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Position Statement: Advancing Equity and Patients' Rights in the Review of Human Resources for Health Remuneration and Deployment Policies

(Joint submission by the Rural Health Advocacy Project and SECTION27 to the Ministerial Advisory Committee on Human Resources for Health)

Executive Summary

This joint submission by the **Rural Health Advocacy Project (RHAP)** and **SECTION27** to the Ministerial Advisory Committee (MAC) on Human Resources for Health (HRH) calls for a rights-based review of South Africa's HRH remuneration and deployment policies. Grounded in the constitutional principles of equality, dignity, and access to healthcare, this submission situates HRH reform as a matter of justice for patients and accountability for the state. Both organisations emphasise that equitable access to skilled and motivated health workers is a prerequisite for realising the right to health, particularly for rural and underserved populations that continue to bear the greatest burden of system inefficiencies.

From a patient perspective, the current frameworks governing **Community Service**, **Rural Allowance**, **Remunerative Work Outside of the Public Service (RWOPS)**, and **Commuted Overtime (COT)** are no longer aligned with their original intent. While each was designed to enhance access and retention, poor implementation, weak oversight, and fragmented planning have eroded their effectiveness. As a result, patients face unstable staffing, inconsistent service delivery, and inequities in access to essential care. In particular, RWOPS and COT have evolved into coping mechanisms for systemic weaknesses - acting as income stabilisers for clinicians rather than instruments of equitable service provision - while community service and rural allowances fail to ensure long-term retention or continuity of care in underserved areas.

RHAP and SECTION27 therefore call on the MAC to embed seven guiding principles; **Equity, Transparency, Accountability, Integration, Patient-Centredness, Sustainability, and Human-Rights Impact Assessment**, into all HRH policy reforms. These principles frame patients' safety, dignity, and continuity of care as the central measure of success. The MAC is urged to modernise HRH policies as tools of equitable redistribution and to reject their use as stop-gap measures for deeper workforce and management failures. A coherent, transparent, and rights-based HRH strategy must strengthen and not substitute for the public health system.

RHAP and SECTION27 affirm their commitment to supporting this process through evidence generation, community engagement, and advocacy for a fair, ethical, and sustainable health workforce that serves every patient, everywhere.

Organisational Background and Approach

Rural Health Advocacy Project (RHAP)

The Rural Health Advocacy Project (RHAP) promotes, protects, and realises the right to rural health care by connecting **practice, policy, and partners**. RHAP works towards a health system in which people living in rural areas can access equitable, quality health care services - delivered by a fairly distributed and adequately supported health workforce.

RHAP's work is grounded in Section 27 of the Constitution, which enshrines the right of everyone to access health care services, and obligates the state to progressively realise this right within available resources. This obligation includes the development and implementation of a comprehensive Human Resources for Health (HRH) plan that ensures sufficient numbers of health workers are trained, attracted to, and retained in the public sector.

RHAP draws on constitutional and statutory imperatives to demand equity and accountability in the distribution and management of human resources for health. Through this lens, RHAP bridges policy, practice, and community voice, advocating for decisions that reflect the realities of rural health delivery and the lived experiences of patients and health workers alike.

SECTION27

SECTION27 is a public interest law organisation that works to influence, develop, and use the law to advance constitutional rights in South Africa - particularly the rights to access healthcare services and basic education.

Its approach is a hybrid of law and activism, combining **strategic litigation, advocacy, legal literacy, research**, and **community mobilisation** to achieve systemic change. Guided by the values of human rights, equality, dignity, and accountability, SECTION27's work seeks to ensure that state institutions and private actors fulfil their constitutional obligations.

Through collaboration with civil society organisations, social movements, and communities, SECTION27 aims to achieve structural transformation in health systems. Its interventions blend legal action with public advocacy to:

- Secure equitable access to essential health services;
- Promote transparency and accountability within governance structures; and
- Build public understanding of constitutional rights and civic responsibility.

In the context of this position statement, SECTION27's contribution lies in situating HRH policy reform within the constitutional framework of positive state obligations, ensuring that legal, administrative, and financial mechanisms work together to advance equality and human dignity.

Shared Advocacy Approach

Together, RHAP and SECTION27 bring a complementary blend of **grassroots insights, legal expertise,** and **evidence-based advocacy**. Both organisations are committed to:

- Promoting equity and social justice in health policy and implementation;
- Strengthening accountability and transparency in public health governance;
- Ensuring that policy development is informed by constitutional rights and community realities; and
- Working collaboratively with government, professional bodies, and civil society to achieve systemic, rights-affirming change.

This joint submission reflects our shared conviction that human resources for health policies must be coherent, equitable, and rights-based - ensuring that every person, regardless of geography or income, can access the quality care they are entitled to under the Constitution.

Our submission therefore takes a patient-rights and equity lens, affirming that all HRH policies must be assessed against South Africa's constitutional and ethical obligations, which include:

- Section 27(1) – the right to health care services;
- Section 9 – the right to equality and non-discrimination;
- Section 195(1) – principles of public administration including transparency, accountability and equitable service provision.

From a patient-rights perspective, we assert the following:

- **Equity in access:** No policy should perpetuate structural inequities in who receives care or where health professionals choose to serve.
- **Continuity of care:** Service users must not experience fragmented care because clinicians are overextended through commuted overtime or dual practice.
- **Accountability:** Patients and communities must be able to hold the state accountable for ensuring adequate staffing and reasonable working conditions.

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Policy Implications and Interactions (from a patient perspective)

1. Community Service (CS)

The recruitment and retention of health professionals in rural and underserved areas is a challenge that persists globally.[1] The one year community service program was established to strengthen primary health care,[2] guarantee the availability of human resources in underserved areas and create an environment that would make it possible for new healthcare professionals to gain experience.[3]

Although the existing Community Service policy only provides temporary posts for healthcare professionals, from a patient's perspective, this increases the likelihood that communities that generally do not have access to qualified healthcare professionals will now have them available to provide care. In some instances, patients that live in rural or underserved areas with limited services may receive services that would otherwise be unavailable to them. This consequently contributes to improvements in health equity and access throughout various areas.

However, the effectiveness of community service is dependent on the way in which placements are assigned and facilitated.[4] Further challenges arise including insufficient supervision of newly qualified health professionals, limited rest periods or breaks, and longer shift durations.[5] In recent years, community service doctors have been experiencing burnout.[6] These challenges

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[1] World Health Organization, "Global Policy Recommendations for the Retention of Health Workers in Remote and Rural areas" (2010) *WHO* 1-72, available at https://www.who.int/publications/i/item/increasing-access-to-health-workers-in-remote-and-rural-areas-through-improved-retention.

[2] L Ned *et al*, "The experiences and challenges faced by rehabilitation community service therapists within the South African Primary Healthcare health system'" (2017) 6:0 *African Journal of Disability* 1, available at https://doi.org/10.4102/ajod.v6i0.311.

[3] The Foundation for Professional Development, "Report of the Community Service for Health Professionals Summit held on the 22nd April 2015" (2015) at page 4, available at https://www.foundation.co.za/document/publications/reports/CS%20Summit%20Final%20Report%2016052016.pdf.

[4] L Maseko *et al*, "Factors that influence choice of placement for community service among occupational therapists in South Africa." (2014) 44:1 *South African Journal of Occupational Therapy* 36, available at https://scielo.org.za/scielo.php?script=sci_arttext&pid=S2310-38332014000100008#:~:text=On%20a%20broader%20policy%20scale,the%20public%20service%20as%20well.

[5] Yoliswa Sobuwa, "Junior doctors battle burnout and unsafe working conditions" (2025), available at https://health-e.org.za/2025/05/20/junior-doctors-battle-burnout-and-unsafe-working-conditions/.

[6] GM Purbrick "Burnout among community service doctors in South Africa" (2024) 16:1 *African Journal of Primary Health Care & Family Medicine* 5, available at https://pmc.ncbi.nlm.nih.gov/articles/PMC11151387/.

may ultimately erode patient care, especially for those with chronic conditions and complex illnesses, who may experience inconsistent care, poor outcomes, or complete lack of access if services are unavailable.

Another concern from a patient advocacy perspective relates to the lasting stability and retention of staff. While community service may temporarily increase the number of hands available in the public sector, there is no guarantee that staff will remain in the public sector after completing their community service work, especially in rural areas, where only 8% of study participants intended to continue in public rural practice in 2023.[7]

If this decline persists, patient care could remain unstable, and communities may face ongoing staff turnover, which in turn would jeopardise continuity of care, trust, and overall healthcare for patients who rely on public healthcare.

2. Rural Allowance (RA)

The Rural Allowance was introduced to provide a financial incentive to attract and retain skilled health professionals in rural and underserved areas, where historically there has been a marked maldistribution of personnel. This additional allowance was intended to partially compensate for the hardship, isolation, and opportunity costs associated with rural practice (e.g. limited private practice opportunities, fewer amenities), making rural public service more attractive[8,9,10].

However, the implementation of allowance has faced significant structural and policy challenges which have diluted its effectiveness. These include an unclear and varied definition of “rural” across provinces; eligibility restricted only to certain cadres of health workers, and a lack of robust monitoring, evaluation, or transparent communication about who qualifies and why[11].

Moreover, many health professionals report that the allowance alone is insufficient to offset the broader disincentives of rural service: inadequate housing or infrastructure, limited career progression, lack of specialist support, and social isolation. In some instances, RA has led to

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[7] TJ Baytopp *et al*, “Influences of Western Cape community service doctors’ choice regarding public, rural practice.” (2025) 67:1 *South African Family Practice* 3, available at https://doi.org/10.4102/safp.v67i1.6125.

[8] Maphumulo WT, Bhengu BR. Challenges of quality improvement in the healthcare of South Africa post-apartheid: A critical review. *Curationis*. 2019 Jan 1;42(1):1-9, available at https://journals.co.za/doi/abs/10.4102/curationis.v42i1.1901.

[9] Ditlopo P, Blaauw D, Bidwell P, Thomas S. Analyzing the implementation of the rural allowance in hospitals in North West Province, South Africa. *Journal of Public Health Policy*. 2011 Jun 1;32(Suppl 1):S80-93, available at https://link.springer.com/article/10.1057/jphp.2011.28.

[10] Mburu G, George G. Determining the efficacy of national strategies aimed at addressing the challenges facing health personnel working in rural areas in KwaZulu-Natal, South Africa. *African Journal of Primary Health Care and Family Medicine*. 2017 Feb 22;9(1):1-8, available at https://journals.co.za/doi/abs/10.4102/phcfm.v9i1.1355

[11] See reference 9.

divisiveness and dissatisfaction among staff - especially those cadres excluded from the allowance - undermining morale rather than bolstering it[12].

These implementation failures translate into concrete impacts on patients and rural communities' access to care. Because the allowance does not sufficiently overcome the structural and professional drawbacks of rural service, many rural facilities continue to suffer from staff shortages, high turnover, and unstable staffing. For patients, this can mean unreliable or inconsistent access: frequent staff changes, gaps in service delivery, longer waiting times, and compromised continuity of care. Equally, because eligible staff may still seek to leave or decline rural posts, rural health services remain fragile, undermining the equity and access goals that RA was meant to address[1314].

3. Remunerative Work Outside of the Public Service (RWOPS)

In South Africa, the Public Service Act 103 of 1994 allows remunerative work outside of the public service. RWOPS is defined as any business activity conducted or service provided by an employee outside of their official duties, for which they receive payment.[15] RWOPS is intended to allow healthcare professionals to perform limited private work, outside scheduled working hours, without compromising their public duties.

RWOPS was intended to allow clinicians to maintain skills and earn supplementary income but has instead become a structural escape valve for inadequate remuneration and poor working conditions. Weak monitoring and discretionary approvals create inequities in implementation and divert time from public service obligations, leading to abuse of the policy[16], in particular the prioritisation of private practice, leading to staff shortages in public health facilities. This may cause long waiting periods for patients and creates a delay in access to services and ultimately compromise of patients' rights when the system tolerates conflicts of interest between public and private commitments.

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[12] Mapukata NO. Beyond the Rural Pipeline Approach: Policy Considerations in the Making of a Rural Workforce, available at https://www.researchgate.net/profile/Nontsikelelo-Mapukata/publication/395740711_Beyond_the_Rural_Pipeline_Approach_Policy_Considerations_in_the_Making_of_a_Rural_Workforce/links/68d2b34dd221a404b2a1f3ac/Beyond-the-Rural-Pipeline-Approach-Policy-Considerations-in-the-Making-of-a-Rural-Workforce.pdf

[13] Makapela NC, Useh U. Rural allowance and the retention of health professionals in selected hospitals in the North West Province of South Africa. *Journal of Human Ecology*. 2013 Nov 1;44(2):129-38.

[14] Cooke R, Couper I, Versteeg M. Human resources for rural health. *South African health review*. 2011 Jan 1;2011(1):107-17, available at https://journals.co.za/doi/abs/10.10520/EJC119079.

[15] BP Matiwane *et al*, "Perspectives of doctors, nurses and rehabilitation therapists in Gauteng and Mpumalanga provinces' public hospitals on remunerative work outside of the public service" (2025) 115:4 *SAMJ* 29, available at https://www.scielo.org.za/scielo.php?script=sci_arttext&pid=S0256-95742025000400006.

[16] See reference 15.

Furthermore, despite aims of RWOPS to enhance public sector retention, dual practice linked with unstable public-sector retention, through potential overworking which can expedite decisions on leaving the public sector, which can be further facilitated by RWOPS acting as a 'stepping stone' to private practice establishment. This undermines the presumption that RWOPS ensures retention, meaning public patients lose continuity of care as well as access to specialist care[17].

4. Commuted Overtime (COT)

The Commuted Overtime system in South Africa was introduced to ensure the continued provision of essential health services outside of regular working hours, particularly in hospitals and emergency units. The original rationale was twofold: to retain scarce clinical skills within the public sector by compensating for extended working hours and high workloads, and to guarantee patient access and continuity of care during nights and weekends when health facilities are often understaffed[18].

However, over time, the implementation of COT has deviated from its original intent and has increasingly functioned as a supplementary income mechanism for public sector clinicians, contributing a significant amount of total monthly earnings and subsequently making many clinicians financially dependent on overtime work to sustain their livelihoods[19]. This dependency has created systemic vulnerabilities, where overtime becomes a de facto income stabiliser rather than a service planning tool.

Research shows that doctors who work excessive hours without sufficient rest experience higher rates of fatigue-related errors, lower productivity, and impaired clinical decision-making, all of which can directly compromise patient outcomes[20]. In many hospitals, where COT is used as a substitute for permanent staffing, overdependence on COT leads to unstable after-hours coverage - particularly in rural hospitals - and subsequently it undermines the development of sustainable, stable teams and continuity of care for patients. This results in longer waiting times,

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[17] Ashmore J, Gilson L. Conceptualizing the impacts of dual practice on the retention of public sector specialists-evidence from South Africa. *Human resources for health*. 2015 Jan 19;13(1):3, available at https://link.springer.com/article/10.1186/1478-4491-13-3.

[18] Government Technical Advisory Centre (GTAC). *Commuted overtime performed by medical doctors* [Internet]. Pretoria: National Treasury; 2022 [cited 2025 Dec 9]. Available from: https://www.gtac.gov.za/pepa/wp-content/uploads/2023/02/Commuted-Overtime-Report-1.pdf

[19] See reference 18.

[20] Kotze K, van der Westhuizen HM, van Loggerenberg E, Jawitz F, Ehrlich R. Doctors' extended shifts as risk to practitioner and patient: South Africa as a case study. *International Journal of Environmental Research and Public Health.* 2020 Aug;17(16):5853, available at https://www.mdpi.com/1660-4601/17/16/5853.

treatment delays, and reduced quality of care, disproportionately affecting low-income and rural patients who cannot access private alternatives.

From a patients' rights and equity perspective, the current COT system undermines both the quality and reliability of public healthcare. While it was designed to secure continuous service provision, it has evolved into a mechanism that relies on clinician exhaustion to keep facilities functioning. It risks perpetuating a cycle of burnout, absenteeism, and attrition, further destabilising service delivery in already-fragile public facilities.

Guiding Principles for Coherent HRH Reform

Rather than specific prescriptive recommendations, RHAP and SECTION27 propose that HRH policy reviews be guided by these **seven principles**:

Theme	Patient-Centred Concern	Recommendations for Reform
Equity	Patients in rural and underserved communities continue to face unequal access to healthcare due to uneven distribution of health professionals and services. Without equitable deployment and monitoring, patients experience delayed, inconsistent, or absent care, reinforcing cycles of exclusion and poor health outcomes.	All HRH policies and incentives must advance the fair distribution of health personnel and services, prioritising rural and underserved populations. Every new or revised HRH policy should be assessed for its impact - including on rural and under-served communities - to ensure alignment with the National Human Resources for Health Strategy, National Health Insurance implementation plans, and the constitutional obligation to progressively realise the right to health.
Transparency	Patients often cannot see how HRH decisions are made or how resources are allocated. Lack of public reporting on RWOPS, commuted overtime, and allowances undermines trust and makes it difficult for communities to hold the system accountable when care is compromised.	Approval, allocation, and monitoring processes (for RWOPS, COT, and allowances) must be publicly reportable and accessible, reinforcing trust and deterring misuse.
Accountability	When ethics and oversight structures exclude patient voices, communities lose mechanisms to	Ethics structures must include patient and civil-society representation. Oversight

	report neglect or conflict of interest. Patients experience the consequences of mismanagement - cancelled services, absent staff, and eroded service reliability - without accessible channels for redress.	mechanisms should have clear sanctions for neglect of public obligations or conflicts of interest.
Integration and Coherence	Patients experience fragmented and uneven care when HRH policies operate in silos. Without integrated planning across remuneration, deployment, and workforce support, service continuity breaks down, leaving patients caught between exhausted, rotating, or absent providers.	HRH incentives (RWOPS, COT, Rural Allowance, Community Service) must be harmonised within a unified financing and deployment framework that balances worker motivation and incentives with patient outcomes.
Patient-Centredness	Patients' safety, dignity, and continuity of care are directly compromised when workforce policies prioritise administrative or financial efficiency over patient outcomes. Overwork, burnout, and unstable staffing reduce quality of care and trust in the health system.	Patient safety, dignity, and continuity of care must be the core metric of HRH policy success; no reform should disadvantage patients or compromise their right to timely, quality care. Equity should be measured by improvements in patient access and continuity.
Sustainability	When health workers leave or burn out due to poor working conditions, patients lose continuity of care and relationships of trust. Frequent staff turnover and dependence on temporary or overtime-based coverage undermine safe, consistent, and compassionate care.	Workforce policies must promote long-term retention, well-being, and career progression to stabilise service delivery and prevent burnout.
Human-Rights Impact Assessment	Without explicit assessment of how HRH policies affect patients' rights, inequities in access and quality persist unmeasured. Patients, especially those in rural and under-served areas, bear the human cost of policies that fail to	Every HRH policy should undergo a human-rights impact assessment evaluating its effects on equity, access, and quality of care, ensuring progressive realisation of the constitutional right to health.

	uphold constitutional guarantees of dignity, equality, and the right to health.	

Call to Action

- The MAC for HRH is urged to adopt a **human-rights-based review framework** that explicitly evaluates how HRH policies affect patient access and equity.
- The Rural Allowance and Community Service systems must be **modernised** as tools of equitable redistribution, not relics of compliance.
- The MAC should promote **transparency, alignment, and accountability** across all remuneration-related policies, ensuring that financial incentives reinforce, rather than distort, public service delivery.
- Importantly, HRH policies must not serve as **stop-gap measures or pressure valves** for deeper systemic shortcomings. Mechanisms such as RWOPS, Commuted Overtime, and the Rural Allowance should not compensate for inadequate staffing, weak management, or poor working conditions. Instead, they must form part of a coherent, sustainable HRH strategy that strengthens the system itself rather than merely relieving its symptoms.
- RHAP and Section 27 affirm their commitment to supporting this process through **evidence, community voices,** and **ongoing advocacy** for a fair, ethical, and equitable health workforce.

For enquiries, please contact:
Rural Health Advocacy Project - Celene Coleman: ccoleman@rhap.org.za
SECTION2727 - Patience Phiri: phiri@section27.org.za