Equity in Health in Southern Africa: Turning Values into Practice

By the
EQUINET Steering Committee

Overview prepared for the EQUINET Regional Conference on
"Building Alliances for Equity in Health"
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1. INTRODUCTION: EQUITY ASPIRATIONS AND WIDENING INEQUALITY

This is a region of significant inequality. In some countries, the richest tenth of people in are 30 times more wealthy than the poorest tenth. A child born to a low income household in Mozambique has a ten times greater chance of dying before their first birthday than one born to a middle class family in neighbouring Zimbabwe. The same poor child has a significantly lower chance of having safe water supplies, a healthy diet or access to health services for immunisation or treatment of basic diseases than her wealthier counterpart.

This region mirrors inequalities that occur at an even more profound level globally. 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 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).

In this context of profound inequality, all southern African governments have a policy

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commitment to equity in health. Whether under national liberation platforms, socialist and redistributive policies or market based liberalisation reforms, 'equity' has been a consistent aspiration of health systems. This signals a deeply rooted desire to better distribute the gains (and losses) of economic growth across the populations of the region, and to widen the social wellbeing of people in the region. Despite this, inequality persists, is exacerbated by HIV/AIDS, and is widening under market led reforms. These trends indicate that the consistent policy commitment to equity is inadequately translated into practice.

Why? Is it one of those policy priorities that is number one, *after* all the other number one priorities have been addressed? Is the evidence of inequity inadequate to inform planning or implementation of equity oriented policies? Is it a question of how resources and capacities are allocated and used, within and beyond health systems, or is it that the voices that need to remind us about equity goals become a distant hum when decisions on resources are made?

'Poverty alleviation' and 'equity' are terms that are also appearing in the language of international finance institutions, international agencies and donors. The *language* is being incorporated but do we all mean the same thing? The 2000 World Health Report, for example, identifies countries such as India as having *unfair* health financing systems because the rich are paying more as a share of their income, for their health than the poor. Is this a commonly accepted definition of 'unfair'? (WHO 2000).

- There is general agreement that inequity in health status refers to differences in health status that are unnecessary, avoidable and unfair. Of course concepts such as 'avoidable ' and 'unfair' are themselves subjective and socially defined. From common disaggregations used in descriptions of inequalities in health it would appear that we have in this region a social aversion to disparities by race, rural/urban status, socio-economic status, gender, age and geographical region.

- In a situation of avoidable disparities in health status, equity motivated interventions can both seek to ensure equivalence in health inputs between those whose needs are the same **(horizontal equity),** or differences in inputs in those whose needs are different **(vertical equity).** The latter has been identified in recent years as a particularly important principle for resource allocations, requiring that resources are preferentially allocated to those with the worst health status. In relation to health care financing, equity considerations demand that contributions be linked to income levels, with higher income groups contributing more than those on lower incomes.

These two dimensions of equity have stimulated much technical work *within* the health sector, to measure avoidable inequalities in health, and identify interventions that meet the criteria of vertical equity. One plenary paper that will be presented at this conference (Woelk et al 2000) outlines, for example, how routine data sets such as the Demographic and Health Surveys can be used to plot progress towards implementing equity policies and highlight disparities across a range of social and economic variables. Other papers explore ways of responding to these inequities within health systems.

This focus on health status and health sector inputs in equity related work is challenged in two respects, however. Firstly, as macro-economic policy and poverty have a deepening effect on health issues, equity in health concerns call for analysis of social and economic inputs to health *beyond* the health sector and thus have wider implications for policies that aim at redistributing societal and health resources (Gilson 1998).

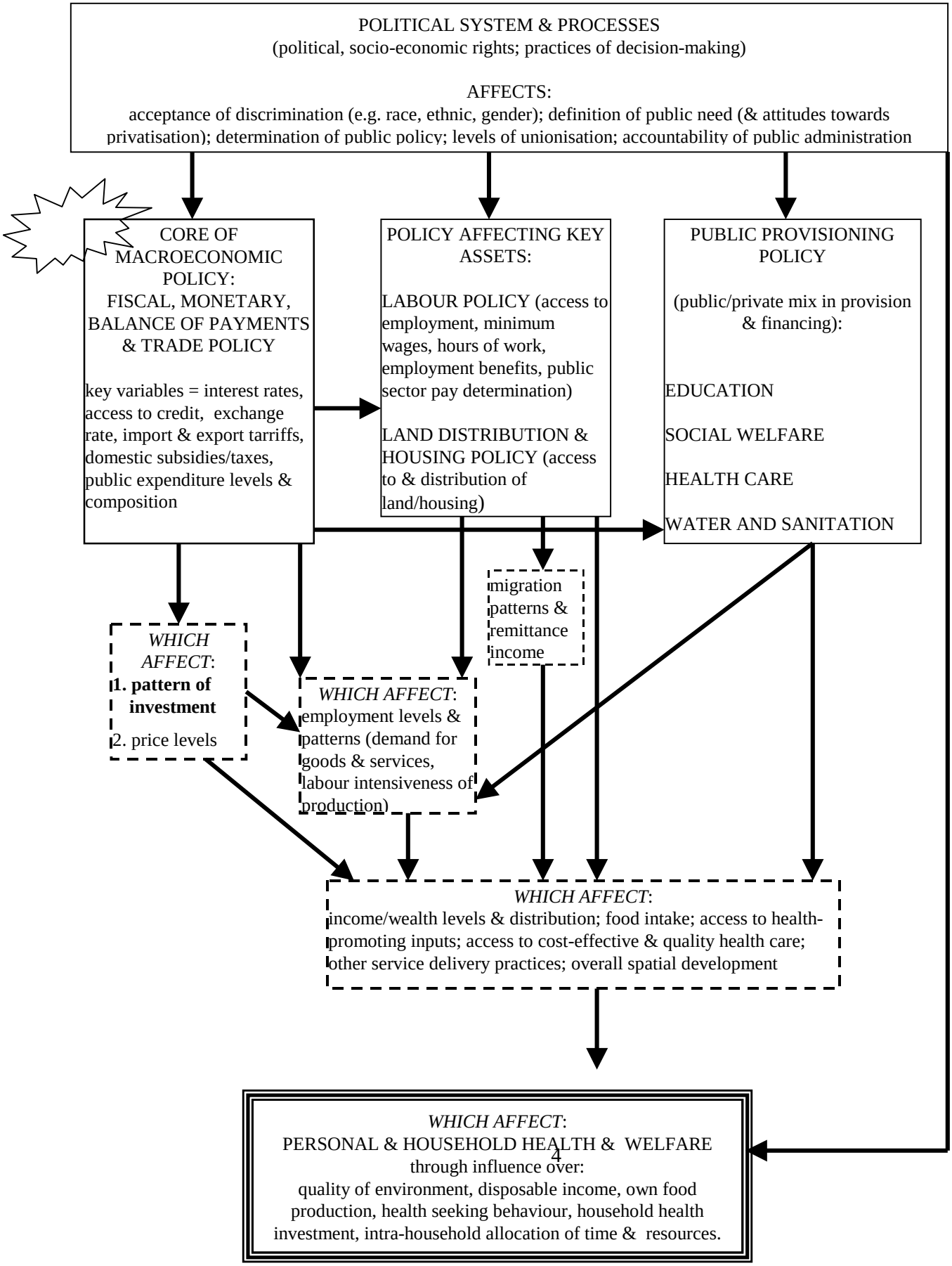
Further, the intensifying political struggle around scarce health resources signal that equity approaches are self limiting when they place the populations concerned in a passive role, affected by inputs and reflecting outcomes. We suggest that equity related work needs to define and build a more active role for important stakeholders in health, including communities, health providers and funders, health professionals and other sectors. This would need to incorporate 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 Steering Committee 1998) .

How far do equity policies in southern Africa take on these issues of non health sector inputs and wider stakeholder roles? How does the health sector work with such issues that may be perceived as outside its direct mandate?

2. PROGRESS TOWARDS EQUITY IN HEALTH

There are many determinants of household health and wellbeing and many mechanisms through which government policy can influence this (e.g. Berman et al. 1994; Whitehead 1995; Sen 1992). Some of these are highlighted in Figure 1 below. The figure emphasises that household health production is not simply a matter of household action but is directly and strongly influenced by the broader environment and, in particular, the impact of state policy measures. Goudge and Govender (2000), in an EQUINET commissioned paper, show that household health and welfare are inextricably intertwined. The poorest households suffer from low incomes as well as 'capability deprivation', lacking access to the range of economic, social and political resources that enable them to lead healthy and productive lives (Dreze and Sen 1995; Sen 1992). Consequently, the way in which government policy influences the distribution of these resources between households will influence patterns of health inequity at the household level.

FIGURE 1: POLICY FACTORS AND MECHANISMS INFLUENCING PERSONAL & HOUSEHOLD HEALTH AND WELFARE (Source: Gilson and McIntyre 2000)



The health sector is affected by policies formulated in other sectors. National macro-economic policy, for example, affects the cost of food and employment levels and patterns, as a result of action around price levels, the inflation rate, exchange rates, subsidies/taxes, access to credit and technology and the labour-intensiveness of production. Changes in food prices or levels of employment in turn affect households' food intake, income levels and use of resources in other health producing ways. Other national policies also affect households. For example, labour laws that shape job security and employment rights, without paying attention to skills and value added gains, may raise the costs of formal employment and so encourage the casualisation of some sections of the labour market with consequences for wage levels, benefit rights and employment. Policies affecting asset distribution, such as land reform, influence the non-wage assets on which households can draw in generating income. Some also suggest that inequality in income and wealth patterns have a more direct influence over health, although this is a subject of considerable current debate (e.g Wilkinson 1996).

Macro-economic policy also has an indirect influence over household health production through its influence over public expenditure levels and composition, which in turn affect the nature and extent of public provisioning. Educational provision is likely to be particularly important given that educational levels affect both the income earning capacity of households and the health seeking and health promotion practices.

Policies affecting access to health care or to other safety nets (such as cash or food welfare benefits) for the most vulnerable are also important and may exacerbate or mitigate the 'poverty ratchet' of ill-health (Chambers 1983). When sick, the poorest groups may have to use their savings or assets to cover the transport and other costs of being ill. Those with few savings or other resources may even have to go into debt to cover health care costs or may delay seeking treatment to try and avoid making the payments. The first action impoverishes them and the second may result in more expensive treatment, life-affecting disability or even death (Russell 1996; Sauerborn et al. 1996).

Finally, access to the political system and processes, social and political rights and public administration and practices are increasingly recognised to influence household health and welfare indirectly. These factors affect the degree to which the poorest households have access to information, representation and decision-making - and so influence the groups whose needs are considered in policy-making as well as the strategies identified as being important in tackling these needs (Wuyts 1992). They are likely to be particularly important in relation to intra-household distribution of economic, social and health resources. For example, gender inequity is linked to the voicelessness of women and their powerlessness in tackling gender-biased resource allocations.

As noted later, the health sector needs to find ways of influencing policy debates within these areas of economic and social policy, given their profound influence on health. One of the most difficult problems for this is to gather convincing evidence of associations between macro-economic measures, public provisioning and health outcomes. Multi-country studies, such as the one reported at this conference by Simms (2000) offer opportunities for providing such evidence.

2.1 Equity in non health sector inputs to health

There is evidence of increasing gaps in the range of socio-economic, demographic, environmental, social and macro-economic policy and political factors influencing health and its distribution outlined above. Widening 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).

As inequality implies increasing levels of deprivation for an increasing number of people and social groups, work on equity has common concerns with work on poverty. Townsend (1987: 125) notes that "Deprivation may be defined as a state of observable and demonstrable disadvantage relative to the local community or the wider society or nation to which an individual, family or group belongs". Two key aspects are material and social deprivation. The EQUINET paper on resource allocation and health equity by Gilson and McIntyre (2000) presents international literature that demonstrates a strong relationship between poor health status and material and social deprivation, particularly in relation to :

- Living in inadequate housing and without access to adequate sanitation and clean water;
- Illiteracy or low educational levels;
- Having few employment opportunities and/or lack of rights in employment;
- Low income levels;
- Belonging to a group which has been subject to racial discrimination;
- Women; and
- Living in rural or peri-urban areas.

Social deprivation plays an equally important role in health inequities. Lack of integration into the community, such as occurs with single mothers and the elderly living alone without family support, is of particular importance in this regard (SA-PPA 1997). The separation of families, through for example labour migrancy, is also another important contributor to social deprivation.

How do SADC countries feature in relation to these indicators of deprivation?

Table 1 provides an overview of the extent of human, economic and gender development, as well as data on health-related social service access for 11 SADC countries for which information was available (UNDP 1999).[2] Human poverty affects more than a quarter of the population in all SADC countries, with the exception of South Africa and Lesotho. The highest levels of poverty in SADC countries are found in Mozambique and Malawi. In 8 of the 11 SADC countries listed in Table 1, the Human Development Index (HDI) ranking is lower than their Gross Domestic Product (GDP) ranking. In these countries, relative economic prosperity (compared with levels of economic development in other countries) is not being translated adequately into human development. Botswana, South Africa and Namibia are proving particularly unsuccessful in this respect. Despite relatively high levels of economic development in these three countries in comparison with other SADC countries, there are significant inequities in the distribution of income or economic resources within these countries, which contributes to their weaker human development performance.

SADC countries have been particularly poor performers in redressing human development backlogs over the past two decades, with 3 SADC countries (South Africa, Zimbabwe and Zambia) being explicitly noted in the Human Development Report as countries making the slowest progress in this regard (UNDP 1999). The impact of AIDS in SADC countries does need to be considered in these indicators, particularly for its impact on life expectancy. Zambia's HDI in 1997 was for example lower than in 1975, largely as a result of the impact of HIV/AIDS.

There are also significant disparities in the HDI and Human Poverty Index (HPI) within countries. These include differences between geographic areas, "ethnic" or "race" groups and between men and women. For example, the HPI is 11.7% in urban areas in Botswana, compared with 27% in rural areas. Gender inequities have been receiving greater attention in recent years. UNDP (1999) data are helpful in considering gender inequities through comparison of the Gender Development Index (GDI) and the general HDI. In all SADC countries, GDI and HDI are similar implying limited gender disparity. The table presents, in all SADC countries, a GDI rank that is higher than the HDI rank, which suggests that there is an equitable distribution of human development between men and women in the SADC countries relative to the performance of other countries. This would seem, however, to belie experience on the ground.

[2] The Human Development Index, Human Poverty Index and Gender Development Index are composite indices derived from weighted measures that are judged to relate to development (life expectancy at birth, adult literacy, GDP per capita), poverty (% people dying before age 40, % adult illiteracy, % people with access to health services and safe water and % malnouriushed children under 5 years) and gender equity (using the HDI measures but imposing a penalty through adjusting for gender inequality) respectively. Such measures are limited both in the accuracy of the data used and in the values and choices used in the composition of the index, and need to be interpreted against this caveat.

Table 1: Overview of development indicators in SADC countries

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

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

Source: UNDP (1999)

In fact, there is, there is evidence that health differentials between the poor and the non-poor are consistently higher for women than for men in SADC countries, suggesting that socio-economic dis-advantage affects women in our countries more severely than men (see Table 2). For example, in Lesotho, while poor men have a 2.6 times higher chance of dying between 15 and 59 years than non-poor men, poor women have a 5.4 times greater probability of dying in this age group than non-poor women. Zimbabwe has the lowest differential between men and women. While these data highlight gender disparities, they also highlight the substantial disparities in health between the poor and the non-poor.

TABLE 2: DISPARITIES IN HEALTH BETWEEN THE POOR AND THE NON-POOR (SADC COUNTRIES FOR WHICH DATA ARE AVAILABLE)

Country	% in absolute poverty*	Poor:non-poor ratio in probability of dying between ages 15 and 59		Poor:non-poor ratio in probability of dying between birth and age 5	
		M	F	M	F
Botswana	33	2.3	4.0	4.9	4.8
Lesotho	49	2.6	5.4	3.9	5.2
South Africa	24	1.7	3.6	4.7	5.3
Tanzania	11	2.1	3.3	5.6	5.0
Zambia	85	2.5	3.6	3.5	3.9
Zimba-bwe	41	2.1	2.3	4.1	5.0

M = Male F = Female

* The WHO has used a different measure of poverty (based entirely on income) to that used by UNDP (which reviews poverty in relation to lack of income, reduced longevity, lower literacy and no access to basic services).

Source: WHO (1999)

The data presented above indicate that many SADC countries have relatively high levels of deprivation, with poor access to essential services such as water and sanitation as well as low levels of human development relative to their economic development levels (see Table 1). This is of central concern to health equity issues, as the distribution of access to essential services and to components of human development (such as income and educational status) within each country will impact on health inequity and generate increased social and economic burdens for health sector work.

Deprivation also influences individual's and household's ability to direct resources to address health needs. Goudge and Govender (2000) consider the impact of deprivation on health seeking behaviour in some detail in another Equinet paper. They show, for

example, that women have less direct access to household resources and thus to health care at times of need. Deprived households also generally have relatively limited coping strategies available to them when confronted with ill-health. The relationship is not unidirectional - ill health can itself lead to further impoverishment of the most deprived individuals and households.

2.2 The distribution of health outcomes

Health outcomes are a result of both non health sector and health sector inputs. In an environment where economic growth is not adequately translated into human development, health sector inputs become an even more important factor in health outcomes, placing both a challenge and a burden on health systems. Indeed, many countries in Southern Africa achieved remarkable gains in health in the 1970s and 1980s (Mehrotra 1996), primarily through public health measures and technologies, such as safe water, sanitation, oral rehydration solution and immunisation, particularly when 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.

It is now 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 1980's, 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).

These changes in health status were unequally distributed across the countries of the region, and within countries across race, class, gender and geographical area. 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).

Recent health and economic indicators available for the region indicate significant variability in basic health status indicators, as shown in Table 3 below. The table indicates that there is signficant variability between countries of the region, with nearly a third of children in aggregate underweight, one in ten infants dying in their first year of life and one in 200 women dying due to pregnancy or childbirth.

TABLE 3: SELECTED HEALTH STATUS INDICATORS FOR SADC COUNTRIES

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

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

As noted earlier, health differentials exist between male and female, urban and rural, between social groups with different levels of education, between races and between poor and non poor. Hence for example data from World Bank analysis of Demographic and Health surveys (DHS) shown in Table 4 below indicate as much as twofold differentials between the poorest and richest quintiles (fifth of the population) in relation to malnutrition and fertility, and 50% higher levels of mortality in children. At the same time, as will be discussed later, access to health services is lower in these groups. The effects of policy measures in this situation are important to understand and not always linear or expected. World Bank analysis found for example that health services provided free at point of contact have benefited richer over poorer groups (Gwatkin 2000), while Zimbabwean data indicated that the highest income quintile experienced greater declines in selected health status indicators over the period of economic adjustment than the lowest (Woelk 2000). These findings need to be further explored, but signal that differentials in health status are as important to monitor in a timely and accurate as aggregate trends, if policy measures are to be properly assessed. We hope that this conference

will address how to avoid both sins of overcollection, unnecessarily burdening health services, and sins of omission, and identify ways of monitoring that are strategically linked to policy measures.

TABLE 4: POOR /RICH RATIOS FOR SELECTED HEALTH STATUS INDICATORS FOR SELECTED SADC COUNTRIES

(Ratio of the poorest quintile to the richest quintile in the selected indicator)

COUNTRY	Namibia	Malawi	Mozambique	Tanzania	Zambia	Zimbabwe
Infant Mortality Rate	1,11	1,33	1,98	1,37	1,77	1,25
Under five year Mortality Rate	1,46	1,47	1,92	1,44	1,57	1,50
% Children under 5 yrs stunted	2,19	1,53	2,19	1,75	2,08	1,93
% Children under 5 yrs underweight	2,83	1,96	2,58	2,19	2,45	2,04
Total fertility rate	1,92	1,18	1,18	2,00	1,68	2,21
Immunsation coverage % children under 1 yrs with all immunisations	0,85	0,82	0,23	0,70	0,83	0,84
% ARI cases seen at a public health facility	1,03	0,73	0,38	0,79	1,20	0,91
% deliveries attended by a medically qualified person	0,56	0,57	0,22	0,33	0,21	0,59
% women knowing a methods of HIV prevention	na	0,90	0,65	0,60	0,81	0,77

Source: Gwatkin et al 2000

Much ill health and mortality in the region is now attributable to HIV/AIDS, with southern Africa the worst affected region in the world. Tuberculosis, pneumonia, other communicable diseases and malnutrition have increased and life expectancy decreased due to HIV/AIDS. As a result southern African countries perform particularly poorly with respect to global measures of health outcomes. The Disability Adjusted Life Expectancy (DALE) (*note not the actual life expectancy)* in the most affected countries is among the lowest in the world with, for example, Botswana at 32.3, Zambia 30.3, Zimbabwe 32.9 and South Africa 39.8 (World Health Report: 2000)[3]. A few years ago, these countries had some of the highest life expectancies in Africa.

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,

[3] The DALE is a measure developed by WHO as the expectation of life lived in equivalent full health (ie adjusting for all causes of disability and reflecting age specific mortality).

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). The 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). HIV transmision 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. The impact of AIDS on the poorest groups has been to precipitate them deeper into poverty, and to facilitate the intergenerational transmission of poverty (Loewenson and Whiteside: 1996).

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 (eg: 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. If economic systems within SADC countries are efficient at transferring the burden of diseases such as AIDS to household level, and towards vulnerable groups, how efficient are health systems at transferring resources for prevention and health care towards these groups?

2.3 Equity in financing and providing health services

As noted in Table 4, with few exceptions health services continue to be more accessible to social groups who experience lower levels of ill health, even with respect to basic preventive and curative services for diseases that are more commonly experienced amongst the poor. Obtaining a better picture of how health sector resources are distributed and used within and across SADC countries is difficult as the few routinely available sources of summarised data only offer average figures for each country, and often suffer from data gaps or inconsistencies. Table 5, for example, presents data drawn from the World Bank's World Development Indicators 2000. The empty cells either result from data gaps or from the lack of comparability in indicator definitions across countries.

TABLE 5: HEALTH EXPENDITURE, SERVICES AND USE 1990-98*, PLUS KEY MORTALITY DATA

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

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

Nonetheless, the table highlights differences amongst SADC countries, in comparison with the average for middle and high income countries from 1990-1998. Namibia, South Africa and Zimbabwe not only spend more on health as a percentage of GDP, and Botswana and

South Africa spend more per capita, than other SADC countries but also than the average level for all middle income countries. *It should be noted that these data include both public and private health care expenditure.* In some countries a relatively high proportion of spending occurs in the private sector (eg: Zimbabwe and South Africa).

Only Botswana and South Africa are classified as middle income countries on the basis of their GNP per capita. None of the SADC countries achieve the average level of middle income countries in relation to the two other World Bank resource-related indicators, although these are related mainly to hospital services.

Comparison of the resource-related indicators with the two mortality statistics presented suggests that whilst the level of spending on health care may have some influence over health status levels, it does not fully explain them. For example, Nambia's health expenditure per capita is around half of that of Botswana but its infant and maternal mortality rates are around the same or slightly better than those of Botswana. At the same time, Zimbabwe spends considerably more on health that Zambia or Madagascar but has a substantially higher IMR than either country, if also a lower MMR. Moreover, the US$5 per capita spent on health in Madagascar apparently buys considerably better health status levels than the same amount in Malawi. AIDS related mortality has clearly complicated this relationship between health spending and health outcomes, particularly as the drugs to make an impact on AIDS mortality remain outside the economic reach of the governments and most of the populations of the region.

Although not allowing strong conclusions to be drawn, particularly due to the AIDS impacts noted above, these data do partly 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). According to Sen (1999) and Mehrotra (1996), basic primary health care and medical care services with the strong potential for improving health outcomes can and have been provided by countries with low per capita GNPs. 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.

There are also many positive examples within the countries of Southern Africa to support this broad conclusion. These include successful primary health care approaches and 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. 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). Review of periods of high health gain in Southern Africa indicate that health systems can improve

health status in high risk groups and reduce inequalities in health. To do this they must 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 1999; Loewenson et al 1991; Haddad and Fourier 1995; Albaster et al 1996; Jhamba 1994; Curtis 1988).

Yet, in practice, health systems in the SADC region are often characterised by patterns of inequality in access and resource use that run counter to these good practice guidelines. Inequalities between different population groups have 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 periurban status, socio-economic status, age, gender, geographical region and insurance status (EQUINET 1998).

Pre-Independent South Africa offers a particularly strong counter example to the successful primary health care examples found in other countries of the region. In 1992/93, only 11% of recurrent public health expenditure was spent on primary care delivered outside the hospital setting, with academic and tertiary hospitals accounting for 44% of total expenditure. Moreover, there were nearly three times as many beds and nurses per 1000 population in the richest compared to the poorest province, over nine times as many doctors and 14 times as many pharmacists (McIntyre et al. 1995). Table 6 presents further data on the considerable variation in South African public sector resource availability between magisterial districts (the primary geographical administrative unit of the country) of different income levels at the time.

A further resource use pattern affecting the equity of health systems is the distribution of resources between the public and the private sectors. Using South Africa as an example, in 1992/93 it was estimated that although only 23% of South Africans enjoyed some degree of regular access to private sector health care, around 58% of total health care expenditure was accounted for by this sector. The private sector also captures a higher proportion of all types of personnel, except nurses, than the public sector (McIntyre et al. 1995; Soderlund et al. 1998).

TABLE 6: INDICATORS OF THE AVAILABILITY OF PUBLIC SECTOR HEALTH CARE RESOURCES BETWEEN MAGISTERIAL DISTRICTS (1992/93)

Indicator	"Poorest"	"Richest"

	districts	districts
Hospital beds/1,000 population	2.1	3.8
Population per clinic	16,260	12,442
Outpatient visits per capita	1.0	2.6
Doctors (general and specialist) per 100,000 population	5.5	35.6
Nurses per 100,000 population	188.1	375.3
Health inspectors per 100,000 population	1.1	6.7
Pharmacists per 100,000 population	0.5	5.4
Per capita health care expenditure (1992/93)	R122	R437

Source: McIntyre et al. 1995

This pattern is also found in other SADC countries, such as Zimbabwe, which have well established private sector health services. Health care expenditure is biased towards the higher levels of care, less relevant to the needs of majority of the population (Sahn and Bernier 1996). Personnel gravitate towards urban rather than rural areas, and as health facilities and personnel tend to be more available to higher than lower income groups, expenditure patterns also favour them.

If, as shown in Tables 4 and 6, the poor continue to have worse access to public sector health care resources than the rich, despite bearing the greatest burden of ill health, then there is an important challenge to achieve greater levels of vertical equity. This demands in part clear identification of the most disadvantaged groups, and further, promoting the preferential allocation of limited public resources towards meeting their health needs.

Expenditure patterns in health in southern Africa also reflect the influence of economic recession and of structural adjustment policies. Public spending on health in the region 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). As real public health budgets have fallen, health care resource allocations have remained systematically biased against primary care (Sahn and Bernier 1996). Greater problems have also been experienced in relation to staffing constraints, poor conditions of service and inadequate resources for the effective implementation of tasks by health workers (Loewenson 1999; WHO 2000). This range of problems has led to a plateauing or loss of coverage and poorer quality care, particularly at primary care level (UNICEF MoHCW 1996).

Decades of declining real wages of health workers and increasing inequalities between private and public earnings have only encouraged the attrition of skilled personnel to private practice in many countries. An EQUINET commissioned paper presented at this conference further explores the distribution of health personnel and the factors affecting this (Mutizwa

Mangisa and Mbengwa 2000). The inequitable distribution of health personnel between geographical areas and between public and private sectors has had a major adverse effect on health services. Health staff morale has also fallen, in part due to real wage declines, but also due to poor working conditions, unresponsive industrial relations systems, increased (perceived and real) occupational disease risk and poor career structures (Mutizwa Mangisa and Mbengwa 2000; Klugman and McIntyre 2000). This adversely affects staff attitudes and health worker – patient interactions, creating further obstacles to health service access (CWGH 1997).

Some strategies aimed at improving equity, such as retention of staff in the public service through permitting limited private practice, appear in fact to have yielded the opposite effect. 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 that we hope this conference will provide an opportunity to outline further. We would also suggest that more equity oriented human resource policies need to be discussed and negotiated *with* the associations of health workers, to ensure mutual commitment towards these policies.

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 also 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. As the EQUINET commissioned paper on public-private subsidies shows, public subsidies to the private sector can have equally powerful pro- or anti- equity effects, depending on how and where they are directed, calling for greater investment in public sector capacities in defining, managing and monitoring such subsidies (Mudyarabikwa 2000).

The issues raised above give evidence for policy attention to be directed to effectively directing resource flows towards proven health interventions and services that reach deprived groups. With a rising HIV/AIDS epidemic and powerful macro-economic, market and social pressures acting against spending on primary health care and public health systems, no country in the region could afford complacency over vertical equity issues in the past decade. Despite this, efficiency driven perspectives dominated international health policy prescriptions (Gilson 1998) and focused attention away from the interface of services with communities, as well as away from how resources are allocated to the community level. Instead, 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. Such reforms may, in fact, have done little to enhance efficiency (Mills 1996), even while they may have worsened quality of or equity in health care (Bijlmakers and Chihanga 1996; Molutsi and Lauglo 1996). Moreover, 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. In many countries, the experience of implementing user fees has had a negative impact on equity, and has further increased the gap between services and communities, undermining the effective management of health issues in the community (Gilson 1997; Lennock 1994; Hongoro and Chandiwana 1994; Zigora et al 1996; Loewenson 1999).

Fairness of financial contributions to health systems has been given particular attention. this year by the World Health Organisation's 2000 World Health Report. Using a new and somewhat experimental evaluation approach, the report presents a fairness index that seeks to measure the fairness of financial contribution and financial risk protection. It is based, in particular, on an assessment of households' financial contributions to health system financing and reflects both the inequality of that contribution and picks up on households that are at risk of impoverishment from high levels of health expenditure.
Table 7 provides data on the index score, per capita health expenditure levels and the SADC country rankings within the total number of countries included in the assessment[4]. The table strongly suggests that levels of per capita expenditure have little relation to the fairness of the system generating the funds. For example, whereas as Mozambique and Tanzania spend low amounts per head on health care they perform relatively highly in terms of relatively of the fairness index. South Africa, in contrast, spends a relatively large absolute amount on health care but performs less well in terms of the fairness index.

Yet it is the lowest income countries that are under greatest pressure to introduce the cost recovery systems that undermine the fairness of their financing patterns. When households have to make direct payments for health services, there is consistent information that the lowest income groups bear a disproportionate burden.

TABLE 7: WHO INDICATORS OF HEALTH SYSTEM FINANCING, 1997

[4] Ranking implies a degree of accuracy in the data that is probably not applicable to the data used. It may have been better to use bands of similar performance rather than specific ranks. Also, as noted in the introduction, a definition of 'fair' as equality in income shares to health across income groups, rather than progressively increasing shares to health in higher income groups may not be generally shared.

	Fairness ranking (out of 191 countries)	1997 fairness index value*	Health expenditure per capita ranking (out of 191 countries)	Per capita health expenditure 1997 (US$, international dollars)**
BOTSWANA	89-95	0.934	85	133
LESOTHO	89-95	0.934	123	100
MADAGASCAR	116-120	0.919	190	18
MALAWI	89-95	0.934	161	49
MOZAMBIQUE	38-40	0.964	160	50
NAMIBIA	125-127	0.915	66	312
SOUTH AFRICA	142-143	0.904	57	396
SWAZILAND	156	0.890	116	118
TANZANIA	48	0.959	174	36
ZAMBIA	155	0.891	148	64
ZIMBABWE	175	0.850	110	130

Data is noted to have varying degrees of reliability
* an index value of 1 represents equality of household contributions.
** international dollars
Source: World Health Organisation, 2000.

For example the percent of income spent on malaria in Malawi 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). The WHO strongly recommends that instead of mobilising resources through cost recovery systems countries give much greater attention to extending insurance and pre-payment coverage, of all kinds, within the population to protect households from the negative consequences of catastrophic illness (WHO 2000).

In practice, therefore, 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 actually exacerbated inequity. What has weakened our ability to detect and respond to inequities within our health systems?

2.5 Obstacles to achieving vertical equity

The first section of this paper argued that the current level of inequality and poverty in this region calls for deliberate vertical equity policies, and particularly for public resources to be

directed to those with greatest levels of economic and social deprivation. The second section indicated past strengths and weaknesses in achieving vertical equity policies, and current trends in the distribution of financial and human resources that would seem to counter known good practice. It suggests that there is a need for a more timely and sensitive system for monitoring deprivation and inequality, linked more closely to resource allocation tools that give more attention to resources reaching poor communities. It also proposes that resource mobilisation systems give greater focus to progressive tax financing and involve pre-payment, solidarity and risk pooling in their design. Given the growth of private health providers, much more attention should be given to how the public sector uses its subsidies to direct these providers to more equitable and relevant forms of care. We also note that human resource strategies that address much needed concerns of distribution of health personnel also need to satisfy income security, career, working conditions and occupational risk concerns of health workers for them to be sustainable. As noted, various papers in this conference will address these issues and the policy options they imply more specifically.

While necessary, are the technical solutions sufficient to redirect scarce resources and subsidies towards groups with greater health needs? One paradox raised in studies from southern Africa is that macro-economic and health sector reforms have enabled more powerful business, medical and middle class interest groups – who are also more technically qualified - to exact health sector 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).

Perhaps now more than ever, there is a need for explicit policy on the two additional dimensions of equity posed in the beginning of this paper – the wider context for health equity policies and the role and organisation of social groups in actively promoting equity oriented policies.

The social production of health gains in the region have perhaps been somewhat underplayed, compared to the role of technical developments. While the provision of health services in the southern Africa region had its roots in colonial systems and the domain of charities, its character underwent radical transformation in anti-colonial struggles based on popular movements that organised around rights to land, to education, to organise, to work, to housing, the right to be free from brutality etc. In almost every case, the right to health – as well as the right to access to health services – was a fundamental demand of the popular movements. At independence, governments conceded to the popular demand for the state to accept its responsibility for both the provision of health services and for some wider inputs to health, such as safe living environments. State interventions produced the type of health gains outlined in an earlier section of this paper, challenging the current caricature of the state as being "inefficient" and unable to deliver effective services (World Bank 1989).

But at the same time that these governments intervened to ensure universal health care, they also began to transform the very essence of the movement that had brought them to power.

Whereas the liberation movements were motivated by the struggle for rights and popular participation, in the post independence period health or education became less something people organised around than a “technical problem” that could be addressed only by technicians and experts. This was compounded when the new occupiers of the state machinery perceived themselves as the "sole developer" and "sole unifier" of society, in a centralising and controlling role. This made ‘development’ a benefit to be delivered by the state, with many social movements or grassroots groups, unless under state patronage, seen as irrelevant or to be controlled. It was not about development in the sense of developing the productive forces, nor in a manner that recognised that poverty was the result of denial of fundamental rights (Cowen M, Shenton R 1996).

Civil, political and many social rights were recast as a "luxury", to be enjoyed at some unspecified time in the future when "development" had been achieved. For the present, said some African presidents, "our people are not ready" - mirroring, ironically, the same arguments used by the former colonial rulers against the nationalists' cries for independence a few years earlier. Hence states built closer relationships with official “aid agencies”, than with their own popular organisations. Even where health rights were articulated, they were often codified in laws whose relevance or application was determined by guardians of the state (Shivji 1989).

Community participation, a key element in all post independence health policies and gains in the region, was generally cast as mobilisation to effect health programmes planned and financed at higher – often central- levels, and was more dependent on state than self organisation. As discussed further in EQUINET commissioned research paper, ‘participation' implies not only what communities and health services *do* to implement health interventions, but also the relative degree of control between communities and health systems in decision making and over resources (Loewenson 2000). As the level of community control increases, there are shifts in authority from health workers and managers to communities, shifts that may not always be trusted or welcomed. Distrust may arise as different types of knowledge and experience are brought to bear on decision making and as different norms and values are applied. With strong state driven forms of participation, usually controlled by medical decision makers, there were limited real shifts in authority (and resource control) towards communities. This was reinforced by perceived weaknesses in capacities at community and primary care level, and failures of health systems to find ways of addressing these weaknesses.

The introduction of structural adjustment programmes in this scenario seriously weakened the state’s ability to provide for even its own model of development. At the same time multilateral lending agencies (with the support of the bilateral aid agencies) became more directly involved in political and economic decision-making processes, including in relation to the level and form of state involvement in social sector. The impacts of structural adjustment programmes on inequalities in health and access to health care are noted elsewhere in the paper. Not surprisingly they sparked protect, strikes and other expressions of discontent, particularly from the urban poor and from civic groups. The state response to this was often repressive, while aid agencies and multilaterals put thought into how to

present the same economic and social programmes with a more "human face" (Cornia, Jolly and Stewart 1987).

Significant volumes of funds were set aside aimed at "mitigating" the "social dimensions of adjustment", or to minimise the more glaring inequalities emanating from adjustment policies. Funds were made available to provide social services for the "vulnerable", not necessarily by the state, but by the NGO service sector. As state services declined, state led forms of participation dwindled and failed to satisfy community demand (Loewenson 2000). The social value that people gave to health and health services did not match the resources allocated to health, nor were these resources adequately allocated to those aspects of health systems that people prioritised. Used to strong state driven policies and systems, people became spectators of a collapsing national asset. As a review commission on the health sector in Zimbabwe noted, "The system is characterised by apprehension and uncertainty about its future among the general public and health workers. The system seems to be falling apart under the weight of the numerous problems besetting it." (Health Review Commission 1999).

While some constituent civic organisations pressured for social norms, rights and standards, the availability of funds for social mitigation programmes generated its own pressure for civil society organisations to become service providers instead of social activists, filling in the space created by the retrenching state. It was backed by a rationale of NGOs as being more able to reach vulnerable groups, more efficient and more cost effective than the state. In fact, service NGOs are no more accountable to the population than private companies, and demonstrated great variability in their accountability to local populations served and to outside funding agencies.

The stress within health systems has however also positively stimulated advocacy for health and health care at wider and higher levels of decision making, encouraging a re-examination of priorities and bringing about a shift in perceptions of who is responsible for health. As communities find themselves losing access to basic health inputs and services, they begin to see health not just as another sector or service, but as a fundamental right and a political obligation. For health services and citizens alike, the stress of declining resources and increasing public demand and expectation is raising demand for a review of the collaborative arrangements between different social parties on agreed objectives of their health systems and how to attain them.

If we are to meet equity objectives, the governance of health systems needs to be as carefully designed as the technical interventions. There is evidence that in the absence of an open, participatory system with procedures and mechanisms for reaching collective resolution, it can be the more powerful medical interest groups who exact concessions in this scenario of health sector reform, sometimes at the cost of the poorer, less organised rural health workers, or the urban and rural poor. Various authors describe the role of powerful groups, including the medical profession in supporting inequalities in health through implementing health care systems and forms of

institutional care designed to suit medical, professional and social interests, rather than more appropriate forms of care (Van Rensburg and Fourie 1994; Bennett et al 1995). Rising demand by better off sectors for medical technology can potentially crowd out less effectively voiced demand by poorer sections for the health inputs they need. Given the relatively poor evidence base for some health reforms, it is important that systems of procedural justice exist for adjudicating subjective claims within policy reforms (Kalumba 1997; Lafond 199l; Storey 1989).

While this issue is further discussed in another paper to this conference, one experience of health policy reform exemplifies the importance of giving greater attention to issues of participation, governance and accountability to achieve health equity objectives. Decentralisation of public sector management generated significant public expectation of shifts in authority and responsibility, including widening participation in governance in health. Evidence from experience questions some of the claims of decentralisation, particularly those that are mutually incompatible, such as reducing expenditure *and* improving quality and access (Mogedal and Hodne Steen 1995). Decentralisation in Kenya, for example, was associated with improved financial performance but significantly reduced access to MCH/FP services, outpatient and special services (Owinya and Munga 1997). Weaknesses in past performance of local level planning have often been linked with the existence of centrally imposed budgets, with little room for local discretion (Gilson et al 1994). Local planning may, however, continue to be weak, even where budget devolution takes place, in the absence of specific measures to enhance accountability, and there is weak evidence of promised benefits in equity, access, quality, accountability or in increased public participation (Gilson et al 1994, Gaventa and Robinson 1998, Loewenson 2000). Decentralisation was found in Botswana to have weakened public health surveillance and planning based on population indicators and led to greater bureaucratic inputs to decision making, with little evidence of enhanced community participation or intersectoral co-ordination (Lauglo and Molutsi 1995). Constituents at local level have reported poor communication on or understanding of the content or implications of decentralisation (CWGH 1997). Central government appointed boards were observed to have little accountability to the public. Mills (1997) noted that free of central control, hospitals may become more self interested, placing interests of local politicians above those of consumers. On the other hand, various reviews have noted that hospital boards have been delegated few responsibilities in practice, particularly over revenue raising and retention, financial controls and staffing, weakening their ability to make significant impacts on hospital performance (Bennet et al 1995; Smithson et al 1997). Decentralisation has in many situations taken place in a poorly defined legal framework, with inadequate resources, qualified personnel, transport and other inputs for planning and monitoring health activities. Under-resourced and thus poorly motivated health workers have regarded public demands for accountability and greater control as one more burden in such situations. While there is clearly no single formula for how to balance power, authority and responsibility between central and local levels, and between state and society, unless these issues are more effectively, systematically and transparently addressed they run the risk of becoming obstacles rather than vehicles for improved health systems.

This is particularly the case if southern African countries are to develop equity-oriented

policies in the face of significant external pressures. Globalisation has deepened the liberalisation trends initiated by the structural adjustment programmes, driven by market expansion, forcing open national borders to trade, capital and information. The principal channels for the transmission of these changes were the Bretton Woods institutions and the Uraguay Round of GATT that gave birth to the World Trade Organisation (WTO). The trade negotiations at Uraguay extended the concept of trade liberalisation to new areas including trade in services, trade related investments and intellectual property rights. These "multilateral agreements" have been backed by strong enforcement mechanisms that are not only binding on national governments but drastically reduce their scope for making policy. The WTO has come to wield authority over national governments, and transnational corporations to have more power than many states. These bodies remain virtual unaccountable to anyone but their few selected shareholders. There are no mechanisms for "making ethical standards and human rights binding for corporations and individuals, not just governments." (UNDP 1999)

New agreements such as the Trade Related Aspects of Intellectual Property Rights (TRIPS) do provide space for countries to act in interests such as public health, but demand significant institutional resources and capabilities to explore those spaces, resources not always available to individual countries in the south. Regional co-operation, such as at SADC level, is an important mechanism for managing the responses to these global pressures. Hence for example an EQUINET policy paper on WTO and public health in Southern Africa proposes both national actions and regional co-operation to enhance capacities currently unevenly distributed across the region to respond effectively to WTO (Munot et al 2000).

Such co-operation is itself challenged by global pressures for unilateral integration, country by country, into the global economy, and by suspicions and conflicts between states within a region, and between civil society and states within countries.

That we need to define a more coherent engagement between SADC countries and the global economy is evident in the paradox of hunger and environmental diseases coexisting in a world where spectacular advances have been made in science and technology. Co-operation between state and civil society at regional level has for example already highlighted the gross inequities inherent in the current trade of Antiretroviral drugs. It is equally important to highlight issues such as the fact that one in every **two** households in the region does not have access to a toilet or a safe water supply, at a time when half or more of national revenue is paid outside the region to finance debt.

Today's globalization 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. Certainly this includes questioning the validity of the basic assumptions of what has become known as the "Washington Consensus". Are "privatization of services, targeting of social programs and introduction of cost-sharing measures" the only choices for social policy? After all, are they not the ones that have been proposed with regular monotony by the World Bank and other institutions for the best part of the last two decades, and which have resulted in – without exception – in widening social disparities in the region?

3. FROM VALUES TO ACTION: ADVANCING AN EQUITY AGENDA IN SOUTHERN AFRICA

Global attention is growing on the extent to which inequalities within and between countries threaten security and sustainable development. More attention is being given to addressing the ways in which global institutions, policies, rules and standards that subordinate human development to profit or that unfairly distribute the returns from markets. This inevitably draws attention to health, as patterns of ill-health draw into focus socio-economic and political inequalities and injustices (Gilson 1998). Various measures signal this concern, including G8 debt relief funds being applied for HIV/AIDS, TB and malaria, questioning of the mandates of institutions of global governance, and greater donor advocacy for issues of poverty alleviation and equity to be included in the design of strategies and programmes. The language is there – but does this mean we are on the right track?

This paper raises the issue that we need to do more than franchise NGOs to reach the poor, or throw significant funds at vertical programmes, if we are to get to the crux of the deprivation and inequities affecting our societies. We need to scrutinise and not accept as given those economic and social policies that will have negative health impacts, particularly in terms of widening current inequalities in health and access to health care. We need to pay more attention to the state capacities, structures and mechanisms through which needs are identified, programmes designed and resources allocated, and how these also relate to civil society and the market. We need to pay more attention to the workers and professionals *within* health systems, and reach more coherent ways of promoting vertical equity without sacrificing their longer term professional interests.

We also need to stop doing things *for* or *to* the poor, and start strengthening the capacities of

the poor *to do* things themselves, as households, as associations and in interaction with a supportive public sector framework. We suggest that the technical tools to do this within the health sector are reasonably well known in the region, and that greater attention be given to the social and institutional mechanisms and processes through which we make those technical resources available.

Our ability to confront these global market forces and direct new global resources for health depends also on the profile and attention we give 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. The past experiences of the region, outlined in earlier sections, provide a strong foundation for future action to re-emphasise the crucial role of primary health care strategies in promoting equity in health, with a wider engagement of people and health workers around their health systems, in a manner that generates a more informed and capable use of resources for health, that fosters more effective and efficient use by households of health care resources, and that ensures that available resources reach those with greatest social need. The paper signals a need for governments to take more concerted action to address inequitable forms of private-public mix in health systems.

These obligations continue to centre on the state, and the vital role that it plays in organising and sustaining equitable health systems. It is however also apparent that effective action at local, national and regional level depends on the ability of the state to achieve greater consensus and involvement amongst a broader range of health related actors, and to draw a wider alliance for public health goals. This means giving greater attention to the social forces that drive policy choices, and providing specific measures for organising and investing in opportunities for informed and adequately resourced participation of all social groups and particularly the poorest in their health systems, and for building health system responsiveness and accountability to social groups. 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). In this we suggest that the state avoid the path of pessimism, that populations may not make rational public health or pro-equity decisions, and in so doing to continue to prescribe 'what is best', to attempt to control resources, often centrally, within the state, and to miss the opportunity of tapping a much wider struggle for health within the population as a whole.

SADC itself is powerfully placed to take on some of these roles, to network the range of actors needed to take on some of the issues within the global agenda and to exchange and support the replication of positive experiences within the region. This demands research, information, advocacy and other support from institutions within the region.

As a network of professionals drawn from research, civil society and health sector organisations in health in Southern Africa, the southern African Regional Network on equity in health (EQUINET) seeks to support this wider engagement of key institutions in the

region around issues of equity in health

- to make visible unnecessary, avoidable and unfair inequalities in health,
- to assess and propose ways of more effectively implementing vertical equity, and
- to promote and widen the involvement of key stakeholders in equity oriented health policies and debates

In its first eighteen months, EQUINET members have worked on theme areas that were identified through a survey of literature and policy statements on equity in health in the region. The Box below outlines some of the actions that EQUINET has taken around these theme areas. They also form the basis for this conference, as a means of feeding back the policy insights and proposals gained and to identify further or new areas of work, advocacy and action.

The network has invested in building some tools for informed promotion of equity oriented policies from within the region, including

- A platform for dialogue in and beyond the region
- Reflection, deeper discussion and analysis on specific equity theme issues
- A formal collaboration with SADC
- A resource base in terms of skills, information and some funds
- Moral, skills and networking support for people interested in equity issues

A regional channel to international equity initiatives

We have done this from within the region, because these inputs are perceived as important to overcome isolation, to give voice, promote networking and as an in-road to influencing policy; through approaches that stress regional networking, bottom-up approaches and shared values. We acknowledge the support that international colleagues such as IDRC have given to a programme that was defined by southern African institutions. We were stimulated to build this network by the conference in Kasane in 1997. The 2000 conference in South Africa will hopefully stimulate further consolidation of the network that will support and promote equity oriented health policies.

BOX 1: EQUINET WORK IN 1999

EQUINET has in 1999/2000 carried out 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.
EQUINET has since its inception

- Put together and disseminated a bibliography on equity in health in Southern Africa that has been widely used
- Established a co-ordinating centre, a data base of resources on equity, a web site and a mailing list with about 120 corresponding members'

- Prepared through UZ Medical School a profile of data on equity in health in Southern Africa
- Made formal collaborating links with the SADC health sector (SADC HSCU) and established links with other international equity initiatives (Rockefeller, World Bank, WHO, Somanet, Equity Guage)
- Sponsored research and reviews on resource allocation mechanisms for health; on public participation in health; on monitoring equity using routine data bases, on public-private mix in health services, on household resources for health, on human resource distribution in the health sector, on health rights and on WTO and public health
- Organised through TARSC and in co-operation with WHO a regional meeting on public participation and health and co-operated through University of Cape Town with an HST workshop on Equity Gauge Monitoring of Equity benchmarks
- Made presentations at fora on equity in health in Southern Africa and EQUINET
- Strengthened links with other equity related initiatives in Southern Africa

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We have proposed in this paper some areas of continuing focus for equity related work, nationally and regionally, viz that we:

- focus on issues of vertical equity, and monitor progress towards it;
- make strong links between work on equity in health and work on poverty and develop stronger tools for including measures of deprivation in resource allocation systems;
- pay closer attention to how health resources are spent, particularly in relation to the allocations to the lowest income communities, to primary health care, to preventive care, and to primary and secondary levels of the health system;
- more decisively develop and implement measures that ensure a more equitable outcome of the private-public mix in health services;
- review human resource policies to facilitate a better distribution of health personnel, but in a manner that involves associations of health professionals and reasonably meets professional, income and safety aspirations of health personnel at different levels;
- recognise that health gains are a product not only of technical inputs but also of social action, and reflect this in the governance, procedures and social relations within health systems;
- increase visibility, identify contributors to and propose policy measures for unacceptable health differences at global level.

We face the challenge that we must match technical knowledge with informed social action. This raises the question: What alliances do we need to build for equity? What are the alliances that will help us generate the analysis, debate and knowledge needed to implement equity values within key areas of health systems, and within macroeconomic and wider social systems? What alliances do we need to advocate and build action on that analysis? What alliances will enable the state at national and regional level to more effectively engage

with its own national institutions, and with global issues and institutions?

We are constantly reminded that things are changing. Indeed many health workers wish for a little less change, and a little more time to consolidate. It is therefore important to remind ourselves of the persistence and durability of the equity agenda in this region, and its continuing relevance. We have a platform of experience, institutional and social memory and capacity to draw from. The wheel has already been invented – let us find a way to build its forward momentum!

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