

annotated bibliography and overview



Annotated bibliography and overview:

Equity in health in the Southern African Development Community (SADC) region

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1. INTRODUCTION

Regional Network on Equity in Health in Southern Africa

ANNOTATED BIBLIOGRAPHY AND OVERVIEW:

EQUITY IN HEALTH IN THE SOUTHERN AFRICAN DEVELOPMENT COMMUNITY (SADC) REGION

Zimbabwe, May 1998

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1. INTRODUCTION

1. INTRODUCTION AND OVERVIEW

This bibliography is the first edition of 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:

- a. Develop further the conceptual framework and policy issues in relation to equity in health in Southern Africa
- b. Gather and analyse information to support scientific debates and decisions on equity in health in Southern Africa





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- c. 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.

This document represents the first edition of that bibliography. It was compiled at Training and Research Support Centre (TARSC) Zimbabwe from materials available to the members of the core working group. It was reviewed and finalised at meetings involving members of the network. It is intended that this bibliography be circulated widely. Feedback is invited to the network at TARSC on additional materials that can be incorporated into the next edition. *At this stage, evidently, many relevant papers may not be included in the bibliography, and there are apparent gaps in particular countries. A guideline sheet provided at the end of the bibliography for information on further materials for inclusion in later editions.*

The bibliography includes

- i. an analysis and overview of the concepts, issues and debates arising in Southern Africa around equity in health;
- ii. proposed areas of future work to be carried out on equity in health in the region;





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- iii. 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 millenium 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 spiralling 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. CONCEPTUALISING EQUITY IN HEALTH





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.

2.1. CONCEPTUALISING EQUITY IN HEALTH

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

- equality, 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).





2.1. CONCEPTUALISING EQUITY IN HEALTH

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)

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).

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2.1. CONCEPTUALISING EQUITY IN HEALTH

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.

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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 capital² 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 unfair³; 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; 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.

2.1. CONCEPTUALISING EQUITY IN HEALTH





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 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 individual⁴ and a social right⁵. 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.

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

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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.

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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.
- vi. regulation of the rights and relationships between health professionals

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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 care⁶. 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.

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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 care decisions. There



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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 1996; 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.





2.3 EQUITY IN HEALTH AND HEALTH CARE

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





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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 Harrison (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 referral system and significant levels of commuting between providers (Loewenson et al 1991); concentration of costly health manpower in urban, high level and private care (McIntyre et al 1995), staffing





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constraints and poor conditions of service and inadequate resources 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 EQUITY IN HEALTH AND HEALTH CARE

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 surveillance 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 referral 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

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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 needs⁷;
- iii. continued gaps in knowledge on approaches to improving the referral system, and in particular to ensuring adequate quality of care at primary care levels⁸.

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 resistance, 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.





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 access those resources. Socio-economic determinants of ill health are noted in many papers to not only influence health





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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 extent 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

2.4 EQUITY IN RESOURCE ALLOCATIONS FOR HEALTH

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, Lennox 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.

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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





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and directing choice through prices and levels of provision

- 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
- 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 implementation. 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

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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 degenerative 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 targeted 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.

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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





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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





2.4 EQUITY IN RESOURCE ALLOCATIONS FOR HEALTH

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 care⁹, 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 communities¹⁰.

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 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.





2.5 MONITORING EQUITY

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





2.5 MONITORING EQUITY

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 period¹².

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





2.5 MONITORING EQUITY

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 utilization indicators	Immunization coverage. Antenatal coverage. % of births attended by a qualified attendant. Current use of contraception.

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.

2.5 MONITORING EQUITY





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

- v. the extent to which 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;
- 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.





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vii.the extent to which 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,





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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





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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?





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- 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





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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





2.6 ISSUES ARISING

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.





FOOTNOTES

- ¹ *The concept of capability as raised by Amartya Sen has been proposed elsewhere 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*
- 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.*
- 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.*
- 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.*





FOOTNOTES

- 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.*
- ¹¹ *Hence, for example, health differentials by sex would be regarded as avoidable and unfair.*
- 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%."*





3.1 CONCEPTUALISING EQUITY IN HEALTH

3.1.1

Author: Aday L A and Andersen R M

Title: Equity of access to medical care: a conceptual and empirical overview

Publisher: Medical Care 19

Year: 1981

Country: General

Keywords: equity, conceptual overview

Location: TARSC Library

Pages: 23pp.

Abstract: This paper summarizes the major ethical consideration in the conceptualisation and measurement of the equity of access concept, presents national and community data on the most current profile of access in the United States, and discusses the implications of these conceptual and empirical issues. Changes in health care policy and the future of the "equity of access" objective in the US are also discussed.

3.1.2

Author: Carr-Hill R A

Title: Efficiency and equity implications of the health care reforms

3.1 CONCEPTUALISING
EQUITY IN HEALTH





3.1 CONCEPTUALISING EQUITY IN HEALTH



Publisher: Social Science and Medicine 39(9):1189-1201

Year: 1994

Country: General

Keywords: Health care reforms, accountability and equity, effectiveness, efficiency and evidence

Location: TARSC Library

Pages: 12pp

Abstract: The paper reflects on the recent health care reforms in both developed and developing countries, in the light of evidence that has accumulated over the last few years about the efficiency and equity of different fiscal and organisational arrangements. The scene is set by a brief review of the definitions of efficiency and equity and of the confusions that often arise; and of the problems of making assessments in practice with real data. Among OECD countries, there is little evidence that variations in the levels and composition of health service expenditure actually affect levels of health; equity in financing and delivery appears to mirror equity in other sectors in the same countries; about the only transferrable conclusion is that costs can be kept contained through global budgeting. In the OECD countries despite calls for 'freedom' to opt out, public finances continues to be preferred and evidence that health care markets can actually function is 'weak'. Whilst geographical redistribution of finance has proved to be possible, inequalities in health remain in most countries. User charges in the South seem unlikely to raise a significant fraction of overall revenue; exemptions intended for the poor do not always work; and other trends are likely to exacerbate the patchy coverage of health care system. The final section reflects on the pressures for increased accountability. The emphasis on consumerism in the North has led to an increasing number of poorly designed 'patient satisfaction'



3.1 CONCEPTUALISING EQUITY IN HEALTH

surveys; in the South, there has been an increasing rhetoric on community participation, but little sign of actual devolution of control. Outcome measurement is strongly promoted but with little rigour.

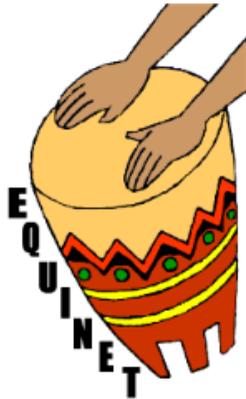
3.1.3

Author: Cuyler A J, Wagstaff A
Title: Equity and equality in health and health care
Publisher: Journal of Health economics 12
Year: 1993
Country: General
Keywords: Equity, equality, health care
Location: Unknown
Pages: 26pp.
Abstract:

3.1.4

Author: de Beer C
Title: Achieving health service equity: dilemmas for policy makers
Publisher: South Africa Review 7 Anonymous
Year: 1993
Country: South Africa
Keywords: South Africa; health services; equity, policy; health; review
Location: Unknown
Pages: Unknown
Abstract:





3.1.5

Author: de Kadt E and Tasca R

Title: Promoting equity: a new approach from the health sector

Publisher: Pan American Health Organisation; World Health Organisation

Year: 1993

Country: Brazil

Keywords: Risk; equity; targeting for health; disease; inequity; social patterns in health

Location: WHO

Pages: 91pp.

Abstract: This book is about equity its promotion, measurement and the policy tools to promote it. The book uses experiences from urban areas of Brazil, in which a new information system was integrated into planning and decision making procedures. The system collected data from official and informal sources, together with simple surveys and observations based on rapid appraisal approaches. The information identified inequities, both objective and subjective. The authors noted that while society has incorporated universal values into their practices, what is regarded as inequitable in one society may not be seen in this way in another. Such universal values nevertheless provide guidance to policy makers and managers.

3.1.6

Author: Evans T G

Title: Increasing global capacity to promote equity in health

Publisher: Strategic planning team health sciences division Rockefeller Foundation March 28

Year: 1997

Country: United States

Keywords: Health, equity, challenges

3.1 CONCEPTUALISING EQUITY IN HEALTH





Location: TARSC

Pages: 16pp.

Abstract: Equity or fairness in health has and continues to be a driving force in health policy worldwide. National systems of health insurance emerged from a societal belief in the importance of equitable access to medical care. The World Health Organisation's mission of health for all by the year 2000 similarly reflects a global commitment to equity. Despite the attractiveness of this noble objective a number of disturbing signs prompt concern for the future status of equity in health. This paper focuses on three specific areas where knowledge generation is a pre-requisite for developing a global capacity to promote equity in health: a global health equity initiative; ii. a socio-economic project and; iii. vital research capacity for equity in health.

Inequities in health are frequently defined by drawing on a standard or basis of comparison such as socio-economic status, age-group, race etc. The choice of these variables reflects society's general aversion to disparities in health within these domains. The challenge is, to understand the causes of these differentials. To what extent are they related to differences in genetic stock, access to medical care or health behaviour? In developed and developing countries alike, access to health care has not averted the trend towards increasing inequalities in health status, and fiscal constraints societies are forcing the public sector to down-size with few for those in need. Evidence suggests that factors such as employment grade, social hierarchy and social supports are major determinants of disparities in health status, while inequity and disparity are themselves factors shaping social and political integration and cohesion. If equity in health is to be achieved, the poor and less privileged need to be protected from the high costs of medical care through as free treatment and abolition of user fees in rural hospitals.

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3.1 CONCEPTUALISING EQUITY IN HEALTH

Governments are also compelled to continue funding the public health care delivery system to ensure that health remains within the means of every citizen.

3.1.7

Author: Makhoul N

Title: Assessment and implementation of health care priorities in developing countries: Incompatible paradigms and competing social systems

Publisher: Social Science and Medicine 19(4):373-384

Year: 1984

Country: Developing countries

Keywords: Health care, health, development

Location: TARSC Library

Pages: 11pp.

Abstract: Health care priorities in developing countries potentially destabilized by foreign development, agencies who interpret the miserable state of health prevailing in developing countries to avoid conflict with economic systems. In fact the pattern of public health in developing countries is specifically in related to their role in the division of labour, the alleviation of disease demands an alteration in the mode of production itself. In the context of under-development, increased productivity is at the necessary cost of public health. Orienting health care priorities in line with belief in the instruments of profit for eradicating the diseases of under-development is counter-productive. This paper points out that developing countries suffer not only from the under-development of capitalism but also from its development.





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3.1.8

Author: Mooney G

Title: Equity in future South African Health Care: A tale of minimally decent Samaritans or good South Africans?

Publisher: University of Cape Town Medical School

Year: 1998

Country: South Africa

Keywords: Equity; health economics; South Africa

Location: TARSC

Pages: 21pp.

Abstract: In the context of equity in any health care system, health policy makers will fail to build an equitable system of health care if they deny the importance of the health care system as a social institution. The paper describes a communitarian perspective on health care and its impact in creating a sense of community, to gain a greater recognition of the embeddedness of individuals in a community of citizens with shared values, here citizens of the new South Africa. What constitutes equity and an acceptable conceptualisation of equity, is determined socially. What constitutes minimal decency is dependent on the links and the relationship, between individuals in the group or community within which minimum decency is to be exercised. The paper argues that policy makers can get important new insights into policies for equity if they adopt or at least understand the communitarian perspective. Adopting such a stance means that it is not just that we are interested in social values and aggregation of individuals' preferences, or whatever qua individuals but in these as part of community or society where the community itself is valued additionally to the individuals. Most important of all, if health policy makers can take up the challenges of communitarianism in health





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care, there may be hopes that such considerations might then spill over into other aspects of the economy and of social life more generally. The building of new alliances and of new communities in South Africa looks to be crucial for the development of a unified society - one nation - in the future and none more so than at the level of South Africa per se as a community. The paper argues that there can be few places that are better and potentially more fruitful to further this process than the South African health care system. The health services can act as a bridgehead in the building of that better and fairer community that will be the future South Africa.

3.1.9

Author: Pereira J

Title: What does equity in health mean?

Publisher: Journal Social Policy 22(1):19-48 Cambridge University Press

Year: 1993

Country: General

Keywords: Equity, health

Location: TARSC Library

Pages: 29pp.

Abstract: Up until very recently, the international debate on health inequity tended to disregard the issue of specifying equity objectives precisely. This was unfortunate, given the importance of normative analysis for understanding why people care about social justice in the field of health; how the concept should be measured; and how rational policies may be formulated and monitored. This article critically appraises six well established approaches to defining equity-egality, entitlement, the decent minimum, utilitarianism. Rawlsian maximum, and envy-free allocations





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- as well as two alternative formulations recently proposed by health economists - equity as choice and health maximisation. All of these are found wanting in some respect when applied to the sector. It is argued that Sen's capabilities concepts, strangely ignored by health services researchers in the past, could prove an effective framework within which to organise research and policy formulation in the area of health and health care inequality.

3.1.10

Author: Price M

Title: Policies for Health sector development - Where does equity feature?

Publisher: Paper delivered to conference on equity in Health: Policies for survival in Southern Africa, Botswana

Year: 1997

Country: South Africa

Keywords: Health sector development policies; Equity in health

Location: TARSC

Pages: 13pp.

Abstract: The paper highlights similarities and differences between policies for health sector development in the countries of the region. It also explores the meaning of health sector development and the obstacles to such development. This leads a discussion of critical policy measures to overcome these obstacles. The author presents a conceptual framework to analyse health sector financing and looks at the impact that aspects of the public/private mix policy may have on health sector development and equity. The decline in the level of government funding for health services has had widespread impacts on public health services, affecting salary levels, maintenance and infra-structure provision, supervision and management,





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drug supplies and access to, and quality of, care more generally. This applies to almost all the countries of the region. While the policy of equal care for equal need is a noble goal that should be pursued by countries, poor countries facing increasing inequality must pursue a policy of distributive justice which holds as its first goal, that the well-being of the poorest should increase, but only as a secondary goal that the degree of inequality should be reduced. In brief, the principle is inequality can be tolerated only in so far as it increases the well-being of the worst.

3.1.11

Author: Vagero D

Title: Equity and efficiency in health reform. A European view

Publisher: Social Science Medicine 39(9): 1203-1210

Year: 1994

Country: General

Keywords: Health care reform, equity, European health policy, cost containment

Location: TARSC Library

Pages: 7pp

Abstract: Health care reform in both eastern and western Europe is on the agenda, and in both parts of Europe the importance of equity targets has been questioned. In the East, the previously strongly held equity goals were largely a facade, covering privilege systems brought equity as a concept into disrepute. Present developments mean that equity will be brought back on the agenda. In the West, equity has been linked to non-market systems of health care. In moving towards market systems, equity is perceived as conflicting with efficiency goals. This contra-positioning of equity and efficiency is based on confusing strategic goals



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with the implementation of those goals. Equity could be seen as a strategic goal in its own right while one may ask what are the most efficient ways of financing, managing and delivering medical services to achieve that goal. Clearly this has not been the question on the agenda. Cost containment has been imperative, and the consequences for general health, equity in health or the health and care for those suffering most, has been relegated to second place. The reduction of inequalities in health can be seen as an overall strategy for the improvement of a population's health, and as helpful in the maintaining and improvement of its human capital. If the focus is on reducing inequality in health, however, policies other than those preoccupied with the financing, management and delivery of medical services must be given much more thought and a more strategic role. The concept of health reforms must embrace a wider range of policies and considerations than those of medical care reform.

3.1.12

Authors: Vagero D and Illsley I

Title: Explaining health inequalities: beyond Black and Baker

Publisher: European Sociological Review Vol 11(3) Oxford University Press

Year: 1995

Country: General

Keywords: Health inequalities; Poverty and health; Britain

Location: UZ Medical Library

Pages: 219-237pp.

Abstract: The paper examines the explanatory framework provided by the Black Report on 'Inequalities in Health'. It also examines a new medical theory, praised as representing a paradigmatic shift in medicine, developed by the British





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epidemiologist David Baker. The answers given by Black and Barker to the above question are related and both are riddled with problems. The typology of four explanations introduced by Black reveals a number of unspoken sociological assumptions. The typology is sometimes obscuring, sometimes not helpful. The favoured explanation is also ambiguous, particularly since there is no clear idea about how poverty is translated into disease in modern society. Baker's theory that disease results from poverty-driven 'biological programming' in foetus, or in infancy, moves the focus of explanation back to the social conditions that existed when the generations now living were born. The link between childhood conditions and adult health, however need not be biological in character. The authors suggest an alternative interpretation based on studying health inequalities across the life cycle and in their historical context. Co-evaluation of health and social achievement could provide an explanation beyond those of Black and Baker.

3.1.13

Authors: Wagstaff A

Title: Quality-adjusted life years (QALYs) and the equity trade off

Publisher: Journal of health economics Vol. 10

Year: 1991

Country: General

Keywords: Quality-adjusted life years; equity and efficiency; equality of access; equality of health; equity and choice.

Location: UZ Economics Department Library

Pages: 20pp.

Abstract: As the volume of research on quality-adjusted life years (QALYs) has increased, concern has begun to be expressed about equity aspects of resource allocation





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decisions based on this indicator. This paper suggests that a common theme running through the criticisms of the QALY approach is a concern about inequality. It also suggests that the method for incorporating distributional concerns which is currently being pursued by advocates of the QALY approach reflects a concern about inequality. It also suggests that the method for incorporating distributional concerns which is currently being pursued by advocates of the QALY approach will not effectively capture concerns about inequality. The paper discusses whether the definition of equity can provide a basis for determining an equitable allocation of resources, whether there is a conflict between equity and efficiency and whether equity can be captured simply by weighting QALYs appropriately. The paper concludes that the social aversion towards inequalities in health outcomes. can be incorporated into resource allocation decisions.

3.1.14

Author: Waters H

Title: Literature Review: Equity in the Health sector in Developing countries: With lessons learned for sub-Saharan Africa. Prepared for BASICS project

Publisher: Unknown

Year: 1995

Country: General

Keywords: Equity, health

Location: TARSC Library

Pages:

Abstracts:





3.1.15

Author: Whitehead M

Title: The concepts and principles of equity and health

Publisher: World Health Organisation Regional Office for Europe Copenhagen 1990

Year: 1990

Country: General

Keywords: Equity; Health; Determinants of health, Monitoring and evaluation

Location: TARSC

Pages: 28pp.

Abstract: The 32 member states in WHO-European adopted a common health policy in 1980, followed by unanimous agreement on 38 regional targets in 1984. The first of these targets is concerned with equity, and it sets out that by 2000, the differences in health status between countries and between groups within countries should be reduced by at least 25% by improving the level of health of disadvantaged nations and groups. Equity is an underlying concept in many targets. At present, the targets are also being reassessed and revised, in other particular moving away from a focus on physical health status as measured by mortality to encompass, wherever possible, other dimensions of health and wellbeing. While Equity in health has been judged to be as important for the 1990s, it has not always been clear what is meant by equity. The paper sets out to clarify the concepts and principles. Differences in the health profiles of different nations and different groups within the same country are highlighted, as measured from standard health statistics. Not all of these differences can be described as inequities. Equal access to available care for equal need implies equal entitlement to the available services for everyone, a fair distribution throughout the country based on health care needs, ease of access in each geographical area, and the removal of other barriers

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to access. Differences in utilisation rates of certain services between different social groups, does not automatically imply inequity as there is need to ascertain why the rates are different. Where use of services is restricted by social or economic disadvantage, there is a case for aiming for equal utilisation rates for equal need. Equal quality of care, implies equal opportunity of being selected for attention through a fair procedure based on need rather than social influence. Equity does not therefore mean that everyone should have the same health status or consume the same amount of health service resources irrespective of need. Accepting equity as a goal is a stimulus to recognise and challenge the causes of inequities involving a range of levels and sectors of activity.





3.2 EQUITY IN HEALTH RIGHTS AND POLICIES

3.2 EQUITY IN HEALTH RIGHTS AND POLICIES

3.2.1

Author: African National Congress

Title: A National health plan for South Africa

Publisher: ANC

Year: 1994

Country: South Africa

Keywords: Health, planning, South Africa

Location: TARSC

Pages: Unknown

Abstract: The challenge facing South Africa is to design a comprehensive programme to redress social and economic injustices. In the health sector this will involve the complete transformation of the national health care delivery system and all relevant institutions. The plan outlines the broad approach towards achieving this, as part of the broader Reconstruction and Development Programme.

3.2.2

Author: Beattie A and Rispel L

Title: Problems and prospects for health sector: Links in the Southern African Region: The role of South Africa

Publisher: University of Western Cape Southern African Perspective





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Year: 1993
Country: South Africa
Keywords: Health; inequities; health services; South Africa; political economy
Location: Unknown
Pages: 21pp.
Abstract: Recent political developments in South Africa provide many opportunities for the development and extension of health sector links in the Southern African region and the possibility to move away from past hostilities towards a constructive future. The need to address health issues at an inter-government level is becoming more urgent as poverty, drought and homelessness take their toll on the health of the region's population. The paper examines the prospects for and problems with regional integration in the health sector. It begins by outlining the historical context of regional sector links and discussing crucial issues that have to be addressed in relation to future regional activities. Proposed areas in the health sector that would benefit from cooperation, it is proposed that many of the crucial health issues affecting the region are inter-sectoral; such as nutrition, disease control and environmental health and require cooperation between sectors of government as well as between governments.

3.2.3

Author: Bloom G
Title: Two models for change in the health services in Zimbabwe
Publisher: International Journal of Health Services 15(3):451-68,
Year: 1985
Country: Zimbabwe
Keywords: Health services, Zimbabwe





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Location: UZ Medical Library

Pages: 17pp.

Abstract: The health situation in pre-Independence Zimbabwe was much as elsewhere in the Third World. While the majority suffered excess mortality and morbidity, the affluent enjoyed a health status similar to that of the populations of developed countries. The health services also showed the familiar pattern, with expenditure concentrated on sophisticated facilities in the towns, leaving the rural majority with practically no services at all. With independence, the previous pattern of controlling access to facilities on the basis of race could not continue. Two broad routes forward were defined. On the one hand, the private doctors, the private insurance companies, and the settler state proposed a model on improving urban facilities, depending on a trickle-down to eventually answer the needs of the rural people. On the other hand, the post-independence Ministry of Health advocated a policy of concentrating on developing services in the rural areas. The pattern of the future health service will depend on the capacity of the senior health planners and on the enthusiasm of front-line workers but, of overriding importance will be the political commitment to answer the needs of the majority and the outcome of the inevitable struggle for access to scarce health sector resources.

3.2.4

Author: Brevman P, Tarimo E, Creese A, Monasch R and Nelson L

Title: Equity in health and health care: a WHO/SIDA initiative

Publisher: World Health Organisation - Geneva

Year: 1996

Country: Global





3.2 EQUITY IN HEALTH RIGHTS AND POLICIES

Keywords: Equity, health care, health

Location: TARSC Library

Pages: 50pp

Abstract: Social gaps in health and in health care are unacceptably wide and are widening throughout the world. Developing countries and industrialised countries alike are finding it difficult to implement equitable policies and often feel caught between considerations of equity and short-term efficiency. This document describes an initiative of the World Health Organisation, with seed funds from the Swedish International Development Cooperation Agency, to place equity in health and health care higher on the public policy agenda and to evaluate and promulgate promising practical approaches to achieving equity in health development.

3.2.5

Author: Brevman P

Title: Comments and recommendations for next phase of equity work in Zimbabwe, Nyanga Workshop on Equity in health

Publisher: Mimeo Report

Year: 1997

Country: Zimbabwe

Keywords: Equity, health, Zimbabwe

Location: TARSC

Pages: 5pp.

Abstract: The paper reports on a workshop in August 1997, attended by parliamentarians, central and provincial-level health decision-makers, program managers, experts and representatives of relevant NGOs on equity in health in Zimbabwe. It was noted that Zimbabwean MoHCW needs to carry out a systematic process of field





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consultations involving appropriate stakeholders among the public and policy makers not only in the health care sector but in all the key sectors affecting health at the provincial/city and district levels. Provinces/cities and districts would develop their own strategic plans of action, within which they would set a limited number of specific, measurable equity targets to be achieved within the next 5-10 years, which they perceive as achievable despite likely resource constraints.

3.2.6

Author: de Beer C
Title: Achieving health service equity: dilemmas for policy makers
Publisher: South Africa Review 7 Anonymous
Year: 1993
Country: South Africa
Keywords: South Africa; health services; equity, policy; health; review
Location: TARSC Library
Pages: Unknown
Abstract: See 3.1.4

3.2.7

Author: Gilson L
Title: In defence and pursuit of equity
Publisher: Centre for Health Policy
Year: 1997
Country: South Africa
Keywords: equity, efficiency, health care reforms
Location: TARSC Library





3.2 EQUITY IN HEALTH RIGHTS AND POLICIES

Pages: 13pp.

Abstract: The paper discusses the equity implications of efficient policies in health. The critique identifies weaknesses in efficiency driven approaches in narrowing the domain of health policy to health care, in excessively orienting debates to new sources of revenue rather than adequately protecting existing public budget allocations, and in ignoring the broader relationships between public health provision, and household health and welfare. Efficiency approaches are further criticised for inadequately taking on board the capacities of systems and behaviours of people, and for being value neutral. The paper proposes that an equity driven approach promotes a broader vision for policy making and discusses how this would be defined and achieved.

3.2.8

Author: Gilson L

Title: Re-addressing equity: the search for the holy grail?

Publisher: Centre for Health Policy and LSHTM

Year: 1998

Country: South Africa

Keywords:

Location: TARSC Library

Pages: 17pp.

Abstract: This paper specifically acknowledges the range of socio-political barriers to equity-oriented health reforms and builds on an egalitarian perspective to equity. It has four starting points: (1) health inequity results from differences in health outcomes between groups that are unnecessary, avoidable and unfair; (2) Equity-promoting action in the health sector must put the needs and interests of the poorest and

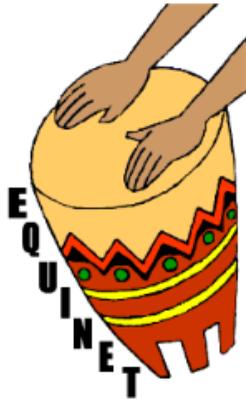




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most vulnerable at their heart, as the relatively worse health outcomes of this group in comparison with other groups are most often a function of circumstances beyond their control; (3) Ill-health and poverty are inter-linked and so a concern for health demands the development of strategies to combat poverty rooted in analysis of the factors that influence the ability of the poorest individuals and groups to gain access to the range of resources which enable them to lead healthy lives; (4) The intended beneficiaries must be involved in identifying, formulating and implementing all equity-oriented health policy interventions as they always play a role in the implementation of any policy intervention, actively adapting and using it rather than passively receiving it. Overall, the paper is rooted in the understanding that ethical processes are critical in promoting equity. At the heart of these processes is the pursuit of procedural justice, rather than only distributional justice, a fundamental respect for the innate worth of other people and a recognition of each citizen's own responsibility to promote equity. The 'public action' required to secure this vision is, therefore, not solely the function of some combination of financing and provision reforms but, more importantly, a broader process of social change in which all groups play an active role. Perhaps the most critical factor underlying this public action is the development of an enabling state which protects and promotes the interests of the poor through 'public interest' institutions health care financing mechanisms and strategies are critically important to the promotion of equity goals. However, in contrast with recent reform packages, the perspective of this paper stresses the need to consider how such mechanisms can support ethical processes within the health system rather than how they can mobilise resources or promote efficiency. Such a perspective suggests that rather than promoting divisions between population groups in the level, quality or source of care, financing mechanisms should





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promote social solidarity and cohesive health systems which give special attention to the needs of the poorest through, in particular, cross-subsidisation between population groups.

3.2.9

Authors: Hammer J S and Berman P

Title: Ends and means in public health policy in developing countries

Publisher: Health Policy Vol 32

Year: 1995

Country: Developing countries

Keywords: Developing countries; Public health; policy; Equity

Abstract: International discussions of public health policy strategies in developing countries have been characterised by strong and conflicting positions. Differences regarding the means of health sector improvement can often be traced to differences about the ends, that is, the goals of the health sector. Three types of health sector goals are reviewed; health status improvement, equity and poverty alleviation, and individual welfare (utility) improvement. The paper agrees that all three must be considered in developing health sector reform strategies in all countries. Highly normative policy positions often can be attributed a unidimensional affiliation with one health sector goal and denial of the relevance of the others. The current global interest in using cost-effectiveness analysis to set national health priorities is assessed in light of this elect approach. Examples are provided of how a health sector strategy based on cost-effectiveness would give sub-optimal solutions. These examples include situations where a private health care sector exists and provides some degree of substitution for publicly provided services; significantly high income elasticities exist for health care such that higher income beneficiaries



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may differently capture public subsidies; and market failures exist in insurance. It is argued that these conditions are virtually universal in developing countries. Thus national policy development should explicitly consider multiple goals for the health sector.

3.2.10

Authors: Herman L, Puelma F and Connor S S

Title: The right to health in the Americas

Publisher: PAHE: A comparative constitutional study scientific publication No. 509

Year: Unknown

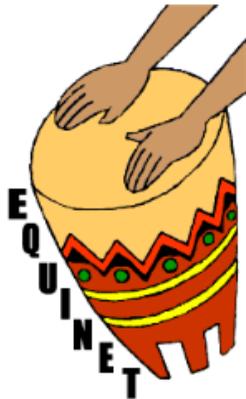
Country: USA

Keywords: Rights, health; constitutional rights

Location: UZ Medical School Library

Pages: 12pp.

Abstract: The article explores the meaning of the term right to health, as it relates to the state's role in assuring an individual right to health and the health of the nations. It analyses the modern concept of health, the distinction between public health and individual health care services, and the various elements of a "right to health", the constitutional texts purporting to frame a "right to health"; and cursorily the national legislative policies towards public health and the provision of health care. Perfect health, particularly if defined as "a complete state of physical and emotional well-being", is not a realistic goal: due to natural limitations, infinitives imposed by age, and untreatable maladies will prevent the individual entertainment of perfect health. While there is thus no real dispute about the duty of the state to safeguard the health conditions of society, there is certainly no uniformity on minimal standards or means of assuring them. No true agreement on a legal definition of health can be reached. Health may be defined in terms of prevailing standards.



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3.2.11

Author: Kalumba K

Title: Towards an equity-oriented policy of decentralisation in health systems under conditions of turbulence: The case of Zambia Discussion Paper No. 6

Publisher: World Health Organisation

Year: 1997

Country: Zambia

Keywords: Equity; health sector reform; health transition; health policy; monitoring and implementation; financing the reforms.

Location: WHO

Pages: 47pp.

Abstract: See 3.3.25

3.2.12

Authors: Kamanga K and Himanga H B

Title: An overview of health reforms in Zambia

Publisher: Republic of Zambia Ministry of Health

Year: 1995

Country: Zambia

Keywords: Zambia; Health policy reforms; Health financing; Equity

Location: WHO Library

Pages: 13pp.

Abstract: The document discusses the reforms introduced by the Ministry of Health in order to deal with the health situation which had led to the deterioration of the country's health delivery system. The government articulated radical policy reforms, characterised by a move from an excessively centralised system to a more





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effective decentralised system in which the centre provides support and national guidance. Underlying these reforms was the desire to build effective leadership, accountability and partnership in order to provide equity of access to cost-effective quality health care as close to the family as possible.

3.2.13

Author: Kapembeza-Muwanigwa V

Title: Need for adequate AIDS policies in Southern Africa

Publisher: Mimeo

Year: 1996

Country: Southern Africa

Keywords: AIDS socio-economic effects

Location: SARDC

Pages: 2pp.

Abstract: This paper calls for development of adequate policies and strategies for an enabling environment to combat the socio-economic effects of HIV/AIDS in terms of the Southern African Trade Union Coordination Council draft regional code on AIDS and Employment. The AIDS crisis has brought out the inadequacies of the extended family in alleviating the situation. A mixture of financial difficulties, and a breakdown in the traditional obligation to care for extended family members has made it necessary to have some interventions which are guided by policies. Despite several countries having adopted some policies, enforcement measures and channels for redress are not so clear cut. In some instances, the bureaucracy discouraged people from seeking help.



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3.2.14

Author: Kelly J and Sairr P

Title: The politics of health care in South Africa: a general overview

Publisher: ASSA

Year: 1988

Country: South Africa

Keywords: Political, economy, health

Location: Unknown

Pages: Unknown

Abstract:

3.2.15

Author: Klugman B

Title: The role of NGOs as an agent for change: Paper prepared for the seminar Equity in health: policies for survival in Southern Africa

Publisher: University of the Witwatersrand

Year: 1997

Country: South Africa

Keywords: Non-government organization

Location: TARSC

Pages: 22pp

Abstract: The view that NGO participation is essential to good policy making and implementation, is widely accepted and has been institutionalized in international agreements. In some cases this view is framed by anti-statist policies which support NGOs as part of an overall strategy towards non-state delivery of development; in others it is framed by those concerned with facilitating access of





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the poor and powerless. This paper considers the conditions under which NGOs can influence policy in the direction of equity; the skills required by NGOs in order to play this role; the strategies required in order to influence the policy process; and the legitimacy of NGOs as role-players in the policy process. The paper uses case studies for illustration, and draws conclusions about the challenges facing all those concerned with health and equity, regarding the role of NGOs in Southern Africa. The paper bases its arguments on a global context in which economic growth is understood as the means to reduce poverty, yet is associated with increased inequity and in which the promotion of citizenship in its fullest sense encompasses the goal of equity.

3.2.16

Author: LaFond A

Title: Sustaining Primary Health Care

Publisher: Earthscan Publications Ltd London

Year: 1995

Country: General

Keywords: Primary health care; Planning; Health care market

Location: TARSC

Pages: 195pp.

Abstract: The paper discusses the factors that determine the sustainability of any health system. It argues that while laws and policies set the parameters of investment, direct support for the health system depends on the actions and attitudes of local stakeholder who have the financial muscle to influence policy and government. Building a sustainable national health system therefore requires a constituency that treats health as a priority enough to continue supporting investment in health





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development. In developing countries a supportive community of local stakeholder is essential due to the extreme scarcity of resources, and the competition with other viable sectors for the national funds. However, the trend has often been that those with power have tended to influence the way resources are used and their distribution. Interest groups often distort the distribution of resources in favour of tertiary care which is out of reach of the poor who are the majority. For example, public sector spending in developing countries such as Ghana, Pakistan and Uganda, public spending is systematically biased against primary level services partly because PHC lacks its own power base. In terms of sustainability, constituents affect the health system according to: the range and number of stakeholder groups; specific stakeholder interests; the relative economic capacity of different stakeholder; and the organisation of stakeholder relations within the health system.

3.2.17

Author: Mann J M

Title: AIDS: discrimination and public health

Publisher: Report of the IV International Conference on AIDS

Year: 1988

Country: General

Keywords: AIDS, Discrimination, Public health

Location: TARSC Library

Pages: 3pp.

Abstract: The paper outlines the United Nations position on non discrimination against people with HIV/AIDS and calls for member states to protect the human rights and dignity of people with HIV/AIDS. This policy is said to be critical to the success of





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HIV/AIDS prevention programmes. Stigma can lead to the problem being hidden, interrupting the necessary information and contact with support services, including those aimed at preventing future transmission. Discrimination is thus a danger to public health - the protection of the uninfected majority depends upon and is inextricably bound with the protection of the rights and dignity of infected persons.

3.2.18

Author: Manyeneng W G

Title: Community participation and involvement for health in Botswana

Publisher: Federal Health Education Division

Year: 1981

Country: Botswana

Keywords: Botswana, Community participation, health services

Location: National Institute of Development Research and Documentation

Pages: 4pp.

Abstract: In Botswana, the Ministry of Health support a health care system in which people play a major role, making decisions about their own health. The system allows everyone to participate in prevent and promotive health programs. People participate from the initial planning stage to evaluation. Seminars are run using the problem posing method, intended to raise the people's awareness of their existing health problems, helping to sensitize them to the fact that they have the power to solve problems and to change conditions. In the effort to involve people in their own health care, focus is on encouraging their ideas rather than placing the whole responsibility for health on the people. The primary objectives of the Community Leaders Health Seminars are to educate the community leaders in the major health problems to improve family community, and ultimately national



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health; to develop and improve family community, and knowledge, skill, and attitude in organising different health education activities; and to develop health education process in the country. The role of the health educator is both to set up educational programs to change individual's health related behaviour and to help people challenge health damaging conditions in their communities and work places and work toward health promoting conditions. During the Community Leaders Health Seminars, some villages suggested the establishment of standing committees of modern health workers and traditional healers. This began communication between the 2 groups involved in public health. The existence of such committees has resulted in a continuous exchanged of ideas and cooperation, consensus being reached by both groups over which disease can best be treated by WHO, considerable improvements in the referral system, and the traditional doctors suggesting that research is needed to learn just what is in the herbs they are using.

3.2.19

Author: McIntyre D

Title: Towards equity in health in an unequal society: health finance and expenditure in South Africa

Publisher: Unknown

Year: 1997

Country: South Africa

Keywords: equity, health sector reform, resource allocation, health finance, South Africa

Location: TARSC Library

Pages: 15pp.

Abstract: South Africa is one of the world's most unequal societies and its health sector





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mirrors these inequalities. Since the first democratic elections in 1994 the government has been under enormous pressure to diminish disparities between population groups in access to health services. This paper documents the structural inequalities in the health sector and discusses the strategic options that are being considered for reducing them. The overall level of health expenditure is high, amounting to 8.5% of GDP. However, less than 40% of expenditure is on public health services and three quarters of that is on acute care hospitals. A more detailed analysis of public health expenditure reveals large differences between census districts. The districts where household incomes are low tend to have fewer public health services. Public health expenditure per capita was lower than the estimated cost of providing basic primary health care in a fifth of districts. The most urgent need is to improve the services likely to reduce excess mortality and morbidity. This will involve additional funding of primary health care services, particularly in under-served localities. Government cannot increase public health budgets rapidly and it will have to re-allocate funding from hospitals. The paper discusses options for achieving this, including the introduction of social health insurance. It argues that restructuring the health sector is complex and there is a risk of failure. Governments should base their strategies on a good understanding of the health sector and of the likely impact of different reform options.

3.2.20

Authors: Nightingale EO. Hannibal K. Geiger HJ. Hartmann L. Lawrence R. Spurlock J.

Title: Apartheid medicine. Health and human rights in South Africa.

Publisher: JAMA. 264(16):2097-102

Year: 1990

Country: South Africa





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Keywords: Health; human rights

Location: U.Z. Medical Library

Pages: 6pp.

Abstract: Human rights and health care under apartheid in South Africa were studied. Human rights violations, such as detention without charge or trial, assault and torture in police custody, and restriction orders, have had devastating effects on the health of persons experiencing them. These violations have occurred in the context of a deliberate policy of discriminatory health care favouring the white minority over the black majority. South Africa's medical societies have had mixed responses to the health problems raised by human rights violations and inequities in the health care system. The amelioration of health care for all and prevention of human rights violations depend on ending apartheid and discrimination and greater government attention to these problems.

3.2.21

Authors: Pillay Y G, Bond P

Title: Health and Social policies in the new South Africa

Publisher: International Journal of Health Services 25(4): 727-43,

Year: 1995

Country: South Africa

Keywords: Health policy, South Africa, health

Location: UZ Medical Library

Pages: 16pp.

Abstract: South Africa's first democratic government is today confronted with the challenge of recasting apartheid social and health policies, transforming a moribund bureaucracy's mode of governance, and restructuring a variety of public and





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private institutions, including the national department of health. In the attempt to redress racial, gender, and class inequities, enormous barriers confront health policy analysts and planners, progressive politicians and activists within civil society who work in the field of health. This article sets the broad social policy context for the emerging strategies, documents some of the continuing inequities in the health sector, and recounts some recent experiences in one of the nine provinces (KwaZulu-Natal), to illustrate the difficulties and potentials that change of this magnitude presents under the prevailing conditions of neo-liberal politics and economics.

3.2.22

Author: Roemer R

Title: The right to health care

Publisher: School of Public Health, University of California

Year: 19??

Keywords: Health; Health care; Right to health

Country: General

Location: UZ Medical School Library

Pages: 23pp.

Abstract: This feature examines the historical evolution of health care as a legal right and the nature and scope of the right to health care. Medical care and the right to health are also discussed. It examines expanding concept of health as a social responsibility and the assurance of quality of social conditions. Health is posed as a natural right for all human beings. If we assume a right to life, then we must grant a right to health protection. The right to health is both an individual and a social right. The individual right to health must include the protection of an





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individual's physical integrity and human dignity. It may entail a moral obligation to avoid harm to one's health. The social right to health care expresses the responsibility of society to protect the health of its citizens and to assure them care in times of illness. While the right to health is an absolute or, at least, a basic right, enforcement of the right depends on what society may feasibly grant. Thus, while the right may apply at all times and places, its attainment must vary with society's capability to provide a certain level of care and protection at each specific time and place. In the gradual evolution of health care as a social responsibility and expression of the right to health care in national constitutions is valuable as a principle. Translation of that principle into reality depends on the expectations and actions of the citizenry and on the political will of governments to assign a high priority to health care for the people.

3.2.23

Author: Segall M

Title: Planning and politics of resource allocation for primary health care: promotion of meaningful national policy

Publisher: Social Science and Medicine 17(24):1947-1960

Year: 1983

Country: Zimbabwe

Keywords: Health policy, planning, resource allocation

Location: TARSC Library

Pages: 13pp

Abstract: Securing resources for primary health care (PHC) involves consideration of the entire health sector: the higher levels of the health as well as the primary level, and the private and/or social security sub-sectors as well as the government service.





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Reshaping resource distribution is less a redistribution of existing resources than the allocation of new resources in accordance with PHC priorities. In this the planning of future current costs is a crucial element and requires a budgetary system that identifies expenditures by geographical area and level of care. Resources should be allocated geographically to reduce health care inequalities through the provision of an appropriate mix of different levels of care. Central resource planning and local health care programming (with 'dialogue' between the two) should be the basic planning division of labour, which largely resolves the so-called top/down/bottom-up dichotomy. The private medical sub-sector exerts economic, ideological and political influences on the public health service. Compulsory health insurance schemes can have some similar effects. Success of a PHC policy requires that governments adopt a holistic approach to the health sector. The allocation of health care resources on the bases of need and equity, as opposed to demand, is a political decision. The establishment of a national PHC policy backed up by adequate resources involves a specific politico-technical exercise with four components: research, planning, policy formulation and government policy decision making. The resource planning method, based on social epidemiology, is contrasted with conventional health planning methods, based on epidemiology. The articulation of these two approaches is discussed in terms of WHO's Managerial Process for National Health Development.

3.2.24

Author: Storey P

Title: Health care in South Africa: the rights and responsibilities of the community

Publisher: Medicine and Law 7(6):649-655

Year: 1989





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Country: South Africa

Abstract: Both community mobilisation and expert intervention are required for health care. All members of the South African Community have a right to justice, equity and participation in their health care system. Justice demands equal facilities for all, and in South Africa cannot be achieved without fundamental political change. Equity demands freedom from financial anxiety. Arguments for the further privatisation of health care in South Africa are immoral and unconvincing. Participation demands that a patient be actively involved in deciding the nature of health care rather than merely a 'consumer'. This requires both demythologising the medical profession and vesting power in the community. Practical steps towards this are suggested.

3.2.25

Author: Uganda National Council for Children

Title: Equity and vulnerability: a situation of analysis of women, adolescents and children in Uganda, 1994

Publisher: The Government of Uganda

Year: 1994

Country: Uganda

Keywords: Women, children, health rights, equity

Location: Unknown

Pages: Unknown

Abstract: This book deals with women and children's education, health, rights and their culture in Uganda. It notes a need to achieve more equitable distribution of resources and opportunities for the most vulnerable groups; including women, adolescents and children, attention to equity between rural and urban areas as





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well as for the various districts in different regions. It calls for a balance between the concerns of the intended beneficiaries, the implementers, the planners and the controllers and between needs and resources, present and future. To a much greater extent than presently occurs, the voices of women, adolescents and children need to be heard in the process of identifying needs. This applies to all vulnerable persons, including orphans, the disabled and adolescent mothers. The problems and their determinants are complex, involving multiple sectors, and issues, such as equity, lack adequate attention because no single unit or sector takes responsibility for them. This calls for innovative problem solving and creative resource sharing that cuts across sectorial boundaries.

3.2.26

Author: Unknown

Publisher: British Medical Journal Vol 311, 1 July 1995

Title: Health and economic policy

Year: 1995

Country: Global

Keywords: Health, economic policy

Location: UZ Medical School Library

Pages: 2pp.

Abstract: The paper advocates for an intersectoral collaboration in the development of policies in different sectors such as health, transport, housing, energy and many others. It calls for health to play a pivotal role in influencing decisions made in other sectors so as to minimise accidents, loss of lives, wastage of resources and pollution of the environment. The paper argues that what happens in one sector will 'trickle down' to other sectors and as such it is the challenge for the health





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sector to advance the agenda of sustainable development and to identify the potential health gains and losses from different policies. One of the most important being macroeconomic policy. Health sector has a potential to make useful contribution to the current development of macro-economic policy in a number of ways. Four possibilities present themselves. Firstly, the health costs of socio-economic inequalities, unemployment, poverty and crime can be brought to policy makers' attention whenever possible. Secondly, health professionals should join the social and environmental critics of macroeconomic policy to ensure that the health costs and benefits of macroeconomic policies are examined in policy making. Thirdly, more health professionals can contribute locally to healthy city projects and other intersectoral activities. The health sector can also promote wider understanding of the many positive implications for public health of environmentally sustainable development.

3.2.27

Publisher: University of Botswana, The National Institute of Development Research and Documentation

Title: Equity in health policies for survival in Southern Africa: an Agenda for action

Year: 1997

Country: Botswana

Keywords: Equity in health; Policy

Location: TARSC

Pages: 12pp.

Abstract: The seminar on equity in health -policies for survival in Southern in Southern Africa was jointly organised by the National Institute of Development Research and Documentation of the University of Botswana and the Dag Hammarskjold





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Foundation, Uppsala, Sweden in March 1997, in Botswana. This agenda for action from the seminar calls for research to develop regional indicators of equity in order to facilitate the monitoring of equity in health both within and between countries in Southern Africa, sharing of experiences with coordination at regional level, a wider regional debate and action by stakeholder on equity in health.

3.2.28

Authors: Van Rensburg H C, Fourie A

Title: Inequalities in South African health care. Part II Setting the record straight

Publisher: South African Medical Journal 84(2):99-103,

Year: 1994

Country: South Africa

Keywords: Health care; health policy; equity

Location: UZ Medical Library

Pages: 5pp.

Abstract: While Part 1 of this article analysed the problems of structural inequalities in South African health care, this follow-up explores a policy strategy to deal with these discrepancies and disparities, weighed against prevailing realities. The conclusion is reached that for the foreseeable future the chances for equality in South African health care appear to be rather slim; a myriad interest groups with vested interests in the status quo are at play, opposing any fundamental reform to ensure greater equality. This should motivate endeavour to minimise these inequalities, through a recognition of health care as a basic human right and a public concern, the universalisation of health care benefits to every citizen; a social contextualisation of health care provision accompanied by community-based, democratised planning and regionalisation of health care; the integration of authority into a central



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controlling body and the centralisation of the financial process.

3.2.29

Author: Yach D and Bettcher D

Title: The globalisation of public health: threats and opportunities

Publisher: World Health Organisation, Geneva

Year: 19??

Country: Global

Keywords: Public health; Globalisation; health policy

Location: WHO Library

Pages: 6pp.

Abstract: The globalisation of public health poses new threats to health but also holds important opportunities in the coming century. This commentary identifies the major threats and opportunities presented by the process of globalisation, and emphasises the need for transnational public health approaches to take advantage of the positive aspects of global change and to minimise the negative ones. Transnational public health issues are areas of mutual concern for the foreign policies of all countries. These trends indicate a need for cross-national comparisons, for example in the areas of health financing and policy development, and for the development of a transnational research agenda in public health.

3.2.30

Author: Yach D and Bettcher D

Title: The globalisation of public health: the convergence of self-interest and altruism

Publisher: World Health Organisation - Geneva

Year: 199?





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Country: Global
Keywords: Global, Public health globalisation
Location: World Health Organisation - Geneva
Pages: 7pp.
Abstract: The trans-nationalisation of disease and health risks will require global awareness, analysis, and action, and indicates a need for global cooperation. These transnational actions must be built on firm local and national foundations, but also require new forms of transnational collaboration in order to minimise risks and build on the opportunities. In a world characterised by the globalisation of public health, countries and communities will need to look beyond their narrow self-interest in defining and confronting the shared problems which are emerging. In fact, a strong case can be made that enlightened self-interest and altruism converge in the increasingly interdependent world being shaped by the process of globalisation.

3.2.31

Publisher: Zimbabwe Ministry of Health and Child Welfare

Title: Planning for "Equity in Health"

Year: 1982

Country: Zimbabwe

Keywords: Health; equity; Zimbabwe

Location: MoHCW Library

Pages: 73pp.

Abstract: This white paper outlines the health policy linked to the economic policy of "Growth with Equity", which sought to establish a socialist, egalitarian and democratic society in Zimbabwe. Political independence is the necessary first step





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in the long march towards national development which can be measured by a nation's state of health. The policy notes racial and social class related inequalities in health and health care. Planning for "Equity in Health" seeks to redress this imbalance and demands that the rural population be cared for first. It advocates the adoption of the primary health care (PHC) approach whose key components are appropriateness, accessibility, affordability and acceptability of the care provided. This approach advocates for a conscious acceptance by a community of the responsibility for its own health.

3.2.32

Author: Zimbabwe Ministry of Health and Child Welfare

Title: Zimbabwe health for all action plan

Publisher: Ministry of Health

Year: 1986

Country: Zimbabwe

Keywords: Health policy, Health planning

Location: TARSC

Pages: 60pp.

Abstract: The document outlines the plan for the Ministry of Health from 1985-1990 to respond to the major public health problems in the country.

3.2.33

Author: Zimbabwe Ministry of Health, Blair Research Laboratory

Title: A study on the regulation within Private Medical Sector in Zimbabwe

Publisher: Government Printers

Year: 1995





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Country: Zimbabwe
Keywords: Private medical care, regulation, Zimbabwe
Location: Blair Research laboratory
Pages:
Abstract:

This study was to look at the regulatory environment currently in place for the private sector especially in as far as they addressed the variables price, quality and quantity of care and assess the effectiveness of the regulatory environment. The findings of the study showed that although the health sector was administered by the Ministry of Health and Child Welfare, implementation of provisions of the regulations was generally not effective. For instance, the Health Professions Council, as the official guardian of medical standards in the country, did not have an important unit such as the Inspectorate. Therefore, local authorities conducted inspections on behalf of the Health Professions Council before issuing licences to providers. Until recent moves by the Health Professions Council, there had not been national minimum standards for health institutions in the country and each local authority was using their own by-laws during inspections. With regards to the services done by private practitioners, Medical Aid Societies were thought to be in a better position to evaluate any improper conduct by practitioners since their investigative departments investigated all claims sent by practitioners before payment.

3.2.34

Author: Zwi A B, Mills A

Title: Health policy in less developed countries: past trends and future directions

Publisher: Journal of International Development 7(3)

Year: 1995





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Country: General

Keywords: Health policy, less developed countries

Location: TARSC Library

Pages: 29pp

Abstract: Health policies worldwide have changed dramatically in the last few decades. We reflect upon these changes, highlight current trends and identify key issues and challenges as the year 2000 approaches. The article comprises five sections: (i) comments on concepts of health and of policy; (ii) historical developments which have influenced policy; (iii) discussion of the context within which health policies in low income countries are formulated and implemented, including macro-political and macro-economic developments, health needs and determinants, financing, approaches to health planning and priority setting, and the key international health policy actors; (iv) an overview of the content of current health policy proposals in less developed countries which considers the financing, organisation and management of health systems, and (v) a concluding section which identifies key issues for the coming years. The recent World Bank Development Report, Investing in Health (1993) and other health sector reform efforts, form the backdrop for this discussion.





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3.3.1

Author: Agere S

Title: Issues of equity in and access to health care in Zimbabwe

Publisher: Journal of Social Development in Africa 5(1): 31-38

Year: 1990

Country: Zimbabwe

Keywords: equity, health care, Zimbabwe

Location: TARSC Library

Pages: 7pp.

Abstract: This paper identifies and analyses, within the health care delivery system in Zimbabwe, certain categories of people or social groups who may or may not have access to health care. The paper gives the reasons for the maldistribution of health resources and the implications this has for the population of Zimbabwe. Solutions are proposed within the socio-economic and political context of the Zimbabwean stage of development and its historic past.

3.3.2

Author: Akhtar R and Izhar N

Title: The spatial distribution of health resources within countries and communities examples from India and Zambia in Curacao

Publisher: Social Science and Medicine 22

Year: 1986

Country: Zambia

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Keywords: health resources, distribution

Location: TARSC Library

Pages: 14pp.

Abstract: "Between one country and another, one province and another and even one locality and another there will always exist a certain inequality in the conditions of life, which it will be possible to reduce to a minimum but never entirely remove," said Friedrich Engels in 1875, The paper describes wide disparities in the availability of welfare facilities including health at international, national, regional and inter-regional levels. At the same time such disparities are increasing over time. In terms of spatial distribution, not only the developing world but even developed countries such as the USA and the United Kingdom, face problems resulting from wide imbalances in the provision of welfare facilities. In this paper, an attempt has been made to study inequalities in the distribution of health facilities in India and Zambia.

3.3.3

Authors: Andersson N and Marks S

Title: The state, class and the allocation of health resources in Southern Africa

Publisher: Social Science and Medicine 28(5):515-530

Year: 1989

Country: Southern Africa

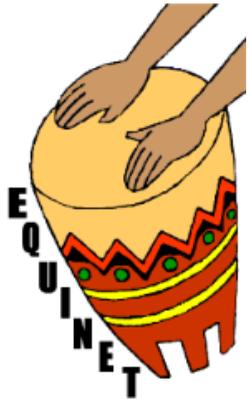
Keywords: Southern Africa, state, health, class, race, gender

Location: TARSC Library

Pages: 15pp.

Abstract: In Africa the literature specifically linking the state, class and the allocation of health resources is sparse, and the evidential base for health research is





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inadequate and difficult to interpret. This paper looks at ways in which state, class and health may be related in Southern Africa. The region provides useful comparisons because of the starkness of the relationships between class, race, disease patterns and health care in much of the sub-continent; the different types of state and class structure and the changes in ideology and to some extent health practice which came with the political independence of some of its component parts. Using both historical and contemporary data, it pinpoints the importance of analyzing the specific and changing form of the state in the different countries of the region, in order to understand the social determinants of disease and the allocation of the health resources, and looks at the significance of class, race, ethnicity and gender in the incidence of health and the state's response. It highlights the specific colonial legacies, continuing imperial linkages and location of countries in the international division of labour which inhibit changes in health care. Within the region, the migrant labour system and South Africa's aggressive policies of destabilisation create particular problems for weak states and for individuals within them attempting to implement more progressive health care programmes. The paper also argues that the ideological role played by health has to be understood, and shows the diverse uses to which it is put across the region. The paper concludes that the position of the state in the international and regional economy, its specific form and the nature of its class relations are predictors to some extent of health and health care. The specificities of internal social dynamics, local class ethnic and gender struggles and political conflicts are however also crucial.





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3.3.4

Authors: Andersson N.

Title: Tuberculosis and social stratification in South Africa.

Publisher: International Journal of Health Services. 20(1):141-65

Year: 1990

Country: South Africa

Keywords: TB, South Africa, distribution

Location: U.Z. Medical Library

Pages: 24pp.

Abstract: Tuberculosis (TB) continues to be a barometer of poverty, determined by racial classification, in both town and countryside in the Republic of South Africa. Despite the fact that whites with the disease stand a greater chance of being diagnosed than their black counterparts, because they have very much better access to health care, the risks of TB for people classified by the state as black and coloured are 27 and 16 times, respectively, the risk for whites. Black gold miners also have increased TB rates. The risks of TB have increased over recent years among coloureds and blacks. Rates of tuberculous meningitis have also increased over the past decade, and show the dramatically worse health care available to people classified as black and coloured. Although about 60,000 new TB cases are reported in the country each year, there have been cutbacks in the resources available for TB control and treatment.

3.3.5

Authors: Arblaster L, Lambert M, Entwistle V, Forster M, Fullerton D, Sheldon T and Watt I

Title: A systematic review of the effectiveness of health service interventions aimed at reducing inequalities in health





3.3 EQUITY IN HEALTH CARE AND HEALTH CARE

Publisher: Journal of Health Services Research and Policy 1(2): 93-103

Year: 1996

Country: General

Keywords: Health care, health inequalities, health interventions

Location: TARSC Library

Pages: 10pp

Abstract: The paper reviews the literature to identify interventions which health services alone or in collaboration with other agencies to have reduced inequalities in health. The literature was undertaken using a number of databases including Medline (from 1990), Applied Social Science Index and Abstracts (1987-1994), and the System for Information on Grey Literature in Europe (1984-1994). Ninety-four (94) studies were identified which satisfied all the inclusion criteria and 21 reviews were included. Interventions aimed at improving the health of groups disadvantaged by socio-economic class, ethnicity or age can, if properly targeted, reduce health inequalities, depending on the characteristics of the programme. Characteristics of successful interventions specifically aimed at reducing health differentials include: systematic and intensive approaches to delivering effective health care; improvement in access and prompts to encourage the use of services; strategies employing a combination of interventions and involving a multi-disciplinary approach; ensuring interventions address the expressed or identified needs of the target population; and the involvement of peers in the delivery of interventions.

3.3.6

Author: **Betts G**

Title: Local Government and inequalities in health

Publisher: Avebury





3.3 EQUITY IN HEALTH CARE AND HEALTH CARE

Year: 19..?
Country: General
Keywords: Inequalities in health
Location: School of Social Work Library
Pages: 4pp.
Abstract: This book describes and analyses inequalities in health at a local level and the role local authorities play in health. On the basis of this analysis, it sets out a strategy that local authorities might adopt in order to reduce local inequalities in health, given their influence over the material and social environment at a local level.

3.3.7

Author: Bijlmakers L A, Bassett M T, Sanders D M
Title: Socio-economic stress, health and child nutritional status at a time of economic structural adjustment - a three year longitudinal study in Zimbabwe
Publisher: Uppsala: Nordiska Afrikainstitutet,
Year: 1996
Country: Zimbabwe
Keywords: health, structural adjustment, Zimbabwe
Location: TARSC Library
Pages:
Abstract:

3.3.8

Author: Bijlmakers L and Chihanga S
Title: District health service costs, resource adequacy and efficiency: a comparison of three districts





3.3 EQUITY IN HEALTH CARE AND HEALTH CARE

Publisher: Ministry of Health and Child Welfare, Zimbabwe
Year: 1996
Country: Zimbabwe
Keywords: District health services, health financing
Location: Ministry of Health and Child Welfare, Zimbabwe
Pages: 10pp.
Abstract:

3.3.9

Authors: Centre for Health Policy

Title: A complex problem: academic hospitals and the National Health System. 11
Publisher: Nursing RSA 9(1):24-5
Year: 1994
Country: South Africa
Keywords: Health care, hospitals
Location: UZ Medical Library
Pages: 2pp
Abstract:

3.3.10

Author: Curtis C

Title: Botswana: reaching out to a scattered population
Publisher: People 15(2)
Year: 1988
Country: Botswana
Keywords: Botswana, health services, delivery of health care, family planning programs,





3.3 EQUITY IN HEALTH CARE AND HEALTH CARE



Location: population policy, social policy, adolescent pregnancy, state of the art. National Institute of Development Research and Documentation

Pages: 3pp.

Abstract: Diamonds and cattle combine to make Botswana's economy the soundest in Africa. Its foreign reserves are comparable to those of Saudi Arabia and, in a country roughly the size of France, there are just over a million people. But 3/4 of the land is the sand and scrub of the Kalahari. A rapidly rising population, most of it squeezed into the more fertile eastern belt, has alerted the Government to set about preparing a national population policy. Botswana's government has identified teenage pregnancy as a severe and growing problem. Government alarm over teenage pregnancy was aroused in 1984 when the Botswana Family Health Survey showed that nearly 1/4 of 15-19 year old girls were already mothers. Basarwa families were very reliant on their health clinics. The health condition of the Basarwa on the farms was described as abject and pathetic. A large-scale rehabilitation project aims at developing and integrating the Basarwa and other remote area dwellers into Botswana society. Leaders of family planning clinics look back regretfully that men were not involved in family planning from the start.

3.3.11

Author: Decosas J and Whiteside A

Title: The effect of HIV on health care in sub-Saharan Africa

Publisher: Development Southern Africa 13(1): 89-100

Year: 1996

Country: Southern Africa

Keywords: HIV/AIDS, health care, Southern Africa

Location: TARSC Library



3.3 EQUITY IN HEALTH CARE AND HEALTH CARE



Pages: 11

Abstract: This paper examines the effect of HIV on the delivery of health care in sub-Saharan Africa. The task is hampered by a lack of data. In most countries there have been no sentinel HIV surveys, and thus no clear idea of the magnitude of the epidemic. However, it is certain that HIV will alter the demand for health care, and the supply and quality of services. Demand will grow as infected adults and children seek care. Most HIV-related illness is found in people who would not normally require care, therefore creating additional demand. Demand for care will also be determined by the availability and accessibility of services. Ironically, the middle-income countries may face higher bills and in this sense the economic effect of the HIV epidemic may be worse in the more developed countries. The supply of services will be affected by increased morbidity and mortality among health care workers as is already happening. The generous terms and conditions of service that most governments offer to workers in the public sector will increase costs. HIV has served to improve the quality of health care in most of the developed world. Patients have sought to take control over their own care, and staff have been more rigorous in taking universal precautions. But in developing countries external aid often determines how health care is organised, and money spent on AIDS is diverted from other areas. This may also be true of local funding. The effect of HIV on health care is lamentably under-researched. This is particularly worrying as the effects of HIV will be felt first by the health care sector. The problem must be confronted urgently from the point of view of the suppliers of health care services, the users and the policy-makers.



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3.3.12

Author: Doherty J, McIntyre D, Bloom G

Title: Value for money in South African health care: findings of a review of health expenditure and finance

Publisher: Department of Community Health Medical School, University of the Witwatersrand

Source: Central African Journal of Medicine 42(1): 21-4, January

Year: 1996

Country: South Africa

Local

messages: UZ Medical Library

Pages: 3pp.

Abstract: This article highlights the findings of a review of health expenditure and finance in South Africa in 1992/3. The paper discusses the level of national expenditure on health care and the distribution of resources between the public and private sectors, the maladministration of financial, physical and human resources on a geographic basis, racially and between levels of care, and the cost of redressing inequities, at least at the primary care level, given the additional sources of finance. The paper notes that those living in poor areas clearly have much less access to public health services than those living elsewhere; that additional capital and recurrent funds will be needed to build community hospitals and to develop specialist services in undeserved areas, and to integrate and decentralise administrators; that the extension of private sector care to a greater proportion of the population is a potential strategy for improving access to services; and that donor support will be important in financing the high costs of transition, especially for the development of infrastructure. The reprioritisation of health services and the process of structural change need to be comprehensively planned. Piece-meal



3.3 EQUITY IN HEALTH CARE AND HEALTH CARE



planning could impede the establishment of effective services in poor areas and damage staff morale. Planning should occur primarily at provincial and district levels, including the formulation of a building plan, a strategy for improving and expanding primary services rapidly, and a strategy for making better use of the available resources, especially in hospitals.

3.3.13

Authors: Ettling M. McFarland DA. Schultz LJ. Chitsulo L.

Title: Economic impact of malaria in Malawian households.

Publisher: Tropical Medicine & Parasitology. 45(1): 74-9, 1994 Mar.

Year: 1994

Country: Malawi

Keywords: Malaria, Malawi, Household spending

Location: Unknown

Pages: 5pp

Abstract: Household heads were questioned about household income and household expenditures on the treatment or prevention of malaria in a nationwide malaria knowledge, attitudes, and practices (KAP) survey conducted in Malawi in 1992. Very low income households with an average annual income of \$68 constituted 52% of the sampled households. The primary income source for these households was farm production (92%), with the majority of goods produced consumed by the household and not available as discretionary income. Expenditure on malaria prevention varied with household income level. Only 4% of very low income households spent resources on malaria preventive measures compared to 16% of other households. In contrast, over 40% of all households, independent of income level, reported expenditures on malaria treatment. Almost half of the reported



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malaria cases sought treatment at a health facility at a cost of \$0.21 per child case and \$0.63 per adult case. The overall direct expenditure on treatment of malaria illness in household members was \$19.13 per year (28% of annual income) among very low income households and \$19.84 per year (2% of annual income) among low to high income households. The indirect cost of malaria, calculated on the basis of days of work lost, was \$2.13 per year (3.1% of annual income) among very low income households and \$20.61 per year (2.2% of annual income) among low to high income households. Very low income households carried a disproportionate share of the economic burden of malaria, with total direct and indirect cost of malaria among these households consuming 32% of annual household income compared to 4.2% among households in the low to high income categories.

3.3.14

Author: Gaisie K; Cross R A; Nsemukila G

Title: Zambia Demographic and Health Survey 1992

Publisher: Government of Zambia

Year: 1993

Country: Zambia

Keywords: Health status, demography

Location: WHO

Pages: Unknown

Abstract: This report summarises the findings of a University of Zambia study of women of reproductive age designed to provide, among other things, information on fertility, family planning, child survival and health of children.





3.3 EQUITY IN HEALTH CARE AND HEALTH CARE

3.3.15

Author: Gillies P, Tolley K and Wolstenholme J

Publisher: AIDS Care (8)3

Year: 1996

Country: General

Keywords: HIV/AIDS; Development; Poverty; Equity; Inequality

Location: SAfAIDS

Pages: 351-363

Abstract: This paper considers the evidence for AIDS as a disease of poverty. It describes the influence of the social and economic context of HIV/AIDS and of those behaviours associated with HIV transmission, and urges for a shift in emphasis in the conceptualisation of the 'AIDS problem'. The relationship between poverty and AIDS is explored, particularly in relation to global economic development, urbanisation, homelessness and the disintegration of neighbourhood, migration and systems of labour and production. AIDS is related to urbanisation, particularly homelessness, industrial developments and rural to urban migration; the system of migrant labour and production; the breakdown of social networks within neighbourhoods making individuals particularly to HIV. Examples of socially driven community-based responses to the prevention and control of HIV epidemic in diverse cultures are discussed and the need for new outcome measures for assessing community initiatives is proposed.

3.3.16

Author: Haddad S, Fourier P

Title: Quality, cost and utilisation of health services in developing countries. A longitudinal study in Zaire





3.3 EQUITY IN HEALTH CARE AND HEALTH CARE



Publisher: Social Science and Medicine 40(6): 743-53

Year: 1995

Country: General

Keywords: Health services, cost, utilisation

Location: UZ Medical School

Abstract: Many developing countries, particularly in Africa, have recently introduced payment schedules based on the selling of essential drugs. This is one of the main elements of the Bamako Initiative according to which the income generated would ensure a reliable supply of drugs and would improve other aspects of the quality of the services offered. Thus, quality improvements would compensate for the financial barrier and as a result the utilisation of public health services would be increased or at least maintained. These hypotheses have proven to be partially valid, since there have been cases where the utilisation of health services has increased and other where it has decreased, these inconclusive results have fuelled criticisms concerning the inequitable nature of these measures. This longitudinal study in a rural community of Zaire shows that the utilisation of health services had diminished by close to 40% over 5 years (1987-1991) and that 18-32% of this decrease is explained by cost. The regular supply of drugs and the improvement in the technical quality of the services - technical qualification of the staff, allocation of microscopes, and renovation of the infrastructures - was not enough to compensate for the additional financial barriers created by the increased cost of services. However, on a local level, the interpersonal qualities displayed by some of the nurses sometimes helped to compensate for the negative effects of the costs, and even to increase the level of utilisation of some health centres. The quality of public services has often been neglected in developing countries. While some attention is given to technical qualities, the interpersonal components of the



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quality of the services are generally ignored or underestimated by planners and they are the very components which are most resistant to change. It will be a major challenge for health systems to address this issue of quality of care in order to minimise the negative impact of the introduction of user payment schemes. Therefore, now is the time to place quality next to coverage in planner's agendas.

3.3.17

Authors: Hamel J

Title: Survey on public health care in Zimbabwe

Publisher: Harare; Cemebo 1991

Year: 1991

Country: Zimbabwe

Keywords: Health survey, health services, health policy, Zimbabwe

Location: Unknown

Pages: Unknown

Abstract: This report presents the results of a study commissioned by Cebemo to enable it to formulate its policy on future assistance to the (Catholic) church health services. The report contains a description and analysis of the organisation and functioning of the Zimbabwe Public Health System and the Church Health services that are described as complementary to the public health systems.

3.3.18

Author: Health Systems Trust

Title: South African Health Review

Publisher: Henry J Kaiser Family Foundation

Year: 1995





3.3 EQUITY IN HEALTH CARE AND HEALTH CARE

Country: South Africa
Keywords: Health systems, research
Location: Centre for Health Policy South Africa
Pages: 237pp.
Abstract: Provides an annual review of health in South Africa covering; imperatives for health systems reform; health systems reform in South Africa; priorities of the Ministry of Health; an agenda for policy-directed research.

3.3.19

Author: Health Systems Trust
Title: South African Health Review
Publisher: Henry J Kaiser Family Foundation
Year: 1996
Country: South Africa
Keywords: Health systems, research
Location: Centre for Health Policy South Africa
Pages: 230pp.
Abstract: Provides an annual review of health in South Africa covering; imperatives for health systems reform; health systems reform in South Africa; priorities of the Ministry of Health.

3.3.20

Author: Health Systems Trust
Title: South African Health Review
Publisher: Henry J Kaiser Family Foundation
Year: 1997





3.3 EQUITY IN HEALTH CARE AND HEALTH CARE

Country: South Africa
Keywords: Health systems, research
Location: Centre for Health Policy South Africa
Pages: 248pp.
Abstract: Provides an annual review of health in South Africa covering; the broad picture; health status and determinants; health and development; legislation; private sector; provincial restructuring; local government restructuring; hospital restructuring; financing and expenditure; human resources; drug policy; health information systems; research upgrading health facilities; community involvement in health; health and the media; maternal, child and women's health; mental health; oral health; occupational health; disability HIV/AIDS; tuberculosis; sexually transmitted diseases; nutrition; injury and trauma; tables of health and related indicators.

3.3.21

Authors: Hirschowitz R, Orkin M

Title: A National household survey of health inequalities in South Africa: Overview Report

Publisher: Community Agency for Social Enquiry (CASE)

Year: 1995

Country: South Africa

Keywords: Health survey, inequalities in health

Location: TARSC Library

Pages: 29pp.

Abstract: This report presents a survey of different population groups in South Africa. The findings indicate that the black population are significantly worse compared to





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3.3.22

Authors: Hogh B, Petersen E

Title: The basic health care system in Botswana: a case study of the distribution and cost in the period 1973-1979

Publisher: Social Science and Medicine 19(8)

Year: 1984

Country: Botswana

Keywords: Botswana, adolescence, child, health

Location: National Institute of Development Research and Documentation

Pages: 6pp.

Abstract: Since 1973, Botswana has developed its basic health services with an extensive network of clinics and health posts staffed with nurses, health assistants and Family Welfare Educators (11 weeks in preventive medicine). In 1977 it was estimated that 80% of the population lived within 15km of either a health post or a clinic. In the study period the annual number of new registered outpatient diagnosis per inhabitant increased from 0.65% to 1.50, but even the heavy investment in the rural areas the annual number of visits per rural inhabitant, was in 1979, 0.8 compared to 2.8 in the urban areas. In 1979 the per capita health expenditure was US+18.7, of which the basic health service accounted for US+8.8. The relationship between Botswana's basic health service and a primary health care system as described in the Declaration of Alma Ata is discussed.



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3.3.23

Authors: Jelley D, Madeley RJ.

Title: Primary health care in practice: a study in Mozambique.

Publisher: Social Science & Medicine. 19(8): 773-82

Year: 1984

Country: Mozambique

Keywords: Primary health care, health workers

Location: Unknown

Pages: 9pp.

Abstract: This study investigates the delivery of all aspects of Primary Health Care (PHC) in a case study of one urban health centre in Maputo, Mozambique. Within the context of overall social and economic change, Mozambique has given priority to primary health care as the driving force in its newly developed National Health Service. The urban and rural health centres are intended to be the principal vehicles for PHC delivery, and in this study one of Maputo's recently opened health centres was investigated by observing all clinic sessions, interviewing all health centre workers and collecting data from health centre records. It was found that a dichotomy exists between the tasks ascribed to the health centre in the PHC framework, and the feasibility of their execution given existing personnel and material resources. This derives in part from lack of involvement of PHC practitioners in the organisation and planning of PHC, plus resource allocation which remains in favour of secondary and tertiary rather than primary care. Prevention is accorded priority in PHC theory, yet investigation showed that the major demand on the health centre is for curative care. The quality of both curative and preventive care was evaluated on the need for training in specialist diagnostic skills, and a more socially-based understanding of the determinants of health status and risk.



3.3 EQUITY IN HEALTH CARE AND HEALTH CARE

3.3.24

Author: Jhamba T

Title: Mortality determinants in Zimbabwe: a policy implications

Publisher: University of Zimbabwe Sociology Department

Year: 1994

Location: SAfAIDS

Pages: 24pp.

Country: Zimbabwe

Keywords: Mortality; Zimbabwe

Abstract: This paper presents a view of available data on mortality in Zimbabwe including; infant and child mortality, maternal mortality and general adult mortality. The risks of maternal mortality vary being generally high for very young women, women over age 35 years, women in their first pregnancy or in the fifth or higher pregnancies, women with pre-existing health problems, poor, malnourished, and uneducated women. Women without easy access to adequate health care are also at relatively high risk of maternal mortality. Differences in infant and child mortality reflect differences in the distribution of resources (income, food), the social attributes of the parents (education, beliefs and norms), the availability of amenities such as water supply and sanitation, access to health services and the physical environmental conditions. They also reflect differences in skills and knowledge of the promotion of health and prevention and treatment of diseases. The diversity of determinants of mortality indicate that reducing mortality requires a multi-sectoral development approach, that socio-economic and political inputs at the national, regional, household and individual levels.





3.3 EQUITY IN HEALTH CARE AND HEALTH CARE

3.3.25

Authors: Kahn K and Tollman S

Title: Political transition, health service reform and COPC in South Africa

Publisher: COPACETIC Vol 2 (2)

Year: 1995

Country: South Africa

Keywords: South Africa; Health service reform; Primary health care

Location: UZ Medical Library

Pages: 7pp.

Abstract: The article traces the origin and development of COPC from 1940 to the present period. The formation of COPC which led to the establishment of a health centre in Pholela, an under-developed and poor African community in rural KwaZulu-Natal was a first and important step in the South African government's efforts to seriously address the great and unresolved rural health problem. The Government of National Unity has opened the door for profound health service reform in line with the approach used to address the anomalies in the health care system left by the apartheid era. The first wave of health reform rightly focuses on equity and access to care. The article further reviews some of the features of the COPC approach in light of the South African situation as it stands at the present.

3.3.26

Author: Kalumba K

Title: Towards an equity-oriented policy of decentralisation in health systems under conditions of turbulence: The case of Zambia Discussion Paper No. 6

Publisher: World Health Organisation

Year: 1997





3.3 EQUITY IN HEALTH CARE AND HEALTH CARE

Country: Zambia

Keywords: Equity; health sector reform; health transition; health policy; monitoring and implementation; financing the reforms.

Location: WHO

Pages: 47pp.

Abstract: This paper looks at health policy and practice in Zambia. It reviews the influence of international trends and the local environment on the direction of health policy, discusses the design and implementation of Zambia's 1991 health sector reforms and outlines future developments in Zambia's health system. The report notes that under conditions of macro-economic instability, social interests play an important role in influencing the pattern of state intervention and health policies. Past attempts at institutional reforms of health systems in countries like Zambia have led to increased bureaucracy and centralisation of health care, associated with a crisis of health policy, and bureaucratic incompetence. Equity has been a desired principle in many reform efforts. However, the organisation of the public sector medical systems have been built on the logic of hierarchical state administration, which is not designed in a way that promotes achievement of equity. The struggle over health care in Zambia is a struggle for democratic empowerment. The current reforms should serve the health needs of the majority through technologies or approaches that reflect their needs, and their own participation.

3.3.27

Authors: Kanji N. Harpham T.

Title: From chronic emergency to development: an analysis of the health of the urban poor in Luanda, Angola.

Publisher: International Journal of Health Services. 22(2): 349-63, 1992.





3.3 EQUITY IN HEALTH CARE AND HEALTH CARE

Year: 1992
Keywords: Urban health, war, Angola
Country: Angola
Location: U.Z. Medical Library
Pages: 14pp.
Abstract: There is a dearth of published literature on health care systems in Angola. Like many sub-Saharan African countries, Angola is experiencing rapid urbanization. The authors provide an analysis of the health status, environmental health conditions, and health-related behaviour of the urban poor in Luanda, Angola. Although data are patchy and rarely disaggregated to reveal severe conditions in the shanty towns, a grave picture emerges. An average infant mortality rate of 104/1,000, with malaria and intestinal infections the main causes of death in children under 1 year old, reflects the poor environmental conditions, which are worsening as urbanization continues at a rapid rate. Use of health services is limited; for example, 50 percent of women give birth at home, mainly unassisted, and only 28 percent of children are covered by measles immunization (as validated by card). A discussion of existing health strategies, programs, and their constraints is set in the context of the future possibilities of the ending of the 15-year war and the introduction of structural adjustment policies.

3.3.28

Author: Kanji N, Harpham T
Title: After the war: Prospects for the health of the in Luanda, Angola
Publisher: GeoJournal 26(1)
Year: 1992
Country: Angola





3.3 EQUITY IN HEALTH CARE AND HEALTH CARE



Keywords: war; health; Angola; equity
Location: SARDC Library
Pages: 6pp.
Abstract:

3.3.29

Author: Krige D

Title: The basic needs approach to development: the question of health care for black people in Natal

Publisher: University of Natal

Year: 1990

Country: South Africa

Keywords: Basic needs, health care

Location: ZIDS

Pages: 12pp.

Abstract: Health care is an important facet of the basic needs approach. Health care for black people in Natal is fragmented both with regard to the responsible authority (Department of National Health and Population Development, Natal Provincial Administration, Development Services Board, local authorities and welfare clinics) and spatially (since there is an overlap with KwaZulu health services). Access to health facilities (permanent and mobile), although adequate in some areas, is insufficient in others: the deficiency is most marked in rural areas and with regard to permanent health facilities. Crucial statistical data pertaining to health status are inadequate partly because of the aforementioned fragmentation and partly because they are collected for administrative rather monitoring purposes. Questions are posed regarding future access to health care in the light to the new



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constitutional dispensation, privatisation and the inadequate attention being given to primary health care.

3.3.30

Author: Lennock J

Title: Paying for health: Poverty and structural adjustment in Zimbabwe

Publisher: Oxfam Publications

Year: 1994

Country: Zimbabwe

Keywords: Health; Poverty; Structural adjustment; Zimbabwe

Location: OXFAM

Pages: 35pp.

Abstract: Zimbabwe made impressive progress in health-care in the years following independence in 1980. Life expectancy increased to 60 years, immunisation programmes were extended to cover over 80 per cent of the population, and by 1989 infant mortality rates had fallen to 46 per 1000 live births. These achievements prompted a recent UNICEF report to describe Zimbabwe as a beacon for progress towards child survival and development in Sub-Saharan Africa. By contrast with the rest of sub-Saharan Africa, Zimbabwe's health status indicators compare favourably with those of countries in other developing regions, including those with higher income levels. Today however, the achievements of Zimbabwe's post independence health policies are under threat. The resources available for investment in the social sector have been reduced, and the welfare of poor people undermined, by a combination of factors; slow growth during the 1980s, a crippling economic down-turn caused by drought in 1992, and the budgetary constraints imposed by a structural adjustment programme (SAP)



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administered under the auspices of the World Bank and the International Monetary Fund (IMF). Expenditure per capita on health and education has fallen steeply, eroding the quality of provision in both areas. The introduction of user fees-initially on the recommendation of the World Bank - as a mechanism for meeting targets to reduce the fiscal deficit has excluded poor people from the health system, with increasing inequities within the health system, and high costs of administering user-fees. The exemption system ostensibly designed to protect the poor, has failed to do so effectively, because it suffers from poor design and implementation. This suggests that more effective mechanisms for protecting the poor should be built into adjustment programmes.

3.3.31

Author: Lesotho Ministry of Health

Title: 1993 National coverage survey on ARI/CDD/EPI/MHC/FP

Publisher: Ministry of Health and Social Welfare - Lesotho

Year: 1993

Pages: 10pp.

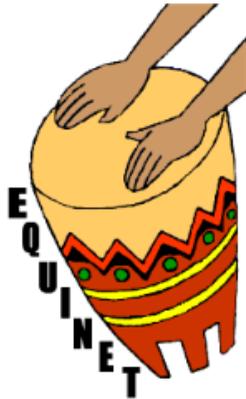
Location: SARDC

Country: Lesotho

Keywords: Lesotho, primary health care coverage

Abstract: An external evaluation of Maternal and Child Health programmes in Lesotho found that more than half the children with ARI problems are treated at home using over the counter drugs and traditional herbs. Treatment is initiated too late, after two or more days, for a large number of children, irrespective of the severity of the disease. This delaying practice predisposes children to premature deaths due to pneumonia, the major cause of infant deaths in Lesotho. Only a few health





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facilities were equipped with oral rehydration for diarrhoeal diseases and some of the health staff do not know the management and treatment of dehydration in children, and the correct recipes for preparing salt, sugar solution (SSS). Most children were managed at home using SSS, ORS or other home made fluids, but most mothers and caretakers could not give the correct recipes for these preparations, due to inadequate health education at clinics. The coverage of full immunisation increased from 67% and 1990 to 71% in 1993 with limits to coverage rates arising in management problems within the health systems. Teenage and above 35 year old, high risk pregnancies are common. Gestational age at first attendance of antenatal care is late and knowledge of advantages of tetanus toxoid vaccinations during pregnancy is low. 45% of the mothers attend post-natal care, with a significant number of home deliveries conducted by untrained people and a misconception among mothers that PNC is not useful.

3.3.32

Authors: Lewis M A, Miller T R

Title: Public-private partnership in water supply and sanitation in Sub-Saharan Africa

Publisher: Health Policy Planning 2(1)

Year: 1987

Country: General

Keywords: Kenya, water supplies, health providers

Location: National Institute of Development Research and Documentation

Pages: 1pp.

Abstract: Concerned about the provision of a public water supply and sanitation services in developing countries, with special reference to Africa, this paper explores the questions of who delivers such services, the extent to which the private sector is





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involved, the strengths and weaknesses of existing patterns of service delivery, and alternative means of improving service delivery cost, efficiency, and effectiveness, especially through public-private partnerships. Most water systems in the developing world are built and operated by public entities which are plagued with overcentralisation and politicisation as well as poor management. As in most developing nations, central governments in Africa like to be involved in the operations of water authorities, to set policy for them, and to use them as tools for political ends, with problems of maintaining the system of tariff issues and efficient operations. Some of the managerial problems stem from central government interference in what is best handled by municipalities. Approaches to public-private partnerships in the Ivory Coast, Botswana and Kenya are reviewed.

3.3.33

Author: Loewenson R

Title: The health status of labour communities in Zimbabwe: an argument for equity

Publisher: University of London

Year: 1984

Country: Zimbabwe

Keywords: Health, labour, health care

Abstract: The organisation production are analysed in Zimbabwe within the commercial farming, mining and urban sectors, with major factors identified as: i. the extent and distribution of local and foreign ownership of productive assets. ii. the orientation of sector production towards external markets. iii. the extent of low wage and insecure employment, and iv. the structure and extent of labour organisation and political representation. The historical analysis shows that by 1980, commercial farm labour was in the worst position politically and





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economically followed by mine labour and then urban workers. In the absence of any published, coherent assessment of the relative health status of these groups, an epidemiological study was carried out in 1981/2 Mashonaland Central, to test the hypothesis that the inequalities in economic and political status indicated above would be reflected in corresponding inequalities in health status. The results indicated that with respect to the nutritional, dietary, environmental, socio-economic and service factors assessed, commercial farm labour had the poorest health status and conditions, with improving status in mine and then urban labour groups. Decreasing levels of labour organisation, political representation and supportive legislation from urban to mine to commercial farm labour are noted, indicating the decreasing potential of the respective labour group to control the material factors affecting their health. The final section explores the policy implications of the findings within the economic and social policy of Zimbabwe since Independence in 1980.

3.3.34

Authors: Loewenson R. Sanders D. Davies R.

Title: Challenges to equity in health and health care: a Zimbabwean case study.

Publisher: Social Science & Medicine. 32(10): 1079-88, 1991.

Year: 1991

Country: Zimbabwe

Keywords: Equity, health care, Zimbabwe

Location: TARSC Library

Pages: 9pp.

Abstract: The current economic crisis in Africa has posed a serious challenge to policies of comprehensive and equitable health care. This paper examines the extent to which





3.3 EQUITY IN HEALTH CARE AND HEALTH CARE

the Zimbabwe government has achieved the policy of “Equity in Health” it adopted at independence in 1980, or provision of health care according to need. The paper identifies groups with the highest level of health needs in terms of both health status and economic factors which increase the risk of ill health. It describes a series of changes within the health sector in support of resource redistribution towards health needs, including a shift in the budget allocation towards preventive care, expansion of rural infrastructures, increased coverage of primary health care, introduction of free health services for those earning below Z\$150 a month in 1980, increased manpower deployment in the public sector and the reorientation of medical training towards the health needs of the majority. The implementation of equity policies in health have however been challenged by several trends and features of the health care system, these becoming more pronounced in the economic stagnation period after 1984. These include the reduction in allocations to local authorities, increasing the pressure for fees, the static nominal level of the free health care limit despite inflation, the continued concentration of financial, higher cost manpower and other resources within urban, central and private sector health care and the lack of effective functioning of the referral system, with high cost central quaternary facilities being used as primary or secondary level care by nearby urban residents. While primary health care expansion has clearly been one of the success stories of Zimbabwe’s health care post 1980, the paper notes plateauing coverage, with evidence of lack of coverage in more high risk, socio-economically marginal communities. Measures to address these continuing inequalities are discussed. Their implementation is seen to be dependent on increasing the capacity and organisation of the poor to more strongly influence policy and resource distribution in the health sector.





3.3 EQUITY IN HEALTH CARE AND HEALTH CARE

3.3.35

Author: Loewenson R, Chisvo M

Title: Transforming social development: the experience of Zimbabwe

Publisher: UNICEF

Year: 1994

Country: Zimbabwe

Keywords: Social development, health, education, Zimbabwe

Location: TARSC Library

Pages: 30pp

Abstract: This document outlines the trends in social development, including health, food security, education, population and women's status, from before independence into the 1990s. Positive changes after 1980 are noted with respect to infant and child mortality, reduced in child morbidity from malaria, measles in maternal mortality and areas of adult morbidity. One of the most sustained improvements after 1980 described in paper is that of nutrition. From a situation of wide differentials in nutritional status between income groups, urban and rural, and between different economic sectors pre-1980, there was an absolute reduction in acute and general under-nutrition and in the differential between groups. In all the social sectors the 1980's are noted to have encouraged and developed policies of community participation levered by state resources and organised/supported through state structures. The paper shows that social investments can be made as specific public policy decisions, even under stagnant/low growth. The paper suggest that one of the most negative impacts of the 1990s has been the weakening of the complementarity between the state and households in meeting health needs.





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3.3.36

Author: Loewenson R

Title: Policies for health and Development

Publisher: Dag Hammerskold Foundation

Year: 1997

Country: Zimbabwe

Keywords: Health policy development

Location: TARSC Library

Pages: 19pp.

Abstract: Globally and in Southern Africa, the majority of ill health is due to preventable communicable diseases, adequate knowledge exists to prevent such diseases and the per capita resources exist to implement this technical knowledge. The paper explores why such diseases continue to exact such an enormous toll in the region. Poverty is noted as the most significant cause of ill health and under-development. Over the past 15 years the world has seen spectacular economic advance for some countries, while for others, particularly in Sub-Saharan Africa and Latin America, there has also been unprecedented decline. A relatively constant half or more of the people in SADC countries live in poverty, even under conditions of GDP growth, signalling a need to examine the **distribution** of these resources towards the health and development of the poorest. Within this context, the author argues that health and development policies that create a basis for sustainable improvement in the health of the regions population need to consider the constitutional right to health; that health, as part of human development, is an essential objective of economic policy; that investing in health, as part of investment in human capability, is an essential *contributor* to economic growth and development and the issue of health being a function of participatory democracy.



3.3 EQUITY IN HEALTH CARE AND HEALTH CARE

3.3.37

Authors: Loewenson R, Saunders R

Title: Industrial Relations and Conditions in the public health sector

Publisher: Mimeo

Year: 1997

Country: Zimbabwe

Keywords: Public health, manpower, industrial relations

Location: TARSC library

Pages: 15pp.

Abstract: The paper explores the human resource situation in the health sector in Zimbabwe, noting the shortfalls in many categories of personnel, and the uneven distribution of personnel by level of care, between urban and rural areas and between private and public care. The real earnings of health workers have declined and their conditions of service worsened. This situation needs an effective industrial relations system to manage potential conflict, but the paper outlines a collective bargaining and dispute resolution system that exacerbates rather than manages potential areas of conflict.





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3.3.38

Authors: Margaret R, Gabr M

Title: Nutritional effects of structural adjustment in sub-Saharan Africa

Publisher: Oxford University Press

Year: Unknown

Country: Sub-Saharan Africa

Keywords: Sub-Saharan Africa; Nutrition; Structural adjustment programs; Policy reforms

Location: WHO

Pages: 33pp.

Abstract: This book presents a discussion of the major policy issues with regard to nutrition which have been evolving during the last decade. Although this is a policy book, it contains considerable original information in its report of major studies from industrialised and developing countries.

3.3.39

Author: Makombe K

Title: Primary health care in Southern Africa (Health Series 2)

Publisher: Southern Africa News Features

Year: 1992

Country: Southern Africa

Keywords: PHC, Southern Africa

Location: SARDC Library

Pages: 3pp.

Abstract: The paper focuses on the successes and failures made in primary health care (PHC) by SADC member states. While important strides have been made in SADC nations in the post independence era, AIDS, economic structural adjustment





3.3 EQUITY IN HEALTH CARE AND HEALTH CARE

programmes and drought proved to be serious setbacks to the achievements of PHC. This was particularly the case with Mozambique where the situation had been aggravated by the war. Malnutrition persisted as a major problem due to low household earnings and budget into and declining currencies have interrupted the coverage of PHC, led to increased costs and acute shortages of drugs in hospitals. Water systems in Tanzania have deteriorated both in urban and rural areas and 40-60 percent of rural children suffer from malnutrition and 20-30 percent of urban children. While Zimbabwe's "framework for economic reform" states that the government will continue to extend basic health and family planning services hospital fee increases, AIDS, low harvest yields shortages of food and water, has contributed to a deterioration health particularly for the low income groups.

3.3.40

Author: Makombe K

Title: AIDS in Southern Africa: Health series 4

Publisher: Southern African News Features

Year: 1994

Country: Southern Africa

Keywords: AIDS, health facilities, AIDS education, prevention

Location: SARDC

Pages: 3pp

Abstract: The feature looks at the impact of AIDS on health facilities in the region. It also looks at attempts at AIDS education, awareness, prevention and the effects of programmes to date. The rising number of people with AIDS in need of health care is putting a strain on the limited health facilities and comprising the quality of care. The epidemic has spread in Southern Africa at a time when many





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3.3.41

Author: Mhloyi M M

Title: Population and equity in health

Publisher: Prepared for the Dag Hammarskjold Foundation on Equity in Health: Policies for survival in Southern Africa, Kasane, Botswana, March 15-16

Year: 1997

Country: Southern Africa

Keywords: Equity in health; Fertility and health

Location: UZ Department of Sociology

Pages: 18pp.

Abstract: The paper analyses the relationship between population trends and economic development. High population growth undermines productive investment and consequently economic growth. However, increasing access to secure incomes, rather than high national economic growth per se, is linked to improvements in health and education with consequent fertility declines. The paper describes the populations of the Southern African region and the relationship between growth, fertility, mortality, migration and health. Populations of Southern Africa are still growing at fairly high levels, albeit with some significant fertility declines in





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3.3.42

Authors: Molutsi P P, Lauglo M

Title: Decentralisation and health systems performance: The Botswana Case Study

Publisher: DiS Centre for Partnership in Development

Year: Unknown

Country: Botswana

Keywords: Decentralisation, health care

Location: National Institute of Development Research and Documentation

Pages: 4pp.

Abstract: This study examined whether the transfer of the RHTs resulted in the expected benefits of decentralisation, and looked at the wider picture of decentralisation in Botswana. Decentralisation aimed to lead to transfer and more appropriate decision making at the local level. While the CEOs and matrons perceive an improvement in local level decision making, the CHIs have not. However, the DMOs noted less support from the MOH while the MOH expressed frustration over increased barriers to appropriate decision making regarding professional matters after the transfer. Lack of appropriate technical access for the MOH to PHC





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operations, inadequate technical support, and unclear leadership of senior health managers are areas identified as needing attention. The paper explored whether the RHT transfer has led to an improvement in the quality of PHC services, but could not assess whether RHT transfer led to an overall improvement in the quality of PHC services as it is not possible to disentangle the effects of other changes in the system. Accessibility to PHC services has increased since 1986 in that more facilities were built in remote areas. Most service users were unaware of the transfer so we were unable to ask whether they thought services were delivered in a more appropriate manner. One complaint which was generally expressed and recognised by the community, local authority officers, and central government staff was in the area of indifferent or rude treatment of patients by clinic staff. One benefit was to provide one hierarchy for health personnel at the local level thus solving what were viewed as conflicting lines of supervision and accountability, still lingering instances of resentment and conflict. The transfer however, led a weakened link for the MOH with the local councils in the areas of surveillance. It was hoped that 'decentralisation' would help councils set their own priorities. There was little evidence of health sector planning and priority setting (other than for capital investment). Hampered by the lack of good health systems, districts seemed to plan activities around the availability of staff and previous activities. This underlines the need to strengthen management skills of health managers and to orient non-health council officers to the linkages between health and other sectors. While greater decentralisation is expected to lead to increased community participation, it did not, calling for an urgent need to reassess the meaning of community participation, the constraints on it, and ways to enhance it. Council committees were dominated by bureaucrats and professionals and the general public is uninvolved in the running of health services. Concrete and





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systematic efforts to translate community participation into local influence on matters relating to health would facilitate decentralisation and serve the intent of the PHC strategy but decentralisation of decision making at the local level can fragment national policy goals, such as of equity.

3.3.43

Author: Moyo I; Hlangabeza T B, Ndlovu F, Dhlamani T, Khumalo T D, Ncube T N, Masocha M, Ndebele P L, Mlotshwa M P

Title: Report of a study into factors affecting staffing level of health institutions in Matabeleland North.

Publisher: Report

Year: Unknown

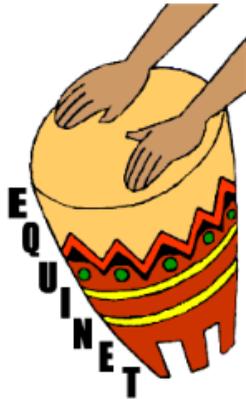
Country: Zimbabwe

Keywords: Health care, manpower

Location: Ministry of Health and Child Welfare, Zimbabwe

Pages: Unknown

Abstract: There has been a reasonable expansion in Health Care Services infrastructure in Matabeleland North Province since 1980 with very little increase in the staffing levels. It is observed that there is reluctance amongst health workers to work in rural areas. This study analysed staffing levels and investigated factors affecting staffing levels. Staffing levels were investigated in relation to existing approved establishment. About 77% of the establishment nursing posts and 50% of doctors posts were filled. It has been found also that there is need to expand the current establishment, to meet the projected criteria of 1983 manpower projections. A descriptive study was carried out into aspects of conditions of service and social environment affecting health workers attitude to working in rural areas. It was



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found that conditions of service were generally poor especially more in rural areas than urban areas. It was found that health services in both urban and rural areas were unsatisfactory, with drugs and equipment are in short supply.

3.3.44

Author: Muchando P T G

Title: Politico-socio economic impact of HIV/STD/AIDS on the individual, family and society

Publisher: Unknown

Year: 199?

Country: Zimbabwe

Location: SAfAIDS

Pages: Unknown

Abstract: The book summarises the social, economic and political effect of AIDS on the people of Zimbabwe, and details on how AIDS affects individuals and society. Increased infant mortality due to AIDS has resulted in the erosion of the successes of the child survival programmes in the past decade. AIDS is resulting in a significant loss in the workforce, a massive resurgence of tuberculosis, premature death of both parents and orphans. These situations result in complex social problems, overcrowded hospital wards and straining the inadequate resources of Ministries of Health. AIDS is more than a medical problem. It is a social and economic problem which demands a multi-sectoral response.

3.3.45

Author: Mugwetsi T, Balleis S J

Title: The Forgotten People: The Living and Health Conditions of Farm workers and their families



3.3 EQUITY IN HEALTH CARE AND HEALTH CARE

Publisher: Mambo Press

Year: 1994

Country: Zimbabwe

Keywords: Health, farmworkers, Zimbabwe

Location: School of Social Work, Zimbabwe

Pages: 60pp

Abstract: This booklet aims at making the plight of the farm workers and their families better known to the wider public. The booklet outlines, based on survey findings, the health nutrition, health care status of farmworkers and the economic living conditions underlying ill health. The report confirms earlier picture of poor health status in these communities.

3.3.46

Author: Msengezi T

Title: Health infrastructures in Southern Africa

Publisher: Special report

Year: 1992

Country: Southern Africa

Keywords: Health infrastructures, SADC

Location: SARDC Library

Pages: 4pp.

Abstract: The paper examines health infrastructures in SADC, the problems associated with lack of health facilities infrastructure and the impact of health financing on programmes and infrastructure. The distance a person has to travel to the nearest clinic of hospital affects a person's willingness to seek medical care. Where people walk long distances, cross rivers, pay bus fares etc people may prefer to visit





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3.3.47

Author: Mwanyisa G

Title: Equity in Health: The Zimbabwean experience

Publisher: Paper presented to the Equity in health policies for survival in Southern Africa Conference, Kasane - Botswana; 13-16 March

Year: 1997

Location: TARSC

Pages: 17pp.

Country: Zimbabwe

Keywords: Equity; health care; Zimbabwe

Abstract: The role of health as a determinant of the level of productivity that a nation can achieve, is a reason many nations invest in the health of their citizens. Each person has a right to an equal basic share in health resources of a country, quantitatively and qualitatively. Inequity typified the health care delivery system in Zimbabwe, with facilities and personnel concentrated in urban areas where the minority lived. Health services were provided as divided system with access to health care being characterised by inequalities based on race, geographic location and economic status.





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3.3.48

Authors: Myers J E, Pelteret R

Title: Conceptualising health services in terms of level and location of care - a view from the academic health complex

Publisher: South African Medical Journal 85(5):347;51 1995 May

Year: 1995

Country: South Africa

Location: UZ Medical Library

Pages: 4pp.

Abstract: The origin and characteristics of academic health complexes (AHCs) are briefly outlined, along with pressures for restructuring of health services towards primary levels of care within the primary health care (PHC) approach. Weaknesses and strengths of the PHCs together with imbalances in the overall health system of which they are part are discussed. The Cape Town PHC is used to exemplify a suggested framework for analysis and development of other PHCs in South Africa and their transformation in accordance with the PHC approach. A method of





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service mapping is employed to aid an appreciation of the complexity of PHC services. Planning for potential transformation may be facilitated by conceptualising services in two dimensions, viz: level and location of care. Two important additional dimensions of service component linkage are integration of levels of care along a vertical axis, and integration across different services at primary level along a horizontal axis (comprehensiveness). PHCs, however skewly developed in terms of level and location of care, are complex combinations of services. They encompass all levels of care provided both within and beyond the walls of multiple health care facilities which are located both centrally and peripherally. PHC services are managed by health professionals in specific academic disciplines. They include PHC functions at the interface between primary and specialist care provision, and community health functions which are principally located outside the health care facilities in the community.

3.3.49

Author: Ojermark M

Title: Rural/Urban differentials in Health in Zambia

Publisher: SIDA/Ministry of Health

Year: 1992

Country: Zambia

Keywords: Health status, Zambia

Location: Unknown

Pages: Unknown

Abstract:





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3.3.50

Author: Pan-American Health Organisation

Title: The search for equity

Publisher: PAHO

Year: 1995

Country: America

Keywords: Equity; health systems; health promotion

Location: WHO

Pages: 102pp.

Abstract: The report summarises the steps that have been taken by Pan American Organisation to ensure equity in the provision and access to health care services. It acknowledges the need to identify gaps in equity and access to ensure effective actions that target populations at greatest risk are programmed and implemented. Data gathered and studies and analysis conducted supplies invaluable information to political and strategic planning and management processes and to efforts to evaluate and redirect technical cooperation activities. These data also will inform technical cooperation activities directed at defining and formulating investment projects or special programs and effective disease prevention strategies. Further, the information will help mobilise financial resources, define research priorities, and provide data for periodic publications on monitoring the health situation and trends in the region. The paper notes that vast differences exist between countries in health expenditure. Poorer countries tend to invest a lower percentage of their GDP, and this trend tends to widen inequities in availability and accessibility to health care. The availability of medical care decreases in the groups of countries where the per capita GNP is lower. Inequities in the risk of becoming ill and dying prematurely correlate with inequities in the distribution of resources, as evidenced



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by the distribution of infant mortality for countries in the Region. The search for equity accepts the differences that are a fact of human existence, but seeks to put in place systems that recognise the essential and the needs of that humanity.

3.3.51

Author: Ransome-Kuti O

Title: When will sub-Saharan African countries have equitable National Health system

Publisher: Mimeo, Speech delivered at the Dag Hammerskjold Seminar on equity in Health, Botswana, 13-16 March

Year: 1997

Country: Southern Africa

Keywords: Equity; health financing, health services

Location: TARSC

Pages: 15pp.

Abstract: PHC is the most appropriate, cost effective health care system to ensure an equitable distribution of health resources, and a level of health for all citizens to lead a socially and economically productive life. Sub-Saharan countries identified eight components of primary health care to be delivered through National Health Systems in an integrated and comprehensive service. While primary health care projects have been developed throughout Africa, none have grown to become national systems. Existing health problems how co-exist with AIDS, calling for new strategies to combat them, health improvements have had an uneven pace. Problems in health systems, corruption, inequities, if not resolved, will hamper progress in reducing the burden of premature death and disability, and frustrate efforts to respond to new a major health challenges such as a AIDS, malaria and tuberculosis.



3.3 EQUITY IN HEALTH CARE AND HEALTH CARE

3.3.52

Author: Sanders D

Title: Equity in Health: Zimbabwe Nine years on.

Publisher: Journal of Social development in Africa vol 5 No. pp 5-22

Year: 1990

Country: Zimbabwe

Keywords: Health, structural adjustment, development

Location: TARSC Library

Pages: 17pp.

Abstract: This paper summarises Zimbabwe's legacy in both health (or disease) and health services. It then examines the changes in the economic environment which have taken place in Zimbabwe since independence in April 1980, concentrating on those which are relevant to health. It also describes the post independence restructuring of the health sector itself. Access to health care and some aspects of the functioning of the referral system are also briefly dealt with. The questions of community participation in health and accountability of health workers, both central to the Primary health care (PHC) approach, are addressed by a brief discussion of the Village health worker (VHW) programme. The relevance of this example for the health sector as a whole is briefly examined. Finally, the paper considers some changes which have taken place in health status since independence and attempts to analyse the sources of these.

3.3.53

Authors: Sanders D. Davies R.

Title: The economy, the health sector and child health in Zimbabwe since independence.

Publisher: Social Science & Medicine. 27(7):723-31, 1988.





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Year: 1988
Country: Zimbabwe
Keywords: Health care, child health, Zimbabwe
Location: UZ Medical Library
Pages: 9pp.
Abstract: This paper examines the changes in the economic environment which have taken place in Zimbabwe since independence in April 1980, concentrating on those which are relevant to health. It also describes the post-independence restructuring of the health sector itself. Finally, it considers some changes which have taken place in the health status of children. Despite a prolonged drought, economic recession and the imposition of economic stabilisation measures, there is evidence in the 1980s of a improvement in infant and young child mortality. This has resulted almost certainly from an energetic expansion and reorientation of health care provision, and particularly from greatly improved access to immunisation and oral rehydration therapy. The adverse effects of drought and stabilisation measures have been partially offset by aid-supported relief feeding and particular health programmes. However, the economic crisis has resulted in a decline in real incomes for a large number of households since the immediate post-independence boom. This is reflected in high levels of childhood under-nutrition which seem to have remained static despite the health care drive. This emerging divergence between death rates and quality of life as reflected by nutrition levels is reflective on the one hand of rapid expansion in effective health care provision, and on the other of little change in socio-economic conditions for the majority of the population.



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3.3.54

Author: Simon C

Title: Community participation and health: towards the study of human resources in the development of local healthcare.

Publisher: Development Southern Africa

Year: 1991

Country: South Africa

Keywords: Community Health Services, Zimbabwe, Transkei

Location: Unknown

Pages: Unknown

Abstract: This article observes that community participation in health involves the activation of local material and human resources. It follows this that the study of local resources is essential in planning community health care. With this in mind, the article discusses family care as a key human resource in handling disease. Using a case study from rural Transkei, the article illustrates the role and functions of family health care as a potentially viable unit for stimulating community participation in local and health care.

3.3.55

Author: Tapscott C

Title: The political-economy of health in Namibia: overcoming the past towards an uncertain future: Paper to a workshop on economic policy, equity and health, Harare, February 1991

Publisher: Namibian Institute for social and economic research; University of Namibia.

Year: 1991

Country: Namibia





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Keywords: Health access; facilities; health services; health policy; health economies.
Location: ZIDS
Pages: 13pp.
Abstract: Independence in Namibia in 1990 marked the end of more than a century of colonialism under German and subsequently South African rule. The paper outlines the tasks of transforming an ethnically fragmented society, of redressing extreme imbalances in access to resources and of building a more advanced an equitable economy with the particular issues posed for the health sector.

3.3.56

Authors: Taylor C, Sanders D, Basset M, Goings S
Title: Surveillance for equity in maternal care in Zimbabwe
Publisher: World Health Statistics Quarterly - Rapport Trimestriel de Statistiques Sanitaires Mondiales. 46(4):242-7,
Year: 1993
Country: Zimbabwe
Keywords: Surveillance, equity, maternal care
Location: UZ Medical School
Pages: 5pp.
Abstract: The hope and promise of post-independence efforts to promote equitable health care in Zimbabwe started with three years of dramatic improvement. The major constraint to equity was the entrenched pattern of sophisticated, high technology health care which continued to monopolise resources. In spite of the excellent beginning, development of services for the poor was thwarted by recession, prolonged drought, cutbacks in funding for health care as a result of economic adjustment policies. Disparities in maternal care are especially severe and can be



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improved only by building the infrastructure providing antenatal and perinatal services. The paper recommends that a few selected indicators be used in surveillance, relating directly to control measures so that understanding of causal linkages does not get lost in intervening variables. Each indicator should be measurable at minimal cost in money and time. They should be discrete, readily analysed and easily understood by the people. A menu of possible indicators can help district and community decision-makers think through their alternatives and concerns. A spectrum is desirable which should include, input indicators to measures equity in access, process indicators to quantify utilisation and outcome indicators directly measuring the impact of services. If only input and output indicators are used they tend to produce a conceptual conflict between equity and efficiency. Simplicity and speed in analysis and feedback reporting are more important for management purposes than the detail and precision of data needed for research. Only the most necessary items of data should be gathered through routine reporting because it is easy to overload the information system. For the highest priority problems in an area, surveillance can help standardise responses. Deviations from expected trends in indicators or localised high prevalence should trigger action. The number of interventions implemented at one time should be limited and introduced in a phased sequence.

3.3.57

Author: Tevera D S and Chimhowu A

Title: Intra-provincial inequalities in the provision of health care in the Midlands province of Zimbabwe

Publisher: Geographical Journal of Zimbabwe Vol 22

Year: 1991





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Country: Zimbabwe

Keywords: Health care, inequality, Zimbabwe

Location: ZIDS

Pages: 12pp.

Abstract: The paper assesses the magnitude of spatial inequalities in opportunity levels for access to health facilities and personnel in the Midlands province of Zimbabwe. Districts with large urban centres were found to have more favourable population-doctor ratios than the rural, more peripheral districts because of the doctors preference for the large urban areas. There is a gradual deterioration in health services with increasing distance from urban areas. Lack of doctors in some districts implies that patients have to travel long distances to urban centres where doctors are available. Although doctors periodically visit the health institutions in communal areas, the irregularity of their visits coupled with the long lists of priority patients for attention make it more difficult for the less serious cases to be seen by doctors. Few hospital beds have led to situations whereby people who under normal circumstances, would need closer medical attention and rest in a hospital bed, have to commute as out-patients or to travel long distances to the nearest hospital for admission. This results in long recovery periods, loss of time and money and congestion. The perpetuation of such inequalities suggests that attempts to achieve an equitable spread of health services have had limited success. Given constraining factors of expenditure and drought, to minimising the rural-urban gap may require a radical social reform package that includes preferential treatment of some of these remote districts with poor living conditions.





3.3 EQUITY IN HEALTH CARE AND HEALTH CARE

3.3.58

Author: Unknown

Publisher: Journal of social change and development: 29: 14-15

Title: ESAP and health

Year: 1992

Keywords: Structural adjustment, health services

Country: Zimbabwe

Location: ZCTU Library

Pages: 2pp

Abstract: The feature reviews about effects of the economic structural adjustment policy on hospital and clinic attendances in Zimbabwe. It notes a fall in clinic attendance this does not automatically mean that people's health is worse. If small children are not attending clinics for preventive measures, it cautions that preventable diseases may rise. A fall in hospital attendances also indicates that people may be ill at home paying rather than escalating hospital fees.

3.3.59

Publisher: UNICEF, Ministry of Health and Child Welfare Zimbabwe

Title: District health service costs, resource adequacy and efficiency: a comparison of three districts.

Year: 1996

Country: Zimbabwe

Keywords: District health services; utilisation, efficiency; Zimbabwe

Location: ZIDS

Pages: 10pp.

Abstract: This report presents the results and recommendations from three studies on





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district level health care services in Shurugwi, Gutu, and Binga districts of Zimbabwe between 1993 and 1995. The studies found that although most services were adequate, there were major gaps for maternal care and environmental health services, attributed to a mixture of staff and/or skill shortages, lack of incentives for rural postings, transport and communication problems, and centralised reimbursement systems. Lower unit costs, particularly at mission facilities do not necessarily indicate efficiency but may indicate poorer quality of care due to severe under-staffing and inadequate patient management. Major gaps exist for material resources (e.g drugs, stationery), and for services (e.g maintenance of vehicles and buildings). Over-centralisation of responsibilities and financial control is severely hindering service provision. This is particularly so for day to day operational expenses (such as travel and subsistence allowance), and for those items under the control of other ministries (such as minor building repairs and vehicle maintenance and repair). It is proposed that the Ministry of Health review the human resource requirements and support systems necessary to provide maternal and environmental health services on a wider basis, that government allocations to health be maintained at current levels (in real terms) and increased if possible, that allocations to districts be weighted by total district workload, not merely district hospital workload, and preferably be split between the district hospital and peripheral facilities. The MoH should review staff establishments on the basis of workload, not merely the facility level or bed numbers, and develop a more participative approach to planning and management at district level. District health budgets for recurrent costs should be placed in district bank accounts, and DHGs given authority to effect payment.





3.3 EQUITY IN HEALTH CARE AND HEALTH CARE

3.3.60

Authors: van Bergen JE.

Title: District health care between quality assurance and crisis management.

Possibilities within the liits, Mporokoso and Kaputa District, Zambia.

Publisher: Tropical & Geographical Medicine. 47(1):23-9, 1995.

Year: 1995

Country: Zambia

Keywords: District health services, quality

Location: U.Z. Medical Library

Pages: 6pp.

Abstract: A tension exists between objectives of health policy makers to achieve high quality standards of care on one hand, while battling for survival of the (public) health system is questioned. The collapsing health services as well as the deteriorating living conditions affect the health status of the population and contribute to an increase in (health) inequalities both nationally and internationally. Constraints and some examples of achievements in district health management in two districts in Northern Province, Zambia, are presented. A strong focus on community-based health care, partnership with communities and accelerated health-system support via strengthening of on-site supervision is advocated. Decentralization and self-reliance are potential tools in flexible crisis management, but require continuity in human resource development and appropriate 'care for the carers'. In order to increase operational efficiency, the need is expressed to conceptualize a practical approach of 'minimum primary health care'.





3.3 EQUITY IN HEALTH CARE AND HEALTH CARE



3.3.61

Authors: Van Rensburg H C, Fourie A

Title: Inequalities in South African health care. Part I The African Problem - manifestations and origins

Publisher: South African Medical Journal 84(2):99-103, 1994

Year: 1994

Country: South Africa

Keywords: Health care; inequalities; socio-economic factors

Location: UZ Medical Library

Pages: 5pp.

Abstract: This paper analyses and contextualise the complex problem of structural inequality in South African health care. Socio-economic conditions, racial divisions and geographical location are isolated as the main determinants of inequality in the provision, allocation and distribution of health care, the prevailing inequalities are attributed to a wide range of underlying causes, including the prominent role of apartheid and white domination, the free market, the influence of the medical profession, and the unique socio-cultural set-up of the country. The urgent need for deliberate strategies to equalise the prevailing disparities and discrepancies is posed. South African health care was strikingly characterised by absence of a central, binding health policy. Loose and incoherent legislation, problematic authority structures, and a typically pluralistic health care system were established, leading to a highly divided health care structure, fragmented along lines of race and geographical area, and with inequality based on race and colour. The prominent role for the free market in health care gave rise to a laissez-faire deployment of health personnel and facilities, with lack of co-ordination in health care, inequality and deprivation. The dominance of the medical profession



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established specific priorities and emphasises and modelled care delivery structures to suit medical, vocational and professional interests, often neglecting and ousting forms of care more appropriate. From these emanated the heavy emphasis on curative and institutional care, themselves strikingly conducive to disparities. The diversity of ethnic groupings, cultural systems of knowledge, beliefs and symbols, impinge on the health, illness and consumption behaviour of its people. These determine what people conceive as health and illness, what they deem as appropriate health care, and whom they prefer as healer and consult during episodes of illness. Naturally, these factors produce another dimension of inequalities in health care, albeit in the acceptance or rejection of provided health care.

3.3.62

Author: Van Rensburg H C J

Title: Inequalities in South African Health Care and Prospects of Equalisation

Publisher: Department of Sociology, University of the Orange Free State.

Year: 1992

Country: South Africa

Keywords: South Africa; Health care; inequalities; Health finance

Location: WHO Library

Pages: 14pp

Abstract: At present, as has been the case for decades now, health care in South Africa is plagued by multitude of problems, constraints and deficiencies. The nature of these problems and deficiencies pertains on the one hand to the health care system as a provider or distributor of health care, and on the other hand they are related to the population as clientele of that system. The paper comments on the





3.3 EQUITY IN HEALTH CARE AND HEALTH CARE



possibilities and prospects of greater equality of South African care through exploring the current inequalities in health care in the country.

3.3.63

Authors: Vos J. Borgdorff MW. Kachidza EG.

Title: Cost and output of mobile clinics in a commercial farming area in Zimbabwe.

Publisher: Social Science Medicine. 31(11):1207-11, 1990.

Year: 1990

Country: Zimbabwe

Keywords: Mobile clinics, agriculture, health economics, Zimbabwe

Location: UZ Medical Library

Pages: 4pp.

Abstract: Mobile clinics may be useful to improve the geographic accessibility of health services, but their cost may be higher than that of static clinics. In this paper it is determined to what extent mobile clinics in a commercial farming area in Zimbabwe improve geographic accessibility. The opportunity cost of mobile clinics, comprising cost of staff time and transport is estimated. Staff time appears to be more efficiently utilized in mobile clinics than in static clinics. The cost of transport comprises the cost to the health service and that to the population using the service. The consequences of two extreme assumptions are determined. If the first assumption (outreach does not increase coverage) were true, total transport cost would increase if outreach were discontinued. If the second assumption (outreach increases coverage by the number of attendances at mobile clinics) were true, a substantial increase in coverage would be obtained in particular for growth monitoring, immunizations and child spacing, without increasing the cost per contact. It is concluded that outreach clinics should continue in this commercial



3.3 EQUITY IN HEALTH CARE AND HEALTH CARE



farming area. The sites of the mobile clinics are being reconsidered as a result of this study.

3.3.64

Authors: Walker G and Gish O

Title: Inequality in the distribution and differential utilisation of health services: a Botswana case study

Publisher: Journal of Tropical Medicine and Hygiene 80(11):238-243

Year: 1977

Country: Botswana

Keywords: Health services, Botswana, Inequality

Location: NIDR Botswana

Pages: 5pp.

Abstract: The uneven provision of health care in a developing country, Botswana, is examined. Curative out-patient attendance and in-patient hospitalisation rates were found to vary markedly for groups of the population living at different distances from health facilities. Those people living 10 miles or less from clinics and hospitals had far higher utilisation rates than those living at further distances. If the disparity in service provision described is to be altered then the planning and development of health services should concentrate upon the provision of basic health care and adapt to the manpower and economic constraints within which such systems operate.



3.3 EQUITY IN HEALTH CARE AND HEALTH CARE



3.3.65

Author: Wang'ombe J

Title: Health sector reform policies on cost recovery, the sub-Saharan Africa experience in the 1990s

Publishe: Mimeo

Year: 1997

Country: Africa

Keywords: Health reform, cost recovery

Location: TARSC Library

Pages: 30pp.

Abstract: The paper discusses cost recovery as a means of health financing in Africa, and uses the stated reasons for their introduction as a means to evaluate their effectiveness. The author notes that user fees have negligibly revenue generating capacity except as part of community based initiatives, and in this case success often depends on strong support from outside personnel. User fees are also argued to have negative consequences for equity, with falls in utilisation of health care and inefficient exemption mechanisms that have significant leakages of the deserving out and the non deserving into safety / exemption nets. Fee retention is noted to improve application of user fee revenue for public utility services and to quality of care, however it is noted that this too is more successful when applied and administered at local level. Cost recovery on a sliding scale by level of service has been used to enhance referral systems, but it is observed that this depends on investments in improved quality of care. The paper reviews the problems in implementation systems. The author concludes that the way forward is in community based projects, external injection of funds for quality of care, and other revenue sources such as social and private health insurance should be pursued.



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3.3.66

Author: Wilkinson D, Sach M E, Abdool Karim S S

Title: Examination of attendance patterns before and after introduction of South Africa's policy of free health care for children aged under 6 years and pregnant women

Publisher: British Medical Journal Vol 314

Year: 1997

Country: South Africa

Keywords: Health care; Maternal child health, health financing

Location: TARSC Library

Pages: 2pp.

Abstract: The paper reviews the impact of the new policy measure providing free health care for children under 6 years and pregnant and lactating mothers in South Africa. It examines this in particular through the evaluation of the mobile clinic services in Hlabisa, Kwazulu/Natal. In these clinics under 6 services were always free, but pregnant women paid for antenatal care. The survey found no important changes in attendance patterns in children after the free care measure, but a significant increase in the number of new child patients registering for treatment services and a decrease in the proportion referred to hospital. Women's use of antenatal care did not change significantly. The reduction in referred cases was attributed to the presentation of earlier or milder forms of illness, (a positive change) or to an increase in self limiting illness reporting to services (a negative change). It was also noted that the workload increased for staff and that increased demand for treatment may if not controlled steer attention and resources from preventive and promotive services.



3.3 EQUITY IN HEALTH CARE AND HEALTH CARE



3.3.67

Author: Willmore B and Hall N eds.

Title: Health manpower issues in relation to equity in and access to health services in Zimbabwe

Publisher: Jrnal of Social Development In Africa, School of Social Work

Year: 1989

Country: Zimbabwe

Keywords: Health services, Equity, manpower

Pages: 18pp.

Abstract: Issues of equity and access in health are important areas of concern in post independent Zimbabwe. The country inherited a fragmented health delivery system at independence in 1980, with a strong bias against the black population. Most services were concentrated in cities, and urban hospitals were better equipped with drugs and manned by skilled personnel. Rural health facilities were poorly managed and faced an acute shortage of medical supplies and personnel. Following government interventions after 1980, race has been replaced by class as a more important determinant of health outcomes, with a continuing rural-urban dichotomy in health care. Manpower distribution continues to be biased towards urban areas, conditions of service are poor in rural areas, and conditions differ in the mission, local council and private company services. The referral system does not operate for almost all medical conditions, about half of those coming to central facilities coming from within 10km of the facility, using the referral centre as a frontline service. This implies a need for a close review of utilisation and referral practices of different levels of care, as well as the need for compulsory rural service, improved conditions of services and facilities in rural areas, and the continued inclusion of rural attachments in the training of doctors.



3.3 EQUITY IN HEALTH CARE AND HEALTH CARE

3.3.68

Author: World Health Organisation

Title: Equity in health and health care: A WHO/SIDA initiative

Publisher: WHO-Geneva and SIDA-Seden

Year: 1996

Country: Global

Keywords: equity, health care

Location: TARSC Library

Pages: 51pp.

Abstract: Social gaps in health and in health care are unacceptably wide and are widening throughout the world. Developing countries and industrialised countries alike are finding it difficult to implement equitable policies and often feel caught between consideration of equity and short-term efficiency. This document describes an initiative of the World Health Organisation, with seed funds from the Swedish International Development Cooperation Agency, to place equity in health and health care higher on the public policy agenda and to evaluate and promulgate promising practical approaches to achieving equity in health development.

3.3.69

Author: World Health Organisation

Title: Final Report of Meeting on policy-oriented monitoring of Equity in health and health care
Publisher: WHO-Geneva and Council for International Organizations of Medical Sciences and the NGO Forum for Health

Year: 1997

Country: Global

Keywords: Monitoring, equity, health policy





3.3 EQUITY IN HEALTH CARE AND HEALTH CARE



Location: TARSC Library

Pages: 38pp.

Abstract: The challenge of promoting equity in health and health care is the major theme of the Equity Initiative launched by the WHO and Sida in 1995. One of the strategies adopted has been the development of indicators to monitor equity, with an emphasis on using these to influence the policy process. The report summarises the outcome of a WHO Meeting on Policy-Oriented Monitoring of Equity in Health and Health Care in September/October 1997 to develop policy-oriented monitoring, in the context of development, implementation and advocacy. The report notes that a precise definition of equity is not available. However there was agreement that health inequities exist when there are inequalities in health status, risk factors, or health service utilisation between individuals or groups, that are unnecessary, avoidable and unfair. This requires equity in the distribution of the determinants of health including health services. Reducing inequalities in health status to the point where we can judge them unavoidable and fair, requires: special health sector steps to compensate for inequalities in risk factors arising from other inequalities (socio-economic, gender etc) and further efforts to reduce these other inequalities through intersectoral action. The report notes that routine data from the health sector needs to be supplemented with additional routine information from other sectors to identify neglected groups, socio-economic differences and their health consequences. Four key criteria for selecting indicators for monitoring equity were recommended: Relevance to policy on equity in any relevant sector; accessibility of disaggregated data; simplicity; and meeting standard scientific and ethical criteria. Different ways of formulating an equity target with a given indicator are presented. Formulating an equity target is probably more important than which specific indicator is selected, as the target provides comparisons



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among the more and less advantaged. The report recommends indicators for monitoring equity in health and health care and the range of obstacles to equity, e.g lack of clarity of the concept, lack of awareness among policy-makers, lack of data, lack of analysis of existing data management of the health sector, general acceptance of inequities and global issues such as the role of private companies. Strategies for overcoming these obstacles and advance equity were recommended.

3.3.70

Authors: Yach D, Harrison D

Title: Inequalities in health: determinants and status in South Africa

Publisher: Kluwer Academic Publishers

Year: 1994

Country: South Africa

Keywords: Health inequalities, South Africa

Location: National Institute of Development Research and Documentation

Pages: 1pp.

Abstract: The paper outlines the epidemiologic transition in South Africa, in which pre - and post-transitional diseases co-exist in the same population. The paper notes that a protracted transition may lead to epidemiologic polarisation in which quantitative and qualitative inequalities within a population are aggravated, as certain sectors present not only with higher rates of diseases, but also different kinds of diseases. Failure to recognise this phenomenon may result in health services exacerbating social inequality, while diminishing resources allocated to the 'left over' problems of common infectious diseases and malnutrition. The paper outlines how in South Africa, apartheid and associated macro-economic policies have determined access



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to basic needs (housing, clean water, sanitation and safe energy) social development (education, income, occupation) and preventive and curative health services. Basic demographic, epidemiologic and educational indicators vary profoundly by race. Consequently, analysis of inequality in South Africa must continue to be stratified by race for decades to come. The paper goes beyond racial inequalities in health determinants and status and indicates that under a non-racial democracy, social class will emerge as a more potent and determinant on inequality than race. The paper discusses the determinants of inequality in childhood, adolescent and adult mortality in South Africa, as fundamental indicators of differential health status. The implications for policy development are then outlined in terms of the strategies for reducing inequity, the uneven application of known effective interventions and a focus on effect preventive intervention on childhood and adolescents as a means of reducing ill health later in adult life. The paper concludes that strong political commitment is needed for moving beyond individual intervention to addressing the roots and determinants of inequalities in health.

3.3.71

Authors: Yach D, Tollman S M

Title: Public health initiatives in South Africa in the 1940s and 1950s: Lessons for a post-apartheid era

Publisher: American Journal of Public Health 83(7)1043-50, July

Year: 1993

Country: South Africa

Keywords: Public health, health assessment

Location: Centre for Health Policy South Africa





3.3 EQUITY IN HEALTH CARE AND HEALTH CARE

Pages: 7pp.

Abstract: Inspiration drawn from South African public health initiatives in the 1940s played an important role in the development of the network of community and migrant health centres in the United States. The first such centre at Pholela in Natal emphasised the need for a comprehensive (preventive and curative) service that based its practices on empirical data derived from epidemiological and anthropological research. In addition, community consultation preceded the introduction of new service or research initiatives. The Institute of Family and Community Health in Durban pioneered community-based multidisciplinary training and developed Pholela and other sites as centres for service, teaching, and research. Several important lessons for South African health professionals emerge from the Pholela experience. First, public health models of the past need to be reintroduced locally; second, the training of public health professionals needs to be upgraded and reoriented; third, appropriate research programmes need to respond to community needs and address service demands; fourth, community involvements strategies need to be implemented early on; and fifth, funding sources for innovation in health service provision should be sought.

3.3.72

Publisher: Zimbabwe Ministry of Health and Child Welfare

Title: A situational and trend analysis in equity in health and health care in Zimbabwe

Year: 1996

Country: Zimbabwe

Keywords: Health, health care, equity, Zimbabwe

Location: Ministry of Health and Child Welfare, Zimbabwe

Pages: Unknown





3.3 EQUITY IN HEALTH CARE AND HEALTH CARE

Abstract: This study describes the current situation regarding equity in health and health care in Zimbabwe and describe trends over time in equity in health and health care in relation to major policies and conditions outside as well as within the health sector. Indicators are presented under three different headings: basic determinants of equity in health, social and geographic inequalities in health status, and social and geographic inequities in health care. It was concluded from the data presented that presently in Zimbabwe there was a high degree of disparity in health status and access to health care among social groups. Disparities could be found in many indicators among provinces, male and females, rural and urban areas, and people of various levels of education. Three recommendations were put forward: (a) Government should put in place a monitoring mechanism of its policies to evaluate the impact of policy changes on patterns and trends in equity in health and health care, (b) The Ministry of Health should develop skills to more effectively monitor access to health care in a liberalised health market. (c) A special task force should be set up to capture available expertise on equity patterns and trends and to define equity standards. Additional tasks would be to prepare strategies for achieving these equity standards as well as related training materials for health planners and managers.





3.4 EQUITY IN RESOURCE ALLOCATIONS FOR HEALTH

3.4 EQUITY IN RESOURCE ALLOCATIONS FOR HEALTH

3.4.1

Author: Abel-Smith B, Rawal P

Title: Can the poor afford 'free' health services? A case study for Tanzania

Publisher: Health Policy and Planning 7(4)

Year: 1992

Country: Tanzania

Keywords: user fees; Tanzania; equity; health services

Location: TARSC Library

Pages: 12pp.

Abstract: This paper reports on research undertaken for the Government of Tanzania to investigate the case for the introduction of user charges in the health services. A parallel report is being completed on the potentiality of compulsory health insurance for those in regular employment. Five studies were undertaken at the national level. The main studies were interviews of nearly 900 outpatients at the main hospitals and interviews with over 1 800 households all over the country with access to both government and mission hospitals. Information was collected on travel time, travel costs, and waiting time, which health facilities were chosen and why the cost of using them, and difficulty in finding the money to pay and willingness to pay user charges. The most important conclusion was that the





3.4 EQUITY IN RESOURCE ALLOCATIONS FOR HEALTH

because of inadequate supplies of drugs and of food at hospitals many patients had to incur substantial costs to use the 'free' services in addition to travel costs. It is therefore concluded that modest charges with attempts to exempt the poor would be less inequitable than the existing situation, if the revenue could be used to ensure that supplies were always adequate at government health services. The level of charges suggested was based on what the majority surveyed said they were willing to pay.

3.4.2

Authors: Andersson N and Marks S

Title: The state, class and the allocation of health resources in Southern Africa

Publisher: Social Science and Medicine 28(5):515-530

Year: 1989

Country: Southern Africa

Keywords: Southern Africa, state, health, class, race, gender

Location: TARSC Library

Pages: 15pp.

Abstract: See 3.3.3

3.4.3

Author: Bachmann M O

Title: Would national health insurance improve quality and efficiency of health care in South Africa? Lessons from Asia and Latin America

Publisher: SAMJ 84 :153-157

Year: 1994

Country: South Africa





3.4 EQUITY IN RESOURCE ALLOCATIONS FOR HEALTH

Keywords: Health insurance, quality, efficiency

Location: TARSC Library

Pages: 4pp.

Abstract: Arguments for and against national health insurance (NHI) for South Africa are illuminated by the experiences of other middle-income developing countries. In many Latin American and Asian countries the majority of their populations are covered by NHI, coverage having steadily increased over the last decade. Patterns of care under NHI tend to be inefficient - hospital oriented, highly specialised and technical, with excessive investigation, surgery and medication, neglect of primary care and severe cost escalation. In some cases, however, urban primary care has been promoted through polyclinics and health maintenance organisations. Inequalities in funding, access and utilisation exist between the insured and uninsured, between strata of the insured, and between urban and rural areas. These inequalities have at times been ameliorated by expansion of coverage, subsidisation of poorer beneficiaries and initiation of programmes that extend care to rural areas. NHI can improve or impair efficiency and equity in health care, depending on structures and processes of revenue generation, payment and organisation of care. These depend in turn on how those likely to lose or gain from each option exercise their collective power.

3.4.4

Author: Balasubramaniam K

Title: Structural adjustment programmes and privatisation of health: prospects and problems for health for all-now

Publisher: Consumers International Regional Office for Asia and the Pacific, Malaysia

Year: 1995





3.4 EQUITY IN RESOURCE ALLOCATIONS FOR HEALTH



Country: General

Keywords: Primary health care; Structural adjustment; Health privatisation

Location: Unknown

Pages: Unknown

Abstract: Based on a critical analysis of data on the health of the people and the economic conditions in several developing countries, this paper calls attention to the urgent need internationally for a new approach to mobilise the interests, commitments and resources of a broader constituency of support for the poor. International agencies set up to provide assistance to improve the health and well-being of the people and to strengthen economic development have failed, and some have dismantled the little gains made by developing countries during 1960-1980. The real per capita income of the poor has decreased during the last 20 years. The vast majority of the world's rural population, particularly in Africa, lives below the poverty line. Infants and young children continue to die in equal numbers today as 15 years ago of preventable diseases. In 1978, WHO supported the Alma Ata Declaration on Primary Health care (PHC) based on success stories from countries with very limited material resources, significantly improving the health of their people through national health policies based on primary health care. Unfortunately PHC was strangled soon after its birth by the very forces supposed to assist in implementing it, the medical establishment; UNICEF through GOBI-FFF and the World Bank and IMF through their structural adjustment programmes. The paper proposes that people have lost faith in these international agencies, that the World Health Assembly as a forum of health policy makers has not succeeded in changing health care policies that would be directed mainly to the poor and that people need is an alternative world forum - A people's World Health Assembly. This paper provides ideas on the structure, objectives and functions of a People's World Health Assembly.



3.4 EQUITY IN RESOURCE ALLOCATIONS FOR HEALTH

3.4.5

Authors: Benatar SR.

Title: Economics of health in South Africa: past, present and future.

Publisher: Medicine & Law. 8(2):111-7

Year: 1989

Country: South Africa

Keywords: Health economics

Location: Unknown

Pages: 7pp.

Abstract: The paper presents some of the background factors to the present structure of medicine in South Africa, economic aspects of the current (inadequate) health care service and tentative suggestions regarding the directions in which health services should be moving to facilitate the legitimization (political) and accumulation (economic) processes required to meet the needs and demands of all the people of an internationally recognized, just and free South Africa.

3.4.6

Authors: Bennet S, Modisaotsile I

Title: The costs and financing of selected PHC activities in Botswana

Publisher: Bamako Initiative Management Unit - Botswana and UNICEF - New York

Year: Undated

Country: Botswana

Keywords: Health financing, PHC

Location: National Institute of Development and Research

Pages: Unknown

Abstract: The study presents a survey-based assessment of the costs of providing EPI, CDD





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and ARI services at the clinic and health post levels, with support activities at central and district levels. Although the study focuses on three programmes, many findings are generalisable to other PHC programmes. In addition, a pilot “private costs survey” was carried out on costs incurred in seeking care, such as transport cost and time spent at the facility. The study found that the unit costs of PHC in Botswana are high, and there is a significant amount of variation between facilities. The main component of these high costs is personal emoluments, which amount to about 60% of total programme costs. Expenditure on drugs and vaccines is also high. The structure of expenditure between different levels of the health care system is encouraging: 50-70% of the funds go to the facility level. Thus the programmes are not too heavy with high central organisational costs but few funds are reaching the operational level. The GoB has provided an extensive health care network across a large and sparsely populated country. The low catchment and consequently low attendances at many remote facilities partly explain the high unit costs found. The other main factors affecting costs were location of facility (whether in the east or west of the country) and type of facility (clinic or health post). Both of these variables were significantly correlated with output. The private costs were generally low when compared with the costs of providing the services. Total private costs in urban areas averaged about P3.20, most of which was in the form of opportunity cost of waiting time. Combined with evidence of high expenditure on medical care (Household Income and Expenditure Survey 1985/86), the study suggests that many of the urban population would be prepared to contribute towards health care services, provided that there was some improvement in these services, such as reduction in waiting times. A number of inefficiencies in programme delivery were identified. The situation in rural areas is less clear cut. It is suggested that any experimentation with cost sharing be closely



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monitored so that impact on uptake of services can be minimised. It is proposed that a data base on unit costs be expanded to cover a wider range of services, and such unit costs be monitored on a regular basis to identify inefficiencies arising in the system. Such a data base could assist in the development of a more programme-oriented budgeting system, in which budgetary allocations depend on objectives identified by the district.

3.4.7

Author: Bijlmakers L, Bassett M, Sanders D

Title: Health and structural adjustment in rural and urban Zimbabwe

Publisher: Uppsala: Nordiska Afrikainstitutet,

Year: 1996

Country: Zimbabwe

Keywords: Health, Structural adjustment, Zimbabwe

Location: TARSC

Pages:

Abstract: See 3.3.7

3.4.8

Author: Bijlmakers L and Chihanga S

Title: District health service costs, resource adequacy and efficiency: a comparison of three districts

Publisher: Ministry of Health and Child Welfare, Zimbabwe

Year: 1996

Country: Zimbabwe

Keywords: District health services, health financing





3.4 EQUITY IN RESOURCE ALLOCATIONS FOR HEALTH

Location: Ministry of Health and Child Welfare, Zimbabwe
Pages: 10pp.
Abstract: See 3.3.8

3.4.9

Authors: Bourne DE. Pick WM. Taylor SP. McIntyre DE. Klopper JM.

Title: A methodology for resource allocation in health care for South Africa. Part III. A South African health resource allocation formula [published erratum appears in South African Medical Journal 1991 Aug 3;80(3):145].

Publisher: South African Medical Journal. 77(9):456-9, 1990 May 5.

Year: 1990

Country: South Africa

Keywords: Health care, health financing, South Africa

Location: U.Z. Medical Library

Pages: 4pp.

Abstract: A formula to calculate the proportion of the public sector budget that should be allocated to various geographical regions of South Africa is described. The formula is broadly classified into curative and preventive components. Using data that are routinely available, indices of need are calculated for each of these components. It is concluded that resource allocation on a macro level should closely approximate regional population distribution if cross-border flow of patients and additional teaching-hospital expenditure are ignored.

3.4.10

Authors: Broomberg J, De Beer C, Price M R

Title: The private health sector in South Africa - current trends and future developments





3.4 EQUITY IN RESOURCE ALLOCATIONS FOR HEALTH

Publisher: South African Medical Journal 78(3):139-142; discussion 142-3
Year: 1990
Country: South Africa
Keywords: Private health care, South Africa
Location: UZ Medical Library
Pages: 5pp.
Abstract: The private health sector is experiencing a crisis of spiralling costs, with average annual cost increases of between 13% and 32% over the decade 1978-1988. This trend is partly explained by the high utilisation rates that result from the combination of the 'fee-for-service' system and the 'third-party' payment structure of the sector. Medical schemes have responded by promoting the idea of 'flexible packages', and have won the right to 'risk-rate' prospective members. It is argued that these measures will undermine the principle of equity in health care, and will not solve the problems of the private sector. Instead, a more significant restructuring of the sector is likely to emerge. This may take the form of 'managed care' structures, along the lines of the health maintenance organisation model from the USA. 'Managed care' structures are shown to be potentially more rational and efficient than the current structure of the private sector. Although some resistance to 'managed care' structures can be expected, the convergence of interests of large employers and trade unions in containing health care costs suggests that their emergence is a likely development.

3.4.11

Authors: Broomberg J. Rees H.

Title: What does primary health care cost and can we afford to find out?
Rationale and methodology for a cost analysis of the Diepkloof Community





3.4 EQUITY IN RESOURCE ALLOCATIONS FOR HEALTH



Health Centre, Soweto.

Publisher: South African Medical Journal. 83(4):275-82

Year: 1993

Country: South Africa

Location: U.Z. Medical Library

Pages: 7pp.

Abstract: Accurate information on the costs of providing primary health care (PHC) services is now an urgent priority for health policy makers and planners, if the Government's stated commitment to an adequate PHC system is to be realised. Cost information is also a critical management tool for both public and private sector providers. In this context, the inability of public sector PHC providers to generate accurate cost accounting information is a serious shortcoming. In an attempt to address this lack of local PHC cost data, a detailed analysis of the costs of PHC services was undertaken at the Diepkloof Community Health Centre (DK) in Soweto during 1990. The study aimed to assess the cost of each service provided at DK and where possible, to identify areas of inefficiency. This paper is the first of two that report the findings of this study. It briefly describes the methodology employed and presents the major results. These raise several important management issues. Most importantly, the study suggests that there is excess capacity in the administrative and in several of the clinical areas of this community health centre; this implies that the average cost per service could be reduced in several areas. Certain services, such as home visits, are particularly expensive and require careful evaluation. The policy implications of this analysis are also examined. The high cost of several services implies that extension of this type of PHC service to all urban and rural areas is likely to be unaffordable.



3.4 EQUITY IN RESOURCE ALLOCATIONS FOR HEALTH

3.4.12

Author: Carr-Hill R A

Title: Efficiency and equity implications of the health care reforms

Publisher: Social Science and Medicine 39(9):1189-1201

Year: 1994

Country: UK

Keywords: Health care reforms, accountability and equity, effectiveness, efficiency and evidence

Location: TARSC Library

Pages: 12pp

Abstract: See 3.1.2

3.4.13

Authors: Cornia G A, Jolly R, Stewart F

Title: Adjustment with a human face Vol 2: Country Case studies

Publisher: Clarendon Press: England

Year: 1988

Country: General

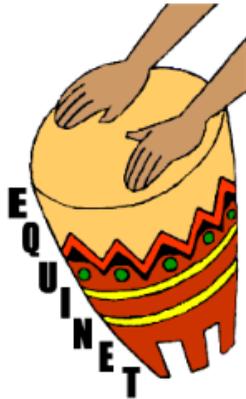
Keywords: Economic conditions, health

Location: National Institute of Development Research and Documentation

Pages: Unknown

Abstract: This is UNICEF's 2nd volume on its analysis of how economic conditions of most developing countries worsened during the 1980s, forcing the World Bank and the IMF to introduce strict structural adjustment policies (SAPs). These SAPs accelerated the deterioration of the most vulnerable groups, including children, through neglect of social welfare interventions, health and nutrition. In light of the





3.4 EQUITY IN RESOURCE ALLOCATIONS FOR HEALTH

widespread poverty, UNICEF's alternative policies, "Adjustment with a human face" are "designed to protect the conditions of the vulnerable during periods of economic decline and adjustment as well as accelerating economic growth over the medium and long term". This Volume provides country studies to help the reader understand, in-depth the effects of the economic recession on each country and those of SAPs. The countries are Botswana, Ghana, Zimbabwe, the Phillipines, South Korea, Sri Lanka, Brazil, Chile, Peru and Jamaica. The basic format used for each study is a description of the initial conditions, the effects of the economic deterioration and macro-economic responses, analysis of development policies and the countrys' compensatory programs in response to its socio-economic problems and the conclusion. Each country chapter also includes a series of tables giving such data as economic indicators, budget deficits, wage increases, income distribution and nutritional status of children

3.4.14

Author: Creese A

Title: User fees: they don't reduce costs, and they increase inequity (editorial)

Publisher: British Medical Journal 315

Year: 1997

Country: General

Keywords: User fees, equity, health

Location: UZ Medical Library

Pages: 2pp.

Abstract: If user fees for health care are the solution, what exactly is the problem?

Proponents of user fees recommend them in two situations. The first is when health spending in total is low or falling-fees are recommended as a way to





3.4 EQUITY IN RESOURCE ALLOCATIONS FOR HEALTH

mobilise more money for health care than existing sources provide. The second, paradoxically, is when health expenditure is high or rising quickly, when fees are recommended as a way of improving efficiency by moderating demand and containing costs. Opponents of user fees attack them as a political strategy for shifting health-care costs from the better off to the poor and the sick, pointing to the trade off between this method of raising revenue and maintaining access to care based on need rather than ability to pay. The author notes that in Southern Africa user fees have been used to supplement health spending, but with extremely modest gain in revenue. The cost of implementation, problems with exemption mechanisms, increased ill health and changes in access to care have been negative consequences of user fee policies. User fees have outside Africa been used as a way of controlling demand, but also with limited success, and also at the cost of ignoring the powerful role played by providers in health care patterns. The higher the mix of use fees in health financing, the greater the relative share falling on poor people. The author thus recommends that user fees only be considered after other alternatives have been tried.

3.4.15

Author: Davies R

Title: Structural adjustment and health in Zimbabwe

Publisher: The Societies of Southern Africa Collected Seminar Papers No. 48

Year: 1994

Country: Zimbabwe

Keywords: Health; structural adjustment; health care; Zimbabwe

Location: SARDC

Pages: 11pp.





3.4 EQUITY IN RESOURCE ALLOCATIONS FOR HEALTH

Abstract: The paper reviews the evolution of Zimbabwe's economic problems and policies since 1980, focusing particularly on health-care provision. The author argues that there has been a decline in the factors determining health since 1990 and that the proximate cause of this is the implementation of ESAP. The structural adjustment policy had the following effects, the introduction of user fees in hospitals and clinics with increases in health care charges of up to 88% since 1993, and areas also for drugs; the devaluation of the Zimbabwe dollar resulting in astronomic increases in the cost of drugs. In January 1994, imported drugs cost about 20% more due to devaluation; the removal of food subsidies, retrenchment and decline in real incomes.

3.4.16

Author: Davies R, Loewenson R

Title: Macro-economic trends in the Health Sector

Publisher: Department of Economics, University of Zimbabwe and TARSC

Year: 1997

Country: Zimbabwe

Keywords: Macro-economic trends; health financing

Location: TARSC Library

Pages: 12pp.

Abstract: This paper describes the overall trends in health financing in Zimbabwe between 1980-1990s. The paper shows that the overall per capita supply of health workers has declined since independence relative to the growth of population, and the contribution of the health sector to GDP has continued to decline from 2% in the early eighties to 1.5% in the nineties. Health worker earnings have risen as a share of output in the sector but fallen relative to the cost of living. This poses an





3.4 EQUITY IN RESOURCE ALLOCATIONS FOR HEALTH

important stress between keeping down costs of health care and providing adequate wages to health workers. The trends in the economics of the health sector shown in this report signal a need to address revenue sources, wage constraints and resource allocations in the health sector in Zimbabwe.

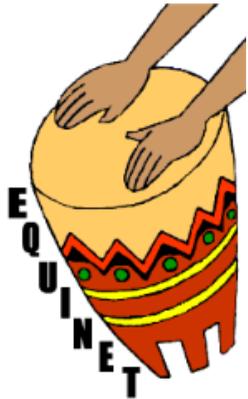
3.4.17

Author: Davies R, Sanders D
Title: Stabilisation policies and the effects on child health in Zimbabwe
Publisher: Review of African Political Economy 38:3-23
Year: 1991
Country: Zimbabwe
Keywords: Child Health, Zimbabwe
Location: UZ Medical Library
Pages: 20pp.
Abstract:

3.4.18

Author: de Ferranti D
Title: Paying for health services in Developing countries: an overview World Bank staff working papers Number 721
Publisher: The World Bank Washington DC USA
Year: 1985
Country: General
Keywords: Health care; developing countries; health policy
Location: ZCTU Information Centre
Pages: 11pp.





3.4 EQUITY IN RESOURCE ALLOCATIONS FOR HEALTH

Abstract: This paper presents an overview of the principal issues, problems, and policy options in financing health services in developing countries. The shortcomings of existing policies, which finance health care to a significant extent from public revenue sources, are reviewed. Alternative approaches are identified and examined, with particular attention to: (i) opportunities for greater cost recovery from users, through fees for services and/or fees for health care 'coverage'; (ii) the potential role of risk sharing arrangements, which can range from large, formal insurance plans to small, informal community - based cooperatives; (iii) the public/private mix in both providing and financing care, and (iv) to the structuring of subsidies and their incentive effects. Issues relating to these options are discussed concerning efficiency, equity, financial viability, ability and willingness to pay, externalities, users lack of complete information or understanding of health problems and service benefits, and 'merit good' and 'public good' arguments along with several other considerations. Present health financing policies in most developing countries need to be substantially reoriented. Strategies favouring public provision of services at little or no fee to users and with little encouragement of risk-sharing have been widely unsuccessful while new initiatives reversing these trends do not always lead to improvements in efficiency or equity. Increased cost recovery from users should be pursued through fees for coverage; i.e. by encouraging increased application of risk-sharing arrangements. Tendencies to expand the public role in providing care should be restructured to improve incentives.

3.4.19

Author: Doherty J, McIntyre D, Bloom G

Title: Value for money in South African health care: findings of a review of health





3.4 EQUITY IN RESOURCE ALLOCATIONS FOR HEALTH



expenditure and finance

Publisher: Central African Journal of Medicine 42(1):21-4, 1996 January

Year: 1996

Country: South Africa

Location: UZ Medical Library

Pages: 3pp.

Abstract: See 3.3.12

3.4.20

Authors: Dyer JJ.

Title: Comparative costs of mobile and fixed-clinic primary health care services.

Publisher: South African Medical Journal. 86(5):528-30

Year: 1996

Country: South Africa

Keywords: Health services, cost benefit, mobile clinics

Location: U.Z. Medical Library

Pages: 2pp.

Abstract: With restructuring and rationalisation of health services in South Africa imminent, the development of methods for comparing and evaluating health services is of great importance at both national and local level, including comparisons of cost-efficiency and cost-effectiveness. The costs of different methods of delivering primary health care in a local authority through mobile and fixed-clinic services have been analysed and aspects of their cost-efficiency compared. The information gained from such an analysis can be used for management purposes to optimise both the use of resources and the quality of service provided at local level.



3.4 EQUITY IN RESOURCE ALLOCATIONS FOR HEALTH

3.4.21

Authors: Ettling M. McFarland DA. Schultz LJ. Chitsulo L.
Title: Economic impact of malaria in Malawian households.
Publisher: Tropical Medicine & Parasitology. 45(1):74-9, 1994 Mar.
Year: 1994
Country: Malawi
Keywords: Malaria, Malawi, Household spending
Location: Unknown
Pages: 5pp
Abstract: See 3.3.13

3.4.22

Authors: Forder AA.
Title: How best to utilize limited resources.
Publisher: Journal of Hospital Infection. 30 Suppl:15-25
Year: 1995
Country: South Africa
Keywords: Health financing
Location: UZ Medical Library
Pages: 10pp.
Abstract: South Africa's new health policy embraces the primary health care (PHC) approach for all and includes good primary, secondary and tertiary care. The policy aims to provide the highest possible standards of care, yet be of a scale and complexity that the country can sustain into the future. There will almost certainly be rationalization of many of the tertiary teaching hospitals, with inevitable cut-backs in their budgets. This in turn could carry the risk of damage to the fabric of these





3.4 EQUITY IN RESOURCE ALLOCATIONS FOR HEALTH

institutions, which might be impossible to repair. Medicines offer a simple, cost-effective answer to many health problems in Africa, provided they are available, accessible, affordable and properly used. A problem in African drug markets is inefficiency and waste. The use of counterfeit medicines has reached unparalleled heights. It is vital that there should be a competent, honest, accountable and independent national drug regulatory authority, secured in law, to provide the necessary infrastructure for the acquisition of sound drugs. Medicines are central to a sound national health policy, but there is great public concern about their costs. Anti-infective drugs are amongst the most widely used class of drugs in the world. Inappropriate use of these drugs is widespread and guidelines need to be established for their correct use. The control of all medicines in South Africa is governed by the Medicines & Related Substance Act of 1965. The Medicines Control Council is mandated to ensure that all medicines (including antibiotics) available to the public are efficacious, safe and of high quality. An informally-constituted Antibiotic Study Group has been established to monitor aspects of antibiotic therapy that impinge on more general issues of public health, country-wide. The Antibiotic Study Group has instituted an Antibiotic Surveillance Programme to monitor the development of antibiotic resistance nationally. In addition the majority of the tertiary teaching hospitals have comparable in-house antibiotic control policies to help prevent such resistance and to cut costs. These issues need to be debated and resolved. Once in place and working effectively, they will in the long-term supply the most cost-effective means of providing health care for all.





3.4 EQUITY IN RESOURCE ALLOCATIONS FOR HEALTH

3.4.23

Author: Gibbon P (ed)

Title: Structural Adjustment and the working poor in Zimbabwe: Studies on labour, women informal sector workers and health

Publisher: Nordiska Afrikainstitutet

Year: 1995

Country: Zimbabwe

Keywords: Structural adjustment, health, Zimbabwe

Location: SARDC

Pages: Unknown

Abstract: The three studies in this text provide a detailed account of the situation of various vulnerable groups. These studies, dealing with formal labour, women informal sector workers, and the situation of one urban and one rural community, were carried out as a part of a programme on "The Political and Social Context of Structural Adjustment in Sub-Saharan Africa". The volume deals with the relation between affecting structural adjustment and changes in the social conditions affecting lower income social classes in Zimbabwe.

3.4.24

Author: Gish O.

Title: Economic dependency, health services, and health: the case of Lesotho.

Publisher: Journal of Health Politics, Policy & Law. 6(4):762-79

Year: 1982

Country: Lesotho

Keywords: Economics, health services

Location: Unknown





3.4 EQUITY IN RESOURCE ALLOCATIONS FOR HEALTH

Pages: 17pp.

Abstract: This paper is concerned with two factors affecting health in Lesotho: (1) the nation's function as a reserve labour economy (the primary source of income for about half the country's male labour force is employment in South Africa); and (2) the health care system (its size, composition, accessibility, and efficiency). Although such diverse factors are often analyzed independently, they might be combined to provide a more complete understanding of the determinants of health. The paper concludes that any substantive solutions to the problems of Lesotho will be found primarily in the wider southern Africa setting, and not within the context of small, dependent nation states. At the same time, these small, dependent nation states must make development decisions considering existing geopolitical realities. Foresightful decision making on these issues could both contribute immediately to the health of the people of Lesotho, and also increase in longer-term possibilities for a better life for all the people of southern Africa.

3.4.25

Author: Haddad S, Fourier P

Title: Quality, cost and utilisation of health services in developing countries. A longitudinal study in Zaire

Publisher: Social Science and Medicine 40(6): 743-53

Year: 1995

Country: Zaire

Keywords: Health services, cost, utilisation

Location: UZ Medical School

Abstract: See 3.3.16





3.4 EQUITY IN RESOURCE ALLOCATIONS FOR HEALTH

3.4.26

Author: Health Reforms News

Publisher: Health Reforms News April-June

Title: Health reforms does not equal user charges: the need for reflection and careful action

Year: 1995

Country: Zambia

Keywords: Health reforms; Independent fee schedules; Utilisation; Changes in government health system

Location: WHO Library

Pages: 2pp.

Abstract: The article examines the effect of the introduction of user fees for health in Zambia. These were introduced into the government health sector in 1989. The article questions the necessity user charges for health criticises the lack of guidelines on the structure or level of charges to the levied, with resulting implementation varying widely across the country, some decisions being taken at district level, others at provincial or even facility level. The paper suggest that since the success of the reforms depends on popular support, districts should regularly monitor health service utilisation and local about charges in order to be clear about the effects of policies and practices.

3.4.27

Authors: Hogh B, Petersen E

Title: The basic health care system in Botswana: a case study of the distribution and cost in the period 1973-1979

Publisher: Social Science and Medicine 19(8)





3.4 EQUITY IN RESOURCE ALLOCATIONS FOR HEALTH

Year: 1984
Country: Botswana
Keywords: Adolescence, Adult, Botswana, Child, Pre-school
Location: National Institute of Development Research and Documentation
Pages: 6pp.
Abstract: See 3.3.22

3.4.28

Authors: Kale R.

Title: Restructuring South Africa's health care: dilemmas for planners.
Publisher: BMJ. 310(6991):1397-9, May 27.
Year: 1995
Country: South Africa
Keywords: Health care, health planning
Location: U.Z. Medical Library
Pages: 2pp.
Abstract:

3.4.29

Authors: Kane-Berman JD. Taylor SP.

Title: Containing costs in public sector hospitals--a strategy for the future. Lessons from a large teaching hospital.
Publisher: South African Medical Journal. 78(3):154-7, 1990 Aug 4.
Year: 1990
Country: South Africa
Location: U.Z. Medical Library





3.4 EQUITY IN RESOURCE ALLOCATIONS FOR HEALTH

Pages: 3pp.

Abstract: Escalating costs of providing health care are cause for worldwide concern. In South Africa there is increasing concern about expenditure in the public and the private health care sectors. Although public sector expenditure has increased in per capita terms over the past 2 decades, at the micro-level comparison of expenditure over a 14-year period in one major teaching hospital region indicates that, despite increasing complexity and sophistication, real costs have not escalated at a greater rate than the consumer price index, if extraordinary factors are discounted. The development and utilisation of productivity and performance indicators are reviewed and some mechanisms for containing costs in public hospitals are discussed. These include formalized strategic planning and allocation of resources, rationalisation and reorganisation of services, improved productivity and utilisation of scarce health manpower, improved accounting and management information systems, and the development and use of measures of outcome. Concern is expressed regarding excessive quantification of costs and efficiency to the detriment of health care in general.

3.4.30

Author: Kinghorn A W

Title: Implications of the development of managed health care in the South African private health care sector

Publisher: South African Medical Journal 86(4): 335-338 April

Year: 1996

Country: South Africa

Keywords: Managed health care, South Africa

Location: UZ Medical Library





3.4 EQUITY IN RESOURCE ALLOCATIONS FOR HEALTH

Pages: 3pp.

Abstract: The South African private health care sector has been looking to managed health care (MHC) to control the unsustainable cost escalations of the last decade. This paper draws on experience of MHC in other countries, particularly the USA to assess its potential for solving the private sector's difficulties. In addition, it looks at problems which may be associated with MHC in a South African setting. The conclusion reached is that MHC alone cannot be seen as a panacea for the private sector's financial problems, although it may produce a degree of saving and be part of a solution. It is argued that MHC per se seems unlikely to compromise equity, quality of care or the public health care sector and that it may potentially promote national health policy objectives. However, if MHCs benefits are to be promoted and potential negative effects controlled ongoing monitoring of MHC, coupled with an appropriate regulatory and incentive environment, will be required.

3.4.31

Authors: Klopper JM. Taylor SP.

Title: The health and wealth of South Africa.

Publisher: South African Medical Journal. 72(11):799-801, 1987 Dec 5.

Year: 1987

Country: South Africa

Keywords: Health, political economy

Location: U.Z. Medical Library

Pages: 2pp.

Abstract: The per capita gross national product (GNP) in South Africa is examined as it relates to life expectancy and the infant mortality rate. Despite South Africa's





3.4 EQUITY IN RESOURCE ALLOCATIONS FOR HEALTH

relative wealth in per capita GNP terms, life expectancy at birth is 63-65 years and the national infant mortality rate according to Unicef, is unlikely to reach the target of 50/1,000 live births by the year 2000. The distribution of expenditure on health is contrasted between the former provincial administrations, the major local authorities, the national states and the homelands. The health resources allocation distribution is unlikely to ensure health for all by the year 2000.

3.4.32

Author: LaFond A
Title: Sustaining Primary Health Care
Publisher: Earthscan Publications Ltd London
Year: 1995
Country: General
Keywords: Primary health care; Health planning
Location: TARSC
Pages: 195pp.
Abstract: See 3.2.16

3.4.33

Author: Lennox J
Title: Paying for health: Poverty and structural adjustment in Zimbabwe
Publisher: Oxfam Publications
Year: 1994
Country: Zimbabwe
Keywords: Health; Poverty; Structural adjustment; Zimbabwe
Location: OXFAM





3.4 EQUITY IN RESOURCE ALLOCATIONS FOR HEALTH

Pages: 35pp.
Abstract: See 3.3.30

3.4.34

Author: Lesotho Ministry of Health and Social Welfare

Title: Health: Building partnership for the Lesotho Health sector reform.

Publisher: Round Table Conference on Health and Population

Year: 1995

Country: Lesotho

Keywords: Lesotho; Health sector; Health sector goals

Location: WHO Library

Pages: 8pp.

Abstract: This document, arises directly out of a Round Table Conference for Lesotho aimed at promoting dialogue and consensus between government and its development partners on the policies, priorities and programmes in the above sectors, and to raise the resources required for their implementation. The macro-economic situation in which these planned developments are located is one of contrast and uncertainty. On the one hand, macro-economic reforms involving tight expenditure controls and more effective revenue raising measures have been highly successful in correcting serious deficits in the fiscal and external balances. On the other, growth has been highly uneven and poverty and unemployment have risen. However, the scope for an across the board demand stimulus is limited, and further structural reforms to the economy, including civil service reform and a transformation of the economic role of the state, have been identified as important pre-requisites for sustainable and equitable growth.





3.4 EQUITY IN RESOURCE ALLOCATIONS FOR HEALTH

3.4.35

Author: Lesotho Ministry of Health

Title: Report of a workshop on National Health and Social welfare policies for the decade 1993-2003

Publisher: Ministry of Health and Social Welfare, Lesotho

Year: 1993

Country: Lesotho

Keywords: Health policy

Location: Unknown

Pages: Unknown

Abstract: The workshop on health and social welfare policies identified diseases such as tuberculosis, STDs, AIDS infection as problems in adults and adolescents. Some diseases such as diarrhoea were identified as contributing to the high mortality and morbidity.

3.4.36

Author: Litvack J I, Bodart C

Title: User fees plus quality equals improved access to health care: results of a field experiment in Cameroon

Publisher: Social Science and Medicine 37(3)

Year: 1993

Country: Cameroon

Keywords: user fees; health; Cameroon; Africa; financing; access; quality; teaching; equity; 2; health care

Location: UZ Medical Library

Pages: 14pp.





3.4 EQUITY IN RESOURCE ALLOCATIONS FOR HEALTH



Abstract:

3.4.37

Authors: Loewenson R. Sanders D. Davies R.

Title: Challenges to equity in health and health care: a Zimbabwean case study.

Publisher: Social Science & Medicine. 32(10):1079-88

Year: 1991

Country: Zimbabwe

Keywords: Equity, health care, Zimbabwe

Location: TARSC Library

Pages: 9pp.

Abstract: The current economic crisis in Africa has posed a serious challenge to policies of comprehensive and equitable health care. This paper examines the extent to which the Zimbabwe government has achieved the policy of "Equity in Health" it adopted at independence in 1980, or provision of health care according to need. The paper identifies groups with the highest level of health needs in terms of both health status and economic factors which increase the risk of ill health. It describes a series of changes within the health sector in support of resource redistribution towards health needs, including a shift in the budget allocation towards preventive care, expansion of rural infrastructures, increased coverage of primary health care, introduction of free health services for those earning below Z\$150 a month in 1980, increased manpower deployment in the public sector and the reorientation of medical training towards the health needs of the majority. The implementation of equity policies in health have however been challenged by several trends and features of the health care system, these becoming more pronounced in the economic stagnation period after 1984. These include the reduction in allocations



3.4 EQUITY IN RESOURCE ALLOCATIONS FOR HEALTH

to local authorities, increasing the pressure for fees, the static nominal level of the free health care limit despite inflation, the continued concentration of financial, higher cost manpower and other resources within urban, central and private sector health care and the lack of effective functioning of the referral system, with high cost central quaternary facilities being used as primary or secondary level care by nearby urban residents. While primary health care expansion has clearly been one of the success stories of Zimbabwe's health care post 1980, the paper notes plateauing coverage, with evidence of lack of coverage in more high risk, socio-economically marginal communities. Measures to address these continuing inequalities are discussed. Their implementation is seen to be dependent on increasing the capacity and organisation of the poor to more strongly influence policy and resource distribution in the health sector.

3.4.38

Author: Loewenson R, Chisvo M

Title: Transforming social development: the experience of Zimbabwe

Publisher: UNICEF

Year: 1994

Country: Zimbabwe

Keywords: Social development, health, education, Zimbabwe

Location: TARSC Library

Pages: 220pp.

Abstract: See 3.3.35

3.4.39

Author: Maveneka L





3.4 EQUITY IN RESOURCE ALLOCATIONS FOR HEALTH

Title: IMF cuts wreck Zimbabwe's health achievements
Publisher: Development and cooperation No.5 pp27-28
Year: 1994
Country: Zimbabwe
Keywords: Health care; structural adjustment, Zimbabwe
Location: ZIDS
Pages: 2pp
Abstract: The number of women dying in child-birth has doubled in Harare since Zimbabwe entered the Economic Structural Adjustment Programme. In 1989, the last full year before the programme imposed cuts in health spending, 101 maternal deaths were recorded. Two years later the total rose to 242. Until the introduction of the adjustment programme in October 1990, Zimbabwe's health achievements were held up as a model for the region. Infant mortality fell from 140 per 1000 live births in 1980 to 50 in 1989 largely as a result of massive government commitment to improving primary health care. Since the introduction of fees in 1991, people are making fewer visits to hospitals and clinics. Other measures taken under ESAP have lowered the living standards of the poor majority of the population already suffering from the impact of HIV infection and the worst drought of the century. The devalued currency, high inflation, removal of price controls and reduced real minimum wages in many sectors of the economy, along with rising unemployment, all render the poor more vulnerable to hunger and illness. For many Zimbabweans the real cost of 'adjustment' is illness and mortality.

3.4.40

Authors: McIntyre D E, Dorrington R E

Title: Trends in the distribution of South African care expenditure





3.4 EQUITY IN RESOURCE ALLOCATIONS FOR HEALTH

Publisher: South African Medical Journal 78(3):125-129

Year: 1990

Country: South Africa

Keywords: South Africa, health economics

Location: UZ Medical Library

Pages: 4pp.

Abstract: The lack of critical distinction between the public and the private health sectors and what they represent has allowed the claim to be made that South African health care expenditure levels compare favourably with international standards. This paper considers the distribution of health expenditure between the public and the private sectors in South Africa, within these sectors and also on the basis of population group. The extent of maldistribution of health care resources among the people of South Africa is highlighted. The data analysed in this paper indicate that an increasing proportion of public sector expenditure has been spent on curative services, that the gap in real; per capita expenditure between the 'homelands' and other public sector departments has been widening, and that per capita expenditure has been increasing more rapidly in the private sector, particularly in the 1980s.

3.4.41

Authors: McIntyre D, Bloom G, Doherty J and Brijlal P

Title: Health Expenditure and finance in South Africa

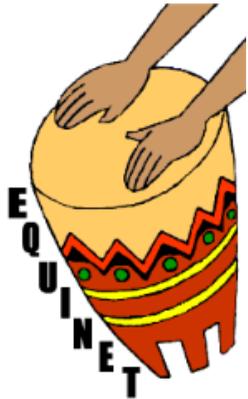
Publisher: Health Systems Trust and the World Bank

Year: 1996

Country: South Africa

Keywords: South Africa; Public health services; Health finance





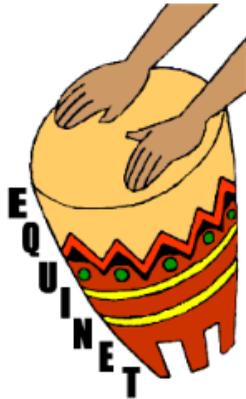
Location: UZ Medical School Library

Pages: 15pp.

Abstract: This comprehensive survey of public and private expenditure on health care was undertaken to provide the newly elected government with information relevant to managing to the process of change in the post-apartheid South Africa. It reviews the current levels and distribution of health system expenditure as well as health personnel and facilities - both within the public sector (for example, distribution between provinces, and rural and urban areas) and between the public and private sectors. Data are primarily drawn from the 1992/93 financial year. It reveals for the first time the extent of spending on private health care. Although only 17% of the population are members of a medical scheme 23% use private sector services on a regular basis, almost three fifths of health expenditure is on private sector services. Nearly two-thirds of this private sector expenditure was funded through medical schemes in 1992/3 and around 23% was funded by direct payments. Expenditure by medical schemes increased faster than the rate of inflation over the previous decade. Approximately 62% of general doctors, 66% of specialists, 93% of dentists and 89% of pharmacists practice in the private sector. The survey illustrated that public health services were biased towards curative, hospital-based care and were distributed inequitably between provinces. An unusual feature of the review was that it included a micro-geographic area analysis of some aspects of resource allocation. Magisterial districts were sorted by income quintile and then compared. The richest districts employed 4.5 times as many doctors, 2.4 times as many registered nurses and benefitted from 3.6 times as much public expenditure per head of the population as the poorest districts. The survey findings are used to review a number of policy options that the government might consider, including: improving value for money in public hospitals, generating

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3.4 EQUITY IN RESOURCE ALLOCATIONS FOR HEALTH



revenue through user fees, the use of donor funding and the critical need for careful planning in ensuring that the process of structural change benefits poorer areas.

3.4.42

Authors: Mills AJ. Kapalamula J. Chisimbi S.

Title: The cost of the district hospital: a case study in Malawi.

Publisher: Bulletin of the World Health Organization. 71(3-4):329-39

Year: 1993

Country: Malawi

Location: U.Z. Medical Library

Pages: 10pp.

Abstract: The paper analyses the cost to the Ministry of Health of providing district health services in Malawi, with particular emphasis on the district hospital. District resource allocation patterns were assessed by carefully disaggregating district costs by level of care and hospital department. A strikingly low proportion of district recurrent costs was absorbed by salaries and wages (27-39%, depending on the district) and a surprisingly high proportion by medical supplies (24-37%). The most expensive cost centre in the hospital was the pharmacy. A total of 27-39% of total recurrent costs were spent outside the hospital and 61-73% on hospital services. The secondary care services absorbed 40-58% of district recurrent costs. Unit costs by hospital department varied considerably by district, with one hospital being consistently the most expensive and another the cheapest. A total of 3-10 new outpatients could be treated for the average cost of 1 inpatient-day, while 34-55 could be treated for the average cost of 1 inpatient. The efficiency of hospital operations, the scope for redistributing resources district-



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wide, and the costing methodology are discussed.

3.4.43

Author: Mills A

Title: Current policy issues in health care reform from an international perspective: the battle between bureaucrats and marketeers

Publisher: London School of Hygiene and Tropical Medicine

Year: 1996

Country: General

Keywords: Health care; Market reforms

Location: TARSC

Pages: 27pp.

Abstract: The starting point of the paper is the increasing emphasis being placed on the failures of public sector provision of health services, and the need to reduce public involvement in provision and encourage competition as a means to increase efficiency. The paper examines the respective cases for two alternative health policy paradigms, one seeing improved management of public facilities as the means to increase efficiency; the other competitive forces. It reviews the evidence that either has been or is likely to be successful in increasing efficiency, concluding that the evidence is unconvincing either that public sector provision has necessarily failed, or that competitive contracting can do much better. It argues that while competitive efficiency, it may also introduce a new set of problems. Hence reforms to encourage competition must be introduced carefully and selectively; and be accompanied by evaluation.



3.4 EQUITY IN RESOURCE ALLOCATIONS FOR HEALTH

3.4.44

Author: Mooney G

Title: Equity in future South African Health Care: A tale of minimally decent Samaritans or good South Africans?

Publisher: University of Cape Town Medical School

Year: 1998

Country: South Africa

Keywords: Equity; health economics; South Africa

Location: TARSC

Pages: 21pp.

Abstract: See 3.1.8

3.4.45

Author: Mwabu G

Title: Financing health services in Africa: an assessment of alternative approaches

Publisher: The World Bank

Year: 1990

Country: General

Keywords: Financing health services; Equity

Location: UZ Medical School Library

Pages: 19pp.

Abstract: The paper outlines a strategy for financing health services in Sub-Saharan Africa. The strategy takes into account the fact that the African continent consists of highly heterogeneous economies in terms of their stages of socio-economic development and types of political systems, so that a uniform method of financing





3.4 EQUITY IN RESOURCE ALLOCATIONS FOR HEALTH

3.4.46

Authors: Ogbu O. Gallagher M.

Title: Public expenditures and health care in Africa.

Publisher: Social Science & Medicine. 34(6):615-24

Year: 1992

Country: Africa

Keywords: Health care, health financing

Location: UZ Medical Library

Pages: 9pp.

Abstract: Unfavourable economic conditions in most of Sub-Saharan Africa have meant austerity and deceleration in government health spending. Given the dominant role of government in providing health services in Africa there is a need to investigate the links between public spending and the provision of health care. Analyzing information from five Sub-Saharan African countries, viz Botswana, Burkina Faso, Cameroon, Ethiopia and Senegal, the authors investigate the impacts of shifting expenditure patterns and levels on the provision of health services as well as on delivery of health care. The country analyses indicate that in addition to the level of





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public spending, the expenditure mix (i.e. salaries, drugs, supplies etc.), the composition of the health infrastructure (hospitals, clinics, health posts etc.), community efforts, and the availability of private health care all influence health care delivery. Consequently, per capita public expenditure alone as a measure of the availability of health care and especially for cross-country comparisons is inadequate. Reductions in government resources for health care often result in less efficient mixing of resources and hence less health care delivery, in quality and quantity terms. Given recent trends in health spending there should be greater effort to increase the efficient use of increasingly scarce resources, yet the trend in resource mix has been in the opposite direction. Given the input to public health care of local communities, as well as the provision of private health care, government spending on health care should be counter-cyclical, i.e. government health spending should accelerate during periods of economic down turns. Such counter-cyclical spending would tend to offset the difficulties facing local communities and the declining ability of individuals to pay for private health care. Recommending counter-cyclical health spending may seem wishful, but it points up the necessity of understanding what is likely to happen to health care in African countries in the face of economic difficulties, and particularly in the face of fiscal austerity.

3.4.47

Authors: Pillay Y G, Bond P

Title: Health and Social policies in the new South Africa

Publisher: International Journal of Health Services 25(4): 727-43,

Year: 1995

Country: South Africa





3.4 EQUITY IN RESOURCE ALLOCATIONS FOR HEALTH



Keywords: Health policy, South Africa
Location: UZ Medical Library
Pages: 16pp.
Abstract: See 3.2.21

3.4.48

Author: Price M

Title: The consequences of health services privatisation for equality and equity in health case in South Africa

Publisher: Social Science and Medicine Vol 27

Year: 1988

Country: South Africa

Keywords: South Africa, health services; equity; health economics

Location: TARSC Library

Pages: 13pp.

Abstract: The trend towards the privatisation of health services in South Africa reflects a growing use of private sources of finance and the growing proportion of privately owned fee-for-service providers and facilities. Fee-for-service methods of reimbursement aggravate the geographical maldistribution of personnel and facilities, and the competition for scarce personnel resources aggravates the difference in the quality of the public and private services. Thus, the growth in demand for these types of providers may be expected to increase inequality of access in these two respects. The potential expansion of medical scheme coverage is shown to be limited to well under 50% of the population, leaving the majority of the population without access to private sector health care. Even for members of the medical schemes, benefits are linked to income, thus clashing with



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the principle of equal care for equal need. The public funds needed to overcome financial obstacles to access to private providers could be more efficiently deployed by financing publicly owned and controlled health services directly. Taxation also offers the most equitable method of financing health services. Finally, attention is drawn to the dilemma resulting from the strengthening of the private health sector: while in the short term this can offer better care to more people on a racially non-discriminatory basis, in the long term, health care for the population as a whole may become more unequal and for those dependent on the public sector it may even deteriorate.

3.4.49

Author: Price M

Title: Policies for Health sector development - Where does equity feature?

Publisher: Paper delivered to conference on equity in Health: Policies for survival in Southern Africa, Botswana

Year: 1997

Country: South Africa

Keywords: Health sector development policies; Equity in health

Location: TARSC

Pages: 13pp.

Abstract: See 3.1.10

3.4.50

Authors: Quinn V, Cohen M, Mason J, Kgosidintsi B N

Title: Crisis-proofing the economy: the response of Botswana to economic recession and drought From Adjustment with a human face 2: country case studies edited





3.4 EQUITY IN RESOURCE ALLOCATIONS FOR HEALTH



by Cornia G A, Jolly R and Stewart F

Publisher: Clarendon Press

Year: 1988

Country: Botswana

Keywords: Botswana, socio-economic factors, child health

Location: National Institute of Development Research and Documentation

Pages: 24pp.

Abstract: Botswana's response to its economic recession and drought during 1981-1986, reduced its domestic food supply and made the poverty of the 80% rural population much worse. Botswana must import about 60% of its staple food supply. During the 1970s and 80s Botswana had the highest growth rate of all non-oil exporting countries, but was dependent on only 1 product, diamonds, and on strong trade links with South Africa. In 1981 the diamond market faced a declining demand forcing the Government to take a series of adjustment policies to side step the potential economic crisis resulting in the successful increase of foreign exchange reserves. However, in spite of a short lived crisis, in 1982, the country began a 5-year drought that has 'remains the most critical development issue facing Botswana'. The worst effect of the drought has been the lack of food availability forcing the Government to accept increasing amounts of food aid reaching a level 62% of the population by 1985-86. The economic crisis led the government to develop Early Warning Technical Committee (EWTC) as part of the drought relief program to monitor the drought and its effects on people's lives. The Food Resources Department was organised for the administration of food aid in the country. Botswana's Drought Relief Program has been effective in protecting the welfare of its most vulnerable groups, children and farmers, through such measures as diverting large amounts of funding to relief activities, the ability to



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attract donor support in food aid and technical assistance, the participation of the private sector, and the fact that the 1.13 million people are still a small population in a country where infrastructure is very good.

3.4.51

Authors: Roemer M I and Roemer J E

Title: The social consequences of free trade in health care: a public health response to orthodox economics

Publisher: International Journal of Health Services 12(1)

Year: 1982

Country: General

Keywords: Free trade, public health, health outcomes

Location: TARSC Library

Pages: 1pp.

Abstract: In recent years, difficulties in US health services have been ascribed to excessive government intervention and regulation; high costs and other problems would be solved, it is argued, by 'return to the free market and competition'. Examination of the past operations of free trade and competition in health care, however, shows that in this market not one of at least five conditions necessary for effective competition exists. Numerous adjustment made by society reflect strikingly the problems caused by these market deficiencies (such as seriously inadequate information or the presence of major social 'externalities'). Furthermore, even these adjustments - such as medical ethics or health insurance - have generated serious secondary problems. Many types of waste and social inequity also persist, in spite of all the attempts to compensate for market failure. In effect, the so called free market in health care has survived only because of the extensive regulations and other actions taken to patch it up. Abandoning these adjustments would



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further aggravate current problems. Only replacement of free trade by systematic social planning could hope to achieve a health care system that allocates resources and distributes services both efficiently and equitably.

3.4.52

Author: Russell S

Title: Ability to pay for health care: concepts and evidence

Publisher: Health Policy and Planning 11(3):1-9

Year: 1996

Country: General

Keywords: Health financing; micro-economics

Location: Centre for Health Policy - South Africa

Pages: 19pp.

Abstract: In many developing countries, people are expected to contribute to the cost of health care from their own pockets. As a result, people's ability to pay for health care has become a critical policy issues in developing countries and a particularly urgent issue where households face combined user fees burdens from various essential service sectors such as health, education, and water. Research and policy debates have focused on willingness to pay for essential services and have tended to assume that WTP is synonymous with ATP. This paper questions this assumption and suggests that WTP may not reflect ATP. Households may persist in paying for care, but to mobilise resources that may sacrifice other basic needs such as food and education, with serious consequences for the household and individuals within it. The opportunity costs of payment make the payment unaffordable because other basic needs were sacrificed. An approach to ATP founded on basic needs and the opportunity costs of payment strategies (including non-utilisation) is therefore proposed. From the few studies available, common



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3.4.53

Authors: Russell S; Gilson L

Title: User fees at Government Health services: is equity being considered?

Publisher: London School of Hygiene and Tropical Medicine Mimeo

Year: 1996

Country: United Kingdom

Keywords: User fees; Health Services; Equity

Location: UZ Medical School Library

Pages: 6-8pp

Abstract: The report talks about the trends in health financing in different countries. The role of the state in the financing and delivery of health services is reconsidered. The report analyses a wide range of options available for governments to promote equity in health provision without exempting the poor from medical care. Relevant information about the potential impact of fees on equity and the feasibility and effectiveness of policy mechanisms which can be designed to protect the poor is given. The report concludes that policy development needs to take place more





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cautiously and in a more informed environment. The actual or potential impact of fees on different population groups, and the feasibility of implementing policies which are designed to promote equity (such as exemptions for the poor), need to be seriously considered to prevent user fees exacerbating existing inequalities in health care financing and provision.

3.4.54

Author: Segall M

Title: Planning and politics of resource allocation for primary health care: promotion of meaningful national policy

Publisher: Social Science and Medicine 17(24):1947-1960

Year: 1983

Country: Zimbabwe

Keywords: Primary health care, health planning, political economy

Location: TARSC Library

Pages: 13pp

Abstract: See 3.2.23

3.4.55

Authors: Shaw R P, Griffin C C

Title: Financing health care in sub-Saharan Africa through user fees and insurance

Publisher: The World Bank

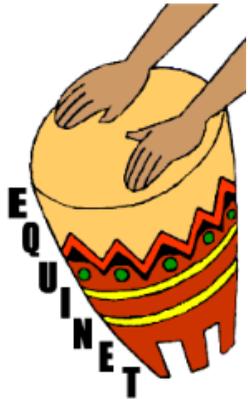
Year: 198?

Country: United States

Keywords: Financing health care; User fees and insurance

Location: School of Social Work





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Pages:

11pp.

Abstract:

The feature analyses the implications of the principle of cost recovery introduced by the World Bank in 1987. It revisits the debates and policy thrusts on the economic and social implications of such an approach. In the of sub-Saharan Africa, agreement is growing that some kind of cost sharing is needed in view of escalating health costs and the limited capacity of Ministries of Health to finance or deliver subsidised health care to all citizens. The government's ability to finance and expand health services has been undermined by unstable economic performance, unprecedented rates of population growth, and the immense cost that the AIDS epidemic is imposing on public health budgets. The paper notes that charging user fees clearly affects the use of health services, but the negative impact of prices on the demand for services can be greatly offset, sometimes, by improving the quality of services offered. This offsetting mechanism affects even the poorest households. Several African governments are adopting user fees and promoting self-financing health insurance to help restore efficiency and equity to national health systems. Such initiatives are creating a more rational referral system through price signals; employing cost sharing to supplement funding for essential supplies, particularly drugs; increasing incentives to providers by allowing them to retain fees they collect; and expanding local participation in both sharing the costs and managing the proceeds. The authors assert that as countries gain experience in administering and collecting fees and as users of health services become more familiar with the system and willing to pay for treatment, the gap between the potential and actual roles of cost sharing narrows. Closer scrutiny of countries where self financing was believed to be virtually non-existent has revealed a surprising amount of small-scale activity. Governments have a critical role in pushing these positive development further, particularly in



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3.4.56

Author: Snyman I

Title: Financing health care: experiences and opinions of some South Africans

Publisher: HSRC South Africa

Year: 1994

Country: South Africa

Keywords: Health financing; health services

Location: SARDC Library

Pages: 68pp.

Abstract: South Africans have fairly good access to health services but among Blacks provision for medical expenditure is limited in the country, particularly rural ones were also less well provided than others. A questionnaire was carried out to explore the opinions and experience of South African's on health services and their cost. The issues surveyed included views on the availability, accessibility, affordability and quality of health services preferences regarding the location or setting of services and extent of respondents own provision for health care.





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3.4.57

Publisher: UNICEF, Ministry of Health and Child Welfare Zimbabwe

Title: District health service costs, resource adequacy and efficiency: a comparison of three districts.

Year: 1996

Country: Zimbabwe

Keywords: District health services; utilisation, efficiency; Zimbabwe

Location: ZIDS

Pages: 10pp.

Abstract: See 3.3.59

3.4.58

Publisher: University of Zimbabwe, Department of Economics

Title: Draft project proposal: Macroeconomic adjustment policies (MAPs), Health sector reforms and impact on access to utilisation and quality of health care in Zimbabwe

Year: 1997

Country: Zimbabwe

Keywords: Macroeconomic adjustment; health sector reforms

Location: TARSC Library

Pages: 25pp.

Abstract: The paper analyses the changes that have taken place in the health delivery system from the pre-independence period to post independence period. It focuses attention particularly on health sector reforms introduced by the new government aimed at addressing inequities in health care in three consecutive periods: 1980 to 1987, 1987 to 1989 the ESAP period 1989 to the present. These periods highlight changes in government policy and thrust which led to structural changes in the





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health delivery system, access to and provision of health care. Structural adjustment policies led to the introduction of cost recovery measures and cuts in government public spending provision.

3.4.59

Author: Vogel R J

Title: Cost recovery in the health care sector in sub-Saharan Africa

Publisher: International Journal of Health Planning and Management vol 6: 86-191

Year: 1991

Country: Sub-Saharan Africa

Keywords: User charges; Efficiency; Equity; Africa

Location: UZ Medical School Library

Pages: 16pp.

Abstract: Cost recovery continues to be a politically delicate subject in sub-Saharan Africa. Nevertheless, ministries of health are now beginning to understand that the selective pricing of health care services can be a powerful tool for achieving the efficiency and equity goals that can be used to improve the quality of care offered. This article provides a blue-print for these nascent cost-recovery efforts. After a consideration of the rationale for cost recovery with a theoretical context, a set of pricing principles for the whole public health sector is presented and a prototypical systematic price schedule is derived from the principles. Constraints to effective and equitable cost-recovery are then discussed, and topics for further empirical research suggested.



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3.4.60

Author: Walker G

Title: Primary health care in Botswana: A case study in cost-effectiveness

Publisher: Proceedings of the Royal Society of Medicine 69(12)

Year: 1976

Country: Botswana

Keywords: Botswana, cost benefit analysis, evaluation, primary health care, health services

Location: National Institute of Development Research and Documentation

Pages: 3pp.

Abstract: This discussion describes how the techniques of cost efficiency and cost effectiveness were used in Botswana to help in choosing between alternative ways of delivering primary health care: by mobile air and land services by static permanently staffed clinics. With regard to cost efficiency, the land mobile and fixed clinics were similar, while the air service was just over twice as expensive per patient contact. In regard to cost effectiveness, the cost of the fixed clinics was about 1/8 that of the land service and about 1/14 that of the air service, due almost totally to the larger proportion of patients seen at the fixed clinics where it was considered, due to continuous availability of care, that effective treatment was likely. The proportion of patients in whom effective care was thought to be likely seen by the periodic mobile services was much smaller. All the patients contacted by the mobile services were seen by the doctor, but only a minority of patients were seen by a doctor at the fixed clinics only. During visits made by the mobile services very little preventive health care was carried out. If greater emphasis had been planned upon such preventive measures as immunisation then the cost effectiveness of the mobile services could have been increased appreciably. The study findings suggest that mobile health services have a limited place in the



3.4 EQUITY IN RESOURCE ALLOCATIONS FOR HEALTH

3.4.61

Author: Walker G

Title: Unknown

Publisher: Medical Care 15(4)

Year: 1977

Country: Botswana

Keywords: Botswana, mobile health units, cost effectiveness

Location: National Institute of Development Research and Documentation

Pages: 10pp.

Abstract: Cost effectiveness techniques are used to simplify resource allocation decisions on land and air transport systems in the health services of a developing country. Outcome classifications are produced for patients seen by mobile and fixed primary care units. The mobile services examined were more costly (8-14 times greater per likely effective patient contact) than comparable care from permanently staffed fixed clinics. This was particularly so for the air-delivered service. This disparity in cost effectiveness was due mainly to the small proportion of patients seen by the mobile services who could be treated effectively in contrast to a far larger proportion at fixed clinics. This was a consequence of the periodic availability of care from the mobil services against the continuing provision of care at fixed clinics. The main justification for the use of transport in connection with primary health care is regular supportive (not policing) visits by skilled health workers to rural clinics. Land vehicles are cheaper than aircraft for visiting the





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more accessible facilities; for those more distant, the cost of journey by land vehicle is similar to those by aircraft.

3.4.62

Author: Watkins K

Title: Cost recovery and equity in the health sector: issues for developing countries

Publisher: OXFAM UK and Ireland Policy Department

Year: 1997

Country: UK

Keywords: Equity, health sector, cost recovery

Location: TARSC Library

Pages: 41pp.

Abstract: Over the past decade the poorest countries have struggled to maintain the provision of basic health services in the face of economic problems, the resurgence of poverty-related infectious disease, and population growth. Various prescriptions have been advanced for redressing the widening gap between need and resources. One such prescription is cost recovery. Rooted in market-oriented approaches to health finance, user-charges have been recommended by international agencies such as the World Bank and aid donors to mobilise new resources and rationalise service delivery. It is also claimed that cost-recovery programmes, supported by targeted exemption system, enhance equity by increasing the quality and quantity of services available to the poor. This paper traces the influence of cost-recovery prescriptions to the decline in political support for the universal provision of health services and the demise of rights-based approaches. The paper reviews cost-recovery programmes. It concludes that, contrary to the claims of their architects, such programmes have excluded



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vulnerable populations from access to basic health provision with damaging implications for equity. Exemption systems have generally failed to protect the poor. Evidence of a willingness to pay for health on the part of poor people, widely cited in defence of user charges, has been misinterpreted as evidence of an ability to pay, without reference to the costs associated with coping strategies adopted in response to health costs. The paper also questions whether national cost recovery schemes have succeeded in their objective of mobilising significant new resources. Cost-recovery programmes are often introduced in the context of structural adjustment programmes. The design and implementation of health reforms under these programmes are the outcome of a complex interaction between economic pressures, domestic political processes, and dialogue between governments and the World Bank. The paper describes the outcome of this process in Zimbabwe, where cost-recovery has reinforced other pressures now threatening to erode the gains in human welfare achieved since independence.

3.4.63

Author: Willmore B, Hall Nigel eds.

Title: Health manpower issues in relation to equity in and access to health services in Zimbabwe

Publisher: Journal of Social Development In Africa, School of Social Work

Year: 1989

Country: Zimbabwe

Keywords: Health manpower, equity, health services

Pages: 18pp.

Abstract: See 3.3.67





3.4.64

Author: Wyszewianski L, Donabedian A
Title: Equity in the distribution of quality of care
Publisher: Medical Care Vol 19 Supplement
Year: 1981
Country: General
Location: Unknown
Pages: 28pp.
Abstract:

3.4 EQUITY IN RESOURCE ALLOCATIONS FOR HEALTH

3.4.65

Author: Yach D
Title: Development and health: the need for integrated approaches in South Africa
Publisher: Mimeo
Year: 19??
Country: South Africa
Keywords: Health; development
Location: UZ Medical Library
Pages: 23pp.
Abstract: The impact of development policies on health are outlined within the context of epidemiological and demographic transition. Macro-economic policies have a major impact on the nutritional status of the population; agricultural policy and particularly changing patterns of land use have in the past resulted in forced resettlement with concomitant health effects, while the development of new irrigation schemes has increased the risk of vector-borne disease. Industrial and energy policies increase the risk of the population for a range of environmental and





occupational pollutants. Several adverse health impacts associated with urbanisation include poverty related disease (measles, nutritional diseases); all forms of trauma (from motor vehicle accidents to interpersonal violence); behavioral injurious to health (associated with tobacco, alcohol and sugar consumption); and sexually transmitted diseases. AIDS could well become a major impediment to all aspects of future development. The article concludes by recommending greater interaction between epidemiologists and economists so as to ensure that an integrated approach to development will result in enhancement of the health of people.

3.4 EQUITY IN RESOURCE ALLOCATIONS FOR HEALTH

3.4.66

Authors: Yusuf A, de Beyer J, Elmendorf E A, Kim S, Lamboray J L, Mohan P C, Niimi R, Obeng L, Peters D, Roseberry W, Shafer J, Shaw P

Title: A framework and indicative cost analysis for Better Health in Africa: Technical working paper No. 8

Publisher: Human Resources and Poverty Division: Africa Technical Department

Year: 1993

Country: General

Keywords: health, health economics, cost-benefit analysis

Location: National Institute of Development Research and Documentation

Pages: 2pp.

Abstract: District based-health care is equitable, effective, efficient, and now, as this paper illustrates, low cost. The concept of decentralised health care is widely accepted and increasingly implemented in many African countries. The analytical framework presented in the paper provides planners with a tool to conduct cost analysis, to evaluate current services and cost structures and to design health





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programs that are cost-effective and responsible to the health needs of the community. Using the framework outlined in this paper, it is estimated that a network of health centres, a district hospital, and a district health management team can deliver a package of services that could effectively meet over 90% of the health care needs of the majority of the population for approximately \$13.0 per capita per year in low income Africa. There are a wide variety of health care systems in Sub-Saharan Africa. Clearly, systems operating with several tiers cannot be expected to immediately convert to district based systems. The criteria for comparison between current systems and district based systems should be: equity in delivery service to all; effectiveness; efficiency in terms of the gap between potential and actual outputs; and cost effectiveness in terms of achieving the greatest benefits for the largest number of people for the lower cost.

3.4.67

Authors: Zigora T A, Chihanga S L, Makahamadze RB, Hongoro C, Hongoro F

Title: An evaluation of health financing reforms with special focus on the Abolition of user fees at rural health centres and rural hospitals.

Publisher: Ministry of Health and Child Welfare - Zimbabwe

Year: 1996

Country: Zimbabwe

Keywords: Health financing reforms; abolition of user fees; rural health centres and rural hospitals

Pages: 8pp.

Abstract: In March 1995 Ministry of Health and Child Welfare decided that no user fees would be charged at rural health centres and rural hospitals. In addition to this, the new policy prescribed that all referred patients were exempted from paying





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consultation fees at the next referral centre. The main aims of this policy change were to prevent the under utilisation of the rural health centres and to reduce the congestion at out patient departments at secondary, tertiary and quaternary levels of the health care system (strengthen the referral chain) as well as to cushion the rural majority from some of the negative effects of reforms in the health care sector. Being mostly interested in investigating whether the first objective had been successful, the researchers analysed utilisation statistic from all provinces on a number of districts. It was found that the out-patient attendance increased at the rural health centres and rural hospitals from March 1995 peaking in July 1995, after which utilisation declined probably due to lack of drugs and general shortage of essential inputs. Furthermore, there was a general increase of referrals from rural health centres and rural hospitals to district level and the district level out-patient attendance increased. It was noted that other factors than the reform could have impacted on the utilisation pattern.

3.4.68

Author: Zimbabwe Ministry of Health and Child Welfare

Title: Strengthening district health systems - an approach towards equity in health: the Zimbabwe experience

Publisher: Ministry of Health

Year: 1989

Country: Zimbabwe

Keywords: Health policy, Health services

Location: Zimbabwe Ministry of Health and Child Welfare

Pages: Unknown

Abstract:





3.4 EQUITY IN RESOURCE ALLOCATIONS FOR HEALTH

3.4.69

Author: Zimbabwe Ministry of Health and Child Welfare

Title: Hospital fee retention in Zimbabwe: Management and Impact

Publisher: Ministry of Health and Child Welfare

Date: 1996

Country: Zimbabwe

Keywords: Health care, fees, financial management

Location: Zimbabwe Ministry of Health and Child Welfare

Pages: Unknown

Abstract: Prior to 1996/97 all fee revenues collected by Government including health facilities were deposited into the Treasury's Exchequer Account, and fee income did not affect allocations made. Consequently, total hospital fees collected by the Ministry of Health were only 2% of government annual recurrent allocation to health in 1990/91-1995/96. In September 1996, government decided that hospital fees being paid by patients would be retained by the collecting institution. While the study is not completely finalised, preliminary results showed that of the seven provincial hospitals visited, in five of these there seemed to be a tendency (weak or strong) to increasing fee income after September 1996. Moreover, there was no clear indication that utilisation of health services declined as measured by the out patient attendances per month in the provincial hospitals.





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3.5.1

Author: Brevman P

Title: Comments and recommendations for next phase of equity work in Zimbabwe, reflecting discussions during and immediately following Nyanga Workshop on Equity

Publisher: Zimreport A14 13/8/97

Year: 1997

Country: Zimbabwe

Keywords: Equity, health

Location: TARSC

Pages: 5pp.

Abstract: See 3.2.5

3.5.2

Author: Carr-Hill R A

Title: The measurement of inequities in health: lessons from the British experience

Publisher: Social Science and Medicine 31

Year: 1990

Country: UK

Keywords: Measurement, equity

Location: UZ Medical Library

Pages: 11pp.

Abstract:





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3.5.3

Author: Castellanos P L

Title: Health situation analysis and inequities in health.

Publisher: American Public Health Association

Year: 1992

Country: USA

Keywords: Monitoring, equity, health

Location: Unknown

Pages:

Abstract:

3.5.4

Authors: Chandiwana SK, Moyo I, Woelk G, Sikosana P, Brevman P, Hongoro C

Title: The essential step: An interim assessment of equity in health in Zimbabwe.

Publisher: Report prepared for the workshop on A situational and trend analysis in equity in health and health care in Zimbabwe, 2-4 August

Year: 1997

Country: Zimbabwe

Keywords: Equity in health; health indicators, Zimbabwe

Location: TARSC

Pages: 5pp.

Abstract: An equity in health project was formerly embarked upon in October 1996, in Zimbabwe. The first-phase conducted a situation and trend analysis on equity in health and health care in order to inform multi-sectoral policies. The report noted the need to work out equity standards, prepare strategies for achieving these as well as related training materials for health planners and managers. Such





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standards should be used for monitoring and surveillance of equity. An important role of the public sector is that of setting standards and regulating the private sector to ensure quality of services. Training is needed for development of a constituency and institutional mechanisms for ensuring equity considerations in health projects and for tracking internal and external resource flows. There is need for a transparent monitoring and evaluation mechanism to assess the extent of equity in health care.

3.5.5

Author: de Kadt E, Tasca R
Title: Promoting equity: a new approach from the health sector
Publisher: Pan American Health Organisation; World Health Organisation
Year: 1993
Country: Brazil
Keywords: Risk; equity; health measurement
Location: WHO
Pages: 91pp.
Abstract: See 3.1.5

3.5.6

Publisher: Health Reforms News
Title: Health reforms does not equal user charges: the need for reflection and careful action
Year: 1995
Country: Zambia
Keywords: Health reforms; health financing, monitoring





3.5 MONITORING EQUITY IN HEALTH

Location: WHO Library
Pages: 2pp.
Abstract: See 3.4.26

3.5.7

Author: Husein K, Adeyi O, Bryant J, Cara N B

Title: Developing a primary health care management information system that supports the pursuit of equity, effectiveness and affordability

Publisher: Social Science and Medicine 36(5)

Year: 1993

Country: General

Keywords: Primary health care; equity; health information system

Location: UZ Medical School

Pages: 11pp.

Abstract:

3.5.8

Author: Krieger N, Moss N

Title: Measuring the social inequalities in health

Publisher: Public health reports: 110 May-June

Year: 1995

Country: United States

Keywords: Inequalities in health; political economy monitoring

Location: Unknown

Pages: 3pp.

Abstract: Although socio-economic inequalities in health were high on the public health





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agenda during much of the first half of the 20th Century, they do not have a high profile in the United States. Unlike many European countries where public health data are routinely reported by a socio-economic measure (most often occupation), the United States generally presents health data by age, sex and race. This severely limits understanding of how and why differentials in health outcomes occur. In an era when cost-effective and targeted health planning is more important than ever, these deficiencies in the availability and reporting of data are no longer acceptable. Socio-economic data collected routinely that linked to health include employment status, amount and sources of income, size and composition of household supported by this income, hardship (poverty), assets (including housing tenure and sources of wealth), health insurance coverage, and completed educational level. Three different levels of socio-economic data should be evaluated, individual, household and neighbourhood, to allow for sharper distinctions among contributing causes of social inequalities in health and to target interventions more effectively.

3.5.9

Authors: Krieger N, Moss N

Title: Accounting for the public's health: An introduction to selected papers from a US Conference on "Measuring Social Inequalities in Health"

Publisher: International Journal of Health Services 26(3): 383-390

Year: 1996

Country: USA

Keywords: Public health, health management, political economy

Location: TARSC Library

Pages: 7pp.





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Abstract: Accounting for, and being accountable to, the public's health requires carefully documenting and analysing social inequalities in health. Controversies abound over which measures of socio-economic position to use, at which points in time, and at what level-e.g, individual, household, and neighbourhood. Important debates also concern how to analyse these data and relate them to inequalities race/ethnicity and gender. To improve tools for evaluating socio-economic gradients in health, in 1994 the US Public Health Service and National Institutes of Health sponsored a conference on Measuring Social Inequalities in Health. Research on social inequalities in health reveals that the "socio-economic status" (SES) scientific discourse is very limited in its ability to explain increasing inequalities in health globally. The Weberian category of status of individuals and construct of "life chances" that characterises most scholarly US research on social inequalities does not account for the remarkable growth in these inequalities and their relations to the global economic and social change in the United States and the world today. In recognition of these limitations Wright emphasises class rather than SES to understand growing social inequalities, relating them to the social relations of production rather than SES relations. Developing more powerful theories and methods to explain and eliminate social inequalities in health is necessary given the economic and political changes transforming the structure and composition of the global workforce and the degree of economic inequality within as well as between nations.

3.5.10

Authors: Mackenbach J P Kunst A E

Title: Measuring the magnitude of socio-economic inequalities in health: an overview of available measures illustrated with two examples from Europe.





3.5 MONITORING EQUITY IN HEALTH

Publisher: Social Science Medical 44(6): 757-771
Year: 1997
Country: Great Britain
Keywords: Inequalities in health; health measurement
Location: UZ Medical School Library
Pages: 21pp.
Abstract: This paper reviews the available summary measures of socio-economic inequalities in health. Measures differ in a number of important respects, including the measurement of (i) relative or absolute differences; (ii) effects of lower socio-economic status or of the total impact of socio-economic inequalities in health upon the health status of the population; (iii) simple versus sophisticated measurement techniques. Eight different classes of summary measures are distinguished. It is however, assessed that measuring inequalities does not revolve particularly given data limitations. Rather a blend of different summary measures may contribute to an understanding of these inequalities and their changes over time.

3.5.11

Authors: McCoy D, Gilson L
Title: Improving and monitoring the equity of health care provision: A discussion of the selection of indicators
Publisher: Mimeo
Year: 1997
Country: South Africa
Keywords: Monitoring equity; health care
Location: Centre for Health Policy, South Africa





3.5 MONITORING EQUITY IN HEALTH

Pages: 20pp

Abstract: The promotion equity of demands measures of health care provision that are useful for monitoring indicators to identify and target disadvantaged population groups and areas of the country for preferential attention and to identify appropriate strategies and interventions for preferentially improving health care provision to disadvantaged population groups and areas. It is also important to collect non-quantitative indicators used to guide and promote certain policy-making and health management processes. Indicators need to be selected and used in a way that drives the process of change, rather than to simply monitor change. Indicators that are used to monitor fairness need to be seen as tools that development rather than as tools of measurement.

3.5.12

Author: McPake B, Kutzin J

Title: Methods for evaluating effects of health reforms

Publisher: London School of Hygiene and World Health Organisation

Year: 1997

Country: United Kingdom

Keywords: Health policy; equity; health financing monitoring

Location: Unknown

Pages: Unknown

Abstract: This paper aims to identify simple methods to evaluate the effects of health sector reforms and to discuss the relative usefulness of various methods in different situations. It is noted that, where feasible, it is desirable to combine cross-sectional with longitudinal approaches (in addition to the descriptive analysis) to strengthen confidence in one's conclusions about the changes that are due to the





3.5 MONITORING EQUITY IN HEALTH

reform(s). Both longitudinal and cross-sectional approaches encounter the problem of controlling for the influence of external factors. For longitudinal approaches, looking for discontinuities in trends where a policy change is quite discrete, looking for changes which are sufficiently large to exclude the likelihood of a long term trend; and generating hypothesis about other explanations of a trend which one then attempts to reject, are all approaches for assessing such factors. Cross-sectional approaches, minimising the expected influence of confounding variables should be done in the design stage. A conclusion on the effects of a reform in one circumstance does not automatically apply in other settings or from local to national level.

3.5.13

Author: Mocumbi P

Title: Equity in health - Policies for survival in Southern Africa: Mozambique's Experience

Publisher: Mimeo

Year: 1997

Country: Mozambique

Keywords: Equity; Health, monitoring

Location: TARSC

Pages: 12pp.

Abstract: The paper looks at issues of equity in Mozambique and government and the efforts to increase equity. Equity in health care provision is achieved through an improved resource allocation mechanism that provides for measures of distribution and efficiency. The paper outlines several approaches towards monitoring equity being used in Mozambique, particularly in terms of the relationship between need and human and financial resource allocations. These





3.5 MONITORING EQUITY IN HEALTH



methods also allow for evaluation of efficiency in the relationship between resource allocations and output.

3.5.14

Author: Montoya-Aguilar C, Marin-Lira M A

Title: International equity in coverage of primary health care: examples from developing countries

Publisher: World Health Statistics Quarterly 39

Year: 1986

Country: General

Keywords: equity; primary health care; measurement

Location: TARSC Library

Pages: 8pp.

Abstract: This paper refers specifically to equity in health care coverage using the essential components of primary health care. A review of the experience of the industrialised countries shows that they are still confronted with problems in the assessment of health in equity and that they have less information on inequity in health care than on inequity in health status. It is thus important to measure population proportions with access to services and activity to population ratio. In carrying this out in some countries, inequalities in access are greater for sanitary facilities than for safe water and inequalities in access to safe water are greater than for health care units. Inequalities also seem to be greater for coverage with attendance for deliveries than for antenatal care. Measures of the inequality variable find their best application in the monitoring of trends, but they should not preclude the use of simple profiles. For the purpose of analysing inequalities in coverage, it is most practical to use population sub-divisions based on



3.5 MONITORING EQUITY IN HEALTH

geographical areas and sub-areas. This is the most frequently available information and possibly the most useful.

3.5.15

Author: Musgrove P
Title: Measurement of equity in health
Publisher: World Health Statistics Quarterly 39
Year: 1986
Country: General
Keywords: Equity, health, measurement
Location: Unknown
Pages: 10pp.
Abstract:

3.5.16

Author: National Institutes of Health
Title: Recommendations of the conference "Measuring social inequalities in Health".
Publisher: International Journal of Health Services 26
Year: 1996
Country: General
Keywords: Inequality in health measurement
Location: Unknown
Pages: 6pp.
Abstract:





3.5 MONITORING EQUITY IN HEALTH

3.5.17

Author: Pan-American Health Organisation Annual report of the Director

Title: The search for equity

Publisher: WHO

Year: 1995

Country: America

Keywords: Equity; health systems; monitoring

Location: WHO

Pages: 102pp.

Abstract: See 3.3.50

3.5.18

Author: Taylor C E

Title: Surveillance for equity in primary health care: policy implications from international experience

Publisher: International Journal of Epidemiology Vol 21

Year: 1992

Country: General

Keywords: Health surveillance, equity, primary health care

Location: TARSC Library

Pages: 6pp.

Abstract: This paper presents evidence from international experience showing that equity is not only justified morally, but makes primary health care effective and efficient. The papers provides the major arguments for equity, taking equity to mean the distribution of benefits according to demonstrable need rather than on the basis of political or socioeconomic privilege. The paper outlines a framework for





3.5 MONITORING EQUITY IN HEALTH

surveillance of equity, to identify high risk groups amongst whom health problems are concentrated and to trigger priority action. The paper outlines practical issues in the implementation of surveillance for equity and international field experiences of such surveillance, and in particular community based surveillance.

3.5.19

Authors: Taylor C, Sanders D, Basset M, Goings S

Title: Surveillance for equity in maternal care in Zimbabwe

Publisher: World Health Statistics Quarterly - Rapport Trimestriel de Statistiques Sanitaires Mondiales. 46(4):242-7,

Year: 1993

Country: Zimbabwe

Keywords: Surveillance, equity, maternal care

Location: UZ Medical School Library

Pages: 5pp.

Abstract: See 3.3.56

3.5.20

Authors: Wagstaff A

Title: Quality-adjusted life years (QALYs) and the equity trade off

Publisher: Journal of health economics Vol. 10

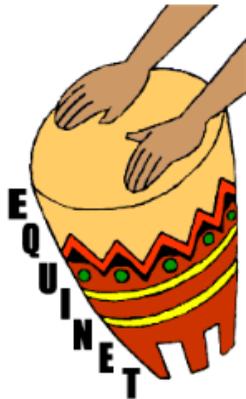
Year: 1991

Country: General

Keywords: Quality-adjusted life years; equity and efficiency; equality of access; equality of health; equity and choice.

Location: UZ Economics Department Library





3.5 MONITORING EQUITY IN HEALTH

Pages: 20pp.
Abstract: See 3.1.13

3.5.21

Authors: Wagstaff A, Paci P and van Doorslaer E

Title: On the measurement of inequalities in health

Publisher: Social Science and Medicine 33(5):545-557

Year: 1991

Country: General

Keywords: Inequalities in health, health measurement

Location: TARSC Library

Pages: 12pp.

Abstract: This paper offers critical appraisal of the various methods employed to date to measure inequalities in health. It suggests that only two of these-the slope index of inequality and the concentration index-are likely to present an accurate picture of socio-economic inequalities in health. The paper also presents several empirical examples to illustrate of the dangers of using other measures such as the range, the Lorenz curve and the index of dissimilarity.





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