RuReSA

Rural Rehab South Africa

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Worst inequities: a human rights catastrophe

- People with disabilities should be prioritized for services, particularly in quintiles 1 and 2
- Rural and low resource settings have the worst inequities in service coverage, access to assistive devices and health outcomes at present and should be prioritized
- Service design affects access, utilization, retention in care and health outcomes
- Service design affected by contracting and payment approaches as well as meaningful integration of D&R across program planning and implementation and the inclusion of PwD as end users in planning and implementation
- Inter-sectoral collaboration is poor and we will never achieve good health outcomes without a holistic approach. CBR is an appropriate strategy for this at grass roots- currently ‘on the margins’ of NHI considerations
- Supportive of Transitional Approach suggested in earlier slides
- Gatekeeping: urgent need to increase quality, availability and accessibility of care at PHC level!
- Undocumented migrants and stateless persons should have access to comprehensive services based on a needs analysis. Savings gained through efficiencies and governance should be able to cover this vulnerable group.

Stop the lip service!

Disability consistently touted as a vulnerable group, yet:

- Where is your data on disability in relation to health service coverage & utilisation?
- Where is your data on disability in relation to disability & rehabilitation service coverage & utilisation?
- Where is your “disability” programme?
- Where is your budget for disability services?
- Where is your CBR strategy as outline in the National rehab Policy 2000?
- Is your disability & rehabilitation service really accessible?

Why invest in Disability and Rehabilitation?

Return on investment estimated at 1:9!

- Gains in health, for the community and the economy
- Access to AT can make the difference between failure or success in school, between a job or unemployment, between a life of opportunity or a life of dependency

BUT

- Access to AT is broader than merely issuing a device- includes WHO's 8 steps to service delivery, skilled, accessible and comprehensive rehabilitation and disability workforce
- Supply chain and procurement challenges
- Health systems strengthening, addressing causes of inequities in financing, service design and delivery

The case for investing in Assistive Technology, AT Scale 2020

Available at https://atscale2030.org/investment-case

Key issues

- Recognising PwD as a priority group
- How do we provide rehab when Hospital discharge rates are so high and poverty prevents access to rehab?
- Service design must address underlying causes of inequities and barriers to uptake and retention in care
- Rehab standards to be established: MDT, equipment & consumables, and service package
- Coordinating care across platforms and professionals

Rural/LRS specific concerns:

- PHC services require longer term commitments- significant health strengthening and community engagement required
- What is the specific plan for institutions/practices not meeting accreditation standards in LRS: incentives? Timeframes?
- What is the specific plan around CPUs not meeting the full health benefits package? Transport to neighboring sub-district not acceptable for moderate and severe disabilities. Turnaround time for compliance? Interim?
- D&R planning and service implementation needs to be at sub-district level for coverage and quality
- MLRW: a critical component for coverage, quality and acceptability. Urgent and immediate progress needed
- Consider CSO retention in LRS as an initial start towards addressing coverage concerns. Therapists do want to stay, but no current options to stay.

Contracting:

- **Unbundling and funding of key PHC services** that require significant health systems approaches, require specific skills not often available in general practice, or require significant inter-sectoral and community engagement. These unbundled services should still intersect and collaborate closely with general rehabilitation services provided within institutions and clinics.
- **Piloting of different aspects** of D&R services in different settings is required before final decisions are made.
- **Health care provider/establishment contracts** must have specific requirements around the need to budget and provide for D&R services
- **Data requirements** to do needs assessments and design and manage contracting
- **Integration of MLRWs** into contracting?

Contracting

Possible uses:

- Building MDT within the facility: “making up the numbers” (outpatients, inpatients)
- Contracting private to cover services difficult to access in rural areas in the short and medium term (eg acute care neurological rehabilitation: facilities)
- Contracting in urban areas to allow shift of DoH workers to under resourced areas
- Contracting to free up “DoH rural/PHC experts” to do PHC/CBR instead of “hospital based service”
- Contracting local NGOs/NPOs/DPOs to cover services needed but not provided e.g peer supporters
- Contracting post-community service therapists towards building capacity of rural and LRS workforce
- Unbundling specific services
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