Equity in Health in Southern Africa: Challenges to Research

By Dr Rene Loewenson

Training and Research Support Centre [1]

Southern African Regional Network on Equity in Health (EQUINET)

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Abstract:

The paper presents evidence that poor households in southern Africa have borne an inequitable share of the cost burdens of major public health problems such as HIV/AIDS, Malaria and TB. This burden shift derives in part from weaknesses in access to the social and economic protection that comes from housing, clean water, literacy, education, employment opportunities, assets, incomes, access to services and social networks. Research indicates that these are critical determinants of poverty, but also barriers to improved uptake of new resources. These patterns of deprivation are now well described, as are their links to the distribution of health sector inputs and of social and economic opportunity. Responding to this there have been a range of 'poverty reducing' interventions aimed at improving access to health inputs, through direct targeted interventions, mobilisation of new resources for health and through promotion of more equitable public and private resource allocations for health. In southern Africa, evidence and historical experience both suggest that health gains have been more sustained when health systems redistribute resources to areas where poverty is high and on pro-poor services. So why do the cost burdens of ill health continue to shift to poor households? This paper explores the factors emerging from EQUINET and other research in southern Africa on the deeper determinants of whether societal and health resources will be directed towards proven interventions, nationally and globally. It traces these downwards, to the capacities and mechanisms for communities to participate in, claim and benefit from entitlements in national systems. It also traces these upwards in the values, policies and practices that inform global trade, investment and economic policies. The paper explores the implications for the areas of focus, approaches and alliances to be pursued if a research agenda is to contribute towards a more equitable distribution of resources for health.

[1] 47 Van Praagh Ave, Milton Park, Harare, Zimbabwe; Ph 263-4-708835 email rene@tarsc.org

1. INTRODUCTION: EQUITY ASPIRATIONS AND WIDENING INEQUALITY

Southern Africa is a region of significant inequality in a world of even greater inequality. A child born to a low income household in Mozambique has a ten times greater chance of dying before their first birthday than one born to a middle class family in neighbouring Zimbabwe. The same poor child has a significantly lower chance of having safe water supplies, a healthy diet or access to health services for immunisation or treatment of basic diseases than her wealthier counterpart.

At global level, the income gap between the fifth of the world's people living in the richest countries and the fifth in the poorest was 74 to 1 in 1997, up from 30 to 1 in 1960. This is the widest this gap has ever been (UNDP 1999). The statistics speak for themselves: By the late 1990s the fifth of the world's people living in the highest-income countries had:

* 86% of world GDP, while the bottom fifth had 1%
* 82% of world export markets, while the bottom fifth had 1%
* 68% of foreign direct investment, while the bottom fifth had 1%
* 74% of world telephone lines, while the bottom fifth had 1.5%

The assets of the top three billionaires in the world are more than the combined GNP of all least developed countries and their 600 million people (UNDP 1999).

In this context of profound inequality, all southern African governments have a policy commitment to equity in health. Equity has been a consistent aspiration of health systems, signalling a deeply rooted desire to better distribute the gains (and losses) of economic growth across the populations of the region, and to widen the social wellbeing of people in the region. Despite this, inequality persists, is exacerbated by HIV/AIDS, widened under market led reforms and has further widened in the current trade environment.

Why is it so difficult to translate policy commitments to equity into practice? What research agenda and practice will support the process of turning equity values into practice?

These are some of the questions that have motivated work in the southern African Regional network on Equity in Health (EQUINET). EQUINET seeks to understand, produce evidence and analysis on equity in health in southern Africa. We seek to stimulate policy, practice and political choice that has an impact on differences in health status that are unnecessary, avoidable and unfair. Concepts such as 'avoidable ' and 'unfair' are socially defined, and this embeds any research in a deeply value driven and social process towards justice.

One only has to think about some of the pressing health challenges we face to understand the concern for equity:

Why is it that overconsumption and obesity in one part of the world coexist with hunger and malnutrition in another, both as leading determinants of mortality?

Why is it that when drugs exist to significantly reduce AIDS related mortality, those regions

of the world most affected by AIDS have least access?

Why is it that health systems that once achieved significant rates of primary health care expansion and coverage are now contracting and in some cases collapsing?

Why are health workers trained using public funds in countries with high health need flowing to private sectors in countries of low health need?

This paper argues that resolving these and other equity issues is now fundamental to translating existing knowledge into practice and to building sustainable improvements in health.

2. INEQUITABLE HEALTH BURDENS IN POOR HOUSEHOLDS

International literature demonstrates a strong relationship between poor health status and material and social deprivation. The major factors that mediate poverty-health relationships in southern Africa are quality of and access to housing, sanitation and clean water, literacy and educational levels, employment opportunities, income levels and social inclusion and cohesion. Such health promoting inputs are found at reduced levels in people in insecure jobs, in rural areas, in women and in groups that have been subject to past discrimination, such as racial discrimination (Gilson and McIntyre 2000). They vary widely across countries and communities in the region.

While there is variation in these dimensions of deprivation, there are also significant absolute levels of poverty, with indications that absolute poverty is increasing in some countries of the region. Poverty affects more than a quarter of the population in all SADC countries, with the exception of South Africa and Lesotho (Figure 1).

Such deprivation generates increasing social and health burdens. Existing patterns of service delivery do not adequately compensate for these burdens (See for example Table 1). The poorest communities within southern African countries thus continue to have highest levels of ill health and lowest levels of access to health care. (See Table 1). This difference is worse for women than for men in many SADC countries(See Table 2)

This relates in part to lower levels of service resourcing and provision in areas where poverty is greatest (See for example data from South Africa, Table 3).

There is also evidence that even where services are provided, poor households face social barriers in access to health services (opportunity costs, information barriers, transport costs), obtain lower value for money when they use services (due to poorer service provision in low income areas), spend a greater share of their income on health care and are more deeply affected by health shocks such as AIDS, but have a lower individual and household ability to direct resources to address health needs (Goudge and Govender 2000).

FIGURE 1: POVERTY LEVELS, SOUTHERN AFRICA 2001

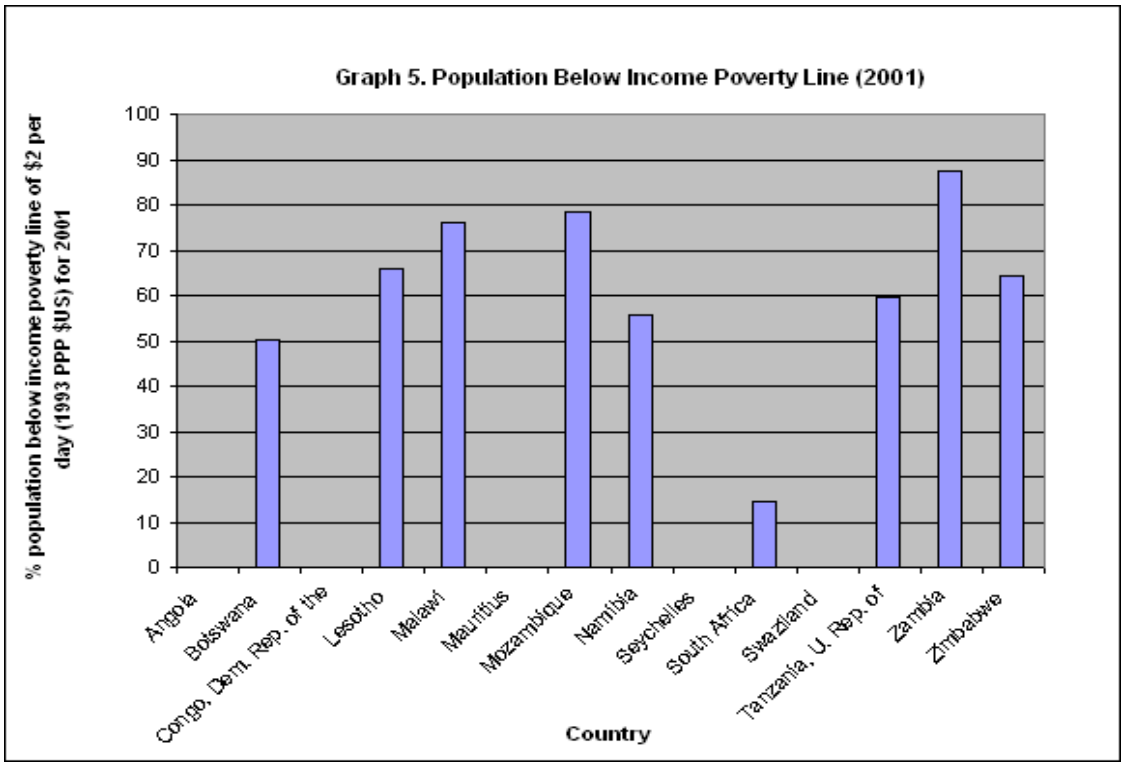


TABLE 1: POOR /RICH RATIOS FOR SELECTED HEALTH STATUS INDICATORS FOR SELECTED SADC COUNTRIES

(Ratio of the poorest quintile to the richest quintile in the selected indicator)

COUNTRY	Namibia	Malawi	Mozambique	Tanzania	Zambia	Zimbabwe
Infant Mortality Rate	1,11	1,33	1,98	1,37	1,77	1,25
Under five year Mortality Rate	1,46	1,47	1,92	1,44	1,57	1,50
% Children under 5 yrs stunted	2,19	1,53	2,19	1,75	2,08	1,93
% Children under 5 yrs underweight	2,83	1,96	2,58	2,19	2,45	2,04
Total fertility rate	1,92	1,18	1,18	2,00	1,68	2,21
Immunsation coverage % children under 1 yrs with all immunizations	0,85	0,82	0,23	0,70	0,83	0,84
% ARI cases seen at a public health facility	1,03	0,73	0,38	0,79	1,20	0,91
% deliveries attended by a medically qualified person	0,56	0,57	0,22	0,33	0,21	0,59

Source: Gwatkin et al 2000

TABLE 2: DISPARITIES IN HEALTH BETWEEN THE POOR AND THE NON-POOR

Country	% in absolute poverty*	Poor:non-poor ratio in probability of dying between ages 15 and 59		Poor:non-poor ratio in probability of dying between birth and age 5	
		M	F	M	F
Botswana	33	2.3	4.0	4.9	4.8
Lesotho	49	2.6	5.4	3.9	5.2
South Africa	24	1.7	3.6	4.7	5.3
Tanzania	11	2.1	3.3	5.6	5.0
Zambia	85	2.5	3.6	3.5	3.9
Zimbabwe	41	2.1	2.3	4.1	5.0

M = Male F = Female

* The WHO has used a different measure of poverty (based entirely on income) to that used by UNDP (which reviews poverty in relation to lack of income, reduced longevity, lower literacy and no access to basic services).Source: WHO (1999)

TABLE 3: INDICATORS OF THE AVAILABILITY OF PUBLIC SECTOR HEALTH CARE RESOURCES BETWEEN MAGISTERIAL DISTRICTS (1992/93)

Indicator	"Poorest" districts	"Richest" districts
Hospital beds/1,000 population	2.1	3.8
Population per clinic	16,260	12,442
Outpatient visits per capita	1.0	2.6
Doctors (general and specialist) per 100,000 population	5.5	35.6
Nurses per 100,000 population	188.1	375.3
Health inspectors per 100,000 population	1.1	6.7
Pharmacists per 100,000 population	0.5	5.4
Per capita health care expenditure (1992/93)	R122	R437

Source: McIntyre et al. 1995

There have in the late 1900s been many efforts aimed at responding to such disparities. These include successful primary health care approaches and the redistribution of investments towards accessible primary medical services extending simple and effective technologies to the population, through a broad based presence of health workers, including community health workers. Various studies describe the health gains made when public health measures are specifically designed and invested in to complement household capacities (Sanders and Davies 1988; Loewenson and Chisvo 1994). Review of periods of high health gain in Southern Africa indicate that health systems can improve health status in high risk groups and reduce inequalities in health. To do this they redistributed budgets towards prevention; improved rural and primary care infrastructures and services in terms of both access and quality; deployed and oriented health personnel towards major health

care problems, backed personnel with adequate resource inputs; invested in community based health care; provided prompts to encourage effective use of services, such as dissemination of information on prevention and on early management of illness and removed cost barriers to primary care services at point of use (Loewenson 1999; Loewenson et al 1991; Haddad and Fourier 1995; Albaster et al 1996; Jhamba 1994; Curtis 1988).

However, there is also evidence over recent decades of persistent and sometimes growing inequalities in access to care, and of reversals in health gains.

Inequalities between different population groups have been documented in access to TB control and treatment, antenatal care coverage, public health measures, access to quality primary care facilities and to referral facilities (Andersson 1990; Doherty et al 1996; Lesotho MoHCW 1993; Loewenson et al 1991; van Rensburg 1991; Msengezi 1992; Tevera and Chinhowu 1991). These differences distribute across a number of parameters, including race, rural, urban and periurban status, socio-economic status, age, gender, geographical region and insurance status (EQUINET 1998). As indicated in Table 3, these relate in part to lower levels of resourcing in low income districts and lower levels of services, both in terms of financial, personnel and management resources. This not only reduces service provision in primary care levels of the public health services used by low income communities, but also the capacity to draw in and benefit from new resources for health care. Table 4 indicates for example the variation in STI drug and vaccine availability for different levels of health services in Zimbabwe in 2000 and 2001, indicating lower and falling levels at primary care levels of services (Loewenson and Ropi 2003).

Table 4: Drug availability for STI drugs and vaccines, Zimbabwe 2001

Facilities	**% availability 2000**		**% availability 2001**	
	STI drugs	**Vaccines**	**STI drugs**	**Vaccines**
Central hospitals	82		81	
Provincial hospitals	81		80	96
District hospitals	80	96	78	88
Rural health centers	60	82	52	72
Urban health centers	74	100	62	97
Mission hospital	75	95	69	81
Average	(38 – 92)		(32 – 93)	

Source: Ministry of Health and Child Welfare (2001) *Public Sector Essential Drugs* Survey

Such trends are exacerbated where there is inequity in the distribution of resources between the public and the private sectors. Using South Africa as an example, in 1992/93 it was estimated that although only 23% of South Africans enjoyed some degree of regular

access to private sector health care, around 58% of total health care expenditure was accounted for by this sector. The private sector captures a higher proportion of all types of personnel, except nurses, than the public sector (McIntyre et al. 1995; Soderlund et al. 1998).

The spread of the HIV/AIDS epidemic in southern Africa itself exemplifies how inequalities in health and health care emerge. Differences in HIV seroprevalence by occupational group, educational status, sex, and geographical region indicate that HIV first moved through skilled, mobile, educated and urban groups in the region, but has rapidly spread to rural, lower income groups, and from adults to adolescents (Forsythe 1992). The pattern of transmission indicates the common spread of HIV from more socially and economically powerful adult males to poor and economically insecure females, particularly female adolescents (ILO, 1995; ILO 1995c; ILO 1995b; Gillies et al 1996; Forsythe 1992). HIV transmision has been rapid where people move for trade, work, food, social support and where such mobility links people with some disposable income and those who live in poverty, particularly where the latter are women. Hence areas of migrant employment, transport routes and urban and peri-urban areas have been high risk environments for HIV. The impact of AIDS on the poorest groups has been to precipitate them deeper into poverty, and to facilitate the intergenerational transmission of poverty (Loewenson and Whiteside: 1997).

As AIDS has led to a massive increase in illness and mortality, it has also increased the demand for health services, for terminal care and for survivor support. It has been estimated that the impact of AIDS can cost economies about 1% of GDP annually. Company impacts have been projected at about USd200 / employee annually. Insurers have predicted collapse of benefits schemes due to AIDS. Analysis of 51 countries at different HIV prevalence rates, controlling for other influences, indicates however that HIV/AIDS has had a small and statistically insignificant negative impact on such macroeconomic indicators (eg: growth rates, per capita income). The impacts have been found to be least visible at the macroeconomic level and most visible at household level, where AIDS can lead to chronic and potentially intergenerational poverty (Loewenson and Whiteside 1997). Death, disability and medical insurance schemes have excluded people with HIV or reduced benefits, reducing coverage and household savings and shifting the costs of unsecured risks to public and household budgets. Health services have promoted home based care approaches that have often been inadequately supported, further stressing households, and particularly women caregivers. Studies have found that households unsupported by social security spend four times the share of annual household income on AIDS related health costs when compared with households covered by social security (Hanson 1992). Such findings are located within the context of a global environment where barriers to access to treatment have meant that the significant majority of those infected by HIV cannot access resources now available to prevent mortality. This contradiction has been labeled a ‘global health emergency’ by World Health Organisation in 2003.

There is thus a significant base of evidence on inequalities in health and health care in southern Africa, of the impacts of positive health care interventions aimed at addressing inequities in health, and of continuing gaps in the resourcing and provisioning of such forms of care, with consequences for increased burdens on households.

Measuring and making visible these continuing inequities is important to stimulate policy responses. University of Zimbabwe co-ordinated research with EQUINET support to explore use of the Demographic and Health Surveys to monitor health equity outcomes. Addressing identified inequities within health services is important to enable new resources for health to flow to underserved communities. Hence for example work by the University of Cape Town in south Africa has explored ways of integrating deprivation into public budget resource allocation formulae to facilitate higher health resource flows to areas where deprivation is higher (McIntyre et al 2001). Similar work is now being carried out in Tanzania and Namibia with support from EQUINET and in Zimbabwe and Zambia. Work being carried out by CHESSORE and INESOR in Zambia and by TARSC in Zimbabwe is exploring the effectiveness and areas for strengthening joint community – health service structures towards enhancing integration of community preferences in health planning and drawing greater resources towards community health activities. Work being done through Health Systems Trust in South Africa with other countries in the region is seeking to explore options for enhancing the retention of personnel within the public health system, particularly in underserved areas. EQUINET supported work in four countries in southern Africa has now led to the development of proposals for strengthening equitable health systems responses to ensuring access to anti-retroviral treatment for HIV/AIDS.

These areas of research aimed at informing health policy and practice seek to enhance equitable practice within health systems.

However, such work faces the reality that health outcomes, health and health care inputs are increasingly being shaped by macro-economic and trade interests and by interests outside national boundaries.

Research evidence is also being produced within a context of an intensifying political struggle around scarce health resources. Research work thus needs to understand 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 Steering Committee 1998) .

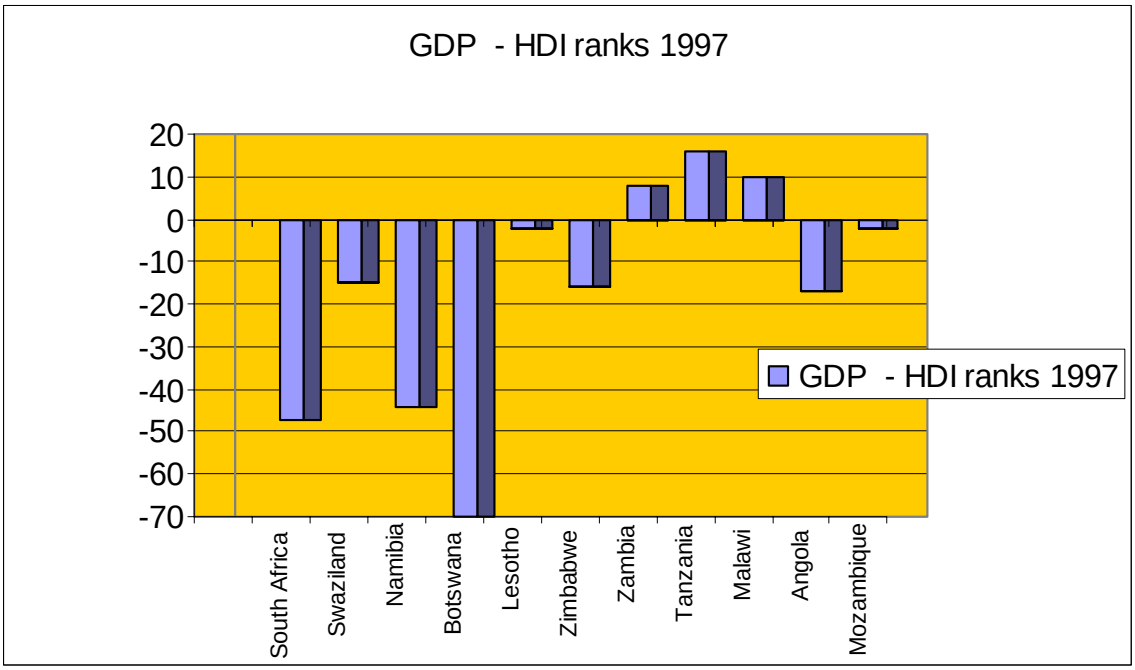
3. DETERMINANTS OF EQUITY IN HEALTH

In a majority of SADC countries, the Human Development Index (HDI) ranking is lower than their Gross Domestic Product (GDP) ranking. This signals that even where economic growth occurs, the growth in wealth is not being translated adequately into human development. (UNDP 1999).[2] (See Figure 2)

[2] The Human Development Index, Human Poverty Index and Gender Development Index are composite indices derived from weighted measures that are judged to relate to development (life expectancy at birth, adult literacy, GDP per capita), poverty (% people dying before age 40, % adult illiteracy, % people with access to health services and safe water and % malnouriushed children under 5 years) and gender equity (using the HDI measures but imposing a penalty through adjusting for gender inequality) respectively.

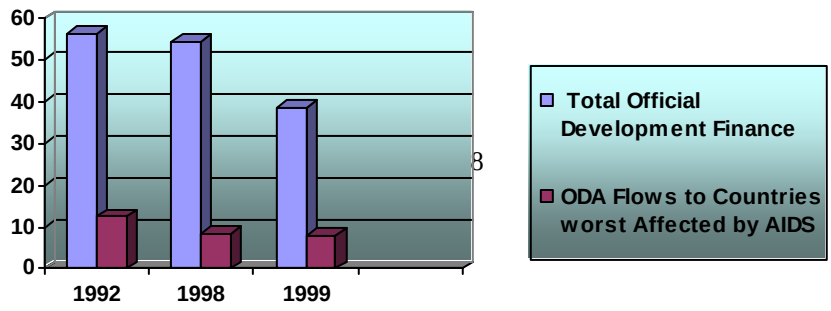
While AIDS is a major contributor to this disparity, it is not exclusively the cause. There is evidence of increasing poverty, falling employment, chronic malnutrition, and rising household poverty during the structural adjustment programmes have also weakened the returns to households from growth (Commonwealth secretariat 1989; Sanders and Davies 1988; Kalumba 1991; Loewenson 1993; Loewenson and Chisvo 1994; Semali and Kimambo 2003).

FIGURE 2: GDI – HDI RANKING IN SADC COUNTRIES, 1997



For example, public spending on health, a major factor in improved household health, declined in the region under structural adjustment programmes in a number of countries (Price 1997, Lennock 1994; Loewenson and Chisvo 1994). As real public health budgets fell, health care resource allocations were systematically biased against primary care (Sahn and Bernier 1996). Greater problems were experienced of staffing constraints, poor conditions of service and inadequate resources for the effective implementation of tasks by health workers (Loewenson 1999; WHO 2000). This led to a plateauing or loss of coverage and poorer quality care, particularly at primary care level (UNICEF MoHCW 1996). Health sectors became more dependent on external financing, even through external financing itself fell (Loewenson and Whiteside 2001, See Figure 3).

FIGURE 3: OFFICIAL DEVELOPMENT FINANCE FLOWS 1992-1999



Bond and Dor (2003) show that two decades of IMF, World Bank led market-oriented, export-led state policies, characterized by the commercialization /privatization of public sector functions in Africa produced a number of negative effects on health systems. These included disincentives to health-seeking behavior, witnessed by lower utilization rates and declines in the perceived cost and quality of services, falling household ability to meet major health care expenses; reduced size of and real incomes in the civil service, declining health worker morale and the increasing commodification of basic health-related goods and services (such as food, water and energy) that made many unaffordable. Over the period of structural adjustment the total debt stock in Africa rose from US$60.6 billion in 1980 to US$206.1 billion in 2000, while investment and saving rates declined. Debt servicing levels exceed expenditures on health in almost all countries in the region. As debt has consumed an increasing share of revenue, public health expenditure has fallen to well below the US$30-$40 needed to provide reasonable quality basic health care (Bond and Dor 2003). Liberalisation enabled a wider spread of providers, with an inadequate state infrastructure to regulate quality or ensure equity in the growth of private providers. The liberalised growth of private care under conditions of declining access to basic public services led to parallel worlds, where those with wealth and connections could access the highest technology while many poor people cannot get or afford secure access to TB drugs or to safe water supplies. (Mudyarabikwa 2000). Many of these changes not only changed the funding and affordability of services, but also meant that citizens who once expected safe water or health care as a right delivered by the state now had to negotiate as consumers with a plethora of providers and bureaucracies.

Efficiency driven perspectives dominated international health policy prescriptions (Gilson 1998) and focused attention away from the interface of services with communities, as well as away from how resources are allocated to the community level. This led to the development of approaches aimed at cost effective rationing of scarce resources for health care and of management and measurement tools to support these approaches. Such reforms may, in fact, have done little to enhance efficiency (Mills 1996), even while they may have worsened quality of or equity in health care (Bijlmakers and Chihanga 1996; Molutsi and Lauglo 1996). Moreover, as public budgets fell, greater attention was given to resource mobilisation for health, often with weak attention paid to how resource mobilisation strategies affect equity or the relationship between communities and health services. In many countries, the experience of implementing user fees, for example, negatively impacted on equity, increased the gap between services and communities and undermined the effective management of health issues in the community (Gilson 1997; Lennock 1994; Hongoro and Chandiwana 1994; Zigora et al 1996; Loewenson 1999).

Globalisation has now deepened the liberalisation trends initiated by the structural adjustment programmes, forcing open national borders to trade, capital and information. The changing trade environment poses enormous challenges to southern African countries. The trade

negotiations at Uruguay extended the concept of trade liberalisation to significant new areas, including trade in services, trade related investments and intellectual property rights. The Uruguay round created a powerful enforcement mechanism, the Dispute Settlement Body, that can authorise a country to impose sanctions against a member who fails to honour its commitments. This enforcement mechanism favours the richer countries. These "multilateral agreements" have been backed by strong enforcement mechanisms that are not only binding on national governments but drastically reduce their scope for making policy. The policies of countries at various levels of development have differing priorities, a factor that is not accommodated by the WTO's "one-size-fits-all" approach. Adding to past conditionalities, this further reduces the power of governments to regulate in favour of national development objectives. So while governments are still held accountable by the people for the service provision, they have fewer powers with which to exercise their mandate.

EQUINET work on trade agreements such as the WTO's Trade Related Aspects of Intellectual Property Rights (TRIPS) and General Agreement on Trade in Services (GATS) with the Southern and Eastern African Trade and Information negotiations Institute (SEATINI) has identified a number of specific areas where trade agreements negatively impact on health, including:

- International agreements that limit governments ability to promote and safeguard public health
- Challenges to food sovereignty and barriers to market access in agricultural trade
- International piracy of unpatented indigenous knowledge systems and biodiversity
- Liberalisation and limits to regulation and cross subsidies in essential services (health, water, electricity)
- Patent barriers to cheaper drug access
- Institutional demands to satisfy global trade agreements
- Political exclusion of poor countries in WTO governance mechanisms (Muroyi et al 2003).

While trade agreements do provide limited space for countries to act in interests such as public health, they demand significant institutional resources and capabilities to take advantage of them. These resources are not always available to individual countries in the South. When southern countries exercise these powers they often meet major challenges. In South Africa, for example, legal processes for the compulsory licensing and parallel importation of generic drugs met not only with legal challenges but threats of sanctions from northern countries. These challenges were raised even though the measures taken were compliant with the WTO TRIPS agreement.

There are clearly huge research demands around these challenges to health. A number of studies, cited earlier, have traced the impact of structural adjustment policies on health. Such studies have raised serious doubt about the initial evidence base from which claims were made by the World Bank about the gains in health and health care to be made through market reforms. For many Africans who watched strong public health systems severely eroded by structural adjustment reforms, there is a lesson to be learnt in looking behind international finance agency prescriptions at the real interests that inform them and critically examining the evidence raised. Hence, for example, EQUINET and SEATINI propose to support national

institutions and authorities to audit the implications of their current and proposed commitments under GATS to avoid any commitments that could compromise public goods or the widest protection of public health. There is also a need to use research and analysis to support alternatives to meeting health challenges.

Two areas now present themselves as examples of areas where research that builds equity oriented health system responses is urgent and critical, not simply for the response to the immediate issues, but for the future of health systems in Africa.

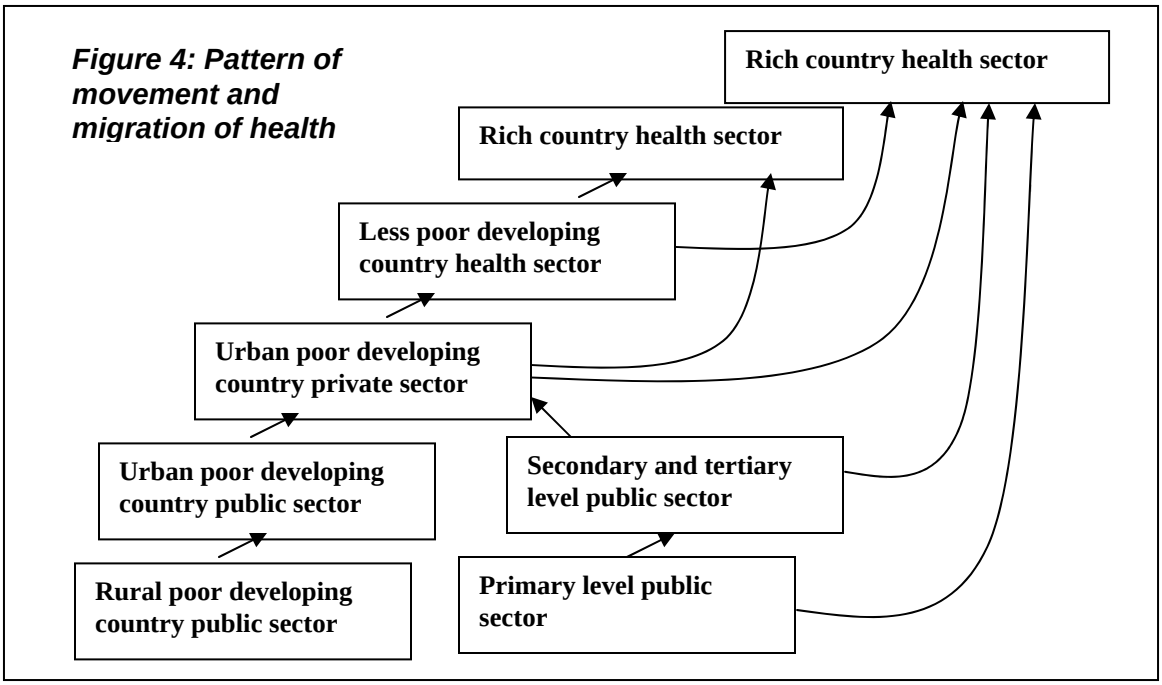
The first area relates to how to make new global technologies and resources for **treatment with anti-retrovirals (ARVs)** accessible to populations through health systems. In a region where even with new resources from the Global Fund for AIDS, TB and Malaria only 10% of people will benefit from treatment, there is a need to tap these new opportunities to strengthen the wider health systems for sustained coverage and roll out and for equitable access to ARVs. EQUINET is now carrying out work in this area, and has through country analysis in Tanzania, Malawi, Zimbabwe and South Africa and on nutrition and health personnel identified options for a health systems approach to widening treatment access (EQUINET 2003b; McCoy 2003; Kemp et al 2003; Chopra 2003; Aitken 2003). Some dimensions of this response are to

- Deliver ARVs through mechanisms that strengthen the whole service and public health approach, especially at the periphery
- Balance resources for prevention, treatment and care and chose points of entry that provide best options for doing this
- Balance treatment and care burdens across public and private sectors
- Invest in complementary resource needs, especially in human resources, to avoid resource diversion from essential health services
- Ensure transparency and objectivity in rationing decisions
- Address not for profit drug research and full exercise of TRIPS flexibilities.

The second area relates to understanding the factors driving the exodus of **healthcare workers** from areas of poverty and low socio-economic development, to more highly developed areas and countries, following a hierarchy of 'wealth' resulting in a global conveyor belt of health personnel moving out of public health services, increasing inequity, as shown in Figure 4.

Statistics cited in an EQUINET discussion paper on the problem highlight the scale of loss to southern Africa and resource flow south-north:

- Of 1200 physicians trained in Zimbabwe in the 1990s, 360 were still practising in the country in 2001
- Zambia's public health system has retained only about 50 of +600 doctors trained since independence
- The developing world subsidises industrialised countries by about $500 million a year through the migration of healthcare professionals
- 31% of the UK healthcare workforce is from overseas
- About 20% of the permanent medical workforce in Canada, Australia and United States is made up of international medical graduates
- 25% of Canadian hospital-based physicians are foreign (Padarath et al 2003).



Source: Padarath et al 2003 EQUINET discussion paper 4

EQUINET is now carrying out work on the relative impact of factors influencing personnel flows on different mixes of personnel, the distribution of costs and benefits from current trends and the options for policy responses. The process used to generate and analyse evidence will also be accompanied by opportunities for reflection and input from key stakeholders, from national to international level. It aims not only to develop understanding and propose alternatives, but also to strengthen the voice and agency of those seeking greater equity to articulate and take forward these policy responses.

4. DRIVING FORCES FOR EQUITY IN HEALTH

Research and new knowledge can generate an understanding of *what* to do in relation to the major challenges to health equity outlined above. However, given the interests and values that lie around such choices, making the research to policy /practice link depends on understanding and informing social processes and procedural systems.

The contribution of social action to the production of health gains in the region has perhaps been somewhat underplayed, compared to the role of technical developments. While the provision of health services in the southern Africa region had its roots in colonial systems and the domain of charities, its character underwent radical transformation in anti-colonial struggles based on popular movements that organised around rights to land, to education, to organise, to work, to housing, the right to be free from brutality etc. In almost every case, the right to health – as well as the right to access to health services – was a fundamental demand of the popular movements (EQUINET Steering committee 2000). At independence, governments conceded to the popular demand for the state to accept its responsibility for both the provision

of health services and for some wider inputs to health, such as safe living environments. State interventions produced the type of health gains outlined in an earlier section of this paper.

But at the same time that these governments intervened to ensure universal health care, they also began to transform the very essence of the movement that had brought them to power. Whereas the liberation movements were motivated by the struggle for rights and popular participation, in the post independence period health or education became less something people organised around than a “technical problem” that could be addressed only by technicians and experts. This was compounded when the new occupiers of the state machinery perceived themselves as the "sole developer" and "sole unifier" of society, in a centralising and controlling role. This made ‘development’ a benefit to be delivered by the state, with many social movements or grassroots groups, unless under state patronage, seen as irrelevant or to be controlled. It was not about development in the sense of developing the productive forces, nor in a manner that recognised that poverty was the result of denial of fundamental rights (Cowen M, Shenton R 1996).

Civil, political and many social rights were recast as a "luxury", to be enjoyed at some unspecified time in the future when "development" had been achieved. For the present, said some African presidents, "our people are not ready" - mirroring, ironically, the same arguments used by the former colonial rulers against the nationalists' cries for independence a few years earlier. Hence states built closer relationships with official “aid agencies”, than with their own popular organisations. Even where health rights were articulated, they were often codified in laws whose relevance or application was determined by guardians of the state (Shivji 1989).

Community participation, a key element in all post independence health policies and gains in the region, was generally cast as mobilisation to effect health programmes planned and financed at higher – often central- levels, and was more dependent on state than self organization (Loewenson 2000). With strong state driven forms of participation, usually controlled by medical decision makers, there were limited real shifts in authority (and resource control) towards communities. This was reinforced by perceived weaknesses in capacities at community and primary care level, and failures of health systems to find ways of addressing these weaknesses.

Structural adjustment programmes weakened the state, and led to protest from civil society groups over both their shrinking access to food security, safe water, health care etc, and over the lack of consultation of citizens in these changes. States and governments were seen as being more responsive to people from international finance and donor institutions than to their own citizens. In the struggle over scarce resources, more powerful medical interest groups were often able to exact concessions, sometimes at the cost of the poorer, less organised rural health workers, or the urban and rural poor(Van Rensburg and Fourie 1994; Bennett et al 1995).

While some constituent civic organisations tried to resist and confront these changes, others came in to fill the gaps in service provision created by state withdrawal or falling access due to commercialization. This was backed by a rationale of NGOs as being more able to reach vulnerable groups, more efficient and more cost effective than the state. In fact, evidence indicates that while NGOs have reached marginalised communities, they have generally not achieved the level of national coverage needed to sustain health

systems, have not been able to provide sufficiently comprehensive health interventions, are no more accountable to the population than private companies, and demonstrated great variability in the quality of input provided (Loewenson 2002a,b,c). As state resources have fallen, the better salaries offered by some NGOs has also drawn scarce personnel away from public sectors with wider coverage towards more focused NGO activities (Kemp et al 2003). Hence even while NGO pilots have demonstrated innovations in responding to key challenges like treatment access at primary care level, they have not been able to answer to the health systems issues that need to be addressed to build national coverage, address national equity concerns nor sustain such access.

Making sense of the systems of governance, power and procedural justice that influence health outcomes has now become even more important, given the increasing challenge to government authority within global trade processes. The bottom line is that the deep economic, social and political inequities that underlie inequities in health are driven by a global trade and investment system that currently operates in the self interest of wealthy countries. Confronting equity is thus as much about organizing evidence for equity oriented health policies and interventions as it is about advancing the interests and power of southern African countries, low income communities and marginalised social groups to take these policies forward.

5. RESEARCH AIMED AT DETERMINANTS AND REINFORCING DRIVING FORCES FOR EQUITY IN HEALTH

These conditions call for state, civil society, professionals and elected leaderships and organisations to be increasingly informed and conscious, networked and organised in putting forward changes and policies that protect public health, including at regional and global level.

While there are many processes that contribute to this, one of these is a research practice that not only

- Describes and analyses the distribution and causes of inequalities in health
- Evaluates and informs options for pro-equity health policy and practice, but also
- Understands and supports the social analysis and action that drives pro-equity choices.

Hence for example, research by London (2003) through EQUINET has explored through analysis of case studies in the region when health rights are (and are not) tools for promoting health equity. Analysis of civil society actions to take up rights to treatment access, to patient rights and to access to primary health care indicates that when civil society pursue social and economic rights relevant to health through social action (rather than individual litigation) and through agency on the part of those most affected, then health rights can offer powerful tools to support social justice and institutional transformation towards equity and public health goals (London 2003).

Institutions within EQUINET (TARSC, CWGH (Zimbabwe), and CHESSORE, INESOR (Zambia)) are carrying out work that seeks to understand the systems that enable or obstruct inclusion of community preferences in decision making on health resources, to understand and shape the forms of participation that will contribute to health equity. Centre

for Health Policy in South Africa work is seeking to strengthen understanding of the processes through which health policy is made, including how different forms and sources of evidence are used and judged in policy development. Action and participatory research approaches, and building processes of dialogue with the state and parliament and civil society engagement and networking have provided vehicles for research to involve affected communities more directly in such analysis and identification of options.

EQUINET thus seeks to explicitly place the populations concerned in an active role, understanding inputs and influencing outcomes. We seek to engage in ways that support different groups of people to make and articulate choices over health inputs and use these choices towards health.

Decades of health struggle driven by social values and of economic and health practice driven by self interest and market goals underlie the outcomes described in this paper. This indicates that knowledge is not value neutral, nor is the production and use of new knowledge independent of processes that are driving different strategic interests. The growing contradiction between the current processes of globalization and the pursuit of public health is nowhere more sharply felt and visible than in Africa. The questions asked at the beginning of this paper point to that conflict. The reality described in this paper of economic conditions and developments and their impact on health in the region threaten to undermine and make hollow global aspirations for health.

As researchers we also make and demonstrate our choices in this conflict. The Global Health Research Forum has raised an important issue of the 10:90 gap in research resources, with 90% of resources going to 10% of problems. Let us also close another gap – that of using our scarce but strategic research resources in the most effective manner. This paper proposes that this includes using research resources to inform and shape alternatives built firmly on public health principles and values of equity and social justice and ensuring that our work strengthens the power of those who seek to implement those alternatives.

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