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## RESEARCH ARTICLE

### Stakeholders' Perspectives on the Barriers to Accessing Health Care Services in Rural Settings: A Human Capabilities Approach

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#### Abstract:

##### Background:

Despite efforts to achieve universal access to health care by various stakeholders globally, most developing countries continue to face serious health delivery challenges, especially in rural areas.

##### Introduction:

These inhibit individuals and communities' ability to obtain health care services when needed and the freedom to use health care. Although issues of access to health care have been widely researched in South Africa, a detailed account on access to health care in particular communities is necessary for developing interventions that are tailored to the specific needs of that community. Understanding the accounts of stakeholders to the perceived barriers to access to health care services can help comprehend the issues that hinder people from accessing health care. Therefore, this study explored the stakeholders' perspectives on the barriers to accessing health care services in rural settings in South Africa.

##### Methods:

A qualitative approach was used to guide the collection and analysis of the data. Data were collected from a sample of stakeholders selected from three rural areas in South Africa and analysed through thematic analysis. According to the stakeholders interviewed, there are some barriers that exist in the community that impede access to health.

##### Results:

These are limited or lack of health care facilities and personnel, shortages of medicine, distrust in the health care providers, opening hours of health care facilities and financial constraints, which resulted in the perceived poor health status of the people in those rural areas.

##### Conclusion:

This study calls for multifaceted health care reforms and strategies to address infrastructure deficiencies, human resources and medicine shortages to ensure equitable provision of high-quality public services. These strategies or measures must be tailored to the specific needs of rural communities.

**Keywords:** Access, Barriers, Health care, Rural settings, Human capabilities, Stakeholders.

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## 1. INTRODUCTION

The human capabilities approach provides a basis for analyzing the well-being of people by breaking away from the income-centric traditions of well-being [1]. According to the capabilities approach, to live a dignified life, focus should be

on the genuine opportunities that a person has to do things according to what he or she values in life [2 - 4]. Society's role is to provide every person with opportunities to live a dignified life that they aspire to live. The Capabilities Approach considers "a person being able to do certain basic things" [5] as the end, and resources and utilities as only means to this end [6]. Nussbaum's human capabilities approach looks at the opportunity each person has, resources available and the role of the society in promoting these opportunities and substantial

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freedoms which people can exercise or not based on their own choices [2]. Therefore, there is a need to expand people's real opportunities for a healthy life through the provision and access to health care facilities and a healthy lifestyle. Not having access to health care may be an inhibitor of a person's functioning in terms of their health. Resources are important in the development of capabilities as they are a means to a certain functioning [7]. The human capabilities approach points out that in order to tackle capability deprivation of people, it is important to improve people's access to resources as one of the possible solutions [7].

According to Anand (2009), there are ten central capabilities that all individuals are entitled to, for them to live a minimally just and decent life worth of human dignity [2]. Bodily health is an integral feature for well-being, and it is essential for the realization of other central human capabilities. The problem of denied or lack of access to health care creates a capability deprivation in the area of bodily health, which affects the quality of life for individuals. Capabilities associated with bodily health require the individual to retain the ability to live to the end of human life of normal length, without dying prematurely or experiencing a reduced quality of life, such that life becomes not worth living [8]. Therefore, this study utilizes Nussbaum's human capabilities theory to articulate issues regarding barriers to access to health care for people in rural settings in the quest to redress the barriers and to ensure opportunities for all individuals to be healthy despite their geographical location.

In this paper, we present the background information on access to health in various contexts and identify the research gap and the research methods utilized. The findings from the data are also presented according to themes, interpreted, and discussed in relation to the existing literature. Recommendations to promote justice and access to health care in a rural setting are also given.

## 2. BACKGROUND

Issues concerning access to health care services for various economic and social groups have been a subject of the WHO for a long time. Access to health care is a major health issue and compromised access affects the performance of health care systems globally [9,10]. Lack of access to health care comprises the opportunity to obtain and appropriately use quality health services and while access does not guarantee good health, it is critical for a person's well-being and optimal health. Access to health care includes the availability, affordability and acceptability of health services [11]. Different groups have different health statuses, which are often referred to as health inequalities. These inequalities are frequently considered in terms of socioeconomic position, race, ethnicity, geographical location, gender and age [11]. Access to quality health care services is a persistent issue in all countries, but the extent and seriousness of its manifestation differ with each location. The accessibility of health care resources generally declines with the decline in population density and as geographical isolation increases [12]. The above implies that rural areas, smaller populated and more remote areas are often lacking hospitals, specialized care and other health care

resources. According to Cordasco, Mengeling, Yano and Washington [13], rural areas and remote communities worldwide often experience high levels of inaccessibility of health care. Concerns over access to health care in rural areas have existed for decades with people living in the rural areas and remote areas facing multiple challenges in accessing appropriate health services [10,14,15].

The technical and social infrastructure in rural areas is much poor, and as a result, the access to doctors, particularly specialists, hospital service, preventative care and emergency services, is limited [16,17]. Such a situation might be further exacerbated by the lack of transport and the long distance to the health care facilities. The lack of access to health care may lead to the poor management of certain illnesses or delayed care in times of emergencies which consequently causes poor health outcomes and at times premature death. Furthermore, according to studies conducted in the United States of America (USA), people living in rural communities are more affected by chronic conditions such as heart disease, cancer, stroke and respiratory diseases [17,18]. Due to geographical location, lower socioeconomic status, higher rates of risky behaviours and decreased access to quality health care, people living in rural areas in the USA experience higher mortality rates, lower life expectancy and higher rates of pain and suffering as compared to their urban counterparts [18-20]. Compromised access to health care in rural America includes the lack of services, paucity of medical practitioners, specialist facilities, hospitals and clinics in the rural area [21 - 23]. This is further intensified by the fact that rural residents are more likely not to have health insurance nor medical cover, which obstruct them from accessing alternative private care [20].

African countries are also not immune to the challenges associated with access to health care. They are faced with continuous health care delivery and access problems, with less than one health care worker per thousand people [24]. The vast rural areas in Sub-Saharan Africa are either underserved or unserved with reports of lack of or limited access to health care due to shortages of skilled health care workers, geographical accessibility of the health care facilities, long waiting hours, poor service quality, hours and limited resources universal in all the regions of the African continent [25 - 29]. A study conducted in Eritrea on stakeholders' perspectives on facilitators and barriers to the utilization and access to maternal health care services showed that poor quality of care, short clinic hours, and shortage of health care workers were obstacles to accessing care [30]. Zimbabwe is one of the countries facing serious health care challenges in Africa due to its economic crisis, which has negatively affected health delivery. Although barriers to access to health care in Zimbabwe are pervasive nationally, the rural population (majority population) is much more affected influenced by long distances and travel times to the health care facilities, financial constraints, lack of infrastructure, shortage in supply of medicines and nurses [31 - 33]. These scenarios give a true reflection of the state of the health care sector in most African countries.

South Africa has a constitutional mandate to fulfill the right to access health care services for everyone living in the

country [34]. Despite this mandate and significant progress made as compared to its African counterparts, there are considerable disparities in health status across racial groups and geographical locations, with the poorest groups who are more vulnerable to ill health using health care facilities less [35]. Additionally, several scholars indicate that the health outcomes in South Africa remain polarized, unequal and unfair [35 - 37], as evidenced by the unequal distribution of health care professionals and facilities among provinces [38,39]. During the apartheid times, these disparities were influenced by policies of racial segregation and exclusion; today this is still visible through the unequal distribution of health resources and differential access to health care services for specific race and class groups [39]. The majority of black South Africans, especially those in rural areas use public facilities and have limited and heavily constrained access to health care than the wealthy, self-paying, medically insured population (minority by far), who have access to private facilities and practitioners that are concentrated in urban areas [39, 11, 40]. The majority of black Africans (75,5% or 25,2 million) rely on the public health sector, which is under-resourced [41]. These disparities in the type of care according to racial groups and geographical location ultimately results in different health outcomes across different subpopulations. This is evidenced by a study on inequalities in access to health care in rural South Africa, which indicated that black South Africans, poor, uninsured and rural respondents experienced the greatest barriers to health care access and reported poor health more than people from other racial groups [42].

Given the disparities in access to health care across geographical locations, it is important to prioritize access to health for the communities which are more deprived of access, especially the rural communities, as a matter of promoting justice. Understanding the barriers to health care access is significant in designing more effective interventions to overcome these barriers for all patients in different geographical locations. Additionally, rural residents have the same rights to quality health care as compared to their urban counterparts; therefore determining the barriers to their health care access is not only necessary in improving their health status but in promoting social justice.

Although research on barriers to access to health care in South Africa exist, there are still large information gaps about access in some rural areas that remain isolated. Research on access to health care from a human capabilities approach in rural South Africa is also limited. As such, we conducted a study in specific rural areas in South Africa to fill these gaps and to examine the access barriers from the key stakeholders in the community.

### 3. METHODS

This study employed an explorative qualitative research design to guide the research process. This approach was used in this study to understand the world of the respondents through their understanding and interpretation. Data were collected in rural settings across three provinces in South Africa. That is Lamberts Bay, a small fishing town in the Western Cape Province with a total population of about 6120

people, Calvinia a small farming town in the Northern Cape Province with a total population of about 9680 people and Philippolis also a small farming town in the Free State Province with a total population of about 950 people.

The participants of the study comprised of a wide range of stakeholders who agreed to share their perceptions on the barriers to accessing health care services in rural settings. These stakeholders consisted of social workers, health workers, child and youth workers, cleaners and police officials who work in the three rural communities. Purposive sampling was used to select the participants of this study working in different departments in the community, for example the Department of Social Development and the Department of Health. A total of 23 stakeholders were interviewed, 13 from Lamberts Bay, 6 from Calvinia and 4 from Philippolis. In Table 1, a summary of the characteristics of the 23 stakeholders that were included in the study is presented.

**Table 1. Characteristics of the participants.**

Characteristics	Participants (N=23)	Percentage (%)
<b>Gender</b>	-	-
Male	8	34.8
Female	15	65.2
<b>Age</b>	-	-
20-29	4	17.4
30-39	10	43.5
40-49	4	17.4
50-59	4	17.4
60-69	1	4.3
<b>Education</b>	-	-
High School	2	8.7
Completed Matric	11	47.8
Diploma	3	13
Degree	5	21.7
Postgraduate	2	8.7
<b>Profession</b>	-	-
Health worker	4	17.4
Child and youth worker	4	17.4
Social worker	7	30.4
Police officer	1	4.3
General Manager	1	4.3
Cleaner	6	26.1
<b>Language</b>	-	-
English	2	8.7
IsiXhosa	17	73.9
Afrikaans	4	17.4

The study utilized semi-structured interviews to collect data from the stakeholders. The interviews were guided by the interview schedules developed beforehand based on Nussbaum's 10 Human Capabilities. Examples of questions that were contained on the interview schedule include: how would you describe the health services in the community?; What are the available health services in this community?; Are the health services easily accessible by the community members? Describe your perception towards access to mental health services in this community?; In your view, what hinders

many people in this community from accessing health services? Probing questions were asked to follow up on the participants' responses. The interviews were conducted in English and Afrikaans, which were the predominant languages in the three areas. The interviews ranged between 40 to 70 minutes.

Data were analyzed through thematic analysis. The researchers familiarized themselves with the transcribed data by reading and re-reading the transcripts then after they generated initial codes. After coding was completed, themes generation commenced through sorting different codes into related clusters. Then, themes were named and defined. The coding and theme development were performed by a team of researchers to ensure that the findings are credible.

#### 4. RESULTS

Six sub-themes were identified under the main theme of barriers to accessing health care: (1) limited/ unavailability of health facilities which has to do with absence or limited hospitals, general and specialist health care facilities, hindering people from getting health care; (2) human resources shortages specifically mental health practitioners and general nurses, impacting on health care delivery; (3) shortage of medicine which led to people going for days without medicine and buying from alternative providers; (4) distrust in the health care providers mainly resulting from perceived lack of quality care and incompetence by the health care providers; (5) opening hours of the facilities which has to do with limited or no access to health care facilities outside the opening hours of the facilities and in times of emergency contributing to care deprivation and at times death; and (6) financial constraints which limited people from accessing private health care and travelling to access hospitals and specialized treatments. Below is the presentation and interpretation of each theme supported by the quotes by the participants.

##### 4.1. Limited/ Unavailability of Health Care Facilities

According to the data, there are limited health care facilities in the communities. The participants reported unavailability of mental health services, hospitals, general and specialist health care services. One of the stakeholders mentioned how access to mental health is a challenge in the community:

*Oh, that is very poor, we struggle with mental health issues and we also do not have facilities for people. We only have one mental hospital in Kimberley so it is far away from home. (36-years old, Dietician, Calvinia)*

*... But if for instance, the patient gets sick or breaks down or becomes psychotic then the patient with the help of the police and a medical certificate that the family fills in will be taken to the nearest hospital which is Clanwilliam, 60 kilometres away. But it's also a struggle because for example, if today we have a family member that is psychotic then I struggle and struggle, then I must get a form from the sister in the clinic and then we have to take the form to the police and then there isn't a van. Then, the patient walks up and down the community and it's a struggle but when the patient gets to Clanwilliam then he is taken good care of. (44 years old,*

*Clinical Nurse, Lamberts Bay)*

From the explanations by the participants, it can be noted that people with mental health issues cannot easily access mental health care due to the absence of mental health facilities in their area. Even though mental health facilities are available in their provinces, the distance and the travelling expenses hindered the people from accessing these services. For example, whenever in need of mental health institutions, people from Calvinia were referred to Kimberly, which is about 7 hours' drive and those from Lamberts Bay were referred to Clanwilliam, which is about an hour's drive. This left the family members with the burden to take care of the mentally ill patients without proper knowledge and resources to do so.

General health care was also a major concern that was raised by the participants with hospitals, specialist and other services out of their reach. The participants mentioned that they only had clinics in their vicinity and had to travel to other areas for hospitals, emergencies and specialist care. Some of the participants shared their sentiments as follows:

*We only have a clinic, so if you giving birth, you get injured then you must drive 62 km to get to the hospital, in Clanwilliam. (Stakeholders group discussion 1, Lamberts Bay)*

*In the community, it is the clinic that provides health services and then we have Dr David's (pseudonym) consultation room and I think that is the only services available in the community. (40 years old, Female, Nurse, Philippolis)*

*But he is – he likes to go overseas, he likes to visit friends, so if there's no – if he is away for the weekend, you just get a voicemail "I'm not available – call the office – call the ambulance. (60 years old, Female, Social Worker, Lamberts Bay)*

The explanations by the stakeholders signify the limited health care facilities, specifically in Lamberts Bay and Philippolis. Although the participants indicated that they are clinics available, these do not provide specialist services. As such, the community members have to travel long distances for emergencies, specialist services, and hospitals. This hindered some of the people from getting these services due to distance and financial constraints linked to travelling to major hospitals. Furthermore, in Philippolis and Lamberts Bay, the participants mentioned the availability of a general practitioner for alternative care in their communities, but according to a stakeholder from Lamberts Bay, the general practitioner is always not available when needed, which left people stranded at times.

##### 4.2. Human Resources

The study indicated that there are limited staff or health care personnel in all three rural communities (Calvinia, Lamberts Bay and Philippolis). The areas had limited staff who offer mental health-related services and general health services, for example, general nurses. It was stated that due to the staff shortages at the clinics, the waiting period becomes long and some people end up going back home without receiving the health care services. Some of the participants highlighted that:

I don't think there's also enough professionals to cover the number of people in the community or to service the number of people in the community. (26 years old, Female, Calvinia)

I'm sure it's just – you have to be patient, you know cause you have to sit there and wait, uhm but I haven't heard them complain, it's just that it's a long wait. It's like when you go to the clinic, you have to be sitting there for the whole day. (60 years old, Female, Social Worker, Lamberts Bay)

Waiting period. We have got two nurses and one service manager, so it is a bit difficult for them. You can come here at half past-seven and end up going home at quarter past two or three. (36 years old, Male, Community Health Worker, Philippolis)

We don't have a psychiatrist, we don't have a psychologist. People who try to commit suicide, there's no proper, nothing, nada, support, there's no support, there's no psychiatrist, there's no psychologist. (Male 39 years old, Manager Calvinia)

From the statements made by the participants, it can be denoted that the health care facilities were under-resourced in terms of personnel to provide the health services to the people in the community. This resulted in long waiting hours for people to get attended and at times, they would not get attended at all. Furthermore, there was a shortage of mental health personnel within the communities and even in their referral hospitals resulting in no support for people with mental health issues. Such shortages of health personnel and the associated waiting period are major concerns in one's ability to access health care.

#### 4.3. Distrust in the Health Care Providers

Another theme that was derived from the data was distrust in the health care services in the community. This stemmed from the perceived lack of quality health care and incompetence of the health care providers. It was noted that there was a once a week doctor visit in Philippolis and one doctor's surgery in Lamberts Bay. Participants in Lamberts Bay pointed out the reports of the doctor giving people the wrong diagnosis and not making time to give fully examine the patients. Some of the participants had this to say about their perception of health care services:

*"what also people use to say is that Dr Thomas (pseudonym) of the town is sometimes diagnosing them with the wrong diagnoses. (37 years old, Female, Social Worker, Lamberts Bay)*

*I don't know, but from what I can hear he doesn't take time. When you go to the clinic, it's free of charge obviously, but according to what their experience is, he doesn't take the time to sit with you and examine you properly, but my experience when I go to him and I pay R400 and my experience is that he gives you good medicine. (37 years old, Female, Social Worker, Lamberts Bay)*

*...we only have one doctor here in town, and I'm sorry to say but Friday he took a pin out of my leg, but he isn't for all of us, and the manner in which he handled us is pathetic."* (Stakeholders Group Discussion, Lamberts Bay)

The participants pointed towards the community's negative views on the health services providers in the community as they were demonstrated to be less responsible in their work and less interested in the wellbeing of their patients. Interestingly, one stakeholder from Lamberts Bay indicated that the service care provider gave less attention to the patients at the clinic because they received free services and better treatment was given to those who consulted for a fee at his/her surgery. The failure to give adequate attention might also be attributed to the issue of limited health care personnel in the area, which makes it difficult for the health care provider to provide quality services as a result of the overwhelming work or lack of competition from other providers. Distrust in the health care providers might lead to the reluctance of the patients in consulting whenever they need help.

#### 4.4. Shortages of Medicine

Furthermore, the participants reported that medicines were sometimes not available in their local health care facilities. People had to go sometimes for long periods without the medication. The shortage of medicine acts as a barrier to both accessing health care services and achievement of bodily health because people will see no reason to visit the clinics when they cannot get the necessary treatment they require. Two stakeholders alluded to the lack of medicine at their local clinic as follows:

*"The clinic does not always have medication that people need like my father is waiting two weeks now for his tablets and he needs it so the medication is not always available". (36 years old, Child and youth worker, Calvinia)*

*"I know they often say they come and buy medicine at our facility. And then they would say there isn't any available at the other clinic I know they complain a lot about sitting for long hours there. In order to receive their medication, so many of them are coming here to buy medication out of their pockets because they do not have the time to sit the whole day at the clinic". (40 years old, Female, Nurse, Philippolis)*

The statements by the participants highlight that there are challenges to access to free medicines for people in rural areas to cure, treat, prevent or minimize the symptoms of certain conditions. In some cases, people end up looking for alternatives to access the medicines mostly by buying medicines from private facilities. Such a situation compromises the health of many people in rural areas who often cannot afford to buy these medicines due to their economic status. Thus, leading to some going for long periods without the medication because they do not have any other option.

#### 4.5. Opening Hours of Health Care Facilities

The stakeholders indicated that the opening hours of the health care facilities did not allow the people to access health care services whenever they feel like. The clinics were open during the day and did not provide 24-hour services. Therefore, people could not get services outside of the opening hours of the facilities, at night and in times of emergency; they have to travel to hospitals that offer 24-hour services. Some of the participants shared their sentiments as follows:

I believe so, yes. Because the other day when I phoned this lady, she said it's now time to go home. Yes, clinics aren't open overnight. There aren't overnight stays. ... There are no hospitals here. (Female, Social Worker, Lamberts Bay)

Like I said, the health services, they need to be after hours, so if the accident happens, a child is burning...or whatever, must I wait until the ambulance is coming from wherever not sure what you call it ... the fact that there's no hospital in Lamberts Bay, you need that unit...to see people 24/7. (Female, 59 years old, Social Worker, Lamberts Bay)

So, for people not to go to the hospital, some of them are dying along the way to the hospital. So at least if the clinic can have a ward to admit. (Male, 39 years old, General Manager, Calvinia)

Explanations from the stakeholders denote the absence of health care facilities that are always open whenever the patients need help. This makes people travel many kilometres in times of emergencies which place their lives at risk as some die on their way to the hospitals. This is worsened by the fact that transport to the 24-hour facilities is sometimes problematic. This is supported by the statements below:

No here there isn't any ambulance station. It varies. Sometimes it is within an hour, sometimes they can wait four to five hours for the ambulance to come. (40 years old, Female, Nurse, Lamberts Bay)

Yes we have an ambulance but it is working in different places, sometimes you can call but it's not immediately... (37 years old, Female, Social Worker, Lamberts Bay)

Reports by the stakeholders in Lamberts Bay bring to light that there is an ambulance meant to take people to hospitals in cases of emergencies but the ambulance was highlighted to be inefficient because it was serving a lot of places. Resultantly, it could not be in all the places in time when needed; other people had to wait. This might lead to delays in care or medical treatments, especially in times of emergencies.

#### 4.6. Financial Constraints

Financial constraints were identified by the participants as one of the significant barriers that restrict people from getting quality health care. In the presence of under resourced-public facilities, the only option for some is to seek for private health care which is often costly or travel to other areas to seek health care. However, accessing private care and travelling to other areas was also highlighted to be impossible or difficult due to the costs involved. Participants spoke of how costs are a barrier to quality health care access:

You have to go to Clanwilliam which is again expensive because people have, it's not that there's transport for them. They have to get there on their own. (60 years old, Female, Social Worker, Lamberts Bay)

I think if I must speak out from our consultation room it should be reachable/accessible for everyone. Everyone must be able to come to receive services and unfortunately, they need to pay for the services. (40 years old, Female, Nurse, Philippolis)

I know the clinic is full almost every day from the morning

to the afternoon they sit there. The private doctor – it's the police officials and those people that will make use of him because they have the R400 right now. (37 years old, Social Worker, Lamberts Bay)

Participants in Lamberts Bay revealed that to get some specialized health care that is not available in the area some people had to go to Clanwilliam and to avoid spending time at the clinic there was an option of consulting a private doctor who is available in the area. Although this was a solution for some people in the community who are employed, most people could not afford private care as a result of the high rate of poverty in the community. This situation was also similar in Philippolis where a doctor was available for consultation but this was at a cost, which meant that poor people could not afford his/her services.

## 5. DISCUSSION

Evidence from this study points out that there are some factors that act as barriers to accessing health care services in the three rural communities. There were reports that there were limited health care facilities, general and specialist health care services were limited or absent, this is contradictory to the South African Constitution, which guarantees every citizen access to health care services [43]. People had to travel many kilometers to access specialist services and for emergencies. One example identified was that of the absence of mental health institutions and staff who specifically deal with mental health issues which meant that people had to travel to other areas to access these. Travelling to access health care services was also pinpointed as problematic due to the socio-economic status of the community which resulted in some people not affording to travel for these services even when they need them the most. Even though some health services are provided for free, monetary and time costs of travel may result as an important blockade for vulnerable parts of the population, leading to overall poorer health [44]. Data from a study conducted in South Africa indicate that there is limited use of referral hospitals by lower socio-economic groups; with the likelihood of using a health service is far lower for those living furthest from health facilities [11]. This consequently results in poorer management of chronic illnesses and poor health outcomes. Therefore, to promote increased use of specialist services and hospitals, these have to be located where the people can easily access them.

Associated with the lack of or limited health care facilities was the absence of 24-hour health care services and admission facilities in the area. This made people not get services outside of the opening hours of the facilities, which deprived them of their right to be healthy. Due to the absence of 24-hour health care services and admission facilities, people had to go to other areas to access these, which was reported to be leading to fatalities which might have been avoided by having 24-hour facilities which offer admissions for patients. This shows that lack of access may have significant repercussions for premature death [11].

Lack of human resources and understaffing were also noted as a major concern in accessing the health care system in the study context. Lack of health care personnel dealing with

mental health issues and specialist doctors were also indicated to be scarce and this compromised the bodily health of people in the community. Local clinics were reported to have shortages of staff nurses, which consequently resulted in long queues, prolonged waiting hours for patients and some of the patients not being attended. The shortage of health care personnel hampers sufficient delivery of health care [45,46]. Developed countries, including South Africa, face shortages of health care personnel with uneven distribution between sectors and geographical areas [35, 47, 48]. The availability of health personnel is also a key element of access to quality health care [11]. This implies that shortages or lack of health care personnel present a barrier for the fulfillment of the right to health care.

Adding on to the problem of the shortage of health care personnel, there are also shortages of medicine in the public health care facilities whereby these facilities sometimes go for long periods without medication. Due to this, some people who need medication to manage their illnesses are turned away. Such a situation resulted in some people not taking medication and others opting to buy their medication from other facilities which again is a challenge especially in a setting where most people are unemployed and depend on social grants. Linked to the above, the costs of utilising private health care in cases where people cannot access the public health care system were also noted as a barrier for many people due to the related costs. Only those who had better-paying jobs were reported to be affording to utilise these. Financial constraints were also cited as a barrier to accessing other distant health care facilities with better resources and specialised care. According to Gaede & Versteeg (2011) [49], many families in rural areas are not able to access health care services due to the costs involved and the higher levels of deprivation.

Even though rural populations are largely dependent on public health facilities, barriers to access health care in rural areas can result in substitute care such as private doctors. Private doctors are an essential component of the health care system. While this is true, the study brought to light issues of distrust in the private health care providers who were described as less responsible and cared less for the well-being of their patients, as evidenced in the reports on giving the wrong diagnosis and not spending time in examining the patients. Such a situation can be attributed to the shortages of doctors in the area, which might make the work overwhelming for the doctor and without competition from others providers the doctors might also be reluctant in providing quality care. According to Douthit, Kiv, Dwolatzky & Biswas (2015), rural doctors often find themselves overburdened and this hinders them from further training which results in the failure to improve or update the care they provide for their patients [16].

## 6. RECOMMENDATIONS

In order to minimize these challenges in the health care system of South Africa that continue to persist even after democracy, there is a need for the health department to adopt a needs-based resource allocation mechanism for distributing resources across districts, instead of relying on historical budgeting, which has contributed to entrenching inequalities in

public health spending within provinces. Health care reforms should be multifaceted taking into consideration strategies to address infrastructure deficiencies, human resources and medicine shortages to ensure equitable provision of high-quality public services.

Ways to improve access to health care should take into consideration what the real health care needs of that community are, improvements must be tailored to the needs of rural communities. The needs of specific rural communities should be presented at national levels and the issues raised in this study calls for different stakeholders, including policy-makers, government, non-governmental organisations, community leaders and ordinary citizens to come up with solutions and collaborate in implementing the suggested solutions to improve access to health care in rural areas. Further research is also required on issues of user acceptability dimension to access, which is important in determining the use of health facilities by the consumers.

## CONCLUSION

Accessing health care in the rural areas of South Africa continues to be a challenge. As confirmed by the study, there are significant barriers that impede people in rural areas from accessing health care. These include limited or lack of health care facilities and personnel, shortages of medicine, distrust in the health care providers, opening hours of health care facilities and financial constraints. The barriers to health care access significantly impact the bodily health of people in rural areas. To meet the Sustainable Development Goals and ensure social justice, the South African government should ensure the provision of adequate, quality and accessible health care to all people in the country, including those in rural areas.

## ETHICS APPROVAL AND CONSENT TO PARTICIPATE

Permission to conduct the study was obtained from the Human Social Sciences Research Ethics Committee at the University of the Western Cape, South Africa (Ethics Reference number: HS 20/4/29) on 11 June 2020.

## HUMAN AND ANIMAL RIGHTS

No animals were used in this research. All human research procedures followed were in accordance with the ethical standards of the committee responsible for human experimentation (institutional and national), and with the Helsinki Declaration of 1975, as revised in 2013.

## CONSENT FOR PUBLICATION

The research purpose, aims and objectives of the study and research process were explained to the participants. Participants were encouraged to ask questions and after they had understood the details of the study, they were provided with a consent form which they completed before participating in the study. Confidentiality was ensured by allocating pseudonyms to each of the participants masking their personal details.

## AVAILABILITY OF DATA AND MATERIALS

The datasets used and/or analysed during the current study are available from the corresponding author [R.C.] on reasonable request.

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## CONFLICT OF INTEREST

The authors declare there is no conflict of interest, financial or otherwise.

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