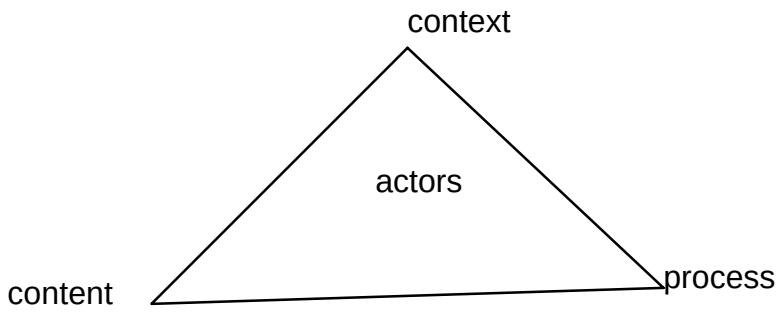
Poverty and health - - does research matter? Experiences in South Africa

Introduction

The relationship between poverty and health research on the one hand, and policy making and implementation on the other, is both complex and characterised by all the inconsistencies (irrationalities) that mark the relationship between other modalities of health research and policy interventions (Levine & Lilienfeld, 1987). To what extent has research, or rather, research findings influenced national and global responses to poverty? What have been the responses to poverty and health in South Africa, and what has been its relationship with research and research findings? Almost from its inception as a Union in 1910, South Africa has been concerned with issues of poverty, and a number of major poverty-related inquiries were conducted (Carnegie Commission, 1932); (Wilson & Ramphele, 1989). This paper reports on some of these investigations, examines the role of research, and attempts to identify factors that favoured the translation of recommendations into policy/implementation, as well factors that served as impediments thereto. A concluding section draws lessons from the South African experience.

In order to answer the questions posed above, three major poverty or poverty-related surveys were examined, using a modification of the methods of policy analysis advocated by Reich (Reich & Cooper, 1995) and Walt (Walt & Gilson, 1994). The Reich model considers policy content, the players, opportunities and obstacles. The players are ranked in terms of their degree of support for the policy and their position of power.



Walt and Gilson proposed the simple model for policy analysis shown above, but recognised that it represented many complex inter-relationships. They emphasise that the

context influences actors/role players and that the power position, values and expectations of the different actors, in turn, influence the process of policy-making. The model ensures that the tendency to focus on the content of health policy is offset by the recognition that the context, process and actors are equally important. Clearly, both models reflect the views (and biases) of the analyst, and this needs to be borne in mind when applying these models. However, they provide useful frameworks for understanding the relationship between research and policy-making.

What is poverty?

Poverty has been defined as "the inability of individuals, households or communities to command sufficient resources to satisfy a socially acceptable minimum standard of living (May, J., Govender J., Budlender, D., Mokate, R., Rogerson, C., Stavrou, A., Wilkins, N., 1998). It has many dimensions, and Narayan states that "poverty is pain", physical, emotional and moral (Nayaran, Patel, Schafft, Rademacher, Koch-Schulte, 2000). It is characterised by "continuous ill-health, arduous and often hazardous work for low income, no power to influence change, and high levels of anxiety and stress" (May et al, 1998). This is often further compounded by unequal gender relations and violence. The poor regard their healthy bodies as their most valuable asset. When they are healthy they can work in order to survive, and illness is one of the most important triggers that propel the near-poor into poverty. Canning argues that poverty alleviation is economically advantageous when it involves the near-poor but that poverty alleviation in the poorest of the poor does not hold the same economic benefits (Canning, 2000). Bloom and Canning produce compelling econometric evidence that more health equals less poverty (Bloom & Canning, 2000). Simulations covering 30 countries with a total population of 3.1 billion by 1990 showed that a 10% improvement in life expectancy in 1990 would have lifted 30 million people out of absolute poverty by 2015. The link between poverty and health also works in the opposite direction, i.e. less poverty equals more health.

What then has been the experience in South Africa?

Poverty and Inequality in South Africa

South Africa is a middle-income country with an annual per capita income ±US$2,500, but with a Gini Coefficient of 0.58, the poorest 40% of households (half the total population) receive only 11% of total income, while the richest 10% of households (equivalent to 7% of the population) receive over 40% of total income (May et al, 1998). However, the degree of inequality varies by geography, between and within 'race groups, and is influenced by gender'. Most of the poor live in rural areas - - 50% of the population are rural but 72% of the poor are rural, while the Gini coefficient within African families is 0.54, signifying considerable inequality within the majority population.

Following the emergence of democracy after 1994, there has been a growing interest in equity issues. While much epidemiological research drew attention to the health inequalities in South African society, very little research was concerned with the inequitable allocation of resources in the South African health care system (Bradshaw, 1987; Yach, 1988; Bourne, Pick, Taylor, McIntyre & Klopper, 1990; McIntyre, Taylor, Pick, Bourne & Klopper, 1990). The issue of resource allocation has received increasing attention in recent years and the emergence of Equinet has led to high quality research in this area in South Africa. One study by McIntyre et al reflects the potential usefulness of research in guiding decision making (McIntyre, Muirhead, Gilson, Govender, Mbatsha, Goudge, Wadee & Ntutela, 2000). The diagrams (Figures 1&2) illustrate the degree of deprivation in different magisterial districts, based on a general index of deprivation (GID), which was developed from 1996 Census data. The GID was derived from data on the proportions of the population in each magisterial district that: are female; children under 5; live in a rural area; are older than 25 years and have no schooling; are unemployed; live in a traditional dwelling, shack or tent; have no piped water in their house or on site; have no access to electricity for lighting; and live in households headed by a woman. The variables were weighted. In comparing the findings of the GID with a policy-perspective index of deprivation (PID), which was based on an analysis of policy documents issued by government, it was found that there was a close correlation between the two indices, which reflects the accuracy of the policymakers' perceptions of the location of social deprivation, as well as the likelihood that simpler indices could provide sufficiently reliable information for resource allocation. These indices could be of great value in measuring the impact of interventions to reduce inequalities.

Figure 1: General Index of Deprivation per magisterial district

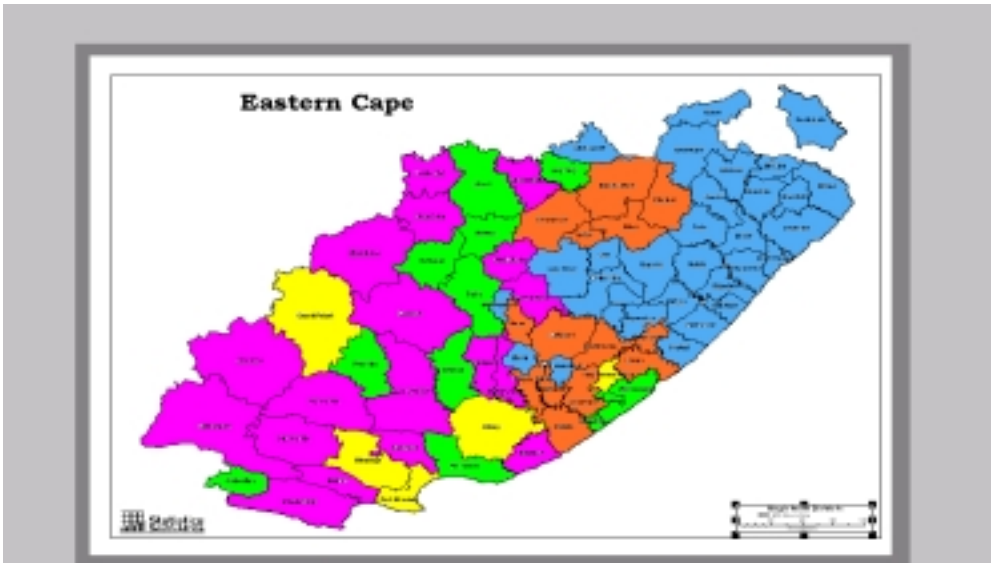
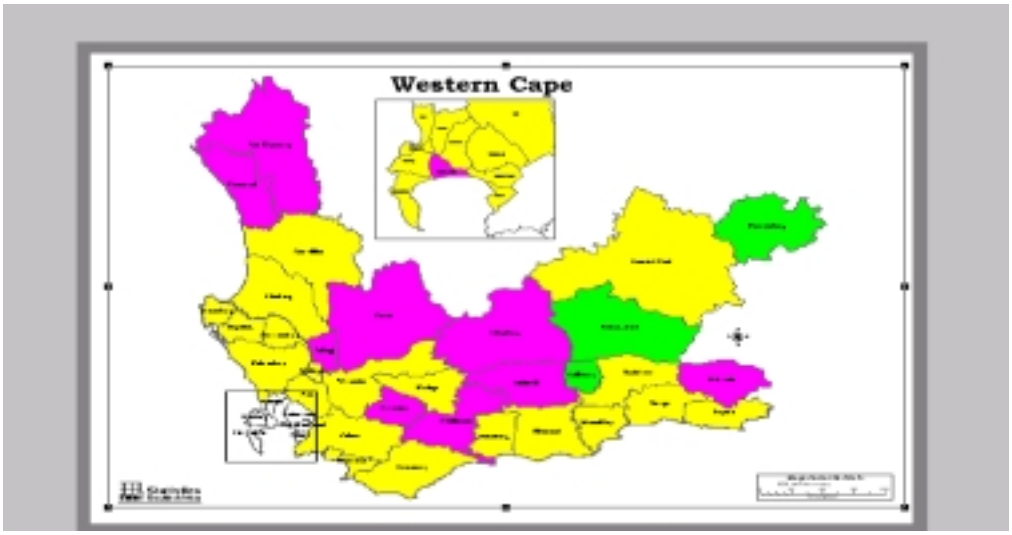


Figure 2 : General Index of Deprivation per magisterial district



However, it is not immediately obvious how these research findings could be translated into policy formulation and implementation. In an attempt to better understand how such research can influence policy-making and implementation in the South African context, three national commissions are examined.

The Carnegie Commission of Investigation on the Poor White Question in South Africa

The findings of the first major inquiry into poverty in South Africa were published in 1932 (Carnegie Commission, 1932). The inquiry stemmed from a visit by the president and secretary of the Carnegie Corporation to South Africa in 1927, after which the Dutch Reformed Church requested support for an investigation into the poor white problem. The Commission presented its findings in the form of six mini-reports, viz. Economic, Psychological, Educational, and Health reports, with two sub-sections in the Sociological Report, one on "The poor white and society", and the other on "The mother and daughter in the poor family". The Commission clearly understood the many dimensions of poverty and recognised the centrality of the links between health and poverty. A major thrust of the Commission was to establish the facts, and a considerable part of the report focuses on research into the extent of the problem. "Poor whites" were defined as: "persons of European descent who gained (or are still gaining) their livelihood chiefly by farming" and constituted a "class consisting principally of poor landless tenants ("bywoners"), hired men, owners of dwarf holdings or of small undivided shares (sic) of land, poor settlers, and the growing group of unskilled or poorly trained labourers and workers outside of farming." These were further sub-divided into two groups, viz. those who were largely rural, and those who had left the farms. Those on the farms were further sub-divided into 6 different categories, largely determined by geographic location, while those that had left the farms were sub-divided into four categories. Different methods were used to quantify the problem. A survey of schools (50% of all schools) was conducted and 17.5% of the scholars were classified as "very poor". The census of 1926 reflected that approximately 12% of all white male workers were employed in occupations that coincided with poverty. The Commission examined the causes of poverty and commented, "It must be admitted that a certain lack of industrious habits contributed to the process of impoverishment". It cites economic decline, poor farming methods, the changing economic environment following the discovery of gold and diamonds a few decades earlier, an inability to adjust to these changes, educational disadvantage and isolation as contributory causes to poverty.

Health and Poverty Research

Attempts were made to use archival information for research purposes but, because of the poor quality of record keeping, nutritional surveys of schoolchildren were conducted in specially selected poor areas. Fifty-nine schools were visited in two provinces and 1,749 children between the ages of 9 years and 15 years were examined. However, the research had major limitations. No adjustment was made for the light clothes worn by the scholars and a spring balance was used. No calibration was recorded, although the author noted the inevitable inaccuracies in measurement. Dietary histories were elicited for more than 63% of the children but no account was taken of problems of recall. The authors conclude (not surprisingly) that the incidence of phthisis, lupus, acute rheumatic fever and middle ear disease was more common among the poor than the well-to-do. Geographic variation was found in the proportion of children considered anthropometrically poorly nourished, and the author states that the poor nutritional status was largely caused by dental caries!

Rural families were found to have more children, poorer sanitation and poor quality housing. Poverty was also reflected in the mortality experience of 126 families. An infant mortality ratio (IMR) of 117/1,000 live births was found. No mention is made in the report about the representivity of these families. This was compared with the average IMR for whites at the time, viz. 70/1,000 live births. The table from the report illustrates South Africa's relative position vís a vís infant mortality in the world.

Country	***Year***	***Infant mortality /1000 live births***
New Zealand	1928	37
Australia	1927	54
England and Wales	1927	65
Union of South Africa	1928	70
United States of America	1926	73
Canada	1927	94
France	1926	97
Italy	1926	130

From the above it seems that the poor white IMR of 117/1,000 compared favourably with the overall rates in some countries of the North.

The Commission refuted the notion that climate was in any way responsible for the "poor white problem", which was advocated by some. However, spleen rates were measured in 20 schools in malarious areas and an average rate of 45.6% (range 13% to 93%) was found. However, the evidence suggested that malaria did not affect the nutritional status of the poor significantly.

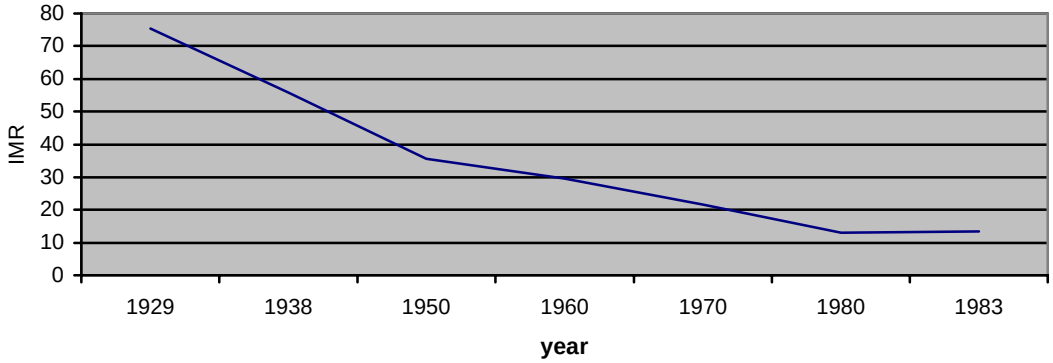
Recommendations

Some of the major recommendations of the Commission included:

- Better education through improvement of farm schools, compulsory education up to the age of fifteen years, the formation of local committees and the provision of social workers to improve the lot of poor rural whites.
- Health education of poor communities in malaria areas.
- A system of adult education, in addition to the establishment of a nursing organisation to perform medical and educational activities. These would be supported by local and central government with schools and churches playing a central role in mobilising the communities. (Note the direct reference to health care in these recommendations).
- Increased state support for housing for the poor.
- The protection of poor whites from competition for jobs from the "non-European". A strong recommendation was made to rehabilitate the rural poor white as "the poor economic position of the landless rural European" was regarded as the "crux of the problem". Urban industries were to receive the rural poor white more favourably, and job reservation, which was already practised at the time, was to be regarded as a transitional arrangement designed to enable them to be trained "to greater efficiency…".
- The creation of a state bureau of social welfare was recommended to give expression to these recommendations.

Most of the recommendations were implemented and remarkable socio-economic and health gains were made by the poor white population over a few decades, reflected in part

Figure 3: Decline in white infant mortality rate (/1000 live births)



Graph constructed from Table 1 in Rip MR, Bourne DE & Woods DL. Characteristics of infant mortality in the RSA 1929-1983. South African Medical Journal 73, 1988: 227-229

by the overall improvement in the white infant mortality rate (IMR) between 1929 and 1983 (Rip, Bourne & Woods, 1988).

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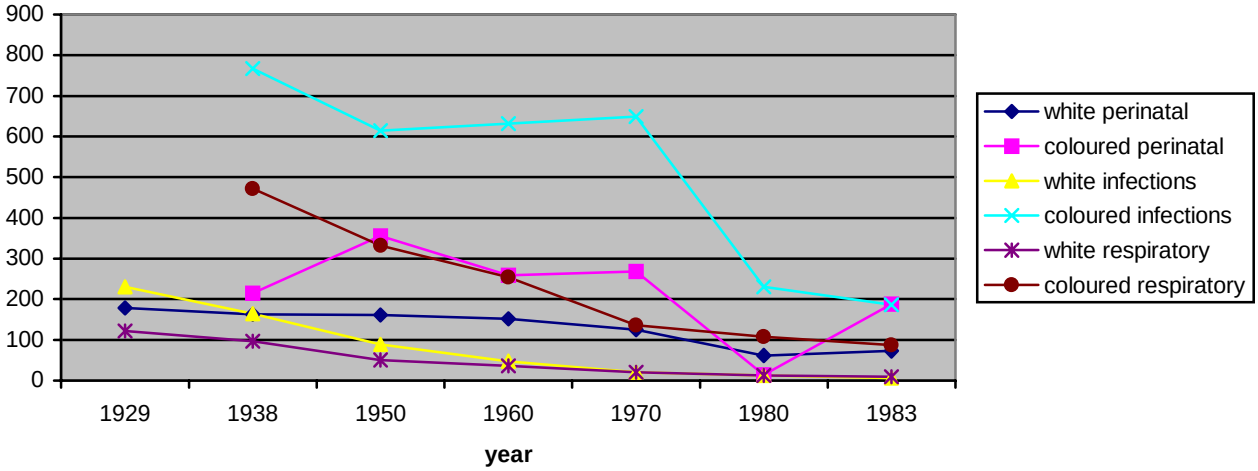
The graph (Figure 3) illustrates the dramatic decline in the white infant mortality rate between 1929 and 1950, two decades after the First Carnegie Report. The IMR for whites was about one quarter that of 'coloureds'[1] in the 1970s and 1980s. The IMR for Africans was not available but was generally higher than that of 'coloureds'. The same authors found that death in the first year of life due to infections fell dramatically in whites over this period but less so in coloureds. Coloured infants were 28 times more likely to die from infections than white infants between over the 54 years between 1929 and 1983 (Figure 4).

[1] 'Coloureds' are defined as people of mixed descent in the South African context. It is customary to use inverted commas to denote the arbitrary nature of the definition.

Figure 4: IMRs (/10,000 live births) for major causes of death



Graph constructed from table in Rip MR, Bourne DE & Woods DL. Characteristics of infant mortality in the RSA 1929-1983. Part II. Causes of death among white and coloured infants. South African Medical Journal 73, 1988: 230-232.

Why were the recommendations of the Commission implemented?

The Context

The first Carnegie Commission started its investigation a few decades after the establishment of the Union of South Africa, following years of bitter war. The state was comparatively weak. Farmers suffered from the effects of the Anglo-Boer War, which left farms devastated while the mining and subsidiary industries thrived. The concern of competition from the indigenous population, which had been excluded from government when the South Africa Act was promulgated in the British parliament in 1909, enabled much of the implementation of these recommendations. The Commission report is permeated by the notion of white superiority and the fear that the "inferior races" will weaken the "poor white" who had lost contact with his European roots. This should be seen in the context of the colonial subjugation of indigenous populations.

The political changes in Europe, marked by the rise of Fascism and Nazism, gave added impetus to a political system based on notions of racial superiority. The legalisation of this ideology through the system of *apartheid* led to the application of anti-poverty

measures, which accounts for dramatic health improvements in white South Africans over a few decades.

The Actors

The *apartheid* state was powerful, enjoyed the support of rich countries in the North for many decades, and as one of the world's largest producers of gold and diamonds, platinum and other minerals, could afford to implement many of the anti-poverty measures recommended by the Commission. The black majority, in contrast was largely landless, and was relegated to labour reserves occupying a small proportion (about 13%) of the land, and was not able to mount any significant opposition. The Dutch Reformed Church saw as its mission the upliftment of poor white people and was a powerful actor in implementing the recommendations of the Commission. Not only did the church initiate the investigation, it played a central role in the implementation of its recommendations. The church, furthermore, provided the theological justification for the system of *apartheid*. The role of the donor agency, the Carnegie Corporation, which not only provided financial support for the Commission's work, but also provided expertise from the USA and resources for the production of the report, was a significant one.

The National Health Services Commission (The Gluckman Commission) - - A health systems approach to poverty

Health, poverty and the Commission

The National Health Services Commission was in essence a health systems response to poverty which came at the end of the Second World War, when there was a general movement to rehabilitate the war-ravaged countries in Europe. The mood in the United Kingdom was reflected in the British colonies, and this mood was translated into health systems reform in both the United Kingdom and elsewhere in the Commonwealth. The world was looking for answers to poverty and ill health. In its introduction the report notes that the Industrial and Agricultural Requirements Commission attached "great importance to health in relation to labour efficiency, national productivity and national prosperity" (National health Services Commission, 1944). Insofar as this Commission expressly addressed the health needs of all the inhabitants of South Africa (including

whites and blacks[2]), it was very different from the first Carnegie Commission, to which it alluded in its report. The Commission was committed to democratising the organisation of health care and was a response to the contradictory suggestions for the re-organisation of the health care system prevalent at the time (Van Rensburg & Harrison, 1995). The Commission was very mindful of the inter-relationship between health and poverty and a great deal of emphasis is placed on this relationship in Chapter VI of Commission's report. The Commission noted that the grinding poverty of the majority population stood out in the a survey which was conducted in many parts of the country. It goes on to state that "poverty places even elementary environmental health services beyond the reach" of many, denies many access to health care resources, and prevents many inhabitants from acquiring adequate nutrition. The Commission recognised the need to address poverty through the mobilisation of other sectors in government, discusses its effects on environmental health and refers to both the poverty of the inhabitants and the municipalities, which led to inadequate housing, water supplies and sanitation. The Commission thus anticipated the multi-sectoral coordination advocated so eloquently at Alma Ata in 1978. Furthermore, the Commission cites social surveys which showed that even low-cost diets were unaffordable to large sections of South African society. The Commission ascribes, at least in part, the outbreaks of typhus to the unaffordability of soap, clothing and blankets to large sections of the population. The poverty of the citizens is cited as a barrier to health care generally, and the Commission excluded the possibility of a national health insurance system because of the widespread poverty of South Africans. The Commission stated that "if the best results are to be obtained from such a national health service, its establishment must be accompanied by a rapid development of educational and other social services, and of agricultural and industrial expansion throughout the land." Thus the linkages between health and poverty were established as a central theme throughout the report of the Commission. But more than that, the Commission advocates a central role for the National Health Service in the alleviation of poverty and the socio-economic development of the country.

[2] The Commission refers to black South Africans as 'non-Europeans'.

Evidence was gathered from government officials, local authorities, members of provincial governments, hospital boards, food control boards, representatives of voluntary organisations, spokespersons from industry, commerce, the professions, experts from the universities, traditional leaders, medical missionaries, and other individuals. Written memoranda were collected from many of those who provided oral evidence. The Commission addressed questionnaires to local authorities, general hospitals, mission hospitals, and health professionals, in the process establishing an archive of "economic, physical and mental factors in connection with the nation's human resources."

The Policy Content

The Commission recommended a restructuring of the health system such that the curative bias was replaced by a holistic approach to health. It recommended the establishment of a National Health Service to cater for the needs of all the citizens of South Africa, with health centres as its building blocks. Each person would have access to health care according to need. Extensive use was made of research, such as nutrition surveys carried out by academic institutions, in support of its recommendations, central to which was the role of the state. The first health centre was established by Drs Sidney and Emily Kark in 1940 and the number increased to 40 by 1948 (Harrison, 1993). The Health Centre soon became the location of development initiatives, as the link between health and poverty became more and more apparent. However, the establishment of the National Health Service did not materialise, despite the fact that its recommendations were consonant with popular professional sentiment at the time.

Why did the health centre movement fail?

The Context

The Gluckman Commission was established shortly after the horror of World War II. Nations were searching for ways and means of preventing a recurrence of the barbarity witnessed in Europe and elsewhere. It was a time when the social conscience of the world had been stirred and the world was swept by social democratic reorganisation of nations. This was a time when the nations of the world examined their social systems, and as mentioned above, the remarkable similarity between the Gluckman Commission

report and the Bhore and Beveridge reports in the United Kingdom and India respectively, reflects this global movement. However, the ideologies of Nazism and Fascism, even though defeated in the war, had its adherents. Given the horrendous experience of the Afrikaner community at the hands of British during and after the Anglo-Boer wars, it was not surprising that there was considerable support for Germany in certain sections of South African society. This support was expressed in the coming to power of the pro-Nazi Nationalist Party in 1948.

The Players

The Smuts government was not committed to the central thesis of the National Health Services Commission, viz. to provide an organised (unitary) national health service for all sections of the of the population. It implied that the power of the 4 provinces, which had until 1909 been independent sovereign states, would be diluted by a national re-organisation of health services. When the Nationalist Party came to power it instituted the system of *apartheid*. The power of the *apartheid* state and the aggressive implementation of the affirmative action for poor whites, recommended in the First Carnegie Commission Report, led to extreme inequality in health and health care between white and black South Africans. The conflict between the vision of the National Health Service Commission and the government eventually led to the closure of the health centres.

The Obstacles

A further obstacle to the implementation of the findings of the Gluckman Commission was the fear of private family practitioners that the health centres would attract their patients and jeopardise their incomes. This perception led to vigorous opposition to the recommendations of the Commission by the Medical Association of South Africa, which represented mainly private practitioners (Harrison, 1993). The progressive nature of the recommendations became an obstacle when it was felt to be too 'socialist', and came at a time when the rise of socialism in Europe, China and elsewhere was perceived as a threat. The programmes that were recommended, therefore, did not receive the political support necessary to ensure their implementation.

The power of the political forces in society and its influence on the formulation of policies that are related to health (and poverty) are amply demonstrated by this experience. It does, however, also highlight the importance of support from actors such as the health professionals in facilitating the implementation of research/policy recommendations.

The Second Carnegie Inquiry into Poverty and Development

The second Carnegie Inquiry into Poverty and Development in Southern Africa followed almost 50 years after the first one. The idea of another major study was suggested from time to time, including in the mid-1930s by one of the first Carnegie commissioners and in the later 1940s by the historian C. W. de Kiewiet. However, the idea lay dormant until the beginning of 1980 when it was decided to begin work on a second major inquiry into poverty and development. Unlike the first Carnegie Inquiry, this was to include *all* South Africans, black and white, and as most poverty occurred amongst black South Africans, the "centre of gravity of the Inquiry had to be black rather than white". In January 1980, a feasibility study was commissioned, which was followed by two years of preparatory work and consultation with various stakeholders. The Inquiry was not publicly launched until more than two years after work on it first began. Then followed another two years of active research, before all those working on the subject were drawn together in a conference held at the University of Cape Town in April 1984. Over 300 papers were delivered and about 450 people participated. A series of post conference workshops and papers were initiated, and the book by Wilson and Ramphele[3] provides an overview of the nature and causes of poverty in South Africa, and draws together the main ideas for action that emerged during the course of the Inquiry.

The tone of the report is captured in its opening statement: "Poverty is a profoundly political issue". It then proceeds to focus on the various faces of poverty (hunger, illness, unemployment, widespread inequalities, the lack of adequate fuel), a wide range of causes and an array of strategies for integrated development. The Commission makes

clear references to the linkages between poverty and health, and using malnutrition as an example, relates poor health to poverty and economic inefficiency to poor health. Mindful of the complex web of forces that propel people into the poverty trap, the Commission mounts four cogent arguments for addressing the issue of poverty, viz. the damage inflicted upon individuals who must endure it; the economic inefficiency of poverty manifested by the impairment of learning in hungry children, the lack of productivity of malnourished workers, the reduced demand for goods and services of the poor, which does not encourage the production and marketing of goods that are most needed; the consequences for any society where poverty is also the manifestation of great inequality; and finally, the fact that poverty is itself the symptom of a process that simultaneously produces wealth for some, while impoverishing others.

Southern Africa's poverty had its roots in the development of the single economy in the region, particularly during the preceding one hundred years of industrial revolution. The fifty years of *apartheid* further entrenched inequality the produced by the 'land acts'[4] and the migrant labour system. The *apartheid* state's attack on the poor took the form of a shift in policy from incorporation to dispossession, anti-black urbanisation, forced removals, both urban and rural, Bantu education, crushing of popular organisations and destabilisation. All of these were compounded by the macro-economic changes occurring globally.

Vulnerability

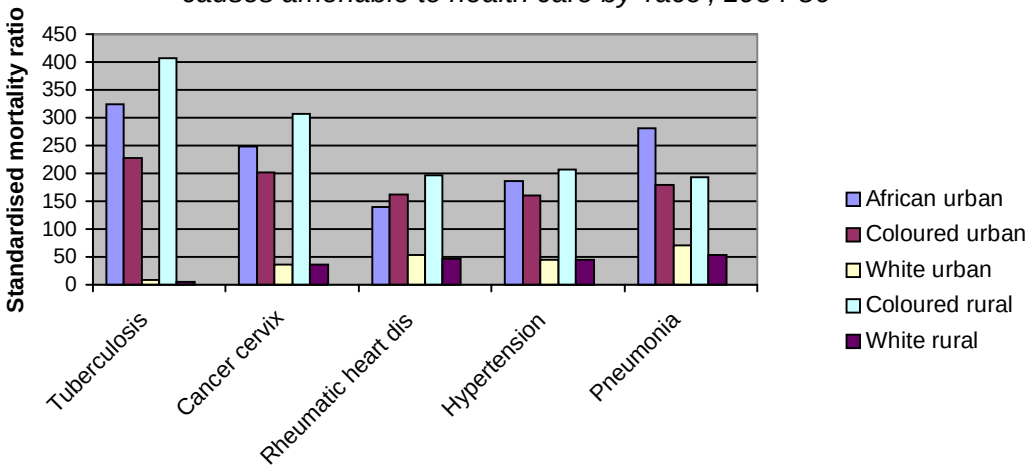
Vulnerability is marked by the risk of destitution, starvation and death. The Commission identified four groups that were vulnerable to poverty in Southern Africa, viz. children, women, the elderly, and adults who are disabled or weak in some way.

The unequal child mortality rates in the different groups and the potential reductions in mortality with relatively low cost interventions were discussed by the Commission. The poor nutritional status, wasting and deprivation of black children were noted. The plight

[3] See Wilson F, Ramphele M. *Uprooting poverty: The South African Challenge*. Cape Town, David Philip, 1989. This book also constitutes the report for the Second Carnegie Inquiry into poverty and Development in Southern Africa.

of rural women, in particular, was stressed by the Commission, and special reference was made to the impact of unequal gender and power relations on the feminisation of poverty. The vulnerability of elderly people approaching pensionable age was of concern to the Commission. The synergistic effect of poverty and disability was noted, and a multi-faceted strategy for poverty reduction was advocated. However, the Commission observed that the redistribution of political power was essential for uprooting poverty in South Africa. The chart below (Figure 5) illustrates the inequality in mortality from diseases amenable to health care between urban and rural populations as well as different 'race' groups in South Africa between 1984 and 1986. It confirms the urban-rural and white-black inequalities in health care prevalent in the country at the time of the Commission.

Figure 5: Urban vs Rural Standardised Mortality Ratios for selected causes amenable to health care by 'race', 1984-86



Data from Sayed AR, Pick WM, Bourne DE, Bradshaw D (Unpublished).

Key strategies proposed by the Commission included:

- Halting the systematic assault by the state on the poor, some of the major components of which included structural discrimination in the form of forced removals, anti-urbanisation policies, land laws, colour bars.
- Addressing infrastructural needs e.g. water and sanitation, energy, an improved rural transport networks, soil conservation, land reform, housing.

[4] These were laws which prohibited Africans from owning land outside the reserves, which comprised a mere 13% of the total land surface area in South Africa.

- The democratic reconstruction of health, education and welfare.
- Adopting an integrated approach, that could ensure clean drinking water, sufficient food and adequate living conditions simultaneously.

The Commission made a number of recommendations on health. It pleads for greater equity in the allocation of resources e.g., greater equity between white and black, between urban and rural, between curative and preventive medicine, and between social services and defence. It recommends that the training of health workers, in particular medical education, be revisited. It also makes reference to a three to five year spell of service in a rural area after qualification for health professionals. It also recommends the establishment of a national health service - - and makes reference to the Gluckman Commission in this regard - - in order to overcome the problems associated with fourteen health ministries, which obtained under *apartheid* at the time. Other key recommendations include a food stamp programme to counter malnutrition, the provision of welfare pensions, unemployment insurance, workmen's compensation, and a variety of other transfer payments such as maternity benefits and disability grants to the poor.

Extent to which key recommendations were implemented

The Context

The Second Carnegie Inquiry into Poverty occurred at a time of great political ferment. The popular resistance to *apartheid* culminated in street battles between security forces and citizens, mobilisation of workers, and the re-emergence of the liberation movements that had been banished two decades earlier. The authors of the Commission Report characterise the state of South Africa as "pre-revolutionary". It is in this context that the contribution of the Commission to the shaping of the new South Africa must be seen. It was just about 5 years after the inception of the Commission that the *apartheid* government capitulated. The contribution of the ideas generated through the Second Carnegie Inquiry to the reconstruction of South African society, is thus not surprising.

The context within which these recommendations were formulated changed in the early 1990s. The Commission's key recommendation was met with the first democratic

elections in 1994. The Reconstruction and Development Programme (RDP) (African National Congress, 1994), which became the blueprint for social development in South Africa, drew extensively on the work of the Commission. It presents an integrated, coherent, socio-economic framework for reconstruction and development based on certain key principles:

- Integrated and sustainable programmes
- A people-driven process
- Peace and security for all
- Nation building
- Linking reconstruction and development
- Contributing to the democratisation of the state.

The RDP also identifies the link between health and social development and proposes:

- A national health system, which will draw together different role players and services.
- A focus on women and children in the form of free health care for children under 6, improving maternal and childcare, reproductive rights.
- Attention to mental and psychological health
- Particular attention to sexual health and Acquired Immunodeficiency Syndrome (AIDS) epidemic
- The development of human resources for the National Health Service (NHS)
- The provision of finances and drugs for the NHS.

What has been done and who were the players?

One of the reasons why the Second Carnegie inquiry into Poverty had such a direct effect on the programmes of the liberation organisations was the fact that many of the participants in the Inquiry were themselves politically active. Furthermore, the Commission was at great pains to canvass the opinions of the poor themselves, and painstakingly sought the views of the poor over many years. Poor people themselves thus became major players in the Inquiry. Concurrently, the 1980s saw the emergence of a number of progressive health worker organisations, some aligned with the liberation

organisations. These organisations were preoccupied with a critique of the South African health care system and propounded a primary health care oriented national health system, such as is evolving in South Africa at present.

It is therefore not surprising that, as these activists entered government after 1994, almost all of these proposals were enshrined in government white papers and Acts of parliament. Since 1994 South Africa has gone through two distinct development phases. The RDP was the basis for many of the initial changes. The unification of the bantustans and common area of South Africa has reduced the fragmentation, which marked the previous era. However, the creation of nine new provinces with substantial executive powers, poses new challenges to the establishment of equitable, effective local government, and the development of a district health system. A provincial resource allocation formula, based on population size and degree of deprivation, has been used to reduce the financial inequality across provinces, and spending on primary care has been increased. The public sector health care budget increased by 30% in FY 1996/97, most of the increase directed at the provision of primary care. A vigorous clinic building and upgrading programme was further evidence of the commitment to improving the access of the poor to health services. Concurrently, more than a million South Africans (an estimated 20% of those in need) were provided with safe potable water and by the end of 1994, 8.4 million houses, i.e. 44% of all houses in South Africa, were electrified. The number of connections per annum has undergone a ten-fold increase from 30,000 in 1991 to 300,000 in 1995 (Mokaba and Bambo, 1996). Since 1997, a slower than anticipated economic growth rate prompted government to adopt a macro-economic strategy for growth, employment and redistribution (GEAR). While this strategy has as its aim the creation of a labour-absorbing economy, re-prioritisation of the budget has been conflated with across-the-board budget cuts, with a decline in per capita spending on health.

Compulsory community service for doctors, which was recommended by the Commission, has been introduced, thus providing health care for under-served, mainly rural, populations. The role of the Junior Doctors Association was crucial in gaining acceptance by new graduates. Policies to acquire cheaper drugs for the poor are being

challenged by the multi-national pharmaceutical industry on the basis of the protection of intellectual property rights, and the power of this group of actors has delayed the process. A major determinant of the implementation of the findings of the Second Carnegie Commission of Inquiry was the political commitment of the new democratic government to providing "a better life for all". An important player in the process has been the civil service, which has a mix of ‘old guard’, and 'new guard' elements with problems of obstruction, lack of experience and division hampering the implementation of many policy decisions (Human & Strachan, 1996). It would not be unfair to say that the one critical factor that determined the implementation of the recommendations of the Second Carnegie Inquiry into Poverty was timing. The authors of the report did not, and could not, anticipate the rapid political change that occurred within one year of the publication of the report. The report appeared in 1989 and in February 1990 De Klerk, the then President of South Africa unbanned the liberation organisations. We will never know whether the recommendations would have been implemented had the political changes taken place a few decades later.

Conclusions

Lessons learned

What lessons can be learnt from the South African case study?

From the evidence, it would appear that the quality of the research underpinning anti-poverty strategies is not of as great consequence as might be thought, which reinforces Walt & Gilson's argument that the content of policy is sometimes less important than the context, the actors and the process. Policy-making is not only about politics. The role of donor agencies, professional associations and the church proved crucial in the South African case study. These actors play a key role in translating policy into practice.

The case study demonstrates that the fortuitous co-existence of the right actors, in the right context, at the right time, has an influence on the process of implementing research findings.

The Second Carnegie Inquiry demonstrates the importance of civil society organisations in preparing the way for policy implementation. The measures taken by the new South African government were shaped by the activities of political as well as academic

activists who debated issues of poverty relief long before political change occurred. This experience confirms the importance of influencing civic opinion by making the results of research available and popularising them, if they are to influence policy making and implementation. Insinuating research findings into popular debate as a means of enhancing the likelihood of their being implemented requires skill. It is not a skill that researchers usually have. It is, however, a skill that can be acquired. Researchers need to be trained in the techniques of lobbying politicians, civil society and non government organisations. One of the skills that are required is an ability to 'read' the situation. A thorough and insightful understanding of the context and the process of policy making is thus valuable.

As has often been stated, the relationship between research, policy-making and implementation is not linear. Successful translation from research into policy and implementation is often a function of the confluence of events. The 2 successful examples, viz. Carnegie 1 and Carnegie 2, reflect a lag phase before implementation. It is thus important to understand the reasons for the delay in implementation. These reasons were quite different in the two examples, but both were a function of the coming to power of a new government, and in both cases, there was a strong ideological basis for implementing the research results. This is particularly important in poverty research, where the terrain is not infrequently contested by parties of differing ideological persuasion. While this may be seen as an impediment to implementation, it can strengthen the contribution of research. Incontrovertible, 'ideologically neutral'[5] evidence may find resonance even with opposing parties.

It is clear that besides the effect of political change, other factors contribute to the implementation or otherwise of research findings. The relative power of the actors is a major determinant of policy making and implementation based on research. Power relates to not only the capacity to implement, but also the ability to conduct the requisite

[5] Some will argue that no evidence is 'ideologically neutral'. However, if research can demonstrate that certain health interventions will alleviate poverty, and that certain health gains are to be made through poverty alleviating strategies, it will be more difficult to defend an ideological position which runs contrary to such findings.

research in the first place. In all 3 commissions, the resources required for research were made available by the party with a vested interest in the findings. But resources are more likely to be made available if the issue is of interest to those with the power to provide the resources. It seems therefore, that one way of ensuring that research findings are taken to the stage of implementation is to identify which areas of policy making are of interest to those with power. Alternatively, getting the support of those with power by 'selling' the issues to them - - the policy entrepreneur - - improves the likelihood that research findings will be utilised. It is thus important to insinuate research findings into the deliberations of the different decision making fora such that both policy and implementation are influenced by research.

And finally, the complexity of poverty and health requires a multi-disciplinary approach to research. The development of a common terminology and a shared understanding, derived from the different disciplines, disciplinary codes and disciplinary languages remain major challenges. Which disciplines address which issues better and in what combination? These are difficult questions that will confront researchers for many years, but need careful consideration. Not enough attention has been paid to the identification of the disciplines required, nor is enough attention paid to the relationships between these disciplines, for considering the complex questions in health and poverty research. It is hoped that these matters will receive the attention of researchers, policy makers and implementors over time

The Emerging Research Agenda

It is clear that a partnership between poor countries and rich countries is required in order to set the agenda for poverty and health research. However, an exciting agenda for research into health and poverty is already emerging globally. Health and social inequalities is emerging as an important area for ongoing research, while the search for indisputable evidence of the economic benefits of poverty reduction is an area that has enjoyed the increasing attention of economists recently. Research into the mechanisms through which health improvement reduces poverty is critical.

Health systems responsive to poverty and the need to reduce inequality, need to be developed, while more participatory research with the poor and near poor should be conducted in order to better understand the process of poverty. A greater understanding of how to make health systems more responsive, how to measure their responsiveness and how this relates to the reduction of poverty needs to be sought. The value of social capital, methods of measuring social capital and quantifying the benefits of social capital is emerging as a potentially fruitful area of research. Our understanding of these complex societal phenomena needs to be deepened. In order to study and demonstrate the relationship between health improvement and poverty, best practice sites should be developed and studied.

At the same time ongoing research should be conducted into the major emerging health threats to the poor, e.g. AIDS, tobacco, violence, in addition to the traditional problems of communicable diseases.

It is clear that health research has the potential to influence the anti-poverty agenda. However, the implementation of research results is dependent on the willingness of the non-poor to listen. Health research will only influence poverty reduction if it can persuade those with power that it is the interest of all that poverty be reduced through health interventions. Understanding how this should be done is intrinsic to any agenda for research into health and poverty, and this paper marks an attempt to improve such understanding.

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