RHAP
Rural Health
Advocacy Project

Discontinuing Community Service - Impact on Rural Health

Problem statement

Recruitment and retention of healthcare professionals in rural areas is an ongoing problem globally.[1] In South Africa, a year of community service for all healthcare professionals was introduced in 1998 following an amendment to the Health Professionals Act no. 56 of 1974.[2] The aim of this compulsory community service was two-fold:

- To improve provision of health services, especially to rural and underserved areas;
- To assist young professionals in their career development by providing an opportunity to acquire skills, knowledge and critical thinking.[2]

Even with limited implementation of additional human resource strategies to optimise the community service year, it has been an effective way of recruiting health professionals to rural areas, but not in retaining them.[2]

Nonetheless some studies have shown that around 15% of community service doctors intend to remain in rural and underserved communities after community service.[3] A study conducted in three of South Africa's rural provinces found that almost a third (27%) of the therapists were community service therapists,[4] indicating that rural areas rely heavily on community service professionals to provide rehabilitative services.

Removing the compulsory community service year for health professionals, without another plan in place, will most likely result in the inability of rural health services to provide adequate care to the populations they serve. The increased load on senior staff in rural areas would likely result in mass resignations and lead to the collapse of many health facilities, with detrimental health consequences for these rural communities.

Aims of the policy brief

- The main aim of this policy brief is to strongly recommend that community service be continued.

If, despite our recommendation, the decision is made to discontinue community service, then other aims of this policy brief include to:

- Advise against the abrupt removal of community service, for all professions.
- Propose potential solutions to address the gap that would be left by community service professionals in rural areas, if community service were to be discontinued.
- Present policy options that would help to ensure continuity of quality health service delivery in rural areas if compulsory community service were to be removed from legislation.

Rationale from literature for continuing community service

1. Recruitment and retention of health workforce in rural areas

In its 2010 global policy recommendations, the World Health Organization (WHO) listed compulsory community service as one of the interventions to improve recruitment and retention of health workers in rural areas.[5] South Africa was one of the seventy countries that chose to implement this option.[6] The WHO found that community service in rural areas has the potential to increase health workers'

understanding and appreciation of rural health issues.[5] However, good support and management systems are crucial to its successful implementation, as is the adequate clinical preparation of participants in the programme.[5]

The WHO outlined a number of other evidence-based interventions in addition to compulsory service.[5] In its 2021 updated guidelines on health workforce development, attraction, recruitment and retention in rural and remote areas, the WHO recommends that these "interventions should be interconnected, bundled and tailored to the local context",[1] echoing the 2010 recommendation that multiple incentives be implemented simultaneously.[5] These incentives range from the education of health professionals to financial incentives and personal and professional support.[1,5]

Incentive bundles, including options from all four of the categories listed below, increase the likelihood of successful retention of health workers in rural areas.[7] Implementing these bundles would also increase the acceptability and successful outcomes of community service itself. It is imperative that other interventions, such as those recommended by the WHO, be implemented to make rural settings an attractive employment and lifestyle option for healthcare professionals, before considering the discontinuation of community service.

Table 1. Categories of interventions used to improve attraction, recruitment and retention of health workers in remote and rural areas

Category of intervention	Examples
Education	Students from rural backgrounds
	Health professional schools outside of major cities
	Clinical rotations in rural areas during studies
	Curricula that reflect rural health issues
	Continuous professional development for rural health workers
Regulatory	Enhanced scope of practice
	Different types of health workers
	Compulsory service
	Subsidized education for return of service
Financial incentives	Appropriate financial incentives
Professional and personal support	Better living conditions
	Safe and supportive working environment
	Outreach support
	Career development programmes
	Professional networks
	Public recognition measure

Source: Increasing access to health workers in remote and rural areas through improved retention: global policy recommendations, WHO, 2010.

2. Community service doctors

Around 50% of community service doctors in South Africa were placed in rural hospitals between 2012 and 2014, which was an increase from 24% in 1999.[3] A cross-sectional descriptive study based on

annual surveys of community service doctors in South Africa over a 15 year period, found that 91% felt they had made a difference and 81% felt they had developed professionally, but only about half felt that the clinical and administrative support was adequate.[3]

Community service does not only help with staffing of rural health facilities, but also increases the health professionals' understanding of rural contexts. This has the benefit that when doctors work as registrars or specialists in tertiary hospitals, they have a better understanding of the rural context from which their colleagues are referring patients. In the absence of community service, many health professionals would not have gained this understanding of the challenges faced by rural communities in accessing healthcare.

They would also not have had the positive experiences outlined above and thus issues with clinical and administrative support would likely be even stronger deterrents to health professionals choosing to practice in rural areas. For this reason support systems and management must be strengthened in rural areas to improve recruitment and retention of health professionals, particularly if community service were to be discontinued.

3. Impact on rehabilitation services

According to data collected in 2020, in the three South African provinces with the highest rural population rates and highest poverty levels, 27% of the rehabilitation workforce comprises of community service therapists.[4] What this means in essence, is that if community service is discontinued, a third of the rehabilitation workforce will be removed with immediate effect and the most disadvantaged communities will suffer the greatest impact.

Community service therapists made up a quarter of the physiotherapists (26%) and occupational therapists (25%) in these rural areas.[4] The largest contingent was found in the Speech and Language Therapy profession, where almost half (48%) were community service therapists.[4] Speech and Language therapists treat, amongst other things, a condition known as dysphagia or difficulty swallowing.[8] These swallowing difficulties result from neurological conditions such as strokes[8] and cerebral palsy,[9] and if they are not identified and treated, can result in complications such as aspiration pneumonia, malnutrition, dehydration, airway obstruction or even death.[8] If community service is discontinued, a quarter of physiotherapists and occupational therapists, and around half of the available speech therapists in these rural areas will no longer be available, leaving patients vulnerable to complications.

Mental health services in rural areas would also be affected. A situation analysis of human resources for mental health in rural areas of South Africa between 2014 and 2016, found that 64% of rural primary healthcare facilities did not have clinical psychologists.[10] Where there are no psychologists: doctors, occupational therapists and nurses provide mental health services in rural settings.[11] Discontinuing community service and with it removing the few psychologists available to rural areas, would also remove a quarter of occupational therapists with dire consequences for the delivery of mental health services in rural communities.

Collection and organisation of data on the prevalence of these conditions, and for people with disability in general, must be improved so that the need for all rehabilitation professionals (including specific skills mix and distribution) can be accurately determined, particularly in rural communities.

4. Data for community service in rural areas

The 2022 South African Health Review contains data from PERSAL measuring the numbers of healthcare professionals in multiple cadres, including community service professionals.[12] Using these data, we calculated what proportion of each cadre is comprised of community service professionals at

provincial level (see Table 2). We found that in rural provinces, more than 40% of certain therapy cadres and 23% of doctors were community service professionals.

However, it should be noted that even in provinces that are considered rural, there are often large urban centres and thus more localised data are required to fully appreciate the impact of community service in rural areas. This data should be compiled and analysed before any decision is considered related to the possible discontinuation of community service.

Table 2: Community service professionals as a proportion of the total staff numbers for each cadre per province as per PERSAL data in the South African Health Review 2022[12]

Cadre	No. of Health Professional	SA	EC	FS	GP	KZN	LP	MP	NC	NW	WC
Clinical Psychologists	CS clinical psychologists	69	3	2	34	14	2	2	2	3	7
	Psychologists	780	65	29	243	94	132	48	16	48	105
	Total	849	68	31	277	108	134	50	18	51	112
	CS as proportion of total (%)	**8,13**	**4,41**	**6,45**	**12,27**	**12,96**	**1,49**	**4,00**	**11,11**	**5,88**	**6,25**
	Ratio of CS to Professionals	**0,09**	**0,05**	**0,07**	**0,14**	**0,15**	**0,02**	**0,04**	**0,13**	**0,06**	**0,07**
Dentists	CS dentists	173	18	24	15	36	15	13	15	22	15
	Dental practitioners	1006	146	45	228	108	159	78	26	61	155
	Total	1179	164	69	243	144	174	91	41	83	170
	CS as proportion of total (%)	**14,67**	**10,98**	**34,78**	**6,17**	**25,00**	**8,62**	**14,29**	**36,59**	**26,51**	**8,82**
	Ratio of CS to Professionals	**0,17**	**0,12**	**0,53**	**0,07**	**0,33**	**0,09**	**0,17**	**0,58**	**0,36**	**0,10**
Diecticians	CS dieticians	191	14	18	53	35	7	18	13	27	6
		No data	No data	No data	No data	No data	No data	No data	No data	No data	No data
	CS as proportion of total (%)	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**
Doctors	CS doctors	2137	219	94	417	391	220	303	97	194	202
	Medical practitioners	17413	2071	758	4569	4011	1337	1001	362	1080	2224
	Total (excl. specialists)	19550	2290	852	4986	4402	1557	1304	459	1274	2426
	CS as proportion of total (%)	**10,93**	**9,56**	**11,03**	**8,36**	**8,88**	**14,13**	**23,24**	**21,13**	**15,23**	**8,33**
	Ratio of CS to Professionals	**0,12**	**0,11**	**0,12**	**0,09**	**0,10**	**0,16**	**0,30**	**0,27**	**0,18**	**0,09**
Nurses	CS nurses	3249	584	172	750	493	261	245	57	328	359
	Professional nurses	76293	10953	2676	16323	18827	8778	6270	1511	5369	5586
	Enrolled nurses	31775	3502	1231	7810	10016	3151	1548	253	1225	3039
	Total 1 (excl. students and ENs)	79542	11537	2848	17073	19320	9039	6515	1568	5697	5945
	Total 2 (excl. students)	111317	15039	4079	24883	29336	12190	8063	1821	6922	8984
	CS as proportion of total 1 (%)	**4,08**	**5,06**	**6,04**	**4,39**	**2,55**	**2,89**	**3,76**	**3,64**	**5,76**	**6,04**
	Ratio of CS to Professionals	**0,04**	**0,05**	**0,06**	**0,05**	**0,03**	**0,03**	**0,04**	**0,04**	**0,06**	**0,06**
Occupational Therapists	CS occupational therapists	404	45	28	160	69	11	31	23	25	12
	Occupational therapists	1101	120	53	288	149	193	69	30	47	152
	Total	1505	165	81	448	218	204	100	53	72	164
	CS as proportion of total (%)	**26,84**	**27,27**	**34,57**	**35,71**	**31,65**	**5,39**	**31,00**	**43,40**	**34,72**	**7,32**
	Ratio of CS to Professionals	**0,37**	**0,38**	**0,53**	**0,56**	**0,46**	**0,06**	**0,45**	**0,77**	**0,53**	**0,08**
Pharmacists	CS pharmacists	636	71	72	80	150	70	49	36	66	42
	Pharmacists	5777	887	406	1280	851	583	355	104	284	1027
	Total	6413	958	478	1360	1001	653	404	140	350	1069
	CS as proportion of total (%)	**9,92**	**7,41**	**15,06**	**5,88**	**14,99**	**10,72**	**12,13**	**25,71**	**18,86**	**3,93**
	Ratio of CS to Professionals	**0,11**	**0,08**	**0,18**	**0,06**	**0,18**	**0,12**	**0,14**	**0,35**	**0,23**	**0,04**
Physiotherapists	CS physiotherapists	352	35	29	94	73	8	36	24	29	24
	Physiotherapists	1225	144	53	250	274	164	79	31	70	160
	Total	1577	179	82	344	347	172	115	55	99	184
	CS as proportion of total	**22,32**	**19,55**	**35,37**	**27,33**	**21,04**	**4,65**	**31,30**	**43,64**	**29,29**	**13,04**
	Ratio of CS to Professionals	**0,29**	**0,24**	**0,55**	**0,38**	**0,27**	**0,05**	**0,46**	**0,77**	**0,41**	**0,15**
Radiographers	CS radiographers	355	30	15	113	78	21	33	15	14	36
	Radiographers	3034	382	178	878	609	216	125	73	125	448
	Total	3389	412	193	991	687	237	158	88	139	484
	CS as proportion of total	**10,48**	**7,28**	**7,77**	**11,40**	**11,35**	**8,86**	**20,89**	**17,05**	**10,07**	**7,44**
	Ratio of CS to Professionals	**0,12**	**0,08**	**0,08**	**0,13**	**0,13**	**0,10**	**0,26**	**0,21**	**0,11**	**0,08**
Speech Therapists	CS speech therapists	229	20	15	25	73	9	38	13	31	5
	Speech therapists and audiologists	617	53	11	161	152	72	44	16	31	77
	Total	846	73	26	186	225	81	82	29	62	82
	CS as proportion of total	**27,07**	**27,40**	**57,69**	**13,44**	**32,44**	**11,11**	**46,34**	**44,83**	**50,00**	**6,10**
	Ratio of CS to Professionals	**0,37**	**0,38**	**1,36**	**0,16**	**0,48**	**0,13**	**0,86**	**0,81**	**1,00**	**0,06**

CS as a proportion of total: CS divided by Total multiplied by 100

Ratio of CS to Professionals: CS divided by Independent practitioners for that cadre (e.g. doctors, radiographers, speech therapists and audiologists etc).

Recommendations

- Calculate the proportion of the health workforce comprised of community service professionals in rural areas using PERSAL data.
- Ascertain the number of doctors at rural district hospitals with and without community service; as well as the minimum number of doctors required to provide 24 hour emergency services in these hospitals; to ensure that workload of senior staff is sustainable.
- Develop databases on the prevalence of disability caused by various conditions, to better determine the skills mix and distribution required for rehabilitation professionals.
- Databases should also be established, or improved (where they already exist), for: communicable diseases, non-communicable/chronic diseases and maternal and child morbidity and mortality; to better determine skills mix and distribution of health professionals required to manage these health issues.
- Address issues of support systems and management in rural areas, including clinical and administrative support, to reduce potential deterrents to working in rural areas.
- Implement a bundle or package of incentives to attract professionals to rural posts as per the WHO 2021 guidelines, including options from all four categories (education, regulation, financial incentives and support)[1].

Policy Options

1. Continue compulsory community service for all health professionals. This is the policy option we recommend. We would further recommend that this option be implemented with the additional support for junior health professionals that is listed under policy option 4.
2. Continue compulsory community service exclusively for rural areas where it comprises a significant proportion of the health workforce, particularly for rehabilitation services, and where these professionals are otherwise difficult to attract.
3. Implement a phased discontinuation of community service over a few years in which the community service professionals are offered the option of permanent posts after completing their community service year. This would allow for a transition to permanent posts in rural settings and create continuity of care and the ability to grow and develop expertise within departments. This option may, however, prove challenging to implement because the phased approach, would mean that some professionals have to complete community service while others would not. Nonetheless it would provide a buffer to rural health services in the transition if community service were to be discontinued.
4. Convert community service posts in rural areas to funded permanent posts with active recruitment of graduates and those completing internship to fill these posts. For this to be successful and not result in harm to patients in these communities, junior health professionals filling posts should be offered the following support:
    a. Adequate management structures and senior clinical support at rural facilities.
    b. Where this is not available, additional support must be provided from specialists via the following mechanisms:
        i. Functional District Clinical Specialist Teams (DCST) to grow knowledge and skills pertaining to emergency care for paediatrics, obstetrics (including caesarean section training for doctors), anaesthetics (for doctors) and

resuscitation. Family Physicians (as part of DCST) would also be necessary to grow knowledge and skills pertaining to the outpatient management of chronic illnesses as well as HIV and TB. The DCST should be expanded to include rehabilitation therapists to grow the expertise in junior therapy professionals in rural and remote areas.

ii. Regional hospitals should offer specialist outreach support services to district hospitals.

iii. Telemedicine options for access to senior expertise should be made widely available in these areas.

c. Linked to the above, opportunities for professional development should be made available to help ensure long-term retention of the recruited professionals.

d. Health facilities should develop websites to showcase what they have to offer young professionals and attract them to practice there.

e. There should also be focussed and deliberate recruitment of health professionals to rural areas.

f. Training of health professionals at undergraduate level should include rural specific training.

g. In addition, for doctors, the two-year internship training should be improved and developed to ensure that junior doctors completing their internship are adequately prepared, not only for independent practice, but also unsupervised practice in rural areas.

Conclusion

Discontinuing community service without an opportunity to implement other plans for bolstering the rural health workforce, will exacerbate rural-urban disparities and place health services and the health of patients in these areas at risk. Healthcare for all people, especially for people with disability, will be adversely affected in some of the most vulnerable and deprived areas of South Africa. This will not only lead to a great deal of unnecessary suffering but also place the health system in danger of increased medico-legal costs. It will increase inequity and make the path to universal health coverage (UHC) much more difficult.

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