Rural Health Advocacy Project Press Statement

MTBPS 2016: The Rural Health Advocacy Project warns against further health service cuts to those most in need following continued fiscal consolidation

27 October 2016

Following the Medium Term Budget Policy Statement (MTBPS) by Minister of Finance, Pravin Gordhan, on 26 October 2016, we reflect in this statement on the implications for delivery of health services to most deprived rural communities. As the Minister noted, a "distressed economy", the threat of credit ratings downgrades, and the increasing cost of national debt means that the government will continue to consolidate government expenditure.

In this context it is even more critical that we set the right priorities overall in society and within health specifically. Government spending is a priority-setting process and hence the manner in which we treat the most vulnerable amongst us at times of crisis says a lot about our values and moral compass. It is our view therefore that not only do we have wasteful expenditure in other areas of government which should go towards the continued care for those dependent on the public health system; we should also use our available resources to greatest impact.

Over the last few years we have seen how cost-cutting measures and the deepening of austerity is having severe and long-term consequences for the users of public health services and the health system overall. This includes, for instance, plans announced early 2016 to reduce the number of midwives with over 50% from a rural hospital serving remote, impoverished communities who have no other access to services. While this may lead to direct cost-savings on the short term, it will cause enormous avoidable human suffering, not to speak of further increases to the billions of Rands in annual medico-legal claims in South Africa. While this specific decision has since been reviewed, due to sustained advocacy by various players, this example illustrates the sometimes irrational decisions made in a context of budget constraints at the expense of people's lives and fragile health systems in our country.

In yesterday's MTBPS, the minister introduced a number of structural measures to manage government expenditure which are cause for further concern and that need close monitoring:

Provincial equitable share (ES) allocations will be adjusted downward by R500 million.
The ES is used to determine the proportion of national funds allocated to each province. Each province in turn decides how to allocate its portion across its provincial departments. Within each department, including health, decisions are made where to allocate fund and where to cut costs. It is thus critical that provinces in their decision-making on budget adjustments ensure that such processes do not affect the most vulnerable communities.

Adjustments to the Equitable Share Formula (ESF)
These adjustments are based on revised mid-year population estimates published by Statistics South Africa. Rural provinces that have experienced out migration or whose populations have grown at a slower pace will therefore receive proportionally less of the equitable share than in the past. The problem is that downward adjustments based solely on this capitation method fail to account for the fact that rural provinces have historically been underfunded, that the inequities are greater in the most rural provinces in which former homelands are located, and that the costs of providing services in rural settings is generally higher than urban ones.

The RHAP has for a number of years called for a rural adjuster to be included in the ESF to counteract the impact of the population component of the formula and to account for higher costs. While we have been ensured that this rural adjuster will be included in the ESF, this is now long overdue and should be implemented as a matter of urgency.

Impact austerity measures on health care for vulnerable groups

We have seen over the past years how irrational and inequitable cost-saving decisions lead to a cessation of services and deterioration in access to care to those who need it the most. This disproportionally affects impoverished communities who cannot afford private health care; rural communities who travel far to reach the one single clinic or hospital in the area; groups with special needs such as mental heath care users and children with disabilities in the remote parts of our country. Anyone denying the effects of austerity measures must note that:

- In various parts of the country health care worker posts continue to be frozen for periods of time, and vacant posts are not filled
- Outreach services to rural people with disabilities have already been discontinued; leaving people who cannot access health facilities to fend for their own
- New health facility organograms are being developed in a climate of austerity which risk further cuts to small and fragile rural teams

In last year's MTBPS, and then again in the tabling of the budget in February, the Minister of Finance did make important provision for the protection of frontline posts—including nurses and doctors—in the curtailment of budgets for government employees. The trouble, however, was that no clear guidance was given as to how this should be done, as the need for access to health care workers is still greater than available funds to fill all critical posts, or what should be done about critical posts that are not generally considered as frontline. The need for sufficient security guards to guarantee the safety of health care workers and users at facilities is a case in point.

In this year's MTBPS the Minister has reiterated that "personnel expenditure now has to be contained, through attrition in numbers, more moderate wage increases, and rationalization of the organizational structure of the state." While we welcome his subsequent statement that health staff should be protected, guidance on how to do so remains outstanding. As a result, we anticipate that there will continue to be catastrophic consequences for health care. These include diminished capacity to deliver services; poor supervision of existing staff; weakened support processes (e.g. procurement); additional strain being put on already overburdened staff; and consequently, overburdened staff leaving the public service deepening the crisis.

On a positive note, we welcome the recommitment by the Finance Minister to increase the NHI Conditional Grant to support the contracting of additional GPs into the public system and to bolster support for the school health programme. We are however puzzled how this relates to the recent abrupt discontinuation by the National Department of Health of NHI GP contracts in North West Province. This has caused great distress for service delivery, for the GPs involved and staff remaining behind. It is also likely to affect quality of health care services.

In context of the above, it has long been our position that specific guidance must be provided to provincial departments of health on how cost containment within human resource budgets should be managed. This should include a set of guidelines and processes for the identification and protection of critical posts. More specifically our recommendations include:

1. The National Department of Health in collaboration with the Treasury should provide guidance through policy on how provinces are expected to protect critical posts at times of austerity.
2. Adequate consideration should be given to inhospitable and underserved areas so as to ensure disadvantaged communities are not further marginalised in their access to health care.
3. Critical posts need to be defined locally and these can include health professionals and support staff. Here critical posts are simply defined as those that potentially have catastrophic consequences for service delivery if they remain unfilled.
4. The National and Provincial Departments of Health must ensure Districts have costed HR plans in place. Treasury should provide support in the costing of the HR plans.

5. District management teams should play a central role in deciding where to save costs, based on agreed sets of principles of access and equity.
6. Corruption and unauthorized expenditure should be performance managed instead of punishing all managers and districts by withdrawing their delegations of authorities for the transgressions of others.
7. In the event of a Section100 intervention or when Treasury co-manages a Health Department, there should be an up-front agreement around the prioritization of health needs and clear processes for appointments to occur.

In the context of the country-wide austerity measures in health, we must stress that we welcome recent assurances by the Eastern Cape Department of Health (ECDoH) that service delivery to vulnerable populations, specifically including remote rural communities, will be prioritized in this Province's latest revisions to the new organograms. These new organograms will come into effect in January 2017. We also particularly welcome the commitment by the ECDoH to review earlier decisions that have led to the disinvestments in rural rehabilitation services (by occupational therapists, physiotherapists etc) to the absolutely most vulnerable people in society, namely adults and children with severe disabilities living in remote impoverished communities.

We have reached a point where decisions made now on how austerity is managed will have direct and long-term consequences for the health and well-being of vulnerable communities. It can no longer be the case that the government's fiscal and budget policy position is vague on how departments should go about implementing austerity. Managing the current crises facing the country and its limited resources requires a coordinated effort that effectively balances rights and obligations for the realization with available resources.

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