The Global Charter for the Public’s Health and its potential for Addressing Health Inequities

Professor Laetitia Rispel

Presentation at 2017 PHASA conference

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• Context

• Key elements of the Global Charter

• Implications of the Global Charter for Public Health Practice in South Africa

• Conclusion – 2 exciting initiatives
RSA REMAINS ONE OF THE MOST UNEQUAL SOCIETIES

• 2016 Gini Coefficient of 63.4
• Markers of inequities
  – Race
  – Gender
  – Geographical location
  – Public and private health sectors
• Complex & heavy burden of disease

Source: Statistics SA, 2015; UNDP, 2016
SIGNIFICANT DEVELOPMENTS

• 6th Lindau meeting of Nobel Prize Laureates in economics that was held from 23-26 August 2017

• 2017 Statistics South Africa report on poverty that examines absolute poverty and trends between 2006 and 2015
Rising inequalities at a global level

• Proposed strategies include:
  – Introduction of a universal basic income
  – Unconditional income transfers
  – Capital endowment to each person on reaching adulthood
  – Annual child benefit, to help support the finances it takes to help children have better opportunities
  – Using estate tax to provide a dividend to young people turning 21

• Financing mechanisms
  – Estate taxes
  – Higher taxes on high earnings
  – Wealth taxes
  – Shifting the burden of taxation to capital rather than labour

“A ticking time bomb” (McCauley)

“Since 2011, we have seen poverty levels increase-This means that the country has lost ground in the war on poverty and will now have to reduce poverty at a faster rate than previously planned”, StatsSA, page 18

In 2015: 30.4 million or 55.5% of South Africans lived in poverty or survived on < R992 per person per month

Lower bound poverty line = R501 per person per month

Number of people in extreme poverty - < R441 per person per month
- 2011: 11 million
- 2015: 13.8 million

Children under the age of 17 are the hardest hit

Face of poverty:
- Black African
- Female
- Rural

<table>
<thead>
<tr>
<th>Province</th>
<th>2015 Annual income (Rands)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Western Cape</td>
<td>222 959</td>
</tr>
<tr>
<td>Gauteng</td>
<td>193 771</td>
</tr>
<tr>
<td>Mpumalanga</td>
<td>107 561</td>
</tr>
<tr>
<td>Northern Cape</td>
<td>103 912</td>
</tr>
<tr>
<td>KwaZulu-Natal</td>
<td>101 088</td>
</tr>
<tr>
<td>Free State</td>
<td>98 529</td>
</tr>
<tr>
<td>Eastern Cape</td>
<td>90 156</td>
</tr>
<tr>
<td>North West</td>
<td>86 926</td>
</tr>
<tr>
<td>Limpopo</td>
<td>79 152</td>
</tr>
<tr>
<td>South Africa</td>
<td>138 168</td>
</tr>
</tbody>
</table>

1US$=R13

Source: SA Presidency, 2017
Male-headed households earned significantly more than female-headed households in 2015.

Source: SA Presidency, 2017
The world's most unequal countries
Share of total wealth of richest 1% in selected countries in 2016

- Russia: 74.5%
- India: 58.4%
- Thailand: 58.0%
- Indonesia: 49.3%
- Brazil: 47.9%
- China: 43.8%
- United States: 42.1%
- South Africa: 41.9%
- Mexico: 38.2%

Source: Credit Suisse Global Wealth Databooks
Source: SA Presidency, 2017
WEALTH DISTRIBUTION IN SOUTH AFRICA

• 2016 study used survey data and personal income tax data
• Inequalities in wealth much greater compared to incomes
• 10% of SA population own at least 90-95% of all wealth
• Wealthy elite extraordinarily rich in the face of substantial poverty
• May be hidden in aggregate official statistics
• Both inter-and intra-racial dimensions to wealth inequality

LIFE EXPECTANCY AT BIRTH
FEMALES

Source: Presidency, 2017
CAUSES OF DEATH BY PROVINCE, 2014

<table>
<thead>
<tr>
<th>Province</th>
<th>Communicable diseases</th>
<th>Non-communicable diseases</th>
<th>Injuries</th>
</tr>
</thead>
<tbody>
<tr>
<td>South Africa</td>
<td>36.8%</td>
<td>52.7%</td>
<td>10.5%</td>
</tr>
<tr>
<td>Western Cape</td>
<td>21.8%</td>
<td>64.4%</td>
<td>13.7%</td>
</tr>
<tr>
<td>Gauteng</td>
<td>33.3%</td>
<td>55.8%</td>
<td>10.8%</td>
</tr>
<tr>
<td>Eastern Cape</td>
<td>35.1%</td>
<td>54.0%</td>
<td>10.9%</td>
</tr>
<tr>
<td>Northern Cape</td>
<td>36.0%</td>
<td>52.8%</td>
<td>11.2%</td>
</tr>
<tr>
<td>Free State</td>
<td>39.1%</td>
<td>51.3%</td>
<td>9.6%</td>
</tr>
<tr>
<td>KwaZulu-Natal</td>
<td>40.6%</td>
<td>48.8%</td>
<td>10.6%</td>
</tr>
<tr>
<td>North West</td>
<td>41.4%</td>
<td>50.4%</td>
<td>8.3%</td>
</tr>
<tr>
<td>Mpumalanga</td>
<td>44.1%</td>
<td>45.3%</td>
<td>10.6%</td>
</tr>
<tr>
<td>Limpopo</td>
<td>44.4%</td>
<td>47.3%</td>
<td>8.3%</td>
</tr>
</tbody>
</table>

Source: Statistics SA, 2016
GLOBAL CHARTER
The challenges facing public health, and the broader world context in which we struggle, have become too numerous and too complex for a business-as-usual approach” (Dr Margaret Chan, WHO director-general, 2012).

- 2012: Dr Margaret Chan’s ‘challenge’ to World Federation of Public Health Associations
  - No universal definition of public health and/or global health
  - What constitute essential public health functions or services?
  - Framework and/or practical strategies that could re-energize the world..... Health for all

- “New public health initiative” became one of the main collaborative activities between the WFPHA and WHO

Sources: WFPHA 2015, 2016, Moore et al, 2016
• **Values** of equity, social justice and human rights

• **Goals:**
  – Reduce health inequities
  – Achieve improved population health outcomes
  – Contribute to the development of resilient and secure health systems

Sources: WFPHA 2015, 2016, Moore et al, 2016
GLOBAL CHARTER FOR THE PUBLIC’S HEALTH

Source: WFPHA, 2016
GLOBAL CHARTER

Protection

Promotion

Prevention

• Inequalities
  • Environmental, social, economic & political determinants; resilience; healthy settings

• International health regulations
  • Health impact assessment
  • Communicable disease control
  • Occupational health
  • Climate change and sustainability

Vaccination
Screening
Evidence-based, community-based, integrated, person-centred quality health-care and rehabilitation

GLOBAL CHARTER

• Governance
  – Public health legislation
  – Health and intersectoral collaboration
  – Accountability and ethics

• Information
  – Surveillance
  – Monitoring and evaluation
  – Dissemination and uptake

• Advocacy
  – Leadership and ethics
  – Health equity
  – Education of the public
  – Sustainable development

• Capacity
  – Workforce development for public health
  – Workforce planning: numbers, resources, infrastructure, standards, curriculum, accreditation

IMPLICATIONS FOR PUBLIC HEALTH PRACTICE
CHARTER IMPLICATIONS

Strong National Public Health Association

Values and Philosophy

Governance and Accountability

Capacity Building

Economic and Fiscal policies

Collaboration & Partnerships

Resilient health system
2 exciting research and capacity building initiatives

**Sheiham family endowment to University of the Witwatersrand**
- Research and PhD fellowship programme in social determinants of health and health equity
- Annual lecture on health equity
- Joint short course with UCL
- First PhD scholarship awarded

**Tekano Health Equity South Africa**
- Identify and enable dynamic, values-led social change leaders
- Over time, a catalytic community with shared values who work collectively across sectors and disciplines to achieve the vision of health equity
- First group of 35 fellows selected from more than 100 applications
CONCLUSION

Flexible framework
Advocacy tool
Teaching & Capacity Building
Potential to address health inequities

Source: WFPHA, 2016
ACKNOWLEDGEMENTS

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