ACCESS TO TREATMENT IN THE PRIVATE-SECTOR WORKPLACE pdf

1: Comparing NHS with private cancer treatment | Cancer information | Cancer Research UK

The private sector is now emerging as a major participant in the response. Some companies have been running HIV education and prevention programmes in the workplace for many years, partly because they had the foresight to anticipate the challenges.

Health in Algeria When Algeria gained its independence from France in , there were only around doctors across the whole country and no proper system of healthcare. Over the next few decades, great progress was made in building up the health sector, with the training of doctors and the creation of many health facilities. Today, Algeria has an established network of hospitals including university hospitals , clinics, medical centres and small health units or dispensaries. While equipment and medicines may not always be the latest available, staffing levels are high and the country has one of the best healthcare systems in Africa. Access to health care is enhanced by the requirement that doctors and dentists work in public health for at least five years. The government provides universal health care. Health in Cape Verde Medical facilities in Cape Verde are limited, and some medicines are in short supply or unavailable. There are hospitals in Praia and Mindelo , with smaller medical facilities in other places. Brava also has limited inter-island ferry service. Researchers at the Overseas Development Institute have identified the high prioritisation of health and education both within the government and amongst Eritreans at home and abroad. Innovative multi-sectoral approaches to health were also identified with the success. Health care and welfare resources generally are believed to be poor, although reliable information about conditions is often difficult to obtain. In , the most recent year for which figures are available, the Eritrean government spent 5. The two-year war with Ethiopia , coming on the heels of a year struggle for independence, negatively affected the health sector and the general welfare. In the decade since , impressive results have been achieved in lowering maternal and child mortality rates and in immunizing children against childhood diseases. In average life expectancy was slightly less than 63 years, according to the WHO. Immunisation and child nutrition has been tackled by working closely with schools in a multi-sectoral approach; the number of children vaccinated against measles almost doubled in seven years, from This has helped to some small extent even out rural-urban and rich-poor inequity in health. Health in Ethiopia Throughout the s, the government, as part of its reconstruction program, devoted ever-increasing amounts of funding to the social and health sectors, which brought corresponding improvements in school enrollments, adult literacy , and infant mortality rates. These expenditures stagnated or declined during the â€" war with Eritrea , but in the years since, outlays for health have grown steadily. In the country counted one hospital bed per 4, population and more than 27, people per primary health care facility. The physician to population ratio was 1: Overall, there were 20 trained health providers per , inhabitants. These ratios have since shown some improvement. Health care is disproportionately available in urban centers; in rural areas where the vast majority of the population resides, access to health care varies from limited to nonexistent. As of the end of , the United Nations UN reported that 4. Malnutrition is widespread, especially among children, as is food insecurity. Because of growing population pressure on agricultural and pastoral land, soil degradation, and severe droughts that have occurred each decade since the s, per capita food production is declining. According to the UN and the World Bank , Ethiopia at present suffers from a structural food deficit such that even in the most productive years, at least 5 million Ethiopians require food relief. A polio vaccination campaign for 14 million children has been carried out, and a program to resettle some 2 million subsistence farmers is underway. In November , the government launched a five-year program to expand primary health care. In January , it began distributing antiretroviral drugs , hoping to reach up to 30, HIV-infected adults. Health in Ghana In Ghana , most health care is provided by the government, but hospitals and clinics run by religious groups also play an important role. Health care is very variable through the country. The major urban centres are well served, but rural areas often have no modern health care. Patients in these areas either rely on traditional medicine or travel great distances for care. In , Ghana spent 6. In only 62â€"65 percent of the population was estimated to have access to safe drinking water and only 69 percent to sanitation services of some kind; only 8 percent was estimated to have access to modern sanitation facilities.

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In general government expenditures on health constituted 6. Medical facilities in Mali are very limited, especially outside of Bamako , and medicines are in short supply. There were only 5 physicians per , inhabitants in the s and 24 hospital beds per , in In only 36 percent of Malians were estimated to have access to health services within a five-kilometer radius. Health in Morocco According to the United States government, Morocco has inadequate numbers of physicians 0. The health care system includes hospitals, 2, health centers, and 4 university clinics, but they are poorly maintained and lack adequate capacity to meet the demand for medical care. Only 24, beds are available for 6 million patients seeking care each year, including 3 million emergency cases. The health budget corresponds to 1. Health in Niger Health care system of Niger suffers from a chronic lack of resources and a small number of health providers relative to population. Some medicines are in short supply or unavailable. Government hospitals, as well as public health programmes, fall under the control of the Nigerien Ministry of Health. There were Physicians in Niger in , a ratio of 0. Health in Nigeria Health care provision in Nigeria is a concurrent responsibility of the three tiers of government in the country. Historically, health insurance in Nigeria can be applied to a few instances: In May , the government created the National Health Insurance Scheme, the scheme encompasses government employees, the organized private sector and the informal sector. Legislative wise, the scheme also covers children under five, permanently disabled persons and prison inmates. In , the administration of Obasanjo further gave more legislative powers to the scheme with positive amendments to the original legislative act. Health in Senegal The health budget in Senegal has tripled between and , leading to the Senegalese people leading healthier and longer lives â€" the life expectancy at birth is approximately The public system serves the vast majority of the population, but is chronically underfunded and understaffed. This division in substantial ways perpetuates racial inequalities created in the pre-apartheid segregation era and apartheid era of the 20th century. In , South Africa spent 8. Health in Sudan Outside urban areas, little health care is available in Sudan , helping account for a relatively low average life expectancy of 57 years and an infant mortality rate of 69 deaths per 1, live births, low by standards in Middle Eastern but not African countries. For most of the period since independence in , Sudan has experienced civil war , which has diverted resources to military use that otherwise might have gone into health care and training of professionals, many of whom have migrated in search of more gainful employment. In the World Health Organization estimated that there were only 9 doctors per , people, most of them in regions other than the South. Substantial percentages of the population lack access to safe water and sanitary facilities. Malnutrition is widespread outside the central Nile corridor because of population displacement from war and from recurrent droughts; these same factors together with a scarcity of medicines make diseases difficult to control. Child immunization against most major childhood diseases, however, had risen to approximately 60 percent by the late s from very low rates in earlier decades. Spending on health care is quite low â€" only 1 percent of gross domestic product GDP in latest data. The United Nations suggested, however, that the rate could be as high as 7. Between , and 1. As of late , some 4 million persons in the South had been internally displaced and more than 2 million had died or been killed as a result of two decades of war. Comparable figures for Darfur were 1. Health in Zimbabwe Zimbabwe now has one of the lowest life expectancies on Earth â€" 44 for men and 43 for women, [18] down from 60 in Infant mortality has risen from 59 per thousand in the late s to per by

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2: Health systems by country - Wikipedia

Access to treatment in the private-sector workplace The provision of antiretroviral therapy by three companies in South Africa Introduction The availability of antiretroviral therapy from onwards has made a huge impact.

Social Solutions Health and Human Services The barriers to mental healthcare access are significant issues facing many Americans. More than half of adults with mental illness in the U. That statistic alone is cause for concern. But mental health issues are far more common than most people realize. According to the U. Department of Health and Human Services , 1 in 5 American adults have experienced a mental health issue, and 1 in 25 Americans live with a serious mental illness, such as schizophrenia, bipolar disorder, or major depression. Barriers to mental healthcare access come with a high human cost: The lucky ones find homes with family. The unlucky ones show up in the morgue. For many, it can dramatically reduce or eliminate the risk of suicide, legal issues, family conflict, employment issues, substance abuse, and further mental and physical health problems. In order to increase use of mental healthcare services, we first have to understand what prevents people from accessing them in the first place. Want to learn more? Financial Barriers to Mental Healthcare Even after the Affordable Care Act required medical insurers to provide coverage for behavioral and mental healthcare, the cost of treatment often limits access to mental health services. For many individuals, a lack of financial resources prevents them from seeking help at all. For others, a lack of financial resources can lead to inconsistent or inadequate treatment. Even with insurance or financial assistance, mental healthcare services can be costly. Copays and deductibles add up quickly when a diagnosis requires regular therapy, complicated medication management, or intensive treatment programs. Lack of Mental Health Professionals While the US is facing an overall shortage of doctors, the shortage of mental health professionals is steeper than any other category. According to the Health Resources and Services Administration, This overall shortage of healthcare providers is compounded by other factors. Rural areas often have few to no mental healthcare providers at all, let alone providers with specialties. Urban clinics and providers often have long waiting lists, and patients can suffer for months before they get a basic intake appointment. To make matters worse, inadequate reimbursement from government and private insurance plans means fewer doctors are choosing mental health specialties in school, and some private clinicians are only accepting new patients who can pay out-of-pocket. Those factors can make it very hard for someone to find affordable mental healthcare close enough to their home or work to get reliable and consistent treatment. Mental Health Education and Awareness Physical injuries and illnesses are typically obvious. Mental illnesses, however, are often hard to recognize. Other times, people assume that their emotional or mental status is normal, not realizing that they are suffering from disordered thinking or clinical symptoms. The Social Stigma of Mental Health Conditions Multiple studies have found that the stigma associated with mental illness often prevents people from accessing treatment. At one end of the spectrum, their own beliefs about mental illness can prevent them from acknowledging their illness or sticking with treatment. On the other end, the very real risk of facing discrimination in social and professional circles creates a huge barrier. People may fear that family and friends will avoid them or treat them negatively. They may also be concerned that the disclosure of a mental health condition can lead to negative treatment and perceptions at work. Racial Barriers to Mental Healthcare Access There are significant disparities in mental healthcare access among different racial and ethnic groups. A recent study looked at how the Affordable Care Act has impacted mental healthcare access. The study found that white people are the only racial group in which a majority of people with severe psychological distress get treatment. Conclusion Social Solutions is excited to see organizations and agencies taking the time to understand how these issues apply to the communities and individuals they serve. Understanding what prevents mental healthcare access opens the door to improving that access with better programs and policies.

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3: Top 5 Barriers to Mental Healthcare Access

*Access to Treatment in the Private-Sector Workplace: The Provision of Antiretroviral Therapy by Three Companies in South Africa (A UNAIDS Publication) [UNAIDS] on www.enganchecubano.com *FREE* shipping on qualifying offers.*

Retirement Plan Access and Participation Across Generations Overview Americans do most of their saving for retirement at their jobs, though many private sector workers lack access to a workplace plan. Thus, less than half of nongovernment workers in the United States participated in an employer-sponsored retirement plan in , the most recent year for which detailed data were available. Policymakers at all levels seek to increase retirement security, reduce poverty, and lessen reliance on federal and state social assistance. Many of these initiatives would help more workers save by taking regular contributions from their paychecks. Many Americans have opportunities to save throughout their careers, but their actions tend to change as they age. Earlier research by The Pew Charitable Trusts looked at indicators of financial health by generation, such as overall wealth and how prepared each generation was for retirement. Then it explores some key reasons for those differences and notes similarities in access rates, participation rates, and reasons for not taking part. Participation in retirement plans increases with age: Millennials have the lowest rates, and baby boomers the highest. Access to plans and the percentage that chooses to take part drive the participation rate. Access to plans also increases with age: As workers gain expertise and experience, they more often qualify for higher-paid jobs that are more likely to offer retirement benefits. Older workers also may be more likely than younger ones to stay in jobs long enough to become eligible for workplace plans. Takeup of retirement plans when offered increases with age, education, and income. Millennials were most likely to cite ineligibility as the reason for not participating. Gen Xers most frequently pointed to affordability. Baby boomers noted, about equally, problems with eligibility and affordability. Employer matches to employee contributions can be an important motivator for all age groups. When a match is offered, takeup rises by 15 to The Generations This chartbook defines the age groups this way: Millennials were born from through In this study, we included only millennials 22 and olderâ€”born through â€”to focus the analysis on those who are likely to have finished their schooling. Gen Xers were born from through Baby boomers were born from through Participation rates rise with age. Older workers have greater access to retirement plans and higher takeup rates. In , 31 percent of millennials participated in an employer-sponsored program, whether a defined benefit plan such as a pension or a defined contribution plan such as a k. Though traditional pensions were once the more typical way to build retirement income, participation rates for defined benefit plans varied in a relatively narrow range, rising from 6 percent for millennials to 13 percent for boomers. Thirty-five percent of private sector workers 22 and older do not work for an employer that offers a defined contribution plan or a traditional defined benefit plan. Forty-one percent of millennials who are at least 22 have no access to either type of plan through their employers, compared with 35 percent of Gen Xers and 30 percent of baby boomers. Millennials have faced challenges finding jobs that offer retirement and other benefits, while lower-wage jobs are less likely to come with retirement benefits. When an employer offers a retirement plan, millennials are less likely than their older coworkers to participate. Fifty-two percent of these younger workers take up defined contribution plans when offered, compared with 75 percent of Gen Xers and 80 percent of baby boomers. Millennials are just starting out in their careers and are likely to earn less, as well as to have unsecured debt. For every generation, takeup rates are higher for traditional defined benefit plans than for defined contribution plans when available. Sixty-two percent of millennials, 79 percent of Gen Xers, and 83 percent of baby boomers join a defined benefit plan when offered. Even if an employer offers a retirement plan, certain workers still may not be eligible. Millennials, for example, are more likely than older employees to work too few hours, making them ineligible. For those in Generation X, affordability was most often cited as a reason for nonparticipation, followed closely by eligibility. For Gen Xers, the expenses of raising a family may crowd out saving. Baby boomers cited eligibility and affordability in roughly equal shares. Parenthood may have offsetting effects on retirement saving. Having children may motivate workers to find jobs with benefits, including retirement plans. But raising children is expensive and may increase concerns about whether retirement savings are

affordable. Parenthood increases concerns about affordability among millennials and Gen Xers. Still, even for millennials with children, eligibility concerns trump affordability as a reason for not taking up a retirement plan. Affordability is a more important reason than eligibility for Gen Xers with children. For baby boomers, there is little difference between those with and without children in citing affordability as a factor in participating in a defined contribution plan. That could be attributed to the ages of any children. The youngest boomers, born in , were 48 in when the survey was conducted; for the older members of this generation, children may have already left home. Examining the defined contribution takeup rate by household income sheds light on whether workers see the plan offered as affordable. Takeup of defined contribution plans when offered and when workers meet eligibility requirements rises with household income and age. The one exception involves the highest earners. About 8 in 10 workers with access to a plan benefit from an employer contribution or match. This rate does not vary much across generations. Having some college education or a college degree increases the likelihood that an eligible worker will participate in a workplace retirement plan. Education typically contributes to economic outcomes such as income and job quality, which can be defined in various ways but often includes elements such as health and retirement benefits. In addition, many workers with less education may not have a basic understanding of how to prepare for retirement. The availability of loans and other opportunities to withdraw savings before retirement may encourage some workers to participate in a workplace retirement plan. About 11 percent of millennials have taken loans from their defined contribution plans, compared with 17 percent of Gen Xers and 18 percent of baby boomers. Mean loan balances also increased with age: But taking out a loan means the worker will forgo returns on the borrowed money. This may affect younger workers more dramatically because of the impact on compound returns over longer accumulation. Conclusion Analysts and policymakers often talk about average participants, but averages often hide significant differences among elements of the population. A policy that helps the average worker may not help all workers. As federal and state legislators look at ways to increase retirement security for private sector workers, they will want to be aware of demographic differences in access and participation. Pew has examined some of these differences in earlier publications. And when they are, younger workers are less likely to take part. Millennials often cite a lack of eligibility as a reason for not taking up workplace retirement plans when they are offered. Many in this age group are new to the workforce or have recently changed jobs and may not meet employer requirements for participation. Gen Xers are more likely to cite affordabilityâ€”balancing other claims on their paychecksâ€”as a barrier to participating. Within each generation, higher household income and education increase the likelihood that a worker will take part in a retirement plan. Methodology This analysis relies on data from the Survey of Income and Program Participation, Wave II; the topical module focused on retirement savings plans was collected in The analysis includes private sector workers who are at least age 22 and are employed full time, part time, or seasonally. Agricultural, government, selfemployed, and armed forces workers were not included in the analysis. Participation, Access, and Takeup Participation refers to the share of all employees actually taking part in employer-sponsored retirement plans; the population includes employees who were not offered a retirement plan. Access to a plan means an employee works for an employer that offers a plan, although the employee may or may not be eligible to participate. For an up-to-date summary of state legislation, including bill numbers and legislative histories, see Pension Rights Center, State-Based Retirement Plans for the Private Sector, last modified May , http: May , http: As part of the survey, respondents were asked about plan type. Additionally, plan type was coded as a DB plan if it was reported that participation in Social Security would affect the plan benefit. Plans were coded as DC plans if the primary plan allowed tax-deferred contributions as well as one of the following: We additionally coded plan type as DC if the respondent said the plan was like a k or tax-deferred. Finally, respondents were asked further clarifying questions to determine that they did not actually have access to employer-sponsored plans. Because of these two lines of questions, takeup was determined based on whether respondents said they participated in the primary plan and their answers to the applicable follow-up questions. If answers to the primary and follow-up questions were inconsistent, we used answers to the primary questions. Twenty-eight percent of millennials have been at their jobs for less than one year, and 46 percent of millennials 22 and older have been at their jobs less than two years. Note that the

differences in lifetime earnings may in part reflect the underlying capabilities and characteristics of those individuals obtaining additional formal education and cannot be wholly attributed to the degree itself. Less-educated workers are far less likely to have access to employer-based retirement savings or pension plans. Among workers of all ages who had not graduated from high school or who had a high school or GED diploma, about 54 percent reported having access to a defined benefit or defined contribution plan. Annamaria Lusardi and Olivia S. See also Julie R. Forthcoming Pew publications will address differences in retirement plan participation by industry, gender, and race.

4: Retirement Plan Access and Participation Across Generations | The Pew Charitable Trusts

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