Re-imagining rural: the state of rural health 20 years into democracy

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I recently spent a week visiting clinics in the Quakeni Local Service Area (LSA) as part of a research project looking at the resourcing of rural facilities. Quakeni is a sub-district of the OR Tambo District and encompasses the rolling hills of the Eastern Cape hinterland, dotted with small villages and subsistence allotments, and a small stretch of the Pondoland marine reserve—amongst the most arrestingly beautiful coastline in the world.

While working in rural settings like this—where the beauty of the landscape is matched by the warmth and humility of its people—is certainly rewarding, I am presented with constant reminders of how far we still have to go to ensure that all people, regardless of the personal circumstance or where they live, have access to the kind of healthcare that our constitution demands.

How far did we come with rural health care?

Let me start by saying that we need to remember where areas like Quakeni started from in 1994. The social, economic and spatial legacies of colonisation and apartheid meant that at the turn of democracy rural areas such as this one had little health or social infrastructure beyond what was being provided at mission hospitals. While these institutions were certainly remarkable examples of what could be done with limited resources and a great deal of commitment and care, without significant investment in infrastructure and personnel at all levels of the system, there was no way that they could respond adequately to the growing burden of HIV, tuberculosis (TB) and non-communicable diseases (NCDs) that have shaped demand for care over the last two decades.

To say, without qualification, that there has been no progress in the rural health system over the last 20 years would be disingenuous. For those who access rural facilities and those who work there, there are certainly clear markers of progress. One can take hope from the fact that some of the most remote rural facilities are now electrified, have reliable access to potable water, and many have extraordinary health workers staff. One can also not deny that since at least 2008 there has been a consistent commitment to improving access to care for the most underserved populations in the country. The fact that rural patients who need antiretrovirals (ARVs) are increasingly able to access treatment at their nearest clinic stands testament to that.

Problems with the availability of care in rural areas

The reality is, however, that as a country we are still a long way from meeting the promise of the Constitution and other commitments such as the Alma Atta Declaration and the Millennium Development Goals (MDGs). Access to healthcare, its quality, and outcomes are still all too dependent on ones income and where one lives. This is

true for the vast majority of both urban and rural populations; for rural populations though, the barriers to access are often more acute and more difficult to overcome.

Generally, rural populations continue to experience higher levels of deprivation than their urban counterparts. According to the Health System Trust's (HSTs) Deprivation index, the ten most deprived districts in South Africa are all rural (1). This means that on average people living in these districts have the least access to education, piped water, sanitation, electricity, adequate nutrition and in general are highly impoverished. All of these factors are social determinants of health that make rural populations more vulnerable to ill health and its impact.

In the context of access to health care, poverty is an especially pervasive barrier. A recent study into equity in health care access in South Africa revealed that the cost of transport was the most significant factor in determining if or when rural people accessed care (2). These costs were compounded by additional direct costs such as food, childcare and communication, as well as greater opportunity costs associated with longer travel times, than urban users. The financial impact of these higher costs of accessing care was highlighted by the fact that when rural patients sought outpatient care, expenditure on transport was catastrophic in 15% of all cases (>10% of monthly household expenditure).

Problems with access to care in rural areas do not end with whether or not users are able to get to the facility or not, they extend to the kind and quality of care they receive once there. Arguably the most important determinant in this regard is the presence of sufficient and adequately trained human resources for health (HRH).

In South Africa the distribution of HRH remains skewed in favour of urban areas. Despite the fact that more than 38% of the population live in rural areas they are serviced by only 12% of doctors and 19% of nurses (3). There are indications that things are not improving; of the 1200 medical students graduating annually, it has been estimated that only 35 of these graduates will choose a career in rural health over the long-term (4).

The reasons for this skewed distribution of HRH can generally be distilled into a combination of factors that includes the absence of/poor accommodation for health workers and their families, fear of safety, lack of opportunities for schooling for children, shortage of work opportunities for spouses of health workers, poor social infrastructure and few additional benefits for working in inhospitable settings (5).

For anyone who works at or has accessed services at rural facilities the effects of understaffing are painfully obvious. Patients are often required to wait the entire day to be seen, often without the comfort of shelter from the sun, cold or rain. When they are seen, they are often attended to by health workers who are overstretched and unable to give them the full attention they may need. In those instances where health workers are unable to provide the care needed, patients are forced to travel a long distance to a facility in a large town or city where they can see a doctor or receive specialized care—again, at a significant cost to them and their households.

Problems with the availability of care in rural areas are then exacerbated by supply management systems that are not equipped to respond to the needs of understaffed

and difficult to access rural facilities that often have little administrative and pharmaceutical management capacity. This in combination with weak oversight and accountability mechanisms all too often results in stock-outs of basic drugs and essential medical supplies.

Difficulties in addressing barriers to accessing rural health care

Overcoming these barriers to access requires that we not only address the substantive issues of transport, HRH in rural areas, supply chain management, infrastructure, oversight and management. It requires that we start to address how rural health is understood and catered for in both policy and the allocation of resources.

In this respect there are two broad issues that are at the heart of why it has been so difficult to address barriers to access in rural areas over the last 20 years. The first of these is that health policy in its current form does not explicitly and hence adequately address the rural health context. This is largely because policy makers have tended to view rural as underserved in the same way as impoverished urban settings are underserved. While treating rural as underserved is certainly appropriate in most instances, it does not go far enough in identifying policy interventions that deal with rural specific issues relating to access (e.g. transport) and availability (e.g. HRH).

The second broad issue is that the current system of allocating resources, largely through health budgets, does not account for the differing needs and costs of providing services in rural areas. At the provincial level resources are allocated historically, incrementally and based on a crude understanding of absorptive capacity. This results in what some researchers refer to as an ‘infrastructure inequality trap’ where funds continue to flow to settings with established infrastructure and human resource capacity, reinforcing historical and spatial inequities (6).

Rural-proofing

As the Rural Health Advocacy Project (RHAP) we believe that the starting point in addressing challenges in rural health is to systematically address each of the substantive barriers to access through the development of rural friendly policy and resource allocation processes that include rural factors.

Popularly referred to as rural-proofing (7), this demands that policy makers recognise the importance of adjusting policy and resource allocation processes in ways that progressively improve health care access and delivery in rural contexts and then are provided with the technical support to do this. This is something that the RHAP, with its rural health partners (8), has started to do with some positive progress already.

The National Department of Health has included a rural chapter in its most recent HRH Strategy and is partnering with the RHAP and other rural health stakeholders to find ways that it could be integrated practically into policy implementation. This engagement should have far reaching implications for HRH in rural areas by extending recruitment and retention strategies beyond just remuneration to include key areas such as health education, improvements in living conditions and personal development for rural health workers (4).

This kind of engagement is starting to develop in other areas too. Even the Treasury, a notoriously difficult institution to influence, is starting to accept the need to re-evaluate resource allocation processes and how they can be more responsive to rural need.

It is often easy to forget the lived realities of users and health workers in rural areas when engaging with these technicalities at the policy level though. When crunching numbers as part of a review of health care expenditure one often forgets that reality on the ground. For example, the decision to spend R500 to hire 'private transport' to get a sick family member to a hospital because the ambulance never comes is one fraught with anxiety because it means that the rest of the family may have to go hungry because there is no money for food. When working on rural proofing the HRH we need to remember the many frustrations health workers face in providing the most basic services in contexts that are far removed from their home comforts and support networks.

If we are going to finally see true progress in addressing the historical and structural neglect of rural health it is incumbent on all of us to ensure the voices of both users and health workers inform decision-making. Social justice demands that we do not allow technocratic considerations of efficiency and cost-effectiveness, although important, to be the primary factors that shape the health system.

Driving through Qunu on the N2 back to East London from Quakeni I was reminded that rural areas in South Africa have produced many of the most important leaders of the struggle against apartheid. 20 years into democracy it is important to remind ourselves of the potential inherent in rural people and landscapes. To do this we need to re-imagine rural areas as dynamic and desirable places to live and work. This re-imagining does nonetheless require that we change the material conditions of rural areas through sufficiently rural proofed policy and resource allocation processes.

Note that the views expressed in this article are those of the author and do not necessarily represent the views of PHASA.

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