

**Regional Network for
Equity in Health in
Southern Africa**

EQUINET POLICY

Series

NO. 15

**Reclaiming the state:
advancing people's health,
challenging injustice**

EQUINET STEERING COMMITTEE

EQUINET POLICY SERIES NUMBER 15

September 2004

Produced with support of
the International Development Research Centre (Canada),
the Dag Hammerskold Foundation and the Rockefeller Foundation



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TABLE OF CONTENTS

1. Introduction	1
2. Advancing peoples health in southern Africa	3
2.1 The challenges to people's health	3
2.2 Health systems responses: Positive trends and warning signs	6
3. Reclaiming the role of the state in advancing people's health	12
3.1 A preference for public sector health care	12
3.2 Regional preferences for public sector investment in health	14
3.3 The additional impetus of access to treatment for AIDS and human resources losses	16
4. Challenging injustice	18
5. Equity oriented health systems for southern Africa	23
6. Social action based on shared values	27
6.1 EQUINET as a vehicle for equity and social justice	27
References	29
Appendix 1: Statistical tables	32





Reclaiming the state: Advancing people's health, challenging injustice

By the Steering Committee of the Southern African Regional Network
for Equity in Health (EQUINET)
September 2004

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1. INTRODUCTION

It is six years since EQUINET was formed to support the Southern African Development community (SADC) in its commitment to secure equity in health. In those six years many challenges have been faced, much has been achieved and much remains to be done. This report from the EQUINET steering committee faces the future squarely in the eye. It details the opportunities for equity that lie in the region and highlights the challenges to equity that we must confront. It offers a vision of health systems that serve equity. It presents a rallying call for those striving to work for justice hand in hand with the poor and marginalised.

The Southern Africa regional meeting in 1997 on 'Equity in Health—Policies for Survival in Southern Africa' in Kasane, Botswana highlighted the common commitment to equity in Southern Africa across political, professional and civil society communities. The meeting recognised the need to translate this commitment into analysis, policy and practice. The southern African Regional Network for Equity in Health (EQUINET) was formed in 1998 to support the newly formed SADC Health sector in doing this.

Drawing from a wide range of research and publication, we proposed a guiding concept of equity in health:

'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 Steering committee, Policy Series #2, 1998

In 2000, responding to widening global inequalities in health and a profile of poverty, inequality and ill health in southern Africa, we developed and proposed policy and practical measures to direct resources towards health needs, and towards the forms of health care most appropriate and accessible to those with greatest health needs, particularly through primary health care strategies. We recognized the damage that structural adjustment programmes had caused to health and health care and the important role played by social forces and commercial interests in driving policy choices. The regional conference in 2000 issued a 'Call to Action', that

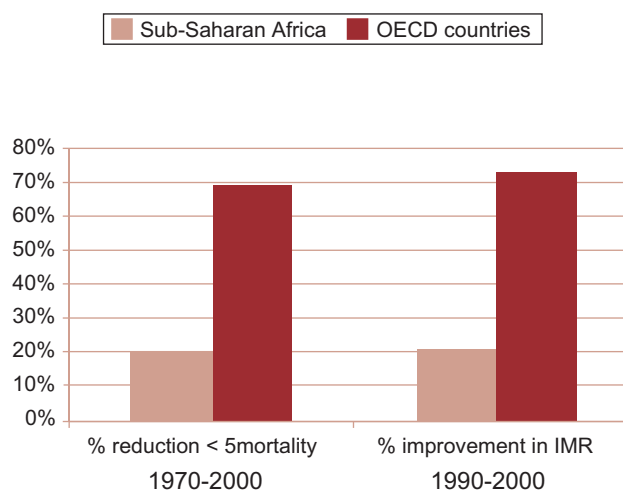
- urged that greater effort be put into dealing with differences in health status and access to health care that are unnecessary, avoidable and unfair.

- noted that economic measures should include human development goals, and efforts be made to reduce the disproportionate burden of poverty and ill health borne by women.
- noted that governments need to move beyond declarations of policy support for equity in health and accept and act on their primary responsibility for improving equity in health. This implies assessing the equity impacts of health policies, monitoring the equity performance of health systems, making public resource allocation systems more responsive to deprivation, investing in those areas of health systems that enhance equity, such as primary health care, and dealing with those that increase inequities.
- affirmed that community participation and involvement of the poor in decision making are important determinants of equity in health. These goals need to be actively pursued in ways that support community involvement with investments in community capacities and that match responsibilities with authority and resources.

Call to Action, EQUINET Regional Conference, South Africa 2000

Southern Africa has many opportunities for meeting this Call to Action and has made some progress towards this. We also faced increasing challenges: from an unfair global trading system, from the accumulated impact of war in some countries and from the huge outflow of financial, human and other resources through debt and migration. Our efforts towards equity locally, nationally and regionally are located in a context of widening global inequity in health, shown In Figure 1. This places even greater pressure on us to develop and organise around a uniting alternative vision, analysis, perspective and practice that delivers on our shared values of equity and social justice in health.

Figure 1: Changes in health 1970-2000



2. ADVANCING PEOPLE'S HEALTH IN SOUTHERN AFRICA

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2.1 The challenges to people's health

With the common focus on poverty and ill health, we often forget that Southern Africa is one of the richest regions in Africa and in resource terms in the world. The Southern African Development Community is a regional community that is made up of 14 countries. The SADC land mass covers 9 066 840 square km (the equivalent of the USA or China), has a population of over 194 million (which is 30% of the total Sub-Saharan African population) and a combined GDP of US\$178 billion in 1999 (Chauvin and Gaulier 2002). Its size and resource base provide both economic and social potential for addressing its health challenges (Muroyi et al 2003).

Despite this wealth of potential, the value of these resources have not yet been adequately harnessed for the people of the region. People have been impoverished by colonial, multinational and elite exploitation of African resources, falling terms of trade for African products, huge resource outflows due to debt, migration, war, displacement, persistent inequalities in access to wealth, poor access to public resources and other factors described further in this paper.

Health assessments by SADC thus point to a profile of the common health problems arising from social and economic poverty and inequality: food insecurity; people who cannot access the basic safe water, sanitation, energy, transport and shelter; high prevalence levels of HIV/AIDS, TB, Malaria and other communicable and non communicable diseases, and illness and mortality related to reproductive roles (SADC 2002). These problems are unequally distributed across urban and rural areas, across high and low income communities, across gender, race and social class groupings (EQUINET SC 1998, EQUINET SC 2000). The different experiences of ill health reflect inequalities in access to incomes and in ownership of wealth: Ten out of fourteen SADC countries have Gini coefficients in excess of 0.50 (SURF 2000)¹.

HIV and AIDS present a particularly profound challenge in the region. The spread and impact of HIV and AIDS is related to and worsens social and economic inequalities.

'The HIV/AIDS pandemic is reversing the developmental gains made in the past decades and is posing the greatest threat to sustainable development of the region..'

SADC Heads of State 2003

Many SADC countries have adult HIV infection rates of over 20%. The statistics estimated for the SADC region are staggering:

- 14 million adults and children currently infected with HIV
- 51% of all infections in Africa
- 10 million people who have died of AIDS related diseases to date
- 5 million children aged 0 –14 years orphaned due to AIDS²
- 120 million people directly or indirectly affected by the epidemic (SADC 2003)

¹ Measures the distribution of income (or consumption) among individuals or households within a country. A value of 0 represents perfect equality, a value of 1 perfect inequality.

² DRC [927,000]; Mozambique [418,000]; South Africa [662,000]; Malawi [468,000]; Tanzania [815,000], Zambia [572,000-800 000] and Zimbabwe [782,000]

There is variation in the epidemic across countries in the region (from low rates in Mauritius to rates of over 30% in Botswana, Lesotho, Swaziland and Zimbabwe), between population groups (urban people generally being more affected than rural, although this gap is closing) and across gender and age groups. The HIV prevalence in young women aged 15-24 years is more than twice that of their male counterparts throughout the region (SADC 2003b). Variations in susceptibility to HIV and the impacts of AIDS have been linked to levels of poverty and income security, household food security, labour mobility, income differentials, access to primary health care, social security and gender equity. (EQUINET 2004; SADC 2003b)

AIDS has compounded household vulnerability to food insecurity, while malnutrition has increased vulnerability, especially of women and children, to AIDS and other diseases. The 2002/3 food crisis in Southern Africa was more widespread and impacted much more severely on households than could be predicted from rainfall patterns. The destructive effect of AIDS on household labour and incomes clearly compounded other threats to food security, such as inequities in access to productive resources and to market access, particularly for women (Chopra 2003; SADC 2003b).

'Total cereal production in the SADC region has remained stagnant for over a decade remaining at the same level in 2003 as it was in 1990, with an estimated 22,753 000 and 22,062 000 metric tonnes respectively. In the same period the population has grown from 152 million to 212 million.'

*2004 SADC Heads of State and Government
Summit on Agriculture and Food Security*

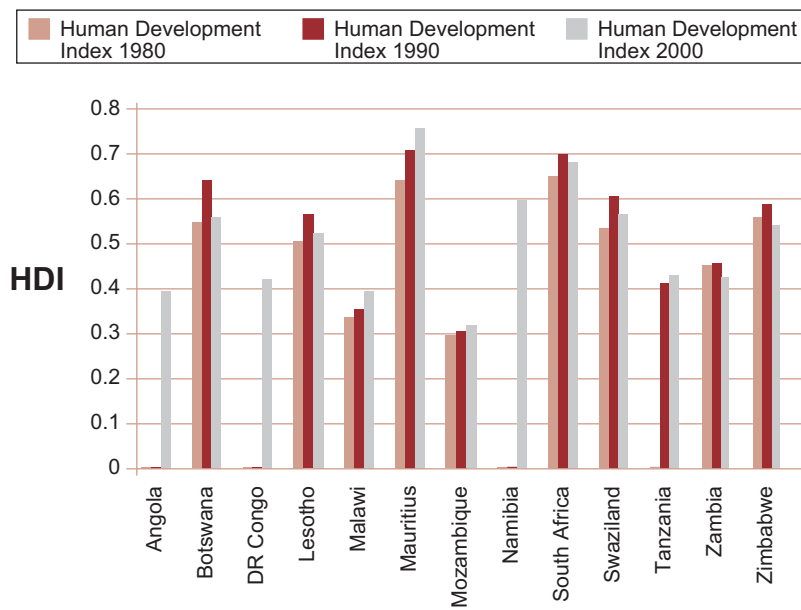
Increased mortality associated with AIDS and other common diseases post 1985 have had negative effects on economic growth and human development across the region, reversing human development gains in most countries, except for Malawi, Mozambique and Tanzania (see Table 1 and Figure 2).

Table 1: Effect of mortality on economic welfare, selected SADC countries

Country	Growth rate per Capita GDP (%)			Contribution of mortality changes to the rate of change in GDP/capita growth (%)	
	1960-75	1980-90	1990-96	1980-85	1985-2000
Botswana		+7.3	+1.3	+2.7	-8.5
Malawi	+2.9	-0.5	+0.8	+1.7	-5.3
Zambia	+1.2	-1.9	-1.9	+1.7	-7.9
Zimbabwe	+1.2	-0.8	-0.5	+2.0	-7.5

Source: World Bank 1980, World Bank 2000 and SADC database

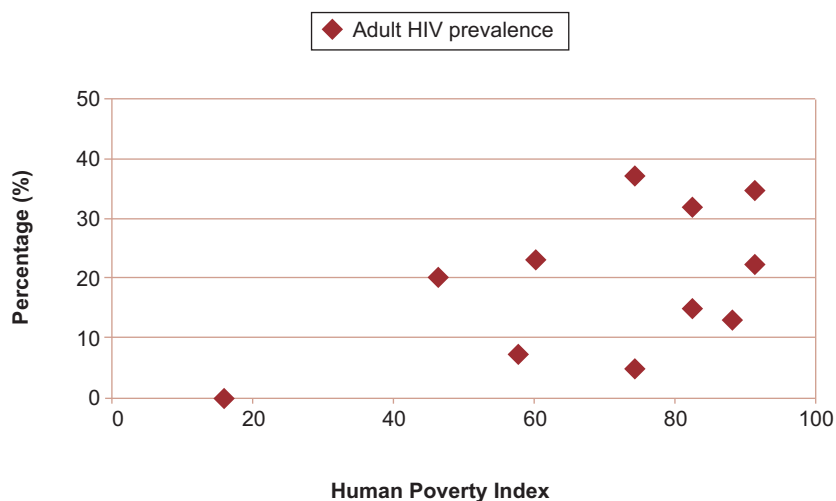
Figure 2: HDI³ changes, Southern Africa 1980-2000



Source: UNDP HDR 2003, see Appendix 1

This effect has been most profound at household level. Poverty creates the conditions for the spread of HIV and AIDS related ill health and mortality increases household poverty (see Figure 3). As the HIV epidemic becomes an AIDS epidemic and mortality increases this two way relationship will predictably worsen, unless prevention and treatment initiatives are able to break the vicious cycle.

Figure 3: Adult HIV prevalence and human poverty in selected SADC countries



Source: UNDP HDR 2003, see Appendix 1

³The HDI is a composite of longevity (measured by life expectancy at birth), education (measured by the combined gross enrolment ratio at primary, secondary and tertiary levels, and adult literacy rate) and standard of living (measured by real per capita income).” UNDP 2003

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The pattern of under-nutrition, HIV/AIDS and communicable disease in the region further discussed in other papers at this conference highlights the significance of improving and reducing inequalities in household food intake, access to education, access to safe water and other non health sector inputs to improve health (EQUINET SC 2000). Any reversals in these areas affect women and lowest income communities most (EQUINET SC 2000). The chronic poverty and the resulting poor health makes households susceptible to acute health shocks, as was experienced in the regional famine in 2002/3.

At the same time evidence from the 1980s indicates the significant positive contribution that improved health makes to human development and economic growth. Advancing people's health has the potential to

- enhance household and national wellbeing
- directly contribute to growth and development
- redistribute resources and opportunity for growth and development, and
- reduce unfair inequalities between groups in society, and
- make society more cohesive.

Political and economic decision makers in the region thus face contrasting possibilities: either virtuous resonance between health and economic wellbeing, or vicious cycles of poverty and ill health. Certainly the current global path is not one that will work in Southern Africa- the 'two worlds' option of the opportunities of the virtuous cycle for an increasingly small minority of people, while the majority are locked into the vicious downward spiral.

2.2 Health systems responses: Positive trends and warning signs

There is significant experience in the region of health systems playing a leading role in building virtuous cycles of health and human development.

Previous EQUINET papers have described this contribution in more detail so this is not repeated here. These overviews highlighted the significant improvements in health status and reduced health inequalities that followed public policies that:

- redistributed health budgets towards prevention;
- improved access to and quality of rural, informal urban and primary care infrastructures and services;
- deployed and oriented health personnel towards major health care problems;
- supported personnel with adequate resource inputs;
- ensured fairer distribution of resources between the public and private sector providers;
- invested in community based health care;
- encouraged effective use of services, by improving dissemination of information on prevention and early management of illness; and
- removed cost barriers to primary care services at point of use (EQUINET SC 1998, 2000).

These policies were backed by policies that also enhanced public provision of education, female literacy, safe water and sanitation, contributing to health improvements and enhancing effective uptake of health services. In some countries policy measures were also introduced to improve access to housing, to employment and to improved incomes (EQUINET SC 1998, 2000).

The policies were based on values of solidarity and equity. Health services were based on public health and primary health care principles and designed to reflect goals of comprehensiveness and universality. Health financing systems were based on progressive financing and risk pooling.

In 2002 SADC Health Ministers reiterated the relevance of many of these policy measures, outlining the most critical health interventions as:

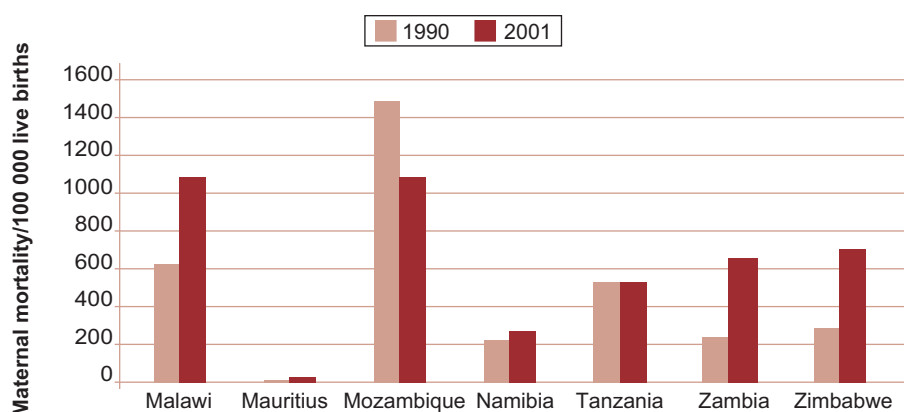
- ensuring adequate supplies of clean water;
- ensuring that health systems function effectively in tackling priorities, provide prevention, treatment and care accessible to those who need them;
- enabling people in need to access essential medicines, commodities, services and community support to prevent HIV/AIDS, maintain reproductive health and provide accessible obstetric care;
- making available therapeutic food for the malnourished, for people living with AIDS, and for the elderly;
- providing measles and other priority vaccines in effective vaccination programmes; and
- distribution of insecticide-treated mosquito nets and other health prevention and promotion interventions (SADC Health Ministers 2002).

There are thus strong political signals that the same values and principles are as, if not more relevant to the region today. Despite this, trends in recent years send warning signs that we need to ensure that our policy choices reflect these values and meet the significant health challenges described in the first section. These warning signs include:

A deterioration in selected key health indicators of population health in some countries

The increase in infant mortality, malnutrition (20% of children under five are under weight, and 36% experience stunting) and in the incidence of malaria (5,550 per 100,000 people) have been noted earlier (Southern African Political Economic Series, 1998). Rates of maternal mortality of more than 800 / 100 000 are now found in the region . As shown in Figure 4, there is evidence that while maternal mortality levels improved in Mozambique and remained constant in Tanzania and Mauritius, they increased in Namibia and increased markedly in Malawi, Zambia, Zimbabwe in 1990-2001.

Figure 4: Maternal mortality 1990, 2001: Selected SADC countries



Source: UNDP HDR 2003; UNICEF/WHO in Woelk 2000

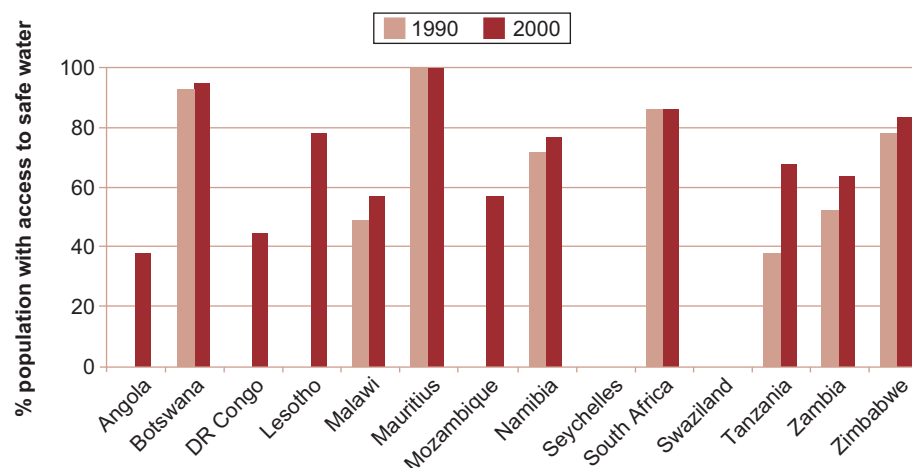
Essential public health measures persistently not reaching the poorest

As shown in Figure 5, key public health interventions like access to safe water continue to show significant regional variations, access continues to be an issue for a fifth of the population or more, and rates of improvement in access in the past decade have been slow in many countries. This reflects the difficulties with extending such measures to the lowest income groups. Inequity in access to the essential services necessary for health are found in even the more highly

⁴Maternal mortality reflects a mix of nutritional, communicable disease (AIDS) and health service factors. These data are drawn from a mix of UN and national data sources which show some consistency. The 2001 Zambia Demographic Health Survey noted for example a level of maternal mortality around 800/ 100,000 live births.

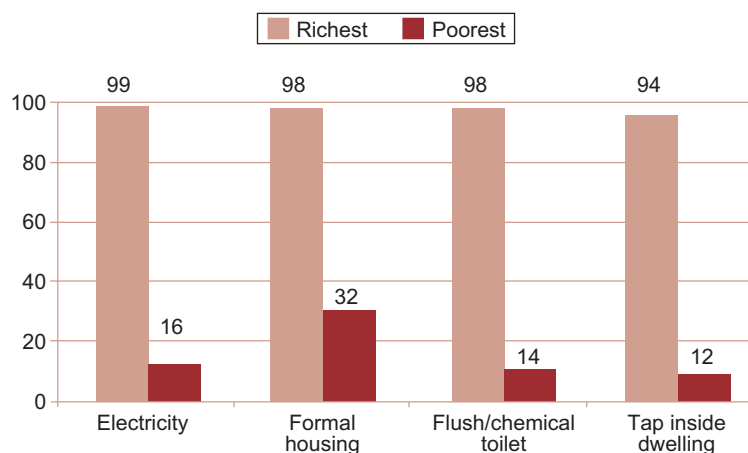
resourced countries in the region (See Figure 6). Equity policies in South Africa led to the rapid expansion of infrastructure such as primary care clinics, water supply and sanitation, particularly in rural areas. Market led reforms have however curtailed public expenditure in such key areas (Marais, 1998) and progress in the redistribution of health care resources (Gilson and McIntyre, 2001). Where resources for public preventive and population health services have fallen and where services have been commercialized, the burden on individuals to promote and protect health is greater, with negative consequences for poor households (MSP 2004). Privatisation also changes the status of communities - from citizens with public rights and responsibilities into consumers with market power, or lack of it. This further weakens the ability of poor communities to demand and access such services.

Figure 5: Access to safe water in Southern Africa 1990-2000



Source: UNDP HDR 2003; <http://devdata.worldbank.org/hnpstats/query/countries.htm>

Figure 6: Access to basic facilities according to income in South Africa, 2000

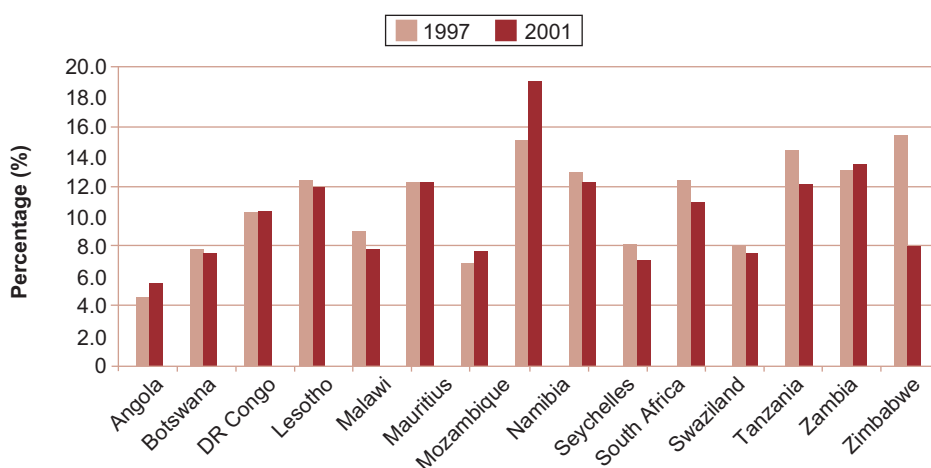


Source: Stats SA 2000 in Ntuli et al 2003
(Access to electricity is defined as using electricity for cooking.)

Shortfalls in public health spending

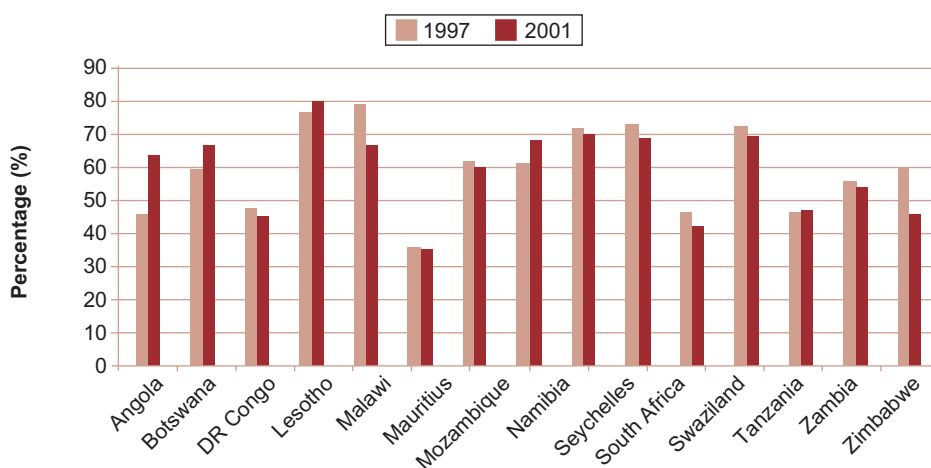
Only four countries in the region are reported to have increased their share of government spending on health between 1997 and 2001 and only one to have met the Abuja (and now NEPAD) commitment of 15% in that period (See Figure 7). Beyond declines in the relative commitments to health, Figure 8 shows some shifts in the public-private mix away from public (universal, progressive, solidarity) financing in the health sector towards private (often out of pocket) financing. While four countries in the region increased their share of public funding, six countries reduced it. Reduced public spending has been associated with increased out of pocket financing, private provision and commercialization, with negative equity impacts. These measures segment services and lead to poor quality services for low income communities. Increased out of pocket financing (eg: user fees) is reported to increase poverty and exclusion from services (EQUINET SC 1998, 2000)

Figure 7: Health as a share (%) of government expenditure, Southern Africa 1997-2001



Source: WHO National Health Accounts database 2004

Figure 8: Public share (%) of health expenditure, Southern Africa 1997-2001



Source: WHO National Health Accounts database 2004

These trends reflect a policy shift in health that has occurred in the past two decades globally, that has also affected policy within the region. Recent policies have emphasised:

- 'provision of health services by a 'mix' of public, private and voluntary providers;
- liberalisation of private clinical provision and pharmaceutical sales;
- retreat of government to a mainly regulatory role, with responsibility for direct provision of services in public health and primary care for the poorest;
- an emphasis on "government steering, not rowing";
- emphasis on local resource gathering and user charges for remaining government health services and for government-provided drugs and supplies;
- the use of contracting-out where possible when governments continue to finance provision;
- autonomisation and corporatisation in the hospital sector;
- liberalisation of insurance provision for health care, and a shift towards insurance rather than tax-based financing mechanisms including mutual insurance schemes;
- the introduction of concepts of pre-paid care or even more direct emphasis on prepaid plans (managed care); and
- competition between insurers and providers and distancing social insurance mechanisms from government, including the abolition of compulsory elements of social insurance and the contracting out of insurance management.

(World Bank 1987; World Bank 1993; WHO 1997; OECD 2003; WHO 2000; Gwatkin 2003; World Bank 1997; Preker and Harding 2003 cited in Mackintosh and Koivusalo 2004 available at www.unrisd.org)

The values motivating this shift have not been made explicit, the proposals have often been presented as purely technical in content and the evidence base for the policy proposals has often been weak. Nevertheless these shifts imply profound changes to our policy values and commitments and to the services used by the low income majority. The three warning signs above call for caution around these policies in the region and indicate their potential of being 'harmful to health'.

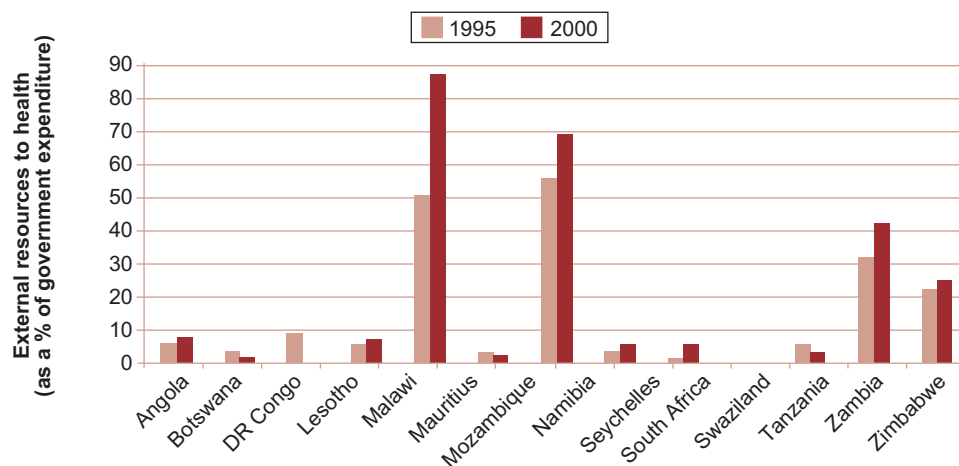
The 'blueprints' advanced in these policies fundamentally conflict with our equity values and commitments in a number of ways: They assign excessive weighting to management factors and market behaviours and do not adequately integrate the values, institutional capacities and wider social and economic goals held by communities and countries in the region. The market reform led segmentation and privatization of essential and health care services undermines the risk pooling and cross subsidization needed to equitably finance services. The administrative and management burdens and sophisticated capacities required often exceed the institutional capacities of public providers and the state, particularly when the real budgets of these institutions are falling. A weakened public sector, relegated as a residual actor in the context of commercialized and regressive financing approaches, is not able to implement the redistributive role of the health sector critical for equity. Limited targeted interventions aimed at 'the poor' neither meet the obligations of the state nor satisfy communities, de-legitimising the state and demoralizing communities, undermining the two most important 'vehicles' for equity oriented health interventions (Mackintosh and Koivusalo 2004; Bond and Dor 2003b).

These policies have also been associated with increased, rather than reduced dependency on external resources, indicated by the **fourth 'warning sign' of a rising share of external financing in health in the region** (see Figure 9). Increased international commitment to health funding in Southern Africa is certainly called for (as discussed later). However its rising share of expenditure where it arises as a result of a *reduced* overall public funding to health and a reduced public share can create problems in terms of both policy influence and capacity to benefit. There are moves for external support now to come in the form of 'general budget support' to the Treasury (e.g. from World Bank, DfID) rather than through sector wide funding to the health and other sectors directly. While this has the benefits of being more integrated into normal budgeting

processes, it also increases the policy leverage of donors upstream over treasuries (e.g. through threats of losing foreign investment, exchange rate drops) and increases Treasury and Ministry of Finance influence on health policies. This poses significant new challenges to the policy authority and leverage of Ministries of health in external funding decisions.

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Figure 9: External resources share of health financing, Southern Africa 1995 -2000



Source: World Health Report 2002; http://www.who.int/whr/2002/en/whr2002_annex5.pdf

3. RECLAIMING THE ROLE OF THE STATE IN ADVANCING PEOPLE'S HEALTH

In response to such warning signs, we would seek to make clear and promote the alternative policies that will address our health challenges and policy commitments in a manner that provides for equity and justice. In the highly unequal societies of southern Africa, this demands health systems that assertively redistribute the resources for health and policies that reflect values of equity, solidarity and universality. We argue that this can be achieved through rising investment through the state and public sector.

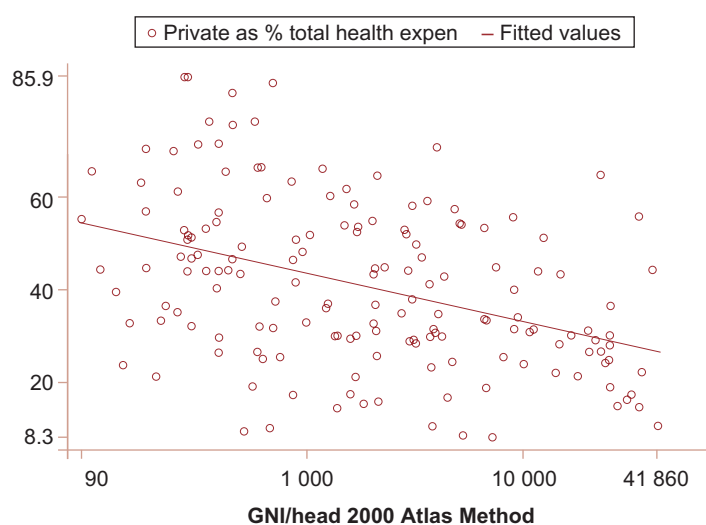
3.1 A preference for public sector health care

Internationally, when countries have faced major health challenges, their responses have centred on rising investment in health through the state and public sector. The most famous example of this is in the establishment in the early and mid 1990s of the comprehensive tax or social insurance funded national health services in Europe. These services followed and backed public health measures introduced during the industrial revolution to deal with the disease epidemics in the rapidly urbanizing population, particularly the public provision of safe water, sanitation, immunization and the promotion of improved diets.

Research in OECD countries found that redistributive policies (related to income, employment and services) are key to improved health status, and particularly to improvements in both the most impoverished and the entire population; and that political systems that back redistributive policies more likely to achieve health gains, particularly in relation to the length of time such pro-redistribution parties remain in power (Navarro et al, 2003).

Industrialised countries have continued to prefer these policies over those promoting commercialization. Mackintosh and Koivusalo (2004), presenting evidence of higher private health expenditure to total health spending in low than higher income countries, conclude that commercialized health care is 'not a system preferred by the better off but an affliction of the poor' (see Figure 10).

Figure 10: Private as % total expenditure on health, by log GNI/ head 2000

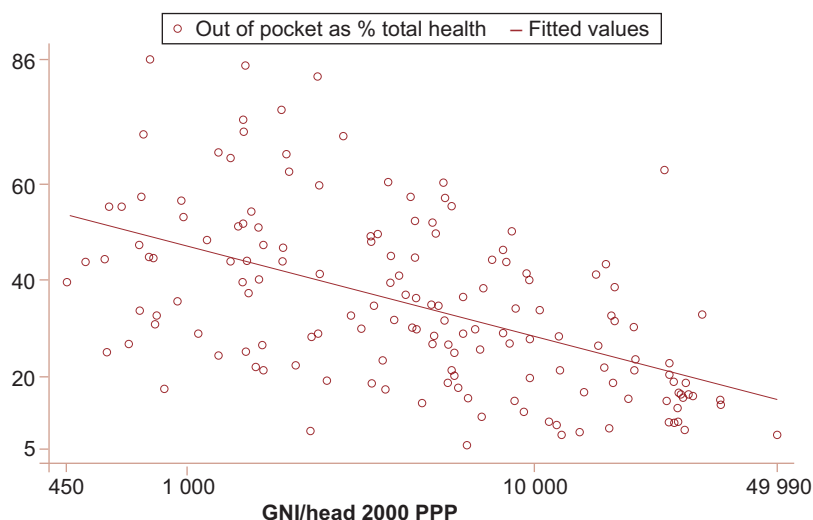


Source: Mackintosh and Koivusalo 2004⁵

⁵ 163 countries (intersection of WHO and World Bank full data set less Pacific islands.) Regression is significant at 1% level. Horizontal axis is log scale; regression x variable is log GNI per head; the association is considerably strengthened using PPP data for GNI/head.

Conversely, countries with higher average incomes spend more proportionately on government and social security expenditure, not on private health spending. The poorer a country, the more likely they were to have regressive out of pocket financing (see Figure 11).

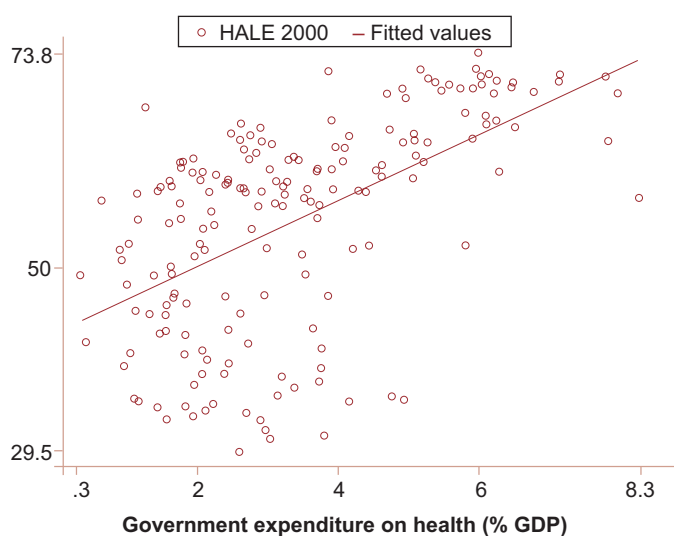
Figure 11: Out-of-pocket as % total health expenditure against GNI /head (PPP basis) log scale



Source: Mackintosh and Koivusalo 2004⁶

Increasing shares of public health expenditure were found to be associated with higher life expectancy and lower under 5 mortality rates (see Figure 12). Across a range of low and middle income countries, better care at birth was associated with a higher share of GDP spent on government financed health care (Mackintosh and Koivusalo 2004).

Figure 12: Healthy life expectancy (HALE) and government expenditure on health as % of GDP 2000



Source: Mackintosh and Koivusalo 2004⁷

⁶ 155 countries (WHO, World Bank data) Regression significant at 1% level. Horizontal axis is log scale; regression x variable is log GNI per head (PPP); The outlier upper right is Singapore.

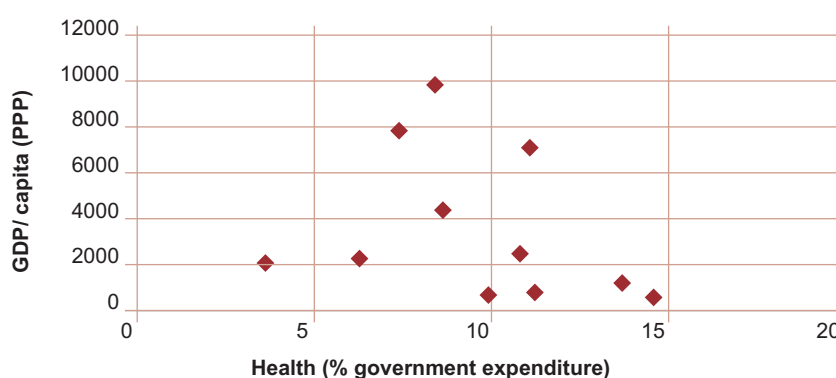
⁷ 163 countries (WHO, World Bank data.) Regression significant at 1% level. Horizontal axis is log scale; regression x variable is log GNI per head.

3.2 Regional preferences for public sector investment in health

Evidence from the region indicates a similar preference for public over private health investment with rising national income and improved health outcomes associated with increased public health spending⁸.

Higher GDP per capita not strongly associated with an increased share of public expenditure on health in SADC countries, but this is mainly due to higher public expenditures being made even in countries with lower per capita GDPs (see Figure 13). There is no evidence of a preference for increased private spending in SADC countries with rising per capita income.

Figure 13: Share of government expenditure on health by GDP/capita (PPP)

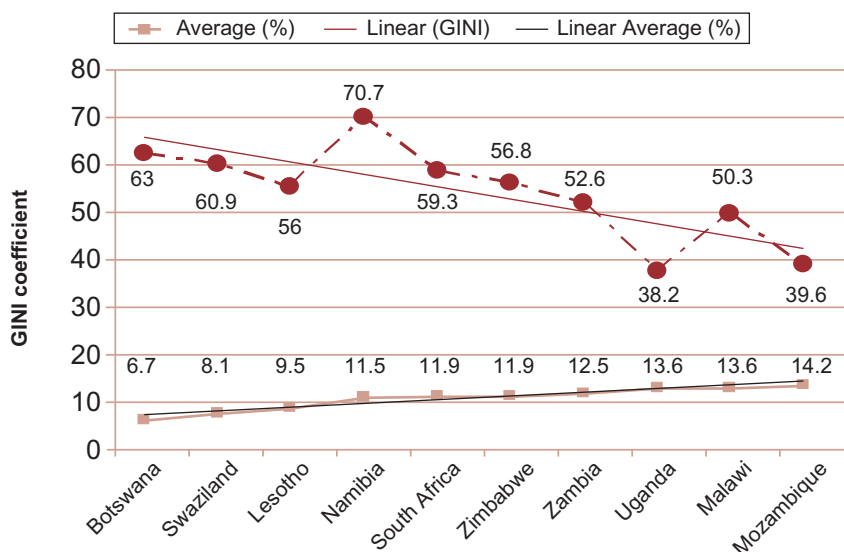


Source: UNDP HDR 2003, <http://devdata.worldbank.org/hnpstats/query/countries.htm>;
World Health Report 2002, http://www.who.int/whr/2002/en/whr2002_annex5.pdf

Countries with higher levels of public expenditure on health also have lower GINI coefficients, indicating the association between increased economic equality and increased public health expenditures (see Figure 14). This relationship is probably bi-directional: Populations from countries with greater economic equity prefer investments public health systems while public health spending contributes to the reduction of poverty and the narrowing of economic inequality.

It thus seems there is a common preference in southern Africa as incomes rise for improved public health investment and a positive association between public health spending and reduced inequality.

Figure 14: Correlation between the GINI Coefficient and % public expenditure on health budget among countries in SADC

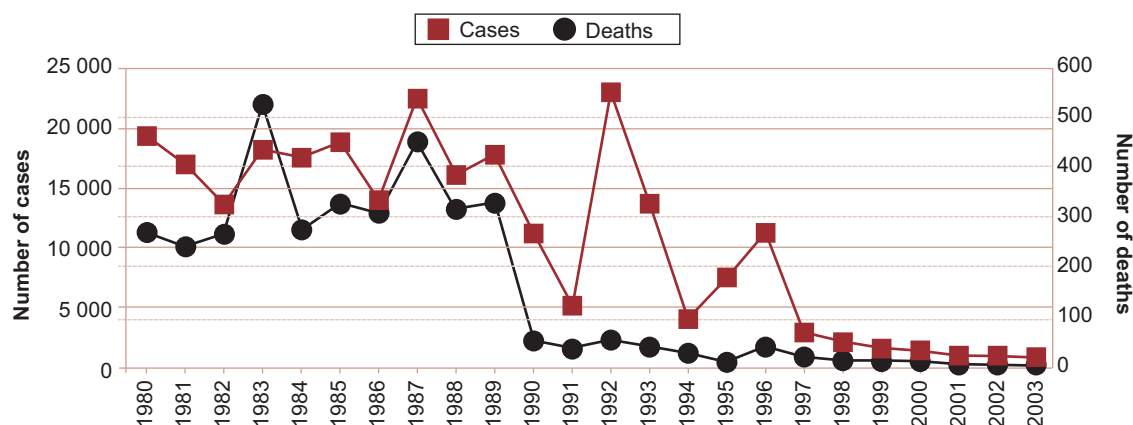


Source: World Health Report 2002; http://www.who.int/whr/2002/en/whr2002_annex5.pdf

Indeed, southern African countries have made deliberate choices to increase public health spending even at times of lower GDP growth, with positive impacts on health outcomes (EQUINET SC 2000).

The arguments for doing this are persuasively made by the real experience of periods of high health gains in the region (EQUINET SC 2000). The relevance of these experiences and policies even in the current macroeconomic conditions is shown, for example, in the positive health impacts of similar measures implemented to improve access to health care in South Africa from the mid 1990s, including introduction of free care for pregnant women and for children under 6 (1994) and the introduction of free primary healthcare for every citizen (1996). These equity oriented policy measures confronted the international trend towards privatization and charging of user fees. They produced positive health gains, such as the sustained control of measles cases and deaths post 1996 (Figure 15; Solarsh et al 2004).

Figure 15: Measles cases and deaths, South Africa, 1980-2003



Source: Measles Surveillance System: Sub-directorate, EPI, Cluster: Maternal, Child and Women's Health and Nutrition, NDoH. Disease notification system, Cluster: Health monitoring and Evaluation, NDoH.

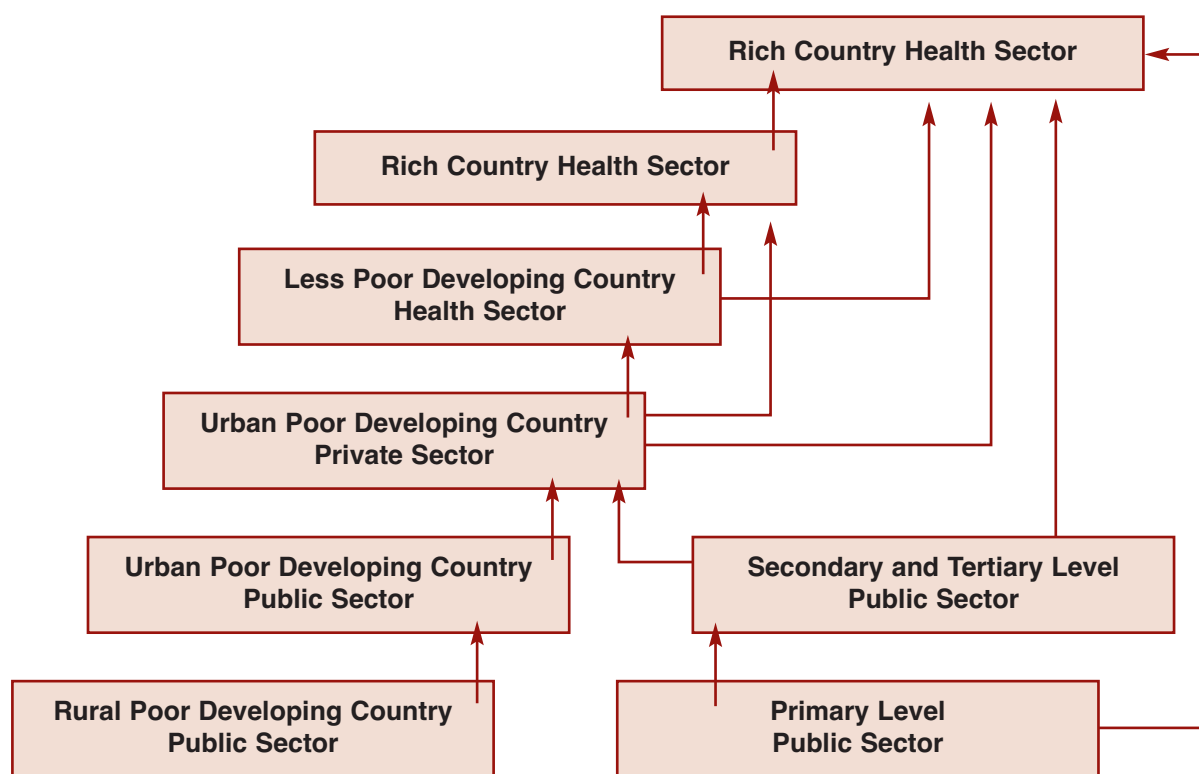
3.3 The additional impetus of access to treatment for AIDS and human resources losses

Southern Africa does not have the luxury of making incorrect policy choices. Decisions made affect both health systems and people's lives profoundly. Two of the most important challenges will be discussed in plenary papers in this conference and so will simply be highlighted here.

The first is the injustice of 10 million deaths due to AIDS in the global context of available antiretroviral therapy (ART), and of only one in every 25 000 people needing treatment in the region able to access it.

The second is the inequity of the 'global conveyor belt' of health personnel and what this implies in a subsidy from poor to rich countries and communities and in service shortfalls to low income communities (see Figure 16).

Figure 16: Pattern of movement and migration of health



The subsidy from migration of healthcare professionals from the developing world to industrialised countries reaches an estimated \$500 million a year.

Padrath et al (2003)

The inequitable distribution of health personnel between public and private sectors is more intense the more developed the private sector in countries. In South Africa, where the private sector consumes 58% of total health expenditure, 73% of general practitioners were estimated to be working in the private sector in 1999, despite the fact that this sector catered for less than 20% of the population (Padrath et al 2003).

These losses and distributional problems have left many countries, districts and communities with significant shortfalls in health personnel relative to WHO standards. (See Table 2)

Table 2: Health personnel/ 100 000 population, selected SADC countries

Country	Year	Physicians	Nurses	Midwives	Dentists
Angola	1997	7.7	114.5	4.3	0
Botswana	1994	23.8	219.1	0	2.2
Dem Rep Congo	1996	6.9	44.2	n.a	1.1
Lesotho	1995	5.4	60.1	47.0	0.5
Namibia	1997	29.5	168.0	116.5	4.0
South Africa	1996	56.3	471.8	n.a	17.8
Swaziland	1996	15.1	n.a	n.a	n.a
Tanzania	1995	4.1	85.2	44.8	0.7
Zambia	1995	6.9	113.1	n.a	n.a
Zimbabwe	1995	13.9	128.7	28.1	1.3

Source: WHO Estimates Of Health Personnel 1998 in Padrath et al 2003

n.a = data not available

These two issues of ART access and human resource losses are strongly linked. The struggle to make life-saving medicines affordable for the poor has finally yielded returns, and the price of antiretrovirals has decreased considerably as a result of political, legal and moral pressure and as a result of competition from generic manufacturers. The scale of mortality and suffering, the pressure from treatment activism, the declaration of AIDS as an emergency and the pooling of significant resources in the Global Fund (GFATM) has had a galvanising effect on efforts to make Antiretroviral therapy (ART) available in Southern Africa. And yet with less than 550 days left to the 2005 WHO target for reaching 3 million people with ARTs, many health systems face significant obstacles in rising to the challenge of meeting the treatment needs.

A week ago the Mozambican Minister of Health, Francisco Songane, estimated that 120 000 people in Mozambique needed ARVs urgently, but that serious shortages of staff and equipment made it unlikely that would be reached in time. "It is slightly impossible to imagine that we can distribute ARVs countrywide. We do not have the capacity to do that. We do not have the trained manpower or the infrastructure to handle such a massive programme. It may be easy to say we should import doctors and nurses and paramedics to do the job but in the long term that does not help the Mozambican people" he said.

Interview with SABC, SABC News, May 24 2004

There is no question that significant investment is needed in southern African health systems to realise aspirations of treatment access for more than a minority. At the same time, recognition of rights to treatment presents a huge opportunity to revitalize public health sector investment by linking the roll out to systematic measures to build health system infrastructure and human resource capacity. We would go further: The evidence that will be reported in this conference indicates that unless ART roll out is implemented through strengthened health systems, backed by adequate human resources, and integrated within wider health services, not only will equity be compromised, but so too will sustained and universal access to treatment, the goal of both public health and therapeutic activists (EQUINET / Oxfam 2004; McCoy 2004; Kemp et al 2004; Semali 2004; Ray et al 2004; Ntuli et al 2004; Loewenson et al 2004).

4. CHALLENGING INJUSTICE

To address these issues we need to engage and draw allies in a global policy environment that is promoting the market led, liberalization and commercialisation reforms noted earlier. The strength and legitimacy for this engagement comes from our efforts to build equitable and just health systems. Deploying and retaining health personnel demands equitable human resource policies nationally but also ethical human resource policies internationally. Ensuring global resources reach communities with greatest need not only calls for fair and solidarity financing nationally and calls for more sustainable, predictable and fair international transfers for health. We need to strengthen the redistributive nature of health systems for ART roll to reach rural women and unemployed youth and to deal with the debt servicing, unfair terms of trade, monopoly pricing, and finance conditionalities that bleed these services of resources.

The ideology of ‘neo-liberalism’ is generally posed as the “natural” and only form of globalisation. Neoliberal policies have been used to remove import/export barriers, liberalize the finance sector, devalue currency, lower corporate taxation, promote deregulation of business and flexible labour markets and privatize or commercialize state-owned enterprises. These policies are far removed from those used, and that continue to be used, by the now developed countries to promote agriculture, industrial development and provide services during their own development. These policies are being made illegal for southern African countries and the policy flexibility within which to address development needs is shrinking in the south.

The gains from these policies for Africa are questionable. Terms of trade for African resources fell from the mid 1970s, while debt levels rose. One study of terms of trade put the income loss from this alone during the 1970s and 1980s at nearly 4% of GDP, about twice as high as that of other countries Africa’s share of FDI fell from 25% of all multinational corporate investments during the 1970s to less than 5% during the late 1990s. Most FDI flows into Sub-Saharan Africa related to mineral extraction, with little value added processing within the region (Bond and Dor 2003b). Further liberalised foreign exchange controls meant that outflows of FDI often exceeded inflows, even without including the outflows due to transfer pricing (Bond and Dor 2003b; SEATINI 2004).

When the General Agreement on Tariffs and Trade (GATT) became the World Trade Organisation (WTO) the scope of issues covered widened from goods trade to diverse issues like monopoly intellectual property rights health services and environmental standards⁹. The WTO has become increasingly invasive on domestic development policies. While the macroeconomic orthodoxy of the IMF and World Bank needed to be agreed to by these states (whatever the pressures that were brought to bear), and could be reversed by state policy the new international trade regulation systems through the WTO do not give such powers to states to reverse policies, and once in force international regulation of these issues effectively “locks in” orthodox disciplines.

The pace of neoliberal globalization is increasing, notwithstanding growing evidence of its costs and contestation over its process and terms (Navarro, 1999; Cornia, 2001; Sitthi-amorn et al, 2001; Thankappan, 2001; Baum, 2001, Loewenson, 2001; Weisbrot et al, 2001; Watkins, 2002).

⁹The spectrum of health issues covered by WTO agreements is widening rapidly. Including areas such as:

- Access to drugs, regulated by Trade Related Intellectual Property Rights (TRIPs)
- Regulation and provision of public services, through the General Agreement on Trade in Services (GATS), including services for the financing and delivery of health care, water and sanitation, and energy.
- In food and agriculture, developing countries have been unable to secure agreements that will allow them to protect their agricultural sectors and have been forced to accept conditions that undermine their food sovereignty, including Genetically Modified Organisms for grain and other foods.
- Trade Related Investment Measures that limit the subsidies and aid that a government may give to destitute parts of its territory.

Most recently the UN World Commission on the Social Dimensions of Globalisation (2004) outlined these costs as a world where:

- global GDP growth has been slower in the 1990s than in previous decades;
- growth in per capita income is unevenly distributed across countries, with 22 industrialized countries representing only 14 per cent of the world's population dominating about half the world's trade and more than half of its foreign direct Investment;
- the income gap between the richest and poorest countries is widening significantly, from US\$ 212 versus US\$ 11,417 respectively in 1960--1962 to US\$ 267 versus US\$ 32,339 in 2000-2002; and
- globally, unemployment has increased, with 185 million people out of work and looking for work in 2003, and 550 million people living on the equivalent of US\$1 per day or less.

“What is the point to a globalization that reduces the price of a child's shoes but costs the father his job?”

Testimony from Phillipines to the WCSDG 2004

- Outflows from countries in the south have increased, while net overseas development assistance (ODA) flows have decreased and are far below the target of 0.7% of GDP, with the average now only 0.23%.

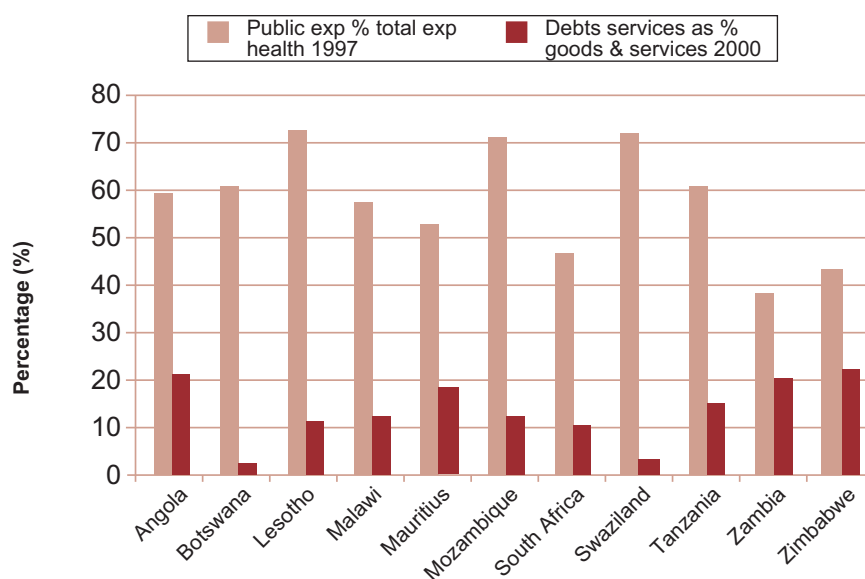
Meeting the 0.7 per cent ODA target would increase assistance by over US\$ 100 billion a year. If all countries had met the target over the last 30 years, an additional US\$ 2.5 trillion would have been available for development

WCSDG 2004.

The challenges to and responses from southern African health systems posed by this trade regime will be presented in a paper to the conference. The outflow of resources to debt servicing and through liberalised currency markets have weakened the real value and levels of public spending on health in southern Africa. Where debt servicing levels are higher, public health expenditure levels appear to be lower (see figure 18). The policy influence in health has been discussed in Section 2. Trade agreements have reduced government flexibility to make laws and policies and to take measures in areas critical to the well being of people in the region.

How then can southern African countries secure the space to regulate and protect the public provision of health and related services on an equitable basis?

Figure 17: Public expenditure on health by debt service levels



Source: <http://devdata.worldbank.org/data-query/>; World Health Report 2002, http://www.who.int/whr/2002/en/whr2002_annex5.pdf

We propose two broad implications:

- **Firstly, countries in southern Africa should have the right to refuse to apply trade rules in their social sectors, particularly in health, and should pursue policies to reverse commitments made under duress and which have negative social consequences.**
- **Secondly, countries in southern Africa should exercise greater circumspection in the international trade system if they want to maintain their sovereign right to meet the needs of their people.**

Assaults on governments' sovereign right to regulate trade, and consequently health, should be resisted, particularly if governments are to deliver on their obligations for the respect, protection and fulfilment of the right to health (and other socio-economic rights).

The paper on globalisation and health at this conference will provide greater detail around these options and the specific measures to achieve them. The resolutions of various meetings held with civil society, parliamentary committees on health and states have proposed some of these options, shown in Box 1 below:

Such recommendations are not easy to implement technically or politically. There has been increasing struggle around the global trade system. Significantly health has been the focal issue in many cases. The clash of value systems has been apparent in these struggles. The Doha declaration on the TRIPS agreement in 2003 was obtained after significant struggle both by civil society and southern governments. It provided for states rights to use compulsory licensing for manufacturing and the parallel importation of generic drugs. It left the 'catch' that foreign generic drug producers could only produce predominantly for domestic use. African countries with little or no production capacity could thus not access generic drugs. Another round of negotiations (and struggle) took place to enable countries to import drugs, while the United States and the European Union worked to extract as much as they could from the impasse. An agreement reached at the WTO before Cancun imposed stringent and cumbersome requirements for use of the waiver. The victory of Doha (which merely restated rights that countries had in any event) was diluted. The struggle over generic drugs continues.

BOX 1

Resolutions on trade and health have proposed:

- raising public and parliamentary debate and awareness of trade provisions;
- carrying out health impact assessments of trade agreements before entering into negotiations, or at least in parallel with on-going negotiations;
- ensuring transparency and parliamentary debate before and after agreements are negotiated, with health sectors represented and consulted;
- protecting government authority in all trade agreements to safeguard public health and regulate services in the interests of public health;
- assert their rights under the Doha Declaration on TRIPS and Public Health to define what constitutes a public health problem;
- taking full advantage of the flexibilities and policy measures allowed in TRIPs and ensuring national legal provision for compulsory licensing, parallel importation, 'government use', and production of generic drugs;
- retaining the right to raise tariffs and demand elimination of subsidies on exports to protect food sovereignty in agricultural production;
- not making any commitments under the General Agreement on Trade in Services (GATS) in health or health related services;
- calling for a change to GATS rules that restrict countries from retracting in commitments already made under GATS;
- participating in and protecting social and public interest in WTO standards generation bodies;
- retaining the right to create monopolies and exclusive service providers prospectively to address new needs for the viability and goals of the sector;
- safeguarding regulatory powers of national policy-makers from domestic regulation threats (which are specifically threatened by the GATS); and
- strengthening institutional and regulatory frameworks including appropriate domestically generated competition laws.

These struggles expose the manner in which WTO processes exclude African countries and the political and economic costs of defending national interests: Every country, in theory has a vote, but decisions are made in "green rooms" where country representatives are literally bullied into submission. The WTO Dispute Settlement Body allows countries that win disputes to 'retaliate' by imposing sanctions on the offender. A small country imposing sanctions on the US, EU or Japan would probably do more harm to itself than to the offending nation. The same system allows the largest economies to trade in their "sins" so that the disciplines of the WTO need not be enforced, to the prejudice of other countries. The rejection of such unfair processes is reflected in the failure of the last few conferences in Seattle, Doha and Cancun¹⁰. At Seattle and Cancun the developing countries, most pertinently Africa, refused a "bad deal" and preferred to have "no deal".

These failures signal the mounting demand for alternative paths to the current forms of neoliberal globalisation. How do southern African countries carve the space to do this? Regional integration has been posed as one means towards achieving this (WCSDG 2004). Countries like Malawi and Zambia who are prejudiced by commitments made under their health sectors need to be able to call on wider regional and African alliances to strengthen their bargaining positions to remove commitments that undermine public health. If effectively used regional integration provides a vehicle for strengthened negotiating power and shared capacities, information and resources. It also offers the opportunity for the market size, resource base, production systems and regional trade necessary for a more internally driven development, growth and trade path that will meet longer term development and health goals.

¹⁰The Doha Ministerial was not regarded as a round and hence was a failure. The majority of Ministers refused to call it a round and merely signed the "Doha Declaration."

Without proper planning and coordination, however, only national interests will permeate the regions negotiating agenda. All the national plans added together will not amount to an integrated regional strategy, necessary to harness the power of regional integration. It is equally important to ensure that the assumptions guiding regional integration do not mirror the failures of the global integration process, and do strengthen the policy space for goals directed at equity and social justice.

A Health Protocol has been developed in SADC in 1999 that promotes both equity and regional co-operation. The protocol has been in the process of ratification by member States since August 1999. The protocol was finally signed and entered into force at the SADC Summit in Mauritius in August 2004.

There are numerous processes acting against an integrated regional strategy. African countries are being split into free trade area or economic partnership agreements directly with northern countries¹¹, configurations of regional communities are being externally promoted and determined, while internal imbalances and distrust weaken proactive processes within regions. Nevertheless there are positive examples of the opportunities of regional processes: The efforts within SADC for example to build ethical recruitment policies for health personnel, to provide for regional drug procurement, or to ensure coordinated political and technical action on the public health flexibilities required in TRIPS reflect such policy opportunities.

¹¹ Such as for example South Africa's own agreement with Europe, the Southern African Customs Union (SACU) free trade area negotiation with the US, African countries being split into many regions under Economic Partnership Agreements negotiations with Europe.

5. EQUITY ORIENTED HEALTH SYSTEMS FOR SOUTHERN AFRICA

Reclaiming the state: Advancing people's health, challenging injustice

We need this policy flexibility and space to build equity oriented health systems.

We seek to have a health system that values and entitles all citizens; that enables health promoting behaviours and actions, and that provides effective support in times of sickness. We seek to have a health system that offers care through the human interactions that occur daily within it, that demonstrates respect for human rights and that provides financial protection against the risk of illness. We seek to deliver on this through rising investment in the state and public sector. We understand that we should not lightly move away from this vision, as it is a vital starting point for a broader societal transformation in the interests of poor and marginalised people.

Two principles are fundamental:

- **Equitable health systems should be able to redistribute and direct resources towards those with greatest need.**
- **This needs, as its absolute precondition, an effective public sector, able to exert leverage over the system as a whole.**

These principles should apply across all the elements of health systems, viz:

- public health, or the protection and promotion of population health and prevention of ill health;
- the provision of relevant, quality health services and care for all according to need and financed according to ability to pay;
- measures to build and secure the human resources and knowledge to shape and deliver public health and health services; and
- measures to protect and ensure the social values, ethics and rights that underlie health systems, including to participation and involvement and including protection of domestic regulatory policy flexibility from encroachments by international conditionalities¹².

What does this imply?

Redistributional, public health systems

The bottom line is surely that of sustained and rising investment through the state and public sector in health. At no time in history have the four core elements of health systems been organised or secured through the market. As observed in Section 3, when democratic countries can afford higher levels of spending, they turn predominantly to public initiatives, social insurance and inclusive systems (Mackintosh and Koivusalo 2004). Hence, while industrial change and markets have significant influence on health systems, and while management and technical interventions must be used to enhance the delivery and quality of care, redistributive roles and equity values cannot be implemented through approaches that treat health care as a commodity, or that ignore the range of non market behaviours that operate in health systems.

¹² This wider vision of health systems is well articulated by Mackintosh and Koivusalo (2004). We agree with them that a definition of health systems goes well beyond the narrow health service definition that is sometimes used. It includes traditional public health policies, including the health implications of policies outside the health sector, particularly those that relate to structural aspects of disparities in health such as trade, employment, provision of safe water and education. It covers to the manner in which health services are financed, organised, provided and regulated and the human resource, knowledge and capacities that support public health and health services. Finally it explicitly covers the values, ethical principles and rights frameworks that govern health services and the mechanisms for developing policies, for building public and health worker confidence and trust and for ensuring accountability of the system.

Population health through collective, population oriented strategies

We argue that such critical population health goals cannot be addressed through the dominant north American approach that emphasises individual behavioural interventions. This is particularly the case for the many economically insecure people who take health risks to secure survival under harsh economic conditions (e.g. through commercial sex, hazardous work, etc). Rather than shifting responsibility to individual patients, policies should rather prioritise collective, population oriented strategies that address the underlying causes of ill health, such as through access to primary and secondary education, especially for female children, to secure shelter and employment and to food production and consumption patterns that enhance health.

Comprehensive, primary health care oriented health services

This implies health services that:

- prioritise district and primary level facilities and services;
- integrate preventive, treatment and care within effective District Health Systems that provide all basic services¹³;
- provide support for patients with chronic illness, holding them within a supportive system that is able to sustain their health;
- co-ordinate services and interventions provided by non-profit organizations with public sector health services and align them to national health policies;
- ensure that private sector provision complements public provision and does not compete for public funding;
- involve users and communities in the planning and running of services; and
- promote respectful and “equal” relationships between providers, users and health personnel.

Fair financing through cross subsidies that serve equity

WHO in their 2000 World Health Report defined fair financing as individuals paying for health services in proportion to their income. We reject this definition as providing an inadequate basis for equity in financing within a health system. Instead we adopt a definition in rooted vertical equity – that the rich should pay *more* than the poor. We propose that fair financing at the household level results from richer households paying a higher proportion of their income towards health care than poor households, so that the healthy and wealthier social groups cross-subsidise the costs of accessing care borne by ill and poor people. The exact level of greater cost burden that the rich should bear is an issue that can only be decided within countries through open deliberation between citizens and policy-makers (Mooney, 1996).

Fairly allocation to and within the health sector

Household level financing must be supported by fair financing at a system level. This implies first, that levels of funding allocated to health care from both government and external resources are fair relative to allocations to other sectors, in that they recognise the role that health systems play in protecting the capabilities of poor people and addressing poverty (Dreze and Sen,1991). Second, fair financing at a system level requires that resources within the health system are allocated fairly between geographic areas, in reflection of health need. The paper on fair financing at this conference provides more details on this, and the measures for achieving it, such as those shown in Box 2.

Widen the application of essential drugs policies

Our current essential drugs policies and programmes provide a firm basis for equitable health systems. These policies should be applied in the private sector, including where necessary mandatory generic substitution (available generic equivalent drug provided when brand name drug prescribed). To secure these policies, national legislation should take full advantage of the TRIPS flexibilities and the Doha declaration, particularly provisions for parallel importation and

¹³The definition of ‘basic’ services will vary between countries dependent in large part on the available resources.

compulsory licensing. Drug regulatory and medicine control authorities should be strengthened, together with drug procurement and distribution systems. The expansion of ART should be included within the essential drugs programmes, through review and update of the essential drugs list. Such policies should be backed by greater levels of public, non profit financing globally for pharmaceutical research and development.

Reclaiming the state: Advancing people's health, challenging injustice

BOX 2

Measures for fair financing in health:

- increase the share of public spending on health to meet Abuja commitments of 15%, hand in hand with debt relief;
- reduce the share of funding from user fee charges and raise public revenue for health through progressive taxation, risk pooling and social insurance/ social security arrangements;
- reduce high shares of out of pocket financing in private financing through wider cover of insurance arrangements in the private sector, with minimum requirements for cover and regulatory and scheme design measures to ensure cross subsidies and avoid risk skimming in the sector;
- allocate public sector resources between areas on the basis of population need, or at a minimum population size as opposed to historical allocations and/or political pressure;
- supervise and regulate the quality of public and private sector provision to limit the costs incurred by households in seeking health care; and
- make transparent resource allocation decisions and integrate stakeholder preferences and equity concerns (see Table 2).

Table 3: National health accounts estimates 1997, revised data as of 31 May 2001, Southern Africa

Percentage Expenditures									
	Tot Health Exp/ GDP	Public Health Exp/ Total Health Exp	Private Health Exp/ Total Health Exp	Private Health Exp/ General Gvt Exp	Social Security/ Total Health Exp	General Revenue share of Public Health Exp	External Resource as share of Public Health Exp	Private Insurance as share of Private Health Exp	Out of pocket as share of Pvt Health Exp
Angola	4.1	47.9	52.1	6.1	0.0	89.1	10.9	0.0	100.0
Botswana	3.4	70.5	29.5	5.9	0.0	98.5	1.6	52.9	37.1
DRCongo	1.6	74.1	25.9	12.3	0.0	90.5	9.5	0.0	100.0
Lesotho	5.3	76.0	24.0	12.4	0.0	79.5	20.5	0.0	100.0
Malawi	7.3	50.6	49.4	14.6	0.0	61.3	38.7	1.6	35.4
Mozambique	3.9	56.2	43.8	11.2	0.0	39.8	60.2	0.0	41.2
Namibia	7.9	54.3	45.7	11.1	0.0	91.6	8.4	91.3	3.0
Mauritius	3.4	51.1	48.9	7.1	0.0	79.1	20.9	0.0	100.0
South Africa	10.3	47.3	52.7	12.7	0.0	99.8	0.2	77.8	20.2
Swaziland	3.4	72.3	27.7	8.2	0.0	79.3	20.7	0.0	100.0
Tanzania	5.1	47.1	52.9	14.8	0.0	63.3	36.7	0.0	85.9
Zambia	6.0	56.5	43.5	13.4	0.0	60.7	39.3	0.0	73.3
Zimbabwe	9.5	59.1	40.9	15.4	0.0	61.9	38.1	21.0	67.0

Source: Adapted from Musgrove et al 2001

Strengthen ethical and equitable policies for health worker retention in the region

We will be unable to provide equitable, relevant, quality health services and care unless we address current problems in the production, distribution and retention of health personnel. With the hemorrhaging of resources through out-migration this demands ethical human resource policy internationally, one that explicitly supports and does not undermine national and regional policies and measures for health worker *retention*, especially in district health services. Ethical international policy would need to reinforce equitable national and regional human resource policies, where production and deployment investments and incentives are targeted at priority levels of the health system and where explicit investments are made in building trust between health personnel and authorities.

Value and entitle citizens

The power and ability people (and social groups) have to make choices over health inputs is central to equity, as is their capacity to use these choices towards health. Informed and organised parliamentary and civil society processes strengthen and widen public voice, as do effective mechanisms for participation in health services. EQUINET supported research in southern Africa reported in this conference highlights that mechanisms to provide for public participation in health at primary health care level should not be taken for granted or undervalued. They can have a real positive impact on health outcomes and the performance of health systems, particularly when linked to mobilisation around collective action to realise social and economic rights. Despite this they are often given weak legal authority, have little real control over decisions and resources and are poorly guided, trained or informed for their work. They also have their own weaknesses in effectively engaging with, involving and representing communities. They have weak representation of the most vulnerable groups, and are undermined by household poverty and the lack of social resources to sustain participation. Their strength and effectiveness is directly linked to the strength of primary health care services.

London (2003) will present evidence in this conference that rights approaches can offer opportunities for public health practitioners to build equitable health care systems and for communities to engage around access to resources for health. For this, states and civil society need to move beyond approaches that focus on standards and the legal redress of violations against individuals to strengthening organized social action of collectives of people in positions of vulnerability (HIV+ people, rural residents, users of public sectors health services, etc.) taking action to address group rights. Included in this are the rights of health workers as a group, to work in health systems that respect their rights while they too act in ways that respect, secure and further human rights.

Strengthen regional co-operation

The SADC Health Protocol provides the commitment to a regional strategy that can facilitate SADC as a regional body playing a role in providing policy space and supporting health systems. This protocol, developed in 1999, finally obtained the necessary numbers of country signatories to come into force across the region at the SADC Mauritius Summit in 2004. SADC could use TRIPS flexibilities and the Doha commitments to implement regional strategies for procurement, price monitoring and negotiation, and quality control of drug supplies. SADC, national governments and civil society can monitor, regulate and act on excessive profiteering and unfair monopolies in the pharmaceutical and health service sector. SADC can provide trade support to initiatives to produce essential drugs for the region by companies within the region, such as the Mozambique-Brazil co-operation to produce generic ARTs through a local Mozambican company.

The various papers in the conference make more detailed proposals for what these proposals imply for public policy and programmes. The proposals are explicitly guided by a shift in the 'default' assumptions informing policy, away from market exchange as the paradigm, towards valuing and promoting a public sector that delivers on equity and solidarity.



6. SOCIAL ACTION BASED ON SHARED VALUES

Reclaiming the state: Advancing people's health, challenging injustice

The global processes described in this paper demand strong, redistributive states that act in the public interest. We need to affirm government as the primary source of democratic legitimacy, and thus campaign to reassert the power of governments against non-accountable market forces (Heywood and Altman, 2000). Our human rights work should make claims against the multinational companies, private sector players and the global institutions that assume increasing authority over key areas of social, economic and civil rights (London 2003).

These outcomes depend on supportive and transformative relations between state and citizens. While orthodox neo-liberal economic policies succeeded in a certain stabilisation of economies, they were much less successful in generating high growth rates and a more equitable income distribution process, and thus to stabilise the legitimacy of post independence democracies and their state processes (Mkandawire and Soludo, 1999). While many governments in the region have attempted to take strong positions to defend national policy in global platforms, there have also been periods in which southern African governments have responded to globalisation by developing their own authoritarian politics, have lost legitimacy due to the implementation of neoliberal policies and have undermined citizen – state relations through privatisation and commercialisation policies that have marginalised and impoverished citizens, leading to loss of confidence in the state. (Olukoshi 1998; Mkandawire 2003). If we are to assert values of equity and solidarity, and deliver on these values through health systems that centre on a redistributive state, then we need to build and strengthen alternative conceptions and forms of democracy in the 'public sphere' at local, national and regional level (Neocosmos 2002). Certainly the Poverty Reduction Strategy processes and other limited consultative interventions have not satisfied the demand for meaningful participation in communities in southern Africa (Bond and Dor 2003; Olukoshi 1998).

We need to build policy institutions and processes that do not privilege commercial interests over the public interest, by giving greater space at the policy table to economic and political elites than to other societal groups. Instead, such institutions should provide spaces for policy engagement throughout society, where all groups, including citizens, community based organisations and other social movements, can express their views and be heard. Such spaces range from health-related committees bringing citizens and health providers or managers together, to popular protest and media reporting and to formal development and political structures. Within these spaces, voices must be raised and heard; listening is as important as speaking; protest must be accompanied by a deliberative process that allows for learning. Such approaches and principles must also be applied at an international level. The voices of the South must be given as much space as the voices of the North, and the voices of citizens should be given more space than the voices of commercial interests.

6.1 EQUINET as a vehicle for equity and social justice

How far does EQUINET, a network based on shared vision and values of equity and social justice, offer opportunities for addressing these issues, for supporting an affirmative equity oriented policy framework and for contributing to the policy institutions and processes needed to implement it?

EQUINET is a network that has been explicitly formed to promote and realize shared values of equity and social justice in health. Professionals, universities, civil society members, policy makers, state officials and others within the region have come together to work through existing government, civil society, research and other institutions in southern and East Africa towards their implementation. Our shared values provide a basis for accommodating a wide range of actors and views and for building a shared perspective.

Our vision is a world where people determine their destiny, where they access the economic and social opportunities and services to live healthy and productive lives and no longer die from preventable conditions, in a supportive community, national and global environment.

We have since 1998 used and supported tools of research and policy analysis, held forums for skills development, analysis, dialogue, learning and engagement, strengthened networks and formed alliances towards achieving health equity and social justice goals. We recognize in this conference in the breadth of disciplines, institutional backgrounds, countries and experiences, a collective strategic resource to each other and to SADC on equity in health.

We have in the past five years implemented work to strengthen these tools for engagement, and in the process to develop an affirmative vision of the health systems that we would want to build and deliver on equity values.

We have proposed and provided evidence that to achieve equity, we need to ‘reclaim the state’ to deliver on **an affirmative vision of the publicly driven health systems that we want in our region.**

We have proposed and provided evidence for **national, regional and global policy and action** that:

1. Provides for rising investments through the state and public sector in health.
2. Uses these resources to build an effective state and public health sector able to exert leverage over the system as a whole.
3. Values and entitles citizens in health systems.
4. Strengthens organized action of social groups to make claims for their social and economic rights against states, multinationals, private actors and global institutions.
5. Redistributes and directs resources towards those with greatest need.
6. Prioritises collective, population oriented strategies and comprehensive primary health care oriented health services.
7. Meets the Abuja commitment of 15% government financing to the health sector, hand in hand with debt relief.
8. Finances health through cross subsidies that serve vertical equity and allocates resources within health systems in reflection of health need.
9. Widens the application of essential drugs policies to all health providers.
10. Mobilises greater levels of public, non profit financing globally for pharmaceutical research and development.
11. Ensures delivery on ethical and equitable human resource policies at national, regional and international level, including north-south transfers to address regressive south-north subsidies from migration of health personnel.

Achieving this implies that we challenge injustice and claim the space and flexibility to make decisions in the public interest. We need to maximize our policy flexibility if we are to deal with our health challenges. This means more effectively and decisively exercising our right to refuse policies and practices which are harmful to our public interests and to people’s health. Specifically we argue that we should refuse to apply WTO trade rules to health and social sectors and organise regionally to reverse those commitments made to WTO under duress that have negative social consequences.

Despite a hostile global environment, which has the potential to subjugate us to political and economic imperatives not of our choosing, we propose that we can and must mobilize collection action to chart and implement a positive vision of and policies on the health systems that we want.



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APPENDIX 1: STATISTICAL TABLES

Table 1: Selected economic and health indicators

	GDP/ Capita PPP US\$	GINI co- efficient	Share of income of poorest	Income ratio Richest 20%: poorest 20%	GDP rank - HDI rank	Health expend- iture/ capita	Health as % Total govt exp	Public exp as % total health exp	Private exp as % total health exp
	2001	2000	2000	2000	2001	1998	2000	1997	1997
Angola	2040	..	..	..	-32	13	3.6	59.6	40.1
Botswana	7,820	63	2.2	31.5	-65	85	7.4	61	39
DR Congo	680	..	..	..	5	20	9.9	0.9	99.1
Lesotho	2,420	56	1.4	50	-13	21	10.8	72.6	27.4
Malawi	570	50.3	4.9	11.6	11	6	14.6	57.6	42.4
Mauritius	9,860	..	..	..	-12	61	8.4	52.9	47.1
Mozambique	1,140	39.6	6.5	7.2	-15	5	13.7	71.3	28.7
Namibia	7,120	70.7	1.4	56.1	-59	79	11.1	51.7	48.3
S. Africa	11,290	59.3	2	33.6	-64	120	11.2	46.5	53.5
Swaziland	4,330	60.9	2.7	23.8	-34	37	8.6	72.3	27.7
Tanzania	520	38.2	6.8	6.7	14			60.7	39.3
Zambia	780	52.6	3.3	17.3	7	12	11.2	38.2	61.8
Zimbabwe	2,280	56.8	4.6	12	-18	33	6.3	43.4	56.6

Source: UNDP Human Development Report 2002, 2003; World Health Report 2002;
<http://devdata.worldbank.org/>

Table 2: Human Poverty Index and adult HIV prevalence

Country	Human Poverty Index	HIV prevalence
Zimbabwe	90	33.72
Zambia	89	21.52
Mozambique	87	13.00
Lesotho	83	31.00
Malawi	82	15.00
Botswana	75	38.80
DR Congo	74	4.90
Namibia	62	22.50
Tanzania	59	7.83
South Africa	49	20.30
Mauritius	17	0.10
Angola	-	5.50

Source: SADC database on health indicators 2003

Table 3: HDI ranking vs GDP/ capita ranking for SADC countries

Country	HDI rank	GDP per capita (PPP US\$)
Mauritius	62	9860
South Africa	111	11290
Namibia	124	7120
Botswana	125	7820
Swaziland	133	4330
Lesotho	137	2420
Zimbabwe	145	2280
Tanzania	160	520
Malawi	162	570
Zambia	163	780
Angola	164	2040
DR Congo	168	1300
Mozambique	170	1140

Source: World Bank 2003; UNDP HDR 2003

Table 4: HDI index SADC countries, 1980-2000

	Human Development Index		
	1980	1990	2000
Angola	...	...	0.403
Botswana	0.556	0.653	0.572
DR Congo	...	...	0.431
Lesotho	0.518	0.574	0.535
Malawi	0.341	0.362	0.4
Mauritius	0.656	0.723	0.772
Mozambique	0.302	0.31	0.322
Namibia	...	...	0.61
South Africa	0.663	0.714	0.695
Swaziland	0.543	0.615	0.577
Tanzania,	..	0.422	0.44
Zambia	0.463	0.468	0.433
Zimbabwe	0.572	0.597	0.551

Source: UNDP HDR 2003

Table 5: Average health expenditure in Southern Africa by year


Country	% Health Expenditure							Average (%)
	1995	1996	1997	1998	1999	2000	GINI	
Botswana	6.6	6.4	7.1	6.4	6.5	7.4	63.0	6.7
Swaziland	8.0	7.9	7.9	8.1	8.0	8.6	60.9	8.1
Lesotho	9.6	8.6	8.1	9.3	10.4	10.8	56.0	9.5
Namibia	12.9	10.2	10.3	10.4	11.3	13.7	70.7	11.5
South Africa	12.6	12.6	12.4	11.3	11.1	11.2	59.3	11.9
Zimbabwe	10.1	11.6	15.4	17.9	10.0	6.3	56.8	11.9
Zambia	11.5	14.6	13.1	12.5	12.3	11.2	52.6	12.5
Tanzania	14.7	15.1	15.5	12.5	12.2	11.4	38.2	13.6
Malawi	11.3	11.7	14.6	14.5	14.6	14.6	50.3	13.6
Mozambique	12.4	17.3	14.8	13.8	13	13.7	39.6	14.2

Source: World Health Report 2002 http://www.who.int/whr/2002/en/whr2002_annex5.pdf

Table 6: Glossary of terms used in graphs and figures

Indicators used in graphs and figures	Definition
Per capita GDP	GDP is the total value of all goods and services produced (consumed) (PPP \$US) within a country. PPP is a theoretical exchange rate based on a comparison of local currency prices for typical goods and services.
Total debt service (as a % of goods and services)	The sum of principal repayments and interest actually paid in foreign currency, goods or services on long-term debt (having a maturity of more than one year), interest paid on short-term debt and repayments to the International Monetary Fund.
Gini co-efficient	Measures the extent to which the distribution of income (or consumption) among individuals or households within a country deviates from a perfectly equal distribution. A Lorenz curve plots the cumulative percentages of total income received against the cumulative number of recipients, starting with the poorest individual or household. The Gini index measures the area between the Lorenz curve and a hypothetical line of absolute equality, expressed as a percentage of the maximum area under the line. A value of 0 represents perfect equality, a value of 100 perfect inequality.
Share of income or Consumption (%) of poorest 20%	The shares of income or consumption accruing to subgroups of population indicated by deciles or quintiles, based on national household surveys covering various years. Consumption surveys produce results showing lower levels of inequality between poor and rich than do income surveys, as poor people generally consume a greater share of their income. Because data come from surveys covering different years and using different methodologies, comparisons between countries must be made with caution.
Richest 20% to poorest 20%	The shares of income or consumption accruing to subgroups of population indicated by deciles or quintiles, based on national household surveys covering various years. Consumption surveys produce results showing lower levels of inequality between poor and rich than do income surveys, as poor people generally consume a greater share of their income.

Human Development Index	A composite index measuring average achievement in three basic dimensions of human development—a long and healthy life, knowledge and a decent standard of living.
GDP rank minus HDI rank	GDP per capita (PPP US\$) rank minus HDI rank
Human Poverty Index	A composite index measuring deprivations in the three basic dimensions captured in the human development index—a long and healthy life, knowledge and a decent standard of living.
% Govt expenditure to military	All expenditures of the defence ministry and other ministries on recruiting and training military personnel as well as on construction and purchase of military supplies and equipment. Military assistance is included in the expenditures of the donor country.
% Population urban (as a % of total)	The midyear population of areas classified as urban according to the criteria used by each country, as reported to the United Nations. See population, total.
Life expectancy at birth	The number of years a newborn infant would live if prevailing patterns of age-specific mortality rates at the time of birth were to stay the same throughout the child's life.
Infant mortality rate (per 1000 live births)	The probability of dying between birth and exactly one year of age, expressed per 1,000 live births.
Maternal mortality rate (per 100 000 live births)	The annual number of deaths of women from pregnancy-related causes per 100,000 live births.
% Female literacy in +15 year olds	The percentage of women aged 15 and above who can, with understanding, both read and write a short, simple statement related to their everyday life.
% Access to safe water	The share of the population with reasonable access to any of the following types of water supply for drinking: household connections, public standpipes, boreholes, protected dug wells, protected springs and rainwater collection. Reasonable access is defined as the availability of at least 20 litres a person per day from a source within one kilometre of the user's dwelling. Other reference
Adults living with HIV/AIDS (% aged 15-49)	The estimated number of people living with HIV/AIDS at the end of the year specified.
TB incidence (cases/ 100 000)	The total number of tuberculosis cases reported to the World Health Organization. A tuberculosis case is defined as a patient in whom tuberculosis has been bacteriologically confirmed or diagnosed by a clinician.
Malaria incidence (cases/ 100 000)	The total number of malaria cases reported to the World Health Organization by countries in which malaria is endemic. Many countries report only laboratory-confirmed cases, but many in Sub-Saharan Africa report clinically diagnosed cases as well.
% Children under 1 fully immunised against measles	One-year-olds injected with an antigen or a serum containing specific antibodies against measles or tuberculosis
% Deliveries attended by a medically qualified person and midwives	The percentage of deliveries attended by personnel (including doctors, nurses trained to give the necessary care, supervision and advice to women during pregnancy, labour and the postpartum period, to conduct deliveries on their own and to care for newborns.



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 the region:

- Public health impacts of macroeconomic and trade policies
- Poverty, deprivation and health equity and household resources for health
- Health rights as a driving force for health equity
- Health financing and integration of deprivation into health resource allocation
- Public-private mix and subsidies in health systems
- Distribution and migration of health personnel
- Equity oriented health systems responses to HIV/AIDS and treatment access
- Governance and participation in health systems
- Monitoring health equity and supporting evidence led policy

EQUINET is governed by a steering committee involving institutions and individuals co-ordinating theme, country or process work in EQUINET: Rene Loewenson, Godfrey Musuka TARSC Zimbabwe; Firoze Manji Fahamu UK/SA; Mwajumah Masaiganah, Peoples Health Movement, Tanzania; Itai Rusike CWGH, Zimbabwe; Godfrey Woelk, University of Zimbabwe; TJ Ngulube, CHESSORE, Zambia; Lucy Gilson, Centre for Health Policy South Africa; Di McIntyre, University of Cape Town, HEU, South Africa; Gertrudes Machatini, Mozambique; Gabriel Mwaluko, Tanzania; Adamson Muula, MHEN Malawi; Patrick Bond, Municipal Services Project; A Ntuli, Health Systems Trust, South Africa; Leslie London, UCT School of Family and Public Health, South Africa; Yash Tandon/ Riaz Tayob, SEATINI, Zimbabwe.

For further information on EQUINET please contact the secretariat:
Training and Research Support Centre (TARSC)
47 Van Praagh Ave, Milton Park, Harare, Zimbabwe
Tel + 263 4 705108/708835 Fax + 737220
Email: admin@equinetafrica.org
Website: www.equinetafrica.org

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