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Putting equity in health back onto the social policy agenda: experience from South Africa

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Abstract

Over the past decade, international health policy debates have been dominated by efficiency considerations. There has been a recent resurgence of interest in health equity, including consideration of the notions of vertical equity and procedural justice. This paper explores the possible application of these notions within the context of South Africa, a country in which inequities in income and social service distribution between ‘racial’ groups were systematically promoted and entrenched during four decades of minority rule, guided by apartheid and related policies. With the transition to a democratic government in 1994, equity gained prominence on the South African social policy agenda. Health equity has been awarded a particularly high priority, not least of all because the health sector is seen as vehicle for achieving rapid equity gains. In addition, many of the other equity-promoting social sector policies (such as improved access to housing and water and sanitation services) have been motivated on the basis of their potential health equity gains. The South African experience since 1994 provides useful insights into factors which may facilitate or constrain health equity progress. In particular, the constitutional entitlement to health and civil society action to maintain health equity’s place on the social policy agenda are seen as important facilitating factors. Certain health sector programmes have also been developed which are intended preferentially to benefit those who have been historically dis-advantaged, and which thus support vertical equity goals. However, there have been no efforts to promote cross-subsidisation between the private and public health sectors, and initial efforts to promote coherency in social policies (through the Reconstruction and Development Programme) appear not to have been sustained. In addition, macro-economic policies (particularly the highly ambitious budget deficit reduction targets of the government) are likely to undermine some of the equity-promoting social policy initiatives. Most importantly, the potential inter-relationship of vertical equity and procedural justice goals has not been adequately recognised. As a result, and despite policy rhetoric, this paper concludes that health equity goals are critically dependent on the central involvement of the dis-advantaged in decision-making about who should receive priority, what services should be delivered and how equity-promoting initiatives should be implemented. © 2002 Elsevier Science Ltd. All rights reserved.

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Introduction

South Africa is regarded as one of the most unequal societies in the world (Fallon & da Silva, 1994). It has

the second (after Brazil) most unequal measured distribution of income in the world and there are also marked inequities in access to social services (May, 1998). Apartheid policies, which promoted differential access to economic and social resources by ‘race’ group, thereby creating marked differences in socio-economic status by race, played a critical role in the creation of these inequities.

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Against this background, the African National Congress (ANC) swept to power in the first democratic elections in 1994, on an election platform committing it to implementing measures to reduce poverty and to redress the disparities in the distribution of income and social services (African National Congress, 1994a). The most detailed sectoral policy within the ANC was that for health. Social equity was the ANC Health Plan's starting point, and the first line of its "Health Vision" stated that: "*The health of all South Africans will be secured and improved mainly through the achievement of equitable social and economic development*" (African National Congress, 1994b, p. 19). The document then outlined a vision for re-structuring the health system which bears remarkable similarities to the Alma Ata declaration giving strong emphasis to primary health care (PHC), community participation and the importance for health of complementary strategies in other social sectors and within the macro-economic sphere. Although not adopted as the official policy of the national Department of Health after the elections, there is considerable synergy between the ANC's Health Plan and the new White Paper on Health (Department of Health, 1997a). Equity is again emphasised, particularly in relation to redressing the historical inequities which arose as a result of apartheid policies.

The key health sector goals were also enshrined in the Reconstruction and Development Programme (RDP) (African National Congress, 1994a), adopted by the newly elected government as its guiding policy document. The RDP described a package of social and economic policies that were aimed at redressing the massive inequities within all spheres of South African life. Many of the broader social sector policies (e.g. improved access to water and sanitation) were specifically motivated in terms of their likely positive impact on health status. In addition, the health sector was given a relatively high priority in the overall RDP, as it was argued that there could be more rapid 'delivery' in meeting RDP targets through health service improvements relative to other sectors. Thus, health equity goals were seen as an integral part of the overall political commitment to tackling poverty and redressing inequity by the first democratic government.

Some might contend that the new South African health policy was hopelessly outdated: possibly as a result of their years of political isolation, South Africans had not perceived that the policy debate had moved away from the principles of Alma Ata. Others would argue that it was visionary to place equity in health on the social policy agenda: a vision based on recognition of the unacceptable inequities arising from decades of apartheid policies. Whichever view is adopted, the South African policy stood in stark contrast to the prevailing international policy trends, which focused primarily on efficiency issues. The ANC's Health Plan and the

government's RDP strongly suggested that the place of equity in health on the social policy agenda in 'the new South Africa' was secure.

The purpose of this paper is to explore the health sector policies developed since 1994 in greater detail, to consider the extent to which the original pro-equity health policy agenda of the new government has survived the post-election 'honeymoon' period and to identify factors which appear to be facilitating or threatening its successful implementation. This analysis is clearly preliminary given the difficulty of fully evaluating the impact of such policies after only a few years of implementation. It feeds into and is complemented by other, parallel analyses of health equity issues in South Africa (Gilson et al., 1999; Gilson & McIntyre, 2001; McIntyre & Gilson, 1999).¹

The paper begins by considering the international context within which the South African policy was developed, identifying some key issues to be considered in its evaluation. The next section provides a brief overview of the South African health sector, and presents some data on the legacy of health status and health care inequities inherited by the new government in 1994. Policies from the health and other social sectors, as well as the macro-economic policy, are then critically evaluated. The final section attempts to draw some conclusions in relation to broad lessons from the South African experience.

International context and debates

Equity has received scant attention in recent international health policy debates. Instead, there has been an almost exclusive focus on efficiency as primary emphasis has been given to ways of making better use of available resources within the public sector (Gilson, 1998a, b). This dominance of efficiency issues has been promoted by the ideological shift to neo-liberal macro-economic policies (Gilson, 1998b; Jimenez de la Jara & Bossert, 1995) and economic difficulties in many countries which have limited the resources available to government for financing and providing health services (Bennett, 1992; Gilson, 1995; Gilson & Mills, 1995).

A key recommendation that has come from the efficiency perspective focuses on the need to restrict public sector health care financing to an essential

¹Such analyses, in which both authors are participating, include a comparative analysis of 'The process of health financing reforms in South Africa and Zambia', funded by the Partnerships for Health Reform project and the European Union, and a South African case study being undertaken as part of the 'Global Health Equity Initiative' co-ordinated by the Harvard School of Public Health and the Rockefeller Foundation.

package of services which are cost-effective and which maximise overall health gain, i.e. to improve the value for money obtained from the public sector dollar (World Bank, 1993, 1994). This proposal is also seen to be equity promoting as it is argued that it will improve the efficiency with which public sector resources are targeted towards the poor (Bobadilla, Cowley, Musgrove, & Saxenian, 1994). This targeting is achieved by: establishing a minimum standard of health care provision to which all, even the poor, are entitled; ensuring the non-poor pay for these services in particularly resource-constrained environments whilst protecting the poor from payment through an exemption mechanism; and requiring the non-poor to buy discretionary services outside the essential package from the private sector.

However, there is concern that this approach will create a tiered and segmented health system, providing only second class care for the poor, who may even choose not to use it (Gilson, 1997a, 1998a). A key problem of the approach and of the wider debates is that the social determinants of health and of health inequities have largely been ignored. Thus, the 'demand-side' barriers to health care utilisation are not considered whilst the links between health and poverty, and the relevance of these links to health inequities, have largely been overlooked (Loewenson, 1993, 1997).² More specifically, interventions which have both health *and* broader social welfare benefits (such as improved water and sanitation services) are not included in the World Bank's essential health service package. They are deemed to be not cost-effective as the non-health, welfare benefits are ignored (Bobadilla et al., 1994; Gilson, 1998b).

The growing debate on these issues reflects a resurgence of interest in equity issues,³ including some re-assessment of the definition and meaning of equity within the health sector. Whilst there is general agreement that health inequity results from differences in health outcomes between groups that are unnecessary, avoidable and unfair (Whitehead, 1992), growing attention is being given to two concepts offering new perspectives for understanding (in)equity and equity-promoting action: vertical equity and procedural justice.

² Although there has been some consideration of the health impact of structural adjustment programmes in broader debates (e.g. Sahn & Bernier, 1995).

³ In the past few years, a number of global and regional health equity initiatives have been developed. These include: WHO/Sida Initiative on Equity in Health and Health Care; Rockefeller/Sida/Harvard University Global Health Equity Initiative; PHR/USAID multi-country study of Equity of Health Sector Revenue Generation and Allocation; Southern African Development Community (SADC) Regional Network on Equity in Health; and Danida/World Bank Study on Equity in Health in Latin America and the Caribbean.

Whereas horizontal equity refers to the equal treatment of equals, vertical equity refers to the unequal (but equitable) treatment of unequals. Generally, equity strategies within health systems have focused on establishing mechanisms for achieving horizontal equity in health care delivery (such as 'equal access for all' or 'universal access') whilst recognising the importance of vertical equity in relation to health care payment mechanisms (i.e. payment on the basis of ability). Mooney (1996), however, has recently motivated that vertical equity should receive more attention as a health policy goal, particularly in countries where there are substantial differences in health status between different groups in society. He argues that "*if, as is normally the case, ill health is not randomly distributed across different groups in society, might that society not want to give preference, on vertical equity grounds, for health gains to those groups in that society who are on average in poor health?*" (Mooney, 1996, p. 102). Such a preference implies that it is not enough to treat those groups with the poorest health status in the same way as others within the population, although this may be fairer than prior practices in which they were discriminated against or systematically dis-advantaged. Rather they must receive specific and particular attention in policy formulation in order to be favoured over others by policy action and so counter the legacy of dis-advantage from which they suffer.

Equity is traditionally understood as being rooted in the notion of distributional justice, that is as purely a function of the pattern of distribution of health outcomes or health care access. However, some recent contributions to equity debates have also highlighted the importance of procedural justice—linked both to the fairness of the procedures by which distributional decisions are made and, more broadly, to the value derived from the institutions, such as health care, shaped by such procedures (Mooney, 1996; Gilson, 1998a). The fairness of the vertical equity approach proposed by Mooney thus lies not simply in the preferential allocation of resources towards the poorest, but also in the very fact of giving special consideration to the poorest in this way. From this perspective, promoting equity requires the active engagement of all citizens in determining how their own actions as well as those of the state can most effectively meet need, particularly that of the poor and deprived (Gilson, 1998a).

The practical mechanisms in which concerns for procedural justice and vertical equity can be reflected are still under exploration. Mooney and Jan (1997) suggest that in determining resource allocation patterns that reflect vertical equity goals it is important to consult widely within a society to identify which groups should be prioritised in policy action and how much additional weight they should receive compared to other groups. Consultation may not, however, by itself ensure that the

voice of the poorest is heard in decision-making. Other specific actions to put the needs of the poorest at the heart of health policy development and implementation might include: establishing or strengthening mechanisms for ensuring the accountability of health services to the population, such as suggestions and complaints boxes as well as existing community-level structures; initiating participatory processes which can help direct local level health action, such as needs assessments and evaluations; strengthening the technical systems of supervision and accountability which safeguard clinical care; and national procedures and strategies to establish citizen's rights and allow the implementation of those rights to be monitored (Gilson, 1998c). The notion of procedural justice emphasises that opening up decision-making processes is important in itself rather than only as a means of determining fair distributional outcomes.

Rooted in an egalitarian perspective, in which services are distributed according to need and financed according to ability to pay, this paper also specifically draws on the notions of vertical equity and procedural justice in its analysis of health equity in South Africa. These two notions not only highlight critical aspects of the authors' own understanding of equity, but also have particular resonance for South Africa. Not only has the South African government inherited the huge socio-economic and health inequities, but it has stated its intent both to reach vulnerable groups through health policy action and to "*foster the empowerment of all citizens*" (Department of Health, 1997a, p. 11). The application of these notions to the South African situation in this paper is, however, exploratory. The paper is intended to provoke debate both about the progress in reducing health inequities within South Africa, and about the understandings of equity used to make such judgements. To this end it is extensive in its coverage of equity issues and so, inevitably, tackles each issue in relatively limited detail.

Inequities in the South African health sector prior to the 1994 elections

Health policy in the apartheid era, like all government action, served the dominant objective of maintaining economic and political power for the white population group. It was shaped to maintain a difference in the quality of life enjoyed by different population groups and so promote political support for the National Party (Price, 1986). As a result, the health system inherited by the new government in 1994 can be characterised as:

- centralised and undemocratic (Health Systems Trust, 1996);
- highly fragmented in structure: health service delivery was divided between a range of health authorities

(e.g. national, provincial, former 'homeland',⁴ and local government structures), and curative and preventive primary care services were provided in separate facilities and administered by different health authorities (de Beer, 1988; van Rensburg, Fourie, & Pretorius, 1992);

- inefficiently and inequitably biased towards curative and higher level services (only 11 percent of total public sector health care expenditure was devoted to non-hospital primary care services: McIntyre, Bloom, Doherty, & Brijlal, 1995);
- inequitably biased towards historically 'white' areas as certain geographic areas (namely rural areas, particularly former 'homeland' areas, 'township' areas, and informal settlements) were systematically underfunded as a result of apartheid policies;
- inequitably biased towards the wealthy minority who use the private sector, estimated to be around 23 percent of the population (Valentine & McIntyre, 1994), and who, for example, had access to the nearly 61 percent of total health care expenditure attributable to this sector in 1992/93 (McIntyre et al., 1995).⁵

The income distribution and social service access disparities arising from apartheid and related policies led to levels of ill health and premature mortality which are high in international terms. Table 1 indicates that while South Africa has better health status indicators than some of its neighbours, its health status is worse than Botswana and Zimbabwe. The differences in health status between South Africa and Zimbabwe are particularly striking, given that Zimbabwe has a GNP per capita which is four times lower than that in South Africa. At the same time, although the level of economic development in South Africa is comparable to some Latin American countries, its health status indicators, and its Human Development Index (HDI), are considerably worse than those middle-income countries considered in Table 1. It should be noted that the 'official' mortality data for South Africa (as presented in Table 1) are likely substantially to underestimate total mortality. For example, it is estimated that as many as 45 percent of deaths within the African population are not registered (Bradshaw, Laubscher, & Schneider, 1995).

⁴In terms of the 1913 'Natives Land Act', Africans were confined to living in ten 'homelands', which were highly fragmented geographic areas scattered throughout South Africa, and established along 'tribal' lines. These 'homelands' comprised less than 14 percent of the total surface area of South Africa. These 'homelands' have recently been reincorporated within the nine newly formed provinces.

⁵In addition, the majority of the most highly trained health personnel work in the private sector: 62 percent of general doctors, 66 percent of specialists, 93 percent of dentists, 89 percent of pharmacists, and 60 percent of supplementary health professionals (Rispel & Behr, 1992).

Table 1
International comparison of health status and other indicators (1990/1991)

Country	GNP per capita (US\$)	Human Development Index (HDI) (1993)	Infant mortality rate (IMR) per 1000 live births	Life expectancy at birth (Years)	Incidence of tuberculosis (per 100,000 population)	% of children (12–23 months) with wasting	% of children (24–59 months) with stunting
South Africa	2560	0.649	54	62	250	10	53
Southern African countries							
Mozambique	80	0.261	149	43	189	—	—
Zambia	360	0.411	106	47	345	10	59
Zimbabwe	650	0.534	48	62	207	2	31
Botswana	2530	0.741	36	68	—	6	37
Selected middle-income countries							
Malaysia	2520	0.826	15	71	67	6	32
Venezuela	2730	0.859	34	72	44	4	7
Argentina	2790	0.885	25	72	50	—	—
Uruguay	2840	0.883	21	74	15	—	16
Brazil	2940	0.796	58	66	56	6	29
Mexico	3030	0.845	36	70	110	6	22

Sources: World Bank (1993): Tables 1, 28, A.3, A.6 and A.7; World Bank (1994): Tables A-1 and A-8; UNDP (1996): Table 1.

Table 2
The apartheid legacy of inequity in health and health care

Group comparison	Indicator	Inequitable difference
Racial differences	IMR early 1990s IMR trends since 1980 MMR 1991	nearly 11.5 times higher for Africans than whites disparity in IMR between Africans and whites increased by 40% whilst the national average declined 31 times higher in African than white women 50 times higher in African than in Indian women
Provincial differences	Mortality rates and life expectancy per capita public sector expenditure 1992/93 Personnel available to the population dependent on public sector health services	worse indicators in the poorer provinces which include large components of the former 'homelands', such as the Eastern Cape, Mpumalanga, North-West and Northern Province 3.5 times greater in most well-resourced province compared to the least well-resourced province 6 times more generalist doctors, 60 times more specialists and 3 times more nurses in the most well-resourced province compared the least well-resourced province
Intra-provincial differences	per capita expenditure on public health services 1995/6	up to 400% difference between most and least well-resourced health district within some provinces
Rural–urban differences	IMR health service utilisation (1995)	1.8 times greater in informal urban areas than 'other' urban areas 2.1 times greater in rural areas than 'other' urban areas 1.6 times greater in rural areas than 'other' urban areas
Socio-economic differences	per capita health expenditure 1992/93	15 times greater among relatively high-income members of comprehensive private health pre-payment schemes compared to public sector health expenditure on the population in the poorest 20% of magisterial districts (where the residents are heavily dependent on publicly financed services)

Sources: Brijlal et al., 1997; de Bruyn et al., 1998; Department of Health, 1995; Fawcus et al., 1996; Gilson and McIntyre (2001); McIntyre et al., 1995; McIntyre, 1997a; Yach and Edwards, 1992.

Box 1

Key equity challenges in health service delivery and financing

Redistributing public sector health care resources between and within provinces
Initiatives to increase primary care utilisation levels for currently dis-advantaged groups, including
Redistributing resources between levels of care to improve resourcing of primary care services (increasing primary care facilities, staffing, improving routine medicine supplies, etc.), while still maintaining adequate referral services; and
Reducing barriers to primary care access (e.g. financial barriers, engendering a 'caring ethos' among health care providers)
Addressing the public/private mix—facilitate making resources currently located in the private sector accessible to a broader section of the population, and/or redistributing resources from the private to the public sector

Apartheid policies also generated substantial health status inequities within the country between race groups⁶ and provinces, and substantial inequities in resource distributions between and within provinces as well as between socio-economic groups (Table 2). For example, comparison of provincial health status and health care resource data indicates that the provinces with the greatest burden of ill-health, and thus the

greatest capacity to benefit from health services, had the least access to such services. Disparities between urban and rural areas, and within urban areas (informal vs. other urban areas), are also evident. The challenges this legacy holds for the new government are highlighted in Box 1.

Translating equity policy goals into specific policies

Health care policies directed at promoting equity

In tackling the legacy of inequity it inherited, three sets of health care policies can be identified as

⁶The use of the terms 'African', 'Indian', 'Coloured' and 'White' indicates a statutory stratification of the South African population in terms of the former Population Registration Act. The use of these terms does not imply the legitimacy of this racist terminology, but is necessary for highlighting the impact of former apartheid policies on the South African system.

Box 2

Initiatives to improve access to primary care services

Improving financial access through the introduction of free primary care services in 1996 (i.e. removal of all fees for primary care services)

Reprioritisation of health budgets in favour of primary care services

Expanding physical infrastructure through the Clinic Upgrading and Building Programme (CUBP)

Efforts to improve the availability of doctors at primary care level (e.g. recruitment of foreign doctors, especially from Cuba, and the introduction of compulsory service for medical graduates)

The development of an Essential Drug List (EDL) and standard treatment guidelines for primary care facilities, and efforts to improve the procurement and distribution of medicines

Efforts to improve efficiency within public sector hospitals, such as the Hospital Strategy Project (1996), to support the relative redistribution of budgets towards primary care services

particularly important to the government's pro-equity agenda (based on the challenges identified in Box 1):

- efforts to reduce geographic disparities in the allocation of public sector health care resources;
- policies and programmes designed to strengthen and improve access to primary care services, particularly for vulnerable groups; and
- policies impacting on the private sector.

Addressing geographic resource disparities

Redressing the historic inequities in access to health services arising from the significant disparities in allocation of public sector health care resources between provinces was regarded as one of the most important challenges facing the health sector in 1994. At that time, provincial health budgets were determined by what was called the 'Function Committee', which included representatives from the national and provincial Departments of Health as well as the Departments of Finance and State Expenditure. In determining allocations between provinces for the 1995/96 budget (the first after the 1994 elections), the Function Committee developed a population-based formula, the goal of which was to achieve weighted per capita equality in provincial health budgets within 5 years. Given the significant disparities in per capita public sector health care expenditure that existed at this time, the 5-year time frame required substantial changes in provincial budgets on an annual basis. For example, the Western Cape faced the largest real budget cut of nearly 19 percent in 1995/96 while the Northern Province received the largest budgetary increase of 17 percent in real terms and 24 percent in nominal terms (Doherty & van den Heever, 1997). Thus, while there was overwhelming support for the geographic redistribution of resources, there were concerns about the pace of change. In the second year of this redistribution process, the national Department of Health recognised the inability of provinces to cope with substantial budgetary changes on an annual basis. A more gradual approach was adopted in 1996/97, with the Minister of Health stating that it would probably take closer to ten, rather than five, years to achieve inter-provincial

equality in weighted per capita spending (Health Systems Trust, 1996).

From the 1997/98 financial year the 'Function Committee' no longer had a role in determining provincial health budgets. The new Constitution, which was implemented in late 1996, created a quasi-federal structure in which considerable decision-making autonomy was granted to provincial legislatures. In line with this constitutional structure, provinces are now awarded global budgets and they decide how to allocate this budget between health and other sectors (a process termed 'fiscal federalism' in South Africa). While the global provincial budgets are allocated according to a population-based formula, there is currently no mechanism for promoting inter-provincial equity in *health* budgets.

Strengthening primary care services

Given the legacy of preventable morbidity and mortality and the significant bias towards 'high tech' medicine, promoting equity within South Africa requires that primary care services are prioritised in future health system development (McIntyre et al., 1995; McIntyre, 1997b).

There have been a number of initiatives to improve access to primary care services (see Box 2). In particular, efforts have been made to reduce financial barriers to access and to promote geographical accessibility and service quality through improving the financial, physical, human and pharmaceutical resources at the primary care level. In addition, specific action has been taken to improve services provided to women and children, and the poor (Box 3), who have been identified by the Department of Health as the key vulnerable groups.

More broadly, it is envisaged that primary care will be supported through the development of the District Health System (DHS). The new White Paper on Health (Department of Health, 1997a, p. 12) identifies the district as the "*major locus of implementation*" for the health system, enabling the development of a single, unified health system emphasising the PHC approach and facilitating community involvement in "*the*

Box 3

Policies and programmes targeting vulnerable groups and diseases of poverty

Action to improve maternal, child and women's (MCWH) health includes

- Introduction of free care for children under 6 and pregnant women
- Development of the National Programme of Action for children
- Development of the Women's Empowerment Policy
- Introduction of the Primary School Nutrition Programme
- Introduction of the accelerated immunisation programme
- Development of a national cervical screening programme; and
- Legalising the termination of pregnancy (TOP)

Improvements to the National Tuberculosis Control Programme (TBCP), particularly to improve facilities for the early diagnosis of tuberculosis, to standardise treatment regimens, and to implement Directly Observed Treatment (DOT) on a national basis

Improvements for other aspects of communicable disease control, such as the adding of Hepatitis B vaccinations to the list of routinely administered immunisations for children, due to the high levels of preventable mortality attributable to this disease in South Africa

planning, provision, control and monitoring of services" (African National Congress, 1994b, p. 19; see also Health Policy Coordinating Unit/Department of Health, 1995). However, the extent to which the DHS will contribute to the strengthening of primary care services and promoting community participation remains unclear.

Private sector initiatives

Various policies have been developed which have an impact on the private sector. Some of them are aimed at regulating its growth (such as a moratorium on the building of private hospitals) whilst others are aimed at controlling some of the worst excesses of private medical care (such as banning private practitioners from dispensing, a practice which had contributed to poly-pharmacy and excessive medication). A Medical Schemes Act was passed by parliament in 1999 which is intended to prevent some of the practices of the private pre-payment medical scheme industry which undermine equity (such as risk-rating, and dumping patients who have exhausted their benefits back on to the public sector) whilst also strengthening management and governance within the industry.

There are, however, two critical concerns about the range of policies oriented towards the private sector. Firstly, a comprehensive policy vision on the sector is lacking. The policies to date have not been co-ordinated or contextualised within an explicit and strategic approach to the private sector (McIntyre, 1997b). Instead they have been seen as discrete and unrelated policies.

Secondly, the key equity challenge concerning the private sector has not been addressed. That challenge is to extend the degree of cross-subsidy within the overall health system by making the resources currently located within the private sector accessible to a broader section of the population. For example, the Committee of

Inquiry into a National Health Insurance Scheme proposed that district health authorities should be able to purchase primary care services from accredited multi-disciplinary groups of private practitioners (South Africa, 1995). This could be an important mechanism for strengthening primary care service provision through the use of human resources currently located in the private sector. However, no action has yet been taken on the Committee's recommendations. Whilst some provinces have increased the number of part-time appointments of private general practitioners in public sector facilities, a coherent policy on mechanisms for drawing on human resources within the private sector has yet to be adopted. Similarly, there has still been no action on the proposal that public hospitals could raise additional revenue by attracting privately insured patients through the provision of improved hotel facilities and then ensuring that full cost, or higher, charges are recovered from them (McIntyre & Khosa, 1996; Hospital Strategy Project, 1996). Yet government subsidies for private sector care (particularly through tax concessions on medical pre-payment scheme contributions) remain in place.

Health-promoting and equity-oriented policies

Within and outside the health sector a range of policies have been directed at addressing some of the critical, preventable factors underlying the country's poor morbidity and mortality situation. The first Minister of Health, for example, took strong measures both to control tobacco advertising and to limit sales by raising the excise duty as a step in the fight against smoking. Over the past two decades, there has been a significant decline in smoking among high socio-economic groups and in the white population group while smoking rates in low-income groups, particularly among the 'coloured' and African population groups,

has increased significantly (Yach, Saloojee, & McIntyre, 1992). Thus, recent initiatives to reduce tobacco consumption are likely to generate health benefits primarily for low socio-economic groups.

Outside the health sector, a diverse array of social policies that have relevance for health (in)equity have been initiated in pursuit of the RDP's goals (May, 1998). These include both other actions to meet basic needs (such as the provision of basic education, improving access to water and sanitation facilities, building houses for the homeless and rural electrification) and actions to provide social safety nets (such as revising but maintaining the non-contributory social security system which provides a significant source of income for the rural poor). However, these policies are only part of the RDP's policy package to tackle poverty and inequality—which also extends to human resource development, job creation and macroeconomic stability. As this paper focuses on health policy, and despite their importance in promoting health, broader social policies are not considered further in this paper.

Are current policies promoting vertical equity and procedural justice?

In order to understand the potential contribution of these wide-ranging health policies to redressing inequity, this section analyses specific elements of the packages in terms of the extent to which they promote vertical equity and procedural justice. The policies chosen for analysis have been selected both on the basis of their likely importance to equity and in terms of data availability.

Pursuing vertical equity within the health sector

Geographic resource re-allocations

The Function Committee formula sought to promote equity through resource re-allocations between geographic areas in reflection of differential and relative need. Although its approach to estimating health need was crude, it was the best possible given the dearth of data for determining other proxies of relative need. In 1995/96, the population in each province was weighted for the provincial average per capita income relative to the national average (i.e. resources were preferentially allocated to 'poorer' provinces which potentially have higher burdens of ill health). In 1996/97, provincial populations were estimated as the total population less those already covered by medical insurance, allowing public resources to be directed towards those areas with larger uninsured populations who are more heavily dependent on public sector services.

Mooney (1996) has argued that, from a vertical equity perspective, it is necessary to go further than simply accounting for differential need in resource allocation

formulae, and that additional weightings should be given to certain groups. He explains that through traditional needs-based resource allocation formulae "those groups in greater need will, *Ceteris paribus*, get more resources allocated to them. Unless...[indicators of relative need for health services] are weighted by a factor other than one, however, it will not be the case that priority will be given to health gains to one group rather than another" (Mooney, 1996, p. 101). Thus, it could be argued that the South African health care resource allocation formula did not give adequate consideration in its design to vertical equity considerations. However, given data deficiencies for quantifying indicators of relative health need in South Africa and the urgent need to initiate a relative redistribution of health care resources after the 1994 elections, this formula provided a useful starting point on which further refinements could be built as and when better data became available.

Using as a relatively crude 'equity target' the national average per capita⁷ expenditure (in 1995/96–1997/98) or budget level (in 1998/99–2001/2002), adjusted to remove the insured population in each province, Fig. 1 indicates that the vast majority of provinces came closer to this target in the 1996/97 financial year, whilst 2 provinces became worse off (McIntyre & Gilson, 1999).

However, after 1996/97 (i.e. from the time when global provincial budgeting was implemented) progress towards equitable provincial re-distribution of public health sector budgetary allocations has been constrained. As Fig. 1 also shows, earlier trends were reversed in certain provinces and analysis based on the 1999/2000 medium-term budgetary projections⁸ suggests that there will be very limited progress towards equity in provincial health budgets for the foreseeable future. Gauteng, in particular, is set to receive substantial health budget increases despite being the most over-resourced province, relative to its population. This pattern partly reflects the fact that the most over-resourced provinces contain the majority of the academic hospitals, whose

⁷It should be noted that the formulae used by the Department of Health in 1995/96 and 1996/97 weighted provincial populations for various indicators of relative need for public sector health services. However, due to difficulties in obtaining accurate and consistent annual information on such need indicators, population data are only adjusted for medical insurance levels in each province in Fig. 1 to illustrate budget allocation trends. Sensitivity analyses undertaken by the authors indicate that if mortality data or other indicators of health need are incorporated in such a formula, it tends to accentuate the pattern evident in Fig. 1 (i.e. the same provinces are either relatively over- or under-resourced, but to a greater degree).

⁸South Africa has recently embarked on a multi-year budgeting process (consisting of 3 year rolling budgets) called the Medium-Term Expenditure Framework (MTEF).

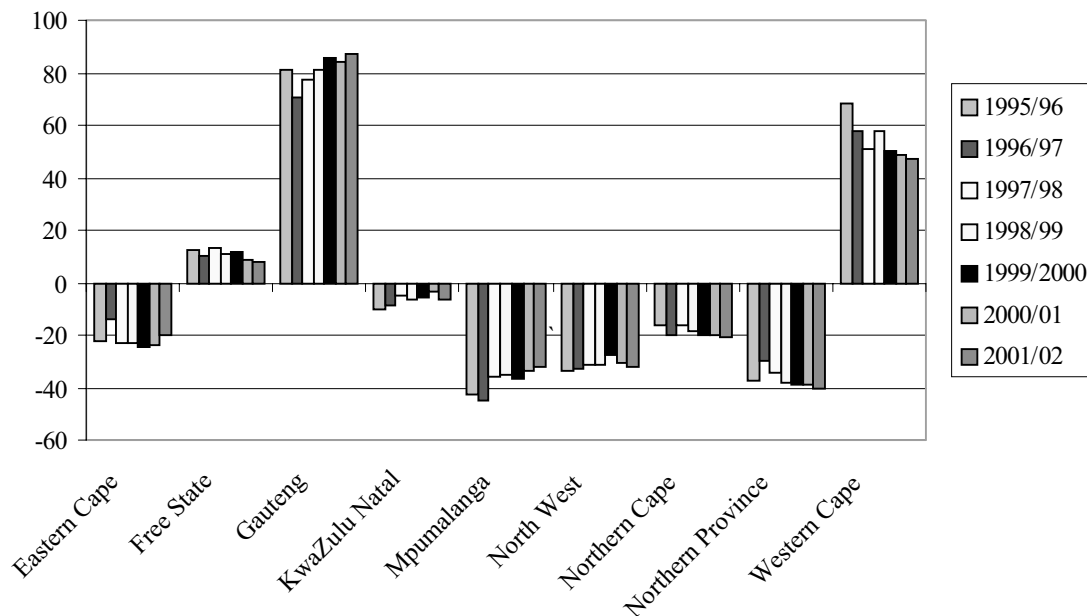


Fig. 1. Trends in real adjusted per capita provincial health expenditure/budgets (% distance from equitable budgetary allocation). *Note:* Expenditure data were only available for 1995/96–1997/98 financial years. Thus, budget data were used for the 1998/99 and 1999/00 financial years and medium-term budget projections were used for 2000/01 and 2001/02. Those covered by medical insurance were excluded from the provincial population in this analysis. *Source:* McIntyre et al., 1999.

services and training activities are regarded as ‘national resources’. It could, thus, be argued that these activities should be excluded from inter-provincial resource redistribution considerations. However, such exclusion would leave the *trends* evident in Fig. 1 relatively unaltered (i.e. the same provinces remain relatively under- or over-resourced even if all expenditure on academic hospitals is excluded from the analysis) (McIntyre, Baba, & Makan, 1998).

Although the initial centrally driven redistribution of health budgets between provinces was an extremely painful process (particularly for the provinces which were expected to reduce their expenditure dramatically with no forewarning which would have allowed for appropriate planning), it was relatively effective in reducing inequitable financial resource disparities. It provided a useful starting point for promoting vertical equity, as those provinces which were the main beneficiaries of resource redistribution (i.e. the Eastern Cape and Northern Province) were those with some of the worst health status indicators. However, the era of fiscal federalism heralded by the adoption of the new Constitution has threatened the achievements of the earlier period. It has slowed the pace of relative redistribution of health budgets considerably, and in some cases has dramatically reversed the redistribution process (McIntyre et al., 1998; McIntyre, Thomas,

Mbatsha, & Baba, 1999). There is particular concern that three of the most under-resourced provinces, namely the Northern Province, North-West and the Eastern Cape, have been particularly unsuccessful in negotiating for a ‘fair’ health sector share of provincial resources. One likely reason is that these provinces have a significant bureaucracy as they have had to combine former provincial and ‘homeland’ authorities. In these provinces, it is critical that reducing the size of provincial bureaucracies receives priority attention if health budgets are to increase to equitable levels.

In addition to concerns about the allocation of health resources *between* provinces, mechanisms for improving the distribution of resources *within* provinces are being explored. For example, the ‘District Financing Task Team’, co-ordinated by the national Department of Health and containing provincial representatives, recommended a needs-based resource allocation formula approach to guide the allocation of provincial health budgets between health districts in late 1997 (Brijlal, Gilson, Makan, & McIntyre, 1997). In practice, however, provinces have adopted varying approaches in their allocation of health resources and it is likely that only limited intra-provincial re-distribution has occurred. The poor availability of data has prevented assessment of this issue.

Improving access to primary care

Partly as a result of the early geographic resource re-allocations that were achieved, the first 4 years of the new government saw a sustained process of budget reprioritisation in favour of primary care. Thus, the percentage of the public sector health budget allocated to ‘basic health services’⁹ doubled between 1992/93 and 1997/98, from 11 to 21 percent (de Bruyn et al., 1998). This process was also accompanied by two key measures to improve access to primary care—the removal of the financial barrier of fees and the reduction of geographical barriers through the Clinic Upgrading and Building Programme (CUBP).

There were two phases to the free care policy. The first involved the introduction of free care for pregnant women and children under the age of 6 years on 1 June 1994. Announced by the State President in his first address after the elections (May 24, 1994), this policy was clearly seen to be of major national importance. The second phase was the introduction of free primary care services for all South Africans on 1 April 1996, together with a by-pass fee for those who chose to access hospital care without first using a primary care facility.

Whilst little evaluation has been undertaken of the second phase of this policy, an evaluation of the first phase showed generally positive impacts (Health Systems Trust, 1996; McCoy, 1996). Health service utilisation increased substantially immediately after the removal of fees and pregnant women started attending ante-natal care at an earlier stage. Current data do not, however, allow any assessment of which specific population groups have benefited most from this policy, whether these initial increases have been maintained over time or whether service utilisation increases have been translated into improved health status. Its effectiveness in promoting vertical equity, thus, remains to be seen. Given that other barriers to accessing care (particularly distance and low perceived quality) are likely to affect rural populations, particularly those in former homeland areas, more than other groups, these particularly vulnerable groups may have actually benefited less than the general population from the fee removal. There were indications that the number and proportion of visits at tertiary hospitals that could have been treated at lower levels increased after the fees’ removal, particularly in areas with poorly functioning primary care facilities (McCoy, 1996). Accessing the benefits of free care in these areas may, therefore, have imposed greater travel and time costs on those less well-served by primary care than those in better served areas. If the same trends also continued under the second phase of the policy, the more dis-advantaged would also

have had to bear the additional cost of the by-pass fee because of their worse access to primary care services.

Improving financial access must, thus, be accompanied by improvements in geographical access if it is to address the needs of the relatively under-served and most vulnerable. Phases 1–3 of the CUBP (extending until the 1996/97 financial year) made allowance for 295 new clinics to be built. Using the World Health Organisation’s (WHO) recommendation that there should be one clinic for every 10,000 people,¹⁰ KwaZulu-Natal, Mpumalanga and the Northern Province had the greatest need for additional clinics at the time that the CUBP programme was initiated although many provinces had access problems in terms of this goal (Govender & McIntyre, 1997). While the WHO recommendation itself reflects a horizontal equity goal (equal access), the pattern of the CUBP’s implementation apparently reflects some concern with vertical equity. The limited number of new clinics were preferentially allocated to the areas with the worst existing levels of primary care infrastructure and over 60 percent of the new clinics were planned for the three most under-resourced provinces. There was also an effort to target communities within each province which had the highest poverty levels and the least access to clinic level services (62 percent of CUBP clinics were planned for the poorest 40 percent of districts). This experience may suggest that vertical equity considerations can guide the pattern of policy implementation in useful ways, particularly in resource constrained contexts, rather than only being seen as an end-point of policy action (as is commonly the case with a horizontal equity goal).

Nonetheless, the implementation of the CUBP was slowed by problems partly resulting from the focus on under-resourced areas and only 92 of the proposed 295 clinics (i.e. 31 percent) had been constructed by the end of the 1996/97 financial year (Govender & McIntyre, 1997). Delays partly resulted from protracted discussions with communities to identify appropriate clinic sites, whilst the lengthy tender process proved to be a major obstacle to rapid implementation. In addition, cash flow problems (resulting from delays in processing

⁹Basic health services refers to the definition adopted in the UNICEF/UNDP 20/20 initiative. It includes all non-hospital primary care services.

¹⁰The WHO indicator is a relatively crude measure of primary care facility accessibility as it does not take into account the size of the facility, or factors such as population density. Thus, in provinces with a high population density, one large clinic can serve significantly more than 10,000 people. In contrast, in provinces with very low population densities, more fixed (and/or mobile) clinics may be required per 10,000 to achieve adequate geographic accessibility. An indicator which is more sensitive to geographic accessibility is that of one clinic per 10 km radius (or an indicator such as a travel time of less than 1 hour). Data of this nature are not available on a national basis, although some provinces are trying to incorporate these considerations in their health facility plans. The WHO indicator also does not take into account mobile clinics.

tender claims) resulted in suppliers halting the delivery of building materials and labour disputes. Not unexpectedly, the areas which were least well resourced and which had the most constrained management capacity were hardest hit by these delays. An even greater concern than delays in building clinics in areas of need is that, as extensive anecdotal evidence suggests, many clinics built through the CUBP have not been put into operation as a result of difficulties in appointing and posting staff to serve in them.

In order to be translated into real access gains, improvements in financial and geographic access must, finally, be accompanied by the improvements in service quality that encourage the use of health care services. There are, however, hardly any data by which to make comparative assessments of quality between areas. The quality weaknesses identified by small-scale studies include infrastructural problems, gaps in drug availability and, perhaps most pernicious, staff discourtesy towards, and even abuse of, patients (Jewkes & Mvo, 1997; Oskowitz, Schneider, & Hlatshwayo, 1997; Schneider, Magongo, Cabral, & Khumalo, 1998; Tint et al., 1996). Given the latter problem it is worrying that both phases of the fee removal policy had a clear negative impact on the morale of front-line health care providers. Staff suggested that the policy had exacerbated poor working conditions, particularly overcrowding and staff shortages at health facilities and expressed strong concerns about the lack of consultation and planning that preceded policy implementation (McCoy, 1996).

The vertical equity gains promoted by strengthening the health care services most relevant to the needs of the most poor, whilst preferentially addressing those access barriers which discriminate against this group may, thus, have been offset by the utilisation deterrent of poor staff attitudes and behaviour towards patients.

Prioritising service provision for vulnerable groups and tackling diseases of poverty

Steps to prioritise service provision for particularly vulnerable groups and to strengthen measures to address diseases of poverty also have potentially positive vertical equity implications. However, there are again some signs that, at least in the early stages of implementation, those who are most vulnerable continue to have least access to these services. A major health policy success of the new government has been to secure women's legal right to termination of pregnancy services, as part of the battle against unnecessary ill-health and premature mortality. But early evidence suggests that the initial gains from this policy have benefited urban over rural populations (Health Systems Trust, 1997). Whilst not surprising, given the stronger and higher quality service provision in urban areas as well as the potential for greater anonymity and the higher levels of female education in

these areas, it is a further indication that policy implementation has not yet tackled the particular problems of the most vulnerable groups. Thus, whilst the mass polio and measles immunisation campaigns conducted by the Department of Health in 1995 and 1996 improved immunisation coverage, the wisdom of a *national* programme has been questioned (Wigton, Hussey, Fransman, Kirigia, & Makan, 1996). In particular, it was suggested that only areas with low coverage should have been targeted to allow more resources to be allocated to improving comprehensive primary care services. Subsequent data also indicate that general coverage levels have *not* been maintained over time (Medical Research Council and Macro-International, 1999).

The lack of adequate management capacity, which is necessary for successful implementation of health policies and programmes, is a further weakness of these measures. For example, the next steps towards the effective provision of the reproductive health services important for women have been identified as including general and technical management support to primary care facilities, innovative management and strong leadership (Stevens, 1997). Similarly, a recent review of DOTS' implementation has observed that "*the translation of plans on paper into action has so far been limited. This has largely been due to the restructuring of health services ... and numerous other health problems competing for attention... In the new South Africa, there is real promise for success in meeting the challenge of tuberculosis. The tools to diagnose and cure are available. Financial resources are available. It is a matter of putting the tools and resources to effective use*" (Health Systems Trust, 1997, pp. 201–2).

Pursuing procedural justice

Although procedural justice is not explicitly identified as a concern of government policy, policy rhetoric may suggest that there is some concern with fair procedures—as indicated by the stated commitments to democratisation and community participation.

A clear and critical foundation for the pursuit of procedural justice is the Bill of Rights contained within the Constitution adopted in October 1996. Clause 27(1) states that: "*Everyone has the right to have access to: health care services, including reproductive health care; sufficient food and water; and social security, including appropriate social assistance, if they are unable to support themselves and their dependants*". The constitutional right to health care that this clause enshrines is important as a goal for South African society, securing a citizen's entitlement to health care rather than leaving health care access subject to the whims of purchasing power (Gilson, 1997a). Clause 27(2) also requires the state to work towards the "*progressive realisation of*

these rights” although such action must be within “the constraint of available resources”. Liebenberg (1997) emphasises that this requires the state to adopt an incremental approach to realising these rights and that resources should be prioritised to ensure that disadvantaged groups have access to essential levels of rights.

The constitutional clause requiring that health care rights be subject to government resource availability may also mediate the potential conflict between individual and collective rights. Thus, in the first case of its kind, the constitutional court ruled against a patient attempting to claim his constitutional right to health care following the provincial government’s refusal to allow him dialysis treatment.¹¹ The Court argued that “Given the lack of resources and the significant demands on them, an unqualified obligation to meet these [health] needs would not presently be capable of being fulfilled” and that conflicting resource demands required the state “to adopt a holistic approach to the larger needs of society rather than to focus on the specific needs of particular individuals within society” (Sunday Times, 30/11/1997). While this case indicates that the collective good will be given priority over individual rights, it raises questions about the enforceability of these rights in the short- to medium-term. Although important as goals for society, the existing individual rights might be complemented by the establishment of community rights (e.g. a community’s demand for the establishment of a clinic as it currently only has access to primary care services located 50 km away) which may be more feasible to implement relatively quickly.

Loewenson (1997) has noted that the establishment of health and other socio-economic rights will also only be effective if accompanied by civic education to inform people of their rights and so encourage their use. Thus, in South Africa it is important that there has been vigorous involvement of civil society organisations in promoting an understanding of health rights and in seeking mechanisms to secure these rights. In particular, the National Progressive Primary Health Care Network (NPPHCN), a grouping of health-related non-governmental organisations and community-based organisations, embarked on a Health Rights Charter campaign. Section 234 of the South African Constitution states that “In order to deepen the culture of democracy established by the Constitution, Parliament may adopt Charters of Rights consistent with the provisions of the Constitution”. The Health Rights Charter campaign has served procedural justice in two ways. Firstly, through the extensive consultation process involved in drawing up

the Charter and the widespread dissemination of the draft Charter, it has engendered greater understanding of these health rights as well as individuals’ and communities’ duties and responsibilities.¹² Secondly, through submitting the Charter to parliament for adoption, it seeks to further entrench the existing rights and to secure additional health rights important to procedural justice within the health sector (e.g. the right to be treated with dignity and respect by health workers) (NPPHCN, 1997).

Another example of how organisations in civil society are seeking to promote the accountability of government to the people is the 1998 South African NGO Coalition’s (SANGOCO) public hearings on poverty. As part of SANGOCO’s ‘Speak out on Poverty’ campaign, South Africans were urged to express their views (by making written and/or verbal presentations) on how poverty and inequity affect their lives, whether or not government policies are adequately addressing poverty and inequity and to make suggestions on how government interventions could be changed or strengthened. Public hearings were conducted all over South Africa for various sectors, including health. The experiences reported and the ideas generated by this process have fed into a ‘Summit on Poverty’ organised by the Anglican Archbishop of Cape Town to strengthen the fight against poverty.

However, the vision of the Constitution and the innovativeness of civil society organisations must be set against the so far limited success in implementing the admittedly enormous task of creating functional and effective local mechanisms of accountability. For example, despite good intentions there has only been limited interaction with communities within the CUBP planning processes due the severe constraint of weak community capacity. Many provincial officials participating in a survey conducted by Govender and McIntyre (1997) indicated that there were no mechanisms to empower and build community capacity and so enable their participation. Similarly, whilst the third sphere of governance envisaged by the constitution, local government, is often seen as the primary locus for local level accountability it remains, both in the health sector (Brijlal et al., 1997) and more broadly (May, 1998) and particularly in the least-resourced areas, bedevilled by capacity weaknesses.

In addition, the speed and manner of some actions within the health system—such as the implementation of free care—may suggest that central levels are not

¹¹Due to limited dialysis facilities, provincial hospitals only provide dialysis to patients who qualify (on medical grounds) for a kidney transplant. In this instance, the man did not qualify due to other health problems, including heart disease.

¹²There has been widespread discussion with communities around the country. All documents disseminated in the Charter campaign advertise a toll-free number from which people can get further information, discuss issues that are unclear and seek advice on how to initiate the development of a charter for their local health facility.

always sensitive or responsive to the voices of concerned stakeholders. As already noted, the potentially negative effect of implementation practices on health workers may itself have exacerbated personnel attitudes which in turn undermine the health system's contribution to procedural justice. This example also appears to reflect a more general trend in decision-making within the health sector as noted by the editor of the South African Medical Journal: "*unfortunately this Ministry is widely perceived as being arrogant and autocratic even by some of its own friends... Granted health policy in the new South Africa constitutes a contested arena with powerful vested interests but this alone should not preclude a democratic process of true consultation*" (Ncayiyana, 1998, p. 1).

Factors constraining equity promotion

Weak conceptualisation of policy needs

Although the notion of vertical equity seems to underlie both policy statements and several of the health sector policies implemented since 1994, there is a lack of clarity in policy which may itself constrain the achievement of a real focus on the most vulnerable. First, the vulnerable groups identified by policy statements do not provide a clear sense of which specific groups should be favoured by policy action. The categories identified as vulnerable groups (most commonly the poor, the rural population, women and children) are too broad to enable a clear focus for implementation strategies. The recent Poverty and Inequality report, for example, has identified that 50 percent of the population can be categorised as 'poor' (earn less than R352.53 per month per adult equivalent) but 27 percent of the population are 'the core poor' (earn less than R193.77 per month per adult equivalent) (May, 1998). Should policy focus on the poor 50 percent or on only the poorest 27 percent? The promotion of vertical equity both within the health and other social sectors requires the clear specification of those who should benefit most from policy action in order to limit the extent to which the non-poor actually capture the benefits.

Second, the White Paper on Health identifies the need both to focus on vulnerable groups and to achieve universal access to an essential package of primary health care interventions (Department of Health, 1997a). Similarly, the constitutional right to health combines consideration of prioritising the most disadvantaged and establishing core minimum obligations or standards. Yet without careful implementation practices these two goals may be in conflict. Vertical equity requires, in part, that public sector resource allocations and service improvements should preferentially benefit the poorest and most vulnerable over other groups. Given the legacy of discrimination against some

groups, establishing universal access to an essential package of primary care services (or minimum state obligations) will ultimately generate gains even for the poorest. However, a policy of 'equal access for all' to a uniform set of services runs the risk of maintaining existing levels of *relative* dis-advantage by ignoring differences in current levels of service availability and differential levels of need between areas of the country and population groups. The poorest groups are likely to require not only greater resources but also a different configuration of health services to meet their health needs in comparison with others. Thus, even if achieving equal access for all entails some allocation of additional resources to the poorest in the short term it may still not adequately address their different needs. Implementation practice must also be sufficiently flexible to allow differences in service packages that respond to differing needs, with consequent implications for resource requirements. Vertical equity is not served by policies rooted in the principle that 'one size fits all'. Equally importantly, the focus on universal access to a basic package of *public* services only is likely to allow the richer portions of the population to maintain their relatively better access to care through the purchase of private services—especially where, as in South Africa, the private sector is large and its regulation weak. Achieving the equity goal of universal access to a basic package of public services may, thus, simply maintain existing inequities if care is not taken to ensure that the needs of the most vulnerable are preferentially addressed and if the need for a coherent and comprehensive policy towards the private sector continues to be ignored (Gilson, 1997a, 1998a).

A third important, and related, area where health policy remains weakly conceptualised concerns the link between primary care and hospital care. Although there is no doubt that strengthening primary care services can generate substantial gains for the most disadvantaged, such gains are dependent on strengthening the provision of hospital care in two important ways. First, there is a need to improve the clinical referral services necessary for effective primary care provision—such as the provision of emergency obstetrical care. Second, it is essential to improve resource use within hospitals in order to allow the re-allocation of resources to the primary level without critically undermining the provision of hospital care. Yet little action has so far been taken to implement the clear policy recommendations that exist on this issue (Hospital Strategy Project, 1996).

An alternative strategy to generate the resources necessary to strengthen the public primary care level, which also highlights the links between public and private financing and between hospitals and the rest of the system, is to introduce a Social Health Insurance (SHI) scheme to cover the costs of public sector hospital

inpatient care for formal sector employees and their dependants. An SHI combined with higher user fees at public sector hospitals for *insured* patients has the potential to generate quite substantial additional revenue for the public health sector, which could then be used for the rapid development of public primary care services and for addressing geographic inequities in public resource allocations, has been recognised both nationally (McIntyre, 1997a) and internationally (Gilson, 1997b). Although SHI proposals have been under discussion for some time in South Africa (South Africa, 1995; Department of Health, 1997b), no action has yet been taken. Whilst this lack of action may reflect concern at some of the possible consequences, such as the need to establish a differential in amenity care within hospitals to attract fee-paying customers, it may be a further stepping stone to continued worse treatment for the poorest. Some sort of care differential is commonly seen as a necessary pre-requisite in securing the custom of more working people for the public hospital system. Only by bringing more people into the public hospital system can the use of the poorest be better cross-subsidised, whilst securing the political support of the working population for the public hospital system is generally recognised to be a critical element in maintaining and improving standards of hospital care. Hesitant action concerning the public hospital system may only condemn the whole public system to a future as second class care for the poor (Mackintosh, 1995).

Finally, the fourth area where policy is weakly conceptualised concerns the potential link between procedural justice and vertical equity. If budget re-allocations are to be translated into service delivery improvements and health gains for the most vulnerable, their needs must be well-understood by policy-makers and enough time must be given for determining those needs. Yet a general comment on the overall budgeting process of government is that it is not open or transparent, undertaken only by a technocratic elite. Therefore, “*budget reform has to ensure a role in budget-making for parliament, and for the poorest in society, that goes beyond rubber-stamping*” (Govender, 1997, p. 3). In addition, the nature, and particularly the pace, of health and wider social policy-making appears, quite understandably, to have been forced by the need ‘to deliver’. Achieving vertical equity may require a slower pace of implementation in terms of output targets in some areas of social provisioning in order to allow for more involvement of the beneficiaries in ways that ensure greater satisfaction with, and use of, the services delivered. Delivering quality outputs may be at least as, if not more, important than meeting quantitative targets in reaching the poorest, particularly as perceived quality of services is often a significant deterrent to service utilisation.

Institutional constraints

Various factors in the institutional framework within which policy development and implementation occurs help explain the various limits on equity-oriented policy action. From the constitutional division of powers between the three spheres of government to the legacy of weak capacity in the very areas that need the most capacity to ensure effective implementation, there are some clear brakes on the pace and pattern of implementation. Whilst these explain some of the implementation lags and must be recognised as part of the inherited legacy, they must also not be seen as an excuse for those lags. They rather help identify where some of the most critical action must be taken to enable implementation. For example, the constitution identifies that the national government can influence provincial allocations of resources through the establishment of ‘norms and standards’. Whilst a difficult task, establishing health norms and standards that influence inter-provincial and intra-provincial resource allocations in ways that promote equity must clearly be a focus of action.

More generally, the need to co-ordinate action across provinces and the capacity constraints of lower levels of the system should not generate a knee-jerk reaction in the form of an increase in the centralisation of decision-making powers. Instead these apparent constraints should be seen as the opportunity for innovative and visionary policy leadership. Relinquishing some central control will enable the centre to take on a more enabling role throughout the system, so allowing the potential of other layers and groups to be released. It is particularly important to address the problem that “*the poor do not know where power is to be found, nor what power has on offer...because institutional structures are opaque and disempowering*” (May, 1998, p. 275). In addition, the pursuit of both vertical equity and procedural justice requires that preferential support be given in the development of management capacity to currently under-resourced districts in order to ensure, for example, that financial resources can be translated into improved service delivery within these areas (Brijl et al., 1997). Promoting equity will always require central level action (Collins & Green, 1994), but cannot be secured by central level action alone.

Macro-economic policy

Careful reading of the RDP policy document should have alerted policy analysts to the ideological and resource conflicts between the stated macro-economic policy and the social sector policies. On the one hand, there was an extremely orthodox economic policy espousing fiscal constraint, reduction of the budget deficit and promotion of international competitiveness. Yet at the same time, there were more populist social

policies committed to providing “*health care, electricity, clean water, and housing as a right*” (Pillay & Bond, 1995, p. 733). While the potential for promoting social service equity within the context of neo-liberal macro-economic policies is the subject of heated debate, it is clear (with hindsight) that the very ambitious RDP targets for improved social service delivery would not be feasible if tight budget deficit reduction targets were set.

While the RDP set the broad parameters for the government’s economic policy, it was the development of the Growth, Employment and Redistribution (GEAR) policy in 1996 (Department of Finance, 1996a) which has had the most dramatic impact on social sector policies. The major difference between GEAR and previous economic policy statements is that GEAR set explicit and very ambitious budget deficit reduction targets. The government maintains that such action is required to ensure the macro-economic stability necessary for investment, growth and redistribution (Fraser-Moleketi, 1998) and emphasises that it is prioritising social sector spending within the government budget. However, opponents criticise GEAR on the grounds that it places enormous pressure on the overall government budget and so on all aspects of public sector service provision. As there is limited scope for further inter-sectoral budgetary redistribution, given that the budgets for defence, other security services and economic services (e.g. energy, agriculture and fisheries) have already been cut since the 1994 elections (de Bruyn et al., 1998), social services will have to bear the brunt of fiscal restraint (May, 1998).

However, the health sector appears to have been granted a reasonably high priority on the government’s overall policy agenda. According to the government’s 1998/99 medium-term budget projections, real per capita health budgets were expected to remain almost constant at current levels until the 2000/01 financial year (McIntyre et al., 1998). Given that the overall government budget was expected to decline in real per capita terms over this period, health’s share of the budget was set to increase. Health captured approximately 10 percent of total government expenditure in 1995/96 and it has been estimated that it will consume a slightly greater share (11 percent) of the total government budget by 2000/01. This was expected to return it to the level of spending achieved in the early 1990s (i.e. health as a percentage of government spending declined from 11 percent in the early 1990s to its current level of 10 percent) (Department of Finance, 1996b). The health sector (unlike certain other social sectors) is, thus, likely to be relatively protected from the full force of the government cuts.

However, the failure to increase health expenditure in real per capita terms will significantly constrain the sector’s ability even to maintain existing levels of care. It faces particular constraints on its ability to maintain

input levels (resulting from salary increases for public sector health professionals and the deteriorating exchange rate) as well as having to cope with the huge additional cost burden of HIV/AIDS care. Any expansion of primary care services will, therefore, have to be funded largely out of reductions in hospital services (i.e. through level of care resource shifts). One challenge is to achieve this redistribution in a way that does not adversely impact on the maintenance of an adequate referral system. As access to primary care services improves, there will be an increase in the number of patients who enter the health care system requiring referral. But because regional hospitals (the first level in the referral chain which provides specialist services) have been under-resourced historically (Hospital Strategy Project, 1996), the fiscal policy will severely constrain the health sector’s ability to improve primary care service access and simultaneously to establish an adequate referral network. The resource constraints it imposes will also slow the pace of intra-provincial resource distribution and constrain action to address inadequate access to health services in poor communities which have been historically under-resourced (i.e. to achieve vertical equity gains). The failure to take forward existing proposals on improving hospital efficiency and introducing a SHI scheme only exacerbates these problems.

The acceptance of tight fiscal targets has similar effects across social policy (Gilson and McIntyre, 2001). Re-distribution is also always “*more difficult when it goes hand in hand with cost containment, as it always means taking something away from the present ‘haves’*” (Budlender, 1997, p. 20). Re-distribution, thus, requires effective strategies to put the needs of the poorest at the heart of policy-making, to strengthen the mechanisms of ensuring procedural justice. On the one hand there is a need “*to strengthen the voice of those who have been disadvantaged and to stand fast against the strong voices of those who are advantaged*” (May, 1998, p. 262); and on the other hand it is important that the fiscal targeting needed to promote vertical equity does not alienate too greatly the near-poor or even those who earn above average incomes and have political ‘clout’. Their support is necessary to prevent the public health system, or other social service provision, from becoming merely a safety net to alleviate the worst effects of poverty. In the fight for equity, the provision of public services must, instead, be a mechanism of re-distribution and of enablement that the whole society supports and values.

Conclusions

In summary, the South African health sector faces major challenges in addressing inequities. However, equity is high on the health and social policy agenda and

a range of specific policies and programmes have been developed to effect the equity goal.

Fiscal constraints will slow the progress towards this goal. Although the public health sector has received greater budgetary protection than other sectors and does have additional financing options open to it, it faces large and growing demands. It is also of concern for health that improvements in access to sanitation, potable water and adequate housing will not occur at the ambitious pace envisaged in the RDP (de Bruyn et al., 1998; May, 1998). Some commentators have also suggested that inability to pay will remain a barrier to the poor in accessing these basic social services, given that there is a requirement for local financing of these services (Bond, Pillay, & Sanders, 1997). Ultimately, this may adversely impact on the extent to which health status improvements can be achieved, and particularly the extent to which inequities in health status can be reduced.

The South African experience raises some interesting issues which may have relevance for other countries wishing to 'put equity in health on the social policy agenda'. There are a number of factors which have enabled health equity to receive a relatively high policy priority in South Africa. Firstly, the constitutional entitlement to health services is important in establishing a clear goal for policy action. This entitlement has been widely promoted through innovative action such as the 'Health Rights Charter' campaign—action which also serves notice to the government that civil society intends protecting and claiming these rights. Secondly, political advocacy for the importance of health equity gains has been critical. One of the key reasons that health strategies have received support from a wide range of politicians is that the health sector was seen by the new government as an area where rapid equity gains could be achieved (e.g. it was logistically easier to deliver on the promise of improved financial access to health services than to deliver on the promise of more houses). However, it must be recognised that improvements in geographic access and the quality of health services have proved difficult to achieve. Thus, the political gains expected from health sector support might prove not to be as substantial as expected.

At the same time, the South African experience highlights some cautionary notes about the pursuit of health equity. The first is the importance, but difficulty, of pursuing procedural justice. There have been few attempts by the national and provincial health departments to engage the community and other stakeholders in any way in the process of health sector decision-making. This weakness has hampered the implementation of certain policies and programmes. The second issue is the need to promote cross-subsidisation in health care financing within and between the public and private sectors as a means to secure both vertical equity and procedural justice. Gilson (1998a, p. 11) recommends

that "*financing mechanisms should promote social solidarity and cohesive health systems which give special attention to the needs of the poorest through, in particular, cross-subsidisation between population groups*". Little progress has been made in this regard in South Africa.

Thirdly, the importance of developing and maintaining a coherent social policy agenda must be recognised. South Africa appeared to be on the right path with the RDP, which presented a relatively comprehensive social policy package and which explicitly recognised the potential health equity gains of non-health sector policies. However, the closure of the RDP office has threatened the maintenance of an overall vision of social services and the balancing of competing claims on resources within the social sector. Certain programmes (such as the water, sanitation and electrification programmes) which would probably have had a more dramatic impact on health equity appear to have received less support than health sector policies. A critical step in re-focusing the social policy agenda must be co-ordinated action to monitor and evaluate the impact of all social policies on health and other measures of well-being, and to feed this information into future policy-making (May, 1998).

The fourth issue relates to the conflict between macro-economic and social sector policies. As the feasibility and nature of social policies are critically shaped by the nature of the economic policies it is critical that social sector policy-makers pay closer attention to emerging macro-economic policies. It may be possible to push forward social policies despite a constraining macro-economic policy framework—but only through careful, informed and strategic action.

Finally, the South African experience indicates that good intentions on the part of government and even some good government policies are simply not enough to promote equity. Effective policy action requires recognition of the need for strategic action and the adoption of new roles by government. In the implementation of pro-equity health and social policy interventions, government must identify a limited number of key tasks which directly tackle inequity and encourage and enable other stakeholders also to take pro-equity action. It is also, and perhaps more, critical that action by groups outside government bring the voice of the poorest to decision-making. The courts, civil society organisations and even the media can play a vital role in ensuring that government action is built on better understanding of the needs of the poorest, as well as in meeting these needs directly. Through their actions, the notion of procedural justice could become the touchstone of government policy-making. This notion ultimately emphasises that the heart of an egalitarian society is the recognition of mutual dependence and mutual support amongst its members.

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