Can research fill the equity gap in southern Africa?

Dr Rene Loewenson
Training and Research Support Centre
Harare, Zimbabwe

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Regional Network for Equity in Health in Southern Africa (EQUINET)

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1. Introduction

In March 1997, a range of people involved with the health sector gathered in Kasane, Botswana to discuss equity in health in Southern Africa. From politician to civic group member, from academic to health service provider, there was agreement across the group that equity in health was a desirable goal. In a region of deep structural inequality in wealth and opportunity, it was agreed that national health care resources should generally flow in a manner that would prioritise those with greatest health needs and with least ability to pay. While participants did not believe that everyone should have equal health status, it was perceived that differences in health status that are unnecessary, avoidable and unfair should be a target of policy attention and of public sector intervention. These differences assume significance as they are generally associated with high levels of deprivation and isolation from essential services where they exist. Equity has become one way of focusing public policy on unacceptable levels of poverty.

It would seem from the Kasane meeting that equity in health is a shared value across the Southern African region. It is certainly articulated in post independence health policies in almost all countries of the region, and has been for two to four decades. How successful have we been in eliminating unnecessary, avoidable and unfair differences in health and in access to health care in the region? What are the potentials and constraints to more evenly spreading health sector gains across the region?

2. Inequalities in health and health care in southern Africa

Many countries in Southern Africa have a reputation for having achieved remarkable gains in health in the 1970s and 1980s (Mehrotra 1996). The successful introduction of public health technologies, such as safe water, sanitation, oral rehydration solution and immunisation have brought significant gains in health, particularly where they have been backed by improved food security, nutrition and maternal education. Indeed, the rise in population growth in many countries was caused in part by the successful reduction of mortality through health interventions, with a time lag in reductions in fertility. There was optimism in the region and in the international institutions working in the region that many preventable diseases could be controlled, if not eradicated.

As the century draws to a close, it is evident that preventable diseases that were once targets for optimistic eradication programmes have persisted and, some have increased in incidence. Old problems such as malaria, diarrhoea, cholera, malnutrition and respiratory infections continue to exact a high toll of morbidity and mortality. This is now exacerbated by HIV/AIDS, and a consequent fall in life expectancy and increase in tuberculosis, pneumonia, other communicable diseases and malnutrition (Loewenson and Whiteside 1997). Sub-Saharan Africa experiences not only the highest burden of communicable disease globally, but also amongst the highest rates of non communicable diseases, such as cerebrovascular disease and diabetes. For adults under the age of 70, the probability of dying from a non communicable disease is greater in Sub-Saharan Africa than in the OECD (established market) countries (Murray and Lopez 1996). In the 1980s, during reforms aimed at structural adjustment and liberalisation of economies in sub-Saharan Africa, infant mortality rates increased (Commonwealth secretariat 1989) nutritional status worsened (Lesley et al 1986; Kanji 1991, Kalumba 1991; Loxley 1990), per capita expenditure on health fell (Cornia et al 1987; Anyinyam 1989; Loewenson and Chisvo 1994); the real earnings of health workers fell and key

personnel were lost to the health sector (CWGH 1997; Cliff 1991; Loewenson and Chisvo 1994).

It also appears to have become difficult to make available effective public health technologies to all the people of the region on a sustained basis, and disparities in access to health inputs and health care have persisted, and in some cases widened in the countries of the region. Inequalities have been observed in relation to the inputs to health, such as literacy, educational status - particularly in women -income, household savings and assets, housing tenure and standards, access to safe water, sanitation and reliable energy supplies (EQUINET 1998). They have been observed in relation to health status and health care. Low income, black and rural communities have been documented to have consistently higher rates of Tuberculosis (Andersson 1990); malnutrition (Bijlmakers et al 1996); mortality (Jhamba 1994); water related diseases (van Bergen 1995); and other morbidity and mortality indicators in the region (Yach and Harrison 1994, Zim MoHCW 1996).

Inequalities between different population groups have also been documented in access to TB control and treatment, antenatal care coverage, public health measures, access to quality primary care facilities and to referral facilities (Andersson 1990; Doherty et al 1996; Lesotho MoHCW 1993; Loewenson et al 1991; van Rensburg 1991; Msengezi 1992; Tevera and Chinhowu 1991). These differences distribute across a number of parameters, including race, rural, urban and peri-urban status, socio-economic status, age, gender, geographical region and insurance status (EQUINET 1998).

While much ill health and mortality in the region is now attributable to AIDS, the spread of the HIV/AIDS epidemic in southern Africa itself exemplifies how inequalities in health and health care emerge. Differences in HIV seroprevalence by occupational group, educational status, sex, and geographical region indicate that HIV first moved through skilled, mobile, educated and urban groups in the region, but has rapidly spread to rural, lower income groups, and from adults to adolescents (Forsythe 1992). HIV transmission has been rapid where people move for trade, work, food, social support and where such mobility links people with some disposable income and those who live in poverty, particularly where the latter are women. Hence areas of migrant employment, transport routes and urban and peri-urban areas have been high risk environments for HIV.

This pattern of transmission indicates the common spread of HIV from more socially and economically powerful adult males to poor and economically insecure females, particularly female adolescents (ILO, 1995; ILO 1995c; ILO 1995b; Gillies et al 1996; Forsythe 1992). The large differentials in wealth and poverty in the region influence both choice and exploitation: Wealth gives people (mainly men) the chance to have many sexual partners, poverty forces other people (mainly women) into sexual liaisons as a survival strategy. Mobility, or the mixing of different social groups, sometimes the product of important improvements in communication, transport and regional integration, shares the consequences of the risk profile of one group with another.

As AIDS has led to a massive increase in illness and mortality, it has also increased the demand for health services, for terminal care and for survivor support. It has been estimated that the impact of AIDS can cost economies about 1% of GDP annually. Company impacts have been projected at about USd200 / employee annually. Insurers have predicted collapse of benefits schemes due to AIDS. Analysis of 51 countries at different HIV prevalence rates, controlling for other influences, indicates

however that HIV/AIDS has had a small and statistically insignificant negative impact on such macroeconomic indicators (e.g.: growth rates, per capita income).

The impacts have been found to be least visible at the macroeconomic level and most visible at household level, where AIDS can lead to chronic and potentially intergenerational poverty (Loewenson and Whiteside 1996). Death, disability and medical insurance schemes have excluded people with HIV or reduced benefits, reducing coverage and household savings and shifting the costs of unsecured risks to public and household budgets. Health services have promoted home based care approaches that have often been inadequately supported, further stressing households, and particularly women caregivers. Studies have found that households unsupported by social security spend four times the share of annual household income on AIDS related health costs when compared with households covered by social security (Hanson 1992).

It would thus appear that our economies continue to have weak mechanisms for distributing health and other resources towards those who have greater need, least power and least access, but are effective at transferring the negative impacts of ill health to household level. Where do the constraints to equity lie?

3. Marginalising health and the poor in the global economy

If it is paradoxical that hunger and environmental diseases persist in a world where spectacular advances have been made in science and technology, then the paradox must be traced back in part to the current pattern of globalisation. A massive expansion has taken place of skills, knowledge, information, technology and wealth in the last century of this millennium, coinciding at an increasingly rapid pace with the growth of poverty and widening inequalities that leave countries and poor communities within countries are marginalised from these spectacular levels of growth in technology, knowledge and wealth (UNDP 1996). While 40 countries have sustained an average per capita income growth of more than 3% a year since 1990, 55 countries, mostly in Sub-Saharan Africa and Eastern Europe and the Commonwealth of Independent States (CIS), have had declining per capita incomes (UNDP 1999). A relatively constant half or more southern Africans live below poverty levels, increasing in recent decades (Onimode 1989).

Inequality has been rising within many countries since the early 1980s, particularly in Eastern Europe. This rise in inequality has also occurred in the richest countries of the world, as OECD countries have registered big increases in inequality after the 1980s-especially Sweden, the United Kingdom and the United States. Inequality between countries has also increased. The income gap between the fifth of the world's people living in the richest countries and the fifth in the poorest was 74 to 1 in 1997, up from 30 to 1 in 1960 and the widest this gap has ever been (UNDP 1999). The sensational flow of boom and bust we have come to associate with global financial markets understate the huge groundswell of chronic poverty that follows market turmoils, the collapse of job markets and of real wages and the fall in budget allocations to social sectors.

The statistics speak for themselves: By the late 1990s the fifth of the world's people living in the highest-income countries had:

- 86% of world GDP, while the bottom fifth had 1%
- 82% of world export markets, while the bottom fifth had 1%
- 68% of foreign direct investment, while the bottom fifth had 1%
- 74% of world telephone lines, while the bottom fifth had 1.5%.

The assets of the top three billionaires in the world are more than the combined GNP of all least developed countries and their 600 million people (UNDP 1999).

Today's globalisation has been criticised for being driven by the mechanisms, standards, rules and institutions for expanding markets and the movement of capital across the world, outpacing the policies, rules and institutions for protection of people and their rights. Poor communities, poor countries, and areas of human development provided outside markets, such as education and health, have suffered in this rather ruthless drive towards satisfying the profit motives of the biggest players in the market. As recurring episodes of financial collapse, poverty induced conflict, warfare and human rights abuses raise awareness in the rich countries that markets have become too dominant in human life, countries in the South should also be increasingly informed, articulate, networked and organised in putting forward the changes that should be introduced to strengthen respect for sustainable human development, justice and human rights, and to share the benefits of growth more widely and more inclusively between the nations and populations of the world.

4. Marginalising health and the poor in the national economy

To confront these global trends, we also have a responsibility towards building ethical, equitable, secure and sustainable human centred development in our own countries. Low per capita GNP cannot in itself be held up as the sole reason for inequalities in health, or for declining access to adequate quality and relevant health care in those with greatest need. According to Sen (1999) and Mehrotra (1996), low GNP/ per capita is not itself a reason for the common and increasing prevalence of diseases associated with poor environments, poor nutrition and weak reproductive rights. Equally they argue that basic primary health care and medical care services can and have been provided by countries with low per capita GNP's. They cite the example of countries such as Kerala and Sri Lanka in Asia, and Zimbabwe (in the 1980s) and Botswana in Southern Africa, where the state made deliberate and above average resource allocations to the poor, with high investments in education enhancing use of health services and specific interventions towards improving food security and the status of women.

These case studies reinforce 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 (Yach and Harrison 1994). In South Africa, for example, it is perceived that there are substantial resources for meeting health needs, but that these resources are poorly distributed (McIntyre et al 1996). Ogbu and Gallagher (1992) note that health care is affected both by the level of public spending, the composition of the health infrastructure and community use of health services.

This means that where market led reforms in Southern Africa have been directly or indirectly associated with reductions in real per capita allocations for health, there is a serious need for review of public policy. Public policy would also need to be questioned where these reforms have also directly or indirectly led to weaker redistribution of health resources towards the poor. As noted earlier, the current experience of macroeconomic reform in many African countries has led to a rising share of public funds being allocated to debt servicing, reducing the real allocations to health and leading to an increased demand on communities to finance health (MoHCW 1984; MoHCW 1997; CWGH 1997). Public spending on health in the region is at or less than 3% of GDP, and has declined under structural adjustment programmes in a number of countries (Price 1997, Lennock 1994), or under conditions of sluggish or inequitable economic growth (Loewenson and Chisvo

1994). When households have to make direct payments for health services, there is consistent information that the lowest income groups bear a disproportionate burden. For example the percent of income spent on malaria ranged from 2% annual income in medium-high income groups to 28% of annual income in very low income groups, indicating the disproportionate burden borne by the lowest income groups (Ettling et al 1995).

It is precisely under conditions where resources are scarce that even greater importance should be given towards ensuring that health care resources are allocated progressively (ANC 1994; Bloom 1985; Zimbabwe MoHCW 1982; Kalumba 1997). In a region ridden by gross inequities in health, vertical equity, or the provision of different inputs according to different needs, would seem to be the most important principle to ensure that those with greatest health needs obtain and access greater public inputs for improved health.

In fact, Southern African countries have many positive experiences to inform public policy aimed at vertical equity on where to spend the money. There are many successful primary health care approaches and examples of the redistribution of investments towards accessible primary medical services extending simple and effective technologies to the population, through a broad based presence of health workers, including community health workers. There is evidence from a number of countries that investments in education, and particularly in female education, are a consistent and important determinant of improved health in the poorest groups (ZMoHCW 1996), as are investments in wage, employment and income security (Loewenson and Chisvo 1994). Various studies describe the health gains made when public health measures are specifically designed and invested in to complement household capacities (Sanders and Davies 1988; Loewenson and Chisvo 1994). The review of periods of high health gain in Southern Africa indicate that health systems reduce inequalities in health and improve health status in high risk groups when they redistribute budgets towards prevention; improve rural and primary care infrastructures and services in terms of both access and quality; deploy and orient health personnel towards major health care problems, back personnel with adequate resource inputs; invest in community based health care; provide prompts to encourage effective use of services, such as dissemination of information on prevention and on early management of illness and remove cost barriers to primary care services at point of use (Loewenson et al 1991; Haddad and Fourier 1995; Albaster et al 1996; Jhamba 1994; Curtis 1988). These positive experiences give us clear direction on where to focus support of health systems and of the communities that they cover.

Despite this, in practice, as real public health budgets have fallen, efficiency driven perspectives have dominated international health policy debates, and focused attention away from issues of relevance of services as they interface with communities, or of how resources are allocated to these levels. There has been a rapid development of approaches aimed at cost effective rationing of scarce resources for health care and of management and measurement tools to support these approaches. There is however inadequate evidence that these reforms have indeed enhanced efficiency (Mills 1996), even while they may have worsened quality of or equity in health care (Bijlmakers and Chihanga 1996; Molutsi and Lauglo 1996). Also as public budgets have fallen greater attention has been given to resource mobilisation for health, often with weak attention paid to how resource mobilisation strategies affect equity or the relationship between communities and health services. For example, the practical experience of implementing user fees has been found in many countries to have had a negative impact on equity, and to have further increased the gap between services and communities, undermining the effective

management of health issues *in* the community (McCoy and Gilson 1997; Lennock 1994; Hongoro and Chandiwana 1994; Zigora et al 1996; Loewenson 1999).

Weak attention to the positive experiences in the region that have emerged from pursuing equity policies - and an over-optimistic pre-occupation with management tools (at a time of declining capacity within public services) - has enabled developments in health systems in Southern Africa that have exacerbated **inequity**. In addition to the absolute reductions in real health budgets, there have also been reductions in relative allocations to primary and preventive care leading to plateauing or loss of coverage and poorer quality care, particularly at primary care level (UNICEF MoHCW 1996); poorly designed cost recovery systems (McCoy and Gilson 1997; Lennock 1994; Zigora et al 1996); poor functioning of the referral system and significant levels of commuting between providers (Loewenson et al 1991); concentration of costly health manpower in urban, high level and private care (McIntyre et al 1995), staffing constraints and poor conditions of service and inadequate resources for effective implementation of tasks by health workers (Loewenson 1999). Decades of declining real wages of health workers and increasing inequalities between private and public earnings have led to attrition of skilled personnel to private practice. Liberalisation has enabled a wider spread of providers, with an inadequate state infrastructure to regulate quality or ensure equity in the growth of private providers. Cost escalation in the private sector has led to a greater share of overall health resources going to a smaller section of the population who could afford such costs and exacerbated the salary differentials that lead to attrition of skilled health professionals from the public to private sector. The liberalised growth of private care under conditions of declining access to basic public services has led to parallel worlds, where those with wealth and connections can have access to the highest technology while many poor people cannot get or afford secure access to TB drugs or to safe water supplies. Many of these changes reflect the fact that macro-economic *and* health sector reforms have enabled more powerful medical and middle class interest groups to exact concessions at the cost of the poorer, less organised rural health workers, or the urban and rural poor (Van Rensburg and Fourie 1994; Bennett et al 1995; Kalumba 1997; Lafond 199l; Storey 1989).

5. Refocusing on what counts: Directing public health resources to the public

In a region where a significant share of the population will in the next decade die from AIDS and have their lives shortened by poverty, it is critical that we clearly define our priorities and how we seek to deliver them. Public health and health services, while integrating some of the features of market reforms, cannot be an area of activity that is provided through the market. Neither can the public health of the majority continue to be so severely crowded out by speculative and profit interests of a minority, particularly when the skills, technology and knowledge exists to prevent and control a large share of the burden of illness and death in the region. The discussion above indicates that this demands changes to those global institutions, policies, rules and standards that subordinate human development to profit or that unfairly distribute the returns from markets.

Even while we confront market forces that have increased poverty and marginalisation, we also need to give higher profile and more attention to national policies that more effectively allocate public resources towards those with greatest health needs and towards forms of health care that are most appropriate and accessible to these communities. This makes equity not simply a value to give lip

service to, but one of the most important targets of practical attention in resource allocation systems, in human resource management, in health service development and in monitoring health systems.

One limitation of past work and of many equity conceptualisations is the extent to which they place the populations concerned in a passive role, affected by inputs and reflecting outcomes. This ignores the social forces that drive policy choices. The amount of resources that people generate, contribute, claim and obtain for health is strongly influenced by the extent to which different groups of people are able to make and articulate choices over health inputs and have the capacity to use these choices towards health. It is also influenced by the extent to which different groups of people have the opportunity for participation and the power to **direct** resources towards their health needs. This makes issues of 'social capital', procedural justice and participation central to equity. As Sen puts it "Issues of social allocation of economic resources cannot be separated from the role of participatory politics and the reach of informed public discussion" (WHO 1999).

Recognition of the importance of equity in national, regional and global agenda's has motivated one regional initiative that aims to use research amongst other tools to promote equity in health.

In follow up to the Kasane meeting, cited in the introduction, a group of professionals from various institutions and countries in Southern Africa resolved to form a network of institutions and individuals working on Equity in Health in southern Africa, called the southern African Regional Network on equity in health or EQUINET. The network is guided by a steering committee with representatives from Zimbabwe, Botswana, Tanzania, South Africa and Zambia, and involves collaboration with colleagues from Sweden and UK. It is co-ordinated at TARSC, Zimbabwe, involves a network of members from countries across the region and co-operation with other equity oriented initiatives. EQUINET aims to bring an enhanced focus, information and informed debate on equity in health in Southern Africa leading to positive policies towards equity in health from local to regional level, and a stronger network of research, civil society and health sector organisations working towards and influencing equity in health in Southern Africa.

The network aims to make visible the extent and dimensions of differences in health status that are unnecessary, avoidable and unfair and the determinants of these inequalities in health, whether they arise at a social, economic or health sector level. It aims to assess policy and practice within and beyond the health sector for how they distribute health and health care inputs to people whose health needs are different, and propose ways of more effectively addressing differences in need (or vertical equity).

The network recognises the role of participation and of social capital in equity, and aims to explore and discuss the extent to which different groups of people in the region have the capacity, power and means to make choices over health inputs and direct resources towards their health needs. These groups include not only those in the community, but also health professionals and other organised groups that have an impact on health policies.

Drawing from an analysis of the current situation in the Southern African region, EQUINET has identified a number of priority theme areas for further work to develop new knowledge and inform policy on Equity in Health, particularly in relation to:

i. Monitoring equity in health, making visible inequalities in health and health care through readily analysed and easily understood indicators and linking this with

standards against which to assess progress and prioritise responses and resource allocations.

ii. Globalisation, macro-economic policy and its impact on equity in health

iii. Governance, social capital and health rights, examining how entitlements to health and health care resources are expressed through human rights approaches and exploring systems of public participation to develop more effective approaches through which different social groups, particularly the poor, can contribute to health interventions and build public accountability in setting and executing health policies.

iv. Resource allocations for health, particularly in relation to the potential usefulness of micro-geographic areas in resource allocation decision making, to develop tools for identifying small geographic areas with high poverty levels, poor health status and inadequate health and other social services for differential resource allocation purposes over the often ineffective measures that target individuals.

v. Various health service issues, including private - public sector subsides, the distribution of health personnel and the impact of essential health care packages on equity in health.

More detailed dimensions of these areas are shown in Table 1 below. These areas of work are informing a programme of research, small grant allocations, commissioning of papers, an internet website and an email mailing list that is aimed at producing sound knowledge and information, influencing policy, facilitating civic dialogue and education on health and disseminating information to various interest groups. The network is inviting researchers to apply for grants for commissioned work and to use the forum to share information, research methods in and perspectives on different aspects of equity, leading toward a Southern African regional meeting in September 2000.

It is our aim that this work strengthen the profile of and informed discussion on equity in health and thus promote positive policies towards equity in health from local to regional level. We also aim to work in a manner that enables participation by relevant interest groups. For example, some of the work in EQUINET is using participatory methods and action research to strengthen participation of affected communities in generating new knowledge, so that they are in a stronger and position to understand and take informed decisions on health issues.

Table 1: Focal areas of EQUINET work

Broad area	Specific issues
Monitoring equity in health	• Making unfair inequalities visible • Identifying the triggers for changes in policy and resource allocations within and beyond the health sector • Reviewing the articulation and implementation of policies on equity in health in Southern Africa • Exploring the negative health consequences of inequalities in health
Globalisation, macro-economic policy and equity in health	• Economic, trade and investment policies and their impact on resource allocations for health • International institutional factors in mobilising resources for health
Governance, social capital and health rights	• The social dimensions of equity, i.e. social capital, participation and procedural justice • Social interests and forces influencing health policy and the impact of systems of governance in health

	• The impact of decentralisation on participation and equity • The expression and claim of health rights in the region and their role in equity in health • Violence and health rights
Resource allocation for health	• The impact at household level of policy measures aimed at efficiency, cost reduction and revenue generation on equity • Strategies for resource mobilisation for health and their impact on equity, in particular at household level
Health Service issues	• Subsidies and contributions between public and private health care and their equity impacts • Causes of and strategies for dealing with the inequitable distribution of health personnel • Equity impacts of minimum / essential health care packages

It may seem like a long path from globalisation to a community in Gokwe, Kwazulu, Blantyre, Chingola or Nampula discussing their health priorities. As described in this paper, globalisation has been associated with the marginalisation of weak economies and people, the polarisation of opportunity between North and the South, and the weakened intervention by governments in human development and social protection. This makes it critical to build networks that link communities in Gokwe, Kwazulu, Chingola and Nampula with national governments, regional institutions and with international institutions and processes.

Equally, for those involved in essential national health research, the development of new knowledge should lead us **towards,** as inexorably as we are moving **away** from, economic and social processes that integrate communities, rather than marginalising them, and that enhance informed and participatory decision making.

New knowledge that reveals the health costs of marginalisation, insecurity and unsustainable development paths is an important warning signal of a need for change.

New knowledge that identifies alternative ways of organising health systems gives direction to that change.

New knowledge that builds empowerment and effective participation in economic and social processes yields a greater likelihood of that change being effected.

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Equity in health *implies addressing differences in health status that are unnecessary, avoidable and unfair. In southern Africa, these typically relate to disparities across racial groups, rural/urban status, socio-economic status, gender, age and geographical region. EQUINET is primarily concerned with equity motivated interventions that seek to allocate resources preferentially to those with the worst health status (vertical equity). EQUINET seeks to understand and influence the redistribution of social and economic resources for equity oriented interventions, EQUINET also seeks to understand and inform the power and ability people (and social groups) have to make choices over health inputs and their capacity to use these choices towards health.*

EQUINET implements work in a number of areas identified as central to health equity in the region:

- Public health impacts of macroeconomic and trade policies
- Poverty, deprivation and health equity and household resources for health
- Health rights as a driving force for health equity
- Health financing and integration of deprivation into health resource allocation
- Public-private mix and subsidies in health systems
- Distribution and migration of health personnel
- Equity oriented health systems responses to HIV/AIDS and treatment access
- Governance and participation in health systems
- Monitoring health equity and supporting evidence led policy

For further information on EQUINET please contact the secretariat:
Training and Research Support Centre (TARSC)
Box CY2720, Causeway, Harare, Zimbabwe
Tel + 263 4 705108/708835 Fax + 737220
Email: admin@equinetafrica.org
Website: www.equinetafrica.org