ConCourt rejects community service case but Rural Health Care Workers call for decisive action to regulate, promote and support community service in understaffed areas

Community Service Position Statement Issued by: RuDASA, RHAP, RuRESA, PACASA

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The Constitutional Court (ConCourt) recently, on the 19th of February 2014, dismissed the case brought before it by junior doctor Miquel Desroches against the Minister of Health and the Health Professions Council of South Africa. Dr Desroches made headlines[1] at the beginning of 2014 for challenging the regulations and the conditions of community service, arguing that the working conditions faced by junior doctors are unconstitutional. Dr Desroches referred to the lengthy working hours, low salary and forced placement in an area outside of his choosing for the duration of his community service period.

Even though the case was dismissed, the application brought the concept of community service, and some of the challenges with its implementation, back into the public domain. This is a positive development, as there are indeed a number of challenges related to community service which need urgent resolution.

Guided by the health rights of rural communities, and informed by the human resources for health shortages in rural areas, it is our position as the Rural Doctors Association of Southern Africa (RuDASA), Rural Health Advocacy Project (RHAP), Rural Rehab South Africa (RuRESA) and the Professional Clinical Associates of South Africa (PACASA), that community service is a pivotal component of a broader rural HRH recruitment and retention strategy. We do not support the notion that community service doctors, or other health care professionals, should be free to choose where they do their community service. This would undermine the objective of community service, which is to help alleviate staff shortages in underserved and rural areas.

Despite this expressed objective, rural health care facilities continue to suffer from crippling human resource shortages. Due to poor implementation of community service across provinces, the majority of community service doctors work at urban-based facilities. Rural district and regional hospitals as well as community health care centres still receive a disproportionately low number of community service medical officers (CSMOs).

In KwaZulu Natal, for example, more than 50% of the 2011 community service allocations went to urban facilities, and 12 rural hospitals did not receive a single community service officer. A similar situation occurred in the Eastern Cape, where over thirty hospitals had no CSMOs allocated in 2010 and a shocking 75% were allocated to urban areas. In 2013, urban and small town hospitals in Mpumalanga received high allocations of CSMOs, up to 20 per

facility, in contrast to the rural hospitals in previous homeland areas, some of which received only one or two community service doctors.

A survey by Africa Health Placements on experiences by the 2009 cohort of CS doctors and dentists[1] found a mixed bag of experiences related to community service. Whereas 95% of 595 respondents felt they significantly contributed to the health of their community, and 87% of respondents felt they experienced significant professional development during the CS year, concerns were stated in relation to other areas – such as dissatisfaction with the quality of accommodation (43% out of 408 respondents) and with the way facility management handled their concerns (50%, n=206). Satisfaction with supervision was reported as worse in rural areas than it was in urban areas.

We thus acknowledge the fact that community service is not without its challenges. It is, however, important to note that despite difficult working conditions, many community service doctors have had positive experiences that continue to benefit them throughout their careers. The following testimonies were made to RHAP by doctors in response to the current debate on community service:

Despite all the challenges, there wasn't a single day that I did not look forward to going to work. You know why? The patient. They made me enjoy my work so much. I learnt a lot from working there. I learnt how to get off my high horse (that I got on as an intern in a "big hospital" at the city). I learnt how to be humble. I learnt to love older people and how to communicate with them. I learnt how to deal with difficult patients in a humble and patient manner. I wouldn't substitute that experience for anything for it is exactly what is lacking in my colleagues today. (Dr Jakavula, comserve doctor in rural Eastern Cape in 2010)

I did my community service year at Zithulele hospital, in the Eastern Cape, from January 2010 to December 2010. After completing that year I stayed on for another five months out of choice. Those 17 months modelled and shaped me into a better doctor and, I believe, a more well-rounded individual. Zithulele taught me about team work like never before. It was hugely rewarding, inspiring work, where lives were saved, and the way I do medicine will be changed forever. Yes there were challenges, frustrations and setbacks, but these cause one to become more inventive, adaptable, and intuitive – life lessons that cannot be taught, and I think what rural medicine is all about. (Dr Wittington, comserve doctor in rural Eastern Cape in 2010)

My community service year was in 2001, and I worked in rural KZN (...)This single year of experience has come back more tangibly in my current practice than any of the specialist training I have received since – I believe I am a more thorough and far more compassionate

[1] Human Resources for Health.2014, 12:14. DOI: 10.1186/1478-4491-12-14 URL: http://www.human-resources-health.com/content/12/1/14

doctor and colleague directly as a result of this experience. (Dr Penfold, comserve doctor in rural KZN, 2001)

I had my heart break over several patients who I saw die as a result of being geographically distant from our referral hospital due to issues such as the time taken to transport a patient who was septicemic due to an acute abdomen but learnt that the answer is not to let those situations put you off working in rural medicine but to recognize the good you do for many others. I think a year of limiting a health professional's right to freedom of movement to benefit these geographically disadvantaged communities right to life is acceptable (Dr Jayned –get full name, comserve doctor in rural KZN, 2012).

The answer to the challenges with community service does not lie in changing the principles of community service. The problems experienced by community service officers are symptomatic of the working conditions of all health care professionals in rural areas. They are also symptomatic of the general human resources for health constraints in most rural areas. Therefore, the solution lies in the urgent implementation of a broad set of recruitment and retention strategies aimed at making rural health a career of choice.

In this regard, our recommendations are as follows:

- Implementation of "Strategic Priority 8: Access in rural and remote areas of the National HRH Strategy for the Health Sector", which contains a holistic set of strategies to recruit and retain health care workers to rural areas. These include improved living condition such as accommodation and opportunities for career development in rural areas
- Careful selection procedures for students wishing to study medicine or other health science degrees, giving increased preference to students with rural origin and/or intent to work in rural areas after graduation, as well as demonstrated social consciousness
- Urgent development of staffing norms for District Hospitals, so that there are sufficient senior doctors, and rehab professionals, to support and mentor the junior doctors and rehab staff
- Adoption of detailed regulations and clear policy guidelines by National and Provincial Departments of Health that facilitate human resource allocations in an equitable, transparent manner
- Discontinuation of CS allocations to hospitals that also receive interns (because they already receive more staff), unless a compelling case can be made on an individual hospital basis, informed by the principles of equity, access and needs of the rural referral hospitals
- Introduction of community service for clinical associate graduates

It is only by drawing and retaining human resources to underserved areas that important initiatives such as the NHI and primary health care re-engineering, aimed at improving health access and outcomes, have a chance of succeeding.

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