# Justice and the distribution of healthcare resources "Leaving No One Behind"

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# One Budget Many Needs

- The Health Gap
- Three strategies to narrowing the health gap (Johansson, 2014)
  - Increase the health budget / national and provincial
  - Improve efficiencies / fight corruption
  - Set priorities / distribution of resources
- Universal health coverage:
  - Universal health care access based on need
  - “Leaving No One Behind”
  - More than ‘free’ healthcare at point of delivery

# Universal Access:

## Financial

## Physical

## Acceptable

# Universal Health Coverage and Resource Constraints

- *UHC is a gradual process: where to start?*
- Thailand, Brazil, Mexico: residents receiving *some services and financial protection, even if the service benefit package is modest, at least initially* (The Elders, Position Paper, p.6)
- A defined package of comprehensive healthcare services, committed to offering a wide range of services 'as possible' (DoH, undated, "Understanding NHI)
- DP Mabuza / Presidential Health Summit: "expansion of benefits within decades to come"
- Beyond currently stated income sources *"It is possible that government will be required to further boost this amount"* (DoH, undated, "Understanding NHI)

# Priority-setting = Unavoidable

- One of the greatest ethical challenges in healthcare
- Dual scarcity
  - External: opportunity costs
  - Internal: unlimited health needs, new technologies & treatments, orphan drugs
- As a result we “ration” healthcare:
  - Tragic & complex
  - Starting off with: distinguishing between morally acceptable and unacceptable principles
- Accountability for Reasonableness

# HIV/AIDS Sector

- Advanced expertise in healthcare priority-setting; eligibility criteria for new treatments, cost-effectiveness studies to inform decision-making etc
- Leading on “access” innovations
- Some decisions have had tragic consequences: 90-90-90 / Dr RSM District / Affecting the worst-off ito socio-economic conditions
- UHC and Our Task Ahead: How do we prioritise scarce resources for comprehensive healthcare access for all
- Underlying principle: Right to Health

# Two dimensions to Priority-Setting

***1) In relation to healthcare***

- Levels and range of healthcare services
- Preventative, promotive, curative, palliative, rehabilitative
- PHC to Tertiary Care

***2) In relation to principles of social justice: fairness and equity***

- Fairness: Making *progress* to UHC fairly, without discrimination/ Fair distribution of benefits and burdens
- Equity demands that everyone who is eligible has access to the defined healthcare service, regardless of socio-economic circumstances
- Social justice: When people's access to healthcare is not negatively influenced by unfair disadvantages caused by inequalities in wealth, opportunities and privileges

# A Fair Health Care System

pay. In more technical language, we may say that a fair system will expand service coverage with financial risk protection by giving priority to policies benefiting the worse-off, where the worse-off are defined both in terms of health itself and in terms of socio-economic status.[11,12]

Fair health systems are concerned with the worse-off in terms of health, socio-economic status, or overall well-being. One

*Norheim (2015) Ethical perspective: Five Unacceptable Trade-offs on the Path to UHC*

# Examples of ethical dilemmas

- Spending more funds on reduced suffering for a few or improving health for many
- Saving lives of identifiable people today or saving 'future lives'
- Extending someone's life with a few months or improving quality of life over a lifetime?
- Improving coverage of *new treatment technologies* in urban South Africa or achieving near full coverage of HIV testing in remote rural areas?

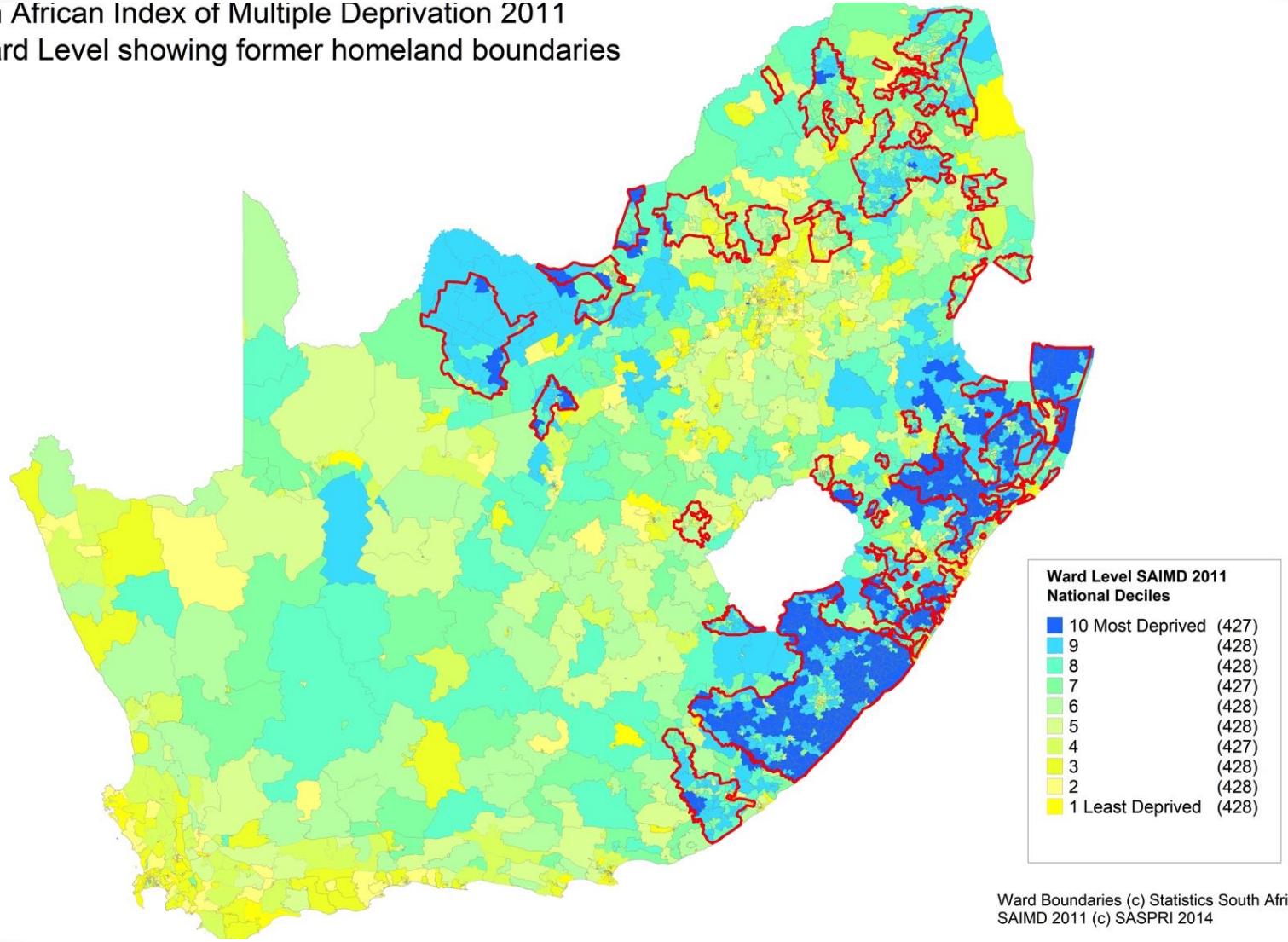
# Answers depend on the ground principles we agree on

- What is Just?
- Different theories in priority-setting
- Far-reaching consequences
  - Slice of the Budget
  - “Fair Share”

# Legal answer

- Progressive Realisation of the right to healthcare access within available resources
- Rational and reasonable
- Equitable
- Special attention to vulnerable groups
- In reality:

South African Index of Multiple Deprivation 2011
at Ward Level showing former homeland boundaries



# Health in Every Hut

- NGO service in Mbashe Sub-District, REMOTE rural villages (2013-2016)
- Household level health screening, surveillance and ongoing monitoring 2289 HHs / 22 589 individuals
- Predominant concern: scarcity and safety of water
- Only 66% of infants born to HIV positive mothers (498) were given nevirapine syrup
- Rate of breastfeeding was less than half (41,5% of children)
- Many breastfed infants weaned on to formula/solids < 6 months
- High rates of hypertension and unsuccessful pregnancy outcomes

Donald Woods Foundation (M&E report, 2017)

# Catastrophic OOP expenditure / % monthly income

| OOP transport to outpatient care | | |
|---|---|---|
| | 5-9% | >10% |
| Rural | 22.4% | 15.3% |
| Urban-informal | 8.6% | 10.6% |
| Urban-formal | 6.7% | 5.1% |

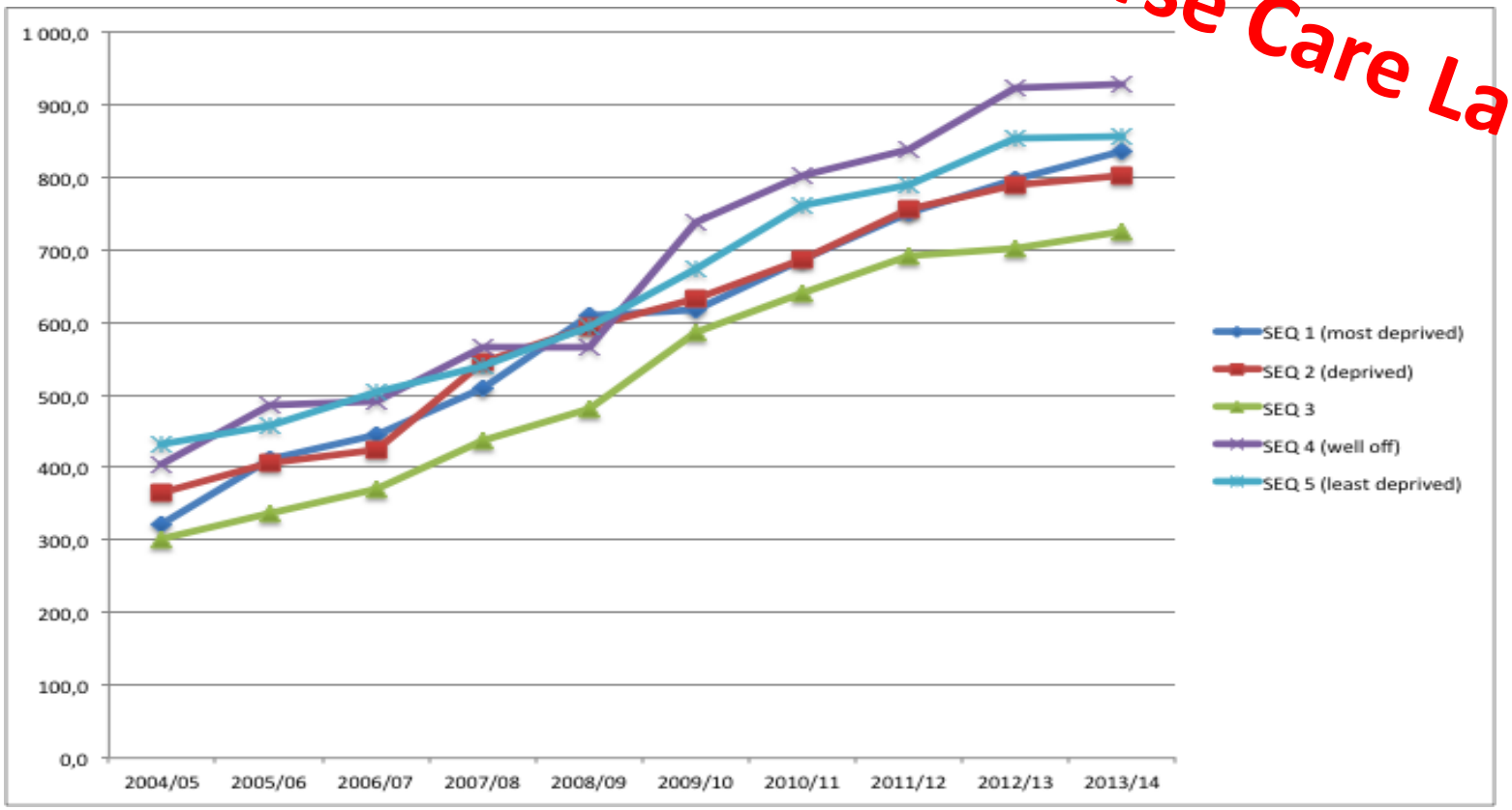
*Expenditure is catastrophic if it exceeds 10% of a household's monthly income

Adapted from Harris. *et al*, 2011

"SOME OF THESE PATIENTS (mainly patients with cancer) *FROM THE RURAL AREAS OF MBIZANA -EASTERN CAPE HAVE TO WAIT AND SLEEP LIKE THIS AT ST PATRICK'S HOSPITAL TO BE FERRIED TO NELSON MANDELA ACADEMIC HOSPITAL THE FOLLOWING DAY IN MTHATHA +/- 250 kms AWAY" - FaceBook post*

# Infrastructure/Inequity Trap: Inequitable financing of health care

**Inverse Care Law**




Graph 3: Per Capita PHC expenditure by Deprivation Quintile 2004/05-2013/14

Source: RHAP, based on DHB data

# What is different about rural

- Poor environmental health conditions
- Access constraints
- Higher levels of unmet need
- Lower economies of scale
- Rural healthcare is more expensive and requires more effort to bring services “in reach”
- “Health promotion and prevention better than cure” particularly relevant where access is poor

So how do we prioritise the budget fairly, justly?

#Leaving No One Behind

# Health maximising principle

- A predominant paradigm in the health sector?
- Given scarcity, the 'right' approach would be that which has a maximising effect for the nation at large
- Focus on end outcomes, not individual patient needs or rights
- Will exclude some groups for sake of larger benefit
- Not intrinsically concerned with past and current social injustices or rural exclusion due to cost drivers
- Does not reduce inequities in access

  - **Ex 1: 90-90-90 withdrawal from Dr RSM District**
  - **Ex 2: Low and reduced investment in outreach / frozen posts rehab services**
    - **Most vulnerable hurt the most; eg PWDs**

# National Health Facilities - North West - Kagisano-Molopo Municipality


## Legend

### Health Facilties

Type

- Regional Hospital
- District Hospital
- Specialised Hospital
- Community Health Centre
- Clinic
- Satellite Clinic
- City/Town
- Main Roads
- North West
- District Municipality
- Local Municipality

### Population

- 1 - 75000
- 75001 - 150000
- 150001 - 250000
- 250001 - 350000
- 350001 - 475000
- Province

Note: All health facilities data is supplied by DHIS
All Distances are measured from Ganyesa Hosptial

FPD COMPASS

# Egalitarianism

- What is equality?
  - Equal resource allocation
  - Equal health outcomes
  - Equal access to healthcare
- A clinic with a full package of healthcare at 20 km from a village is not “accessible” if people have no means to reach the clinic
- Costly interventions to improve equitable access are supported
- Clinic in every village??? A specialist in every village??
- Leveling down and bottomless pit objections

# Prioritarianism

- More important to prioritise the worst-off than to achieve strict equality
- More important to make small gains for worst off groups than possibly more cost-effective gains for better-off groups
- “This will gradually reduce inequities”
- South Africa’s Progressive Realisation approach
- Extent of prioritisation is not specified
- Scores of people remain below an acceptable level of access to basic and high priority healthcare services
- No sense of urgency
- *Tend to focus on Package not Adequate Access*

# A pluralist account

- Equity criteria alongside health-maximising (WHO/Norheim, 2014):
- **Group 1: Criteria related to disease and intervention criteria**
  - Eg: Severity of illness / Past health loss / chronic disability / realisation of potential
- **Group 2: Criteria related to characteristics of social groups**
  - Eg: Areas of living / socio-economic status / race
- **Group 3: Criteria related to protection against financial and social effects of ill health**
  - Economic activity / care for others / catastrophic health expenditures

- Objections: A *"wish list"*, how to prioritise??
- Progress for worst-off may remain too slow
- *Justice requires firmer guidance*
  - *"Unacceptable Trade-Offs" (Norheim, 2015)*
    - *Expanding coverage for lower priorities before near coverage of high priorities*
  - *Define "High priorities"*

# High priority services?

- “Easily preventable or treatable diseases”
- Access to skilled birth attendants and services for easily preventable or treatable fatal childhood diseases
- Oral dehydration therapy for children with diarrhoea
- Antibiotics for children with pneumonia
- HIV and TB testing and treatment
- Cancer screening
- *Allocation principles not clearly spelled out*

# Sufficiency Approach

- Sufficient Access to Sufficient Healthcare for All
- Builds on the priority-setting approach: Thresholds/ Minimum Norms
- Should equally take ACCESS into account: Double Sufficiency
- All should have access to minimum standards of basic healthcare before expanding coverage beyond minimum standards
- What constitutes sufficiency?
  - Sufficient basic human capabilities to live dignified lives and perform vital life tasks within one's range of functioning
  - Not a disease-specific focus

# Objection

- Does not solve “resource scarcity”.
- In defence:
  1) Directs the focus of resources: Double Sufficiency
  2) To avoid an NHI that will benefit urban healthcare users and the privileged
  3) Not equal access but sufficient access, eg
     - “Dignified referral pathways”
  4) Sense of urgency
  5) Give an ethical and fair motivation for introducing “fair limits” to eligibility criteria
     1) Limited funds
     2) Accountability for reasonableness

# What does justice require in "slicing the budget"?

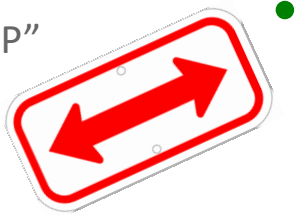
- **Sufficient access**
  - Financial
  - Physical
  - Acceptable / dignified/ quality

- **Sufficient healthcare**
  - "Unlimited health needs"
  - Needs versus wants
  - The benefit package
  - High priority needs, medium, low
    - "Who decides"?
    - "Based on what"?

# National Development Plan

## Package, eg:

- Increased life expectance through progressive improvements in evidence-based preventive and therapeutic interventions
  - Eg “Universal availability to PREP”
- Progressively improve TB prevention and cure
  - Eg: “Successful treatment completion”
- Reduce prevalence of NCDs by 28%
  - Eg Address: lifestyle, raised blood pressure and glucose



## Access / Social Justice

- Financial
- Physical
- Acceptable

# "Unacceptable Trade-Offs"

…"expanding coverage for those with already high coverage before groups with lower coverage"

*"further expansion of reproductive health services or tuberculosis detection and treatment in the big cities before expansion in rural areas"*

Source: Norheim, Ole Frithjof. 2015. "Ethical Perspective: Five Unacceptable Trade-Offs on the Path to Universal Health Coverage." *International Journal of Health Policy and Management* 4 (11):711–14.

# *Leaving No One Behind*

- Has to start with PHC for All
- CHW Programme: Overwhelming Global Evidence of Success
  - CBS represents a very small proportion of PHC expenditure (under 4%), given the role the CBS platform is expected to play in the continuum of services (MRC, RHAP Study, 2017)
- SA CHW Programme
  - DoH: 40 000
  - MRC Investment Case: 70 000 (limited scope)
  - NDP: 700 000 CHWs (broad scope, mix of full and part-time)

# *Leaving No One Behind*

- 1st 1000 days / eg role of nutrition and breastfeeding support
  - Every child deserves a fair chance
  - Missing out on essential at "1st 1000" days: lifelong consequences
- HIV counselling and testing: Have we considered needs and vulnerabilities of rural PWDs?

# Priority-Setting during Austerity / UNHRO (2013)

- The existence of a compelling State interest must be demonstrated
- The necessity, reasonableness, temporariness and proportionality of the austerity measures
- Exhaustion of alternative and less restrictive measures
- Non-discriminatory nature of the measures adopted
- Protection of a minimum core content of the rights
- Genuine participation of affected groups and individuals

# In Conclusion: "Leaving No One Behind"

- Requires all three strategies
- More explicit attention to trade-offs, access/reach, transparency, health care user/community involvement
- No NHI Committee on Access

# Discussion, Questions and Comments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