

**Theory of change driven equity analysis**  
**Protecting equity in the face of privatisation  
of health services in east and southern Africa**



**R Loewenson,  
Training and Research Support Centre**



**In the  
Regional Network for Equity in Health  
in East and Southern Africa (EQUINET)**

**EQUINET DISCUSSION PAPER 125**

**May 2022**

**With support from TARSC and OSF**

## Contents

Executive summary.....	2
1. Introduction: a theory of change equity analysis.....	4
2. Methods.....	5
3. The current situation: the public-private mix in health services.....	5
4. Equity issues in privatisation of health services.....	9
4.1 Equity issues in entitlements, assets and capabilities.....	9
4.2 Equity issues in social, health and financial protection.....	12
4.3 Impact on differential health and wellbeing outcomes.....	15
5. Discussion: Pathways for equity-oriented change.....	17
References.....	22
Acronyms.....	24

**Cite as-** Loewenson R (2022). Theory of change driven equity analysis: Protecting equity in the face of privatisation of health services in east and southern Africa, Discussion paper 125, EQUINET, Harare

**Acknowledgements:** Thanks to Sarah Simpson, EquiAct for contribution to the theory of change framework used and for peer review of this paper. Thanks to colleagues in EQUINET, PHM and other organisations for background discussions on the drivers and impacts of health service privatisation. Thanks to V Kernohan for copy edit of the paper.

Cover photo: Patients queuing for health care at a public service, Cape Town, D Baatjies, 2009, in EQUINET/TARSC,2009; Other photos used under non-commercial creative commons license.

## Executive summary

Funding for public health services paid from general taxation, provided universally and free at the point of access, is considered the most effective way of redistributing resources from high to low income groups while contributing to improvements in health. Nonetheless, in recent decades the privatisation of health services has expanded, through the in privatisation of services and expansion of private sector services in parallel with the public system, or in various forms of commercialised market reforms within public sectors, and the growth of public-private partnerships (PPPs).

In 2021, TARSC, working with EquiAct, explored the development of a theory of change (TOC)-driven framework for equity analysis. In particular, this was intended to use an analysis of drivers of inequities to identify pathways for change. The analytic framework followed the key elements of a theory of change using an equity lens: This included defining the desired changes and the strategic priorities and assumptions, mapping the current situation, and, for specific identified priorities, identifying and mapping the pathways for change. The work covered the 16 east and southern African (ESA) countries covered by EQUINET. Policy documents of ESA regional organisations and situation analyses produced in EQUINET post-2018, were used to identify strategic priorities to address three major areas of equity-oriented change in the region, viz: reducing current inequities in service coverage and health and wellbeing; reducing inequities in relevant services and possibilities for sustained health and wellbeing across the life course and inter-generationally; and reducing unfair, avoidable inequalities in health and wellbeing resulting from or in response to emergencies/shocks.

Based on this assessment, privatisation and commodification of essential health services was identified as one of the strategic priorities to be further explored within the TOC framework, drawing on available public domain documents post-2015 for the ESA region. This paper thus outlines equity-related evidence on privatisation in the ESA region in terms of differential entitlements, assets, endowments, and capabilities; differentials in vulnerability; health outcomes; and in life course, long-term and wider system consequences. Drawing on this evidence, the paper suggests elements of the pathways for responding to the equity dimensions of privatisation and reflections on which elements may have a broad impact on multiple dimensions of inequity. The presentation of areas for action on pathways for change (in Figure 3 in the paper) is not intended to be prescriptive. It rather intends to stimulate and inform dialogue and advocacy, understanding that what may be relevant and feasible depends on the country context.

The findings indicate that:

- a. Health care privatisation varies across ESA countries and takes various forms, from commercialisation within public health systems, contracting-out of services, public private partnerships (PPPs) and for-profit and not-for-profit private financing and service provision at different levels, including in pharmaceuticals and laboratories. It involves both domestic and foreign corporates and informal providers. *Reducing the resulting high out-of-pocket spending due to commercialisation is a priority.*
- b. Private/voluntary health insurance, PPPs and private health service provision are increasing in ESA. There is an acknowledged tension between the for-profit sector goal of maximising profit and the universal provision of health care as a right and public good. On the premise that ways can be found to overcome this, privatisation is being promoted to fill service deficits due to falling public expenditures and to meet rising service demand, especially from wealthier groups.
- c. In practice, the experience in ESA points to flaws in this premise that have implications for equity. In particular, experience in the region signals priorities to address to prevent inequities, particularly in: *a poorly enforced and inadequate regulatory framework; an economic policy focus that encourages investment while overriding health concerns; inequitable tax exemptions and public subsidies; strong corporate capacities and influence; off budget and non-transparent contracting, and weak monitoring of impact.*

- d. Private markets bring new revenue flows and technology, but mainly for the smaller share of formally employed wealthier groups or as informal, sometimes unregulated providers, at higher cost for poorer communities. Beyond this, the features of private for-profit services that undermine equity in coverage and financial protection include: *segmentation, undermining wider risk and income cross subsidies; the private sector pull on public resources, infrastructure and health workers, a distortion of service priorities towards personal, curative care; various drivers of cost escalation (higher priced technology, over-servicing, use of more expensive care and rising charges). The exclusion of pro-poor promotion and prevention interventions for population health and comprehensive primary health care (PHC) in many for-profit private services limits the upstream actions needed to strengthen equity.*
- e. The health outcomes from these trends are poorly assessed. Evidence suggests that those in more *precarious employment, communities around mines and other large projects, lower income households, and women and children*, have poorer health outcomes, in part due to weak coverage of their health needs, barriers to uptake and poor financial protection. More broadly, the shorter term financial gains need to be balanced against longer term, life-course and wider ecosystem consequences, including for managing pandemics and climate-related health risks.

The evidence presented in the previous sections suggests some actions that may be used to address the drivers of inequity from privatisation of services in pathways for equity-oriented change. The proposed actions for identified drivers of inequity are summarised in a figure (*Figure 3*) that shows immediate, mediating and longer-term structural actions and measures.

With ESA countries having different political economies and health systems, as noted, the options in the figure do not intend to be a prescriptive checklist, but rather showing key dimensions/elements of pathways for addressing inequities arising from privatisation in ESA health systems. It is intended to be useful for country context-specific social, technical and policy dialogue on which actions may be feasible priorities, as well as to clarify links, steps and connections between actions, and to identify actions that are key levers for other prioritised measures within pathways for change. Some actions, such as widening rights-based approaches, improved public sector capacities, improved information systems, strengthened public financing and widening options for public input and accountability, are seen to be relevant to more than one of the drivers of inequities associated with privatization of health services. Some actions also have impact on multiple dimensions of inequity. A number of the actions identified as 'immediate' are already being raised in policy dialogue in some ESA countries. Others that are more structural may take time. The theory of change approach to the analysis suggests mediating interventions that can link immediate actions to deeper measures, so that the former act not as an end in themselves, but as levers for deeper changes.

While many of the actions may appear to be primarily technical in nature, protecting and promoting equity and public sector services is inherently a structural and political issue. It demands consistent socio-political support and policy leadership, and negotiations that are inclusive of both technical measures and public interest actors. Evidence may be disregarded unless there is a deeper political, social and policy understanding of, and electoral commitment to, investment in public health systems and in comprehensive PHC as assets in attaining development, equity and economic wellbeing.

Fundamentally, the World Health Organisation (WHO) has unequivocally stated that universal health care services funded through taxation and free at the point of access are the most effective, equitable ways of funding and delivering public health services and delivering on health care rights and state duties. Motivating actions to address the inequities inherent in privatisation implies countering a common narrative that limiting privatisation of services undermines development. In contrast it implies promoting the right to health care, as embedded in many constitutions of ESA countries and the understanding that public sector health systems are central for universal health coverage (UHC) and equity. It calls for policy clarity that any public sector interactions with commercial entities must meet commitments to equity, equality, diversity and inclusion.

# 1. Introduction: a theory of change equity analysis

In 2021, Training and Research Support Centre (TARSC), as cluster lead of the 'Equity Watch' work in the Regional Network for Equity in Health in east and southern Africa (EQUINET), and working with EquiAct, explored the development and use of a theory of change (TOC)-driven framework for equity analysis. In particular, the steps of a TOC were applied to advance from an analysis of the determinants of inequities to analysis of pathways for change to improve health equity. A TOC approach was envisaged to help identify and frame pathways that may lead to desired equity outcomes. Broadly, the stepwise approach for a theory of change involves:

- a. Identifying the desired change.
- b. Analysis of the current situation and context to identify domains of change and choose strategic areas of priority.
- c. Analysis of the drivers of and opportunities and goals for change.
- d. Identifying the pathways of change and the assumptions that inform those pathways.

In a change process, it also involves planning for implementation and identifying processes and measures to monitor, review, and evaluate implementation (van Es et al., 2015; *Figure 1*).

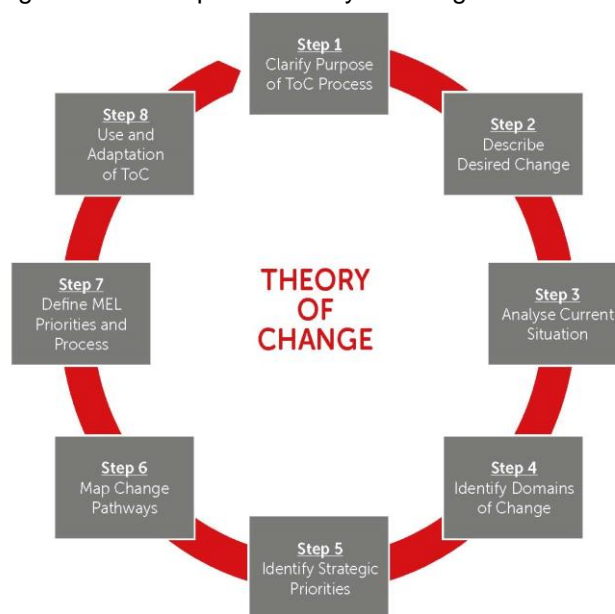
While this is usually implemented as a consultative process involving the affected stakeholders and implementers, this analysis used a desk review of public domain information for key steps of the process. The analytic framework followed key TOC elements using an equity lens to define the desired changes and assumptions, map the current situation, identify strategic priorities; and for the specific identified priorities, to identify and map the pathways for change.

The work covered the 16 east and southern African countries covered by EQUINET. Three major areas of equity-oriented change were identified in the region, viz: reducing current inequities in service coverage and health and wellbeing; reducing inequities in relevant services and possibilities for sustained health and wellbeing across the life course and intergenerationally; and reducing unfair or avoidable inequalities in health and wellbeing resulting from or in response to emergencies/shocks. Policy documents of ESA regional organisations and situation analyses produced in EQUINET post-2018 were used to identify strategic priorities to address these three areas of change. From this, six areas were identified as strategic priorities for health equity in the region, including the area that is the focus of this paper. The domains of change were identified through analysis of differentials in determinants of:

- *Exposures*: In terms of entitlements (rights, law, norms, sociopolitical perceptions of fairness and unfairness), assets or endowments (living/working/social/ecological conditions, financial and employment security) and capabilities (agency, voice, inclusion/networks).
- *Vulnerability*: In terms of social protection and support, norms, regulation, effective institutional and service coverage, access to markets and financial protection.
- *Outcomes*: In terms of measures of health and wellbeing, and
- *Consequences*: In terms of negative or positive feedback loops on exposure, vulnerability and intergenerational/longer life course, or wider family, social, population and ecosystem effects.

Drawing on this evidence, as a discussion section, the immediate, structural and mediating pathways were identified for advancing towards the identified domains of equity-oriented change.

Figure 1: The steps in a theory of change



Source: van Es et al., 2015:34 used under creative commons license  
MEL= Monitoring, evaluation and learning

## 2. Methods

Searches were made in 2021 using as search terms, *privatis/z\** OR *commodify\** OR *commercial AND health services OR equity AND Africa* in online libraries/ databases and institutional websites that provided cross country evidence for the 16 ESA countries post-2015 with a preference for most recent data. The online libraries were global databases (WHO, WB WDI, UNDP, SDG, UN data); regional resources (EQUINET, SADC, EAC, ECSA HC), Google, Pubmed, and the EQUINET newsletter database. Particular attention was paid to differentials in social features (eg: age, gender, racial/ethnic, education, conflict); area (eg: residential, rural/urban etc.); economic features (eg: income/ wealth, employment) and environments/ecosystems. . Prior EQUINET work on the topic in 2021 had also accessed grey literature from online media reports, country specific websites, blogs, international organisation briefs and from EQUINET steering committee members, and this was also integrated in the evidence gathered. A total of 42 documents were included. A structured template was used to capture and organise the evidence from the papers.

Only materials in English were included, with the limitation of exclusion of evidence from the two Lusophone and one Francophone countries in the region. As other limitations, there were variations in the quality and quantity of documented information for all countries, including on the equity dimensions. Some effort was made to triangulate across papers to identify the priority dimensions and drivers of inequalities. We assumed that in a context of limited evidence, best use is made of available evidence, especially where triangulation of evidence suggests major trends/issues. Some countries, e.g. South Africa and Kenya, were more highly represented than others. More detailed assessment within areas is needed to fully explore the equity drivers and implications within countries. Rapid changes in the situation in the region, in part due to the pandemic and its impacts, are also acknowledged. Nevertheless, the evidence gathered consistently points to some key domains of and pathways for change.

As part of the work to explore a TOC-driven framework for equity analysis, we applied various assumptions, that:

- a. Health, including as a right, is not merely absence of disease but complete social, mental, physical and ecological wellbeing, and that wellbeing covers physical, material, economic and psychosocial quality of life, service and ecological dimensions.
- b. Social, economic and ecological dimensions of inequality arise in: exposures to risk; various dimensions of vulnerability; health and wellbeing outcomes; and in longer-term life course and intergenerational consequences, including at ecosystem level.
- c. Public health efficacy and equity implies *acting upstream* (on structural determinants and common factors), and *collectively* in ways that maximise solidarity, universality, rights and self-determined capabilities.

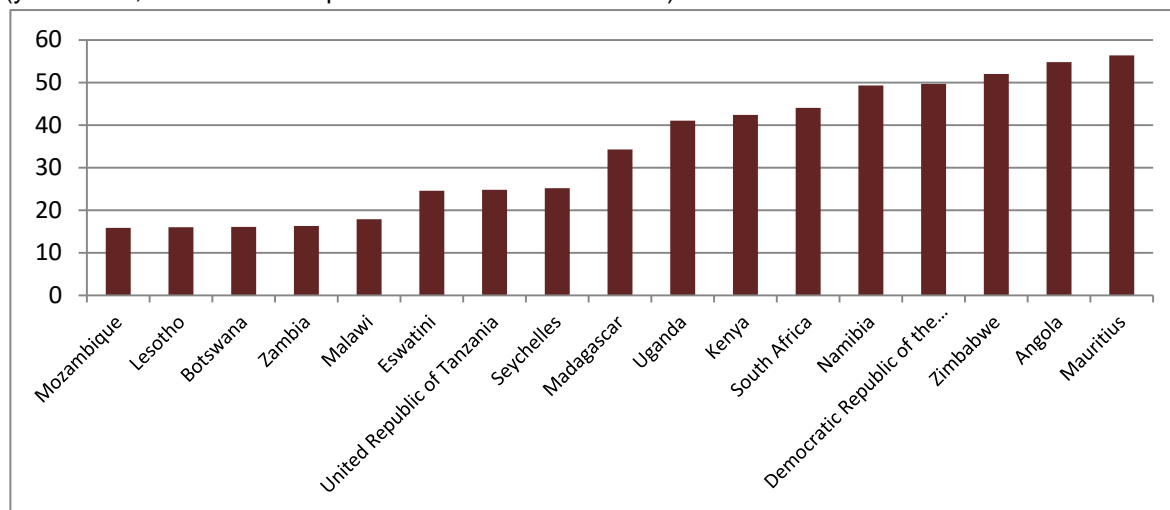
## 3. The current situation: the public-private mix in health services

Public funding for public health services, paid from general taxation, provided universally and free at the point of access, is considered the most effective method of redistributing resources from high to low income groups, and in contributing to improvements in health (Lethbridge 2016). Business principles and practices and profit motives have, however, been introduced in health care services in countries at all income levels, whether as corporatisation, marketisation, commercialisation or privatisation of health services. Private services may be positioned as: parallel systems to the public system; within public services as internal markets; in various forms of purchaser-provider split; or as outsourcing and contracting private actors for particular services and commodities within public services. Health care privatisation may thus build on a continuum of these forms of commercialisation through to public-private partnerships and, ultimately, private provision of health services, or may result from the independent expansion of private services within a national health system (Lethbridge 2016).

Domestic private expenditure as a share of current expenditure varies widely across ESA countries, from 16% in Mozambique, Malawi, Botswana and Zambia, to over 50% in the Democratic Republic of Congo (DRC), Zimbabwe, Angola and Mauritius (See *Figure 1*). In part, the share of private expenditure rises, not only when private financing rises, but also, when public financing falls, as has been the case in Zimbabwe, for example.

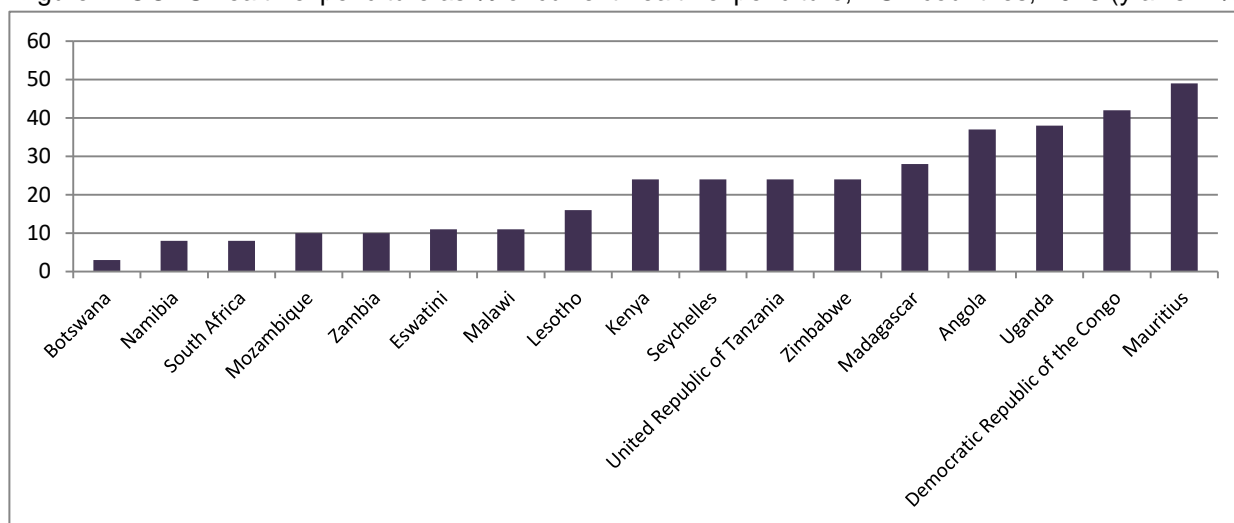
Private financing is contributed to in part in the form of out-of-pocket spending (OOPS) as services are commercialised or privatised. As *Figure 2* shows, countries with a low share of private health expenditure also tend to have low OOPS and vice versa, but this is not always the case. For example, South Africa and Zimbabwe, with higher levels of voluntary insurance have lower shares of OOPS than might be expected from their overall share of private spending. Uganda, in contrast, has a higher level than might be expected, suggesting informal or formal fee charges within public services and weak insurance coverage.

Figure1: Domestic private health expenditure as a % of current health expenditure, ESA countries, 2018 (y axis = %; Democratic Republic of the... refers to DRC)



Source: WHO Global Health expenditure database, 2021  
<https://apps.who.int/nha/database/ViewData/Indicators/en>

Figure 2: OOPS health expenditure as % of current health expenditure, ESA countries, 2018 (y axis = %)



Source: WHO Global Health expenditure database, 2021

The two figures indicate that it may be incorrect to generalise experience in the ESA region. We need to understand whether privatisation is taking place in countries where there is a large private health sector, or as the commercialisation or public private partnerships (PPPs) within largely public health sectors. There is need to differentiate between the *not-for-profit* private sector, which has close collaboration and resource links with public services in many ESA countries, and the *for-profit* private sector in its various forms. The for-profit sector may range from small informal providers to traditional and complementary service providers, to formal primary care/general practitioner, hospital, pharmaceutical and specialist services, and medical tourism (Foster, 2012). This paper focuses on the for-profit private sector, noting that the different forms may have different impacts. *Table 1* provides information compiled by Doherty (2011) on the spectrum of private financing and provision in ESA countries. There is likely to have been subsequent growth in both the scale and variability of providers. Doherty (2011) noted, for example, that private or voluntary insurance, and international organisations/NGOs providing private health services, were particularly targeted for expansion, while the recent COVID-19 pandemic has resulted in an expansion in private testing and care services (Chanda Kapata, 2021).

Table 1: Characteristics of the private health sector in ESA at a glance

Country	For-profit private sector				Not-for-profit private sector			SA health organisations input
	Private health insurance	Private hospital groups	Informal private sector	Medical tourism	FBO	NGO	External funding	
Angola	□□□		□□		□□		√	
Botswana	□	□					□□	x
DRC			□□□			√	□□	
Kenya	□	□	□	□		□□	□□	
Lesotho	□	□			□□		□□	x
Madagascar	□					□□	□□	
Malawi	□					□□	√√√	
Mauritius	□			□			√	
Mozambique	□		√√			√	√√√	
Namibia	□□	□	□		√		√√	x
South Africa	□□	□				√	√	
Swaziland	□	(√)			□□	√	√√	x
Tanzania	□		□□		√	√	√√√	
Uganda	□	□					√√	x
Zambia	□		□□		□□		√√√	
Zimbabwe	□□		□□				√	(x)

Key: √ small < 10% of THE; √√ medium & increasingly important 10–49%; √√√ large > 50% of Total Health Expenditure (THE); x present but no weighting applies; (√) & (x) emerging/ there are plans □ used for √ where the data is more anecdotal. *Sources:* Compiled by Doherty, 2011 from country profile data in Foster, 2012

Following the structural adjustment programmes that began during the 1980s, debt and investment conditionalities and market reforms led to reduced public funding, deregulation and a scaling back of the role of the state in many ESA countries (Williams et al., 2021). This created the conditions for the promotion of both private participation and of commercialisation and privatisation in the early 1990s across ESA countries, including through:

- **service contracts**, whereby private enterprises undertake specific functions on annual contracts;



- **management contracts**, whereby private enterprises manage publicly-owned health facilities and services that can last from two to five years;
- **lease contracts**, whereby private enterprises rent and upgrade existing public health facilities or spaces;
- **concession contracts**, whereby substantial new capital investment occurs in public establishments and the private sector has use of the new facility for a specified time (ten years or more) (Ruiters and Scott, 2009).

More recently, private health has become the fifth most promoted sector in Africa after tourism, hotels and restaurants, energy and computer services (UNCTAD, 2005), with Mauritius, South Africa, Botswana and Namibia named as the growth points for big capital investments in ESA, particularly in the pharmaceutical sector. The International Finance Corporation (IFC) has been a major advocate of the expansion of the private for-profit sector in Africa. The IFC estimated in 2016 that investment of \$25–\$30 billion will be needed from 2016–2026 in health care assets to meet health care demand in sub-Saharan Africa, and that this calls for an increased private sector role in health care (IFC, 2016; Doherty, 2011). Other arguments for privatisation have included the need to respond to an expanding African middle-class able to pay for health care and raising increasing demand for good quality services, the stagnation of external aid funding and the unmet funding gap to provide universal health coverage (UHC) (Doherty, 2011; IFC, 2016). In the wake of the COVID-19 pandemic, privatisation advocates have become even more vocal about the contribution of market activities in the health sector to technology, digital expertise and ‘modernisation’ to services for health security and care, albeit with limited focus on wider comprehensive primary health care services (Eyraud et al., 2021; USAID, 2021).

While the modernisation referred to above often takes place in hospitals and specialist services, much of the for-profit sector in ESA countries also takes the form of informal retail of medicines and local informal providers. Some governments, such as Kenya, South Africa and DRC, have experimented with contracting out primary care services to the private sector as a further area of expansion of commercial funders. The new Health Insurance Fund and Africa Health Fund bring together development funding (from governments and external funders) with funds from business, to provide ‘seed’ money for new private health care initiatives. The private sector-oriented NGO, PharmAccess, has wide influence, with involvement in two funds investing in private health care and various private health insurance initiatives (DAWN, 2021). With respect to ownership, emerging enterprises are either entirely private (sometimes from privatisation of existing public services) or PPPs based on contracts (Doherty, 2011). PPPs exist in social marketing in Tanzania and Kenya, in the use of cash vouchers to pay for services in Zambia, Tanzania and Kenya, in pre-packaged treatments in Uganda, health franchises in Madagascar, Kenya and Zimbabwe, accreditation of pharmacies in Tanzania and contracting-out of health provision in South Africa, Lesotho, Madagascar, Zambia, Uganda, Namibia, DRC and Zimbabwe ((Ruiters and Scott, 2009).

There is a caution that large funding flows and non-transparent contracting can make these initiatives susceptible to corruption (Ruiters and Scott, 2009; DAWN, 2021). In Kenya, for example, the Managed Equipment Service (MES) programme, launched in 2015, signed contracts valued at US\$432 million with the Ministry of Health, county governments and private sector providers, to supply and install specialised medical equipment in 98 hospitals, train staff, and provide regular service, maintenance, repairs and replacement of equipment. Notably equipment was sourced from companies based outside Africa (China, India, Italy, the Netherlands, and the USA), two of which were reported to be under investigation for suspicious sales and allegations of pay-offs to secure government contracts (DAWN 2021).

The erosion of publicly provided health care and of state capacities in health, combined with a poorly regulated for-profit private health system that is weakly integrated into national health information and financing systems are argued to have led to challenges in integrating private resources and providers into the national response to COVID-19, notwithstanding the various forms of co-operation noted (Williams et al., 2021; Chanda-Kapata, 2021). The equity issues and implications of this are further explored in the next sections.

## 4. Equity issues in privatisation of health services

Williams et al. (2020) argue that inequities arising from market activities in the health sector, including during the pandemic, could be predicted in light of the rise in redistributive failures in mixed public-private health systems over time. Equity is often assessed in terms of differentials in 'exposure' in terms of the entitlement, assets and capabilities that different groups have; in 'vulnerability', in terms of social protection and support; norms and regulation; institutional and service coverage; service access and financial protection; and in the distribution of outcomes, in terms of social, health and wellbeing outcomes, and disease and mortality. The equity issues described in this section are derived from applying this lens to the involvement of for-profit private sectors and privatisation of public services.

### 4.1 Equity issues in entitlements, assets and capabilities

Avoidable and unfair inequalities can arise in **entitlements** (rights, law, norms, sociopolitical perceptions of fairness or unfairness); **assets and endowments** (living, working, social, ecological conditions, financial and employment security); and **capabilities** (agency, voice, inclusion or networks).

At a **normative level**, ESA countries pursued health equity policies for decades post-independence, recognising the need for redistributive policies and state intervention to overcome the embedded racial and socio-economic inequalities of colonialism. States have also committed to meet rights to health care, as outlined in the International Convention on Economic and Social Rights and General Comment 14 (ratified by all ESA states), the International Health Regulations 2005, and the national constitutions of many ESA countries. The African Commission on Human and Peoples' Rights (ACHPR) has raised concerns that,

*the growth of private actors' involvement in health and education services delivery often happens without the consideration of human rights resulting in growing discrimination in access to these services, a decrease in transparency and accountability, which negatively impact the enjoyment of the rights to health and education,*

and positions states as duty bearers in protecting rights in relation to private actors' roles in health (ACHPR, 2019). States thus have a duty to use appropriate measures to realise the right to health care, although the Commission is still in the process of developing standards that would guide implementation and adherence (Sehoole 2020).

While these norms exist, this normative and policy framework was deeply affected by the neoliberal policies promoted by governments and development partners globally, and in many low and middle income countries, from the late 1980s. First, through the structural adjustment programmes and then through wider neoliberal reforms, these policies argued for deregulation and liberalised capital flows as a basis for an improved macro-economic performance that was essential for improvements in health and reduction of poverty. This implied reduced public funding for social services and a withdrawal of the state from many areas of economic and social activity. When these policies led to declining public sector performance without the promised wider population benefit from macro-economic performance, the situation became the basis for promotion of a discourse and a belief that public services were too weak and unaccountable to meet population needs; and that private health markets provided a governance and policy solution to the delivery of health services, as noted in the IFC arguments outlined earlier (Williams et al., 2021). The normative framework for the private for-profit sector is that of maximising profit, in contrast to the view of health as a public good to be universally provided as a right. Commercial objectives have led to unhealthy commodities such as ultra-processed foods, as well as business practices and market-driven policies at national and global level that have acted as drivers of ill-health (Mialon 2020). This normative conflict or tension is often acknowledged, but with a proposition that ways can be found to make the two systems complement each other (Ruiters and Scott, 2009). States have, however, faced a challenge in upholding the right to health in the face of significant pressure from global economic institutions and national finance ministries, particularly where a principle of 'progressive realisation' of rights made their fulfilment conditional on available resources. This placed a constitutional burden on affected

populations and institutions to demonstrate feasibility, even when subsidiary public health law generally placed a duty on private actors to do no harm to health (Sehoole 2020).

Backing for an increased role for the for-profit private sector in health spread beyond the IFC to other international agencies and initiatives, such as the WHO, USAID, the Global Fund to Fight AIDS, Tuberculosis and Malaria, the Bill and Melinda Gates Foundation, and a number of western governments. The UK Department for International Development (DFID) encourages PPPs through the Initiative on Public-Private Partnerships for Health (IPPPH), while global PPPs like the Global Alliance for Vaccines and Immunisation (GAVI) and Global Alliance for Improved Nutrition (GAIN), incorporating international companies, became increasingly prominent in financing (Ruiters and Scott, 2009). Over recent decades, the IFC, and some bilateral and multilateral donors accelerated the financialisation of health care services and the expansion of the private sector through targeted investments and seed funding (Williams et al., 2021; Doherty, 2011). Support for private sector participation has emerged in the policy documents of governments and intergovernmental bodies in the ESA region, encouraging private sector investment in health services through tax incentives, contracting and partnerships, as part of a wider government intention to encourage private and foreign direct investment (FDI) and to integrate in the global economy (Doherty, 2011; Chowdhury and Sundaram 2021).

Post 2000, thanks to electronic technology, flexible rules and rapid transport, health services have also become more mobile across national borders. There has been a growth in cross-border delivery of health services, through movement of personnel and clients, including in health tourism, by electronic telemedicine, and through an increasing number of joint ventures and collaborative arrangements between the public and private sectors. The General Agreement on Trade in Services (GATS), 2001, while contested by many countries in the global south, set a global regulatory framework at the World Trade Organisation (WTO) for four modes of such trade in health services:

- **Cross-border delivery of trade (mode 1)**, which includes shipment of laboratory samples, diagnosis and clinical consultation via traditional mail channels, as well as electronically, through telehealth and telemedicine.
- **Consumption of health services abroad (mode 2)**, covering services for ‘medical tourism’, such as a scheme by South Africa’s Grootte Schuur private hospital wards to treat British patients needing heart operations, aimed at cutting hefty hospital waiting lists in Britain.
- **Commercial presence (mode 3)** involves transnational corporate establishment of hospitals, clinics, diagnostic and treatment centres and nursing homes, including through joint ventures and alliances.
- **Movement of health personnel (mode 4)** involves sending health personnel abroad on short-term remunerated contracts to other countries (Ruiters and Scott, 2009).

Within a dominant liberalised global framework, countries have faced challenges in setting and implementing public health regulations that manage these changes, and particularly the tensions between market and public health equity objectives (Competition Commission SA, 2018; Doherty, 2011). There are specific examples of such regulatory shortfalls. For example, concerns have been raised over the weak regulation, transparency and accountability of PPPs, which often do not go through the normal public procurement and contracting procedures, with their contract details often not published and limited meaningful consultation with affected communities (Dawn 2021). In the extractive sector, health risks related to mining beyond contracted workers have been poorly controlled and externalised for people living close to mining sites or near mine dumps, or whose health and livelihoods are tied to environments polluted by mining processes (Chanda Kapata, 2020). Weak regulation has been enabled by an argument that meeting health duties threatens investment and economic returns. Weak monitoring and surveillance of health impacts in communities and lack of information outreach on standards have contributed to deficits in evidence and information, tipping the balance towards economic interests and overriding public health objectives (Chanda Kapata, 2020).

This tension between economic norms and public health rights has been tested during pandemics. The 2014 Ebola outbreak revealed that those countries most affected had greater uptake of economic liberalisation policies and weaker public health systems. In the COVID-19 pandemic, the role of strong public leadership in co-ordinating responses and the existence of public health systems able to reach all communities (discussed further later) highlighted the importance of state and public systems in giving effect to the rights to life and health during emergencies, especially for the most vulnerable (Sehoole 2020).

The challenge in delivering on this relates in part to deficits in **public sector assets**, i.e. service infrastructures, essential health products, health personnel and the spectrum of promotive, preventive, care and rehabilitation services that form the basis for universal health services supporting health equity.

Within countries, a strong private sector market can undermine the public sector by siphoning off skilled personnel, fragmenting financing and risk pools, and building power blocs resistant to regulation (Doherty, 2011). It can be difficult to reverse private sector expansion once it has begun, or to control the behaviour of private sector stakeholders if privatisation weakens state capacities, with a potential for vicious cycles to emerge. For example, in Uganda, a decline in public financing, including in external resources, and in public health infrastructure also triggered the emigration of many health workers with the service gap filled by a rising number of private sector services, including many illegal clinics and unregistered medical practices (Sserwanga, 2013; CEHURD, 2019; Ssenyonjo et al., 2018). More widely in the region, as public finances fell, health sectors encouraged private investment in hospitals and allied health services, such as private wards in public facilities and forms of medical tourism (Chowdhury and Sundaram, 2021). The expansion of these facilities, supported in some ESA countries by private voluntary insurance arrangements, generated a further pull on scarce personnel and an income related two-tier service infrastructure, with different levels and service quality for higher income groups using private services, and lower income groups using public services. The migration of health workers from public systems was reported to lead to higher workloads for remaining personnel and to have reduced service availability for lower income communities, notwithstanding their higher level of need (Vermuyten, 2017). During the COVID-19 pandemic, individual private providers were, however, reported to have faced significant challenges in meeting insured services and ensuring adequate health personnel, along with health worker concerns over risk and slow provision of protective equipment and measures (Williams et al., 2021). While public sectors also experienced deficits in non COVID-19 services, the wider scale of state services enabled the possibility of reallocation of personnel to meet these needs.

Private services do bring technological and digital innovation. However, this comes with equity issues in the sourcing, transparency, cost of, access to and rights implications of these innovations. The expansion of private sector health applications (digital apps) during COVID-19 highlighted, for example, the still limited regulation in ESA countries to protect privacy and use of private health data in digital processes (Chanda Kapata 2021). There are issues of who controls digital technologies. In one health service PPP between Phillips, a private company registered in the Netherlands, and the Government of Kenya, the 'contribution' of digitally connected diagnostic equipment in the service delivery model was reported to use suppliers from outside Kenya. This made the service vulnerable to supply chain disruptions and cost escalations, and diversion of resources, including public resources, away from locally developed technologies catering for the health care priorities of lower income communities (DAWN, 2021). In the roll out of a second PPP in Kenya, local counties faced unexplained increased charges and Kenyans were reported to be paying three times the market price for some equipment. Equipment was also reportedly supplied to hospitals that lacked sufficient electricity, water, or trained personnel to use it, resulting in the equipment remaining unused, while other supplies duplicated equipment already held (DAWN, 2021).

The distribution of such assets is not only an issue within countries. The vaccine inequity in the COVID-19 pandemic highlighted the negative impact of global rules and systems on efforts to ensure equitable distribution and production of medicines, diagnostics and vaccines for the public health response (Mialon 2020). This began in 2020, with constraints in accessing imported reagents

for COVID-19 testing and other key health technologies (SEATINI, TARSC, 2021), and persisted in inequity in vaccine distribution. While high income countries used significant public funding to pre-order sufficient quantities of vaccine candidates to vaccinate their populations many times over, low income countries were unable to purchase or procure adequate vaccines for their populations, or to obtain in 2020 and 2021 an agreed waiver of the global intellectual property regime to facilitate local production of these technologies, regardless of public health need (Stein, 2021).

In relation to **capacities**, poorly negotiated contracts that have not had wider scrutiny can result in increased costs to governments and the public (Lethbridge, 2016; DAWN, 2021). Privatisation arrangements may also bring businesses and their consultants directly into policy processes (Mialon 2020; Lethbridge, 2016). Development aid to ESA countries supporting such initiatives have, for example, been noted to provide significant resources for consultants, but more limited or absent support for state officials or domestic technical expertise to manage contracting processes (Lethbridge, 2016).

While those with the greatest health need are often inversely most affected by the deficits in personnel, commodities and other assets, it is also reported that they are poorly consulted or engaged in privatisation processes. While regional civil society organisations such as Transparency International, the Tax Justice Network and the media have contributed to oversight of funds, contracting and services in the public-private mix, affected communities are poorly funded to scrutinise or involved in giving prior consent to plans within privatisation processes, as may be expected in health impact assessments of large PPP projects. A 2011 report for the International Institute for Sustainable Development found that, in a survey of PPPs around the world, poor communities, particularly women, were often not involved in project design and remained 'voiceless' in the PPP development process, with a consequent limited consideration of social outcomes (Lethbridge, 2016). In a PPP in one central hospital in Zimbabwe, a survey found that most users did not understand the PPP model, and that residents were not consulted on the adoption of the PPP model (ZIMCODD, 2017). PPPs are reported to raise concerns around transparency, as they often do not appear on government accounts, and private commercial records are difficult to access.

In contrast, corporates involved in for-profit private sector contracts are often supported by large professional accountancy and service companies and think tanks (Lethbridge, 2016). Promoters of private service models thus work as formidable consortia that can dwarf state capacities. For example, HANSHEP, a group of development agencies and countries established in 2010, that promotes non-state sector actors in health care includes the Bill & Melinda Gates Foundation; IFC; KfW Entwicklungsbank (KfW) and Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ); Rockefeller Foundation; UKaid; USAID; and the World Bank. From Africa, its only member is the African Development Bank, and the ministries of health of Rwanda and Nigeria (Lethbridge, 2016). While their work includes a PPP advisory facility and some technical assistance for low-income country governments, this is managed by IFC, and not by regional institutions on the continent (Lethbridge, 2016).

## **4.2 Equity issues in social, health and financial protection**

While the previous subsection discussed the equity issues arising from differentials in entitlements, assets and capabilities in expansion of the for-profit private health sector, this subsection discusses differentials in vulnerability in terms of what privatisation implies for differentials in **social protection and support; institutional and service access and coverage; and financial protection**, and for the **norms and regulation of health consequences**.

As noted earlier, the ACHPR has called on state parties to the African Charter to take appropriate policy, institutional and legislative measures to respect, protect, promote and realise health rights, including rights to health care, in the face of service privatisation. This should include regular impact assessments to ensure that the involvement of private actors in the provision of health services does not create adverse impacts on human rights (ACPHR, 2019).

**In terms of regulation**, constitutional and public health law provisions in ESA countries include the duties of all actors, including corporations, to prevent harm to health. Some public health laws, such as Zimbabwe's 2018 Public Health Act, include provision for health impact assessments of projects with potential impact on health (TARSC, MoHCC, 2019). However, few ESA countries have adequate regulation of for-profit private health providers or health insurers (Doherty, 2013). In South Africa, for example, a Certificate of Need is provided for in law, to regulate the distribution of health services, albeit with resistance from professional associations and private hospital groups (McIntyre, 2010). Some legal interventions against anti-competitive behaviour amongst health insurers have not tackled private service provision, a major cause of cost escalation (Doherty 2013). Yet, if left unregulated, the for-profit health sector may lead to distortions in the quantity, distribution and quality of health services, as well as anti-competitive behaviour. Further, even where laws are in place, enforcement is also a challenge, with information duties on the private sector reported to be poorly implemented and sanctions often too low to have any effect (Doherty 2013; Chanda Kapata 2020).

With the neoliberal reforms adopted in ESA countries, economic actors have gained power to resist public health regulation. Providers with sizeable market power can threaten disinvestment or withdrawal unless they receive subsidies, are allowed to impose higher charges, or receive tax exemptions or government funding (Williams et al, 2021). In PPPs, private actors may require government to assume the costlier infrastructure elements, while they take on the profit generating processes. Policy attention to financial and fiscal norms and efficiency targets, often a focus of finance and treasury ministries, may be at the cost of equity (Lethbridge, 2016). The literature documents governments engaging in PPP negotiations agreeing to unfavourable terms as regards the distribution of risk between the two parties; that compromise or ignore wider system or equity goals; or facing difficulties in imposing sanctions when contract terms are violated (Doherty 2011).

Beyond the shift in normative frameworks, treating health as a for-profit commodity and service users as customers or consumers **changes the service model and can divert scarce service resources**. The expansion of the for-profit sector is found to be associated with a primary focus on curative services, given the low profits from provision of preventive care, together with pressures for over-prescribing; limited reach beyond higher income groups; access barriers raised by user charges and fragmentation of risk pools, all of which limit effective coverage for lower income groups, or for those who face time, socio-cultural, disability, age, status and other barriers to service uptake (Ruiters and Scott, 2009; Ngangom and Aneja 2016). In Maseru, Lesotho, a service PPP noted their high clinical standards, but gave less attention to the higher-than-anticipated costs to the Ministry of Health, potentially drawing resources from other service areas, including resource diversion to urban hospital services away from rural and primary care settings, and the absorption of close to half the county's doctors, undermining the allocation of clinicians to underserved districts and broaden access to health care (Hellowell, 2019). In Kenya, private health sector prices were reported in 2011 to have been rising by 20% on an annual basis due to the collapse of agreements on pricing guidelines. The response to introduce new co-payments or to reduce benefits to cope with cost escalation both raise barriers to coverage (Doherty, 2011). In a study of Zimbabwe's central hospital PPP, a survey found that two thirds of respondents felt that services were better before the adoption of the PPP model (ZIMCODD, 2017).

While higher costs may be argued to be due to better quality of care, new technologies and population demand, there is also evidence that it can be a result of business tactics such as over-charging, inflated administrative and managed care costs, over servicing and risk-rating of premiums. In South Africa, various forms of over-servicing were found in private health service markets, including increased hospital admissions and lengths of stay and use of more expensive care than can be explained by the population's disease burden (Competition Commission SA, 2018). There is note of how vertical integration in the for-profit sector, where different companies in the supply chain are owned by the same institution, distort markets and reduces the competition needed for efficiencies. In Zimbabwe, for example, medical aid societies have purchased hospitals, clinics, laboratories, pharmacies, dental, rehabilitation, optometry and imaging services, as well as emergency transport, limiting the services that insured members can use. While in theory this is implemented to control costs, such vertical integration creates monopolies that are more likely to

enable cost escalation (Doherty, 2011). One IFC report admits that private health facilities often use pharmaceutical sales to cross-subsidise their provision costs, while medical aid societies have been reported to have taken advantage of their non-profit status to claim tax exemptions, despite the fact that they also own profit-making non-core businesses (Doherty, 2011).

These reports remain ad hoc, given that the limited information sharing by the for-profit private sector has made it difficult to monitor their impact, particularly on more disadvantaged groups. However the inequity in uptake as a result of these service shifts is suggested by data across fifteen sub-Saharan African countries that showed that only 3% of the poorest fifth of the population who sought care saw a private-sector doctor (Ruiters and Scott, 2009; Chakraborty and Sprockett, 2018). At the same time, falling public financing and a retreat to limited basic services can drive users to expensive private services for needs not met in the public sector, potentially leading to impoverishment from service use, as discussed later (Ruiters and Scott, 2009). The argument that private sectors improve efficiency and quality is also difficult to assess, with comparisons in efficiency between public and private services often misplaced because the two sectors operate within different population groups. The public sector usually covers lower income, high need populations, often providing for those that the private sector excludes (Ruiters and Scott, 2009; Adoyo 2020; DAWN, 2021).

This makes **financial protection** a key area for policy attention in the privatisation of services. As noted earlier, private health insurance plays a key role in only a few countries in the ESA region, including South Africa, Namibia and Zimbabwe. In most others, low levels of formal sector employment and an inability to afford private health insurance has meant that OOPS predominates (Foster, 2012). *Figure 2* has shown the high level of OOPS in many ESA countries. OOPS is regressive, and while voluntary insurance does involve prepayment, the segmentation of these private schemes from wider public financing undermines the fundamental principle of cross subsidies from rich to poor, and from the healthy to the ill, which is key for equity (McIntyre, 2020; Sehoole 2020).

Where OOPS is high, the poor price control in private services noted earlier can place high financial demand on households to meet the costs of health services (Doherty, 2013; DAWN, 2021; Chowdhury and Sundaram, 2021; ZIMCODD, 2017). Even for those covered by private voluntary insurance, members have complained about rising prices and declining benefits, and having to pay still more out-of-pocket when they need care (Heywood 2018). In South Africa, contributions to private voluntary insurance have increased at rates far exceeding general consumer inflation every year after 2000, and more rapidly than average wages and salaries of formal sector workers. While a range of factors underlies these trends, increases have been driven largely by a growth in spending on private for-profit hospitals and specialists (McIntyre, 2020). Lower-income members of voluntary insurance schemes were reported to contribute a higher proportion of their incomes than richer members, while those in greatest need of health care receive the lowest share of benefits from using health services. (McIntyre 2010). It is thus a questionable policy move to try to reduce OOPS by expanding private services, even if this appears to increase total health expenditure.

During the COVID-19 pandemic, the fees for private for-profit clinical, laboratory and, in some countries, vaccine services, meant that they tended to serve higher-income households and insured clients, leaving poorer social groups to seek alternative services or meet escalating costs, thus exacerbating inequities (Chanda Kapata 2021). Closures of small businesses and job and income losses affected peoples' ability to meet rising costs and weakened participation in formal medical insurance systems (Shadmi et al., 2020). Reports from many countries suggest that private insurance companies were delaying payments and settlement due to the financial impacts of COVID-19. In response, private sector providers refused to provide services, triaged or filtered patients based on their ability to pay and raised prices of services, limiting access and raising the potential for financial impoverishment from seeking care (Williams et al, 2021).

The pandemic has highlighted (again) the essential nature of **universal social protection** for equity, and particularly gender equality. A strong link has been found between the provision of public

services and women's ability to enter the labour market, as a result of women moving from unpaid to paid care work and as they can enable the child care that women often have to provide at home (Vermuyten, 2017). While little evidence was found on how health service privatisation is affecting differentials in social protection in ESA countries, one analysis of global data identified that pre-existing market and redistribution failures due to privatisation had undermined the resources, services and state-provider relations needed for adequate expansion of social protection (Williams et al. 2021). Beyond this, the weaknesses noted earlier in for-profit service provision of comprehensive public health and PHC approaches can weaken links between health and social protection systems, or the role of primary care systems as entry points for social protection. In the Kenyan PPP noted earlier, women's lower income and reduced capacity to pay for private services meant that they disproportionately bore unmet care and social burdens arising in PPP services (DAWN, 2021). The risk of impoverishment may be further exacerbated when formal social care, pensions, maternity care, unemployment and other benefits de-facto exclude many in the low-income informal sector, leaving them dependent on social support from within already poor families and communities (Ozano et al., 2019; Vermuyten, 2017).

It is an accepted function of government to correct the market failures described in this section that increase differentials in vulnerability, particularly for those in already disadvantaged conditions (Williams et al., 2021). Within the context of the equity challenges noted, and without measures to counter these challenges, the limitations in state regulatory and other capacities noted earlier weaken possibilities for states to deliver on this duty. This has thus led to concern that loans and financing from international financial organisations for 'COVID-19 recovery' that favour private sector, market-based options through their conditionalities, including in the health sector, would further exacerbate these inequities (Williams et al, 2021).

### **4.3 Impact on differential health and wellbeing outcomes**

Differentials in outcomes from a private market expansion in the health sector are mapped in terms of differentials in **mortality and morbidity** and in **health and quality of life**. Equity outcomes related to privatisation of health services can also be mapped in longer-term wellbeing consequences in the **life course and intergenerational consequences**; as well as **wider family, social, population and ecosystem consequences**.

A robust public and community health infrastructure, owned and managed by the state, is critical to implement effective interventions that keep the population healthy. Without access to safe water and hygiene, adequate nutrition, access to vaccines and so on, there can be no healthy populations. It is thus argued that if financialization is at the heart of policy making, rather than people and community, there are weak feedback loops to reduce the various inequalities in exposure and vulnerability noted earlier, with consequences for health outcomes (DAWN, 2021).

**Differentials in morbidity and mortality** arising as a result of, or associated with health service privatisation, take place in a context of existing social (racial, income, education, gender, residential) inequalities in health in ESA countries. There is evidence that the pandemic has widened these inequalities, with service and economic disruptions having had deeper negative consequences for low-income communities who also have a higher risk of infection, due to overcrowded housing and transport, and in those who have experienced job and income losses and psychosocial pressures (Chanda Kapata. 2021). Data from 44 middle- and low-income countries show increasing exclusion of poor people, and most especially women, from positive health outcomes, particularly as the for-profit sector focuses almost exclusively on curative care and does not participate in wider public health initiatives (Doherty, 2011).

As positive outcomes, IFC (2016) suggests that while outcomes differ across countries, expanding diagnostic laboratories and services enable early detection and improve the overall efficacy of treatment, contributing to positive health outcomes. Telemedicine improves patient health outcomes, while saving time and transport costs, giving many, who could not or would not make the journey to see a doctor, the benefit of a doctor consultation. However they also noted that these potential contributors do not necessarily result in better health outcomes. Positive outcomes depend on



uptake of the services for which there may be barriers in cost and scope of services, as noted earlier, including in terms of population health and prevention interventions that generally have a stronger pro-poor impact (Yoong et al., 2010). As chronic conditions increase in the region, any bias away from population health screening and public health intervention to for-profit services may weaken early detection and prevention of chronic conditions for those already more exposed to risk.

The skew in private for-profit financing and services and in PPPs towards specific personal care services also leaves deficits in the interlinkages and interdependencies of the various functions of comprehensive services and other sectors needed to act upstream and **promote health and wellbeing**, rather than react to illness. Externalising population health needs or sending people back from care services to the conditions that first made them ill creates unsustainable costs for households and public services, especially for those with the greatest health need, weakening the efficiency gained from acting on upstream determinants of health (Allotey, 2012). In the extractive sectors, for example, surveys have found negative health outcomes in communities living around mines, from consuming fish from contaminated rivers, growing crops in contaminated soils, and ingesting toxins in their diets (Chanda Kapata, 2020). These outcomes have been poorly prevented or managed by corporate health services when they are poorly integrated within district health services. School children who attend classes close to mining areas have been reported to be exposed to dust and chemicals, such as lead, that affect brain development and lead to long-term risks, including cancers as adults. While companies provide services for employed workers and their immediate families, these wider population health risks are often poorly integrated within these services and affected communities rely on the surrounding, less well funded public sector services (Chanda Kapata, 2020). As public health and primary health care strategies fall off the priority lists of governments and into the hands of bilateral international agencies and NGOs, the public health infrastructure may also be verticalised into specific outcomes that these providers can account for, weakening the service integration needed for a region currently affected by multi-morbidity and the combined impacts of chronic, communicable and pandemic impacts on health (DAWN, 2021).

While there is an evident need for better monitoring of the morbidity and mortality outcomes of market expansion in the health sector, the health impact of user fee charges and the consequent catastrophic spending noted earlier, have been more widely assessed. While privatisation may expand service availability, this may not translate into the accessibility, uptake and effective coverage needed for improvements in health. One study of user fees as a proxy measure for privatisation in 37 SSA countries found a relationship between increased OOPS and increased under-five mortality and noted that user fees influence the health seeking behaviours of the families of these children, as one contributor to their increased mortality (Karungi et al., 2005). These barriers to uptake are more likely to be in those with lower incomes, both in relation to fee barriers and to transport and other charges.

There is limited evidence on the **life course, intergenerational health and ecosystem consequences** and implications of market-driven approaches in health. There is evidence that corporate sector health services have poorly addressed long-term illness and disability from workplace exposures (as in the mining sector) shifting the burden to home communities and rural public sector services with limited capacity to manage these conditions. Abandoned or closed mines can also be a source of contamination long after mining operations cease, and responses are generally dependent on public sector services (Chanda Kapata, 2020).

These longer term demands add to the impacts of catastrophic climate change and the commitments made in 'leaving no-one behind' in meeting the UN Sustainable Development Goals (SDGs). This calls for strengthened public measures, and revenues. Yet rather than bringing financial flows into the public domain, an inequitable global tax systems and limited tax capacities may not yield the expected public revenues from market activity in the health sector, adding to the non-transparent accounting measures noted earlier than keep PPPs off the government's budget sheet. While a circumvention of public budget transparency is recognised by the IMF to postpone recording the fiscal costs of infrastructure and services, it exposes public finances to fiscal risks, creates a false 'affordability illusion' and increases the level of financial flows that are not subject to

public scrutiny or accountability that may be used for private gain rather than public benefit (Kashimoto and Petitjan 2017). Evidence from the World Bank Independent Evaluation Group found evidence of multiple dimensions of wider negative population and ecosystem consequences include resource diversion and the costs of longer term obligations imposed on the state and population that may not have been well understood upfront (DAWN, 2021).

Market-driven processes in the health sector are embedded within wider liberalised economic activity, many of which are noted to be depleting natural resources, raise climate-related risks to health and generating social deficits in precarious employment, , living and social conditions (Chanda Kapata, 2020). When the expansion of for-profit health sector services generates the various inequities noted earlier, it deprives populations of the critical redistributive public health resources and services needed to confront such risks and insecurity. Not surprisingly, therefore, rising costs, declining access, loss of and perceived or reported abuse of public funds, poor transparency and a loss of control over economic and natural resources in a context of insecurity and emergency, have generated conflict and public protest. It has also generated debate on and initiatives to bring public services 'back in-house'. The options for this have included re-municipalisation initiatives that return services from private to public ownership, integrating private voluntary health insurance within wider national mandatory systems, and models that embed equity objectives and democratic accountability and agency that are central to equity in the longer term (Kashimoto and Petitjan, 2017). These will be discussed further in the next section.

## **5. Discussion: Pathways for equity-oriented change**

The evidence presented in the previous sections suggests some immediate mediating and deeper or longer term actions to address the drivers of inequity in pathways for equity-oriented change, which are presented here as a discussion that draws on the findings. *Figure 3* summarises the key priorities arising from the evidence in Section 4, and the immediate, mediating and structural or upstream domains of intervention they imply within pathways for change towards the desired changes, both in terms of current and sustained improvement in health equity and in the equitable management of 'shocks', many of which are rooted in longer term conditions.

Since ESA countries have different political economies and health systems, *Figure 3* is not intended as a prescriptive checklist. It rather intends to show key dimensions of the pathways for change in addressing the various drivers of inequity related to expanded market privatisation of health services. It is intended to support country context-specific social, technical and policy dialogue on the prioritisation and feasibility of different actions; on the links, steps and connections between actions; and to discuss and clarify actions that are key levers for other prioritised measures within the pathways for change.

The figure highlights that some actions, such as improved public sector capacities, improved information systems, strengthened public financing and widening options for public input and accountability are relevant to more than one of the drivers of inequities associated with the privatisation of health services. Some actions also have impact on multiple dimensions of inequity. A number of the actions identified as 'immediate' are already being raised in policy dialogue in some ESA countries. Others that are more structural may take time. The theory of change approach to the analysis suggests mediating interventions that can link immediate actions to deeper measures, so that the former act not as an end in themselves, but as levers for deeper changes.

Figure 3: Suggested pathways for addressing privatisation-related inequities

CURRENT SITUATION &	DOMAINS OF INTERVENTION				CHANGE
PRIORITIES TO ADDRESS	DESIRED	Immediate	Mediating	Structural/upstream	CHANGE
Commodification, cost escalation increasing OOPS reducing financial protection; segmentation undermining wider risk and income cross subsidies	Increase public health spending Shift from fees at point of care to prepayment; pool funding	Unbundle funder-provider monopolies; capacitate, audit and publicly report sector performance/ impacts	Political commitment to equity; NHI integrating public/private & tax funding, HIA & license renewal including equity	Reduced inequalities in current health and wellbeing	
Falling public spending on health in neoliberal policies creating deficits in universal coverage; quality declines driving privatisation demand/opportunity	Require private reporting in information systems; monitor private sector equity outcomes	Promote external/private funding to public services; bring costs and liabilities of PPPs on govt balance sheet	Exec/MoFin commitment to public sector funding (>15% budget; >5% GDP) to meet health system entitlements & development goals	Reduced inequalities in possibilities for sustained health and wellbeing across the life course and intergenerationally	
Distortion of services towards personal, curative care; excluding pro-poor public health/ PHC	Require basic service package for all funders/providers including PHC; expand 'One health'	Integrate all providers in PHC; purchasing strategies to include PHC; NHA audit benefit incidence of service levels	AU, UN commitment to support for comprehensive PHC as essential for health security, UHC, SDGs; health integrated in social protection	Reduced inequalities in possibilities for sustained health and wellbeing across the life course and intergenerationally	
Inadequate, poorly enforced regulation; loss of key public personnel; tension between health rights and profit motive	Harmonise regulatory authorities; regulate service quality; fund pooling & cross benefit duties	Increase rights literacy; capacitate inspectorate;	UN guidance on commercial actors and health rights; international guidelines on PPPs	Reduced inequalities in possibilities for sustained health and wellbeing across the life course and intergenerationally	
Economic focus encouraging investment overriding health concerns; inequitable tax exemptions and public subsidies	Set policy on private sector; remove health tax exemptions; certify private services' assess the impact of trade agreements	HIA (with public review) of PPPs, resist privatisation in loans/trade; invest in local technology production	Curb illicit financial flows and reform global tax rules; increased Africa seats in IMF/WB boards; WTO TRIPS waiver for public health	Reduced unfair/ avoidable inequalities in health and wellbeing resulting from or in response to emergencies and shocks	
Strong corporate capacities and policy influence; Off budget and non-transparent contracting, and weak public monitoring of impact.	Assess risk benefit pre-contract; parliamentary contract oversight; expose state/ regulatory capture; regular impact assessment of private sector	Regulate conflict of interest in public officials; strengthen public capacities; media, civil society oversight;	Curb illicit financial flows and reform global tax rules; build cross regional alliances on global drivers & impacts on/links to climate, SDGs	Reduced unfair/ avoidable inequalities in health and wellbeing resulting from or in response to emergencies and shocks	

If universal public sector health care services are the most effective, equitable way of delivering public health services and delivering and health care rights and state duties, one area of intervention is to promote understanding that public sector health systems are central for UHC and equity and to counter a narrative that 'private is good' and that limiting for-profit privatisation of services undermines development. This of course needs to be backed by practice, part of which is making clear that commercial entities must meet commitments to equity, equality, diversity and inclusion.

A challenge that must be squarely faced, and that is already a focus of policy dialogue and public advocacy in the region, is how to reverse the decades of under-financing and sustainably and domestically fund public health systems in ways that do not further segment and verticalise systems or deepen aid dependency. Where shortfalls in public financing contribute to a contraction and decline of public sector health services, it would appear self-evident that investment in public sector health services should be increased in line with the 15% government spending committed to by Heads of State in Abuja in 2001, or to, at least, the 5% of GDP noted to be the level reached by countries advancing towards UHC (McIntyre, 2012). This would appear to be fundamental to also funding areas of public sector leadership, and the capacities for regulation, monitoring, information and other areas of state action. It implies understanding, making clear and avoiding the risks to public services caused by the expansion of health care markets.

How revenues are pooled, allocated and spent impacts on equity outcomes. There are equity gains in removing health service fees at the point of care, particularly at primary care level for key populations, and for primary care referrals. This implies replacing fee income with progressive tax and mandatory national insurance funding (Doherty, 2019). Many countries are exploring new public revenue sources and innovative financing to cover this. Small, segmented insurance or vertical funds would need to be pooled to enable risk and income cross subsidies, and private funds merged within public funding pools (Doherty, 2019). Although they may take time to realise, these are matters for immediate planning, through the establishment of a clear policy direction and setting up stepwise processes and interactions for achieving it, and indicators to demonstrate progress.

The evidence gap created by the absence of private sector and commercial reporting to national information systems is a key and immediate obstacle to informed policy discourse and decision-making. Information systems across different funders and providers, including commercial actors, needs to be integrated within one national monitoring and evaluation (M&E) system under the state, to co-ordinate information flow and monitor commercial actors. This may include disaggregated data on quality health care outcomes in relation to service billing models and costs (Sehoolo, 2020; IFC, 2006). This implies defining the information collection and reporting obligations of the private sector in law, setting penalties for breach of these obligations and strengthening government capacity to enforce them and to use and act on the information gathered. Health Impact Assessment (HIA) tools, when provided for in law, can also assist in assessing and monitoring the implications of new market actors in health care and to make license and registration renewals dependent on delivery of national health care objectives, including equity and financial protection. This may help leverage public domain reporting on their performance, including to parliament, and alert to the emergence of harmful outcomes through public hearings on such reports.

The distortion of service models introduced by market providers as noted in *Sections 3 and 4* requires immediate measures, as has been done in some ESA countries, to guide both providers and health funders/insurers to: identify core or essential health services; the development of legislation on service entitlements and quality; and detailed guidelines on expected services and service entitlements for primary and hospital care and emergency services (Loewenson et al., 2018). Addressing the distortions that focus on curative care while skimming off population health, promotion and prevention services, calls for the inclusion of comprehensive PHC into the core services or entitlements covered. The 'One Health' approach has been applied to coordinate health, agriculture, environment, trade and other sectors on commercial determinants of health and can also be a vehicle for engaging commercial actors in the health sector and integrating input from affected communities (Loewenson et al, 2021).

Where service models are driven by what private insurers cover, legislation covering health insurance needs to address specific matters relating to the problems of risk rating, adverse selection and fragmented risk pools and to review the sanctions for misconduct and set them at appropriate levels (Doherty, 2013). As in South Africa, the issuance of a certificate of need can ensure reporting on the

quality of services provided and the promotion of equitable distribution and rationalisation of health services and health care resources. Licensing and registration requirements provide public measures to ensure that ownership of facilities does not create potentially perverse commercial incentives, such as doctors' shareholdings in private hospitals that could contribute to overspending (McIntyre, 2010).

If the interaction between state and private actors is to not to be seen as ad hoc or authoritarian, driving distrust and conflict, it needs to be evidence informed. This can create incentives for both public financing and private funder service models to develop equity-focused financing vehicles for health technology producers and services, and stimulate their alignment to national policy goals (IFC, 2006). This too needs public sector capacities. Governments need to have and use country level tools to identify whether – and under what circumstances – it is desirable to choose PPPs instead of traditional procurement and public borrowing. This means exposing the true cost of PPPs, by reporting the costs of the project and its contingent liabilities in national accounts and statistics. This is argued to boost the transparency and evidence-informed nature of PPP decision-making processes and to increase democratic accountability (Kashimoto and Petitjean, 2017).

Many of these measures call for regulation, regulatory capacities and effective interaction between the various regulatory authorities, often with legal requirements indicated in multiple pieces of law affecting the different sectors, and being understood by both regulators and the industry. Moving towards more effective regulation is a basic measure. While self-regulation – where peers essentially scrutinise one another's behaviour – can be effective where codes of conduct and enforcement capacities are strong, these can be overridden by economic incentives and professional interests (Doherty, 2013). Since public health and equity is at stake, it would seem that states have a duty to opt for stronger regulatory measures rather than voluntary approaches.

Where powerful commercial lobbies with influence over public authorities exist alongside the dominance of a neoliberal economic model, equity needs to be driven by greater transparency. This requires the availability of public-domain information on the implications of commercial markets in health and health literacy for the general public and insurance beneficiaries on current health care rights, standards and entitlements set in bylaws, national laws, constitutions and guidelines, and in international and continental rights and standards, such as ACHPR (ACHPR, 2019). A right-to-health approach and engagement on public interests in health and equity would appear to be essential immediate actions to support state and regulatory action, especially if this is to regulate harmful consequences of commercial actors in health services, and ensure accountability of private health care providers and insurers.

These immediate measures are facilitated by an overarching private sector policy to guide legislation and clarify policy and regulatory objectives. The measures outlined in *Figure 3* may be reviewed in a multi-stakeholder policy development process that also builds literacy and accountability on policy choices. A policy that is owned, monitored and reviewed over time, creates transparency between the various actors especially when stakeholders, including those in finance and economic development ministries, understand its public health, equity and other policy objectives. Given the drivers of inequity, various mediation measures appear important to complement and support actions to motivate and enhance public funding, including:

- Using a range of evidence sources, from 'citizen science', participatory methods, scorecard and routine data monitoring, through to implementation research, economic and public health analysis and health impact assessments (HIAs) of commercial and PPPs health service projects and reporting of findings in the public domain. These can be used to evaluate assumptions, performance and outcomes, and integrate the indicators of equity and financial protection among both public and private funders. Reporting in the public domain and use of such evidence in social and policy dialogue helps inform policy discourses on private and public funding and to audit claims made about both.
- Supporting central and local government procurement capabilities and contract management with the private sector. This has various dimensions, including: making better use of institutions with inspection and oversight powers to monitor commercial activities; building a network of state, academic and civil society experts/practitioners to support evidence, policy options, oversight and negotiations on private financing and services.

- Providing space for civil society input in policy discussions and measures, including through petitions, campaigns, commentaries, community opinion polls and research, as well as litigation on inequities in privatisation of health services and advocacy on funding, strengthening and improving the quality of public sector health services. Various ad hoc initiatives underway could usefully be a basis for wider coalitions across a range of community leaders, associations, unions, residents, workers, patients, professionals, parents, communities, issue networks and other collectives for information sharing and action needed.
- Developing the capacity to enforce laws, including adequate and timely inspections, renewal of practice certificates at realistic intervals and exploring opportunities for decentralising enforcement to enhance the capacity and responsiveness of such systems (Doherty, 2013).
- Involving Competition Commissions in scrutiny of private funders and services, unbundling funder-provider monopolies that generate conditions for price fixing and cost escalation and acting against anti-competitive behaviour. This calls for corresponding capacity in health ministries to engage with private sector practices, contracts and markets (EQUINET, 2012).
- Strengthening regional co-operation on price monitoring, standards, contracting, and exchange of evidence and practice, such as is already underway in the common information management system for regulatory harmonisation of medicines registration in the East African Community (Loewenson et al, 2021).
- Expanding local production of a range of essential health-related technologies (EHTs) within the ESA, such as by providing greater venture capital or catalytic investment in scientific infrastructure, R&D, early proof of concept and its translation into production activities, and investment in needs-driven innovation and prevention technologies accessible in communities and frontline services (Loewenson et al., 2021).
- Assessing the impact of investment and trade agreements and post-pandemic recovery plans and loans on public services, including of the Africa Continental Free Trade Agreement and proposed economic development zones. This can be a useful lever in negotiations to locate public health more centrally within trade agreements and investments, to ensure good practices and highlight health costs. The region plays an important role in co-ordinating the capacities needed for this for harmonising relevant health standards (Loewenson et al, 2021).

Over the longer term, a planned and progressive public sector-led strategy can move funding towards mandatory *pre*-payment based on capacity to pay, integrating funding pools and providers with cross-subsidisation and risk pooling in a National Health Insurance (NHI) system to ensure universality, equity and service quality according to need (Ruiters and Scott, 2009). While this may appear to primarily be a technical question, it is inherently structural and political, achieving this demands consistent social and political support, policy leadership, and negotiation to empower public interest actors and enable technical measures. Evidence may be disregarded without a deeper political and policy understanding of, and electoral commitment to investment in public health systems and the recognition of their role and that of comprehensive PHC as an asset for sustainable development.

Political support is even more critical for structural factors arising at global level. For example, generating a fairer tax system as a structural action to promote public health demands action within the region and globally. Tax losses from global tax rules, illicit outflows and corporate tax practices in low-income countries are estimated to be equivalent to nearly 52% of health budgets. While the African Tax Administrative Forum has proposed regional harmonisation of tax laws to avoid a 'race to the bottom', African finance ministries and civil society have called for a reform of global rules enabling tax outflows, and for tax revenue to be assigned to where those revenues are produced (AU, UNECA, 2014; Ndajiwo, 2020). The AU CDC, regional and continental institutions and the Africa Group of diplomats in Geneva, have engaged most recently on the negotiations on the Trade Related Intellectual Property Rights (TRIPS) Waiver in WTO rules that constrains the distribution of the production of health technologies, in particular, against the COVID-19 pandemic.

The various measures proposed above call for strategic public health authority to contest the narratives and institutional influence of powerful global commercial interests, and the underlying neoliberal paradigm that promotes privatisation and liberalised trade in the health sector. This paper presents both the imperative for equity and the potential to sequence relevant measures and actions and to bring key actors together to construct a countervailing public health understanding, discourse, institutional practice and authority to promote health rights, and public interests and services in health.

## References

1. Adoyo A (2020) The privatization of healthcare in Kenya, mimeo from the series 'Capitalism In My City,' presented in partnership with the Mathare Social Justice Centre in Nairobi, Kenya. <https://africasacountry.com/2020/09/the-privatization-of-healthcare-in-kenya>
2. African Commission on Human and Peoples' Rights (ACHPR) (2019) '420 Resolution on States' Obligation to Regulate Private Actors Involved in the Provision of Health and Education Services', ACHPR/ Res. 420 (LXIV) 2019, Online <https://www.achpr.org/sessions/resolutions?id=444>.
3. African Union (AU), UN Economic Commission for Africa (UN ECA) (2014) 'Report of the High Level Panel on Illicit Financial Flows from Africa,' Abuja: AU/ECA.
4. Allotey P, Yasin S, Tang, S *et al.* Universal coverage in an era of privatisation: can we guarantee health for all? *BMC Public Health* 12, S1 (2012). <https://doi.org/10.1186/1471-2458-12-S1-S1> <https://bmcpublichealth.biomedcentral.com/track/pdf/10.1186/1471-2458-12-S1-S1.pdf>
5. Berer M (2011) 'Privatisation in health systems in developing countries: what's in a name?', *Reproductive Health Matters*, 19:37, 4–9, DOI: [10.1016/S0968-8080\(11\)37565-9](https://doi.org/10.1016/S0968-8080(11)37565-9) [https://www.tandfonline.com/doi/full/10.1016/S0968-8080\(11\)37565-9](https://www.tandfonline.com/doi/full/10.1016/S0968-8080(11)37565-9)
6. Bond P (2010) 'Capitalism, the Privatisation of Basic Social Services and the Implementation of Socio-Economic Rights: Challenges and Advocacy Strategies for Human Rights and Social Justice Actors', Learning from the Johannesburg Water Defeat University of KwaZulu-Natal Centre for Civil Society <https://ccs.ukzn.ac.za/files/Bond%20CJ%20Osisa%2031%20August%202010.pdf>
7. Center for Health, Human Rights and Development (CEHURD) (2019) Comparative review: Implementation of constitutional provisions on the right to healthcare in Kenya and Uganda, EQUINET Discussion paper 118, CEHURD, EQUINET: Uganda and Harare.
8. Chakraborty N, Sprockett A, (2018) Use of family planning and child health services in the private sector: An equity analysis of 12 DHS surveys, *International Journal for Equity in Health* 17(50) 1–12, 2018 <https://tinyurl.com/ycql8jzb>
9. Chanda-Kapata P (2020) Public health and mining in east and southern Africa: A desk review of the evidence, EQUINET Discussion paper 121, EQUINET, Harare.
10. Chanda-Kapata P (2021) Equity in the public and private health sector responses to COVID-19 in east and southern Africa, EQUINET discussion paper 123, EQUINET, Harare.
11. Chowdhury A, Sundaram JK (2021) Africa: Privatised health services worsen pandemic 17 August 2021 Inter Press Service <https://allafrica.com/stories/202108200604.html>
12. Cliff J, Turshen M (2000) Privatizing health services in Africa, *Journal of Public Health Policy*. 21. 109. 10.2307/3343480.
13. Competition Commission (2018) 'Health market inquiry: Provisional findings and Recommendations South Africa'. <http://www.compcom.co.za/wp-content/uploads/2018/07/Health-Market-Inquiry-1.pdf>
14. DAWN, 2021, 'Public private partnerships (PPPs) and women's human rights: Feminist analysis from the global south, development alternatives with women for a new era', *DAWN*. <https://tinyurl.com/35rrvavb>
15. Doherty J (2011) 'Expansion of the private health sector in east and southern Africa', EQUINET Discussion Paper 87. EQUINET, Harare.
16. Doherty J (2013) 'Legislation on the for-profit private health sector in east and southern Africa,' EQUINET Discussion Paper 99, HEU, EQUINET, Harare.
17. Doherty J (2019) 'Critical assessment of different health financing options in east and southern African countries', EQUINET Discussion paper 119. EQUINET, Harare.
18. EQUINET (2012) 'Regional Equity Watch 2012: Assessing progress towards equity in health in east and southern Africa', EQUINET, Harare.
19. Eyraud L, Devine H, Peralta Alva A, et al. (2021b) 'Private Finance for Development: Wishful Thinking or Thinking Out of the Box?' International Monetary Fund, online, <https://www.imf.org/en/Publications/Departmental-Papers-Policy-Papers/Issues/2021/05/14/Private-Finance-for-Development-50157>.
20. Foster N (2012) Private sector involvement in health services in east and southern Africa: country profiles, EQUINET Discussion Paper 89 Health Economics Unit (UCT), EQUINET, Harare.
21. Hellowell M, 2019 'Are public-private partnerships the future of healthcare delivery in sub-Saharan Africa? Lessons From Lesotho,' *BMJ Global Health* 4(2), doi: <http://dx.doi.org/10.1136/bmjgh-2018-001217>, <https://gh.bmj.com/content/4/2/e001217>
22. Heywood M,(2018) 'It's A Stick-Up. Your Money Or Your Health!', Daily Maverick, September 2018 <https://tinyurl.com/y9pt9yfi>
23. Hongoro C, Funani I, Chitha W, Godlimpi L, (2015) 'An assessment of private general practitioners contracting for public health services delivery In O.R. Tambo district, South Africa' *Journal of Public*

- Health in Africa* 6(2) <http://dx.doi.org/10.4081/jphia.2015.525>  
<http://www.publichealthinafrica.org/index.php/jphia/article/view/525/264>
24. IFC (2016) 'The business of health in Africa partnering with the private sector to improve people's lives'.  
[https://www.unido.org/sites/default/files/2016-01/IFC\\_HealthinAfrica\\_Final\\_0.pdf](https://www.unido.org/sites/default/files/2016-01/IFC_HealthinAfrica_Final_0.pdf)
  25. Josiah J, Burton B, Gallhofer S, Haslam J (2010) 'Accounting for privatisation in Africa? Reflections from a critical interdisciplinary perspective,' *Critical Perspectives on Accounting*, 21, 5, 374-389,  
<https://doi.org/10.1016/j.cpa.2009.09.002>.  
<https://www.sciencedirect.com/science/article/pii/S104523541000002X>
  26. Karungi, GK, Niek S (2005) 'Exploring the relationship between privatisation of health care and infant mortality,' *Health Policy and Development* 3 (2) 144–153, UMU Press 2005.  
[http://ir.umu.ac.ug/bitstream/handle/20.500.12280/2532/Karungi\\_HSCIE\\_ARTICLE\\_2005\\_Exploring.pdf?sequence=1&isAllowed=y](http://ir.umu.ac.ug/bitstream/handle/20.500.12280/2532/Karungi_HSCIE_ARTICLE_2005_Exploring.pdf?sequence=1&isAllowed=y)
  27. Kashimoto S, Petitjean O (2017) 'Reclaiming Public Services: How cities and citizens are turning back privatisation'.  
[https://www.tni.org/files/publication-downloads/reclaiming\\_public\\_services.pdf](https://www.tni.org/files/publication-downloads/reclaiming_public_services.pdf)
  28. Kutzin J (2013) 'Health care financing for universal coverage and health system performance: concepts and implications for Policy,' *WHO Bulletin* 91(8) 602–611.
  29. Lethbridge J (2016) 'Unhealthy development The UK Department for International Development and the promotion of healthcare privatisation,' Public Services International Research Unit, 2016.  
[https://gala.gre.ac.uk/id/eprint/16416/7/16416%20LETHBRIDGE\\_Unhealthy\\_Development\\_2016.pdf](https://gala.gre.ac.uk/id/eprint/16416/7/16416%20LETHBRIDGE_Unhealthy_Development_2016.pdf)
  30. Loewenson R, Mamdani M, Todd G, et al. (2018) 'The role of an essential health benefit in health systems in east and southern Africa: Learning from regional research', EQUINET discussion paper 113, TARSC and IHI, EQUINET, Harare..
  31. Loewenson R, Godt S, Chanda Kapata P (2021) 'Framings of and priorities for action on the commercial determinants of health in Sub-Saharan Africa,' TARSC.
  32. Loewenson R (2021) 'Equity Mapping: privatisation of essential health services, Internal brief for Developing a theory of change driven framework for equity analysis,' TARSC.
  33. Mabasa K (2015) 'Privatisation and the health crisis in. post-apartheid South Africa,' Rosa Luxemburg Stiftung.  
[https://southafrica.fes.de/fileadmin/user\\_upload/Health-in-SA-IP-03\\_2015.pdf](https://southafrica.fes.de/fileadmin/user_upload/Health-in-SA-IP-03_2015.pdf)
  34. McDonald DA, Spronk S, Chavez D (eds) (2020) *Public water and COVID-19: Dark clouds and silver linings, municipal services project (Kingston)*, Transnational Institute (Amsterdam) and Latin American Council of Social Sciences (CLACSO): Buenos Aires.  
<https://www.municipalservicesproject.org/publication/public-water-and-covid-19-dark-clouds-and-silver-linings>
  35. McIntyre D (2010) 'Private sector involvement in funding and providing health services in South Africa: Implications for equity and access to health care,' EQUINET Discussion Paper Series 84 Health Economics Unit (UCT), ISER Rhodes University, EQUINET, Harare.  
[https://www.equinet africa.org/sites/default/files/uploads/documents/DIS84privfin\\_mcintyre.pdf](https://www.equinet africa.org/sites/default/files/uploads/documents/DIS84privfin_mcintyre.pdf)
  36. McIntyre D (2012) 'Health service financing for universal coverage in east and southern Africa', EQUINET discussion paper 95. Health Economics Unit (UCT), EQUINET, Harare.
  37. Mialon M, (2020) 'An overview of the commercial determinants of health. globalization and health 16(74), doi: <https://doi.org/10.1186/s12992-020-00607-x>, 2020 <https://tinyurl.com/yyyyj3w3>
  38. Ndajiwo M (2020) Health financing & taxation for sustainable healthcare, Tax Justice Network Africa, Nairobi.
  39. Ngangom T, Aneja U, (2016) Indian private sector investments in African healthcare, ORF Issue Brief 145. <http://tinyurl.com/gu6aw49>
  40. Ozano K, Simkhada P, Porcellato L, Khatri R, (2019) 'Universal health coverage, primary health care and the role of the private sector health systems,' *Global*.  
<https://tinyurl.com/y26p38cp>
  41. Pettinger T (2019) Advantages and problems of privatisation, online, Economics Help.  
<https://www.economicshelp.org/blog/501/economics/advantages-of-privatisation/>
  42. Ruiters G, Scott B (2009) Commercialisation of health and capital flows in east and southern Africa: Issues and implications, *EQUINET Discussion Paper Series 77*. Rhodes University Institute of Social and Economic Research, York University, Training and Research Support Centre, SEATINI, EQUINET, Harare.
  43. SEATINI, TARSC (2021) Brief: Ensuring access to COVID-19 related vaccines and health technologies in East and Southern Africa, EQUINET Brief, Harare.
  44. Sehoole TJ. (2020) COVID-19: 'Pandemic burden in Sub-Saharan Africa and the right to health – The need for advocacy in the face of growing privatisation,' *Afr J Prm Health Care Fam Med*. 2020;12(1), a2476. <https://doi.org/10.4102/phcfm.v12i1.2476>  
<https://doi.org/10.4102/phcfm.v12i1.2476https://hdl.handle.net/10520/ejc-phcfm-v12-n1-a105>



45. Ssenyonjo A, Namakula J, Kasyaba R et al. (2018) Government resource contributions to the private-not-for-profit sector in Uganda: Evolution, adaptations and implications for universal health coverage, *International Journal for Equity in Health*. <https://doi.org/10.1186/s12939-018-0843-8>, <https://equityhealth.biomedcentral.com/articles/10.1186/s12939-018-0843-8>
46. Stein F (2021) 'Risky business: COVAX and the financialization of global vaccine equity,' *Globalization and Health* 17:112 <https://doi.org/10.1186/s12992-021-00763-8>
47. Training and Research Support Centre, Ministry of Health and Child Care (2019) 'Reforming national public health law – building synergies between universal health coverage, health security and health promotion: A Zimbabwe case study,' TARSC, MoHCC, Harare, <https://tinyurl.com/y6as57ma>
48. USAID (2021) 'USAID engages private sector in global health security efforts,' online, accessed April 12 2021, <https://www.usaid.gov/news-information/press-releases/apr-1-2021-usaid-engages-private-sector-global-health-security-efforts>
49. van Es M, Guijt I, Vogel I (2015) [Hivos ToC Guidelines: Theory of change thinking in practice: A stepwise approach](#). *Monitoring and Evaluation News*. The Hague, Netherlands.
50. Vermuyten S; (2017) Healthcare is not a commodity but a public good Public Services International (PSI): *Spotlight on Sustainable Development*, <http://tinyurl.com/y9k72zf8>
51. Williams O; Chun Yung K; Grépin K: 'The failure of private health services: COVID-19 induced crises in low- and middle-income country (Lmic) Health Systems,' *Global Public Health* 16(8-9), 2021 <https://www.tandfonline.com/doi/full/10.1080/17441692.2021.1874470>
52. Yiranbon E, Zhou LL, Asante Antwi H, & Nisar N (2016). 'The Impact of privatisation of healthcare equipment and technology SOEs on productivity in Africa,' *International Journal of Engineering Research in Africa*, 26, 195–205. <https://doi.org/10.4028/www.scientific.net/jera.26.195>
53. Yoong J, Burger N, Spreng C, et al. (2017) 'Private sector participation and health system performance in sub-Saharan Africa,' *PLoS ONE* 5(10), doi: <https://doi.org/10.1371/journal.pone.0013243> <http://journals.plos.org/plosone/article?id=10.1371/journal.pone.0013243>
54. Zimbabwe Coalition on Debt and Development (ZIMCODD) (2017) 'Social and economic impacts of public private partnership agreements to the realisation of the right to health: The case of Chitungwiza central hospital Harare,' <https://tinyurl.com/mfmpzpw>

## Acronyms

ACHPR	African Commission on Human and Peoples' Rights
ESA	East and Southern Africa
IFC	International Finance Corporation
OOPS	Out-of-Pocket Spending
PHC	Primary health care
PPPs	Public Private Partnerships
TARSC	Training and Research Support Centre
TOC	Theory of Change
UHC	Universal Health Coverage
WHO	World Health Organization

Equity in health implies addressing differences in health status that are unnecessary, avoidable and unfair. In southern Africa, these typically relate to disparities across racial groups, rural/urban status, socio-economic status, gender, age and geographical region. EQUINET is primarily concerned with equity motivated interventions that seek to allocate resources preferentially to those with the worst health status (vertical equity). EQUINET seeks to understand and influence the redistribution of social and economic resources for equity-oriented interventions. EQUINET also seeks to understand and inform the power and ability people (and social groups) have to make choices over health inputs and their capacity to use these choices towards health.

EQUINET implements work in a number of areas identified as central to health equity in east and southern Africa

- Protecting health in economic and trade policy
- Building universal, primary health care oriented health systems
- Equitable, health systems strengthening responses to HIV and AIDS
- Fair Financing of health systems
- Valuing and retaining health workers
- Organising participatory, people centred health systems
- Promoting public health law and health rights
- Social empowerment and action for health
- Monitoring progress through country and regional equity watches

EQUINET is governed by a steering committee involving institutions and individuals co-ordinating theme, country or process work in EQUINET from the following institutions:

TARSC, Zimbabwe; CWGH, Zimbabwe; University of Cape Town (UCT), South Africa; CEHURD Uganda; University of Limpopo, South Africa; SEATINI, Zimbabwe; REACH Trust Malawi; Ministry of Health Mozambique; Ifakara Health Institute, Tanzania; Kenya Health Equity Network; Malawi Health Equity Network, SATUCC and NEAPACOH

For further information on EQUINET please contact the secretariat:  
Training and Research Support Centre (TARSC)  
Box CY651, Causeway, Harare, Zimbabwe Tel + 263 4 705108/708835  
Email: [admin@equinetafrica.org](mailto:admin@equinetafrica.org)  
Website: [www.equinetafrica.org](http://www.equinetafrica.org)

Issue editor: V Kernohan