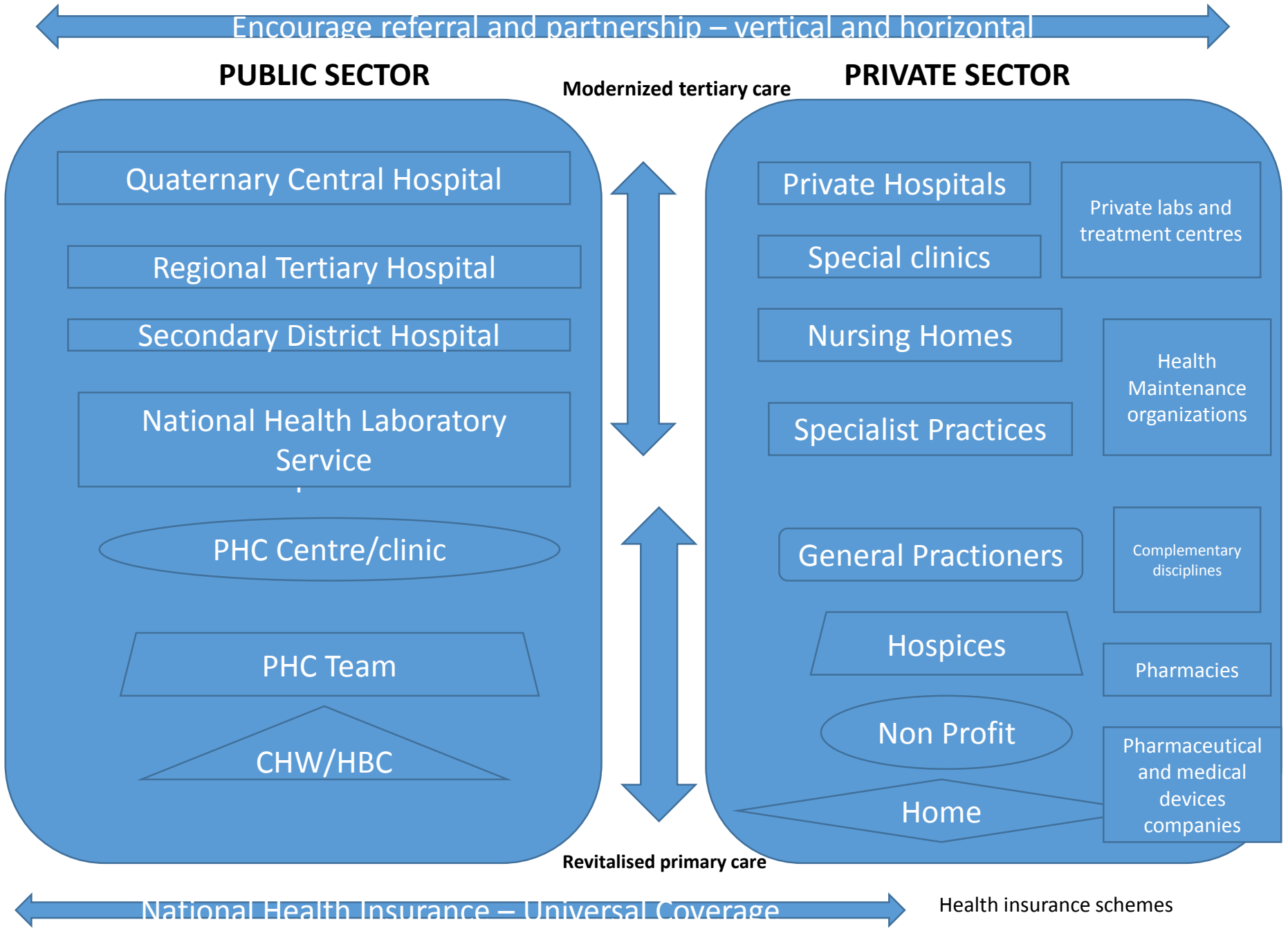
- ***NO ONE MUST BE REFUSED EMERGENCY MEDICAL TREATMENT****.*

NATIONAL DEVELOPMENT PLAN

- **MAIN PROPOSALS**
  - *Address social determinants of health*
  - *Reduce disease burden to manageable levels*
  - *Build human resources*
  - *Strengthen national health system*
  - *Implement the NHI scheme*

BY 2030, THE HEALTH SYSTEM SHOULD PROVIDE QUALITY CARE TO ALL, FREE AT THE POINT OF SERVICE, OR PAID BY PUBLICALLY PROVIDED, OR PRIVATELY FUNDED INSURANCE. THE PRIMARY DISTRICT HEALTH SERVICE SHOULD PROVIDE UNIVERSAL ACCESS, WITH FOCUS ON PREVENTION, EDUCATION, DISEASE MANAGEMENT AND TREATMENT. HOSPITALS SHOULD BE EFFECTIVE AND EFFICIENT, PROVIDING QUALITY SECONDARY AND TERTIARY CARE FOR THOSE WHO NEED IT.

NPC NDP


Encourage referral and partnership – vertical and horizontal
PUBLIC SECTOR
Modernized tertiary care
PRIVATE SECTOR
Quaternary Central Hospital
Regional Tertiary Hospital
Secondary District Hospital
National Health Laboratory Service
PHC Centre/clinic
PHC Team
CHW/HBC
Private Hospitals
Private labs and treatment centres
Special clinics
Nursing Homes
Health Maintenance organizations
Specialist Practices
General Practioners
Complementary disciplines
Hospices
Pharmacies
Non Profit
Pharmaceutical and medical devices companies
Home
Revitalised primary care
National Health Insurance – Universal Coverage
Health insurance schemes

No society can legitimately call itself civilized if a sick person is denied medical aid because of a lack of means……Society becomes more wholesome, more serene, and spiritually healthier, if it knows that its citizens have at the back of their consciousness the knowledge that not only themselves but all their fellows, have access, when ill, to the best that medical skill can provide.

Nye Bevan (1952)

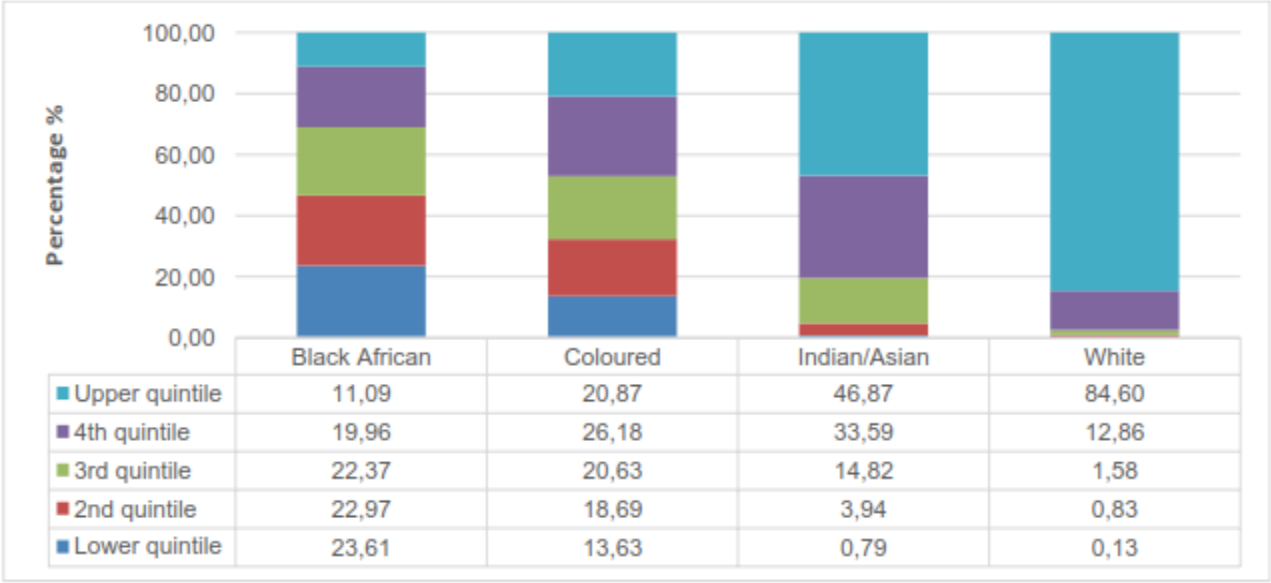
UN SUSTAINABLE DEVELOPMENT GOALS

- End poverty in all its forms everywhere.
- End hunger, achieve food security and improved nutrition and promote sustainable agriculture.
- Ensure health lives and promote well being for all ages.
- Ensure inclusive and equitable quality education and promote lifelong learning opportunities for all.
- Ensure availibility and sustainable management of water and sanitation for all.
- Reduce inequality within and among countries.
- Make cities and human settlements inclusive, safe, resilient and sustainable.

THANK YOU.

Expenditure and income quintiles

Figure 3.5: Percentage distribution of households by expenditure per capita quintiles and population group of the household head



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Living conditions of households in SA – Statistics South Africa 2014/2015, www.statssa.gov.za

Expenditure on healthcare

- South African households on average spent R935 per annum, which accounts for 0,90% of the total household consumption expenditure.

Table 4.5: Overview of consumption expenditure on health by sex and population group of household head, as well as by province and settlement type

	Average (rands)	Proportion of total expenditure (%)
South Africa	**935**	**0,90**
Sex of household head		
Male	1 137	0,94
Female	648	0,83
Population group of household head		
Black African	479	0,71
Coloured	1 313	1,06
Indian/Asian	1 598	0,82
White	4 161	1,19
Province		
Western Cape	2 107	1,29
Eastern Cape	430	0,59
Northern Cape	821	1,01
Free State	1 795	2,10
KwaZulu-Natal	707	0,96
North West	529	0,77
Gauteng	1 025	0,73
Mpumalanga	616	0,74
Limpopo	287	0,47

Living conditions of households in SA – Statistics South Africa 2014/2015, www.statssa.gov.za

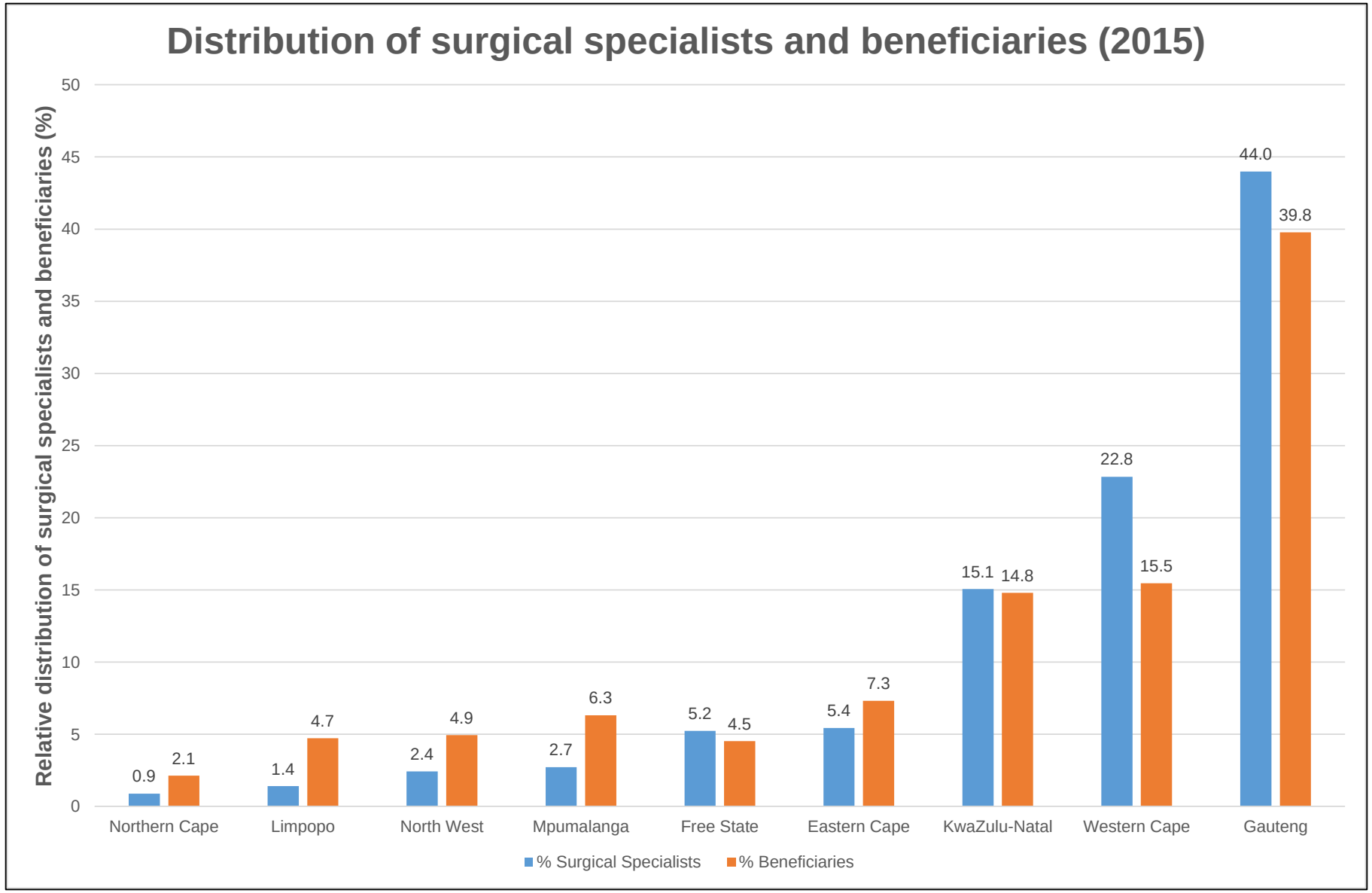
Health inequality between provinces

(Hospitals and clinics: Public and Private)

Breakdown of hospitals and clinics in South Africa in 2014					
Province	**Public clinic**	**Public hospital**	**Private clinic**	**Private hospital**	**Total**
Eastern Cape	731	91	44	17	883
Free State	212	34	22	13	281
Gauteng	333	39	286	83	741
KwaZulu-Natal	592	77	95	12	776
Limpopo	456	42	14	10	522
Mpumalanga	242	33	23	13	311
North West	273	22	17	14	326
Northern Cape	131	16	10	2	159
Western Cape	212	53	170	39	474
Total	**3 863**	**407**	**610**	**203**	**4 473**

Source: https://en.wikipedia.org/wiki/Healthcare_in_South_Africa

Note: Could not verify the numbers with the NDoH and the number of private clinics differ


Distribution of surgical specialists and beneficiaries (2015)
Relative distribution of surgical specialists and beneficiaries (%)
50
45
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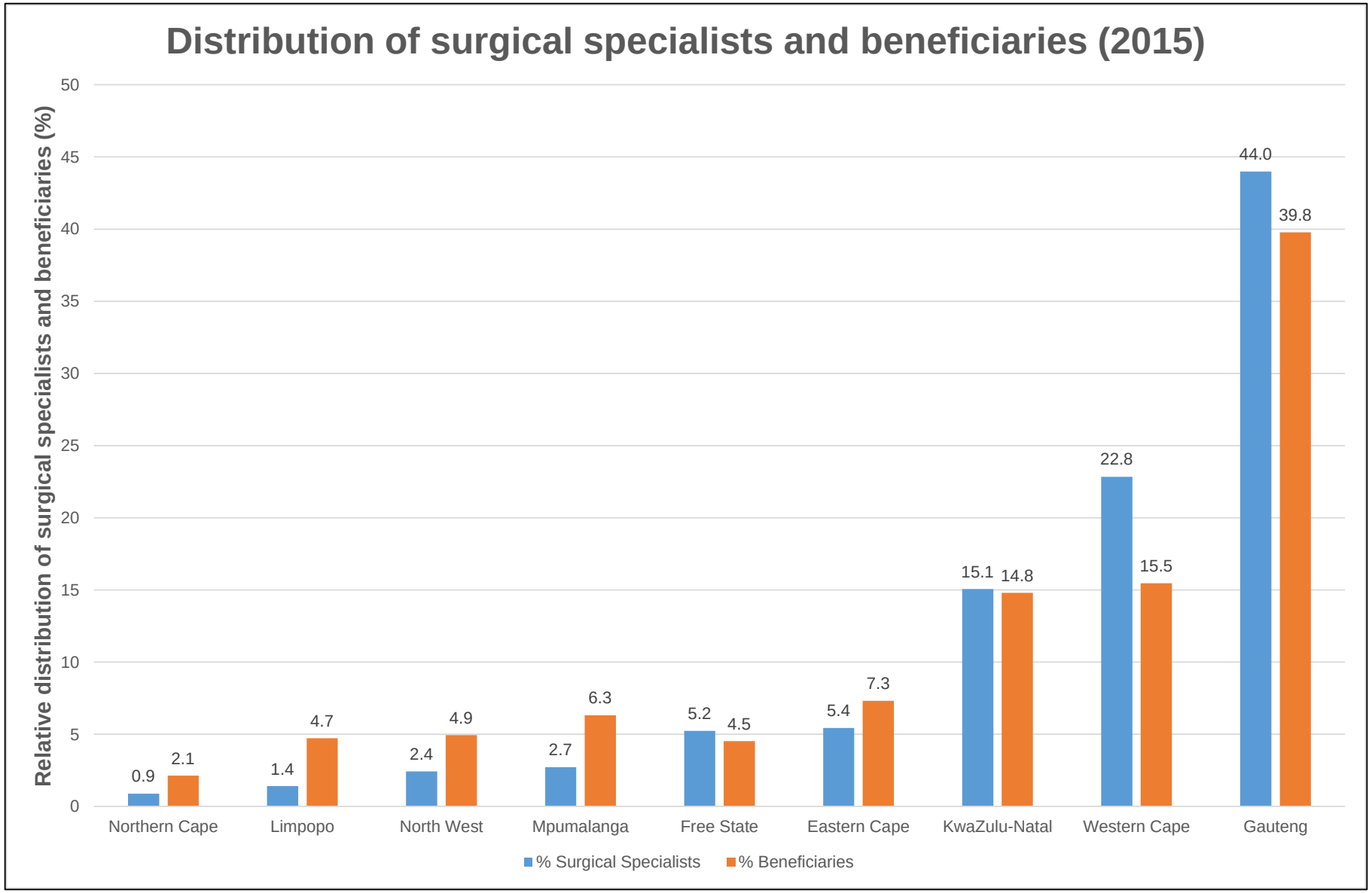
30
25
20
15
10
5
0
0.9
2.1
1.4
4.7
2.4
4.9
2.7
6.3
5.2
4.5
5.4
7.3
15.1
14.8
22.8
15.5
44.0
39.8
Northern Cape
Limpopo
North West
Mpumalanga
Free State
Eastern Cape
KwaZulu-Natal
Western Cape
Gauteng
% Surgical Specialists
% Beneficiaries

Health inequality and inequity

- Inequity invokes moral outrage, it is unfair and indefensible, a result of human failure, giving rise to avoidable deaths and disease. Social justice in this case is literally a matter of life and death. Inequity is often measured in terms of the inequality of health or resources, which is appropriate where one might reasonably expect equality.

- This raises the question "when does inequality in health or resources constitute inequity?" One possible answer is when differences are greater than might be expected on the basis of wealth, this is certainly the case, the relative burden of disease in poor countries is actually far greater than can be explained simply in terms of wealth.

- While much must be done to improve healthcare in the public and the private sectors, it is also imperative to understand that the health of individuals and populations is a complex social construct; it is not easily amenable to improved outcomes simply by spending more money on technologically based medical care.


Distribution of surgical specialists and beneficiaries (2015)
Relative distribution of surgical specialists and beneficiaries (%)
50
45
40
35
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25
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15
10
5
0
0.9
2.1
1.4
4.7
2.4
4.9
2.7
6.3
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4.5
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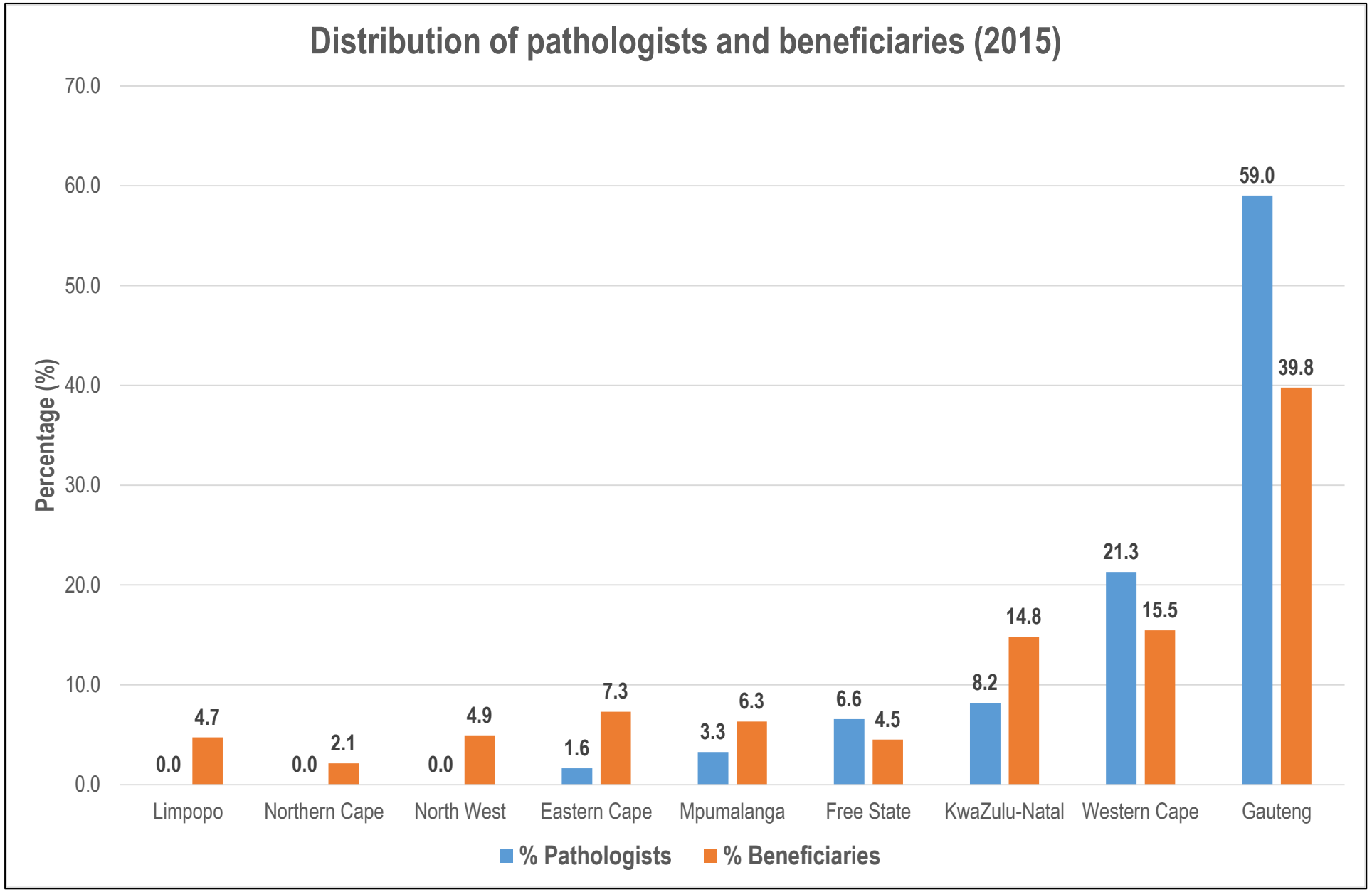
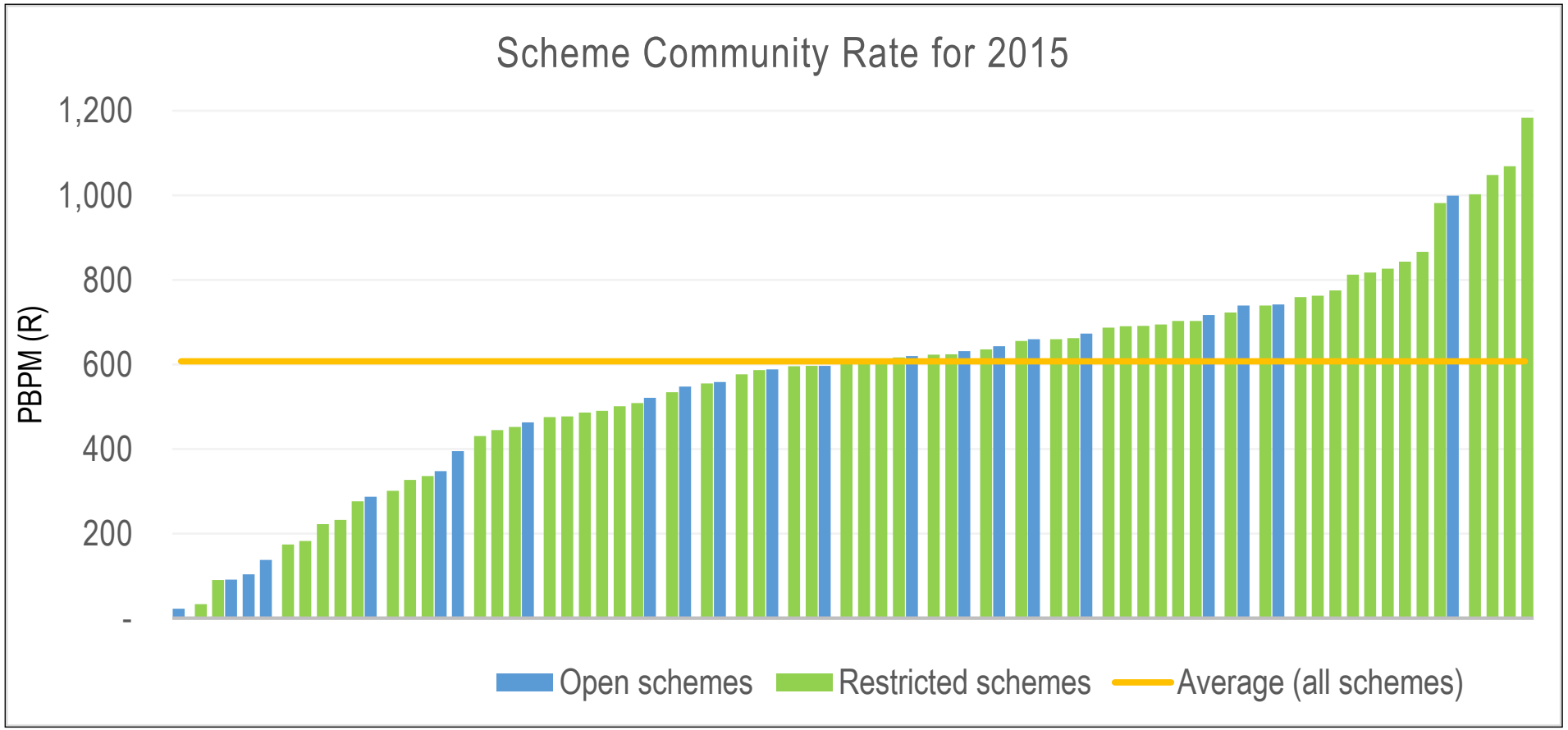

Distribution of pathologists and beneficiaries (2015)
Percentage (%)
70.0
60.0
50.0
40.0
30.0
20.0
10.0
0.0
0.0
4.7
0.0
2.1
0.0
4.9
1.6
7.3
3.3
6.3
6.6
4.5
8.2
14.8
21.3
15.5
59.0
39.8
Limpopo
Northern Cape
North West
Eastern Cape
Mpumalanga
Free State
KwaZulu-Natal
Western Cape
Gauteng
% Pathologists
% Beneficiaries

Global Trends	Physicians per 10 000 population
Global	13.9
Upper middle income countries	16.1
BRICS countries:	
South Africa	7.8
India	7.0
China	14.9
Brazil	18.9
Russia	Not available
African region	2.7

Source: World Health Statistics Report 2015.
Note: Physician in this context means all medically trained doctors (professional qualification) regardless of sp ecialisation.

Cost of the PMB's for 2015 (continue)



Differences in risk profiles of medical schemes