

BRIEFING ON EQUINET WORKSHOP ON RESOURCE ALLOCATION AND DEPRIVATION ISSUES

**Di McIntyre, Health Economics Unit, University of Cape Town with
the EQUINET Secretariat, June 2002**

Over a year ago, Equinet commissioned research into alternative methods of evaluating deprivation amongst communities as part of its effort to address inequity in health status. The findings of the research undertaken in South Africa pointed the way for a resource allocation system that prioritises proportionately those worst off for attention. The report of this work is published in Equinet policy series no 10, available at www.equinet africa.org

The team led by Di McIntyre of the Health Economics Unit at the University of Cape Town in partnership with the Centre for Health Policy at the University of the Witwatersrand, compared deprivation between small areas in South Africa and evaluated patterns of public sector resource allocation.

The dissemination of the findings and methods, together with a guide to the tools used in the project, have drawn interest among SADC countries wanting to explore the potential for resource allocation systems to address growing inequities in health status.

A recent workshop hosted by Equinet brought together research teams from Namibia, Tanzania and Zambia. The teams, comprising a mix of Health Department officials and researchers, discussed the appropriateness of lessons drawn from the South African experience for their own countries. The workshop was assisted by the presence of a team from the Western Australian Department of Health and Curtin University who have been using an innovative and participatory approach to resource allocation issues. This provided a useful contrast to the more statistical approach used in the South African study.

The country profiles showed varying issues of challenge for resource mobilisation. Although Zambia had undergone significant health sector reform, particularly in relation to decentralisation, centralised decision making around resource allocation between levels of care based on historical budgeting continued to perpetuate disparities. However the climate favours a shift of resources toward primary health care from the current situation where hospitals receive 60-80% of resources and for greater access to health care services. There are plans to revise the resource allocation formula to include a wider range of indicators of need such as the distribution of ill-health between districts.

Decision-making around resource allocation based on the historical budgeting process was blamed for the substantial differences in health and socio-economic status between geographic areas in Namibia. Despite improvements in health status since the 1990s, groups such as the San are still vulnerable. Among the challenges is the presence of a substantial private sector, that needs to be included in the equation along with a lack of clarity on how the allocation process takes place and what spending levels are for different geographic areas.

In Tanzania, which is in the process of decentralising its allocation to district level, a map of each district is being prepared to show not only location of infrastructure but also information such as population and health status indicators. This could form the basis for a more sensitive allocation process corresponding to health need. At present, a grant from donor 'basket-funds' is allocated to each district on the basis of

population size. Difficulty is posed by rural-urban and cross boundary migration with its impact on deprivation and confusion of population profile. Another key issue is the complex flow of funds from a range of sources for district health services (e.g. block grants, council own funds, basket grants, other sources) that need to be considered to ensure overall equity in district resources.

The workshop reviewed concepts of equity, deprivation or relative disadvantage and the issue of small area analyses. Equity as a concept was noted to go beyond equal expenditure per capita, to include assessment of need, removal of access barriers and even equality of health as its focus. The workshop identified determined indicators useful for evaluating the distribution of deprivation between geographic areas, including the use of statistical techniques to construct a deprivation index, the use of stakeholder focus group sessions or a combination of the two. The workshop also tested practical approaches statistical modelling, given the limited availability of relevant data.

The workshop identified alternative resource allocation mechanisms, based on evaluating inequities in the current distribution of resources through assessment of public sector health care expenditure data. Many countries have adopted needs-based formula to guide resource allocation decision-making, that include factors such as population size, demographic composition, health status indicators and greater cost of providing services in certain areas. The workshop noted the need to factor in the relative use of private vs public sector services and the generation of 'own-revenue' at the decentralised level. Also noted was the importance of getting 'buy-in' to promoting equitable resource allocation from key stakeholders, implying wide participation in identifying the variables to include and their relative weightings in a resource allocation formula. Stakeholder analysis is also regarded as important to identify and address likely opponents to resource redistribution to build links with policy champions for equity and resource redistribution objectives.

The Western Australian experience provided an example of use of a vertical equity approach to address vast disparities between Aboriginal and non-Aboriginal populations. Positive discrimination in favour of Aboriginal communities included a range of factors, including cultural ones. A consultative approach was used to ascertain Aboriginal community perceptions of factors contributing to ill-health and vulnerability/deprivation, and of the priorities for resource allocation. This involvement enabled communities to defend the allocation of resources. The incorporation of the concept of capacity-to-benefit had the effect of placing the focus on the positive spin offs for allocating more resources rather than on sickness, and directed resources to communities to develop Management, Economic, Social and Human (MESH) infrastructure.

Country teams at the workshop discussed relevant approaches for their context, and developed preliminary proposals for research around resource allocation. They indicated overwhelming support for a vertical equity approach using the definition of equity as equal access for equal need. They endorsed consultative approaches to research, eliciting 'buy-in' and stakeholder views. Interest in undertaking statistical analysis on deprivation issues was qualified by recognition that inadequate data may require simpler methods. Country teams are now finalising proposals focusing on using existing, secondary sources of data, supplemented by consultative processes with key stakeholders. Once country teams have undertaken their research, a further workshop will be held to compare experiences and results.

Further information on this initiative is available from the theme co-ordinator, Di McIntyre (dimac@cormack.uct.ac.za), or from the Equinet Secretariat (rlowenson@healthnet.zw or tmaistry@equinetafrica.org).