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# Equity in health in the post 2015 development goals

*This policy brief reviews how far the promises of fair globalisation; rights to sustainable development, equity and global solidarity in the 2000 UN Millennium declaration were delivered for East and Southern Africa. The evidence points to key issues for the post 2015 agenda: There is an unfinished agenda in the MDGS, with wide inequalities in some areas, and monitoring of progress must be socially disaggregated. An agenda for universal health coverage should explicitly address equity in access and investment in strong primary health care services. Thirdly, economic growth is not enough, and public policies should also close wide gaps in access to resources for health, Finally, beyond development aid, global solidarity needs to more explicitly accelerate measures for wider benefit from markets, innovation and wealth in globalisation.*

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## A look back to 2000: The Millennium Declaration

In September 2000 the United Nations General Assembly 55th session passed the Millennium Declaration (A/RES/55/2). In the Declaration political leaders stated that, *"in addition to our separate responsibilities to our individual societies, we have a collective responsibility to uphold the principles of human dignity, equality and equity at the global level"*. The Declaration provided the political intentions that were the source for the Millennium Development Goals. It is thus an important reference point for reflecting on expectations post 2015. The Declaration explicitly asserted commitments:

- For "globalization to become a positive force for all the world's people", with wider benefit from economic innovation and wealth;
- To make "the right to development a reality for everyone" through policies and practices based on civil, political, economic, social and cultural rights and values
- To take special measures to address the challenges of poverty eradication and sustainable development in Africa, including "debt cancellation,… improved market access, increased flows of Foreign Direct Investment, as well as transfers of technology", reflecting solidarity and shared responsibility.

Beyond the specific goals, these commitments act as a useful reference point and framework for addressing health equity in the post 2015 discussions. The evidence to support this policy brief is drawn from the 2012 EQUINET Regional Equity Watch, country Equity Watch reports, AU and WHO AFRO reports and UN documents on the health theme in the post 2015 agenda.

## An unfinished agenda, and the aggregate is not enough

The 2011 report by the African Union, African Development Bank, UN ECA and UNDP on Assessing Progress in Africa toward the Millennium Development Goals (MDGs) highlights the progress made in Africa in addressing the MDGs, shown in the box overleaf:

**The AU report indicates that despite some progress, there is an unfinished agenda of global health commitments in Africa that cannot be displaced by new goals and must be sustained, supported and tracked post 2015.**



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### *PROGRESS IN AFRICA ON THE MDGS*

**Halve by 2015, the proportion of people who suffer from hunger:** Progress has been sluggish, with a small decline from 25% of people suffering from hunger in 1990 to 22% in 2010, partly due to high food prices.

**Halve the prevalence of underweight children under five years of age:** Progress has been sluggish and it is unlikely that this target will be met by 2015.

**Reduce by two thirds under-five and infant mortality:** U5MR fell by 28% between 1990 and 2009. Infant deaths showed a slight 4% decline from 1990 to 2009. These declines are insufficient to reach the target.

**Increase vaccination of children against measles:** Vaccination coverage against measles improved from 54% in 1990 to 84% in 2009.

**Reduce by three-quarters the Maternal Mortality Ratio:** The MMR declined at an average annual rate of just 1.7%, worse than any other global region.

**Increase the Proportion of births attended by a skilled birth attendant:** Limited progress made with less than 50% of births accessing a skilled birth attendant

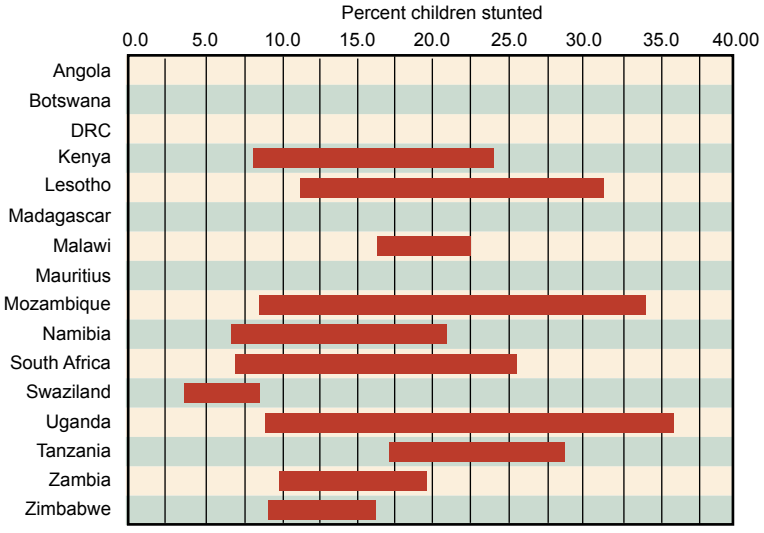
**Have halted and begun to reverse the spread of HIV:** There have been significant advances in availability of prevention and Anti-Retroviral Treatment (ART). HIV incidence has fallen, but so too has mortality from AIDS, so the number of people living with HIV has risen from 20 million in 1990 to 23 million in 2009. (AU et al 2011)

In 2012 WHO and UNICEF stated "The world has met the MDG target of halving the proportion of people without access to safe drinking water". However, 36% of Africans still did not access safe water by 2010, and 66% of poorest rural Africans did not access safe water, compared to 6% of wealthiest urban groups. This leaves 386 million Africans without access to safe water. Similar inequalities are found in infant and child mortality and in child undernutrition, as shown in the graph below. Aggregate figures can hide extremely high rates of ill health and mortality in more disadvantaged groups, and mask widening inequalities, even at times when aggregates have improved.

**It is thus not enough to track the aggregate- we need to track and close the gap within and across countries in reaching the MDGs.**

All countries have made commitments to the International Covenant on Economic, Social and Cultural Rights, which obliges states to ensure: "the right of everyone to the enjoyment of the highest attainable standard of physical and mental health." A gap of over 60% points in access to safe water, or a seven fold difference in child mortality between highest and lowest wealth groups highlights that we need to track and close social inequalities in health within countries, and globally.

**Differences by area in stunting of children under five years, East and Southern Africa, post 2000**




The bar for each country shows the % children stunted for the lowest region on the left to the highest on the right and indicates the range across regions

Source: EQUINET 2012, from DHS surveys post 2000

## *Break the inverse care law –equity in access and strong primary health care services in universal health coverage*

Health systems can confront and mitigate social inequalities in health through providing accessible and quality services and providing financial protection.

However, as shown in the figure below, there are still wide social inequalities in coverage of key services such as skilled birth attendance. Poorer social groups most in need of services have lower coverage.

Universal Health Coverage (UHC) means that everyone should be entitled to access the health services they need, and be protected against the costs of health services.

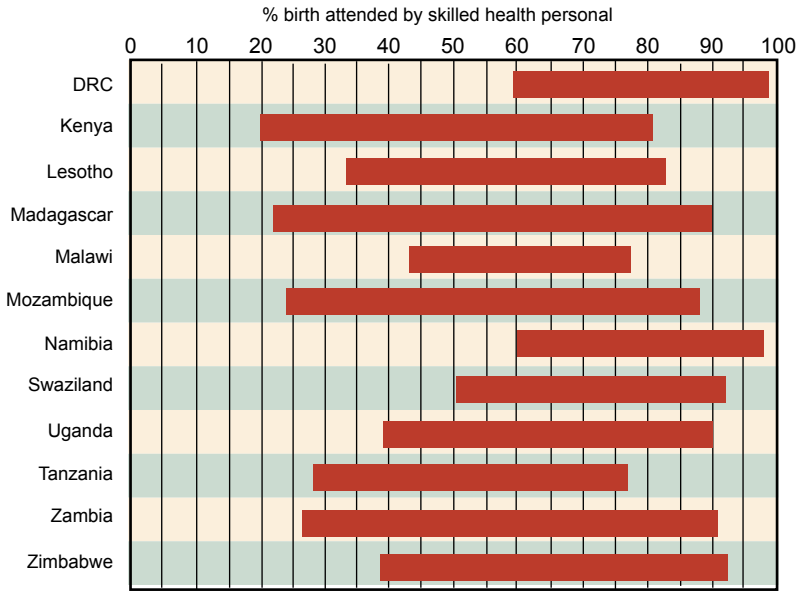
Within UHC we thus need to track how far services break the inverse care law by:

- Providing income and risk cross-subsidies (from rich to the poor and healthy to ill)
- Improving access to acceptable, quality services relevant to health needs
- lifting fees and providing adequate resources to avoid impoverishing costs of care, and
- being accountable to the local community and responsive to the patients and staff.

Evidence from ESA countries suggests that social differences in service coverage are lower when interventions are provided in the community and primary care services that are closer to communities. Inequalities widen when people have to travel to hospitals to get services such as assisted deliveries or antiretroviral therapy, and fall when such services are brought to primary care level. Benefit incidence studies show that public sector primary care services have greater benefit for poorer households.

**Within UHC, therefore, explicit attention needs to be given to ensuring and tracking that primary care services get the staff, medicines, domestic financing and infrastructure to deliver key services, including for non communicable diseases.**

**Differences by wealth in the share of births attended by a skilled health worker, East and Southern Africa, post 2000**




The bar for each country shows the % births attended by skilled personal for the lowest wealth quntile on the left to the highest on the right and indicates the rich to poor range

Source: EQUINET 2012 from DHS surveys post 2000

## Growth is not enough– close the gap in access to resources for health

Female literacy and improved gender parity in primary education have played a role in improved health. However, more limited progress has been made in other determinants, like access to safe water, sanitation and adequate food. This is not just about poverty, but about the way the benefits of growth are distributed. In some countries the same regions that are the source of cereal surpluses are those with highest levels of child stunting. While increased aggregate GDP growth in most ESA countries in the 2000s sets a favourable context for health, there are warning signs that growth is taking place with increasing inequality, and that economic growth alone cannot address poverty unless inequality is also reduced.

Within ESA countries, household and economic surveys show some pathways for this that need to be addressed in the sustainable development goals (SDGs):

- While rural – urban poverty has narrowed in the past decade there are signs of rising urban poverty, indicating that the SDGs need to address rapid unplanned urban growth, job insecurity and rising food prices.
- Wage shares have fallen relative to profit shares after the 1990s, suggesting that SDGs need to tackle investment of surpluses in job creation.
- There are deep gender disparities in agriculture. The SDGs need to show improvements in gender parity in access to land, inputs, information, markets and investment in smallholder food production for improved food security. Large scale foreign land acquisitions carry a risk of deepening these inequalities, especially given the challenges of climate change.

**Our post 2015 SDGs need to take on issues of social cohesion, ecological integrity, and fair benefit in resource flows. In ESA countries this includes reducing urban poverty, tracking investment in new employment and closing gender disparities in access to land and inputs for smallholder farming.**

## Aid is not enough – advance measures for global solidarity

How far have we moved from competitive relations between countries to the positive globalisation and solidarity envisaged in the Millennium Declaration? The Globalisation and Health Knowledge Network of the Commission on the Social Determinants of Health estimated in 2007 that the past 20 years of globalisation have not yielded the expected gains in life expectancy in Africa due to income inequality, economic volatility and capital outflows. By the time of the global financial crisis, developing countries, including those in ESA, were transferring about a trillion dollars more annually to wealthy countries than they received in foreign direct investment. Resources necessary for health flow out of the region through debt and other capital flows, health worker outmigration, unfavourable terms of trade, costs of patent regimes; under-valuing of natural resources and so on. In return, there has been inadequate transfer of technology, and patent rules continue to place barriers on access to health technologies. Privatisation of key public resources like water raise concerns about sustained inequality. In contrast, new public financing, such as through a a tax of only 0.05% on foreign currency exchanges, derivatives, shares and over the counter trading globally could raise $8.63 trillion annually for global goals, or 8000 times the annual amount needed to provide safe water for all.

**The intentions in the Millennium Declaration to ensure wider benefit from globalisation must be reflected and delivered on in the next round of SDGs. That includes accelerating measures for market access, for technology transfer, removing patent barriers through global funding of innovation and access, and improving solidarity funding of global goals.**

## RESOURCES


1. EQUINET (2012). Regional Equity Watch 2012, EQUINET, Harare
2. AU, ADB, UNECA, UNDP (2011) Assessing Progress in Africa toward the Millennium Development Goals, 2011, AU Addis Ababa
3. Global Thematic Consultation on Health (2013) Health in the post-2015 agenda Report of the April 2013 Meeting, Botswana



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