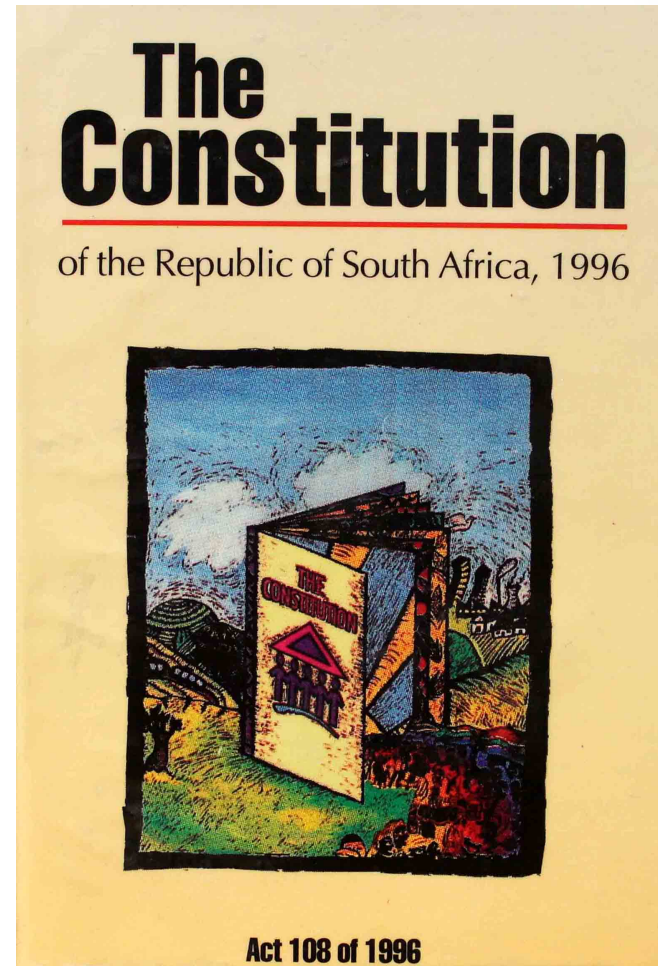


# Human rights, access to care and health activism

Marije Versteeg-Mojanaga, Health Inequities  
Conference, SoPH, Wits, 3 March 2017

# Priority-setting in health care

- Health 2017
- Budget constraints
- Progressive realisation of access to healthcare within available resources





# DECREASING STAFF ESTABLISHMENT

	2015/04	2017/01
TOTAL FILLED POSTS	18710	17411
VARIANCE	-1299 Number of filled posts are decreasing year on year	



# Four Propositions

- Our priority-setting process in allocating “available resources” is flawed and deepens existing inequities
- Ethics aside; to cut services to most vulnerable is inefficient
- The argument of “(un)available resources” does not hold
- Multi-stakeholder activism needed more than ever

# Guidance for Priority-Setting in Health Care

(WHO GPS-Health; Norheim et al, 2014)

- **Priority-setting in achieving health system goals:**
  - **Maximising health outcomes through cost-efficiencies (utilisation rates and economies of scale);**
  - **Reducing inequities;**
  - **Minimising financial burden on patients**
- **Group 1: Criteria related to disease and intervention criteria**
  - Eg: Severity of illness / Past health loss / chronic disability / realisation of potential
- **Group 2: Criteria related to characteristics of social groups**
  - Eg: Areas of living / socio-economic status / race
- **Group 3: Criteria related to protection against financial and social effects of ill health**
  - Economic activity / care for others / catastrophic health expenditures

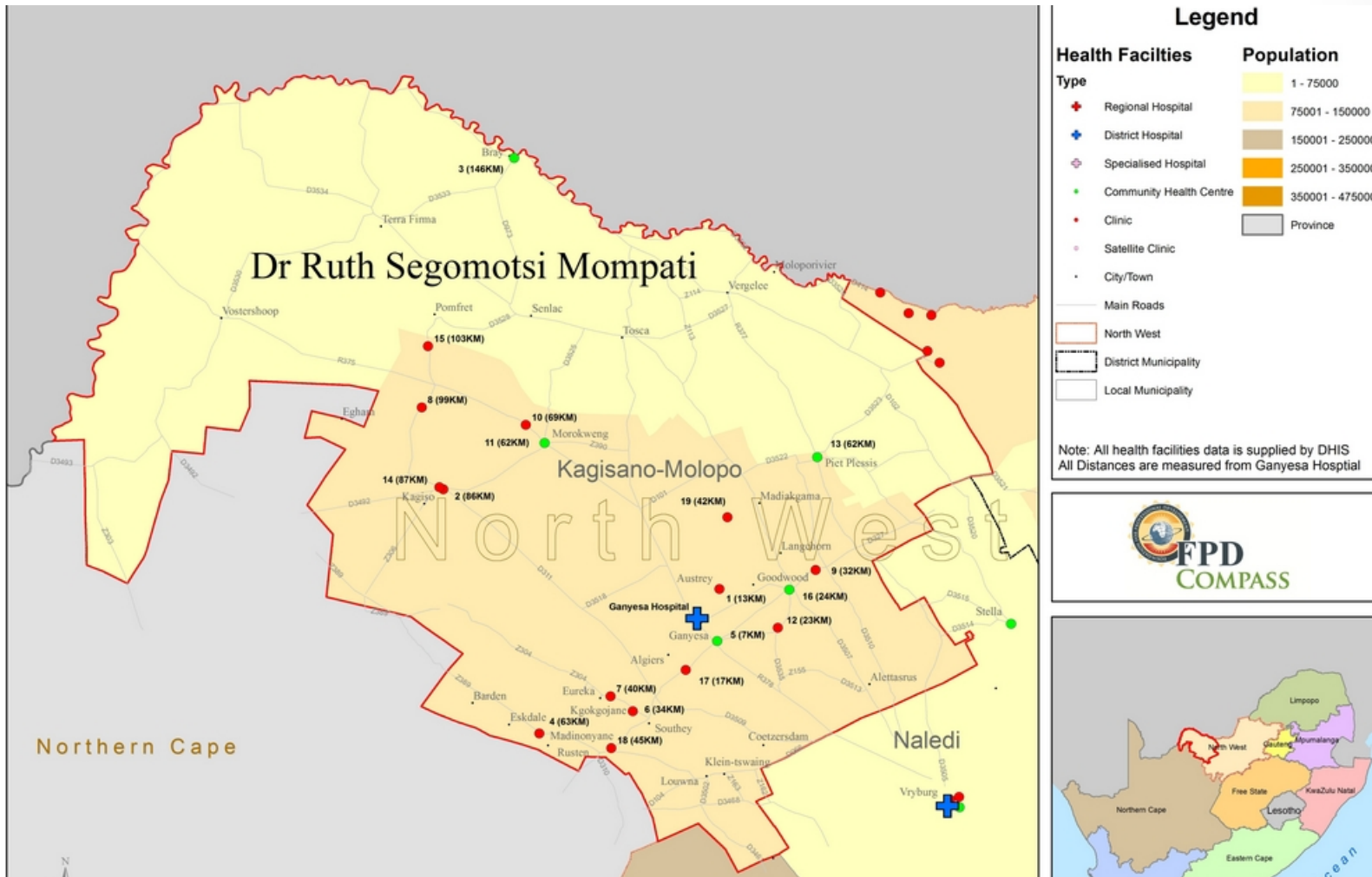
# 1: Priority-setting is flawed

- Theory versus Practice
- Practice favours **Maximising health outcomes through cost-efficiencies**
  - National health outcomes
  - Economies of scale // small facilities
  - Organograms based on utilisation rates
  - Most vulnerable suffer disproportionately

# Proportionality and Decision-Making

- Freezing 1 nurse post in a small clinic (1) of two nurses serving a farming in the northern part of Dr RSM, serving a small population. The nearest alternative clinic is 40 kms away.
- Freezing 1 nurse post in a Zeerust clinic (2) of 4 nurses, serving a large population. The nearest alternative clinic is 8 kms away.
- Based on **utilisation rates**, one might decide to freeze the post in clinic 1
- Based on access and equity, one would prioritize clinic 2

# What does it look like?

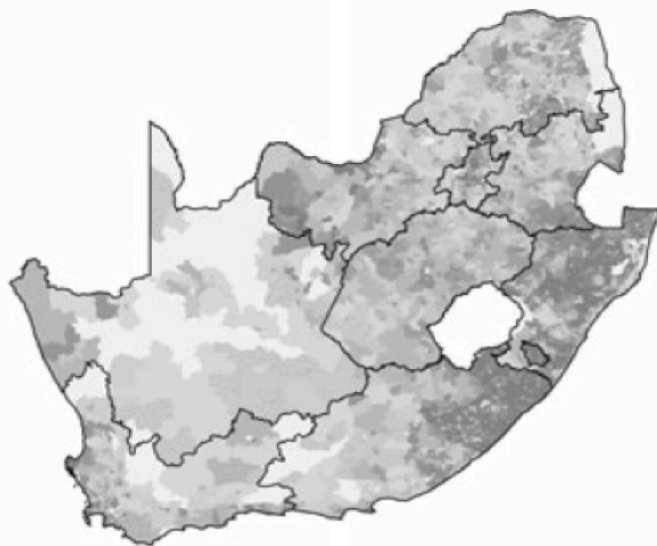




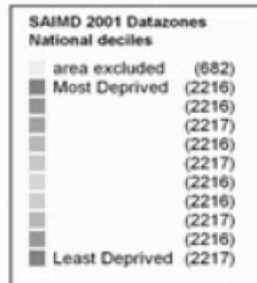
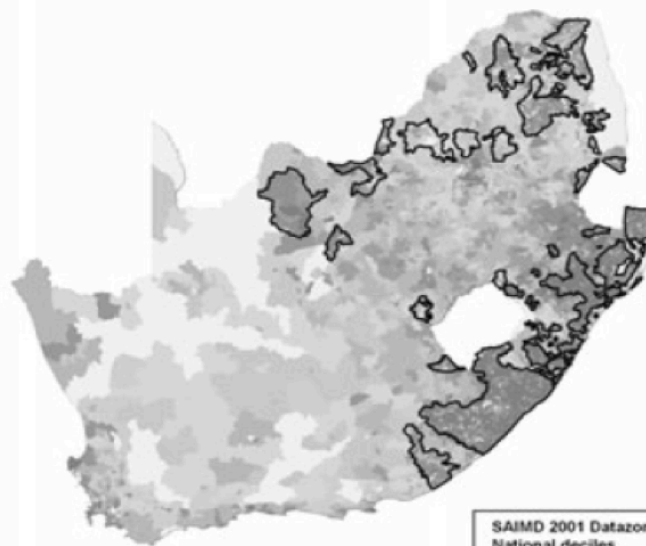
# Entrenching structural inequity

Datazone South African Index of Multiple Deprivation 2001 and with boundaries of Former Homelands overlaid

South African Index of Multiple Deprivation 2001 at Datazone Level



South African Index of Multiple Deprivation 2001 at Datazone Level showing boundaries of Former Homelands



© Copyright: Centre for the Analysis of South African Social Policy, University of Oxford, UK, March 2009.  
Produced for the Department of Social Development of the Republic of South Africa  
and funded by the UK Department for International Development Southern Africa. Data supplied by Statistics South Africa and  
Chief Directorate of Surveys and Mapping.

# Who are affected?

**Mrs Tonyani, Philasanda and family, OR Tambo District, Nov 2016**





# Canzibe Hospital

- Catchment: 100 000 people
- Beds: 120
- Doctors: 3
- Rehab professionals: 0
- Nurse shortage
- Clinic outreach terminated



# 2: Cutting Services Inefficient

- District Hospital, Northern Cape
- Obstetrics Unit Closure – 400 km roundtrip to nearest alternative unit
- Children with birth defects
  - Life long health care
  - Disability grant
  - Loss income > state dependency
  - Legal implications of health care failures by the State
- Inefficiencies offset by lack of patient advocacy/  
rehab posts freeze/ limited reach social movements
- We need more research to document cost to patient, society, the state

3: Unavailable resources: says who?

## “Severity Argument”. A clear case:

*“Maternal and Child services are severely affected, there are not enough nurses, no midwives, and you will find 1 midwife on night duty. It goes against protocol because patients cannot be monitored regularly correctly. This results in **maternal deaths**”.*  
(NW HCW, 2015)



# Constitutional obligations and human rights

“Unavailable resources?”

Population health vs individual rights?



living

alive

[www.ruresa.org.za](http://www.ruresa.org.za)

# 3: Unavailable resources: says who?

- Priorities and trade – offs
- Legal and policy framework, PAJA
- Fair process; allow key stakeholders to agree on what is legitimate and what is fair
- Victims of health care failures?
- The state to explain its priority-setting processes explicitly
  - Criteria for filling vacant posts
  - To counter: frozen posts in most deprived districts in areas with no alternatives and high personal costs in accessing care



# 4: Multi-sectoral activism

- Consensus on these points to build multi-stakeholder health activism from grassroots, to academics and social movements
- Equity in budget allocations (ESF, Provincial Government, within provincial DoH)
- Enforcement of principles of promotion of administrative justice
- Calling government to account for its decisions; explaining to communities how it came to its decisions and what principles it applied
- Research on cost of healthcare neglect, frozen posts, failure to invest (eg roll-out initiatives such as CHW)

# Thank you

## RURAL HEALTH ADVOCACY PROJECT

Marije Versteeg-Mojanaga

- Email: [Marije@rhap.org.za](mailto:Marije@rhap.org.za)
- Web: [www.rhap.org.za](http://www.rhap.org.za)
- Cell: [074 – 1063800](tel:074-1063800)
- [Twitter: RHAPnews](#)
- [Facebook: Rural Health Advocacy Project](#)