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Decentralization, healthcare access, and inequality in Mpumalanga, South Africa

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ABSTRACT

Healthcare access and utilization remain key challenges in the Global South. South Africa represents this given that more than twenty years after the advent of democratic elections, the national government continues to confront historical systems of spatial manipulation that generated inequities in healthcare access. While the country has made significant advancements, governmental agencies have mirrored international strategies of healthcare decentralization and focused on local provision of primary care to increase healthcare access. In this paper, we show the significance of place in shaping access and health experiences for rural populations. Using data from a structured household survey, focus group discussions, qualitative interviews, and clinic data conducted in northeast South Africa from 2013 to 2016, we argue that decentralization fails to resolve the uneven landscapes of healthcare in the contemporary period. This is evidenced by the continued variability across the study area in terms of government-sponsored healthcare, and constraints in the clinics in terms of staffing, privacy, and patient loads, all of which challenge the access-related assumptions of healthcare decentralization.

1. Introduction

Healthcare access and utilization remain a global challenge, particularly for low-resourced settings (Harris et al., 2011; Farmer et al., 2013). Within the Global South, accessing services to maintain health and well-being are constrained by historical patterns of disinvestment, outmigration of health care practitioners, and structural determinants that produce inequities in exposure and opportunities for effective health management (Farmer, 1999). One of the strategies intended to deal with these challenges has been a push towards the decentralization of healthcare (Saltman et al., 2007). Decentralization is a multifaceted and multisectoral process that has the potential, over time, to rectify historical inequality by empowering local administrative units to control their own healthcare agendas and resources with the intention of tailoring service provision to the local population. Decentralization relies on the assumption that local centers will "help leverage scarce resources for maximum effect" (WHO, 2011), resulting in improved service quality, coverage, and access for needy populations (World Bank n.d.). This represents an important transition for healthcare provision as decentralization has become more widely practiced in a number of resource-scarce settings (Saide and Stewart, 2001; Boyer et al., 2010; Jin and Sun, 2011). Regardless of this expansion, decentralization policies globally have been controversial and some studies assert that they have produced mixed results (Dookie and Singh, 2012; Kenworthy, 2014; Koelble and Siddle, 2015). While one aim of decentralization is to decrease the barriers to healthcare access by reducing the time and distance needed to access facilities, in practice, it can be a challenge to distribute equally the burdens of access within rural populations. This can be particularly acute within settings confronting historical systems of inequality, such that decentralization has the potential to exacerbate rather than ameliorate these patterns (Koivusalo et al., 2007).

South Africa's approach to healthcare mirrors recommendations from the World Health Organization (WHO) in advocating decentralization in the provision of healthcare services. The national government is in the process of deconcentrating centralized government health decision-making by transferring accountability to lower level officials, and delegating responsibilities to semi-autonomous organizations (Hendricks et al., 2014). This presents an important case because while the country is classified as a middle-income economy, the landscapes of care in South Africa continue to be shaped by persistent inequities across socioeconomic status, race, and gender that present ongoing challenges,

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particularly in rural areas (Coovadia et al., 2009; Ridde and Morestin, 2011; Harris et al., 2011; Honda et al., 2014). A key feature of the government's early stage approach to decentralization is an emphasis on local clinics and hospitals for the delivery of health care and implementation of the proposed National Health Insurance (NHI) scheme (WHO, 2011; Hendricks et al., 2014; South African Department of Health, 2014). Similarly, provincial governments have incentivized the establishment of home-based care organizations within rural areas, though the funding has been inconsistent. Home-based care organizations work independently but also collaboratively with the clinics and hospitals in encouraging testing for certain ailments, maintenance of health through behavioral practices, and surveilling of the population to ensure residents are adhering to treatment protocols. Given these developments, South Africa's move toward a decentralized health system underscores the need for empirical detail on perceptions of services and healthcare decision-making given the country's efforts to "establish a health system based on decentralized management, principles of equity, efficiency, sound governance, internationally recognised standards of research and a spirit of enquiry and advocacy" (South African Department of Health, 2013).

South Africa is also an important setting because the country has continued to address a significant HIV/AIDS epidemic through the provision of antiretroviral (ARV) drugs that have extended the lives of millions for years (UNAIDS, 2011, 2014). In attending to the epidemic, the national government has worked to overcome historic healthcare disparities by abolishing user fees in the public health system and increasing local access to antiretroviral treatment (ART) (Chopra et al., 2009; UNAIDS, 2012; Honda et al., 2014), efforts that are in line with the core principle of decentralization of the WHO's Treatment 2.0 program for ARV rollout (WHO, 2011). The South African Department of Health has advocated a multi-phased re-engineered primary healthcare strategy that aims to create and deploy municipal ward-based outreach teams in defined geographic areas for both HIV and integrated primary care services (McIntyre and Klugman, 2003; South African Department of Health, 2014). While there have been significant strides in increasing the availability of healthcare services within rural South Africa, true access remains far from uniform (Coovadia et al., 2009; Harris et al., 2011; Honda et al., 2014; Ridde and Morestin, 2011). The consequence is that while international agencies and public health institutions advocate healthcare decentralization, research is needed to understand the specific impacts for rural areas to understand how individuals, households, and communities experience disease and manage health through their utilization of a variety of healthcare options.

The central objective of this paper is to engage with research within health geography and political ecology of health to understand how individual decision-making is connected to political, economic, social, and cultural processes that intersect in shaping the options available to rural populations. These fields broaden theories of access to consider dynamics that have been socially produced while also revealing underlying layers of complexity, ranging from cultural and gendered dynamics to biophysical patterns (Jones, 2004; King, 2017). Related research is showing how the production of places and landscapes involve multiple meanings and contestations that unfold in diverse ways for populations (Leach et al., 1999; Neumann, 2011). Building upon this work, we show the complexity of healthcare access as a result of apartheid-era spatial policies and subsequent uneven health development. Given that South Africa's decentralization process is beginning with the provision of more clinics to increase access to services, we focus on how healthcare access is experienced through clinics in Mpumalanga Province, outside of historically prioritized urban centers.

This is followed by a discussion of the case study and methodology, which reports on the findings from an ongoing research project in northeast South Africa centered on the relationships between livelihoods, disease, and the natural environment (Winchester and King, 2017). We rely on data from focus group discussions, a structured household survey, clinical observations, and qualitative interviews conducted from 2013 to 2016. While the national government's promotion of decentralization of healthcare provision operates with the assumption that the provision of services will be generally evenly distributed within rural areas, we argue that the landscapes of healthcare remain uneven. In order to demonstrate how these patterns vary within rural South Africa, we concentrate in particular on the clinical context, physical distances of healthcare facilities, modes of transport and costs of attending clinics, and perceptions of available facilities. We find that despite increasing availability of services there are a number of other dynamics that shape perceptions and decision-making. We conclude by arguing that these place-specific patterns highlight the need to integrate multiple types of data to advance a broad concept of landscape that advocates for deliberate and careful decentralization rollout, particularly in rural areas.

2. Landscapes of healthcare

The concept of a landscape and the ways that cultural practices shape the resulting physical environment have been central to geographic scholarship for some time (Sauer, 1925). Both political ecology and landscape studies are concerned with transformations to social and ecological systems, interrogations of the multiple understandings of nature, and critical engagements with colonial histories, with an aim to "reveal multiple and contested meanings of nature and natural landscapes among interested social groups" (Neumann, 2011, 845). Recent work on political ecologies of health have shown how local dynamics produce uneven health outcomes and opportunities for management through the generation of particular discourses of health and well-being (King, 2010; Jackson and Neely, 2015). These studies evidence the need to connect the landscape concept from political ecology with place studies from health geography to evaluate the meanings, contestations, and dialectical negotiations that social actors experience in the "production, circulation, and application of knowledge about health" (Jackson and Neely, 2015: 48; Mitchell, 2002). While decentralization has guided South Africa's approach to service delivery, rural landscapes are complex places created through social processes that are unevenly generated and unequally experienced. We engage with landscapes of healthcare to highlight the physical, structural, and symbolic dimensions of place that impact healthcare seeking and produce differential access patterns for populations (Kearns and Barnett, 1997; Hawthorne and Kwan, 2013; Mitchell, 2002). Much of the work in landscapes of healthcare has been conducted in urban areas, and we extend this to show that in rural and semi-rural regions, constellations of factors influencing care seeking are similarly important to understanding access.

Compared to related fields of study, health geography has taken a nuanced approach to the role of place in the access to healthcare, examining proximity to roads (Feldacker et al., 2011) and resources (Messina et al., 2010), population and neighborhood factors (Vearey et al., 2010), and the mechanisms that connect health and place (Macintyre et al., 2001). Geographic approaches to health allow for understanding disease clustering and distribution of resources (Linard et al., 2012; Richardson et al., 2013), in addition to the subjective experiences of space, and consequent impacts on health risks. More recently, studies of health and place have expanded to include low-resource settings and the construction of risk for HIV in particular (Tanser et al., 2009; Feldacker et al., 2010). Linard et al. (2012) further show that regional variations in health are not easily explainable through population-level data in sub-Saharan Africa and emphasize the significance of the meaning of place, particularly in remote or isolated regions.

Distance, one key consideration in healthcare access, is a material feature of landscape, yet experienced through the social lens of infrastructure, transport availability, individual resources, choice, and perceived burdens (Thaddeus and Maine, 1994; Ewing et al., 2011; Schoeps et al., 2011; Blanford et al., 2012; Mills et al., 2012).