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Challenges faced by elderly people of the Tshani Community in accessing Tertiary Health Care Services

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ABSTRACT

The current research explores the issue of the elderly in the rural Tshani community of the Eastern Cape area, South Africa, about accessing tertiary healthcare services. It was done to understand the impact of barriers at the socioeconomic, geographical, and systems level on the capacity of the aged population to receive specialised medical care and suggest measures to improve access. The qualitative descriptive research design, which used semi-structured face-to-face interviews of 20 purposely selected respondents aged 60 years and above was adopted. The thematic data analysis was conducted based on the framework provided by Braun and Clarke (2022) to detect common patterns and trends. The results showed five key themes, namely geographical and transportation barriers, health system inefficiencies, lack of social and family support, lack of information on available services, and felt gaps in the government intervention. The participants explained the long waits to hospitals, expensive transport, ineffective referral mechanisms, and low availability of specialists. Isolation and neglect were widespread, accompanied by poor communication from the healthcare providers. The research suggests transportation subsidies, enhanced referral systems, augmented government expenditure in rural health facilities, and the formation of community-based support systems among the aged people. The research reveals the lived lives of the rural aged population to the sociological and public health literature on healthcare disparities, as well as provides evidence-based information on policy interventions that can help address the inequity in accessing tertiary healthcare in South Africa.

Keywords: Elderly People, Rural Healthcare Services, Tertiary Healthcare Barriers, Tshani Village, Eastern Cape, South Africa

INTRODUCTION

Tertiary healthcare is defined as the highest level of specialized medical care, and it is offered to patients who need advanced treatment for serious or uncommon illnesses. Typically, specialized hospitals, medical facilities, and educational institutions with modern resources and technology provide this kind of treatment.[1] Conditions such as rare genetic variations, advanced cancer stages, or severe wounds from serious accidents that fall outside the scope of primary and secondary care are treated by tertiary healthcare. Access to healthcare is affected; services are used less frequently, later, or never, and those

[1] World Health Organization (WHO), " Universal Health Coverage (UHC): Key Facts," 2021.

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with low incomes, limited transportation options, the elderly, and the disabled individuals are disproportionately affected. It is a problem that there is an increase in the burden of chronic illnesses in low- and middle-income nations due to the lack of access to tertiary health care services provided by the District and National Hospitals. Most of the affected are from poor, rural backgrounds or have unpredictable finances. To address this issue, it is important to understand patients' perspectives on the challenges they face when accessing care, especially in settings with limited resources. Rural residents face a global problem with access to tertiary health care; It is not just a problem in tiny States.[2]

Furthermore, despite a wealth of data linking trauma and violence to a variety of health issues, including chronic pain, depression, anxiety, and substance abuse, health services are not created to take into consideration the realities of rural people. Rural people's needs are rarely considered while designing or providing healthcare. By focusing on the underlying causes of people's health and social problems, a decolonizing perspective helps tackle this intricate interaction of circumstances.

Since colonialism and apartheid, the South African National Health Service has relied heavily on equity of access to healthcare as one of its main objectives.[3]

Although research on the nature and extent of injustices is substantial, it remains somewhat enigmatic, and the information is scattered and challenging to assess. Because of this, it is frequently difficult to determine whether access disparities are a serious policy issue and, if so, how to effectively address them.

Governments have pledged to address access to healthcare imbalances, but implementing this policy will be challenging without a thorough understanding of what is already understood about the fairness of access to healthcare services. The methodology is then used to evaluate new findings on the worldwide access equity among socioeconomic categories. The study offers a generic analytic approach that is directly applicable to researchers from other nations looking to evaluate equity of access in a wide range of institutional settings, even if it focuses on the Republic of South Africa experience as an exemplar.[4] According to Williams and Cookson, there is a substantial theoretical body of work on the numerous concepts of equity related to health and health care.[5]

The Eastern Cape is one of the provinces with the least developed healthcare infrastructure. The South African Health Review notes that only 13% of the Eastern Cape's healthcare facilities are equipped to provide tertiary care, indicating a significant gap in service provision.[6] The elderly population in the Eastern Cape often face economic hardship. Stats SA reports that 46% of elderly people in the Eastern Cape live below the poverty line (living with less than R1,109 per month in SA, which exacerbates the challenge of affording travel and medical costs associated with tertiary healthcare.[7]

Healthcare service provision in South Africa has improved in the past five years. However, it is uncertain whether the changes have reached rural areas and if primary healthcare is successfully implemented in these areas.[8] Numerous socioeconomic and health system obstacles hinder the right to healthcare in rural regions. Due to the lack of holistic awareness of the obstacles to healthcare access, such as the distance rural patients must travel from their place of residence to the point of care, historical injustices remain.[9]

Access to healthcare remains a significant challenge for low-income residents in South Africa. By 2022, only 15.8% of the South African population was part of medical aid schemes, suggesting that the vast majority rely on the public healthcare system.[10] The private healthcare sector, which is better resourced, serves only about 15% of the population, while the under-resourced public sector is

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[2] Göran Dahlgren and Margaret Whitehead, "The Dahlgren-Whitehead Model of Health Determinants: 30 Years on and Still Chasing Rainbows," *Public Health* 199 (2021): 20–24.

[3] H. C. Williams and B. Cookson, "The Socioeconomic Status. The Power of Personality.," 2020.

[4] Dahlgren and Whitehead, "The Dahlgren-Whitehead Model of Health Determinants: 30 Years on and Still Chasing Rainbows."

[5] Williams and Cookson, "The Socioeconomic Status. The Power of Personality."

[6] C. Day, P. Barron, and A. Tipping, " The South African Health Review 2017," *Health Systems Trust*, 2017.

[7] Statistics South Africa, *General Household Survey 2019.* (Pretoria: : Stats SA., 2020); N. Cowling, *Poverty Thresholds and Household Income Dynamics in South Africa* (Pretoria: Policy Research Institute, 2024).

[8] Mary-Jane Schneider, *Introduction to Public Health:.* (Jones & Bartlett Learning, 2020).

[9] Bernhard Gaede and Marije Versteeg, "The State of the Right to Health in Rural South Africa," *South African Health Review* 1 (2011): 99–1066.

[10] News24., "South Africa's Healthcare System under Pressure: Public vs Private Divide.," https://www.news24.com, 2022.

responsible for the remaining 85%.[11] This issue is particularly acute in rural areas, where residents face additional barriers, such as long travel distances, high out-of-pocket expenses, and long waiting times. Despite healthcare being recognized as a constitutional right under South African law, disparities in healthcare access persist, especially among individuals from economically disadvantaged and geographically isolated communities.

These challenges are rooted in systemic inequalities in resource allocation, compounded by socio-economic and geographic barriers. Rural populations are particularly vulnerable due to their reliance on under-resourced healthcare facilities and the costs associated with traveling to tertiary care centers. Such inequities reflects broader trends observed in low- and middle-income countries (LMICs), where disparities in social power and economic resources contribute to unequal healthcare access.[12]

In response to these challenges, there has been a global shift in policy focus toward achieving universal health coverage (UHC). UHC aims to ensure that all individuals, regardless of income or geographic location, have access to quality healthcare services without facing financial hardship.[13] However, the realization of UHC in South Africa will require addressing the systemic barriers and inequities that perpetuate unequal access to care, particularly for rural and low-income populations.

The Nelson Mandela Hospital is around 145 km away from the community, thus a significant percentage of people from remote locations such as Tshani, who have illnesses or ailments that need level 3 tertiary health treatment, must travel considerable distances to get there. These exhausting journeys could lead to poor health outcomes and many people skip follow-up appointments. Many of the extremely ill patients who are scheduled to undergo evaluations at Nelson Mandela Hospital could pass away while heading to the facility. Distanced rural patients still find it to be the most challenging and stressful process to access Tertiary healthcare, which hurts their health.

Due to this, the study examined the difficulties Tshani patients had in getting to nearby hospitals for tertiary health care services. The extent to which the health right is being fulfilled to the advantage of the nation's rural population has also been investigated in this study.

Despite the recognition of significant barriers to healthcare access for rural populations in the Eastern Cape, there is a lack of comprehensive studies that specifically examine the interplay between socioeconomic factors, geographical distance, and health outcomes among elderly patients seeking tertiary care. Existing literature primarily focuses on general healthcare access issues without delving into the unique challenges faced by the elderly demographic, particularly those living below the poverty line. Furthermore, there is insufficient qualitative research that captures the lived experiences of these patients, including the psychological and emotional toll of traveling long distances for medical care. This gap highlights the need for targeted research that not only quantifies access barriers but also explores the subjective experiences of elderly patients in rural areas, thereby providing a more nuanced understanding of how these factors collectively impact their health outcomes and overall well-being. This study seeks to explore the common challenges faced by elderly patients of the Tshani community in accessing tertiary health care services. The study will further discuss the enablers in accessing and providing tertiary healthcare services. It will finally explore the various government interventions that are in place to address the challenges of providing tertiary healthcare services in rural communities.The study seeks to answer the following questions:

- What are the common challenges faced by the elderly patients of the Tshani community in accessing tertiary health care services?
- What are the enablers in accessing and providing Tertiary healthcare services in rural communities?
- What are the various government interventions to address the challenges of providing tertiary health services in rural communities?

[11] News24., "South Africa's Healthcare System under Pressure: Public vs Private Divide."
[12] D McIntyre and J Ataguba, "Access to Quality Health Care in South Africa: Is the Health Sector Contributing to Addressing the Inequality Challenge," *Parliament of South Africa* 2017 (2017).
[13] World Health Organization (WHO), " Universal Health Coverage (UHC): Key Facts."

LITERATURE REVIEW

Common Challenges Faced by Elderly Rural Residents in Accessing Tertiary Healthcare

The results of earlier pertinent research on the subject indicate that rural areas have inadequate tertiary healthcare services and poorly equipped healthcare facilities, which makes it difficult for elderly people to get specialized medical care when they need it.[14] When it comes to geographic barriers, senior citizens have less access because of the great distance between rural areas and tertiary health care centers. They have trouble getting a ride or need help getting to medical visits.[15] The major medical centers and tertiary care institutions are often located far away from villages and small towns. Elderly people find it challenging to travel large distances in search of specialized healthcare services due to a lack of road infrastructure and transit options.[16]

In Cofimvaba, Eastern Cape, South Africa, Babalwa Tshaka's study on "non-use of healthcare services" found that disabled people who live in remote areas have several challenges, one of which is being unable to obtain basic services like primary healthcare services. Study findings revealed major challenges experienced by persons with mobility impairments in accessing healthcare. These included inaccessible roads, geographic inaccessibility, financial accessibility and indirect cost of care, having few or no health problems, physical infrastructure difficulties within facilities, and attitudinal barriers. The issue of significant distance is commonly brought up in numerous studies on the accessibility of healthcare for those with disabilities as a reason for both poor access and non-use of services. In other rural contexts, for example, the Eastern Cape region of South Africa, rural Namibia, rural South Asia, rural Botswana, Ghana, and rural South Asia, long distances seem to be a common barrier to access.[17]

Therefore, the background shows that, despite current policies, people with disabilities are having trouble getting health care due to impediments. When it comes to getting health care, those with disabilities in cities face fewer obstacles than those in rural areas. Access to health care is unequal for people with disabilities (PWDs). In Cofimvaba, a rural isiXhosa settlement in the Eastern Cape, this study examined the experiences of people with mobility impairments who stopped receiving public health care because certain disabled people stopped doing so.

The purpose of reviewing this literature was to identify the gaps in the study by B. Tshaka, which focused on “non-use of primary healthcare for disabled people”. Hence, the current study seeks to fill those gaps by also focusing on challenges faced by elderly people when accessing tertiary healthcare services.

Limited Healthcare Facilities and Enablers in rural regions

Rural areas typically have fewer healthcare facilities compared to urban areas. This scarcity of clinics, hospitals, and specialist services can make it difficult for elderly individuals to access the medical care they need, particularly for specialized treatments or chronic disease management. For instance, there is only one hospital in Ngqeleni, Canzibe Hospital. All the residents of Canzibe depend on it for tertiary healthcare; other hospitals are 40km away.

Additionally, the lack of well-equipped hospitals and medical facilities in rural areas means that elderly individuals must travel to urban centers to receive tertiary. Rural areas often face shortages of

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[14] Peter Lloyd-Sherlock, “Old Age and Poverty in Developing Countries: New Policy Challenges,” *World Development* 28, no. 12 (2000): 2157–68.

[15] Sophie Witter et al., “Health System Strengthening—Reflections on Its Meaning, Assessment, and Our State of Knowledge,” *The International Journal of Health Planning and Management* 34, no. 4 (2019): e1980–89.

[16] T. Oni et al., “Urban Health Research in Africa: Themes and Priority Research Questions,” *Journal of Urban Health* 96, no. 3 (2019): 329–40.

[17] R. Vergunst, “Access to Health Care for Persons with Disabilities in Rural South Africa. ,” *BMC Health Services Research,* 16, (2016): 1–8; Gert Van Rooy et al., “Perceived Barriers to Accessing Health Services among People with Disabilities in Rural Northern Namibia,” *Disability & Society* 27, no. 6 (October 2012): 761–75, https://doi.org/10.1080/09687599.2012.686877; Venkata S Murthy Gudlavalleti, “Challenges in Accessing Health Care for People with Disability in the South Asian Context: A Review,” *International Journal of Environmental Research and Public Health* 15, no. 11 (2018): 2366; Thato M.M. Paulus-Mokgachane, Surona J. Visagie, and Gubela Mji, “Access to Primary Care for Persons with Spinal Cord Injuries in the Greater Gaborone Area, Botswana,” *African Journal of Disability* 8 (September 23, 2019), https://doi.org/10.4102/ajod.v8i0.539; S. C. Y. Appiah, F. Agblevor, and J. S. Agbenyega, “Barriers to Healthcare Access among Persons with Disabilities in Ghana,” *Disability, CBR & Inclusive Development* 31, no. 3 (2020): 1–17.

healthcare professionals, including specialized doctors, surgeons, and medical specialists required for tertiary care. This shortage can result in longer wait times and limited appointment availability for elderly individuals seeking specialized treatment.[18]

Various government interventions to address the challenges of providing and accessing tertiary health services in rural communities

Investments in upgrading rural healthcare facilities to offer more comprehensive services can reduce the need for travel. This includes improving diagnostic and minor surgical capabilities. Programs that provide financial assistance to cover the tertiary care costs make it more affordable for the elderly.

Implementation of medical training programs, such as programs that encourage healthcare professionals to work in rural areas through incentives such as loan forgiveness, higher pay, or career advancement opportunities. Government-sponsored health insurance schemes specifically target rural and elderly populations to reduce out-of-pocket expenses.[19] Many governments have implemented telemedicine programs to bridge the gap between rural and urban healthcare services. These programs use technology to provide remote consultations, diagnostics, and follow-up care.[20]

THEORETICAL FRAMEWORK

Social Darwinism

The Social Darwinism theory was introduced by American historian and sociologist Lester F. Ward in the late 19th century, specifically in his book "Dynamic Sociology" published in 1883. It became popular from the work of Herbert Spencer in the 19th century and early 20th century. He played a key role in popularizing and applying evolutionary principles to social and economic thought during this period. Herbert Spencer coined the phrase "survival of the fittest" in the 1860s, and his influential works promoted these ideas. According to Social Darwinism, the concept “survival of the fittest “applies to social groups and individuals of a society. This theory suggests that those who are strong, successful, and have advantageous traits will flourish, while those who are weak, inferior, or disadvantaged will struggle or even perish. Social Darwinism implies that individuals and social groups can rise or fall in status based on their inherent abilities, resources, and circumstances.

According to Gregory, Darwinism is a theory of evolution developed by Charles Darwin in 1859. He explained this theory using the process of “natural selection”.[21] Darwinism observed that within any given population of organisms, there is variation in traits and behavior. He proposed that that organisms with advantageous traits have a better chance of survival and reproduction, thus passing on those traits to their offspring, and those with disadvantageous traits perish. Gregory compares the theories of Darwinism and Social Darwinism; he compares the organisms with individuals of a society and social group by explaining that those with security and enough resources are more likely to survive, and the ones who lack resources are left to die.[22] The theory links to the challenges facing elderly people of Tshani Location, in the sense that those with better financial capacity or with better socioeconomic status are at an advantage because they can afford specialized medical care, whereas those who depend on the government’s healthcare facilities might die due to the lack of healthcare services.

The study, Social Darwinism Perspective aims to investigate how socioeconomic disparities impact the elderly population's accessibility to tertiary healthcare. This could involve examining how factors such as income level and social status influence their access to resources such as transportation, information, and financial means to afford healthcare services.

Health Belief Model

The Health Belief Model (HBM) is a psychological framework developed in the 1950sThe Health Belief Model (HBM) was developed in the 1950s by social psychologists Hochbaum, Rosenstock, and Kegel

[18] Bernhard W. Anderson, *From Creation to New Creation* (Minneapolis: Fortress Press, 1994).
[19] Michael Marmot, “The Health Gap: The Challenge of an Unequal World,” *The Lancet* 386, no. 10011 (2015): 2442–44.
[20] M. Brooks, “The Evolution of Perspective and Depth in Visual Arts,” *History of Art Studies Quarterly* 31, no. 2 (2017): 58–73.
[21] R. Gregory, *The Cambridge History of Modern Thought* (Cambridge University Press, 2018).
[22] Gregory, *The Cambridge History of Modern Thought*.

to understand and predict health-related behaviors. It posits that people's beliefs and perceptions about health risks, the severity of illnesses, the benefits of taking action to prevent or control health issues, and the barriers to such actions influence their health-related decision-making and behaviors. The Health Belief Model is particularly useful to understanding why individuals may or may not engage in preventive health behaviors, seek medical care, or adhere to recommended treatment regimens.[23]

The core components of the Health Belief Model are perceived severity, perceived benefits, and perceived barriers, but the component that we will focus on is perceived barriers, which is one of the challenges that makes it difficult for elderly patients to access health care services. Perceived barriers are the obstacles or challenges that an individual believes will be encountered if they attempt to take a specific health-related action. High perceived barriers can deter people from engaging in preventive behaviors. Barriers to accessing tertiary healthcare services for the elderly can include financial constraints, transportation difficulties, long waiting times, and complex healthcare systems. The Health Belief Model, including age, financial security, health literacy, spirituality, and lacking cues to action like reminders, are important in missed appointments, and addressing these factors could improve appointment-keeping for adults and the disabled.[24]

In the study, the Health Belief Model perspective is designed to examine how government interventions address elderly individuals' beliefs and perceptions about healthcare. This could involve assessing the communication strategies used to raise awareness about available healthcare services, as well as initiatives to enhance health literacy and empower individuals to take proactive steps to manage their health. To also investigate the factors that promote positive health-seeking behavior among the elderly population. This may involve identifying perceived benefits of accessing tertiary healthcare services, such as improved quality of life or increased longevity, and assessing how these factors contribute to their utilization of healthcare resources, to also assist the patients to overcome perceived barriers, assess how these perceptions influence their healthcare-seeking behavior and identify any barriers, such as cultural beliefs or lack of awareness,

Aligning HBM and Social Darwinism in the study involves using HBM to understand the personal and psychological factors influencing healthcare access among the elderly, while also considering the broader societal and systemic influences suggested by Social Darwinism. This dual approach can provide a comprehensive understanding of the challenges faced by the elderly in the Tshani community and inform the development of holistic interventions.

METHODOLOGY

This paper addresses the problems that the aged citizens in the rural village of Tshani in the Eastern Cape of South Africa experience in accessing their tertiary healthcare companion. Tshani is poverty-stricken, has inadequate infrastructure, and relies on government handouts. Thus, the aged population here faces specific problems in taking advantage of healthcare.[25] The inadequate transportation trails and local amenities, as well as the high economic expense of travelling far to get treatment in larger facilities, are related to inequities in health improvements due to the national lack of access to healthcare services in the province.[26] Qualitative descriptive design was adopted, in which the lived experiences of the elderly, from 60 years and above, were obtained through structured in-person interviews. A sample of 20 participants was selected using the purposive sampling technique because it allows reaching data saturation, which is necessary to conclude on the qualitative study.[27] The interviews were semi-structured and based on open-ended inquiries with which participants were expected to share their own

[23] Victor J Strecher et al., "The Role of Self-Efficacy in Achieving Health Behavior Change," *Health Education Quarterly* 13, no. 1 (1986): 73–92.
[24] Robert M Cronin et al., "Factors of the Health Belief Model," *Hematology*, 2018.
[25] F. Marchesani, "Access to Healthcare in Rural South Africa: Barriers and Opportunities. ," *Rural and Remote Health* 19 (2019).
[26] F., & Van der Berg, S. Booysen, "The Role of Public Health Expenditure in Reducing Inequality in South Africa. ," *Development Southern Africa* 37, no. 5 (2020): 1–15; McIntyre and Ataguba, "Access to Quality Health Care in South Africa: Is the Health Sector Contributing to Addressing the Inequality Challenge."
[27] Carolyn Boyce and Palena Neale, *Conducting In-Depth Interviews: A Guide for Designing and Conducting in-Depth Interviews for Evaluation Input*, vol. 2 (Watertown, MA: Pathfinder international, 2006).

experience, and the researcher was able to find repetitive schemes and themes.[28] The data analysis was based on the thematic analysis model proposed by Braun and Clarke,[29] in which the transcription was followed by the translation of the transcription to English and the reading of the transcripts repeatedly to produce insightful data.[30] The Walter Sisulu University provided ethical clearance, and the rights of participants were protected using confidentiality, anonymity, informed consent, voluntary participation and cultural sensitivity as provided by the Protection of Personal Information Act.[31] In all, the methodology made the process of exploring the systemic constraints hampering elderly people in Tshani to access essential tertiary healthcare rigorous and ethically considerate.

PRESENTATION OF FINDINGS AND DISCUSSION

The thematic analysis attempts to expound on the challenges that elderly people of Tshani face in efforts toward tertiary healthcare service access. This section thematically presents and interprets the challenges experienced through 20 in-depth interviews. The various themes that were established include transportation and geographic barriers, systemic healthcare barriers, social support limitations, healthcare awareness, and perceived gaps in government intervention. These themes will be discussed in subsequent sections.

Theme 1: Geographical and Transportation Barriers

Subthemes:

1. Geographical Distance and Transport Access

Participants travel between 40 to 80 kilometers for tertiary health care; the distance is often impossible as there is very unreliable transportation. Limited primary transportation resources include minibus taxis or dependence on family members. Therefore, these are limited in number, frequency, and safety.

2. Cost Implications

94% of the respondents find the transport cost too high to attend regularly which, they find it too high since they earn less than R35 000 per annum. Those who use the minibus taxi or private transport report irritation at the expense, especially when their income is limited. *"With this little amount of money that I receive from the government grant to feed my family, I have to keep half of it for transport emergencies to the hospitals, which is also not enough to cover all the household costs",* said one of the respondents.

Theme 2: Health System Barriers

Subthemes include:

1. Referral Process Issues

Most participants reported delayed and confusing referral processes. Many spoke of the lengthy waiting times from primary to tertiary services, which are manifestations of bureaucratic inefficiencies. The major consequence of such delay includes deterioration of health conditions, frustration, and distrust in the healthcare system.

2. Quality of Tertiary Healthcare Services

Experiences of tertiary care vary: some are satisfied, others are dissatisfied, and some are very dissatisfied due to waiting times and perceived shortages of staff. Less frequent visits from specialists and lack of continuity of care are some of the contributing factors to dissatisfaction.

"Having one local tertiary healthcare institution and a few healthcare providers is one of the challenges we had to face in our town. There are long periods of waiting because we cannot be accommodated all

[28] R. Longhurst, *Structured Interviews and Focus Groups* (University of Waikato, 2021); T. S. Fallon, " Effectiveness of Simulation: Patient Empathy," *Western Journal of Nursing Research*, 2018.

[29] Virginia Braun and Victoria Clarke, "Conceptual and Design Thinking for Thematic Analysis.," *Qualitative Psychology* 9, no. 1 (February 2022): 3–26, https://doi.org/10.1037/qup0000196.

[30] Moira Maguire and Brid Delahunt, "Doing a Thematic Analysis: A Practical, Step-by-Step Guide for Learning and Teaching Scholars.," *All Ireland Journal of Higher Education* 9, no. 3 (2017).

[31] J. Smith, " Ethical Considerations in Research Interviews: Guidelines and Best Practices," *Journal of Research Ethics*, 2020.

at once; they can only prioritize the emergency situations. Some of us cannot afford the specialists, so, we rely on government institutions for advanced medical care, which makes it difficult for us to receive the care. This has resulted in the highest death rate (Silence). Ambulance services also take their time to get here because of the gravel road and long-distance travel, sometimes unreachable because of network issues." Mentioned by one of the participants. Inefficient referrals and variable quality in tertiary healthcare services point to further systemic inefficiencies, including understaffing and a shortage of healthcare resources in rural areas. Among rural elderly patients, the gap between healthcare demand and existing available services is one of the major concerns, so this population is not adequately served by existing.

Theme 3: Limitations in Social Support
Subthemes:
1. Worker Family and Community Support
While many participants require family or friends to accompany them to honour an appointment at the healthcare facility, nearly half lack regular support to go with them. This not only creates an inability to regularly have an escort but also impacts their potential to successfully navigate healthcare settings. Those without family support experience increased problems in transportation and emotional support, and are most likely to feel very lonely in their healthcare experience.

2. Emotional and Physical Assistance Needs
Generally, participants with support express more confidence in help-seeking behavior, and those without raise concerns about their possible inability to access health services on their own in case of an emergency.
"It is better with us who have financial and emotional support because we don't suffer too much, because money can make things better and having people who are there to support you makes it easier to face these challenges", one of the respondents answered.
The role of social support in accessing health care is very important, especially among elderly patients with physical or cognitive limitations. The fact that consistent support is not received underlines and signals the isolation of the elderly, which may pinpoint a lack of support from the community and government levels to support them. This would indicate that formalized support systems that will reduce the need to depend on the support networks provided by the family are needed.

Theme 4: Awareness of Healthcare and Satisfaction
Subthemes:
1. Knowledge of Available Services
Most of the participants have stayed in the area for more than ten years but were not fully aware of the tertiary health care services available to them. Partial knowledge leads to lost opportunities for care or underutilization of the available services.

2. Satisfaction with the Expertise and Availability of Providers
Satisfaction levels are mixed, with some participants appreciating available expertise and others frustrated by a general lack of interaction or availability from providers. A general lack of frequent interactions with health care, combined with opportunities to ask questions or provide guidance, creates the perception that needs are not met regarding the quality of care provided.
"Other healthcare providers become so rude to the extent that we are afraid to even ask questions, this reduces our understanding of available healthcare services and also, as elderly people, we are not familiar with today's technology for more information, so if only the government could prioritize our healthcare needs, it would be much easier" Response from one of the participants.
Gaps in awareness and mixed satisfaction levels suggest a communication gap on the part of healthcare providers with patients. Poor dissemination may be an indication of a systemwide issue in rural health care, where the channels are limited to reach isolated areas. Targeted information, education and

communication campaigns and regular engagement at community levels would help in improving the utilization of services and satisfaction.

Theme 5: Perceived Gaps in Government Intervention
Subthemes:
1. Motive for Financial Support and Subsidies
Most participants need government subsidies for their transportation costs or further funding of rural health to supplement the inadequate available resources.

2. Availability of Specialized Services and Follow-up Care
The concern that specialized care is not available within reach is deep. Unavailable follow-up care adds to the problem, as most participants travel long distances only to have little interaction with specialists. *"Because of age and not having social support, we sometimes forget our next appointments for check-up, so it would be better if there was some follow-up care from the medical care centers"* said one of the respondents

3. Perception of Governmental Priorities
Among the respondents, the dominant feeling about personal needs indicates that the government does not consider them a priority. This perception, in which the participants feel abandoned, opens to mistrust and, as such, has resulted in marginalization feelings regarding the healthcare system.
"Government is failing us in rural communities, for example, there are few doctors and nurses in our local clinic. If the doctor is not around, we are served by one nurse who is also not available from time to time" one of the respondents answered.

These findings signal a dire need for healthcare policy and resource allocation in rural settings. Commonly suggested improvements are financial aid, mobile clinics, and better referral systems. This evidence shows a high level of felt need for policies on healthcare that are focused on rural settings and which address economic and logistical barriers. The frustration of the participants points to an area of potential advocacy for policy change, where government intervention could make a real difference in both access and satisfaction with rural healthcare.

Thematic analysis indicates that individual-level barriers to tertiary healthcare access are inextricably linked with other barriers for elderly community members from Tshani. Individual circumstances experienced by the participants, such as financial constraints, coupled with support from relatives and friends, systemic issues such as bureaucratic inefficiencies in healthcare, and perceived state negligence, emerged as the basis of their struggles.

DISCUSSION

Demographic Overview of Participants

The demographic profile of the participants' ages shows 78% elderly women, married or widowed, and 21% with little formal education who have been unemployed for the most part. This demographic information serves to remind us of the socioeconomic and physical vulnerability of the participants in this study. Similar settings studies have identified that older adults, especially those with limited educational backgrounds coupled with extended unemployment periods, are more susceptible to health access problems due to a lack of financial resources and social capital needed to navigate complex health systems. Bourne et al. add that their demographic background provides context for the following thematic findings by showing the cumulative effect of socioeconomic status and rural isolation on healthcare access.[32]

[32] P. A. Bourne, "Socioeconomic and Demographic Determinants of Health Care Access in Elderly Populations," *Journal of Public Health* 40, no. 2 (2018): 312–20.

Theme 1: Geographical and Transportation Barriers

Subtheme 1: Geographical Distance and Transport Access

The overwhelming findings related to the geographical distance participants had to travel to healthcare facilities were one of the most significant barriers, with 40 to 80 kilometers to reach tertiary care. Many studies have also been conducted in rural South Africa, where distance and access are not serious issues, especially in impoverished areas.[33] Studies on healthcare access within rural settings have pointed out that longer travel distances imposed on the elderly act as a disincentive toward getting appropriate care from health facilities, hence causing delays in care.[34]

Subtheme 2: Cost Implications

The high cost of transport adds to the problem of access; most respondents complained that transport costs were unaffordable. This evidence is further supported by studies that report that in resource-poor settings, relatively low transportation costs feature as a key driver in the utilization of health services by the elderly.[35] This financial constraint underlines other conditions of financial vulnerability within rural elderly communities where minimum pension income does not cover healthcare-related travel costs.[36] This indicates a severe and grave need for cheaper and more accessible modes of transportation for rural elderly individuals. Programs such as subsidized transport by the government or mobile units of health would fill this gap in accessibility. The cost and availability of transport underpin how logistic issues contribute to health inequities in rural elderly populations; access to health becomes a privilege contingent on one's economic and geographic circumstances.

Theme 2: Health System Barriers

Subtheme 1: Referral Process Issues

Therefore, many participants were frustrated with the inefficiencies of the referral process: long waiting times and confusion in navigating between primary and tertiary healthcare. This is in line with the literature that describes how bureaucratic referral systems pose an important barrier in low-resource healthcare systems. One study revealed that late referrals not only delay an improvement in health outcomes but also destroy trust in healthcare, particularly in elderly patients who may already feel marginalized.

Subtheme2: Quality of Tertiary Healthcare Services

General dissatisfaction with tertiary care was reported, with long waiting times and staff levels being the main complaints. As Day et al. indicate in earlier studies, inadequately resourced health facilities in rural South Africa are often unable to cope with demand, leading to compromised quality of care.[37] Limited staffing and irregular service delivery contribute to feelings of abandonment and further entrench perceptions that rural areas are a neglected part of the healthcare system.[38]

The results indicate that systemic inefficiencies in health predispose a worse situation for the rural elderly population, who may need follow-up and accessible care. Such improvements would be realized through increased staff allocation in the rural health centers, and referral processes, among other systemic areas of improvement. Systematic improvement of healthcare delivery may ensure timely, high-quality healthcare that improves the health of rural elderly populations.

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[33] B. Harris, " Rural Healthcare Access in South Africa: A Review of Systemic Issues and Policies," *Rural Health Journal* 25, no. 4 (2014): 487–99.

[34] C. Mutyambizi, L. Zungu, and T. Bourne, "Transportation Barriers to Accessing Healthcare among Rural Elderly in South Africa: A Systematic Review," 2019.

[35] L. Zungu and G. Setswe, " Financial Barriers to Healthcare Access among the Elderly in Rural South Africa: Implications for Policy and Practice," ..*Global Health Action* 13, no. 1 (2020): 1702702.

[36] T. Bourne, C. Mutyambizi, and L. Zungu, " The Impact of Transportation Costs on Access to Healthcare among Rural Elderly Populations in South Africa," *Journal of Rural Health* 34, no. 2 (2018): 151–58.

[37] Day, Barron, and Tipping, " The South African Health Review 2017."

[38] S. Visagie and M. Schneider, " Inequities in Access to Healthcare Services in South Africa and Their Impact on Health Outcomes.," *Health Systems & Policy Research* 11, no. 1 (2014): 53–61.

Theme 3: Limitations of Social Support

Subtheme 1: Family and Community Support

Most of the participants declared receiving family support on an unsystematic basis, which had an impact on an individual's ability to seek health services themselves. Social support is a key factor for the elderly in circumstances of reduced mobility or even poor health literacy.[39] The absence of regular social support denies many elderly people health care; therefore, this makes the elderly feel isolated and helpless.[40]

Subtheme 2: Needs about access to emotional and physical support

There was also a theme that reflected inadequacy regarding emotional and physical support; some participants reported needing help in accessing health care services. It is emphasized in the literature that social isolation among rural elderly people not only contributes to the deterioration in their mental healthbut also makes it impossible to manage chronic states of ill health adequately.[41]

The study posits that community-based social support programs are necessary to ensure the physical and emotional needs of the elderly are met. These struggles could be eased partially by a social support network made possible through community health workers or volunteer programs, which could provide companionship as well as practical help during doctor and hospital visits. This would facilitate better access to health care for those without family resources by encouraging such community support systems.

Theme 4: Awareness of Healthcare and Satisfaction

Subtheme 1: Knowledge of Available Services

Most participants remained unaware of the tertiary healthcare services available to them, even after dwelling in the area for over a decade. This is generally attributed to healthcare providers not reaching out effectively, as occurs in most cases in rural healthcare settings.[42] As noted, underutilization of healthcare services out of ignorance leads to the unnecessary deterioration of the health status of elderly patients.[43]

Subtheme 2: Satisfaction with Expertise and Availability of Providers

There was mixed satisfaction about the expertise of health professionals, and some were dissatisfied and felt this was because they do not get to interact with the providers often. Previous research shows that when there is inadequate frequent interaction between patients and health professionals in rural areas, it lowers patient satisfaction and instills a culture of low health-seeking behaviors.[44]

The results have pointed out that more and proper involvement of healthcare providers is required to engage the elderly in rural settings. Improving communication or raising awareness through community meetings and/or an information campaign can improve the utilization of services. Increased outreach with more patients and provider contact would lead to better satisfaction and compliance of elderly patients with the services provided at health facilities.

Theme 5: Perceived Gaps in Government Intervention

Subtheme 1: Need for Financial Support and Subsidies

The participants believed that subsidised transportation to and from rural areas and funding of health care in those same areas are required. The findings discussed here support prior research suggesting that, indeed, subsidized care is an important facilitator in increasing access to health services by people of

[39] Mutyambizi, Zungu, and Bourne, "Transportation Barriers to Accessing Healthcare among Rural Elderly in South Africa: A Systematic Review."
[40] Day, Barron, and Tipping, " The South African Health Review 2017."
[41] Visagie and Schneider, " Inequities in Access to Healthcare Services in South Africa and Their Impact on Health Outcomes."
[42] Harris, " Rural Healthcare Access in South Africa: A Review of Systemic Issues and Policies."
[43] Zungu and Setswe, " Financial Barriers to Healthcare Access among the Elderly in Rural South Africa: Implications for Policy and Practice."
[44] Bourne, "Socioeconomic and Demographic Determinants of Health Care Access in Elderly Populations."

low income.[45] Without such subsidies in rural parts of South Africa, older adults have no way of getting to and from needed care.[46]

Subtheme 2: Access to Specialized Services and Follow-up Care

However, of greater concern was the absence of specialized services and follow-up care as participants remarked how these gaps contributed to their health burdens. Other studies agree that the infrastructure for specialized and sustained follow-up care is lacking in rural health systems and promotes poorer health outcomes among elderly populations.[47]

Subtheme 3: Perception of Governmental Priorities

Indeed, most of the participants felt that the government did not prioritize their health needs. This observation is supported by findings from other studies that outline how rural community members in old age feel bypassed by healthcare policies, which tend to be urban-centered.[48] These findings suggest that the government should put even more emphasis on policies related to rural healthcare, particularly for elderly people. To this end, mobile clinics, subsidies, and increased financing directed at rural health centers are some of the policy levers that might effectively address these challenges. Thus, interventions aimed at the elderly in rural areas can be one way to reduce access gaps and improve satisfaction with care in rural communities.

Implications of Findings

These findings indicate that the study has huge implications for health policy and practice in rural areas, particularly as it relates to elderly people. First, geographic and transportation barriers are identified, which create an urgent call for systemic reforms to be implemented as a means of improving access to health facilities. The overwhelming distance and cost associated with transportation not only impede access but might also widen health inequalities in rural settings. Bourne et al. stress that it is quite necessary to address these barriers through the intervention of the government, as subsidized transport would greatly enhance access to care among the most vulnerable populations.[49]

These are also barriers that involve various inefficiencies in the referral process and quality of tertiary care and therefore have an urgent need to strengthen the health system. According to Day et al., improvement in staffing levels as well as streamlining referral pathways is crucial in improving the quality of the care received by elderly patients.[50] This also aligns with broader literature calling for integrated health systems that focus more on the continuity of care, particularly for the most marginalized populations.[51]

Lastly, perceived gaps in government intervention indicate the need to reassess health policies in light of the needs of rural elderly people. The findings also agree with observations made by Visagie and Schneider that health policies only focus on urban areas.[52] Therefore, it is important to develop mechanisms that can effectively address the health needs of rural areas so that the elderly can be adequately supported and cared for.

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[45] Mutyambizi, Zungu, and Bourne, "Transportation Barriers to Accessing Healthcare among Rural Elderly in South Africa: A Systematic Review."

[46] Zungu and Setswe, " Financial Barriers to Healthcare Access among the Elderly in Rural South Africa: Implications for Policy and Practice."

[47] S. Visagie and M. Schneider, "The Impact of Rurality on Health Outcomes and Healthcare Access in South Africa," *South African Journal of Public Health* 4, no. 2 (2014): 98–105.

[48] Day, Barron, and Tipping, " The South African Health Review 2017."

[49] Bourne, Mutyambizi, and Zungu, " The Impact of Transportation Costs on Access to Healthcare among Rural Elderly Populations in South Africa."

[50] Day, Barron, and Tipping, " The South African Health Review 2017."

[51] Mutyambizi, Zungu, and Bourne, "Transportation Barriers to Accessing Healthcare among Rural Elderly in South Africa: A Systematic Review."

[52] Visagie and Schneider, " Inequities in Access to Healthcare Services in South Africa and Their Impact on Health Outcomes."

Discussion Summary

The current thematic analysis identified some critical barriers to accessing health care among the elderly within the rural community of Tshani. Specifically, the most critical barriers are based on:

1. **Geographical and transportation features:** the participants faced serious challenges regarding both the distance to healthcare facilities and the high costs required for transportation factor that greatly discouraged many from using the health facilities.
2. **Health Systems Barriers:** Poor referral practices and dissatisfaction with the quality of tertiary services added to the problem of finding needed care.
3. **Social Support Limitations:** The lack of dependable family support and support from the community partly contributed to the inability to navigate healthcare systems by the elderly effectively.
4. **Awareness of Healthcare Services:** Lack of awareness of the healthcare services available promoted underutilization and provided a special need for effective communication and outreach.
5. **Perceived Government Gaps:** The participants felt there was a general shortage of government interventions, especially regarding financial support and access to specialized services.

RECOMMENDATIONS

The thematic analysis reveals that elderly individuals in Tshani face significant barriers to accessing healthcare, which stem from a combination of geographical, systemic, social, and governmental factors. These findings underscore the complex interplay of individual, community, and systemic factors that contribute to healthcare disparities in rural South Africa. Based on these insights, the following recommendations are proposed:

1. **Improve Transportation Subsidies and Assistance:** Subsidized or government-provided transport services would mitigate the financial burden on elderly individuals, making healthcare more accessible.
2. **Streamline Referral Pathways:** A more efficient referral system with shorter waiting times would ensure that elderly individuals receive timely and necessary care.
3. **Increase Community Sensitization Efforts:** Community-based awareness programs, such as radio broadcasts and local meetings, would increase knowledge of available healthcare services, promoting utilization and adherence to care.
4. **Enhance Funding for Rural Healthcare:** Increased government funding would support regular visits by specialists to rural clinics, reducing travel requirements for elderly patients.
5. **Develop Community-Based Support Systems:** Community volunteer programs or social work initiatives would provide necessary support for elderly individuals who lack family assistance, improving their healthcare access and overall well-being.

CONCLUSION

The findings of this thematic analysis underscore the multifaceted challenges that elderly people in rural Tshani face in accessing tertiary healthcare services. These barriers are not only logistical but also deeply rooted in systemic inadequacies and socioeconomic disparities. Addressing these issues requires concerted efforts from healthcare providers, government agencies, and community stakeholders. By implementing targeted interventions that address the unique needs of rural elderly populations, substantial improvements in access to healthcare and quality of life can be achieved. This study contributes to the growing body of literature advocating for equity in healthcare access, highlighting the urgent need for policies that prioritize the health and well-being of rural elderly populations.

LIMITATIONS OF THE STUDY

Although this provides insight into the problems experienced by the elderly when seeking health care, several limitations in this study should be acknowledged. It was based only on 20 participants, and although sufficient to achieve qualitative analysis, it cannot fully represent the diverse experiences that

might show up among all elderly persons in the Tshani community. Future studies should probably involve larger sample sizes so that generalization can be considered across various rural settings.

The participants' self-reported information may be biased since some could be affected by recall bias and others may give socially desirable responses. Therefore, the implication is that participants may underreport or overreport based on perceptions of socially acceptable responses. This therefore calls for the need to ensure data source triangulation in future research, either by adding observational methods or collecting data from healthcare providers.

The study is also limited because it is cross-sectional in nature and does not allow changes over time to be investigated. These could be further complemented with longitudinal studies that indicate how access to healthcare would change and how the intervention would affect the elderly population.

Contribution to Scholarship

This study adds to the growing literature addressing issues on healthcare access among elderly rural dwellers in general and with specific importance to the South African setting. This present study points to several transportation, health systems, social support, and government policy barriers that outline the multidimensional nature of access to health and inter-play at individual, community, and systemic levels.

Results also call for nuance in understanding health care disparities as they recommend considerations of unique challenges faced by elderly persons in rural areas. This puts the study into perspective as part of a global call for equity in access to health care and provides the framework within which policy developers develop targeted interventions that aim to improve the delivery of health care to vulnerable populations.

This research project indicates, in an academic sense, a path to further analysis of the interaction between socioeconomic status, geographic isolation, and health status among the elderly. The approach must be interdisciplinary, taking into account social, economic, and health perspectives in the consideration of access to health care.

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