



MEDICINE AND THE LAW

The rights of graduate medical practitioners and reforming community service non-placements

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South Africa's public healthcare sector faces a severe shortage of medical practitioners, exacerbated by the failure to place newly qualified graduates in internship and community service positions. Despite the country's urgent need for doctors, many graduates remain unplaced each year, preventing them from practising independently. This article proposes a legislative reform to address these challenges. Currently, the Health Professions Act 56 of 1974 mandates a compulsory year of community service for medical graduates before full professional registration. However, systemic placement failures result in many graduates being left in limbo, unable to work in either the public or the private sector. The article advocates a legally recognised exemption from community service for medical graduates who remain unplaced for more than 3 months after completing their internship. The proposed amendment to the Health Professions Act would enable these individuals to enter private practice or pursue further specialisation, ensuring that trained professionals are not lost to bureaucratic inefficiencies that infringe on their labour rights.

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South Africa (SA) faces a chronic shortage of medical practitioners, a problem that significantly affects the country's healthcare system.^[1] Despite the critical need for medical professionals, every year hundreds of newly graduated medical practitioners are not placed in internships and community service positions.^[2] In 2021, approximately one in seven doctor positions in hospitals and one in five doctor positions in clinics remained unfilled.^[3] This shortage of medical professionals in the public sector is particularly concerning given that over 71% of South Africans rely on government healthcare facilities.^[4]

The recommended minimum doctor-to-population ratio for middle-income countries such as SA is 18 doctors per 10 000 people.^[5] However, in 2022, the actual number of medical doctors per 10 000 population in SA stood at only 7.94, which includes private healthcare facilities.^[6] There are approximately 3 doctors available for every 10 000 patients in the public healthcare system.^[7] Unplaced doctors mean fewer hands in hospitals. Fewer hands mean worse care, hindering the efficient delivery of medical services and exacerbating the existing healthcare crisis.

Moreover, as a result of austerity measures and budgetary constraints, failure to place medical graduates in community service positions is likely to increase.^[8] The SA government invests substantial financial resources in the training of medical practitioners, yet many of these professionals are left in limbo, unable to contribute to the very healthcare system they were trained to support. The paradox of simultaneously experiencing a critical shortage of healthcare professionals while failing to absorb newly qualified doctors into the workforce highlights a policy failure that requires urgent redress.

In SA, newly qualified doctors must undergo a 2-year internship programme at designated state hospitals or clinics (Health Professions Act 56 of 1974^[9] (Health Professions Act), section 61(e), read with the Regulations Relating to the Registration and Training of Interns in Medicine^[10]). After this, they are obligated to fulfil a mandatory community service year, often

performed at a rural healthcare facility, before gaining authorisation to practise independently (Health Professions Act, section 24A). One notable difficulty faced by medical interns is the strenuous work environment in the public health sector.^[11] This challenging setting often means that they sacrifice their own physical and mental wellbeing while providing essential services to patients who are reliant on public health facilities.^[12] However, this issue has been widely discussed and is excluded from the discussion in this article.

A 2015 national survey revealed systemic non-compliance with Health Professions Council of South Africa (HPCSA) guidelines in accredited training facilities.^[12] Interns frequently reported inadequate supervision, excessive workloads and unsafe working conditions.^[12] For instance, more than 30% of interns indicated that they performed medical procedures without proper oversight, raising significant concerns about patient safety and practitioner wellbeing.^[12] These findings align with critiques that call for stricter enforcement of supervision standards and improved resource allocation in training hospitals; however, they are beyond the scope and focus of this article.

This article investigates whether SA's regulatory framework could be adapted to provide flexibility for graduate medical practitioners who have not been placed and therefore cannot complete their community service, including options to be exempted, buy out the community service obligation, or serve in private or international contexts. Drawing on existing legislation, legal precedents and comparative examples from other jurisdictions, this analysis explores whether alternative solutions could alleviate the healthcare system's burden while safeguarding the rights of medical graduates.

The research question driving this study was: how can SA's regulatory framework be restructured to accommodate alternative pathways for unplaced medical graduates while addressing the public healthcare sector's needs? The investigation employed a literature-based methodology, drawing insights from legal analyses, international practices, and SA regulations and legislation.

By addressing these regulatory and placement challenges, the study aimed to propose a more flexible and fair system for medical graduates, ultimately enhancing the efficiency and effectiveness of SA's healthcare system and better serving the interests of medical practitioners.

Legislative and regulatory framework

SA's medical internship and community service obligations are codified under the Health Professions Act^[9] (preamble to the Act), which is the paramount Act regulating community service by medical practitioners along with its associated regulations. The aim of the Act is to establish the HPCSA and professional boards, including the Medical and Dental Professions Board (MDB). The Act provides for control over the education, training and registration, and practising of health professions registered thereunder (preamble to the Act). This is dealt with in more detail in chapter II of the Act (sections 16 - 35).

The Internship and Community Service Programme (ICSP) is the state-run initiative aimed at ensuring that newly qualified medical practitioners gain practical experience while addressing staffing shortages in public healthcare facilities. The goal of the ICSP is twofold: to provide hands-on clinical training for new doctors, and to distribute healthcare professionals to underserved areas, particularly rural and peri-urban communities.^[13] Placements are allocated through a centralised system, with applicants ranking their preferred locations.^[13]

Legal provisions under the Basic Conditions of Employment Act 75 of 1997^[14] (BCEA) and the Labour Relations Act 66 of 1995^[15] offer additional protections, but these are inconsistently applied to medical interns and community service doctors. The BCEA's salary threshold excludes many medical graduates from protections related to excessive working hours and overtime pay.^[16] This lack of legal protection is particularly concerning in the context of community service placements, where unplaced graduates are not only prevented from earning an income but, once placed, may be subjected to excessive workloads without the same labour rights as other professionals. The combination of placement uncertainty and inadequate labour protections exacerbates the already difficult working conditions faced by medical graduates.

Furthermore, section 27(1) of the Constitution of the Republic of South Africa, 1996,^[17] guarantees the right to access healthcare services, while section 29(3) supports equitable access to education and training opportunities and section 22 guarantees the right to practice of a trade, occupation or profession. There exists a tension between these rights and the systemic inefficiencies that hinder the effective deployment of medical graduates. On the one hand, the state has a constitutional obligation under section 27 to ensure the provision of healthcare services, which includes maintaining an adequate workforce of medical practitioners. On the other hand, the failure to place medical graduates in community service posts directly contradicts this duty by leaving qualified doctors unable to work, despite the public health sector suffering from severe shortages. The law says doctors must be allowed to work. The system hinders them from doing so. That contradiction is failing SA. From the perspective of medical graduates, section 22 guarantees their right to practise their profession, yet administrative inefficiencies prevent them from doing so, effectively blocking their ability to contribute to healthcare service delivery.

Section 29 of the Constitution^[17] is equally relevant, as it suggests that once a student has lawfully completed their education and met all necessary training requirements, artificial barriers – such as the failure of the state to place graduates in community service positions – should not prevent them from practising their chosen

profession. The state cannot insist on community service as a prerequisite for full registration while simultaneously failing to provide the necessary placements. This situation places an unfair and unconstitutional restriction on graduates who have completed their formal education and practical training but are still unable to enter the profession. It calls for a constitutional interpretation of the Health Professions Act^[9] and its regulations to ensure that both public health goals and individual rights are upheld.

Regulation 2.3 of the Regulations Relating to Performance of Community Service

Regulation 2.3 of the Regulations Relating to Performance of Community Service by Persons Registering in Terms of the Health Professions Act^[18] establishes SA's community service framework. It mandates that medical practitioners fulfil community service obligations in designated public healthcare facilities as a prerequisite for independent practice. This regulation aims to address disparities in healthcare access by deploying newly qualified professionals to underserved areas, ensuring equitable service delivery across the country.^[13]

Section 24A of the Health Professions Act^[9] provides as follows with regard to community service:

- (1) Notwithstanding section 24, any person registering for the first time in a category of registration listed in the regulations made in terms of this Act shall perform remunerated community service in health care for a period of one year in terms of the regulations contemplated in subsection (2) and shall, on the completion of such service, be entitled to practise the profession.
- (2) The Minister may, after consultation with the council, make regulations concerning the performance of the service contemplated in subsection (1), including but not limited to–
 - (a) the place or places at which it is to be performed;
 - (b) the conditions of employment pertaining to persons who perform such service; and
 - (c) the registration categories excluded from such service.

The Regulations Relating to Performance of Community Service by Persons Registering in Terms of the Health Professions Act^[18] regulate community service and list the professions in respect of which community service must be performed, of which a medical practitioner is one.

Regulation 2.3 provides that 'A person registering for the first time in terms of the Act shall include a person who has completed internship where internship is required by the Act and a person who has obtained his or her qualifications outside the Republic.'

Only once an applicant has successfully completed internship (or satisfied the MDB that sufficient training has been obtained abroad equivalent to internship training in SA) and conducted 1 year of community service will it be possible to practise as a medical practitioner, depending on the category of registration.^[19]

While the intent of regulation 2.3 aligns with public health imperatives, its implementation reveals notable challenges. Firstly, the lack of sufficient placement opportunities in rural and underserved areas leads to delays in fulfilling these obligations, disproportionately affecting newly graduated practitioners. These delays often exacerbate the healthcare workforce crisis by sidelining competent professionals who are ready to contribute.

Secondly, the regulation's rigid deployment structure, like that of the placement system, typically limits the number of healthcare facilities that can be applied to and the number of provinces in which the facilities are situated, and does not sufficiently account

for individual circumstances such as family responsibilities, health issues or financial constraints.^[20] This inflexibility and rigidity often result in personal hardships for practitioners, deterring many from pursuing medical careers in SA, and undermine the broader goal of retaining skilled professionals within the national healthcare system.

Rights of medical practitioners

Medical graduates, like all workers, have fundamental rights protected under both SA law and international human rights frameworks. The Constitution^[17] enshrines these rights in the Bill of Rights, guaranteeing the right to fair labour practices (section 23), the right to choose a trade, occupation or profession freely (section 22), human dignity (section 10), and equality (section 9).^[17] Moreover, legislation must be interpreted in a way that promotes the spirit, purpose and objectives of the Bill of Rights.^[21] Despite these constitutional guarantees, the current medical internship and community service placement system often infringes upon these rights, exposing graduate medical practitioners to exploitative conditions, excessive working hours, inadequate remuneration and unsafe working environments.^[12]

The right to equality, as enshrined in section 9 of the Constitution,^[17] prohibits unfair discrimination by the state and requires that all individuals be treated with equal concern and respect.^[22] The failure to place medical graduates in community service positions, while still enforcing the requirement as a prerequisite for professional registration, creates an arbitrary distinction between those who are placed and those who are not. In *Harksen v Lane*,^[23] the Constitutional Court set out a test for unfair discrimination, which considers whether a law or policy imposes a differentiation that is irrational or unjustifiably burdensome on a particular group. Here, unplaced medical graduates are effectively barred from practising their profession, despite meeting all educational and training requirements, solely owing to the government's administrative inefficiencies. This places them in an unfairly disadvantaged position compared with their placed counterparts, constituting indirect discrimination. The policy further entrenches inequality by disproportionately affecting graduates from historically disadvantaged backgrounds, who may lack the financial means to wait indefinitely for placement or seek opportunities abroad. The government's failure to provide placements while maintaining the community service requirement therefore violates section 9(3) by imposing an unreasonable and unjustifiable barrier that perpetuates systemic inefficiencies while serving no legitimate purpose.

The Constitutional Court in *Affordable Medicines Trust and Others v Minister of Health and Another*^[24] affirmed the constitutional significance of these rights, and in particular the right to practise a trade, occupation or profession under section 22 of the Constitution.^[17] This right is not merely about the ability to earn a living; rather, it is intrinsically linked to human dignity, self-fulfilment and personal identity. The Court emphasised that work is foundational to a person's existence, shaping and completing an individual over a lifetime of professional activity. Any legal impediments to the exercise of this right must therefore be justified on clear public interest grounds and cannot be arbitrary or capricious. The current regulatory framework governing medical community service places an absolute restriction on unplaced graduates, effectively preventing them from practising their chosen profession despite having fulfilled all academic and clinical training requirements. Such a prohibition is inconsistent with the principles outlined in section 22, as it completely forecloses the opportunity for qualified professionals to engage in their vocation without any reasonable justification beyond bureaucratic inefficiencies.

The Court's interpretation makes it clear that the right to choose a profession necessarily includes the right to practise it, and any regulatory framework that denies qualified individuals this right must be carefully scrutinised to ensure that it serves a legitimate public purpose rather than acting as an unjustified rigid barrier to professional engagement as required by section 36 of the Constitution.

The compulsory nature of community service for medical graduates must be assessed in the light of section 36, which provides for the limitation of rights. Section 36 states that rights in the Bill of Rights, including the right to freedom of trade, occupation and profession (section 22), may be limited only in terms of a law of general application to the extent that the limitation is reasonable and justifiable in an open and democratic society. The government justifies compulsory community service as a measure to address the unequal distribution of healthcare professionals and ensure access to medical services in underserved areas.^[25] However, for the limitation to be constitutionally valid, it must meet the proportionality test initially outlined in *S v Makwanyane*,^[26] which requires considering the nature of the right, the purpose of the limitation, the extent of the limitation, and whether less restrictive means exist to achieve the same objective. The current system imposes an absolute restriction on unplaced graduates, preventing them from practising despite meeting all professional requirements. This situation raises concerns about whether the limitation is justified, particularly when alternative, less restrictive measures – such as a structured exemption framework – could achieve the government's objectives without violating fundamental rights. If the state's failure to place graduates results in their complete exclusion from the workforce, the limitation probably fails the reasonableness test under section 36, as it imposes a disproportionate burden on individuals while failing to effectively serve public health needs.

The compulsory nature of community service, which is a precondition for full professional registration, is therefore a major concern. While the rationale behind mandatory service is framed as a mechanism to address the maldistribution of healthcare professionals and improve service delivery in under-resourced areas, mandatory service places an undue burden on medical graduates, compelling them to work in conditions that often do not meet basic safety, supervision or labour law standards.^[11] In this regard, SA's system stands in stark contrast to non-medical professions, where no other graduates are legally mandated to provide government service as a prerequisite for professional practice.^[11] Not only that, but medical practitioners also stand in stark contrast to other medical professionals when it comes to the extended period of state-controlled practice.^[27]

The International Labour Organization has long recognised forced labour as a violation of fundamental human rights. The Forced Labour Convention, 1930 (No. 29),^[28] defines forced labour as 'all work or service which is exacted from any person under the menace of any penalty and for which the said person has not offered himself voluntarily.' SA ratified this convention, yet the compulsory community service system for medical graduates bears concerning similarities to forced labour – particularly in cases where graduates are compelled to work in unsafe environments and face threats of professional exclusion if they refuse placement.

In addition to the Forced Labour Convention, the International Covenant on Economic, Social and Cultural Rights,^[29] which SA has also ratified, underscores the right of individuals to 'just and favourable conditions of work' (article 7), including fair wages, equal opportunity and safe working conditions. The failure to protect medical graduates during their mandatory community service

period and ensure their placement raises serious questions regarding compliance with these international human rights obligations.

Domestically, the BCEA^[14] is intended to provide minimum protections for all employees in SA, including regulations on working hours, overtime compensation, and conditions of employment (sections 7 - 18). However, medical graduates are frequently subjected to excessive working hours, well beyond the standard 45-hour working week, and are often required to work extended shifts exceeding 24 hours, which contravenes both BCEA provisions and global occupational health standards.^[11] However, the BCEA salary threshold exemption excludes medical graduates earning above a certain amount from protections related to excessive working hours and overtime pay. This exemption exacerbates the vulnerability of medical graduates, many of whom work in high-stress, resource-limited environments while being denied basic employment protections.

Similarly, the Labour Relations Act^[15] guarantees workers the right to fair labour practices (section 23), yet the current medical placement system limits the ability of graduate medical practitioners to negotiate their employment conditions. Unlike in the private sector, where employment contracts are negotiated between employer and employee, medical graduates are assigned placements by the state, often without the ability to challenge or refuse assignments based on personal or professional circumstances. This restriction undermines the principles of freedom of contract and fair labour negotiation, creating an imbalance of power between the state and newly qualified medical professionals.

Another significant concern is the lack of adequate occupational health and safety measures in many public hospitals and clinics where community service doctors are placed. Under the Occupational Health and Safety Act 85 of 1993,^[30] all employers – including the state – are legally obligated to provide a safe working environment for employees (section 8(1)). However, many medical graduates report being placed in facilities that lack adequate supervision, personal protective equipment or basic infrastructure, exposing them to occupational hazards, including infection risks, workplace violence, and errors related to extreme fatigue.^[12]

Proposed solution

The current regulatory framework governing medical internships and community service in SA has resulted in significant inefficiencies and inequities in the placement of newly qualified medical practitioners.^[31] It is inconceivable that medical practitioners who are not placed for compulsory community service are also not allowed to get out of this obligation.

To address these challenges, various alternative models could be explored to provide a more flexible and sustainable approach to medical graduate deployment. There are a number of possible alternatives, namely exemption, a buy-out option, private sector placements, or international placements in countries with reciprocal agreements with the government of SA.

While a comprehensive analysis of each proposed model is beyond the scope of this study, it is evident that SA's medical placement system requires urgent reform. This article therefore specifically focuses on the exemption option only, which is considered and discussed.

Exemption option

Effective implementation of an exemption system in SA would require a comprehensive legislative and regulatory framework that ensures fairness, accountability, and the continued provision of healthcare services to underserved communities. The introduction

of such a system must be codified in legislation, with clear provisions governing eligibility criteria, the administration of exemption, and the obligations of medical graduates opting for this alternative pathway.

The most immediate and effective way to formalise this approach would be to have an amendment to the Health Professions Act,^[9] specifically section 24A, which currently mandates a year of community service as a prerequisite for independent practice. By introducing a legally recognised exemption for medical graduates who are not placed within 3 months of completing their internship, the regulatory framework would allow these individuals to enter private practice, secure employment in accredited healthcare institutions, or pursue further specialisation without being unduly restricted by administrative inefficiencies.

Proposed amendment to section 24A of the Health Professions Act

The following amendment to section 24A seeks to address the systemic inefficiencies in the placement of graduate medical practitioners by providing a legislative framework for the exemption of unplaced graduates. The proposed amendment would ensure that medical graduates who have not been placed within 3 months of completing their internship are not arbitrarily prevented from practising their profession, in alignment with constitutional rights and international labour standards.

‘Insertion of subsections (3) and (4) to section 24A: Exemption from Mandatory Community Service for Unplaced Graduates

Amendment:

Section 24A of the Health Professions Act 56 of 1974 is hereby amended by the insertion of the following subsections:

- “(3) Notwithstanding the provisions of subsection (1), any person required to perform community service in terms of this section shall be exempt from such requirement if–
- (a) the person has applied for community service placement through the National Department of Health's Internship and Community Service Programme and has not been allocated a position within three months of completing their internship;
 - (b) the person has provided proof of completion of an accredited internship programme at a recognised medical training facility; and
 - (c) the Health Professions Council of South Africa (HPCSA) has confirmed the non-placement status of the applicant and has issued the appropriate certification for independent practice.
- (4) The Minister may, after consultation with the Council, make regulations concerning the administration and implementation of the exemption contemplated in subsection (3), including but not limited to–
- (a) the procedure for verifying eligibility for exemption;
 - (b) the criteria for determining non-placement status;
 - (c) the obligations of medical graduates granted exemption, including registration requirements with the HPCSA; and
 - (d) any conditions necessary to ensure that the exemption mechanism does not compromise healthcare workforce planning.”

In tandem with legislative amendments, the community service regulations will have to be adapted to integrate the exemption option into the existing medical graduate placement system. These regulations will require substantive revision, which is beyond the scope of this article, particularly as it pertains to aligning the Health

Professions Act and regulatory mandates of the HPCSA with the rights of the healthcare practitioner while simultaneously reaching the essential goal of community service to ensure healthcare provision in underserved areas.

The determination of which candidates can be exempted should be carefully calibrated to balance equity and sustainability. Manipulation of the system by medical practitioners in order to gain exemption should be avoided by appointing a strict oversight committee. Regulations should stipulate clearly that any offer of placement by the National Department of Health (NDoH) within the first 3 months of the end of internship will automatically disqualify the medical practitioner from being exempted, regardless of whether the practitioner was offered a position that was on their preference list or not. In cases where medical practitioners were not offered a position within the first 3 months of the end of internship, they should not be forced to accept the exemption, but rather be offered it as an option to accept or decline. Some candidates may wish to wait for a community service job offer, as it is often a beneficial training year and an opportunity to gain experience in a specific chosen field.

This system will necessitate a timeous start of the community service placement process in order for unfilled or declined posts to be redistributed among unplaced prospective community service medical practitioners. The consequence of a slow placement process will be loss of human resources, as medical practitioners would be exempted from community service. The benefit of this early placement process is twofold: it will ensure that posts that would have been open for the first part of the year are filled timeously, and it has the added benefit for medical practitioners of being able to plan and execute the logistics involved in starting the new community service year in a possibly remote and rural location.

Furthermore, where there is a delay in placing candidates as a direct consequence of administrative inefficiency, but the placement is still offered within the first 3 months of community service, the medical practitioner will not qualify for exemption but should be remunerated for the months during which they were unable to start work, as the NDoH is applying brakes on their careers, resulting in their only being able to join the free job market later than their peers who started their community service on time. These prospective community service doctors also have the added burden of not being able to generate any income based on their formal qualifications during this time, as they have not yet been declared independent medical practitioners. This remuneration should not be applicable in cases where medical practitioners have chosen to decline the exemption and would rather choose to wait for placement.

It is imperative that a review process should be built into the policy, allowing for periodic assessment of its impact on the healthcare sector, and ensuring that it continues to serve its intended purpose. If the policy is implemented incorrectly and is not accompanied by changes in the timeous execution of the community service allocations and placements, the only result will be a greater mismatch between unemployed doctors and unfilled community service positions. This review process should include regular stakeholder engagement with representatives from public health institutions, medical associations and regulatory bodies to assess whether the exemption option is meeting its objectives of greater HPCSA placement efficiency and protection of the rights of the medical practitioner, or requires modification.

If implemented correctly, this model could provide a sustainable, equitable and legally sound alternative to the current rigid and ineffective community service framework, ensuring that SA's healthcare system remains responsive to the needs of both medical graduates and the broader population.

Government bursary holders should also be released from their contractual obligations in cases where the government fails to place them in a community service post within the prescribed period. The obligation to fulfil a service contract must be reciprocated by the government's duty to provide employment opportunities within a reasonable time frame. If the state is unable to meet this obligation, bursary recipients should not be penalised by being indefinitely bound to a contract that prevents them from seeking alternative employment. In Gauteng Province, unplaced junior doctors were recently freed from their contracts because of the government's inability to provide them with positions, setting a crucial precedent for broader policy reform.^[32]

Should mandatory community service be reconsidered?

There have been numerous calls to abolish the compulsory community service requirement for medical graduates in SA, with critics arguing that it constitutes an unfair and exploitative policy.^[11,27] Unlike any other profession, newly qualified doctors are compelled to work in state-designated healthcare facilities, often under severe resource constraints, for a year before being allowed to practise independently.^[11] This obligation, while framed as a means to improve access to healthcare in underserved areas, has been described as a form of state-imposed labour that disproportionately burdens medical professionals.^[11] Advocates for its removal point out that no other field outside of medical science, including law, engineering and education, requires such compulsory service before full professional registration.

Furthermore, the policy has been criticised for failing to address systemic issues such as poor working conditions, inadequate infrastructure, and limited career progression within the public health sector, all of which contribute to the high attrition rate of doctors emigrating or moving to the private sector. However, despite these valid concerns, the sudden abolition of community service could have catastrophic consequences for the already overstretched public healthcare system. Many state hospitals and clinics, particularly in rural areas, rely heavily on the annually placed community service doctors to maintain essential services.^[33] Without these medical professionals, the existing shortage of healthcare workers would be exacerbated and patient care in under-resourced regions would deteriorate further.

Compulsory community service for health professionals has been implemented in over 70 countries since the early 1900s, often as a condition for government employment, postgraduate training, or licensing for private practice.^[34] Moreover, countries such as Australia require rural service for full registration of immigrant doctors, while India mandates a year of rural service for medical graduates.^[34] Ecuador's similar initiative improved staffing, but had little health impact owing to graduates' lack of public health training.^[35] Thailand similarly has a 3-year mandatory service as well as a buy-out option.^[36] The experience in Thailand specifically suggests that a combination of strategies is more effective than compulsory service alone.

If community service is to be reconsidered, careful thought must be given to what would replace it. Simply removing the requirement without implementing alternative solutions would be likely to worsen the healthcare crisis rather than improve conditions for medical graduates.

Conclusion

The systemic and repeated failure to place newly qualified medical practitioners in internship and community service positions is not just an administrative inconvenience, it is a fundamental policy

failure that threatens the integrity of SA's healthcare system. The status quo, in which unplaced graduates are neither allowed to practise nor provided with alternative pathways, is not sustainable. A healthcare system that actively prevents trained professionals from contributing to patient care owing to bureaucratic inefficiencies and a lack of funding is in urgent need of reform.

The current necessity of community service as a mechanism to ensure equitable healthcare access in SA is undeniable. However, the current rigid and inflexible model ignores economic realities, workforce mobility and evolving healthcare needs. It also fails to account for the interdependent relationship between public and private healthcare. SA does not exist in isolation; skilled medical professionals are mobile, and failure to modernise policies will accelerate brain drain, with graduates seeking opportunities in countries where their skills are recognised and fairly compensated.

Ultimately, the debate over community service is not about whether doctors should serve it, it is about how they should serve in a way that is both practical and just. SA has the opportunity to lead in creating a fair, accountable and forward-thinking healthcare workforce model. Whether it chooses to embrace this opportunity or continues to lose skilled professionals to inefficient bureaucracy will determine the future trajectory of its healthcare system.

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