

# ***Not just health: Narrating access to post-apartheid health care as a matter of restorative justice - Bronwyn Harris, PhD***

## **Abstract**

### ***Rationale***

Historically, South Africa's health system perpetuated – in complex and multiple ways – the oppression, neglect, and violations of colonialism and apartheid. The South African Truth and Reconciliation Commission (SATRC) established that “millions of South Africans were denied access to appropriate, affordable health care” and that the system itself was complicit in sustaining the structural and physical violence of the past. Key recommendations were made for reforming the health system. Yet, due to structural and political reasons, these reforms have not been as far-reaching as was envisaged. Twenty one years into the country's democracy, although the right to access health care is constitutionally guaranteed, inequitable access barriers persist. These disproportionately affect many who experienced the dispossession and structural violence of apartheid - black, poor, rural and informal-urban communities- as well as newer marginalized groups, including internal and cross-border migrants, and legal and undocumented refugees with little access to health services and other state care. The social contract has formally changed from apartheid to democracy but exclusion, including from health care, continues.

Transitional justice (TJ) processes are designed to support societies as they move from authoritarianism towards democracy, using strategies of truth-telling, institutional transformation, reparations, criminal prosecutions, and memorialisation. Most popularly associated with the SATRC in South Africa, this approach seeks to restore justice to victims through making individuals accountable, and with social and institutional reforms to ‘make good’. Persistent barriers to health care (structural, institutional, and interpersonal) can thus be seen to reveal the ‘unfinished work’, or perhaps more condemningly, the ‘disappointment’ of TJ as much as they testify to unfulfilled human rights in a post-apartheid context. Yet there has been limited engagement and ‘sensemaking’ between those seeking to reform health systems and those designing TJ reforms.

### ***Aim and methods***

The aim of this thesis is to situate access to post-apartheid health care as a matter of restorative justice, *as part of* South Africa's broader transitional justice agenda to restore, or ‘bring’, justice in the aftermath of apartheid. Conceptually, access is understood as a *negotiation* between patients (households) and providers (health system) around the availability, affordability and acceptability of care. It is seen as a political process, constantly conferred and translated by those implementing and practising policies, often with consequences unintended by policy makers.

This research is nested in the *Researching Equity in Access to Health Care* (REACH) project, a five year, multi-method study of equity in access to tuberculosis (TB) treatment, antiretroviral therapy (ART), and maternal deliveries in several South African provinces, including one rural (Bushbuckridge) and two

urban health sub-districts (Cities of Johannesburg and Cape Town). Between 2009 and 2010, access stories were collected from in-depth interviews with 45 patients and 67 providers, and observations were carried out at 12 health facilities. These stories have been analysed using a narrative approach for 'making sense' of personal experience (stories) in relation to broader socio-political and cultural discourses (narratives). In this approach, different theoretical lenses are drawn on as part of such 'sensemaking' - restorative practices and governmentality; critical social contract theory; and street-level bureaucracy. These narratives have been theorized for continuities and changes with South Africa's past, and examples of 'restorative practices' (as more equitable and inclusive ways of doing health care) have been sought. Additionally, theories of violence and trauma have been introduced as a tentative step towards 'making sense' of the tragic murder of Harry Nyathela (narrated in the Epilogue) – a haunting, seemingly 'senseless' death that fundamentally undermines restorative justice.

### ***Findings***

While restorative provider engagements are expected in health policy, older authoritarian and paternalistic norms persist in practice, undermining active, engaged citizenship and exacerbating affordability and availability barriers to care (largely located in unaddressed structural violence and poverty). Furthermore, institutional 'logjams' and outdated modes and infrastructures, coupled with new epidemiological stresses, have created additional challenges for health system transformation and those practicing care. Provider accountability remains 'upward' (to managers), rather than 'horizontal' (to other providers) or 'downward' (to individual patients and communities). Within this context of change and continuity, new identities, inclusions, and exclusions from health care are produced, and the contradictions and disappointments of a restorative TJ project are revealed.

### ***Conclusions***

Despite the SATRCs vision "to promote national unity and reconciliation in a spirit of understanding that transcends the conflicts and divisions of the past," *this* post-apartheid project is incomplete and disappointing. Strengthening street-level accountability and engendering respectful, empathetic provider practices - a restorative shift from older authoritarian modes - is vital to improving access to services and contributing more generally to the restoration of justice and health in society. A restorative approach to health care requires a health system that does *with* providers as much as providers who do *with* patients. Yet, as with any regime of power, vigilance is needed: what has changed and how? What has stayed the same and why? In complex, subtle ways, power, violence, trauma, and suffering continue to find expression overtime and in the everyday practices of health care, as well as daily life. Accountability requires a collective 'repairing' of human relationships and a problematisation of power at the interface of both patients and providers, *and* communities and the health system. For health policies (including the proposed National Health Insurance system) to restoratively shift South Africa's story of 'lack of access to health services' towards one of 'universal health coverage', it is important to conceptualise restorative justice and health system accountability as a matter for collectives. A 'sensemaking conversation' that draws on lessons from both TJ, and health policy and systems research is recommended to further locate and problematize access to health care as a matter of restorative justice. And with this, an invitation to 'haunting', to seeking out and listening to that which cannot be said yet cannot be forgotten.