Rural-origin health science students at South African universities

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Background. Rural areas in all countries suffer from a shortage of health care professionals. In South Africa, the shortage is particularly marked; some rural areas have a doctor-to-population ratio of 5.5:100 000. Similar patterns apply to other health professionals. Increasing the proportion of rural-origin students in faculties of health sciences has been shown to be one way of addressing such shortages, as the students are more likely to work in rural areas after graduating.

Objective. To determine the proportion of rural-origin students at all medical schools in South Africa.

Design. A retrospective descriptive study was conducted in 2003. Lists of undergraduate students admitted from 1999 to 2002 for medicine, dentistry, physiotherapy and occupational therapy were obtained from 9 health science faculties. Origins of students were classified as city, town and rural by means of postal codes. The proportion of rural-origin students was determined and compared with the percentage of rural people in South Africa (46.3%).

Results. Of the 7 358 students, 4 341 (59%) were from cities, 1 107 (15%) from towns and 1 910 (26%) from rural areas. The proportion of rural-origin students in the different courses nationally were: medicine – 27.4%, physiotherapy – 22.4%, occupational therapy – 26.7%, and dentistry – 24.8%.

Conclusion. The proportion of rural-origin students in South Africa was considerably lower than the national rural population ratio. Strategies are needed to increase the number of rural-origin students in universities via preferential admission to alleviate the shortage of health professionals in rural areas.

and rural as areas outside major urban areas, provincial capitals and towns. Students from foreign countries (128) and those without postal codes were excluded. Names of individual students were not used.

Ethical approval for conducting this study was obtained from the Research Ethics and Publication Committee of UL.

Results

Full data for the 4 years and courses were obtained from 7 of the 9 universities. UCT supplied data for 2001 and 2002 only, and SU for 2002 only. UWC did not offer medicine, and UCT did not offer dentistry. Information on 7 358 students was obtained from all 9 universities. Of the students, 4 341 (59%) did not offer dentistry. Information on 7 358 students was gathered from all 9 universities. UCT supplied data for 2001 and 2002 only, UWC did not offer medicine, and UCT did not offer dentistry. Information on 7 358 students was gathered from all 9 universities.

In 5 of the 9 universities, the proportion of rural-origin students was <25%. UL and UFS had ≥40% rural-origin students (Table I). UL consistently had a proportion of rural-origin students equal to or greater than the national rural population proportion of 46%.

All four disciplines had a rural-student proportion <30% (Table II).

In all courses, the proportion of rural-origin students was less than a third of the total student population (Fig. 1). The proportion of rural students was 16% in one instance. There was no significant trend in any direction in the proportions of rural students admitted over the 4-year period.

![Fig. 1. Percentage of rural-origin students per professional course.](image)

Discussion

These results provide baseline information regarding the domestic origins of health science students at 9 South African universities. The selected professional disciplines play a critical role in the care of patients at public health institutions. The average proportion of rural-origin health science students nationally over the 4-year period was 26%. In the 4 abovementioned disciplines, the average proportion of rural-origin students ranged between 22.3% and 27.5%, compared with the rural population of 46%.

There was a steady increase in the total number of health science students in South African universities between 1999 and 2002, ranging from 20% in medicine to 67% in occupational therapy. However, the proportion of rural-origin students did not increase and, in occupational therapy, the proportion of rural-origin students halved over a 3-year period. These findings are in contrast with Australia and the USA, where deliberate strategies have increased the admission of rural-origin students.5,10

A South African study showed that 38.4% of rural-origin graduates were in rural practice, and 45.9% of doctors in rural areas were of rural origin, which is similar to patterns in other countries. In Norway, 56% of graduates from rural areas continued to work in such areas.18 Rural-origin graduates from the Universities of Missouri, Columbia, and Jefferson Medical College, Pennsylvania, were respectively 3 and 5 times more likely to remain in rural practice than those of urban origins, which suggests that the origin of students in the health science professions is an important determinant in predicting where they eventually practise. The relatively low number of rural-origin students in South African universities indicates that this
factor has not been addressed in connection with the shortage of health professionals in rural South Africa.

The low proportions of rural-origin students in health science faculties could also be the result of lack of policy on preferential admission, poor academic performance of applicants from rural areas, disparity in the levels of education between urban and rural schools, and lack of access by students in rural areas to career guidance and information on university admission criteria. Inconsistency in the proportions of rural-origin students possibly points to the absence of national guidelines or policy regarding preferential admission of students from rural areas. The 2001/2002 DoH annual report acknowledged the significant contribution that selective recruitment and training of people from rural areas could have in solving the human resource problem in rural areas. In the report, the DoH committed to provide conditional grants and to remove disincentives that discourage doctors and other health professionals from working in rural areas. Our study supports the need for such interventions to increase the proportion of students of rural origin. The DoH National Health Summit in 2001 recommended that solving rural manpower shortages would require revised admission criteria, effective recruitment strategies, financial support for students from rural areas, and bursary arrangements to ensure a supply of students from rural and under-served areas. Specific bursaries and scholarships to rural-origin students, as supported by the World Organization of Family Doctors (WONCA) working party on training for rural practice, could also increase admissions on the model of rural scholarship schemes. Such strategies have not yet been developed.

The Higher Education Act (Act 101 of 1997, section 37) stipulates that ‘... the admission policy of a public higher education institution must provide appropriate measures for the redress of past inequalities and may not unfairly discriminate in any way’. Some universities have implemented this policy. UCT differentiates applicants on a racial basis, with different minimum entry requirements for each race to allow for black students with lower points than their white counterparts. UCT’s criterion for admission of black students into medicine in 2009 is 36 points, compared with 42 for white students. A similar admission policy should be adopted by all universities and extended to include rural-origin students, who are at a disadvantage as a result of poor educational background and lack of facilities comparable with those in urban areas.

Our study did not seek to identify reasons for the rural distribution; it was also limited by inadequacy of data regarding students’ demographic characteristics. Most universities would not provide even anonymous demographic data, citing the need to maintain student confidentiality. It was therefore not possible to evaluate the situation regarding pertinent characteristics such as race, sex and high-school locale. The imprecision of using postal codes to differentiate between rural and non-rural areas is acknowledged; however, they provide a reasonable proxy for students’ backgrounds. In the absence of better means of categorisation, the researchers’ knowledge of these areas augmented the final characterisation.

Conclusion

In South African universities, the proportion of health science students from rural areas remains low. In terms of the principle of equity, one might argue that the proportion of rural-origin students at universities should reflect national demographics.

The lower proportion of rural-origin students may partly be attributed to poor education in rural areas and the absence of a policy on preferential admission. There is a need for educational institutions, including universities, to become involved in rural schools and to uplift education levels. Increasing the proportion of rural-origin students at universities will tend to provide more health care workers who are more likely to serve in rural areas. Therefore, South Africa needs to develop an affirmative action strategy for rural-origin students. Incentives, guidelines and quotas to increase the admission proportion of rural-origin students are also needed. These steps should lay the foundation for a lasting solution to alleviating personnel shortages in rural areas.

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References

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