Southern African Development Community (SADC) Health Sector Co-ordinating Unit, and
Regional Network for Equity in Health in Southern Africa (EQUINET)

BRIEFING DOCUMENT ON EQUITY IN HEALTH: KASANE AND BEYOND

In April 2001, the SADC Health Sector is reviewing the issues in and implementation of the Kasane Agenda for Action on Equity in Health in Southern Africa. This document highlights the issues and commitments made at that meeting, post Kasane activities and views on equity in health reported to SADC from country focal points and from the Southern African Regional network on Equity in Health (EQUINET), and the conclusions of a follow up September 2000 conference on equity in health in southern Africa.

The document aims to inform discussions on how far the commitment to equity has been carried forward within the region, to explore:

- The extent to which commitments made at Kasane have been implemented at national and regional level
- The current challenges to equity and the policy priorities and goals to address these
- How the gaps between policy and practice have been and can be addressed.

Kasane, 1997: An agenda for action

The seminar on Equity in Health—Policies for Survival in Southern Africa jointly organised by the National Institute of Development Research and Documentation of the University of Botswana and the Dag Hammarskjöld Foundation, Uppsala, Sweden in March, 1997, Kasane Botswana identifed and discussed critical issues of Equity in Health in Southern Africa and explored possible joint solutions and actions.

'Equity in Health' was understood to involve addressing inequalities in opportunities within and beyond the health sector for achieving health and inequalities in the provision of and access to health care.

It was observed that while Equity in Health should be central to health and development efforts, disparities in health status persist and equity concerns have lost prominence to issues of macro-economic stability, fiscal policy and efficiency, often under the influence of external actors. The HIV/AIDS epidemic has further threatened health and access to adequate health inputs, and has placed its heaviest burdens on the poorest households.

The Kasane meeting thus called for SADC communities to

- Enhance conceptual clarity and provide a clear operational definition for equity, that prioritises vertical equity and that adopts a comprehensive, holistic developmental concept of well being.
- Provide for the constitutional right to equitable access and provision of health care and health promoting services.
- Promote people-centred development paths that prioritise the determinants of health such as education, employment, clean water, sanitation, food security and clean environments and provide intersectoral mechanisms for delivery of these priority inputs.
- Develop resource allocation planning tools that locate equity as a desirable goal.
- Shift the allocation of resources, which are currently in favour of curative services, towards preventive and promotive health services benefiting the majority of populations, particularly the impoverished and under-privileged.
- Review legal barriers to access to health inputs by vulnerable groups
- Establish research on equity issues, train to build public health and health management capacity, particularly at district level, and set up equity monitoring based on agreed regional indicators of equity.
- Develop measures and incentives to curb regional brain-drain of Public Health trained personnel.
- Undertake an assessment of needs and resources in relation to public health training and research in Southern Africa and establish approaches to localising and strengthening public health training in the region
- Strengthen the status and involvement of traditional health systems
- Establish mechanisms for involving civil society and the private sector in national and regional decision-making, and formalise their participation in SADC meetings

- Strengthen the objectives and approaches of SADC sectors which have a bearing on health, so that health concerns are articulated and prioritised.
- Support the establishment of the new health sector within SADC and ensure that it takes a broad, intersectoral approach to health, with Ministers from other sectors also invited attend its meetings.
- Ensure that bilateral and multilateral aid agencies, international organisations and NGOs providing health services do so within the framework of government policy and programme objectives
- Assess the implications of regional integration for the spread of HIV/AIDS and develop innovative mechanisms to minimise the spread of the disease.
- Strengthen a co-ordinated and equitable response to HIV/AIDS

The Kasane meeting endorsed continuing regional networking on equity in health and input to SADC on equity policies.

Equity post Kasane: National Feedback and situation

As shown in Figure 1, household health and wellbeing has many determinants and there are many mechanisms through which government policy can influence health.

As inequality implies increasing levels of deprivation for an increasing number of people and social groups, work on equity has common concerns with work on poverty. According to UNDP (1999) poverty affects more than a quarter of the population in all SADC countries, except South Africa, Seychelles, Mauritius and Lesotho. Income inequities and poor access to essential services such as safe water have contributed to weaknesses in human development performance, as has the AIDS epidemic. Health differentials between the poor and the non-poor are consistently higher for women than for men in SADC countries, suggesting that socio-economic disadvantage affects women in our countries more severely than men. Deprived households have more limited coping strategies available to them when confronted with ill-health, while ill health can further impoverish households.

Selected health status indicators (See for example Table 2) indicate that there is significant variability in health status between countries of the region, between male and female, urban and rural, between social groups with different levels of education, between races and between poor and non poor. AIDS, malaria, TB and non communicable diseases have reversed gains made in health indicators in the 1980s (MoH Botswana 2001). AIDS has not only led to increased illness and mortality, but has also increased the demand for health services, for terminal care and for survivor support. As shown in Table 3, many SADC countries spend above average as a share of GDP for health within the private and public sectors combined, but obtain very different health service and health status outcomes for each dollar per capita spent. . A significant share of health care expenditure is in the private sector, where

it is biased towards higher levels of curative care and higher income groups. The insured share of the population is low (MoH Botswana 2001). Further, the poor continue to have worse access to public sector health care resources than the rich, despite bearing the greatest burden of ill health. User fees have further compromised access to health care in the poorest (MoH Botswana 2001, Tanzania Equinet group 2001). This reinforces the view that it is not only how much a country spends as much as *how* it spends its resources that determines the health status of its population, and particularly the level of resource allocation to integrated national primary health care services, education, enhancing use of health services, improving food security and improving the status of women (Equinet 2000).

SADC Countries have responded to this challenge by reaffirming commitments to equity. Some have put greater policy attention to strengthening district management capacity for PHC, reinvigorating community health worker programmes and paying greater attention to community involvement (Tanzania Equinet Group 2001; MoHCW Zimbabwe 1998). It has been noted that these programme continue to face the additional challenge of skills inputs, with a demand raised to strengthen the level of and regional co-operation in public health training, to localise capacity and strengthen public health systems. A regional public health school is a constructive option for this (MoH Botswana 2001)

EQUINET: Informing equity policies

The Regional network for Equity in Health in Southern Africa (EQUINET) was set up in follow up to the Kasane meeting in 1998. The network engages professionals, communities, civil society and policy makers to develop and widen the conceptual understanding of equity in health, make visible existing unfair and avoidable inequalities in health, gather and analyse information to support scientific debates and policy decisions on equity in health in Southern Africa and to influence and monitor implementation of policies and agendas on health at national and regional level in Southern Africa, including at Southern African Development Community (SADC) level.

EQUINET noted that equity goals not only demand attention to the manner in which policies aimed at redistributing societal and health resources address areas of vertical equity, but also the extent to which different groups of people in the region are able to make choices over health inputs, have the capacity to use these choices towards health and the manner in which policies and measures affect such capacities. EQUINET's equity concept thus added to that defined in Kasane by giving a central role to the extent to which different groups of people have the opportunity for participation and the power to ***direct*** *resources towards their health needs, and the policies that influence this.*

Through national and regional research institutions, government health agencies and non government organisations, EQUINET has produced and widely disseminated an annotated bibliography on equity in health in Southern Africa; maintained a co-ordinating centre, a data base of resources on equity, and a web site (with more than

18,000 visits a year), prepared a profile of data and overview on equity in health in Southern Africa; carried out research and produced publications on various areas of equity related work, including public participation and health, equity monitoring, WTO and public health, resource allocation mechanisms for health, public-private mix in health services; household resources for health; human resource distribution in the health sector and health rights; and held a regional conference in September 2000 in South Africa on Building Alliances for Equity in Health.

South Africa, 2000: A call to act

The Regional Conference on Building Alliances for Equity in Health held in South Africa provided an opportunity to reflect on the additional concepts and evidence gathered in the three years since Kasane. The conference noted that there was a need to go beyond policy commitments towards equity to more firmly operationalising these within health systems.

The conference therefore highlighted some important areas of action:

- Make visible the equity impacts of health policies and monitor the equity performance of health systems, particularly using routine data;
- Integrate evidence on deprivation into public resource allocation systems;
- Put in place measures to protect investments in areas of health systems that enhance equity and reach the poor, such as primary health care;
- Invest in community capacities for participation in health services, strengthen the use of community evidence in health planning and decision making and link mechanisms for participation with authority over resources;
- Improve incentive and management systems to retain and appropriately distribute the human resources in health systems;
- Use legal, institutional and economic measures to promote a more equitable mix between private and public services.
- Develop capacity, legal frameworks and policies that protect public health interests in the context of global trade rules such as GATS and TRIPS.

In relation to international policies, the conference urged that national and regional laws provide for government and civil rights to protect public health interests in relation to trade and economic policies, and that governments reject demands by international organisations or donors for conditionalities on investments and loans that drive inequities, such as user fee charges.

This call to action and the measures proposed are taken forward to the SADC Ministers of Health Meeting in April 2001 for their policy commitment, for operationalising within SADC communities and as issues to monitor at national and regional level to assess performance on equity goals.

In support of SADC objectives, EQUINET has made a commitment to support the implementation of these and other priority actions for Equity in health and

to work collaboratively with SADC. As a network of stakeholders, researchers, government and non government institutions, EQUINET seeks to continues its collaboration with SADC, with national and regional institutions to

- provide appropriate, timely evidence to support equity oriented policy decisions
- support capacity and develop tools to implement equity oriented policies
- network and exchange information and good practice, and
- widen the social alliances that promote equity oriented policies.

EQUINET seeks to strengthen in the next three years:

- networking within SADC countries to support equity oriented policies
- networking between countries to do research, share information and strengthen capacity within the area of the priority actions identified in the South Africa equity conference 2000 and by SADC.

Equinet has also committed itself to mobilise technical, financial and human resources to carry out this work within the key areas of the Call for Action.

FIGURE 1: POLICY FACTORS AND MECHANISMS INFLUENCING PERSONAL & HOUSEHOLD HEALTH AND WELFARE (Source: Gilson and McIntyre 2001)

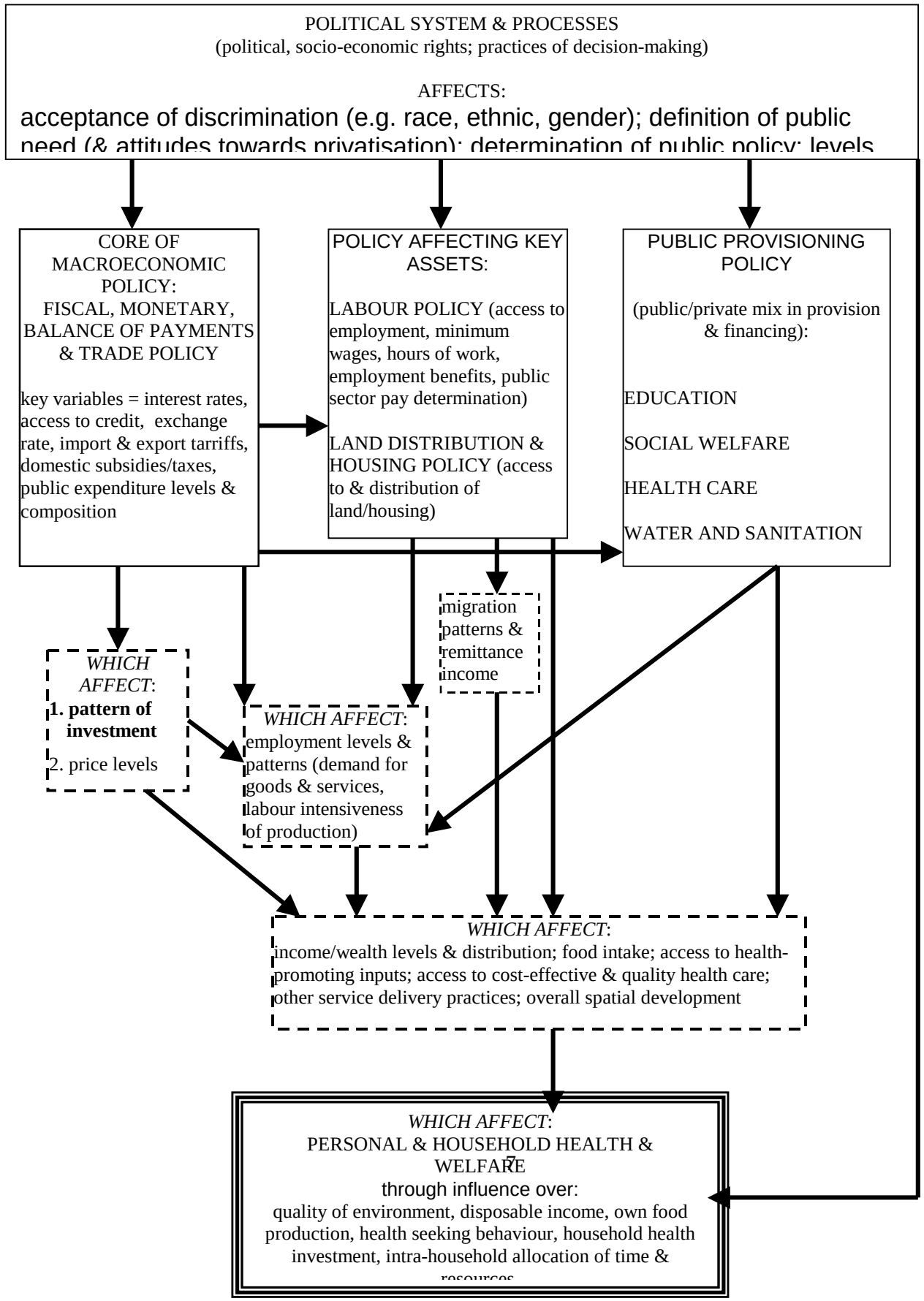

Table 1: Overview of development indicators in SADC countries

Country[#]	LE 1997	Adult literacy 1997	HDI* 1975	HDI 1997	GDP p.c. rank minus HDI rank 1997	Gender-related development index (GDI)	Human Poverty Index (HPI)	% without access to safe water	% without access to health services	% without access to sanitation
Medium human development										
South Africa	54.7	84.0	0.637	0.695	-47	0.689	19.1	13	n.a.	13
Swaziland	60.2	77.5	0.497	0.644	-15	0.636	27.6	50	45	41
Namibia	52.4	79.8	0.604	0.638	-44	0.633	25.0	17	n.a.	38
Botswana	47.4	74.4	0.501	0.609	-70	0.606	27.5	10	14	45
Lesotho	56.0	82.3	0.471	0.582	-2	0.570	23.0	38	20	62
Zimbabwe	44.1	90.9	0.539	0.560	-16	0.555	29.2	21	29	48
Low human development										
Zambia	40.1	75.1	0.453	0.431	8	0.425	38.4	62	25	29
Tanzania	47.9	71.6	n.a.	0.421	16	0.418	29.8	34	7	14
Malawi	39.3	57.7	0.328	0.399	10	0.390	42.2	53	20	97
Angola	46.5	45.0	n.a.	0.398	-17	n.a.	n.a.	69	76	60
Mozambique	45.2	40.5	0.302	0.341	-2	0.326	49.5	37	70	46

[#] Listed from highest to lowest HDI in 1997 * Data for 1975, except for Namibia and Mozambique where data are for 1980

Source: UNDP (1999)

TABLE 2: SELECTED HEALTH STATUS INDICATORS FOR SADC COUNTRIES

COUNTRY	Prevalence child malnutrition (% children <5 yrs) 1990-1996	Under five yr mortality rate /1000 1996	Infant mortality rate /1000 live births 1996	Maternal mortality rate / 100 000 live births 1990-1996
Democratic Rep Congo	34	-	90	-
Lesotho	21	113	74	610
Malawi	28	217	133	620
Mozambique	47	214	123	1500
South Africa	9	66	49	230
Zambia	29	202	112	230
Zimbabwe	16	86	56	280
Tanzania	35	144	86	530
Angola	26	209	124	1500
Namibia	15	92	61	220
Mauritius	-	20	17	112

Source: Woelk 2000 from countries for which data available. Using official estimates. For MMR using UNICEF/WHO estimates based on statistical modeling or indirect estimate based on a sample survey

TABLE 3: HEALTH EXPENDITURE, SERVICES AND USE 1990-98*, PLUS KEY MORTALITY DATA

Country	Health expen-diture as % GDP	Health expen-diture per capita PPP$**	Physi-cians per 1000 people	Hos-pital beds per 1000 people	Infant mortality rate (per 1000 live births) 1998	Maternal mortalit y rate (per 100,000 live births) 1990-98*
Botswana	4.3	310	0.2	1.6	62	330
Lesotho			0.1		93	
Madagascar	2.1	5	0.3	0.9	92	490
Malawi	3.3	5	0.0	1.3	134	620
Mozambique				0.9	134	
Namibia	7.4	150	0.2		67	230
South Africa	7.1	246	0.6		51	
Tanzania			0.0	0.9	85	530
Zambia	4.1	14	0.1		181	650
Zimbabwe	6.4	31	0.1	0.5	138	400
Average middle income	5.7	199	1.8	4.3	31	
Average high income	9.8	2585	2.8	7.4	6	

*Data presented by country are those available for most recent year within the period 1990-98
** PPP$ = purchasing power parity dollars
Source: World Bank 2000.

REFERENCES

EQUINET Steering Committee (1998) Equity in Health in Southern Africa: Overview and issues from an annotated bibliography, EQUINET Policy Series No 2, Benaby Printers, Harare

EQUINET Steering Committee (2000) Equity in Health in Southern Africa: Turning values into practice EQUINET Policy Series No 8, Benaby Printers, Harare

Gilson L, McIntyre D (2001). Experiences from South Africa: dealing with a poor health legacy of apartheid. In: Whitehead M, Evans T, Diderichsen F and Bhuiya A (eds). Challenging inequities in health: From ethics to action. Oxford University Press, New York.

MoH Botswana (2001) Equity in Health – Kasane Report. Feedback to the SADC HealthSector, Memorandum

MoHCW Zimbabwe (1998) Working for Equity and Quality in Health: Natrional Health Strategy for Zimbabwe, Graphtec Communications. Zimbabwe

Tanzania EQUINET Group (2001) Equity in health and heath care – Tanzania, Dar es Salaam, Memorandum

UNDP (1999) Human Development Report 1999, Oxford University Press, New York

Woelk G (2000) Analysing inequities in Health Status and in health care using Demographic and Health Survey data: Zimbabwe Paper presented at the EQUINET conference, Midrand SA September 2000

World Bank (2000) World Development Indicators. Taken from web site HYPERLINK http://www.worldbank.org/data/databytopic/databytopic.html
http://www.worldbank.org/data/databytopic/databytopic.html