

Universal Health Access and Poverty



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The political transformation of South Africa in the past 14 years did not bring about the desired social and health sector transformation. This is, to a larger extent, due to failure to adequately address issues of poverty alleviation and the sustained spread of economic advancement.

The disparity of the past has taken a new form. It has rather become de-racialised since statutory racism was outlawed. The “new apartheid” in health is a class problem. The poor in our country depend solely on the public sector for many of their services, including healthcare. There is nothing wrong if people use certain services out of choice and not out of desperation. There is everything right in most of us

using the public service out of choice. The middle class does not use the public sector out of choice.

The public service in our country is unique in that it is reeling under the immense strain of providing care to large numbers of patients, with long queues, overworked staff, poor management and low morale.

Even if private hospitals were to open their doors tomorrow to admit all patients without affordability considerations, their capacity would only allow them one million more patients. Urgent action is needed. The private hospital sector cannot continue to sit on the sidelines when they are also part of this “National Health System” economy and, therefore, an important

stakeholder in healthcare delivery. It is not difficult to understand that the reason there have been so many controversies around the private hospital industry in this country is also partly because of the poor delivery of services in the public health sector. If the public sector services were more competitive, users of private hospitals would also go to public hospitals.

For many years, healthcare stakeholders have been generally blaming each other for the country's healthcare woes. We have even forgotten that it will not take one stakeholder to change healthcare delivery in SA. Each stakeholder has a responsibility and capacity to contribute positively to the future of healthcare delivery in this country. No section alone, including government, is equal to the mammoth task of bringing about changes in healthcare that will satisfy the ethos of our constitution, namely affordability and accessibility of quality healthcare.

THE PAST

It has been exactly 66 years since SA has been involved in attempts at establishing equity in healthcare. In 1942, the then government established a commission to enquire into and report and advise on:

- The provision of an organised national health service which would ensure adequate medical, dental, nursing and hospital services for all sections of the people of the Union of SA.
- The administrative, legislative, and financial measures which would be

necessary to provide the Union with such a national health service.

The commission was chaired by then Member of Parliament, Dr Henry Gluckman. After two years of diligent work that included a tour of the country to learn first-hand about conditions on the ground, the commission presented its 219-page report, referred to famously as the Gluckman Report.

The report included the following statement:

“We determined at the outset to evaluate the past and the present, and to plan for the future, having regard to neither variations of political creed within the orbit of democracy, nor to rival social theories, but simply to the scientific conception of health... The committee’s aim is economic prosperity, social contentment and creative power. The attainment of this positive ideal must be the primary objective.” (Phillips, 1993)

The ideal has not been achieved 66 years later. “The role of this was to produce a plan for a National Health Service designed to promote and preserve the health of all sections of the people.” The “all” signifies that the ideal national health service plan could not be established in an unequal society. It was an idea before its time.

So, when the National Party was re-elected in 1952, it was the beginning of the end of this experiment in the delivery of healthcare. The only reason was that this meticulously thought-out and planned national health service could not be implemented in a society that

was apart and unequal – apartheid.

THE PRESENT

If apartheid was the enemy of equity and access to healthcare, then what is the enemy today? Is it because private hospitals are too expensive? No. Private hospitals, with 22% of the share of hospital beds, can only absorb a million more patients. In SA, private hospitals provide the same, if not better, standards than in many of the developed and developing countries. At a cost below \$300 per capita, compared to both Canada at \$917 and the USA at \$3 371 (The Monitor Group, January 2004), the South African sector is affordable.

One is, therefore, forced to accept that the enemy of access to equitable and affordable healthcare, especially the private hospital care in SA, is poverty. Those who can afford medical insurance make up about three million. This number climbs to 7,4 million medical scheme beneficiaries, with the inclusion of dependants.

The employed (both formally and informally), but uninsured, are 9,6 million. It can then be argued that the reason why these employed, but poor, are not insured, is because of a tight “disposable” income.

The Government Employees Medical Scheme (GEMS) has significantly lowered the barriers of entry into medical aid for this social class (*The Private Hospital Review 2008*).

The rest of the population is, of course, the poorest of the poor – unemployed and, in many instances, unemployable. Narayan et al (2000) defines

poverty as “pain, physical, emotional and moral”.

May et al (1998), says that this group “is characterised by continuous ill-health, arduous and often hazardous work for low income, no power to influence change and high levels of anxiety and stress”.

Poverty is a terrible disease that needs eradication. Bloom & Canning (2000) conclusively produced compelling econometric evidence that more health equals less poverty. This link also works in the opposite direction, namely that less poverty equals more health.

The Carnegie Commission

We do not need to go far to prove that poverty alleviation improves the health of the nation. The 1932 Carnegie Commission investigating the “poor white” problem in SA recommended that, among others:

- There must be increased state support for the white poor for housing.
- The white poor must be protected from competition for jobs from “non-Europeans”. Job reservation, by the way, was already practised at the time, but was entrenched even more than ever.
- Compulsory education up to the age of 15 and improvement of farm schools.
- Massive community-based health and education campaigns.

Most of the Carnegie recommendations were implemented by the then

government, and remarkable socio-economic health gains were made over a few decades by the poor white population. Was that White Economic Empowerment (WEE)? From that time, white infant mortality went down from 70/1 000 live births to 35/1 000 in two decades and continued to fall to less than 15/1 000 live births (Rip, Bourne and Woods 1988).

These only illustrate the effect poverty alleviation has on general health. The state injected massive amounts of funds into social needs, albeit for whites only, creating imbalances based on race. **Present conditions call for the state to inject even more funds into healthcare and education to benefit all.**

The state is already spending a lot, but more can be done, at least to meet the 15% expenditure set by the Abuja Declaration. Drastic situations call for drastic measures.

POST-POLOKWANE

Prioritising healthcare and education as adopted at the Polokwane ANC conference is a clear message that SA cannot fiddle anymore with these two most emotive and critical deliverables. The resolution to implement the National Health Insurance is but a way of implementing the 66-year journey of a democratised healthcare delivery system. We will be foolhardy if we do not use this opportunity to finally resolve our problems of healthcare delivery.

The Gluckman Report recognised that poverty was a healthcare barrier. The report stated that “if the best results

are to be obtained from such a national health service, its establishment must be accompanied by a rapid development of educational and other social services and agricultural and industrial development throughout the land”. More than anything else, Gluckman advocated a central role for the national health service in the alleviation of poverty and socio-economic development. Hence, it is imperative for all of us to put our hands on deck and work for the common good.

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