Joint submission by the professional associations for Occupational Therapy (OTASA), Physiotherapy (SASP®), Speech Language and Hearing (SASLHA) and Rural Rehab SA (RuReSA) to the Minister of Health, Dr Aaron Motsoaledi

18 July 2017

Dear Dr Motsoaledi,

The Professional Associations, and RuReSA, are writing to you out of concern for the persistent lack of recognition of the needs of people with disabilities in the key national norms and standards, and service packages. These documents impact on health planning, budgeting, service design, staffing norms and organograms; and therefore the implementation of public health services using these documents results in the lack of inclusion of key services for people with disabilities as outlined below:

At PHC level

Documents where rehabilitation services are mentioned include:

- The National Health Insurance for South Africa 2015 Version 40, recognises rehabilitation, and speech and hearing services specifically, as part of the comprehensive package of care; and identifies that these services may be contracted out to private practitioners.
- The Ideal Clinic Manual 2016 states that people will have access to/referral to physiotherapy, occupational therapy and speech and hearing therapy and these are listed on the Dashboard.
- The Implementation Guideline of Health Workforce Normative Guides and Standards for Fixed PHC Facilities 2015-2019 also identifies that therapists will visit clinics.

Our concern, however, is that not all people with disabilities are recognised or identified as needing rehabilitation services in the following PHC documents (for example cerebral palsy is not even mentioned):

- The Primary Health Care Package for South Africa – a set of norms and standards 2000
- Standard treatment guidelines and essential medicines list for South Africa: Primary Health Care Level 2014 edition
- Primary Care 101 Guideline 2013/14
- Adult Primary Care (APC) Guide 2016/2017

This results in an ineffective referral system and an unhealthy life for many with disabilities.

At Hospital Level

The same concerns raised above occur at hospital level as well, and can be seen in the following documents:

- A District Hospital service package for South Africa 2002
- Standard treatment guidelines and essential medicines list for South Africa:
    - Hospital level adults 2015 edition

- Hospital level paediatrics 2013 edition – it is recognised that this document has the best information, so far, on rehabilitation.

It is evident that the level and extent of consultation with key Disability and Rehabilitation (D&R) experts in drawing up these documents remains very low, as these guiding health documents are ***focused largely on doctors and nurses within a curative care approach.*** Rehabilitation professions should be seen as essential members of the comprehensive package of care, but there is little evidence that the input given by D&R experts during public/professional commentary periods is incorporated into the documents. The omission of rehabilitation (in its' simplest form of "refer to rehabilitation professional") significantly impacts the patient's ability to access multi-disciplinary services. Medical and nursing staff are unlikely to refer all patients needing rehabilitation, due to a lack of knowledge and exposure to these professions at undergraduate level as well as their omission in the key guidelines and service packages.

Consequently there is a discrepancy between the vision of the recently adopted and signed Framework and Strategy for Disability and Rehabilitation (FSDR) and the existing documents mentioned above. The FSDR, together with South Africa ratifying the UN Convention on the Rights of People with Disabilities (UNCRPD), should result in improving the access of people with disabilities to general health care services (Article 25), and specifically to rehabilitation services and assistive devices (Article 26). *This can only happen if the doctors, nurses, and other health workers recognise the need for rehabilitation and refer appropriately.* The FSDR specifically outlines the need for integration of disability and rehabilitation services into all health programmes and services.

Furthermore the introduction of rehabilitation professionals at district hospital and PHC level is largely a recent occurrence and staff retention (therapists and doctors) within the public health sector is poor; thus we are faced with an endless cycle of educating health staff about the needs of people with disabilities and rehabilitation services.

IMPACT ON NON-REFERRAL TO REHABILITATION SERVICES

An estimated 7% of all South Africans have a disability (StatsSA). The number is expected to rise, as gains are made in reducing mortality (including HIV and neonatal deaths) and improving life expectancy; and the sharp rise in non-communicable diseases. People with disabilities, in addition to standard health care needs, also have specific health care needs that can only be addressed by therapists and mid-level rehabilitation workers (including peer supporters). They also have specific challenges relating to accessibility, which require an innovative approach to health service design and delivery.

The omission of disability and rehabilitation in these key documents impacts on:

1. Referrals and workload of rehabilitation professionals
2. Visibility of rehabilitation professions, and thus perceived need
3. Rehabilitation staffing levels, including professional, midlevel and support staff
4. Infrastructure and planning for ideal clinics and hospitals
5. Budget and resources for disability and rehabilitation services
6. Service design for improved access and equity in health by people with disabilities

7. Optimal outcomes for people with disabilities, their potential to impact positively in the economy and participate fully in the spheres of education, work, income generation and social interaction, and attain their right to *a long and healthy life*

Rehabilitation professionals also play a significant role in preventing disability (thus cost to state and community), promoting health, reducing bed-stay and readmissions and providing specific rehabilitation interventions to improve quality of life as well as community and socioeconomic participation. Good rehabilitation should ease the financial burden of the Department of Social Development as fewer people will require lifelong disability grants.

MONITORING AND EVALUATION

The current lack of sufficient monitoring and evaluation tools for rehabilitation services contributes to the current situation, e.g.

1. A single indicator at PHC level exists: the provision of assistive devices (wheelchair, walkers or hearing aids).

2. National Indicator Data Set (NIDS) 2017 -2019 gives the indicators as “waiting list for assistive devices” and “provision of assistive devices”.

It should be noted that many people requiring rehabilitation do not require assistive devices, for example people with mental health or respiratory problems; and as issuing of such devices is also dependent on rehabilitation personnel and the rehabilitation budget this is ***not an adequate indicator*** of rehabilitation needs.

UNDER-GRADUATE TRAINING

Finally we are concerned that under-graduate training of health care professionals in South Africa still follows a medical model approach, teaches in “silos”, and places student learning in urban hospitals or tertiary level of care. Graduates, therefore, have little experience or understanding of:

- District hospitals, especially those in rural areas
- Chronic illness and the impact it has on patient, families, and the health services,
- Multi-disciplinary team work

This means they are unprepared for the needs of people with disabilities and unlikely to be part of an efficient and effective referral system at all levels of the public health system.

We would therefore like to request the following:

1. Clarity on the coordination and processes which are followed in drawing up all key clinical and health care planning documents as comments made by the rehabilitation sector seldom seem to be included. *We recommend that specific inclusion of key disability and rehabilitation experts at this level is required.*

2. The review timelines in terms of which documents will be reviewed and when; and guidance on how rehabilitation and disability can be specifically included in this review process. Often documents are circulated in December for comment (a high staff turnover time and holiday time), or circulated with only a few days’ notice before deadlines.

3. The strategies that will be implemented in the meantime to prevent the current omission of Disability and Rehabilitation in the policy documents from impacting negatively on the resourcing and functioning of these services and the impact this would have on persons with disabilities.

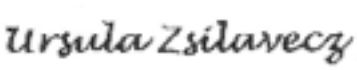
4. An urgent meeting with the Minister to discuss the way forward, especially to discuss the implementation of FSDR.

Thank you for the opportunity to make you aware of our concerns. As disability and rehabilitation professionals and as South Africans, we stand with the Ministry of Health in its commitment to the rights of persons with disabilities in our country as embodied in the UNCRPD. We look forward to discussing the above concerns with you in person, and to working together towards "a long and healthy life for ALL South Africans".

Signed:

Dr Ina Diener

President of the SASP



Ursula Zsilavecz

Chair SASLHA

Maryke Bezuidenhout

Chair RuReSA