Equity in Health in Southern Africa: Overview and Issues from an annotated bibliography on Equity in health in Southern Africa

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The overview in this policy paper draws from an annotated bibliography of published information on equity in health in southern Africa. The full bibliography is available from the EQUINET secretariat at TARSC or on the EQUINET website (www.equinetafrica.org), can be downloaded as an adobe acrobat file or searched as a web database, and is regularly updated. The overview highlights key issues raising with respect to equity in health in Southern Africa drawn from the literature.

1. Introduction and overview

The annotated bibliography on Equity in Health in Southern Africa is the a compilation of publications related to equity in health in Southern Africa. It has been compiled by a network of institutions coming together as a result of the resolutions of the March 1997 Southern African meeting on Equity in Health held in Kasane, Botswana. This meeting, hosted by the National Institute of Development Research and Documentation (Botswana) and the Dag Hammarskjold Foundation (Sweden) gathered participants with backgrounds in government and non government organisations, academia and health professionals. All participants confirmed a commitment to equity in health as a policy goal for the Southern African Region.

An Agenda for action on Equity in Health, produced at that meeting, called for greater networking of professionals, civil society and policy makers to promote the policy of equity in health in the region. In particular it was advocated that further work be done to enhance understanding of the concept of equity in health, on intersectoral collaboration, decentralisation, public health training and health research, and on HIV/AIDS. In response to that agenda, several institutions in the region formed a core working group to initiate a network for follow up activities. Objectives of this follow up network would be to:

i. Develop further the conceptual framework and policy issues in relation to equity in health in Southern Africa
ii. Gather and analyse information to support scientific debates and decisions on equity in health in Southern Africa
iii. Make input to policies affecting health at National and Southern African Development Community (SADC) regional level.

As the first step towards building a wider involvement of individuals and institutions in the region, the core working group has developed an annotated bibliography of current literature on equity in health in Southern Africa, and developed an overview of concepts, debates and issues arising from that literature. Its aim is to inform about the work being done and materials available on equity in health in Southern Africa, to provoke discussion and exchange of information between those working in this area, and to propose areas for follow up research and information activities.

The bibliography includes:

1. an analysis and overview of the concepts, issues and debates arising in Southern Africa around equity in health;
2. proposed areas of future work to be carried out on equity in health in the region;
3. an annotated bibliography of available materials on equity in health in Southern Africa, with materials on conceptualising equity in health, equity in health rights and policies, equity in health and health care, equity in resource allocations for health and monitoring equity in health.

2. Equity in health: Concepts, debates and issues

2.1. Conceptualising equity in health

The term 'equity' is commonly found in health literature and has been a goal of many health policies in Southern Africa. Achieving greater equity in health has been understood to be a measure of health progress. Equity was an essential feature of the redistributive policies in many post independent African countries, and encompassed aspirations to redress the significant levels of inequality and deprivation that characterised African populations under colonialism. The manner in which these equity oriented policies were (and were not) implemented over the past few decades and the factors that influenced this merit further analysis. Certainly prevention and management of the major public health problems and providing access to basic services has dominated health agendas in the region. While major gains have been made in reducing mortality and morbidity and in reducing inequalities in health and access to health care, many preventable inequalities in health persist.

In the late 1990s, more than thirty years after independence in some countries of the region and only a few years after South Africa's liberation from apartheid, equity thus remains an issue of concern. In an era where global competition provides significant economic challenges, in a region facing overwhelming loss of health and life due to HIV/AIDS, where minority wealth co-exists with persistently high levels of poverty of the majority, poverty and inequality have become central issues to address for the wellbeing, growth and security of the region as a whole. The evidence provided in some papers in this bibliography that inequalities have widened in some cases, and the emergent evidence that inequality itself is bad for health have further raised the profile of equity as an important dimension of health policy.

In the health sector, efficiency driven perspectives have dominated international health policy debates in the last decade (Gilson 1998). There has been rapid development of approaches aimed at cost effective rationing of scarce resources for health care and measurement tools to support such approaches. As the decade draws to a close, persistently high levels of aggregate ill health, exacerbated by HIV/AIDS, and persistent inequalities in ill health, mortality and access to health care signal that distributional issues are still inadequately addressed. The region is poised to assess whether it enters the next millennium with a widening gap between necessary and actual public allocations for health, with resources concentrated in centralised curative hospitals and urban private care, and with spiraling costs of seeking and accessing health care for poor communities. Hence while addressing efficiency reforms, Southern African health providers continue to face challenges of re-orienting health systems towards majority needs, and doing this in a manner that addresses the social and cultural values and aspirations of both communities and providers.

The gap that has been left by efficiency oriented approaches has in some instances been taken to imply conflict between equity and efficiency. As noted by Vagero (1994), this interpretation confuses strategic goals (such as equity), with the approaches for implementation of these goals (incorporating efficiency measures). There should in the main be no inherent conflict between equity and efficiency, except in circumstances where cost containment or other efficiency measures are given primacy over equity and population health goals.

2.1.1 Dimensions of equity

This renewed concern with equity is not restricted to Southern Africa, but is a global phenomenon. It is however evident that the term is not used in the same manner by all its proponents. There is no consensus in the literature on the definition of equity. As shown in *Box 1* below, the definitions drawn from various sources across the world vary.

Box 1: Definitions of equity in international sources

Equity in health implies that ideally everyone should have a fair opportunity to attain their full health potential and, more pragmatically, that no-one should be disadvantaged from achieving this potential, if it can be avoided (Whitehead 1990).

A common definition of equity in the public health literature is that the primary determinant in the use of services should be the need for them. Other factors such as income, race, location of residence and so forth should not play an important role in selecting who receives care and who does not (Berman et al 1989).

Access to health care is equitable if and only if there are no information barriers, financial barriers, or supply anomalies that prevent access to a reasonable or decent basic minimum of health care services (Daniels 1982).

Equity means equal opportunity of use of health services for equal need (Newbrander and Collins 1995).

Inequity implies the concept of injustice, not strictly part of the idea of inequality ... issues which involve value judgements often related to the distribution of income, wealth and other benefits and policy choices often related to resource allocation (de Kadt et al 1993).

Equity is a value judgement (de Kadt and Tasca 1993).

Equity concepts derive from and relate to a number of political philosophy concepts, including:

- egality, or equalising individual net benefits or opportunities for such benefits;
- providing for distribution (of goods or services) according to entitlement;
- providing a decent minimum standard or level (of goods and services);
- utilitarianism, or maximising aggregate gain with resources;
- the Rawlsian maximum, or maximising the position of the least well off and
- providing for envy free allocations.

These philosophical concepts are more deeply discussed in the paper by Pereira (1993). Many debates around these different philosophical approaches concern the balance between aggregate gain and distributive goals, between absolute and relative status and between aggregating individual health gains to addressing social aversions to inequalities in health (Pereira 1993).

Is it possible to define equity in a manner that is easily understood, enables clear policy solutions, is specific and rigorous, is subject to empirical verification and intuitively and widely acceptable (Pereira 1993)? From the literature, a number of observations can be made:

A: *One common denominator of many perspectives is that of inequity being differences in health status that are* ***unnecessary, avoidable and unfair.***

Hence equity goals would seek to identify and remove differences in health status in populations that are unnecessary, avoidable and unfair. Concepts such as avoidable and unfair are subjective and thus socially defined. No such definition exists for the SADC region and a consensus on one interpretation of these concepts may not be possible for the entire SADC region. The choice of disaggregations in the papers in this bibliography do, however, reflect dimensions of social aversion to disparities, including race, rural/urban status, socio-economic status, gender, age and geographical region.

B: *Equity motivated health interventions can both seek to ensure comparability or equivalence in health inputs between those whose needs are the same (horizontal equity), and corresponding differences in inputs in those whose needs are different (vertical equity).*

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.

Until recently, the focus has primarily been on horizontal equity. Increasing concern about vertical equity issues has raised the importance of preferentially allocating resources to those with the worst health status. This requires proactive efforts to identify those with the greatest need for health care and the least ability to pay for it, in order that significant additional health care and other health-related resources can be allocated to these groups. In addition to health care, this implies not only addressing the provision of services, but also ensuring equity in use, or that access is not impeded by financial or geographic obstacles, by unequal quality of services and by information, education and other barriers affecting use.

C: *Equity in health must necessarily be seen from a perspective that is broader than the health sector. Health status is a result of both social and economic opportunity and health sector inputs (including preventive and promotive services as well as medical services).*

This recognition motivates a wide framework for addressing equity issues, from identifying the determinants of inequalities in health, whether arising at a social, economic or health sector level, how they are affected by policies within and beyond the health sector, and how the consequent pattern of need relates to provision of and access to health interventions. Equity in health concerns thus contribute to a wider set of policies aimed at redistributing societal and health resources (Gilson 1997).

Addressing issues of social and economic opportunity does not always fit comfortably within the ambit of the health sector and requires a wider sphere of influence. Morris (1990) for example notes that public housing and the reduction in childhood poverty are amongst the most effective interventions in reducing health inequalities, something that has not been given adequate attention as health issues. Mach and Harrison (1994) note that it is often easier to deal with access to health care than the wider range of infrastructural and educational improvements needed to improve health. It is however proposed that regional work on equity in health, while addressing health sector policies and interventions required for equity in **health care,** must widen the scope of its discourse to include contributions to those wider policies that influence equity in **health.**

D: *A fourth observation from the literature is the need to provide a more active role for important stakeholders in health, including communities, health providers and funders, health professionals and other sectors. Equity concepts should thus incorporate the power and ability people have to make choices over health inputs and their capacity to use these choices towards health.*

A limitation of many equity conceptualisations is that they place the populations concerned in a passive role, affected by inputs and reflecting outcomes. It is important to understand and act on the social forces that drive the observed distributions of inputs and outcomes. Further, disparities in areas such as health influence social cohesion and political integration, and thus have their own impact on political participation and stability. Goods and services are thus not exclusively important in their own right, but in so far as they provide opportunities for pursuing a healthy life. Sen takes the argument further to propose that the **guiding** equity principle is equality of basic capabilities, that is of the ability to make choices over goods (or access to health producing goods) and the capacity to use these choices towards health. Changes in capability relate to policies and measures **beyond** the health sector, but are also influenced by the organisation of inputs **within** the health sector.

One reason why issues of 'social capital' and participation are often not included in measures of equity is that they themselves are difficult to measure in a standardised manner. The concept of 'capability', for example, or the capacity that people have to transform resources through human functioning and organisation to utility gain is multidimensional and not easily measured[1].

However, incorporating and making visible these dimensions of social capital and participation in equity debates reflects the understanding that procedural justice is a critical factor in generating distributional outcomes, and that social capital[2] influences the manner in which people access health inputs and convert them into health gains. While these factors are often broadly included amongst factors related to equity in 'opportunity', it is proposed that they need to be highlighted given the importance of enabling those with few social resources (information, skills, confidence) to make and use choices towards improved health. Hence, for example, even where basic issues of availability of health infrastructures have been addressed, providing information in ones own language, ensuring culturally appropriate care or supporting community networks for prevention and follow up of illness are all important factors. Weak presence of these factors would limit people's appropriate access to and uptake of health services, whether preventive or curative.

E: A conceptualisation of equity must incorporate measures and policies relating to how different stakeholders direct resources towards health and health care.

Stakeholder interests would further require the inclusion of the capacity that people have to **direct** resources towards themselves. This concerns issues of power and influence. Power and influence over decision making incorporate the extent to which rights to health and health care are recognised and enforced in society, but also the way in which democratic participation is organised in society generally, and specifically within the health sector.

Based on these observations, a framework is proposed for activities on equity in health in Southern Africa, which would examine:

i. the definition, extent and dimensions of differences in health status that are unnecessary, avoidable and unfair[3];

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[1] The concept of capability as raised by Amartya Sen has been proposed elswhere to better conceptualise issues of poverty, standards of living and growth.

[2] Social capital includes information, social networks and participation, organisational capacities and infrastructures, family networks and so on.

[3] As noted earlier, the process by which inequalities are labelled as avoidable and unfair is important in any discussion of equity

ii. the determinants of these inequalities in health, whether they arise at a social, economic or health sector level and how they are affected by policies within and beyond the health sector;
iii. the specific differences in the distribution of health inputs (in and beyond the health sector) to people whose health needs are different, addressing those differences in need (vertical equity);
iv. the manner in which policies aimed at redistributing societal and health resources address the areas of vertical equity highlighted in (iii) above;
v. 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; and
vi. 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.

To what extent is equity, as conceptualised above, on the agenda in Southern Africa? What forces motivate or impede its being pursued in policy and practice? The discussion which follows draws from available literature to identify the various perspectives and practices in relation to equity in the region.

2.2. Health rights and policies: Where does equity feature?

In much of the literature, equity as a policy goal is built on the position that health has been widely held as a human right. Aristotle expressed the right to health care in the fourth century BC: "If we believe that men have any personal rights at all as human beings, they have the absolute right to such a measure of good health as society, and society alone, is able to give them" (quoted in Roemer undated). This statement encompasses the view that health is a universal human right. In May 1986, the 39th Assembly of the World Health Organisation noted that health as a universal human right "... implies that every member of a given society is entitled to a healthy life, and that satisfying resources for health needs should be within the reach of everyone". This right derives from the right to life and is an individual[4] and a social right[5]. Its enforcement, however, depends on what society may reasonably grant. This establishes the tension that exists between the ethical obligations in health and the ability to provide adequate resources for their fulfilment that occupies much debate. Two factors have been critical in this debate - the level of economic development and thus aggregate resources in society, and the level of knowledge and capacity to prevent and manage ill health. In particular as social knowledge on prevention and management of ill health advances, attention shifts increasingly to access to resources to make that gain accessible to those who need it, not only within countries, but internationally.

Fein (quoted in Roemer undated) notes that citizens have a right to expect that the resource allocations for health care will accord with social perceptions of its value in relation to other areas of spending. This right requires that there be social financing of health (through social health insurance or taxation) and a socially acceptable decision on what proportion of public revenues should be allocated for health. Further, this right implies that the distribution of these resources be based on need rather than ability to pay.

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[4] To protect individual physical integrity and human dignity and avoid harm to ones health

[5] For society to protect the health of its citizens and ensure them care in times of illness.

Debates around this view of the right to health are reflected in the different approaches to health policy. A libertarian view considers medical care an issue of rights to individual choice and that the individual should decide how to use his own means to meet health ends in a 'market' where medical care is a primary good. This would stress the provision of services, and removal of economic barriers to their use as the major issues. An egalitarian view defines liberty in terms of equalising opportunity and choice, so that health, for example, does not undermine other areas of achievement. Health care cannot therefore rest on individual achievement but must be a matter of social intervention, and society has an obligation to ensure equitable access of all citizens to health care.

While most countries in Southern Africa would reject a libertarian view of health, the practical difficulties with achieving a distribution of health resources based on need has led countries to adopt an approach where a social obligation exists for achieving equity, without declaring this as a right.

2.2.1. Constitutional rights to health

Constitutional provisions that express the right to health or health care on their own often simply establish an official policy protecting the health of the all of people. In line with other constitutional provisions, they also establish the protection of public health as a condition for curtailing individual rights, thus the implementation of measures that provide the environments for health without relying on individual behaviour, and the prohibition of conduct injurious to health. Article 1 of the World Health Organisation Constitution, for example, mandates the organisation to aim for the 'attainment by all the people of the highest possible level of health." One of the most detailed constitutional provisions on health in the SADC region, from South Africa, is shown in Box 2 below.

Box 2: Constitutional provisions in South Africa relating to health

Rights to:

- bodily and psychological integrity
- make decisions concerning reproduction
- secure and control over ones body and not to be subjected to medical or scientific experiments without consent [Section 12(2)]
- an environment that is not harmful to their health or well being (Section 24)
- access to health care services, including reproductive health care [Section 27(1a)]
- access to sufficient food and water [Section 27 (1b)]
- guaranteed emergency medical treatment [Section 27(3)]

Child rights to:

- basic nutrition, shelter, basic health care services and social services [Section 28 (1c)]

The state must take reasonable legislative and other measures, within its available resources, to achieve the realisation of these rights.

In providing for the right to health for **all** citizens, constitutions establish a legal framework against which policies may be advocated and judged and claims may be exercised. However, if different social groups have weaker or stronger power to make and win their claims, such legal provisions aimed at universal rights may in fact be exercised by a few, and particularly by those with greater access to and familiarity with legal recourse, often the wealthy. Hence constitutional rights may be a necessary but not sufficient mechanism for the practical expression of the right to health, and the more specific expression of the general right to health in subsidiary law and the systems and procedures by which social groups claim legal rights are equally important.

In other countries in the region the provision is more general, and dependent on specific provisions in subsidiary legislation for its expression. Despite active constitutional and civic rights debates in the region, there has been little focus on how to specify the general right to health and in particular how society will ensure equity in health. In the South African constitution, there is protection of basic requirements for health and of access to health care, but this would clearly need to be further specified in law to ensure that higher income or more organised groups do not use these provisions to claim an unfair share of resources over poorer, less organised groups. It would be useful to explore whether and how any constitution or law in the region goes beyond the expression of minimum standards to specifically provide for equity in allocation of public resources for health care. Given competition in the claim for scarce resources and the greater power of some organised groups to claim these resources, there could be a case for specifically providing for the legal protection of **equity** itself.

Examples of existing legal provisions in the region cover:
i. the prohibition of conduct injurious to health (eg: limiting alcohol exposure);
ii. provision for specific programmes and services (eg: medical services, emergency care);
iii. provision for the production of health resources (eg: drugs);
iv. provision for social financing of health;
v. regulation of the quality of care; and
vi. regulation of the rights and relationships between health professionals.

2.2.2. Health rights in provider-client relationships

The content of these provisions, and thus the articulation of health rights reflect the prevailing approach to health and the nature of the relationship between health professionals and communities. Bell (1996) discusses the changing pattern of how these issues are dealt with as health care has moved from the age of paternalism (emphasising medical decision making), to the age of autonomy (emphasising patient rights and informed consent) to a newly emerging age of bureaucracy' where concerns centre around the states provision and rationing of health care[6]. In a paternalistic model, the patients best interests are narrowly understood in terms of the health professional effecting a medical cure, and, noting that many illnesses are self limiting, in doing no harm. This approach to health care places the patient in a passive position, and leads to potential conflicts between patients exercising rights, such as of refusal of care, and practitioners fulfilling what they perceive to be patient interests. Shifts to autonomy lead to greater patient involvement in medical decisions, but may lead to conflicts between individual rights over public good. Further, consumer rights approaches have not necessarily led to increased devolution of control over health policy and planning. The need to raise individual rights **and** obligations has led to greater emphasis on responsibility for ones own health, to regulation to restrict unhealthy choices and to greater preoccupation with minimum obligations for health care under conditions of limited resources. This has led to bureaucratic health care systems that restrict choice and allocate resources on the basis of risk assessment and efficiency.

This has recently begun to shift the health rights debate to issues of how resource allocations for health are made on the basis of need (rather than demand), and to the balance of power between bureaucratic providers, professionals and communities in health

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[6] In fact, as Bell argues the transition is a metaphor for the different forms of provider / client relationship, and the balance between individual and social rights. In Southern Africa all three stages of this proposed 'transition' seem to exist in the health care system at the same time.

care decisions. There is, in a number of papers, reference to community participation and to systematic consultation with stakeholders as a necessary component of health programmes. At the same time, the administrative systems in health and the mystification of medicine to the community are seen to disempower such participation. This makes it important to examine the structures through which social groups express their position in macroeconomic and health policy (Kalumba 1997). Lafond (1995) also notes that the actions, attitudes and influence of different stakeholders affect health allocations. Van Rensburg and Fourie (1994) describe, for example, the role of the medical profession in supporting inequalities in health through implementing health care systems and forms of institutional care designed to suit their medical, vocational and professional interests, rather than more appropriate forms of care. Hence, it has been proposed that if health resources are to be directed towards poorer groups, there is a need not only for expert intervention, but also for demythologising the medical profession and vesting greater authority in the community (Storey 1989). The authors raising these issues generally note the need to recognise health care as an issue of public concern, to therefore democratise health planning and provide for adequate mechanisms for public participation in health.

The fact that only one paper in this bibliography specifically deals with these issues (Manyeneng 1981) indicates that it is an issue that needs greater policy and technical attention. At the same time there are no papers in the bibliography that address how specific groups of health professionals influence resource allocations and health policies. Again the specific roles of different groups of health professionals in these areas of decision making and the impact they have on equity issues would appear to be an area that merits greater attention.

2.3. Equity in health and health care

Many papers in this bibliography describe inequalities in health. Various papers deal with the distribution of malaria, tuberculosis, HIV/AIDS, nutrition and mortality and profile the importance of poverty, race, rural residence, urbanisation and homelessness, family stability, migration, education, information and skills for prevention and access to health care in the distribution of these health outcomes (for example, Andersson et al 19..; Gillies et al 1996; Sanders and Davies 1988; Jhamba 1994). These inequalities in health are described to show their association either with macro-economic and social policies, health care policies or resource allocations for health, to motivate policy changes in these areas. Inequalities in health are used to profile the distributional effects of macroeconomic, health or health financing policies, and the 'winners' and 'losers' of these policies.

That wider economic and social policies have a profound influence on health is evident in the literature. The Zimbabwe Ministry of Health notes that investment in education, and particularly in female education, is an important determinant of improved health in the poorest groups (ZMoHCW 1996), while wage and employment security are described as further important determinants of health outcomes (Loewenson 1984). Mhloyi (1997) presents the longstanding debate between population growth and income and notes that population health is more closely linked to the distribution of income than to aggregate income.

Various papers describe the complementarity between households and health services, and note that health gains are made when public health measures are specifically designed and invested in to complement household capacities (Sanders and Davies 1988; Loewenson and Chisvo 1995).

Research and reports on the social and economic dimensions of HIV/AIDS note that the massive increase in illness increases new demand for health care, but also affects the supply and quality of services, undermining the match between need and supply. In response to the stress on health services, home based care approaches have been promoted. If not adequately supported, households may be further stressed by this demand. Providing adequate resource and supervision support in rural areas may, however, be costly to services. When other sectors make HIV/AIDS a problem for households and the health sector, and fail to put in place their own mitigatory strategies to deal with premature adult mortality, the burden on overstretched health services and poor households weakens the capacity of both to mount an effective response.

2.3.1. Positive features of health sectors in relation to equity

In relation to health sector interventions, on the one hand papers outline a number of positive features of health care that reduce inequalities in health and improve the health status of high risk groups. The evidence is limited and often restricted to specific countries or areas within countries, calling for wider cross-country analysis in the SADC region of the features emerging from these more localised studies. The features include:

- a redistribution of budgets towards prevention, improvement of rural infrastructures, investment in primary health care, provision of primary care services free to clients at point of use, (Loewenson et al 1991);
- support of primary care level and community based health care, building links between curative and preventive services (Walker G 1976);
- improving quality of services (Haddad and Fourier 1995);
- deployment and orientation of health manpower towards major health problems, effective use of staff time, balancing tasks with resources at primary care level (Haddad and Fourier 1995);
- providing prompts to encourage effective use of services, such as dissemination of information on prevention and early management of illness (Albaster et al 1996; Jhamba 1994); and
- integration of health services with social structures and cultural systems (Curtis 1988).

These interventions are linked to specific types of planning structures. Doherty et al (1996) note the need for comprehensive planning systems in restructuring health care, recognising that piecemeal planning could impede services and damage morale. Jelley and Madely (1984) note the importance of involving primary care practitioners in the organisation and management of local health systems, while Yach and Harrisson (1994) note that equity cannot be achieved without a purposive and systematic programme to unify health systems and to democratise health care, including in decision making, resource allocations and deployment of personnel.

2.3.2. Negative features of health sectors in relation to equity

On the other hand, the papers in the bibliography highlight a number of features of the health system that potentially exacerbate **inequity**, including absolute reductions in overall budgets, and 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; poor functioning of the referal 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 resouces for effective implementation of tasks by health workers.

The nature and distribution of personnel, their remuneration and industrial relations systems have become important limiting factors in health systems in the region. Adding to old problems of absolute shortages and poor distribution of specific health personnel, macro-economic and health sector reforms have led to declining real wages of health workers, increasing inequalities between private and public earnings, attrition of skilled personnel to private practice and across national boundaries and increasing industrial conflict within the sector, often within poorly developed industrial relations systems. Health workers have themselves become more preoccupied with their own health risks and security. The impact of these trends on equity in health is poorly explored, and more importantly, strategies for managing and developing human resources that ensure equity in health are not clearly articulated. Without this, some strategies aimed at improving equity, such as retention of staff in the public service through permitting limited private practice, may in fact yield the opposite impact. While some countries have begun to explore ways of releasing health personnel from public service regulatory controls, and to examine decentralised human resource management systems, these changes do not alone provide for the long term human resource strategies needed to equitably meet health needs. This is clearly an area for future work.

While the bibliography presents a wide range of discussions on health care interventions, in more recent years discussions on resource allocations for health and administrative and planning systems have received substantial attention in the literature. Equity implications raised in the literature of current or proposed administrative and planning systems are discussed below, while the issue of resource allocations is further discussed in section 2.4.

2.3.3. Equity issues in administrative and planning systems

Recent policy has focussed on decentralisation as a tool for improved decision making, equity and quality of services, intersectoral communication and community participation. As a recent approach, there is little in the literature on the practical impact of decentralisation on health systems. In one reported study in Botswana, Langlo and Molutsi (1995) argue that it has not uniformly achieved these goals, and note further that weakened links with the ministry of health have weakened public health surevillance and planning based on population indicators, leading to greater bureaucratic inputs to decision making. They also note that there is little evidence of enhanced community participation or intersectoral co-ordination. The role of decentralisation in enabling a more open and explicit expression of social interests in health is poorly explored, despite the fact that decentralisation has as an explicit aim the devolution of power in health management to local level. The impact of decentralisation (in its different forms) on equity is thus an area for further empirical assessment.

This calls for monitoring and review of how decentralisation affects the distribution of resources, quality of care, particularly at primary care levels, the referal system, professional and client participation and the responsiveness of the health system to major health needs. It would seem to be important that decentralisation is implemented in a manner and at a pace that allows for such review to inform the decentralisation process.

There is also a need for improved management capacity to promote equity. This relates not only to management skills development, but also to other capacity issues such as improving the interaction of organisations and individuals within the task network and improved information systems. Management capacity improvements are particularly important in promoting equity within decentralised health systems. It is common for management capacity to be strongest in the 'richest', urban based areas, which will tend to exacerbate existing resource disparities (in that these areas are able to motivate strongly, with clearly structured plans and budgets, for additional resources and have greater ability to successfully implement service development plans). In order to promote equity in decentralised systems, it may be necessary for more central government levels to specifically support the development of management capacity in historically disadvantaged areas (Makan, Morar and McIntyre 1997).

2.3.4. Is describing inequity an adequate trigger for review of health systems?

The literature provides many examples of inequalities in health, and of health care interventions that enhance or weaken equity in health care. Are these analyses of inequalities in health sufficient cause to motivate changes in health systems? There is a growing call internationally for 'evidence based policy', or that policy decisions be more strongly informed by population information and by evidence of proven impacts of proposed interventions. This arises perhaps, out of a perceived gap between data and its use in policy and practice. What are the obstacles to creating stronger links between data and decision making?

The first issue to deal with are the confounders beyond the specific macro-economic or health policy being critiqued. These may lie in inputs to health and factors influencing health care in and beyond the health sector, leading to debate on whether the effect noted is real and is sufficient cause for policy change.

However, even where inequalities in health, or poor relationships between health needs and health care can be demonstrably linked to certain policies, one author asks: 'What size of difference, gain or loss is needed to motivate a policy change?'. This is not always clear, and probably relates to what level of avoidable differences in health status society has aversion to. Social aversion to differences in health may vary in different groups and sectors, and may be differently perceived by different professional interests. This has been noted and commented on in the previous section. Further, allocations to health, and decisions in health may be affected by policies and priorities beyond the health sector.

Hence, while the bibliography raises a number of areas of inequity in health, and describes the features of health services that promote or weaken equity, incorporation of this knowledge into health policy and practice is limited by a number of weaknesses:

i. lack of clear empirical information on the joint equity and efficiency implications of different alternatives for health management and administration, including decentralisation policies;
ii. insufficient information on alternative human resource development and management strategies in the health sector, that meet both equity and professional needs[7];
iii. continued gaps in knowledge on approaches to improving the referal system, and in particular to ensuring adequate quality of care at primary care levels[8].

Finally, the virtual monopoly of western biomedical approaches to health care must be recognised and considered from an equity perspective. Almost every paper in the bibliography takes western medicine as its model of health care inputs, and regards self help, traditional medicine and other health care systems as 'fallout' or loss to coverage. There is little critique of the patterns of drug dependency and resistence, excessive antibiotic use, biomedical pressures for new microbial strains and other iatrogenic factors in ill health. Current equity debates do not incorporate the question of how different healing systems interact in overcoming unfair differences in ill health, or in providing sustainable approaches to preventing and managing disease. This marginalises a wide range of ways in which people act to improve health in Southern Africa, beyond western health services.

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[7] In the 1970's and to some extent, the 1980's, there was an extensive literature on human resource strategies to support the primary health care approach. Health reforms in the 1990s have paid less attention to these issues.

[8] While there is literature on the management of services that provides some analysis of quality of care, this does not address all dimensions of this issue.

2.4. Equity in resource allocations for health

An analysis of equity issues in relation to resource allocations for health (within and beyond the health sector) must begin with the recognition that health care resources are finite. This, in turn, focuses attention on the criteria and mechanisms for how a 'just' system of allocating these scarce resources can be structured. How are such just approaches defined - on the basis of societal contribution, of 'market choice', or of need?

Many of the approaches and concerns outlined in the bibliography reject the concept that the market is a just mechanism for the allocation of health resources. Even in developed economies, Carr Hill (1994) notes that there is weak evidence that health markets actually function. They examine the manner in which more market oriented mechanisms affect equity or the nature of specific interventions aimed at ensuring equitable resource allocations for health. There is a parallel substantial literature that examines efficiency and cost effectiveness in resource allocation mechanisms that is not included in the bibliography, except in relation to their equity implications.

2.4.1. Household expenditures on health

One important obstacle to equity in health noted in the literature is the lack of adequate household resources for health, and the inequalities in the capacity to acess those resources. Socio-economic determinants of ill health are noted in many papers to not only influence health patterns, but also influence access to health care (For example, Van Rensburg and Fourie 1994; Sanders and Davies 1988; Loewenson and Chisvo 1994). Ettling et al (1995) note for example that 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 very low income groups. Thus ensuring that health care resources are allocated progressively and addressing the often highly inverse allocations of health and other resources in Southern African countries are of greatest importance for equity (ANC 1994; Bloom 1985; Zimbabwe MoHCW 1982; Kalumba 1997).

Doherty et al (1996) notes that in South Africa inequities arise geographically, racially, and between different levels of care. Broomberg (1994) further notes inequities between insured and uninsured populations. Davies (1994) has noted that structural adjustment policies have exacerbated such inequities by increasing prices within and beyond the health sector at the same time as inequalities in wealth have increased. The debates on cost recovery signal the extent to which professionals differ on the exent to which household poverty should trigger social spending. *Willingness* to pay has been equated with *ability* to pay, often with inadequate monitoring of how this affects household spending and assets and thus future health risks, or of household impacts of cost recovery measures. Russell (1996) notes that households may borrow or deplete other assets to meet health costs, with longer term devastating impacts on livelihoods and health. He also recognises that current cross sectional approaches do not adequately detect these impacts. In a situation where greater expectation exists than ever before of household payments for health care, policies would need to be backed by far better understanding and monitoring of household economics than is currently the case.

In order to reduce inequity in health status over time, and in line with the concept of vertical equity, it is necessary to give a greater weighting to the potential health gains of those with very poor health status. Mooney (1998) explains this perspective as follows: "if two areas' needs are in a ratio of 2 to 1 and resources are allocated to these two regions pro rata with needs, i.e. also in a ratio of 2 to 1, then the needs afterwards are likely to remain in a ratio of 2 to 1." While the actual outcome will be influenced by the health gains from health spending in each region, the issue is that it is likely that some form of 'positive discrimination' in favour of those with the worst health status or an additional weighting in a resource allocation formula is required to ensure that health status differentials actually decline over time' (Mooney 1998).

2.4.2. Reduced funding and increasing costs

Equity measures aimed at allocating resources where needs are greatest are challenged by absolute shortages of health funding. Segall (1983) and Doherty et al (1996) both note, for example, that ensuring more equitable allocations, such as towards primary health care, depends on allocating **new** resources in accordance with primary health care priorities. Public spending on health in the region is, however, 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). In some countries in the region, health budgets have fallen due to the increasing share of budgets going to debt servicing. This calls for greater attention to examining how deficit reduction and debt relief could release new resources for health, and how equity could be improved through such a release of resources. Budget falls have been exacerbated by cost increases due to other fiscal measures, such as currency devaluation and retrenchment, leading to rapid falls in drug supplies, cuts in health programmes and staff shortages or real wage declines. Ogbu and Gallagher (1992) note that while government spending on health should be countercyclical, with increases during economic downturns, in fact the opposite has more often been the case. Absolute shortfalls in health, and conversely increasing total allocations or revenue for health, is thus viewed by some as an important demand for achieving greater equity within health systems, particularly in some of the highly skewed health systems in Southern Africa, where high levels of resources concentrate in curative health services for higher income groups.

Budget pressures have increased as health costs have risen. Aday and Anderson (1981) present evidence that while publicly financed programmes have made substantial improvements in health in low income groups, the costs of these programmes have increased and quality of care has declined. In contrast Kane Berman and Taylor (1990) note that many cost increases in health arise from changes in the value of currency and consumer price indices, which are factors outside the health sector. This situation has led to an excessive concern over efficiency and cost management within the health sector, sometimes to the detriment of health care in general. Cost reducing cuts in human resources and institutional capacities become counterproductive, for example, if they lead to other resources not being used effectively.

2.4.3. Mobilising resources: cost recovery

There is also some debate on approaches to raising the necessary revenue for addressing these health needs, and whether these approaches may introduce further inequity. The greatest debate centres around fee charging or cost recovery, and their equity impact. Cost recovery objectives are noted in various papers as aiming to:

- increasing revenues through charges on services;
- improving coverage and quality of care through applying increased revenue to service improvements;
- enhancing equity through targeted spending on the poor;
- improving service utilisation patterns and the referral system by controlling frivolous demand and directing choice through prices and levels of provision; and
- increasing efficiency by making providers cost conscious and encouraging cost effective techniques of providing care.

However, user fees as a mechanism of cost recovery have been criticised for their negative impact on equity, mainly because of:

- poor functioning of exemption mechanisms (leakage of non exempt groups into free care and groups meriting exemptions not accessing them due to lack of information, excessive bureaucratic demands, lack of formal proof of earnings etc);
- reduced use of care in the poorest groups, associated in some cases with an increase in damaging health behaviour and negative health outcomes;
- depletion of household assets to meet health costs, increasing expenditure on future health risk;
- little improvement in quality of care at primary care levels, or of increased budget allocations to these levels;
- insignificant additional revenue generated; and
- weak or temporary impacts on the use of the referral system without corresponding changes in quality of care (McCoy and Gilson 1997; Lennock 1994; Hongoro and Chandiwana 1994; Zigora et al 1996; Wang'ombe 1997).

Mechanisms to offset some of these effects are proposed, such as localising at community level decisions on what level of fees should be charged and how exemption should be managed, retaining fees locally to improve quality of care, encourage local participation in fee management and ensuring that additional revenues raised are earmarked for primary care services (Shaw, Griffen 1982; Wang'ombe 1997). Local level decision making is, however, likely itself to be dominated by local elites and thus does not in itself enable the voices and needs of the poorest to be heard and addressed.

The issue of user fees is by no means resolved. Obtaining better empirical information on the equity impacts of community financing options, and the specific factors that influence these impacts, would provide greater input for decision making on user fees. Still, there is however sufficient data to raise serious questions about the equity implications of user fees, and to call for precautionary approaches to their implementation, including explicit measures for dealing with known negative impacts.

2.4.4. Mobilising resources: other approaches

National and social health insurance is a further revenue raising mechanism. It may enhance equity through the potential for cross subsidy between high and low income contributors, and between contributors and non contributors, but may also increase inequity if it leads to tiered systems in the public sector for the insured and non insured. Some argue that tiering in the hotel aspects of hospital care may be a necessary way of ensuring that higher income groups use hospitals rather than buying private care. Such tiering thus becomes a strategy for maintaining and promoting some form of solidarity within the public system, but should not extend to clinical quality of care tiering. There is also a potential, if government subsidies are applied directly to social health insurance, of the more powerful organised labour force distorting money towards its needs, given their greater power than the unemployed and poor (Price 1997). As in the case of cost recovery measures, there are therefore both positive and negative equity implications of social health insurance that would need to be explored in relation to the specific nature of the proposed scheme and populations covered, and the specific context of its implmentation. There are strong arguments that progressive taxation systems are the most equitable form of health financing, and that social or voluntary forms of health insurance detract from the possibility of building universal comprehensive health systems financed from taxation. There is again a gap in the empirical analysis and presentation of policy options on this area in the region calling for further work.

Other revenue raising mechanisms are hardly explored for their equity implications. There is little analysis in the bibliography literature of equity implications of and measures to enhance equity in private insurance, mutual insurance schemes; donor financing and various earmarked taxes. Some, such as earmarked taxes, would appear intuitively to enhance equity, particularly if they are sin taxes on products consumed by high income groups that lead to high health costs of degenrative disease (such as cigarettes). However, taxes on tobacco products are frequently regressive. This is increasingly a concern given the explicit targeting of low income groups in African and Asian countries by transnational tobacco companies in their marketing strategies. Thus, the relative progressivity of 'sin taxes' should be evaluated within each country before widespread promotion of their use as a potential health care financing mechanism.

Donor financing may be either progressive or regressive. While many areas of donor financing have been targetted at primary levels of the health system, donor funds have also been implicated in distorting health priorities, for example towards larger infrastructural developments or creating pressures for particular technologies and therapies that may not be the most appropriate or equitable. There is no paper in the bibliography that specifically addresses this question and it would also appear to be an area for further work. In addition to considering alternative financing mechanisms individually, there is a need to evaluate the overall equity of health care financing within countries. The progressivity of some sources may be offset by the regressivity of others, hence the need to assess the relative progressivity of the total financing package.

2.4.5. Distributional issues in health financing

While absolute shortfalls in funding may be perceived as a constraint to equity, clearly it is equally important to explore distributional issues. A view is expressed in the bibliography that it is not 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 reinforces the view that per capita expenditure is a poor indicator of health care and that greater analysis is needed of **how** health resources are spent.

While this concern raises both distributional and efficiency issues, preoccupations with issues of cost reduction, allocative efficiency and cost-effectiveness of care have dominated. Mills (1996) cautions that there is inadequate evidence that reforms brought in to enhance allocative efficiency and cost-effectiveness in the health sector have increased efficiency, and warns that they may introduce a new set of problems. This calls for careful and selective planning. Bijlmakers and Chihanga (1996) note that equating a reduction in unit costs with an increase in efficiency is incorrect, as it may relate to worsening quality of care. Mechanisms for enhancing efficiency, such as budget decentralisation, contracting out and purchaser-provider performance contracts are poorly explored in the literature for their equity implications, perhaps because they are relatively new in many African countries. There are, however likely to be both positive and negative equity outcomes in these measures. For example budget allocations based on workload and population health indicators may have positive equity effects over allocations based on hospital data such as beds and bed occupancy (UNICEF/MoHCW 1996).

On the other hand, decentralisation processes with inadequate capacity support may lead to budget allocations being made by district bureaucrats on the basis of higher visibility hospital investments than for primary care or preventive needs (Molutsi and Lauglo 1996). Mills et al (1993) noted for example that the share of supplies costs is much higher in the district hospitals than the surrounding primary care infrastructure, indicating a possibility of redistributing these resources district wide to enable greater levels of health management outside the hospitals. It is evidently necessary to take locally generated resources into account when determining allocations from the central level. This is particularly important in decentralised health systems, where it is necessary for central allocations to actively compensate for the relatively greater ability of certain areas (usually the more 'wealthy' urban areas) to generate user fee and local tax revenue.

There is growing interest in geographic resource allocation issues. While the emphasis in the past has been on promoting equity in the allocation of resources between large geographic areas (such as regions or provinces), more attention is being focused on the potential usefulness of micro-geographic areas in resource allocation decision making. In particular, it is easier to identify small geographic areas with high poverty levels, poor health status and inadequate health and other social services for differential resource allocation purposes than to attempt to target individuals' (McIntyre 1997).

The private sector probably demands much greater focus than the public sector in relation to managing escalating costs. Mooney (1998) argues, for example, in relation to South Africa that "there is no sustainable argument for tax concessions of private care if South African are to build a health care system based on any reasonable set of principles of equity." This view is based on the fact that scarce government resources which should be available for allocation on the basis of social values should not be directed to supporting a system accessible to the minority and driven by the "values of the market place". It might be assumed that cost escalation in the private sector is itself inequitable, as it would lead to a greater share of overall health resources going to a smaller section of the population who could afford such costs, and exacerbating salary differentials leading to attrition of skilled health professionals from the public to private sector. There is some discussion in the literature on the factors influencing this cost escalation, such as third party payment systems and fee for service payments. The literature also discusses mechanisms for controlling such cost escalation, such as the monitoring, regulatory and incentive measures in managed health care. The equity implications of these schemes are poorly explored, except in relation to possible problems of skimming high risk, low income groups out of managed care schemes.

In the main however, the resource flows within the private sector, the hidden and open subsidies from public to private care[9], the concentration of high cost personnel and facilities in the private sector and the lack of private sector investment in preventive and promotive care is weakly addressed. While these issues may be significant contributors to inequity in health, there is a paucity of information on how to manage them, particularly how to do so given the political and professional leverage of private practitioners and their clients.

Other distributional issues affecting equity are also poorly addressed: including the concentration of high cost, skilled personnel in urban, central and curative facilities, the poor functioning of the referral system, the weak interaction with communities[10].

Equity effects are generally little explored across many areas of financial reform in Southern Africa, including areas where inequities are evident, such as distortions in private / public spending and provision, concentration of resources in central, urban facilities and poor

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[9] Such as in the subsidies on fees and taxes for private insurance members, the use of public facilities by private practitioners at subsidised costs, poorly regulated part time private practice by public health professionals, leakage of public drugs and equipment to private practices, public subsidies of health professional training without adequate public service after qualification and so on.

[10] Evidenced for example in late reporting for treatment, poor compliance with therapies and drop-out, growing drug resistance due to poor control of drug use, lack of effective uptake of available technical interventions such as STD treatment, condom use, contraception and so on.

functioning of the referral system. These areas of inequity call for further research and implementation of reforms.

2.5. Monitoring equity

The literature disaggregates health information in various ways to monitor and analyse equity trends. The major indicators that appear in the literature are shown in *Table 1*. The parameters along which the data are disaggregated indicate the dimensions along which 'unfair' differences are perceived, at least by the authors of the papers[11].

It is the relationship **between** various indicators rather than their status per se that provides greater information on equity. For example, Mocumbi (1997) reports use in Mozambique of a quadrant analysis relating health need indicators with health care provision to indicate equity between need and supply. (He also uses a quadrant analysis to relate health care facilities with outputs and with workload to indicate levels of efficiency). Wagstaff et al (1991) use various inequality indices (the slope index and the concentration index) to present a picture of socio-economic inequalities in health. Yach and Harrison (1994) note the relationship between specific socio-economic indicators, health outcomes and health care inputs, such as between socio-economic factors, neonatal mortality and maternity services.

Table 1: Indicators used in monitoring equity
(*based on indicators reported in papers in the bibliography*)

Non health sector inputs to health (opportunity)	Health / health sector indicators	Parameters for disaggregation
• Population growth rate • Urbanisation • Population <15, >65 • Household size Household composition • Literacy • Educational status • Maternal education • Income • Sources of wealth • Poverty • Assets • Occupation • Housing tenure • Room density • Water • Sanitation • Electricity	• Mortality rate • Infant mortality rate • Child mortality rate • Perinatal mortality rate • Adult mortality rate • Perinatal mortality rate • % deaths <5 • % deaths >65 • Life expectancy at Birth • Disease specific • morbidity rates • % pop with access to health care • Coverage rates (immunisation, ANC, deliveries etc) • Health facility: pop ratio • Beds: pop ratio • Health care expenditure/capita • Consultation rates/capita • Expenditure by level of care • Health cadre: pop ratio • Workload of health professionals	• Race • Rural/urban/periurban • Socio-economic status • Age • Sex • Geographical region • Public/private sector

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[11] Hence, for example, health differentials by sex would be regarded as avoidable and unfair.

There is some critique of the indicators used. Krieger and Moss (1995) note that disaggregations by the usual categories of age, sex and race limit understanding of **why** differentials occur, and that distributional data needs to be informed by better socio-economic data at individual, household and neighbourhood level to understand cause and target intervention. The QALY (Quality Adjusted Life Years) indicator has been criticised for not adequately incorporating distributional concerns, calling for selected weightings to reflect equity concerns. Taylor et al (1993) call for use of selected indicators, such as in maternal care, that are discrete, readily analysed and easily understood. The indicators should include measurement of inputs (access), process (use) and outcome (impact), but should be limited to only the most necessary items. Equity monitoring furthermore calls for monitoring of trends over time, particularly to note departures from expected trends and changes after implementation of specific policies. Chandiwana et al (1997) calls for equity 'standards' against which to monitor progress. One such standard, perhaps, is the WHO European policy that by 2000 differences in health status between countries and groups should be reduced by at least 25% through improved health of the poorest (Whitehead 1990). WHO, in their work on developing approaches to monitoring equity propose setting equity targets, expressed as a reduction in differentials between groups over a defined time period[12].

While the published literature in the region on approaches to monitoring is still limited, it is an area where there is work taking place, such as in the WHO initiatives in Southern Africa. This initiative was part of a pilot programme also involving Sri Lanka. The first phase of the initiative was to conduct a situation and trends analysis on equity in health and health care, which would subsequently lead to targeted research involving the collection and analysis of additional new data to address equity concerns in policy making, and propose ways to improve ongoing monitoring of inequities in health and health care. Currently work is taking place on the development and use of indicators from existing data and data sources to monitor equity at district level. In these WHO supported discussions on monitoring equity in the region, some of the indicator categories proposed for measurement of differences between groups include:

Indicator categories	**Indicators measuring differences between population groups**
Health determinants indicators	Prevalence and level of poverty. Educational levels. Adequate sanitation and safe water coverage.
Health status indicators	Under 5-year child mortality rate Prevalence of child stunting Maternal mortality ratio; life expectancy at birth, incidence/prevalence of relevant infectious diseases; infant mortality rate and 1-4 year old mortality rate
Health care resource allocation indicators	Per capita distribution of qualified personnel in selected categories. Per capita distribution of service facilities at primary, secondary, tertiary and levels. Per capita distribution of total health expenditures on personnel and supplies, as well as facilities.
Health care utilisation indicators	Immunization coverage. Antenatal coverage. % of births attended by a qualified attendant. Current use of contraception.

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[12] For example: "By the year _____ reduce child stunting to x% overall, and reduce the disparity in stunting rates between girls and boys by y%."

There is no current standard data base or commonly agreed equity indicators in this area that allows for comparison within and between SADC countries or over time. The development of such standards and indicators would be a useful input to policy making in the region. Information at local level on the relationships between household and community indicators of health needs, opportunities and access to health care, and what factors are driving these relationships is also inadequate. Even less available is an understanding or definition of what communities, health professionals and providers consider to be unfair and avoidable inequalities and whether they share common priorities.

McCoy and Gilson (1997) summarise a motivation that lies behind much of the discussion on equity indicators, which is the need for such data to be selected so that it **drives** change rather than simply monitoring it. This would make the monitoring of equity a tool for development rather than a tool of measurement. If equity monitoring is to play this role, then it would be important to define the triggers for change in policy and practice. It would also be important to define how such monitoring links to the structures in which such decisions are made.

2.6. Issues arising

This overview presents a framework for addressing equity in the Southern African region that incorporates frequently held definitions of equity but extends beyond these to incorporate in a more explicit manner issues of capability (and social capital), participation and procedural justice. Hence the framework proposed for future work (from household to regional level) would explore traditional dimensions of the concept of equity, or:

i. the definition, extent and dimensions of differences in health status that are unnecessary, avoidable and unfair;
ii. the determinants of these inequalities in health, whether they arise at a social, economic or health sector level and how they are affected by policies within and beyond the health sector;
iii. the specific differences in the distribution of health inputs (in and beyond the health sector) to people whose health needs are different, (vertical equity); and
iv. the manner in which policies aimed at redistributing societal and health resources seek to address the areas of vertical equity highlighted in (iii) above.

The conceptual framework however adds further dimensions of the extent to which

i. different groups of people are able to make choices over health inputs and have the capacity to use these choices towards health and the manner in which policies and measures in the region affect such capacities;
ii. 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; and
iii. these issues feature in health and wider policy agendas and the factors influencing their incorporation into policy.

A deeper understanding of equity policies, and the factors influencing their realisation can be built by examining the extent to which such policies **have** been articulated and implemented in the region, and the obstacles to their implementation. The overview indicates a need for such a review.

Reducing differences in health is motivated by the negative implications for the health of all groups of such inequalities, and by social aversion to such differences where they are perceived as unnecessary, unfair and avoidable. In the former issue, the negative aggregate health consequences of inequality in health is poorly explored, and would be an area for further epidemiological assessment. In relation to social aversion to inequality, it is argued that 'unfair, avoidable and unnecessary' differences are socially defined, and that future work more explicitly recognise this subjective dimension and provide clearer analysis of the social interests and forces that influence policy, and the manner in which political, civic and health sector organisation enables or disempowers the influence of particular interest groups. This includes groups from local to supra-national level. Hence, this overview puts forward the proposition that work on equity needs to be informed by both a clear epidemiological understanding of the overall public health implications of inequality, as well as by a clear understanding of the socio-political factors that influence distributive outcomes.

There has been an increase in bureaucratic regulation of health care resources, of claims for individual and social rights to standards of health care and of professional bargaining and action on their interests as stakeholders. This calls for debate and analysis on the systems for balancing power between these groups, and for dealing with some apparently conflicting interests in a manner that enhances equity in health. It also implies a need for a more systematic and well articulated approach to stakeholder participation, including providers, professional groups and communities, in place of the often ambiguous statement of community participation that describes a range of interactions, some of which involve very little devolution of choice and control. This information would be important to inform current debates on and initiatives towards decentralisation.

Many post independence health sector developments stressed access to basic health infrastructures and services. In more recent years, greater focus has been given in health policy to efficiency reforms and resource mobilisation for health. In both cases, weak mechanisms for ensuring sustainable progressive allocation of health resources have been associated with persistent inequalities in health. At the same time new policy measures aimed at efficiency, cost reduction and revenue generation have not been adequately assessed for their impact on equity. This overview concludes that such monitoring would need greater levels of disaggregation and focus on microeconomics than are often provided, to assess impacts on vulnerable groups, on household shifts in assets and spending and on the implications for future health risks.

One of the important issues in pursuing an equity agenda is thus to make visible the inequalities that do exist, to enable society to see and respond to them. This calls for readily analysed and easily understood indicators for monitoring equity (in social and economic opportunity, in health care access and in health status) and a social process to define the standards against which to assess progress, make value judgements and prioritise responses and resource allocations. Hence monitoring should not only measure equity, but also drive changes in policy and practice. There is already work taking place on monitoring equity in the region, such as in initiatives by WHO with various national institutes in Southern Africa. It is suggested that this work further identify triggers for changes in policy and resource allocations within and beyond the health sector, to better link data collection to such policy changes. This would strengthen the development of evidence based policy. Such work also needs to outline the social processes needed to identify those differences in health and health care that are unnecessary, avoidable and unfair.

The overview identifies several areas where there appear to be gaps in our understanding of equity. Relating to the framework provided earlier, the following are suggested areas for future work:

i. How are health rights expressed and claimed in the different countries of the region; what role do such rights and standards play in driving equity and in the relationships between providers and clients of health systems, and how might procedurally just systems enable different social groups to claim their rights to health?
ii. What are the causes of and strategies for dealing with the inequitable distribution of health personnel (nationally and regionally) at different levels of care **within** the public

sector, between the public and private sector and across various socio-economic dimensions, including income groups and geographical areas?

iii. What role have health professionals and their organisations played in health policies and in patterns of resource allocation within the health sector?
iv. Across countries of the SADC region, what features of health systems are associated with improved targeting of and access by high risk groups, and reduced inequity in health care? How has the functioning of referral systems been enhanced and what constraints need to be addressed?
v. What are the projected and real equity impacts of various forms of decentralisation of health systems? How has decentralisation of health systems been linked with various forms and capacities of the decentralised state, including local government.
vi. Across the countries of the SADC region, what strategies are being used for resource mobilisation for health. What are the equity impacts across different socio-economic groups of such resource mobilisation, using in particular household data to understand impacts at that level? How effectively and with what strategies is resource allocation providing greater weighting to the potential health gains of those with very poor health status and how could this be improved? What mechanisms exist for ensuring adequate and sustained budget allocations to health given the highly equitable role of progressive taxation in health financing?
vii. What subsidies exist from public to private care and how can these be eliminated?

The network of organisations compiling and reviewing the bibliography presented here identified strongly with the need expressed at the 1997 Southern African meeting on Equity in Health in Kasane to restore and enhance equity as a policy goal for the region. The organisations recognised the fact that what is defined as 'unfair, avoidable and unnecessary' by one group may be contested by another, calling for wider information input to social decision making. The aggregate gain of addressing inequalities in health and the wide risks of sustained inequity must be clearly demonstrated. Inevitably, work on equity would need to recognise that there is a struggle around these issues.

In what way could a network of professionals contribute to these goals? The organisations involved in compiling the bibliography identified several areas that merit follow up work, noting that at least one area, that of monitoring equity, is already being pursued through a regional initiative supported by WHO. The most important areas identified were:

1. To provide greater focus on and analysis of the social dimensions of equity, ie issues of capability, social capital, participation and procedural justice that influence the relationships between health inputs and their impact on health status, and influence the allocation of resources towards health needs.
2. To explore the equity impact of current and proposed strategies for resource mobilisation and allocation in health, within the public sector, and between the private and public sector.
3. To explore human resource development issues in relation to equity, including the roles played by health professionals in equity policies.
4. To identify the triggers for equity oriented decision making within and beyond the health sector, to strengthen the linkage between monitoring systems and policy and to support evidence based policy.
5. To inform debates on the wider relationships between non health sector inputs and health outcomes, and the role of different health care and healing systems in producing health outcomes.
6. To assess the equity impacts of minimum / essential health care packages and of decentralisation of health systems.

Taking these issues forward through a regional network would enable wider exchange of information and experience, comparison of different approaches across the region, and would also allow for regional dimensions of these issues to be explored. Regional exchange of information and learning on equity in health and health care would promote consensus on the critical dimensions of equity in the SADC region and promote policies that address equity within and across the region.

If equity incorporates issues of capability and procedural justice, it is important that such work seeks to inform policy dialogue in a manner that engages the stakeholders, and in particular those social groups whose interests would be better serviced by more effective pursuit of equity measures in health. The network should thus enable professionals to work with stakeholder groups (community, health professional, providers and others) to incorporate their views and experience and inform their policies.

The Kasane Southern African meeting on Equity in Health provided a powerful mandate for a stronger policy commitment to equity from a wide ranging spectrum of people and institutions. This review has attempted to add content to this policy commitment and to identify some of the critical issues to address in the SADC region if equity in health is to be enhanced. These issues and priorities for future work are presented for wider debate, contribution and collaboration with the ultimate aim of taking joint action on avoidable, unnecessary and unfair inequalities in health.

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.*

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