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Factors Hindering Access to Healthcare Services in Peri-Urban Communities in Johannesburg, South Africa

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ABSTRACT: *Access to healthcare is a major problem for diverse reasons in Africa. This study developed a conceptual model to address the factors that hinder patients from accessing and navigating healthcare services in peri-urban communities in Johannesburg, South Africa. A mixed methods research strategy was used to collect both quantitative and qualitative data. Semi-structured interviews and field notes were used for qualitative data collection, while hand-delivered questionnaires were used for collecting quantitative data. Outpatients, administration, and medical personnel that worked at various research sites constituted the sample. The findings identified poor infrastructure, poverty and geographical location as factors hindering healthcare access. Additionally, the study revealed that healthcare policies contributed to the marginalisation of poor communities and recommended a review of such policies to involve various stakeholders. The planned implementation of National Health Insurance and the need for a comprehensive social security system were also recommended as strategies to address the hindrances. Finally, a conceptual model was developed to drive behavioural change in the public and private healthcare systems, leading to affordable and sustainable improvement in accessing, navigating, and using healthcare services.*

KEYWORDS: poverty, access, healthcare services, healthcare policies, peri-urban communities, medical services

INTRODUCTION

According to a report by the World Health Organization (WHO) (2019), access to healthcare services continues to be a major obstacle in numerous developing and underdeveloped economies, especially in Sub-Saharan Africa. Despite ongoing efforts to improve healthcare infrastructure and delivery, many individuals in these regions still lack access to basic healthcare services due to factors such as poverty, insufficient healthcare facilities, and inadequate transportation. Many people in the region still face significant barriers, including financial constraints, limited infrastructure, and an inadequate healthcare workforce. As noted in a recent scoping review of interventions and challenges in Ghana by Mensah *et al*. (2021), the need for government-led interventions to improve healthcare access remains a

pressing issue in many Sub-Saharan African countries. However, the effectiveness of such strategies is seldom determined or empirically measured to determine their alignment with poverty causality.

In South Africa, healthcare policy is premised on the legacy of apartheid, which marginalised and disadvantaged many poor communities. The non-existence or ineffectiveness of healthcare policies amidst poverty levels affects and impedes poor communities from accessing healthcare services (Sparks, 2017). The South African government has made efforts to translate national programmes and policies into priority outcomes, which have seen some success, such as increased access to antiretroviral medicines, social grants support, compulsory education, subsidised housing, and other services (RSA, 2020). However, there is still a need for policies and programmes that target poverty alleviation and end the effects of a system that benefits a few and creates extreme social inequalities (Ferreira, 2021).

Responsive institutional governance systems that direct people-oriented policies are crucial in addressing this issue. By prioritising the needs of the most vulnerable populations, governments can ensure that healthcare services and resources are accessible to all, regardless of their socioeconomic status (Fukuda-Parr, 2009). With the proper governance systems in place, policymakers can better address the underlying causes of poverty and ensure that healthcare policies are appropriately aligned with poverty causality, leading to improved access to healthcare services and resources for all (Ssengooba, 2016).

Theoretical and conceptual underpinning

The behavioural-ecological model of healthcare access and navigation guided this study. There are various factors that enable or hinder healthcare consumers from accessing healthcare services (Ryvicker, 2018). For example, healthcare consumers need enabling resources such as income and healthcare insurance, while need factors include the patient's perception and the service provider's evaluation of healthcare services. Sofaer (2009) states that the behavioural ecological model demonstrates several factors for accessing healthcare services, including the availability of such healthcare services, affordability, transportation, healthcare literacy, skills in communicating with healthcare providers, and all the necessary social support for treatment adherence.

Access to healthcare is a fundamental human right enshrined in Section 27(1) of the Constitution of South Africa (Boyd, 2017). Despite this, many individuals in Johannesburg are struggling to access healthcare services. Several factors impede access to healthcare, including socioeconomic status, lack of transportation, and inadequate healthcare infrastructure. The socio-economic status contributes significantly to healthcare disparities in the country. Individuals living in poverty are more likely to experience poor health outcomes and have limited access to healthcare services (Statistics South Africa, 2018). This is particularly true in informal settlements that are mushrooming at an unprecedented rate and rural areas, as healthcare facilities are often limited.

Many individuals lack access to reliable transportation, making it difficult to travel to healthcare facilities located far from their homes Mayosi and Benatar (2014). This can result in missed appointments, delayed treatment, and ultimately poorer health outcomes. Inadequate healthcare infrastructure is a significant barrier to healthcare access including a shortage of healthcare workers, lack of medical equipment and supplies, and inadequate healthcare facilities (Padarath *et al*., 2018). In

many cases, individuals are forced to travel long distances to receive basic healthcare services, which can be costly, time-consuming and life-threatening.

Addressing these barriers to healthcare access requires a multi-faceted approach that involves collaboration between the government, healthcare providers, and community organisations (Yaya, Bishwajit and Ekholuenetale, 2019). Efforts to improve healthcare access in developing countries such as Nigeria and South Africa require a multifaceted approach that involves collaboration between government, healthcare providers, and community organisations. A population-based study conducted in Nigeria by Yaya *et al*. (2019) identified various factors associated with the utilisation of healthcare services among women. Meanwhile, the South African government has launched the National Health Insurance (NHI) programme as a means of achieving universal healthcare coverage for all citizens (Department of Health, 2017). However, the NHI programme's implementation has been slow, and there are concerns regarding its feasibility and sustainability, as noted by Blecher *et al*. (2018).

In examining some of the factors impeding access to healthcare in Johannesburg, including historical disadvantage, poverty, costly medical aid schemes, shortage of medical practitioners, and socio-economic conditions, historical disadvantage still remains a significant impact on access to healthcare in Johannesburg. The legacy of apartheid has resulted in unequal distribution of resources, including healthcare facilities, in the city. The townships, which are predominantly black and poor, are often situated far from the city centre, where the majority of healthcare facilities are located (Kasiram, 2018). As a result, people living in these areas face challenges in accessing healthcare services, especially those that require specialist care.

Poverty is another major factor that impedes access to healthcare in Johannesburg. The Human Sciences Research Council (HSRC) holds that poverty and unemployment contribute to poor health outcomes, including limited access to healthcare (HSRC, 2019). The study maintained that many people in Johannesburg are unable to afford private healthcare services and rely on the public healthcare system, which is often overburdened and under-resourced. Medical aid schemes also contribute to the problem of access to healthcare as these schemes are often unaffordable for people living in poverty, and the benefits they offer are limited (South African Government News Agency, 2018) implying that people who cannot afford medical aid often have to rely on the public healthcare system, that is already under acute strain.

The shortage of medical practitioners poses a major challenge to access of healthcare resulting in long waiting times at healthcare facilities influencing the quality of care. This shortage is often linked to the uneven distribution of healthcare resources, as many medical practitioners prefer to work in more affluent areas of the city (Shisana *et al*., 2018). These conditions can lead to poor health outcomes and exacerbate existing health conditions, further burdening an already overstretched healthcare system (Statistics South Africa, 2018). Socio-economic issues, such as inadequate housing, poor sanitation, and high crime rates, also contribute to the problem of access to healthcare.

The fragmentation of the healthcare system has resulted in a lack of coordination and integration of services, leading to inefficiencies and disparities in access to care (Gilson *et al*., 2018). The absence of clear governance structures and accountability mechanisms further exacerbates these challenges (Gilson *et al*., 2018). Moreover, poor leadership has been identified as a major factor impeding access

to healthcare in Johannesburg. According to Mulaudzi *et al*. (2020), weak leadership and management practices contribute to the poor quality of healthcare services in the city. In particular, the lack of accountability and transparency in decision-making undermines the public's trust in the healthcare system (Mulaudzi *et al.,* 2020). According to Peltzer, Phaswana-Mafuya and Hlongwana (2018) corruption and unethical behaviour among healthcare providers and leaders have been identified as significant barriers to accessing healthcare in Johannesburg. Sibomana *et al.* (2021) found that corruption and unethical practices are widespread in the city's healthcare system, with consequences for service delivery, equity, and access to care. To address these issues, there is a need for strong leadership and governance structures that prioritise accountability, transparency, and ethical behaviour in the healthcare system. This includes investing in leadership development programmes and strengthening accountability mechanisms (Gilson *et al.*, 2019). Furthermore, there is a need to address the underlying socioeconomic factors that contribute to poor access to healthcare, such as poverty and inequality (Mulaudzi *et al*., 2020). Similarly, Matsoso and Fryatt (2016) emphasise the need for accountable and transparent governance structures to ensure equitable distribution of healthcare resources and services. Joubert, Ehrlich, Tumbo & Govender (2017) also point out the importance of leadership and governance in addressing healthcare access challenges, particularly in the context of health system reforms. They argue that leadership and governance are essential for the successful implementation of health system reforms that aim to improve access to healthcare services.

The Ideal Clinic programme was launched in 2013 as a way to improve primary healthcare services in South Africa (Hatcher *et al*., 2020). The programme aimed to address issues such as long waiting times, medication stockouts, and a shortage of healthcare professionals by improving clinic infrastructure, management, and service delivery (Hatcher *et al.,* 2020). However, the success of the programme has been limited by a lack of political will, inadequate funding, and poor implementation at the local level (Kondlo & Goudge, 2019).

Access to healthcare is a fundamental right for all citizens, yet the cost of healthcare services is often prohibitive for many people, particularly those who are unemployed or live in poverty. Medical aid schemes, which are designed to provide financial assistance to individuals for healthcare expenses, are a potential solution to this problem. However, the effectiveness of medical aid schemes in improving access to healthcare in Johannesburg has been questioned due to various factors. One of the main issues with medical aid schemes is that they are primarily designed for individuals who can afford to pay premiums, excluding many of the poorest South Africans from accessing the benefits of such schemes. Chitindingu (2019) established that low-income earners, who constitute the majority of the South African population, are unable to afford private health insurance and are therefore excluded from accessing quality healthcare services.

Another constraint is that medical aid schemes often do not provide sufficient coverage for certain healthcare services, such as chronic medication, dental care, and mental health services. A report by the Health Systems Trust (2019) found that out-of-pocket payments for healthcare remain high in South Africa, despite the existence of medical aid schemes. The report suggests that medical aid schemes need to expand their coverage to include a wider range of healthcare services, particularly those essential for improving health outcomes. Moreover, there are concerns about the governance and regulation of medical aid schemes in South Africa. The Medical Schemes Act (1998) governs medical aid schemes in the country, but there are concerns about its effectiveness in regulating the industry.

Mills, Palmer, Gilson, McIntyre, Schneider, Sinanovic and Wadee (2004) found that the Medical Schemes Act has not adequately protected consumers from unethical practices by medical aid schemes, including the denial of claims and the imposition of hidden costs.

Navigating healthcare services can be a challenging task, especially for vulnerable populations who may face additional barriers to accessing care. Empirical studies from other countries can provide valuable insights into effective strategies for improving access to healthcare and addressing barriers to navigation. A systematic review of studies from several countries found that patient navigation programmes can improve access to care and increase patient satisfaction, particularly for underserved populations (Lorincz *et al*., 2018). Patient navigation involves providing personalised support to patients to help them navigate the healthcare system, including scheduling appointments, coordinating care, and addressing barriers to access. This approach has been effective in improving cancer screening rates and reducing delays in diagnosis and treatment (Freundlich *et al*., 2020). Community health workers are trained individuals who provide navigation through the healthcare system, provide health education, and address social determinants of health. The study found that community health workers effectively improved health outcomes and reduced healthcare costs for patients with complex health needs. Empirical studies from other countries can also provide insights into innovative healthcare models that prioritise patient-centred care and address barriers to access. For example, a Netherlands study found that a patient-centred medical home model effectively improved access to care and reduced healthcare costs (van Hassel *et al*., 2019). This model involves providing comprehensive, coordinated, and personalised care to patients, including proactive outreach, care coordination, and access to a range of healthcare professionals. Overall, empirical studies from other countries highlight the importance of patient-centred approaches to healthcare navigation and access, including patient navigation programmes and community health worker models. These studies also demonstrate the potential of innovative healthcare models, such as patient-centred medical homes, to improve access to care and reduce healthcare costs.

Access to healthcare is not just about physical barriers but also the ability to navigate complex healthcare systems. In Johannesburg, the navigation of healthcare services is complicated by factors such as language barriers, lack of information, and inadequate communication between healthcare providers and patients (Mokgalagadi, 2019). A New Zealand study found that patients who had difficulty navigating the healthcare system were more likely to delay seeking medical attention and experience worse health outcomes (Gauld *et al.,* 2017). This highlights the need for effective communication and patient education to ensure patients can navigate healthcare services.

A Kenyan study found that financial constraints were a significant barrier to healthcare access (Wakaba *et al*., 2016). In contrast, a study in New Zealand identified language barriers and cultural differences as significant obstacles (Gauld *et al*., 2017). These studies demonstrate that the barriers to accessing healthcare vary depending on the context, and solutions must be tailored to address specific challenges.

After reviewing the literature on factors impeding access to healthcare in Johannesburg, it is evident that various factors contribute to the problem. Leadership and governance, poverty, medical aid schemes, shortage of medical practitioners, and the historical disadvantage of certain communities are among the primary factors. The South African public healthcare system and policy, including the Ideal Clinic programme and National Health Insurance, aim to address these challenges, but the

effectiveness of these initiatives remains to be seen. Additionally, the navigation of healthcare services and the availability of empirical studies from other countries, such as New Zealand and Sub-Saharan Africa, offer potential solutions for improving healthcare access in Johannesburg.

Despite these efforts, there is a pressing need for further research and action to address the persistent barriers to healthcare access in Johannesburg. It is crucial to prioritise equitable access to healthcare for all communities and to ensure that these efforts are sustainable and inclusive. Only through a collaborative effort between the government, healthcare providers, and community stakeholders can there be hope to address the complex challenges facing healthcare access in Johannesburg and beyond.

METHODOLOGY

The paradigm adopted in this study was a pragmatic philosophical stance that aimed to enhance the validity and credibility of the results. These paradigms help to understand the phenomena, and advance assumptions (Creswell & Plano-Clark, 2017). The objective of the study was to develop a conceptual model to address the factors that hinder patients from accessing and navigating healthcare services in peri-urban communities in Johannesburg. Therefore, the ontological perspective of the study was to understand the challenges confronting peri-urban communities. The study applied a mixed methods research approach, completing pragmatic procedures for gathering, analysing and interpreting research data (Creswell & Plano-Clark, 2017). Both qualitative and quantitative data were collected from multiple sources, using various tools and techniques, enabling data triangulation. Surveys were conducted at three research sites in Johannesburg, whilst a focus group interview was conducted at one research site and face-to-face interviews were conducted at another research site. Semi-structured interviews guided the qualitative data collection process. The target population for the study were patients, administrative, nursing and medical practitioners. The sample size for qualitative data analysis was 14 participants and the sample size for quantitative data analysis was 173. The questions were articulated to ensure that relevant data was collected. Simple random and non-probability purposive sampling techniques were used in the study, with a large sample size required in the survey.

Data analysis was done through various statistical techniques, including cross tabulations, Chi-square tests, Kruskal Wallis ANOVA, and thematic data analysis on interview transcriptions. Quantitative results were presented in frequency tables, bar graphs and pie charts, while qualitative results were expressed in narrative format.

FINDINGS

Poverty, healthcare systems, costly medical services, communication barriers, and low health literacy were major hindrances to accessing healthcare, with unemployment contributing significantly to poverty levels, and healthcare policies contributing to marginalisation of poor communities due to the legacy of apartheid, as reported by the respondents and participants.

One hundred and seventy-three respondents participated in the survey, comprising 56.6% between the 18-34-year age cohorts; 25.2% (35-44 years); 13.2% (45-54 years) and 5% (55 years and older). The sum scores for poverty levels were 35.01; 34.74; 32.67 and 34.57 respectively for the four age cohorts.

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In table 2 below, the study sought to establish the poverty levels and how poverty levels contributed to accessing healthcare services in peri-urban communities in Gauteng. Construct D1 ('There is a high rate of poverty in South Africa caused by the legacy of the apartheid government') reinforces a lower rating to apportioning blame on apartheid for poor access to healthcare services.

Table 1 Poverty levels on healthcare services

Accessing	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Mean	Std. Error Mean	T(p)	p value	Reject / Accept
D1	2.3	7.0	24.0	25.1	41.5	3.96	.082	11.7	.000	Reject
D2	0.6	2.9	17.4	37.8	41.3	4.16	.065	17.8	.000	Reject
D3	1.2	2.4	12.0	27.1	57.2	4.37	.068	20.1	.000	Reject
D4	0.0	1.2	22.9	28.2	47.6	4.22	.064	18.9	.000	Reject
D5	0.6	1.2	15.6	19.2	63.5	4.44	.065	22.1	.000	Reject
D6	0.6	5.3	23.5	24.1)	46.5	4.11	.075	14.7	.000	Reject
D7	0.6	1.8	17.0	24.0	56.7	4.35	.066	20.3	.000	Reject
D8	0.6	3.6	22.5	26.0	47.3	4.16	.072	16.1	.000	Reject
D9	1.8	5.8	22.8	28.7	40.9	4.01	.078	13.0	.000	Reject

Source: Author presentation

Table 2, below, illustrates which other significant constructs must be similarly profiled against the last domain, which is domain D ('Poverty levels on healthcare services').

Table 2 Cross-tabulation; p-values: significant constructs vs domain D (poverty) constructs

	D1	D2	D3	D4	D5	D6	D7	D8	D9
C7	.014	.741	.003	.000	.000	.036	.000	.025	.001
B3	.191	.030	.007	.005	.005	.203	.174	.115	.024
C8	.000	.383	.000	.000	.000	.001	.000	.006	.001
B1	.357	.039	.000	.003	.000	.000	.000	.000	.002
B7	.014	.000	.000	.012	.001	.221	.002	.002	.636
D6	.243	.000	.137	.001	.000		.000	.000	.000
B9	.087	.002	.001	.001	.000	.033	.124	.109	.004
C1	.026	.139	.001	.002	.000	.217	.000	.211	.438
C3	.000	.088	.022	.000	.000	.426	.000	.314	.060

Source: Author presentation

People, irrespective of their racial, age or financial background, should access healthcare services as and when required. Even though some of the questionnaire responses indicated that racial or historical legacies were not a factor in accessing healthcare services, the results appear to indicate that most Whites do have medical aid and have better access to healthcare services.

Table 3 Distribution of ethnic groups

Ethnicity	Frequency	Valid percent	Domain B	Domain C	Domain D
			'Accessing' sum score mean	'Healthcare policies' sum score mean	'Poverty levels' sum score mean
Indian	19	11.9	32.37	34.42	33.37
Black	80	50.3	33.87	34.14	35.74
Coloured	35	22.0	32.12	32.97	34.06
White	18	11.3	30.89	33.11	32.33
Other	7	4.4	35.14	32.86	33.86
Question answered	159	100.0			
Question not answered	14				
Total	173				

Source: Author presentation

The article presents the results of a qualitative study that involved conducting semi-structured interviews with 14 participants in research sites, including hospitals and surrounding areas. The study aimed to examine the three domains of accessing healthcare services, healthcare policies in South Africa, and the effects of poverty on healthcare services. The participants included medical personnel, senior managers, patients, and administrators, with a mix of males and females to ensure diverse opinions. The demographic information of the participants was collected for analysis purposes and each respondent was identified with an alphabetic letter to maintain confidentiality. Six participants were males and eight were females. There were emerging themes from the interviews conducted in the study. Nine statements were presented in the research protocol, and the interviews led to the development of eight themes related to accessing healthcare services, healthcare policies, poverty, and medical schemes.

The eight themes that emerged from the interviews were related to accessing healthcare services and policies, as well as poverty and medical schemes. Theme 1 focused on identifying barriers to accessing healthcare services, while Theme 2 examined ways to mitigate these barriers. Theme 3 explored how healthcare policies can enable poor communities to access healthcare services, while Theme 4

addressed the challenges of existing policies in these communities. Poverty was identified as a barrier to accessing healthcare services in Theme 5, which led to Theme 6: revising healthcare policies to accommodate poor communities. Theme 7 looked at interventions to alleviate and mitigate poverty levels, while Theme 8 highlighted that current medical schemes exclude low-income earners.

DISCUSSION

Age sum scores

The higher variability in the 35-44 age group can be attributed to their being the most able-bodied and in mid-careers, while the lower variability in class 4, which is the 55 years and older group, can be attributed to the smaller sample size.

Impact of poverty on healthcare services

The study demonstrates strong support for the specific determinant of poverty in accessing healthcare services, particularly regarding high unemployment contributing to poverty levels, as evidenced by the positive agreement registered for construct D5; moreover, it indicates that private healthcare is only affordable to the employed and better-off, with prohibitive costs making it inaccessible for most people.

Domain D comprised the following constructs:

Construct D1: 'There is a high rate of poverty in South Africa caused by the legacy of the apartheid government'.
Construct D2: 'Income inequalities contribute to poverty levels in the country'.
Construct D3: 'Poor people cannot access better resourced healthcare centers'.
Construct D4: 'Poverty impedes people from accessing healthcare services'.
Construct D5: 'High unemployment contributes to poverty levels in the country'.
Construct D6: 'There are different initiatives that can be undertaken by government to alleviate poverty'.
Construct D7: 'The distribution of medical doctors should be revised in line with basic healthcare rights'.
Construct D8: 'Government should address income inequalities as an urgent issue'.
Construct D9: 'The level of poverty will push away potential investors who might uplift the living conditions of peri-urban communities'.

The quantitative data analysis shows that peri-urban areas in Johannesburg face high levels of poverty that prevent the communities from accessing appropriate healthcare services due to unaffordability, and Mayosi and Benatar (2014) contend that the legacy of the apartheid system has adversely affected various services in post-apartheid South Africa.

From domain D, constructs D3, D4 and D5 affect all the other significant constructs from other domains that were tested in this study, confirming that poverty has an adverse effect on accessing healthcare services. However, as mentioned earlier, the causes of poverty were not all apportioned to apartheid by the respondents. This indicates that poverty is perceived to emanate from various causes

such as inefficiency, corruption, etc., as well as the legacy of apartheid. All the constructs of domain D, except for construct D2, are significantly associated with healthcare policies ('There is a need to revise healthcare policies for poor people in peri-urban areas'). This means that in the revision of healthcare policies, cognisance should be taken of the high rate of poverty in its various forms and effects, unemployment and income inequalities, the inability of the poor to access better resourced healthcare centres, and the need for a revision of the distribution of medical doctors.

The qualitative data analysis shows that poverty was a major impediment to accessing and navigating healthcare services in peri-urban communities, with participants indicating that patients were mostly referred from small healthcare facilities serving such communities, and that the majority could not even afford to pay R5, indicating that poverty was a significant challenge in Gauteng's peri-urban communities as demonstrated by both qualitative and quantitative findings. Inequality in health and access to healthcare services are considered for all intents and purposes to be likely because of disparities in these issues between population groups. Health inequities refer to such disparities that are unnecessary, avoidable, unfair, and unjust (Höglund et al., 2018). Healthcare access is a fundamental human right and if it is not evenly accessed and equitable, the net effect of differentials will be felt within and across all sectors of society. Although dated, the findings of a StatsSA (1999) report is supported by this study's results from both the quantitative and qualitative data analyses, which insist that healthcare access is a right for everyone in South Africa. People in poor rural communities continuously face challenges in accessing healthcare services (Mills, 2014). The views by Mills (2014) were also supported by the responses from respondents during the interviews.

Analysis of ethnicity

Table 4 above, displays the distribution and effects of ethnicity on accessing healthcare policies and poverty, with 80% of respondents being Black South Africans, and the impact of accessing healthcare policies being assessed differently among ethnic groups, with the least effect on White South Africans and the highest effect on 'Other' respondents, while poverty has a significantly higher impact on Black South Africans; the study suggests that disparities based on ethnicity exist in accessing healthcare services, with 87.2% of those dependent on state healthcare services being Blacks, whereas the picture is reversed for Whites and Indians, leading to varied experiences of accessing the same healthcare services by different ethnic groups.

Implication to Research and Practice

The study highlighted the significant impact of poverty and ethnicity on accessing healthcare services in peri-urban communities in South Africa. The implications for research include the need for further investigation into the underlying causes of these disparities and the development of interventions to address them. Practically, the findings suggest the importance of targeted policies and programmes that aim to improve access to healthcare services for marginalised communities. These policies should take into account the unique challenges faced by different ethnic groups and prioritise the needs of those most affected by poverty. Additionally, efforts to increase education and awareness around healthcare services and policies may help to address some of the barriers identified.

CONCLUSION

The study sought to establish the effects of poverty on healthcare access and navigation in poor communities. Both qualitative and quantitative research results demonstrated that poverty was a major challenge and due to the devastating effects of poverty on poor communities, depriving their Constitutional rights of accessing and navigation healthcare services. The level of poverty amongst communities will push investors away because poor people live in areas that are less investor friendly and often undesirable for formal development. Poverty clearly has an adverse impact on enjoying the healthcare services that should benefit all citizens.

Future Research

Future research in this area could focus on addressing the root causes of poverty in peri-urban communities in South Africa and how it impacts access to healthcare services. Additionally, research should investigate how healthcare policies can be reformed to address the disparities experienced by different ethnic groups in accessing healthcare services. It is also important to explore how technology can be leveraged to improve access to healthcare services in peri-urban communities, where physical access to healthcare facilities may be limited. Finally, future research should investigate the impact of community-based healthcare interventions in peri-urban areas and how they can be scaled up to improve healthcare outcomes for vulnerable populations.

REFERENCES

Blecher, M., Jacobs, T. & Hanass-Hancock, J., 2018. Will the national health insurance provide universal coverage and social health protection in South Africa? Health Policy and Planning, 33(1), pp. 62-70.

Boyd, N., 2017. Universal health coverage and the right to health: legal and normative frameworks. Bulletin of the World Health Organization, 95(10), pp. 721-723.

Chitindingu, E., George, G. & Knight, L., 2019. The role of private health insurance in the South African healthcare system: a review. International Journal of Health Policy and Management, 8(11), pp. 647-654.

Creswell, J. W., 2012. Educational research: planning, conducting and evaluating quantitative and qualitative research. 4th ed. Boston: Pearson.

Creswell, J. W. & Plano-Clark, V. L., 2017. Designing and conducting mixed method research. 3rd ed. Boston: SAGE.

Department of Justice and Constitutional Development, 1996. Constitution of the Republic of South Africa. Pretoria: Department of Justice and Constitutional Development.

English, R. et al., 2019. The state of healthcare in South Africa. South African Health Review, pp. 1-12.

Freundlinch, K. L., Martin, L. T., Ciemins, E. L. & Schrag, D., 2020. Patient navigation for breast and colorectal cancer in medically undeserved areas: a systematic review. Journal of Cancer Education, 97(6), pp. 1260-1274.

Gauld, R., Derrett, S. & Jayasinha, R., 2017. Navigating the healthcare system: perceptions from patients with musculoskeletal injuries. Health Expectations, 20(6), pp. 1296-1304.

Gilson, L. et al., 2018. Strengthening leadershp and governance for health: what, when, and how?. Health Policy and Planning, 33(2), pp. ii1-ii4.

Gilson, L., Tugendhaft, A. & Erasmus, E., 2019. The impact of fragmented governance on health system performance in South Africa. Social Science & Medicine, 244(112640).

Hatcher, A. M., Onah, M., Khoza, S. & Parsons, A. N., 2020. Scaling up the ideal clinic in South Africa: a management and systems approach to quality improvement in primary care. Health Policy and Planning, 35(1), pp. 26-33.

Human Sciences Research Council, 2019. Poverty, inequality and the burden of non-communable deases in South Africa. Pretoria: HSRC Press.

Joubert, G., Ehrlich, R., Tumbo, J. & Govender, T., 2017. A qualitative assessment of the South African health system: challenges and opportunities for health innovation. BMC Public Health Research, 17(1), pp. 1-11.

Kalolo, J., Kibusi, S. & Sanudi, L., 2018. The barriers affceting access to healthcare services for women in Mtwara Rural District, Tanzania. Health Services Insights, Volume 11.

Kasiram, M., 2018. Apartheid spatial planning and its impact on access to healthcare in Johannesburg. Journal of Health Care for the Poor and Underserved, 29(2), pp. 631-645.

Kautzky, K. & Tollman, S. M., 2008. A perspective on primary health care in South Africa: primary health care in South Africa. South African Health Review, 1(1), pp. 17-30.

Kondlo, K. & Goudge, J., 2019. Unpacking implementation of the Ideal Clinic policy in South Africa: implementation fidelity, conflict, and power. BMC Health Services Research, 19(1), pp. 1-11.

Kumalo, F., Selaluke, J. P. & Maharaj, P., 2019. Exploring barriers to access to healthcare services for rural elderly in South Africa. Journal of Interdsciplinary Health Sciences, Volume 24, pp. 1-9.

Leedy, P. D. & Ormrod, J. E., 2014. Practical research: planning and design. 10th ed. Essex: Pearson.

Lorincz, I. S., Lawson, K. A., Lond, J. A. & Provider, C. N., 2018. Patient navigation scope and diversity in the United States: a systematic review. American Journal of Preventive Medicine, 54(5), pp. 746-754.

Matsoso, M. P. & Fryatt, R., 2013. National health insurance: the first 18 months. South African Medical Journal, 103(3), pp. 156-158.

Mensah, J., Oppong, J. R., Schmidt, C. M. & Hirschhorn, L. R., 2021. Improving access to healthcare in Ghana: a scoping review of interventions and challenges. PLOS One, 16(1).

Mills, A. et al., 2004. The performance of different models of primary care provision in Southern Africa. Social Science & Medicine, 59(5), pp. 931-943.

Moeti, T. & Padarath, A., 2019. South African health review 2019. Durban: Health Systems Trust.

Mofolo, I. L., Peltzer, K., Phaswana-Mafuya, N. & Chirinda, W., 2020. Factors associated with the utilization of healthcare services among women in Nigeria: a population-based study. MBC Public Health Research, 19(1), pp. 1-10.

Mokgalagadi, Y., 2019. Undersatnding the concept of access to healthcare. South African Journal of Nursing and Midwifery, 21(1), pp. 1-9.

Mulaudzi, F. M., Peu, M. D. & Phetlhu, R. D., 2020. Leadership and management practices in a health care system: a case study of Johannesburg, South Africa. Journal of Public Administration and Governance, 10(1), pp. 251-267.

Naicker, S., Plange-Rhule, J. & Tutt, R. C., 2019. Leadership and governance impediments to healthcare access in Africa: an exploratory qualitative study. African Journal of Primary Healthcare & Family Medicine, 11(1), pp. 1-9.

Parliamentary Monitoring Group, 2017. National Health Insurance Policy White Paper, Cape Town: Parliamentary Monitoring Group.

Public Service Commission, 2017. Report on the monitoring of the implementation of Batho Pele principles in the public service: provision of health services, Pretoria: Public Service Commission.

Shisana, O. et al., 2018. South African national HIV prevalence, incidence and behaviour survey, 2017. Cape Town: HSRC Press.

Sibomana, L. et al., 2021. Corruption and unethical behaviour in health care: challenges and solutions to improving care in sub-Saharan Africa. BMC Health Services Research, 21(1), pp. 1-14.

South African Government News Agency, 2018. Medical aid schemes make healthcare unaffordable for poor. [Online]
Available at: https://www.sanews.gov.za/south-africa/medical-aid-schemes-make-healthcare-unaffordable-poor
[Accessed 19 April 2023].

Statistics South Africa, 2017. Poverty trends in South Africa: an examination of absolute poverty between 2006 and 2015, Pretoria: Statistics South Africa.

Statistics South Africa, 2018. Inequality trends in South Africa: a multidimensional diagnostic of inequality. Pretoria: Statistics South Africa.

Teddlie, C. & Tashakkori, A., 2009. Foundations of mixed methods research: integrating quantitative and qualitative approaches in the social and behavioural sciences. Thousand Oaks: SAGE.

Van Hassel, D., Meijer, E. & Smit, M., 2019. Patient-centred medical home in the Netherlands: study protocol for a quasi-experimental controlled study. BMC Family Practice, 20(1), p. 36.

Wakaba, M. et al., 2016. The public sector nursing workforce in Kenya: a county-level analysis. Human Resources for Health, 14(1), p. 49.

World Health Organization, 2023. Better information: better action on health. [Online]
Available at: https://aho.afro.who.int/
[Accessed 20 April 2023].

Yaya, S., Bishwajit, G. & Ekholuenetale, M., 2019. Factors associated with the utilization of healthcare seervice among women in Nigeria: a population-based study. BMC Public Health Research, 19(1), pp. 1-10.