

# **Equity in Health in Southern Africa: Turning Values Into Practice**

## **EQUINET Policy BRIEFING From the Equinet co-ordinator May 2001**

In September 2000 the EQUINET steering committee presented a paper to the regional conference on 'Building alliances for Equity in Health' that reviewed the health equity situation in the region, the policy issues arising, the work carried out by EQUINET on these issues and the challenges for the health community in the region.

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.

It was noted that equity motivated interventions in the highly unequal situation in southern Africa should ensure different inputs for those whose needs are different (vertical equity). This means that resources should be allocated preferentially to those with the worst health status; and that higher income groups should contribute proportionately more than those with fewer resources.

It was also noted that macro-economic policies shape the redistribution of social and economic resources and thus affect equity oriented interventions. So too does the power and ability people (and social groups) have to make choices over health inputs and their capacity to use these choices towards health. Where policy measures aimed at greater health equity have overlooked these wider factors, they have been less effective and less sustained in their implementation.

The paper observed the health gains were made in southern Africa, particularly through primary health care and public health interventions, and the set-backs in more recent years. Many SADC countries now have relatively high levels of deprivation, with poor access to essential services as well as low levels of human development (such as income and educational status) relative to their economic development levels. Significant disparities have emerged across geographic areas, "ethnic" or "race" groups, and between men and women, generally, and within health and access to health care.

Macroeconomic policies have also intensified inequalities in household food intake, income and employment levels and access to education, safe water and other non health sector inputs to health. Structural adjustment and market reforms have affected the level and composition of public expenditure, reducing provision of and access to primary health care services, particularly in low income groups. Reduced access to health care and other safety nets have exacerbated the 'poverty ratchet' of ill-health.

### **Reorienting Health Resources for Improved Equity**

These trends are affected by how the state targets its resource allocations for health. The report notes that economic reforms have enabled a wider spread of private providers, but that the benefits of this have been limited to a small share of higher income groups, calling for stronger policy measures and incentives for enhancing equity in the mix of private and public services. Inadequate attention to primary health care and district health interventions, combined with an over-optimistic reliance on health management tools, have contributed to a worsening of equity in some SADC country health systems. Where competition for resources have directed public funds away from pro-poor measures, such as investments in education, safe water, sanitation and housing, food security, primary health care and adequate quality district health services, diminished resources reaching poorer groups has led to declining health equity.

Experience in the region indicates that health systems can improve health status in high risk groups and reduce health inequalities by

- redistributing budgets towards prevention;
- improving access to and quality of rural, informal urban and primary care infrastructures and services;
- deploying and orienting health personnel towards major health care problems;
- supporting personnel with adequate resource inputs;
- ensuring fairer distribution of resources between the public and private sector providers;
- investing in community based health care;
- encouraging effective use of services, by improving dissemination of information on prevention and early management of illness; and
- removing cost barriers to primary care services at point of use.

The report also argues for greater attention to be paid to the social production of health gains and the social dimensions of equity. This includes addressing the social dimensions of deprivation and enhancing the role of community networks and social capabilities in health sector work and ensuring that governance systems for decision making on health include representation of and give meaningful voice and authority to low income communities.

### **Advancing an Equity Agenda in Southern Africa**

Measures are proposed for advancing the equity agenda in southern Africa. These put focus on the importance of the state in organising and sustaining equitable health systems, not in isolation but through building consensus and involvement of a broader range of health related actors, and building wider alliances for public health goals. It is argued that we should pay more attention to the social forces that drive policy choices, and provide specific measures for organising and investing in opportunities for informed, authoritative participation of all social groups and particularly the poorest in their health systems, and for building health system responsiveness and accountability to social groups.

The report also argues for stronger links between equity and poverty related work, and suggests ways of including measures of deprivation in resource allocation systems, and suggests that resources be more strongly applied to primary health care strategies.

The critical role of human resource policies is raised, and the need to address ways of retaining and better distributing health personnel in a manner that involves their associations and recognises health worker interests.

Finally it is observed that networks such as EQUINET provide an important platform for networking research, professional, civic and other communities with an interest in health through information, analysis, policy advocacy and debate to widen the public lobby for equity oriented health policies.

The EQUINET paper placed strong emphasis on the relationship between the technical basis for policy choices, and social organisation that drives these choices in equity outcomes. If these areas are critical, but different components in achieving health equity goals, how can they be strengthened in future work in the region, and what ways can be used to ensure that technical evidence and interventions that promote equity in health link with, and better still strengthen the capacity and voice of social groups who have an interest equity in health? These are challenges against which EQUINET's work in the coming period will be tested.

*This report, Policy Series no 7 and Policy brief no 7 are both available to purchase as hardcopy from the EQUINET secretariat at TARSC ([tarsc@icon.co.zw](mailto:tarsc@icon.co.zw)) or downloadable from the EQUINET website ([www.equinet.org.zw](http://www.equinet.org.zw)).*