

Atlantic Fellows

FOR HEALTH EQUITY
IN SOUTH AFRICA



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HEALTH EQUITY BARRIERS AND OPPORTUNITIES: THE SOUTH AFRICAN EXPERIENCE

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London School of Economics

INSPIRED LEADERSHIP

"My inspiration are men and women who have emerged throughout the globe ... who fight socio-economic conditions which do not help towards the advancement of humanity... . Men and women who fight the suppression of the human voice, who fight disease, illiteracy, ignorance, poverty and hunger. Some are known, others are not. Those are the people who have inspired me."

Nelson R Mandela, 2000

CHALLENGES OF INEQUITY

- **South Africa is a middle income country.**
- **Emerged from a history of racism under the umbrella of apartheid capitalist oppression.**
- **Three social and economic ills, namely, poverty, unemployment and inequality.**
- **Most unequal society in the globe - Gini Coefficient 70%.**
- **Apartheid was particularly harsh to black South African women and children. Under-resourced health services, environmental risks, and precarious food security characterised the lives of many during this period and even now.**
- **By 1994 “infant mortality was ten times higher in the black population than in the white population (infant mortality rate 130 vs 13 per 1000 livebirths), rates of stunting were much higher in black children than in white children (28.4% vs 1.1%), more than 19 000 cases of measles were reported each year...”**

HEALTH OUTCOME INEQUITY

The mortality rates below show clearly the inequity in health outcome during apartheid.

Table 2.6 Age-specific mortality rates of different population groups in South Africa (1970) (deaths per 1000 population)

Group	Age (years)								
	Infant	<1	1-4	5-14	15-24	25-34	35-44	45-54	55-64
Whites	21.6	22.7	1.1	0.5	1.5	1.7	3.8	9.0	20.1
Asians	36.4	41.4	3.6	0.8	1.4	2.3	5.6	14.5	33.9
Coloureds	132.6	139.4	14.7	1.2	2.7	5.1	8.8	17.0	31.2
Blacks	(?)123.9	135.8	15.6	1.4	3.0	4.9	8.3	15.3	27.7

Source: C. H. Wyndham and L. M. Irwig (1979). A comparison of the mortality rates of various population groups in the Republic of South Africa. *South African Medical Journal*, 12 May

THE PERVASIVE NATURE OF INEQUITY

Barriers and opportunities to equity straddle and pervade all aspects of life: social, political, economic etc. It is for that reason that governments have to ensure that the World Health Organisation call for “Health in All Policies” is heeded. Immense progress can be made in inter-sectoral collaboration through the adoption of that process.

Everyone has a responsibility to work towards health equity as was the call in Rio:

“We understand that health equity is a shared responsibility and requires the engagement of all sectors of government, of all segments of society, and of all members of the international community, in an “all for equity” and “health for all” global action”. (W H O Rio Conference, 2011)

“WHAT IS WHAT?”

A few definitions contextualise the discussion that will follow.

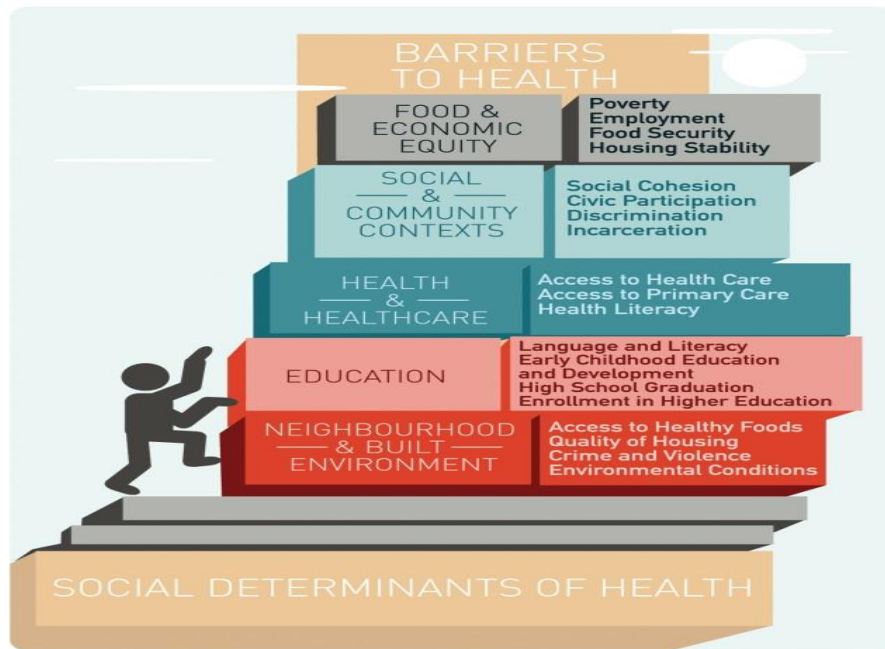
“Health inequalities are systematic differences in health among social groups that are caused by unequal exposure to- and distribution of- social determinants of health (SDH)”. (Linden Farrer et al, 2012)

This definition originates from that of the World Health Organisation: health inequalities are “differences in health status or in the distribution of health determinants between different population groups”

TEKANO (Health Equity South Africa), a new non-profit organisation describes health equity as “fairness in the distribution of health resources and outcomes”

Social determinants of health are “*The circumstances in which people are born, grow up, live, work and age, and the systems put in place to deal with illness*” (Guerra et al, 2016)

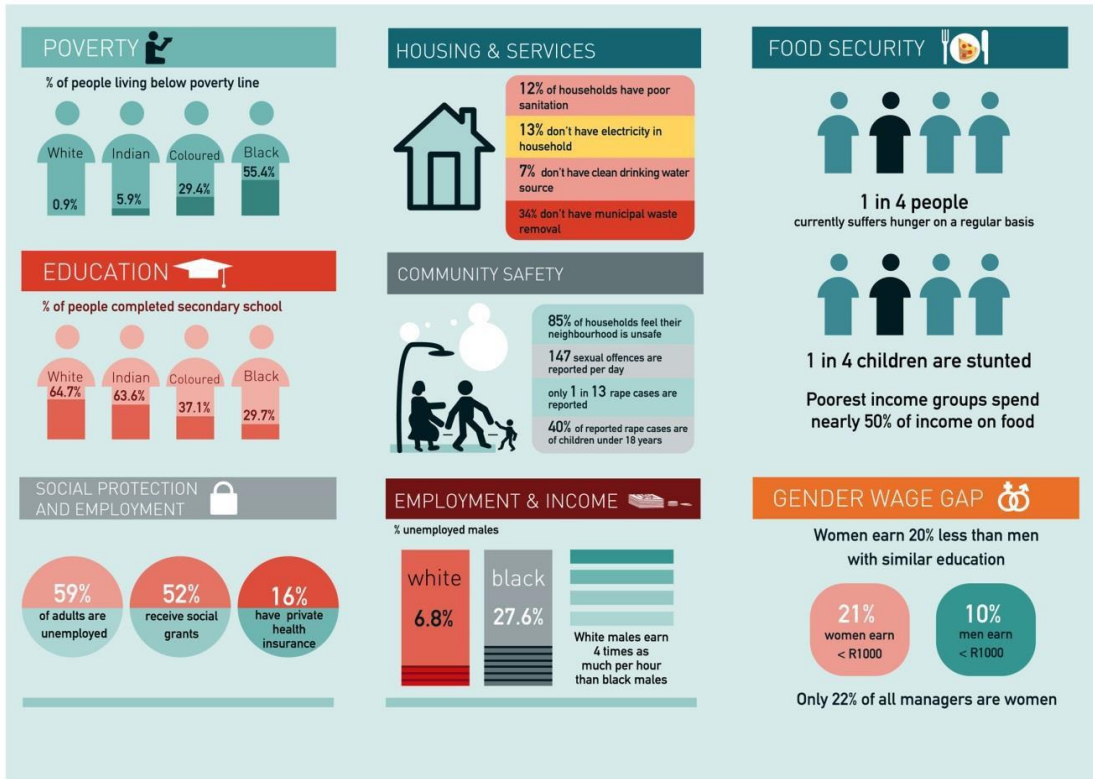
CAUSES OF CAUSES



EVIDENCE OF HEALTH INEQUITY

Tekano founding documents illustrate that “This inequity manifests in continuing disparity between segments of society in terms of health outcomes, education, employment, earning, housing and access to basic services etc”

SDH INEQUITY



ECD Centre

Sanitation challenge

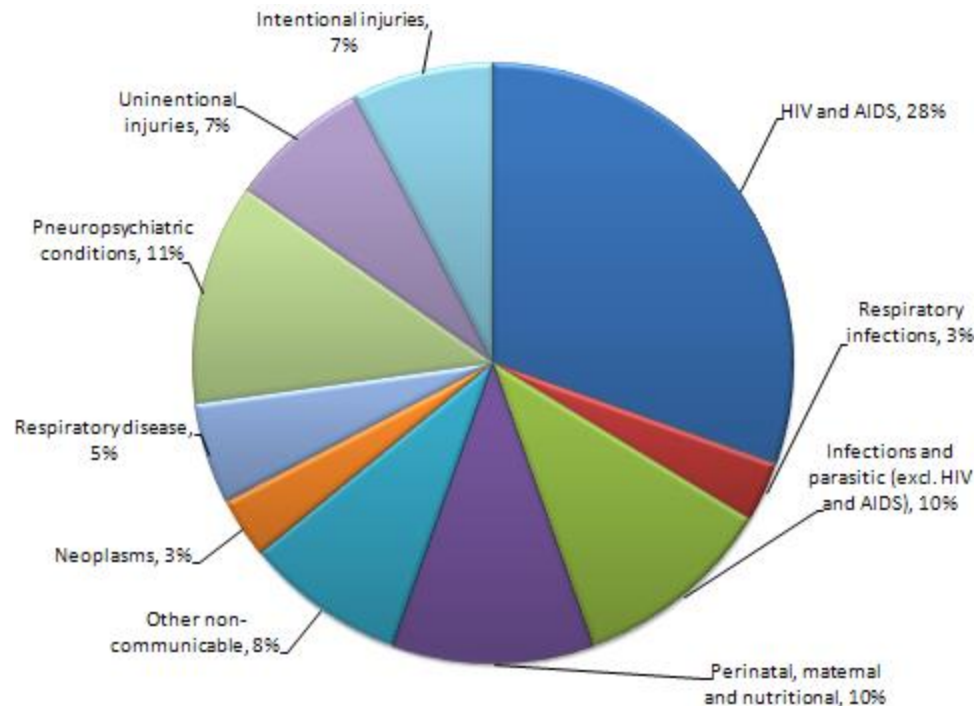


EVIDENCE OF HEALTH INEQUITY

Statistics South Africa data as presented by K. Masiteng (2017) shows that health inequity in terms of outcomes is still along racial lines as shown by the number of non-communicable diseases (NCDs) and communicable diseases (CDs) in the Top 10 leading causes of death according to population group:

POPULATION GROUP	CDs	NCDs
African	5	5
Coloured	2	8
White	1	9
Indian/Asian	1	9

Source: Norman et al, 2007 (As quoted in the DBSA Report of 2012). Burden of disease, DALs in 2000.



RECOMMENDATIONS AND OPPORTUNITIES

- Most causes of inequitable health outcomes are preventable
- The first priority to deal with the health inequities in South Africa is to deal with the social determinants of health in every sector.
- The diseases of poverty and social ills have to be tackled.
- Society and governments should focus on improving the social determinants of health equity: housing, water and sanitation, education, health literacy, safety, decent work, livelihoods and food as well as opportunities for active civic participation are as fundamentally important to health as the availability of health services.

RECOMMENDATIONS AND OPPORTUNITIES

- **Governments have to have policies that put health in the centre of development.**
- **“Health in All Policies” should be the battle cry.**
- **South Africa has an opportunity in the implementation of the National Development Plan (NDP) to achieve this.**
- **The NDP is an integrated comprehensive inclusive plan that deals very well with the SDHs.**
- **Policy implementation is a big challenge for the South African Government.**
- **Organisations like Tekano that aim to develop fellows who are values-based leaders that will drive the mission to achieve health equity should give impetus to government efforts to realise the objectives of the NDP**
- **Advocacy for social justice**

LESSONS FROM THE PAST

- **If one looks at the disease profile in Britain during the 19th century and contrasts that with the profile in the 20th century one will realise that what are now known as tropical diseases were very prevalent in Europe.**
- **The major victory against these diseases was achieved through dealing with the SDHs long before antibiotics were discovered. Medical interventions later added value by improving health care.**

The following table adapted from David Sanders (1982) is very instructive in that regard.

Tackling Social Determinants Turned the British Situation Around

Table 2.5 Death rates (per million) in 1848/54 and 1971 in England and Wales

	1848/54	1971	Percentage of reduction attributable to each category
<i>I. Conditions attributable to micro-organisms (communicable):</i>			
Airborne diseases	7259	619	40
Water- and food-borne diseases	3562	35	21
Other conditions	2144	60	13
Total	12965	714	74
<i>II. Conditions not attributable to micro-organisms</i>			
All diseases	8891	4070	26
	21856	5384	100

Source: Thomas McKeown. *The Role of Medicine: Dream, Mirage or Nemesis?*¹

The Struggle for Health

Figure 2
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RECOMMENDATIONS AND OPPORTUNITIES

- **The other opportunity to drive the mission towards health equity is in the health care system itself.**
- **Access to quality health care for the majority of South Africans is a mirage.**
- **The current ministry has introduced the National Health Insurance as a means of achieving universal access to quality health care. Delays in the full roll out of the system have been experienced whilst pilot sites have been set up for quite a while.**
- **Again civil society organisations need to have well prepared leaders who will drive the mission of organisations like Tekano for the achievement of equity in health**
- **Inspired leaders like Nelson Mandela are needed, *“Men and women who fight the suppression of the human voice, who fight disease, illiteracy, ignorance, poverty and hunger”.***

THANK YOU