Reforming healthcare training: Ending the compulsory community service policy

To the Editor: In 1998, the South African (SA) government introduced the policy of compulsory community service. Unsurprisingly, the first category of public sector workers affected were medical practitioners. In the ensuing years, others followed, with healthcare professionals representing the dominant sector forced to perform mandatory community service after completing their basic training.

The community service plan had an ideological root within the framework of 1990s ANC health thinking, and was something the late President Nelson Mandela envisioned as part of his Reconstruction and Development Programme. The community service policy was ideologically understandable in the 1990s, when rural and peri-urban areas had fewer doctors and other healthcare workers. The aim was to direct and ensure an adequate supply of community service medical officers, or 'COSMOs', to these underserved areas.

Junior doctors initially resisted, but the health minister, Dr Nkosazana Dlamini Zuma, prevailed, and enacted it. Community service was set as a 1-year requirement following a 1-year period of internship. The policy was enabled through a regulatory change to the Health Professions (Medical, Dental and Supplementary Health Service Professions) Act 56 of 1974 that created a category of 'Medical Practitioner – Community Service' after the period of internship. Completion of community service became mandatory before registration in the 'Medical Practitioner Independent Practice' category.

The situation was further compounded by the extension of internship to 2 years in 2004; within a short period of time, new doctors went from a 1-year internship to facing a minimum of 3 years before they could register for independent practice and pursue their careers. No other cadre of healthcare worker or professional group in SA is held to such an extended period of state-controlled practice. In total, our medical graduates now face a minimum of 9 years (6 years of undergraduate study, and 3 years of internship and community service) before they can freely choose where to live or how to work.

In addition to this highly discriminatory legislation, the annual application and allocation process for interns and COSMOs to the various health facilities has created an administrative nightmare for the National Department of Health (NDoH), and has consistently proven to be a complex logistical challenge that it has struggled to manage effectively.

Each year, the process repeats itself: interns and COSMOs left without posts, spouses separated, changes and allocations occurring so late in the year that neither the doctors nor the facilities can plan appropriately. The uncertainty, inefficiency and unfairness of the process cause significant harm to the wellbeing and mental health of our graduates.

We now face a crisis. Austerity is real, and economics is a demanding and unemotional task master.

This year, the NDoH has made a unilateral decision to reduce internship posts and expand COSMO posts for 2025. This decision appears to be in response to the looming crisis of available COSMO posts.

The consequence of this incomprehensible decision is potentially disastrous for our current healthcare systems. The fact that most of us learnt of it through a media report in a national newspaper, *Business Day*, in early October is unfathomable. Internship posts have been cut, and some (but not all) are being replaced by COSMO posts, often in urban areas, inherently undermining the foundational principles of the original policy. COSMOs are not interns, and will not function seamlessly in parallel, and already overburdened systems will be pushed beyond their current limits. This situation highlights a lack of foresight, planning and judgement. In addition, these decisions are still unsettled by mid-November 2024, leaving no time for doctors and healthcare facilities to make informed adjustments.

The COSMO legislation is 26 years old, and much has changed since its inception. We are now facing massive urbanisation, increased immigration and an evolving and intensifying disease burden. The question as to whether the policy has had a meaningful impact is not the purpose of this opinion and warrants a separate factual interrogation.

It is clear that the NDoH's decision on 2025 illustrates that the community service policy has long outlived its purpose. It should have been phased out nearly a decade ago, as practicalities have increasingly outweighed the original ideological rationale needed to forge a new way in our healthcare system.

The internship programme needs strengthening, and after completion, medical officer (MO) and registrar posts must be made available. These positions should offer both generalist and specialist career paths that align with the needs of our healthcare system, address the current disease burden and support the career aspirations of the doctors we aim to train and retain in the system.

Internship is a crucial stage in the training of newly qualified doctors, forming the foundation upon which the careers of the next generation of medical professionals are built. Altering this process unilaterally poses a risk to both healthcare services and the development of the next generation of young doctors.

To ensure the integrity of medical training, every graduate must be given an opportunity to complete the internship without delay, and the additional posts created by scrapping the COSMO cadre must be made available for much needed MO and registrar posts.

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