rural health

Policy on
Rural Practice and Rural Health

2001

Wonca Working Party on Rural Practice
World Organisation of Family Doctors

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Preface to 2nd Edition

The Wonca Policy on Rural Practice and Rural Health is a living document. It derives from the process of recommendation formulation that has been integral to Rural Health conferences since the first Wonca World Conference on Rural Medicine in Shanghai in 1996. The recommendations from that conference, after another iteration through the Durban conference, became the Wonca Policy on Rural Practice and Rural Health, endorsed by Wonca Executive at Kuching in 1999.

The policy underwent another reiteration in Calgary. During the conference, recommendations and endorsements were gathered from the sessions. At the final plenary the conference was presented with the living document for discussion and reiteration. The revised document then went to the Wonca Working Party on Rural Practice and subsequently the 2001 Durban session of Wonca Council where it was endorsed.

The policy, while continuing unchanged in many aspects, does contain significant additions in the areas of:

- Cultural awareness
- Sharing educational resources worldwide
- Increasing the streamlining, coordination and scope of procedural training
- Practical support for rural training
- Reskilling of doctor and spouse
- Locally deliverable team training
- Effective incentives for rural practice
- Medical migration and its effects
- Coping with violence in rural practice
- Issues for women in rural practice
- Aged care
- Disability
- Supporting rural health teams
- Appropriate computerised practice
- Healthy community values
- Community orientated research
- The effects of forced migration
- Coordinated global approaches to rural disease
- Proposals for a WHO Collaborating Centre for Rural Health and a Wonca rural health advisory unit
- Taking a positive view of rural practice

On behalf of the Wonca Working Party on Rural Practice, I would commend the document to you as working document to stimulate your thoughts, whether you be a rural doctor, administrator, academic or consumer. We hope that it will assist you in improving the health of all rural people.

Dr Bruce Chater
Editor
On Behalf of the Wonca Working Party on Rural Practice

Editorial

In presenting this Policy the editorial group has been conscious of the contribution of many to this process. Our thanks go to particularly the Wonca Working Party on Rural Practice and the participants in the First International Conference on Rural practice in Shanghai/Fengxian County China in 1996 and the Second World Rural Health Congress in Durban South Africa in 1997. Special mention should be given to Jo Wainer, Steve Kirkbright, Paula Robinson and Elaine Evans at Monash University School of Rural Health, Australia, for their editorial and presentation skills.

In developing this document we were aware of the rural doctor focus of these recommendations. We have endeavoured to take into account the interests and contributions of all health workers. The conference at Durban expressed these sentiments succinctly as:

- The doctor alone is not the answer to the problems of rural health.
- There is a need for the development and support of health teams with diverse skills and including health workers and community members.
- We cannot speak on behalf of other health professionals but wish to join with other health professionals in partnership to address these issues.
- Many of these proposals with respect to recruitment, support, training and other issues could be applied to all members of the rural health team.

It is recognised that both generalist and rural practice are described using many different terms throughout the world. Many of these have considerable significance to national or local groups. For simplicity a consistent terminology has been used throughout the document. Primary care/Family Medicine/General Practice has been referred to as General Practice and its practitioners General Practitioners. Doctors practising in rural areas are referred to as Rural Doctors. The practice of the extended generalist requiring usually specialist skills and broader community skills is referred to as Rural Practice. Vocational Training has been used to refer to the supervised experience and training following the standard medical qualification. This post-graduate training is designed to adequately equip the doctor with the skills required for general practice and rural practice.

The editorial group hopes that you, the reader, will find this a useful document whether you are a politician, a bureaucrat, an academic, a rural doctor or a community member.

Your contribution to the future refinement of this document through the Wonca Working Party on Rural Practice will be welcomed.

Dr Bruce Chater

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Executive summary

There continues to be a worldwide shortage of general practitioners in rural and remote areas, and in particular doctors with the necessary skills and knowledge to work effectively and comfortably in these areas. All countries have significant shortages of rural doctors, even those developed countries which have an overall oversupply of doctors. In addition, in less well developed countries the majority of the population is located in rural areas, where they may lack basic health requirements such as clean water, adequate sanitation, sufficient food and shelter, and where they often have limited access to modern medical services.

Rural people represent the majority of the world's population and universally have poorer health status than urban people. Often the health status of special needs groups is worse in rural than metropolitan areas. These include the poor, the elderly, women and indigenous people. Despite this, rural health services command proportionally fewer resources and fewer staff than urban health services in almost every country in the world.

While the health of rural people is affected by social, cultural and economic factors, the major detriment comes from the lack of resources, and poverty.

This *Policy on Rural Practice and Rural Health* contains strategies to assist governments and professional bodies to ensure that real progress is made toward the goal of improving the health of rural people. These strategies were developed over the six year period following the establishment of the Wonca Working Party on Rural Practice in 1992. The strategies have been used in many countries and the experiences derived have been presented at international rural health conferences. They have been considered in depth at these fora and the strategies largely reflect the recommendations of these conferences. It is envisaged that these will be refined following further implementation.

Wonca endorses the following Policy and Recommendations to improve rural health.

Recommendations for Rural Practice and Rural Health

1. Preparation for rural practice

Medical schools need to ensure that support and encouragement is given to rural students to embark on a career in rural practice. All students showing an interest in undertaking such a career should be supported. Medical schools should take responsibility to educate appropriately skilled doctors to meet particularly the needs of their geographic region, including underserved areas. Medical schools should work with the national health system in providing regional support for health professionals and accessible tertiary health care.

1.1 Strategies for increasing student interest in rural practice

1.2 Strategies for making undergraduate learning more rurally orientated

1.3 Strategies to integrate undergraduate education more effectively

2. The development, maintenance and enhancement of the skills of rural doctors

Specific vocational training programs for rural practice should be developed to complement general practice vocational training. This needs to be followed by specific continuing medical education for vocationally trained graduates and existing practitioners.

2.1 Strategies to increase skills through rural vocational training

2.2 Strategies for continuing medical education

3. Recruitment and retention of doctors in rural practice

The problems of retaining rural doctors need to be addressed. Solutions to these problems will support recruitment initiatives and will complement undergraduate and postgraduate training initiatives developed to attract doctors to rural practice. Remuneration should reflect the extra responsibilities and workload of rural doctors. Employment conditions should be comparable with the rest of the workforce and should include fair and equitable working conditions. The “brain drain” of doctors from disadvantaged countries needs to be addressed. A career path needs to be established for short and long term rural doctors. Working conditions and support structures should also address the needs of spouses and families of rural doctors.

3.1 Strategies to enhance financial incentives

3.2 Strategies for sustainable work practices

3.3 Strategies for dealing with the international mobility of rural doctors

3.4 Strategies for structuring a career path in rural practice

3.5 Strategies to support the families of rural doctors

4. Meeting community needs

Each rural community has a unique environment, history and economic base which influences the demand for health care and the skills which are needed by the health team. Rural doctors should be prepared for a diverse range of roles requiring a wide variety of skills. While rural doctors have in the past almost always been men, women are increasingly becoming rural doctors, and attention must be given to any identified needs they may have. It is important to increase the flexibility of health services delivery models so that they reflect the diversity of both the rural communities they serve, and the workforce providing that service.

The Rural Health Team is a multidisciplinary team of health workers functioning often in a way beyond the normal boundaries of their own discipline. This team approach is an essential part of Primary Health Care. Providing health care in rural areas requires a well trained and experienced health care team that works closely with a community and is responsive to their needs and preferences.

Information technology and telehealth offer a major potential benefit for rural health care. There is however a danger that telehealth development may spell the end of locally responsive health services. The implementation of these new technologies must have as its primary goal the benefit of the local community.

4.1 Strategies to achieve balanced gender mix

4.2 Strategies to provide appropriate practice and skills mix

4.3 Strategies to improve team approach

4.4 Strategies to ensure the appropriate implementation of IT

4.5 Strategies to encourage health community values

5. A framework for rural health care

There are special problems in rural health care that are not seen in urban health care. There are specific needs and problems which require a specific focus of attention. Affirmative action policies by government structures at national and regional levels are essential to address the needs of underserved rural areas.

The state must recognise its pressing responsibility for ensuring equitable access to health care in rural areas.

Research is needed to inform rural health initiatives and to monitor progress in rural health care. Technical, personnel and financial support for rural research is scarce and needs to be increased.

Support and new initiatives are needed from Wonca and its member organisations to address the needs of rural doctors, the diversity of their roles, and the ongoing drive to develop the rural health workforce.

5.1 Strategies to establish rural health administrative structures

5.2 Strategies for the allocation of financial resources

5.3 Strategies to increase rural health research

5.4 Strategies to enhance the development of rural doctor issues

5.5 Strategies to enhance representation of rural doctor issues

Wonca has accepted the need for rural specific policy in medical education and training. This policy paper develops on those recommendations and presents a tested series of strategies for Rural Practice and Rural Health.

Introduction

The Second World Rural Health Congress issued the "Durban Declaration" on Health for All Rural People. This sets out the concerns and aspirations of rural doctors for the health of rural people around the world. Implementation of the following recommendations will facilitate achievement of that declaration. A combined effort to redress the historical inequities faced by rural and disadvantaged communities is needed through affirmative action for rural people with respect to health care.

The recommendations in this Policy present a matrix of measures designed to assist rural people through the enhancement of rural health services. The philosophy of the recommendations was set out in the Wonca "Policy on Training for Rural Practice":

> "The world-wide shortage of rural family doctors contributes directly to the difficulties with providing adequate medical care in rural and remote areas in both developed and less developed countries. Wonca believes there is an urgent need to implement strategies to improve health services around the world. This will require sufficient numbers of skilled rural family doctors to provide the necessary services."

The Wonca Working Party on Training for Rural Practice was formed following the Wonca World Conference in 1992. At that conference the rural delegates met to discuss matters related to rural practice. The consensus that developed formed the basis for the "Policy on Training for Rural Practice" which was endorsed by Wonca Council on 9 June 1995.

At that 1995 Wonca World Conference, the Wonca working party was expanded and contributed to discussions regarding the organisation of the First International Conference on Rural practice in China.

In the triennium following the 1995 Wonca World Conference the Working Party was involved in the organisation of two international rural health conferences - The First International Conference on Rural practice in Shanghai/Fengxian County China in 1996 and the Second World Rural Health Congress in Durban South Africa in 1997. These Conferences each involved more than 300 delegates from around the world. Participants in both conferences developed a set of recommendations that enhance the Training Policy recommendations and reflect a developing world perspective.

This Policy on Rural Practice and Rural Health seeks to build on the seminal ideas of the Training Policy. Much experience was gained over the six years since the Wonca Working Party on Rural Practice was formed and met to discuss these issues. Many projects have been piloted and tested. Many of these have been the subject of lively presentation and discussion at the International Conferences. This policy seeks to distil from these a set of strategies which will benefit the health of rural people. The Working Party hopes that this document will provide a practical blueprint for Governments, Academies, Colleges and communities to tackle the parlous state of rural health.

Principles of rural health care

The outcomes and strategies proposed in this Policy on Rural Practice and Rural Health are based on a number of important principles elucidated at the Durban Conference in 1997

1. That the necessary infrastructure for the implementation of comprehensive health care delivery for rural, remote and underserviced areas must be a high priority for national governments.
2. That the specific nature of rural practice, including the broader range of skills required of rural doctors, needs to be recognised by governments and professional organisations.
3. That the core general practice/family practice competencies of rural doctors need to be enhanced by the provision of additional skills for rural practice appropriate to the specific location of the practice.
4. That the status of rural doctors needs to be elevated by a co-ordinated approach involving improved career prospects, education and training, improved incentives and improved working conditions. These should be supported by governments, communities and professional organisations recognising the pivotal role of the rural doctor.
5. That the rural doctor and other health professionals should assist the community in assessment, analysis and development of health services responsive to community needs, while recognising the importance of a patient-centred approach at the individual level.
6. That models of rural health services need to be evaluated and promoted, in partnership with rural communities, and in co-operation with regional and national health authorities.
7. That rural doctors need to adopt the philosophy of Primary Health Care as a key to the health of rural communities.
8. That women must be involved in all representative bodies and be there when decisions are being made.

The strategic framework for better rural health care

The health care needs of rural areas can be addressed by an approach that targets the needs of health care professionals - potential students, those in training and those in practice - rural communities, governments and non-government organisations (NGO's). The strategies are thus grouped under the following headings

1 Preparation for rural practice

2 The development, maintenance and enhancement of the skills of rural doctors

3 Recruitment of doctors to and retention of doctors in rural practice

4 Meeting community needs

5 Providing a framework for rural health care

Some strategies necessarily may apply to a number of these headings but have been dealt with under the most applicable heading.

1. Preparation for rural practice

(To be read in the context of the Wonca Policy on Training for Rural Practice 1995)

Recruitment to rural practice will increase when high school students, medical students and new medical graduates see rural practice as a positive career option. This can be achieved by carefully encouraging and selecting school students, sensitising medical students to rural practice early on and providing appropriate clinical teaching in the latter part of the undergraduate course and in the immediate postgraduate period.

1.1 Strategies for increasing student interest in rural practice

Experience around the world shows that students from a rural origin are much more likely to enter rural practice after graduation than urban origin students. In most current medical courses, the proportion of students from a rural origin is significantly less than the proportion of the population which lives in the country. It is important to implement a broad range of strategies that recruit more medical students from a rural background, and provide them with the support and training which will fit them for rural practice.

Support strategies for medical students are also vital. Financial support of medical students from rural areas and encouragement for those going to rural areas is important, particularly in the light of the poorer economic situation of rural people. Strategies such as "Rural Practice Clubs" have been shown to encourage city origin students to develop an interest in rural practice and support rural background students in adjusting to the challenges of city living and university studies. Students with an interest in rural practice can be assisted further through rural doctor mentor schemes whereby each student is attached to a physician practising in the rural town or area. The mentor provides the student with ongoing personal support and encouragement as well as a professional role model.

Strategies

1.1.1 Early exposure of rural school pupils to medical practice

1.1.2 Introduction of programs promoting medicine as a career to rural secondary students

1.1.3 Establishment of scholarships and educational support programs which identify potential medical students in rural areas and assist them with secondary and tertiary education in preparation for medical school entry.

1.1.4 Admission of more students of rural background. This can be achieved by selection processes that encourage admission of students from rural areas. Student selection should target ethnic groups prevalent in rural communities

1.1.5 When selecting and recruiting staff and potential students and trainees, universities should take cognisance not only of academic prowess but also matters of commitment, vision and a willingness to take risks and if necessary, make sacrifices

1.1.6 Bonding/scholarship schemes offering rural service/repayment options

1.1.7 Establishment and support of rural student interest groups such as “Rural Practice Clubs”

1.1.8 Facilitation of international links between such rural student interest groups. This initiative should further increase the sharing of information and enhance relations between rural orientated students from various backgrounds. It is recommended that this include specific programs funded by Wonca and should include research and exchange programs.

1.1.9 Establishment of rural doctor mentor schemes

1.2 Strategies for making undergraduate learning more rurally orientated

Clinical experience in a rural setting is an important factor associated with entering rural practice. Early positive exposure to rural practice encourages more students to develop an interest in rural practice as a career option and fosters a better understanding of rural practice even for those who choose not to work in a rural setting. All students should be introduced to rural practice early in the medical course and have clinical rotations to rural hospitals and rural general practice later in the course.

Decentralised medical schools that allow medical students to take a major part or all of their studies at centres located outside major metropolitan areas are more likely to attract students from rural areas and be successful in producing doctors to practice in rural areas.

Given the shortage of women in rural practice, attachments should provide models that encourage women to consider a career in rural practice.

Strategies

General practice and specifically rural practice should be included in the curriculum by:

1.2.1 Introducing rural health issues early in the curriculum including specific rural practice attachments in rural communities for students early in the medical course and including further clinical rotations to rural hospitals and rural general practice later in the course.

1.2.2 Ensuring that adequate support and resources follow the students in rural placements. *Example, support for travel, living allowance and educational resources.*

1.2.3 Developing enhanced rural training experience for a selected group of students who indicate an early commitment to rural practice.

1.2.4 Establishing decentralised medical schools that allow students to take most or all of their medical school education in centres outside major metropolitan areas.

1.2.5 Developing specific initiatives that encourages women into rural practice.

1.2.6 Ensuring that significant periods of undergraduate learning and teaching should be multi-professional and take place within the rural health team.

1.2.7 Encouraging multidisciplinary links in the training of medical students. The participation of nurses and other health professionals in the education of undergraduates and junior doctors will improve the relationship between doctors and other health professionals and facilitate a greater diversity of approaches.

1.2.8 Supporting the role of the rural doctor in undergraduate education, by the means of financial and educational support.

1.2.9 Integrating cultural awareness into the undergraduate curricula.

1.3 Strategies to integrate undergraduate education more effectively

Medical schools should assume a responsibility to educate appropriately trained doctors to meet the needs of their general geographic region including underserved areas. As well, they should play a key role in providing regional support for health professionals and in providing accessible tertiary heath care. The inclusion of practising rural doctors in medical schools as educators and researchers is integral to the development of an improved understanding of and a supportive attitude towards rural practice.

Strategies

1.3.1 Governments need to provide financial incentives which reward medical schools whose graduates become rural doctors.

1.3.2 Universities should create academic posts for rural doctors

1.3.3 Medical schools should be allocated responsibility for support and training in defined geographical areas in a way which ensures adequate coverage of all parts of a country.

1.3.4 There should be integration and co-ordination of the use of resources for education for all health professionals

1.3.5 To facilitate the global sharing of undergraduate curricula.

2. The development, maintenance and enhancement of the skills of rural doctors

Rural practice is a clinical field whose practitioners, working in a rural or remote environment, are required to be extended generalists, providing primary, secondary and specialised medical care. Rural doctors must be able, singly or in a team, to provide a wide variety of local services appropriate to the needs of rural communities.

Rural practice often includes obstetrics, surgery, anaesthetics and emergency medicine together with hospital access and care of the acutely ill. Rural practitioners are much more likely than urban doctors to be looking after individual patients for all of their medical problems on a continuing basis and to be caring for other family members. Emergency medical skills are an absolute minimum requirement, and rural doctors should be assisted to obtain these so as to perform competently in situations where there is no access to immediate assistance.

Rural medical skills should include the ability to minimise the impact of distance on the family and economic life of rural people caused by non-urgent health care needs. Other skills should be determined according to the characteristics of the community

2.1 Strategies to increase skills through rural vocational training

The 'extended generalist' component of rural general practice requires specific residency training programs for rural practice which prepare new medical graduates for a career in the country. Such programs should ideally be provided in regional centres or rural areas.

Strategies

2.1.1 Flexible, integrated and co-ordinated competency based training should be provided for rural doctors through vocational training, upskilling and CME programs for rural practice developed by or in association with rural doctors. With an emphasis on vertical integration

2.1.2 Appropriate vocational and continuing medical education is an essential component of strategies to recruit and retain rural doctors. Doctors who are well trained in rural practice stay in rural practice, particularly if they are able to use their skills and are supported to retain their skills with continuing education programmes designed to be relevant and accessible.

2.1.3 Specific rural practice vocational training programs should:

- be needs driven, evidence based and learner centred
- have appropriate faculty, hospital and financial support
- provide particular emphasis on training in procedural skills and an appropriate core curriculum of rural practice in addition to a solid general practice foundation
- provide a major portion of training within the rural context
- provide the opportunity and funding for advanced rural skills training in emergency medicine, anaesthesia, surgery, procedural obstetrics, endoscopy, palliative care, rehabilitation and others skills necessary in rural areas
- should be coordinated so as to avoid duplication
- provide opportunities for mainstream general practice trainees to experience the joys and challenges of rural general practice.

Additional skills acquisition should be complemented by a GP appropriate system of recognition and credentialing.

2.1.4 Community service programs must have a training element that is adequately supported

2.1.5 Incentives should be available to those doctors who choose vocational training in rural practice

2.1.6 Upskilling/retraining programs should be available to non-rural doctors, spouses unexpectedly finding themselves in rural practice, and doctors following a prolonged break in service

2.1.7 To facilitate the global sharing of vocational training curricula

2.2 Strategies for continuing medical education

Continuing education programs must be accessible to rural practitioners. Distance education methods of education can be used to bring continuing education to rural practitioners. This includes traditional published materials, CDs and videos, and new technologies including teleconferencing, electronic mail, telemedicine and satellite television.

Strategies

2.2.1 Continuing medical education programs can be made accessible to rural practitioners through:

- locating them in rural regional centres
- making use of distance education methods including modern information technology
- encourage the development of locally deliverable models involving the local health care team. *Example, STARS Human Patient Simulator Unit (Alberta Canada).*
- easy access to library facilities and e-mail at rural health centres
- recognition by continuing medical education and academic structures of the extra demands on and difficulties for rural medical practitioners and provision of support to address these.

2.2.2 Making postgraduate education available via distance education, so as to allow more remote rural doctors to pursue higher university studies without leaving their towns or practices.

2.2.3 Specific tailored continuing education and professional development programs which meet the identified needs of rural general practitioners should be developed through a process including:

- programs developed by rural doctors for rural doctors
- the provision of appropriate university postgraduate diplomas and degrees.

3. Recruitment and retention of doctors in rural practice

It is a goal of this policy that there be sufficient numbers of rural doctors with the appropriate skills to meet the health needs of people in rural and remote areas. Retention of the existing rural workforce is essential to achieve this goal. This will require the removal of disincentives to rural practice, and the provision of incentives which help to counteract the additional responsibility of isolated practice.

Rural doctors have identified financial, work practice and professional issues which can be adapted to enhance the capacity of rural doctors to remain in rural practice.

These strategies will also assist the recruitment of doctors to rural practice.

An integrated approach to rural workforce recruitment and retention will include the following initiatives:

3.1 Strategies to enhance financial incentives

Reasonable working conditions which include a balance between work, on call and free time are essential if doctors are to spend extended periods in rural practice. This requires sufficient local back-up and locum relief to allow doctors to take care of themselves. Adequate financial rewards which recognise the complexity and degree of clinical responsibility accepted by rural doctors are an important incentive.

Strategies

Targeted financial support for rural practice such as:

3.1.1 Funding models that provide security and flexibility for the doctor and recognise the physician as a community resource.

3.1.2 Additional payments to rural practitioners in recognition of higher level of clinical responsibility, services provided and on call demands. *Example, specific remuneration of the rural consultation.*

3.1.3 Specific incentive payments for practising in isolated/underserved areas.

3.1.4 Financial assistance to maintain the economic viability of at least two doctors working together in a rural location.

3.1.5 Funding for travel and other costs for the doctor to attend continuing medical education.

3.1.6 Support and incentives for rural doctors' spouses and families. *Example, travel support, spousal allowance to compensate for loss of career opportunities.*

3.1.7 Suitable adequate and effective financial incentives should be highlighted for international dissemination.

3.2 Strategies for sustainable work practices

The retention of rural doctors is predicated on the satisfaction that they achieve in both their professional and personal life. The isolation of rural practice puts strains on both of these. There is a need to provide an adequate working environment for rural doctors to use the extended range of skills that they have required. Too often the rural doctor has to work in substandard facilities. The extended period of on-call, often single handed, is a source of stress to doctors and their families. Such conditions must be alleviated if doctors are to remain in rural areas. Rural locum schemes, where provided, have been eagerly accepted by rural doctors and their families.

Strategies

Creation of a work environment in which the rural doctor can separate work and personal time and is supported in using her or his skills by:

3.2.1 The establishment of locum relief schemes to permit release of rural general practitioners to undertake continuing education as well as recreation and other forms of leave

3.2.2 Sustainable work practices should also address the need for relief from being on-call and should include, where appropriate, mechanisms such as nurse backup and triage

3.2.3 The provision of facilities, staff and technology support for service delivery commensurate with the level of training of health practitioners

3.3 Strategies for dealing with the international mobility of rural doctors

International mobility of workers is recognised as important in providing much needed skills, cross fertilisation and international understanding. It is vital that such mobility is supported without causing a drain of talented professionals from less developed countries.

Many rural health teams rely on the recruitment of overseas trained doctors. This requires careful management to ensure that the doctors are appropriately trained for their new environment, and that disadvantaged countries do not lose their doctors to countries with a higher standard of living. Attention must be paid to the following:

Strategies

3.3.1 Appropriate processes to enable reasonable international mobility of doctors prepared to undertake rural service positions and exchange programs.

3.3.2 Governments of countries experiencing damaging “brain drain” must be encouraged to explore the reasons why and to ensure regular and fair provision of at least a “living wage” and adequate basic support in terms of tools and equipment to maintain an adequate medical service where they practice

3.3.3 Governments and medical councils that rely on doctors from other countries to serve their needs should be encouraged to consider the effect that their policies are having on the other disadvantaged countries, and take corrective action.

3.3.4 Health services and governments which employ doctors from developing countries should be required to make a contribution to the support of rural doctors in their country of origin

3.3.5 To encourage each country to meet their own needs for medical workforce.

3.4 Strategies for structuring a career path in rural practice

Doctors can be encouraged to stay in rural practice if systems are in place to ensure they do not become professionally isolated and are able to re-enter urban practice if they need to.

Strategies

This requires:

3.4.1 Access to ongoing appropriate continuing medical education to enhance and maintain their skills.

3.4.2 Development of clear and attractive career pathways for rural practitioners.

3.4.3 Preferential access to specialist training for those rural doctors who choose to change career pathways.

3.4.4 There should be no financial, career or regulatory barriers to doctors moving to practice in urban areas.

3.4.5 Academic appointments and support for rural doctors.

3.5 Strategies to support the families of rural doctors

Many doctors leave rural areas for family and social reasons rather than professional ones. Partners often struggle to develop a meaningful role for themselves outside of the practice situation, and children's educational needs are often not met. The health service cannot focus narrowly on the doctor alone if the problems of rural health care are to be addressed.

Careful attention to the needs of the doctor as part of a family unit will increase the probability that doctors will be attracted to and stay in rural practice.

Strategies

These include:

3.5.1 The establishment of spouse and family networks such as the Rural Medical Family Network in Australia.

3.5.2 Education regarding rural doctor/family relationships and professional boundaries.

3.5.3 Education of communities on the needs of rural doctors and their families.

3.5.4 Employment opportunities for doctors' spouses.

3.5.5 Suitable local education opportunities for doctors' children or funding to facilitate education of the doctors' family at distant centres and funding to visit family members undertaking such secondary or tertiary education.

3.5.6 Funding to permit travel by the doctor and family for recreation and other forms of leave.

3.5.7 Financial assistance with accommodation for the doctor and family.

4. Meeting community needs

Each rural community has a unique environment, history and economic base which influences the requirement for health care and the skills which are needed by the health team.

While rural doctors have in the past almost always been men, women are increasingly becoming rural doctors. It is important to increase the flexibility of health services delivery models so that they reflect the diversity of both the rural communities they serve, and the workforce providing that service.

4.1 Strategies to achieve balanced gender mix

There is now a much greater diversity in the medical profession than there used to be. Patterns of rural practice need to be restructured to reflect diverse working styles and preferences if the rural medical workforce is to draw on the full spectrum of medical graduates.

Strategies

4.1.1 Medical schools, national and international medical associations, and colleges of medicine need to support female rural doctors to practise in ways which reflect their multiple roles of doctor, wife and mother, and to develop strategies which empower women and men in rural practice to set their own limits to practice. This may include, but is not limited to, flexible working hours and discontinuous training.

4.1.2 Associations of rural doctors should develop and implement ways in which both male and female rural doctors can support each other. *Example, support groups for women in rural practice.*

4.1.3 Practice patterns preferred by women should be adequately remunerated and acknowledged in fee structures.

4.1.4 There should be recognition of particular problems of rural female doctors and their families, including the particular needs of male spouse

4.1.5 Rural educational arrangements should reflect the difficulty of the doctor leaving town for education while balancing his/her family responsibilities.

4.1.6 Rural practice models should address issues of personal safety by development of undergraduate curricula which increases student awareness of the risks of violence and demonstrates strategies to manage violent incidents.

- Development of support strategies and protocols for use in violent incidents
- Community education about the risks of violence to rural doctors

4.1.7 Locum schemes should promote, where possible, an appropriate gender mix

4.1.8 Specific measure to retain women in rural practice

4.1.9 Establishment of a Wonca working group to advise the Wonca Working Party on Rural Practice on

- The structural underpinnings of rural practice from a gender perspective
- Recommendations as to how these structures could be modified to create female friendly environments
- How to attract women into rural practice
- The identification and development of models of flexible child care, particularly with respect to after hours service provision
- The development of mentor programs so that young women training for rural practice have the opportunity to access the support of role models

4.1.10 Universities should develop medical undergraduate curricula which consider gender and family issues

4.2 Strategies to provide appropriate practice and skills mix

The role of the rural doctor is wide and varied but encompasses a range of skills in the areas of primary health care, public health, clinical practice (including advanced skills) and community development. Doctors working in rural areas need this broad range of skills and may need extra skills in particular areas to meet the needs of the particular community in which they work

4.2.1 Policies should be adapted to the specific circumstances of each region or country and be appropriate to the community, ensuring a mix of primary health care, preventive health, public health, clinical practice, community development, rehabilitation and consideration of environmental issues

4.2.2 Policies should seek to address the specific rural problems of:

- Maintaining the elderly in rural areas, with the respect they deserve
- Cultural awareness
  - Educating medical students, resident trainees and practising doctors in the culture of their community
  - Educating communities on the culture of the doctors they are recruiting, with encouragement to welcome and integrate these doctors
  - Providing palliative care with adequate resources, training and lay support groups

4.2.3 Specific strategies to deal with disability in rural areas should include

- Advocacy on behalf of the rural disabled
- Collaborative research on disability and ways to deal with it
- Creating awareness among rural doctors about prevention and management of disability
- Include rehabilitation in undergraduate and postgraduate rural doctor training
- Encourage families and other resource personnel to assist disabled people
- Inclusion of rehabilitation at Wonca rural conferences
- Inviting disabled people to address Wonca rural conferences regarding their disability

4.3 Strategies to improve a team approach

The Rural Health Team can be defined as "a multidisciplinary team of health workers functioning often in a way beyond the normal boundaries of their own discipline to provide health care to a specific population in a defined geographical area." Not only is the team an essential part of Primary Health Care as defined by Alma Ata, but it also provides support for the doctor who may otherwise be isolated and who cannot hope to tackle the range of problems faced at a community, family and individual level by him or herself. Furthermore, the shortage of personnel in rural areas requires the pooling of skills and knowledge so that team members can together cover the gaps which may arise from time to time.

In the context of serious shortages of doctors and other health practitioners, interdisciplinary co-operation and teamwork amongst health care providers is essential. Teamwork is encouraged both by the rural culture with its focus on ‘getting the job done’,

and by the special relationship between rural practitioners and their communities.

Recognising that rural health care is ideally a team effort in which health professionals appreciate their own and each others' strengths and limitations, and that team work is essential to the philosophy of Primary Health Care we recommend the following strategies.

Strategies

4.3.1 That all categories of rural health practitioners be selected, educated and trained to work as a team appropriate to their community's needs.

4.3.2 That governments support and encourage such teams.

4.3.3 That rural doctors should play a key role in rural health teams which acknowledges their clinical, managerial, and consultative skills.

4.3.4 That there be appropriate utilisation of the skills of each member of the rural health team.

4.3.5 That the advocacy role of the rural doctor be recognised and accepted as an important one.

4.3.6 That the rural practitioner be a catalyst for intersectoral collaboration for rural development.

4.3.7 That any program for health care in rural communities recognise the paramount importance of health promotion in schools and communities while assisting communities to seek their own solutions to their problems.

4.3.8 That rural community health centres be established with facilities and support for doctors and other health professionals.

4.3.9 That significant periods of undergraduate learning and teaching should be multiprofessional and take place within the rural health team.

4.3.10 That general practitioners be included in rural health initiative and teams where appropriate and that the exclusion of general practitioners from many existing programs should be reversed

4.3.11 That rural doctors should seek to form partnerships with traditional healers for the benefit of their patients

4.3.12 That volunteers be supported in and integrated into the rural health team

4.3.13 That remuneration be provided for doctor participation in rural health teams.

4.4 Strategies to ensure the appropriate implementation of information technology

(This section should be read in the context of the proposed Wonca Policy on Using Information Technology to Improve Rural Health Care, 1998).

Information technology and telehealth offers a major potential benefit for rural health care. Specific telehealth applications may provide rural practitioners with rapid access to clinical specialist support and there are many possibilities for the use of information technology to support and train rural doctors.

In any telehealth development it is essential that the experts involved have an understanding and respect for rural cultures or rural health services. Otherwise it may spell the end of locally responsive health services.

Developments in this field may be helpful in the delivery of high quality care in rural and remote areas provided they facilitate enhancement of local skills and services.

Failure to base new developments on local rural needs, and lack of consultation with rural stakeholders may result in the establishment of inappropriate models of health care and undermine locally based services.

Telehealth is the use of electronic multimedia to deliver health services from a distance. Planning for rural telehealth services must include consideration of the range of telehealth services appropriate to local healthcare needs and services. The cultural and social contexts into which the services are being introduced must be understood, and services must be appropriate to support or enhance local rural health services, not replace them.

Strategies

4.4.1 Information technology solutions should be needs based, planned locally and empower local communities to take decisions on matters affecting their own lives. *Example, computer prescribing, CME on the Net, use of digital cameras and store and forward technology*

4.4.2 Information technology must supplement and not supplant the individual focus of health care. *Example, recognise the legitimacy of telemedicine consultations*.

4.4.3 All rural and remote health care workers need to have access to reliable basic telecommunications in their own communities. National governments and organisations should facilitate access to, and use of modern telephonic communications, information technology and telehealth applications to support rural practitioners and enhance rural health care.

4.4.4 Training in the use of computers and information technology should be incorporated into the basic training of all health care practitioners and should be provided for practitioners already in rural areas.

4.4.5 Rural practitioners need to be involved in the field of research and development into telehealth and such research should seek to assess the real value of technology to the local community.

4.4.6 WRITE (Wonca Rural Information Technology Exchange) should continue to act as a forum and to advocate for appropriate information technology within Wonca in cooperation with the Wonca Working Party on Rural Practice and the Wonca Working Party on Informatics.

4.4.7 Evaluation of currently available technologies with their appropriate implementation. *Example, computerised prescribing*.

4.4.8 Facilitate the distribution of computers to developing countries.

4.5 Strategies to encourage healthy community values

4.5.1 Enhancement of the role and educational level of rural women

4.5.2 Encouragement of a healthy diet

4.5.3 Encouragement awareness of and avoidance of farm injury. *Example, Murray Plains Program (Victoria Australia)*.

5. A framework for rural health care

Specific and identifiable financial and bureaucratic resource allocation in regional and national budgets will increase the visibility of rural health, and the accountability of government in meeting the needs of rural constituencies.

5.1 Strategies to establish rural health administrative structures

Rural health care is not the same as urban health care. There are specific needs and problems which require a specific focus of attention.

Strategies

5.1.1 There should be development and implementation of national rural health strategies with central government support through co-operative involvement of communities, doctors and other health professionals, hospitals, medical schools, professional organisations and governments at all levels.

5.1.2 Governments must develop and adequately fund rural health departments which deal with the specific health service needs of the rural areas and develop rural friendly approaches to health issues. These should coordinator and avoid duplication.

5.1.3 There should be development of appropriate needs-based and culturally-sensitive rural health care resources with local community involvement, regional co-operation and government support.

5.1.4 Policies and requirements of governments should be tailored to the capacity and needs of rural areas

5.1.5 Government policies should encourage the development of general practice and in particular, rural general practice.

5.2 Strategies for the allocation of financial resources

Affirmative action policies need to be implemented by government structures in favour of rural areas at national and regional levels. These are essential to address the needs of underserved rural areas. Progress will be made only if separate resources are allocated and personnel are tasked with monitoring outcomes. National governments in particular have a special responsibility to provide adequate financial support for rural health care.

Strategies

5.2.1 Governments should provide appropriate funding to develop and maintain hospital and other health services and referral resources to meet the needs of people in rural and remote communities. Loss of medical service may result in an inability to recruit other industries and eventually a dissolution of the community itself. Government support should recognise the broad scope of rural practice facilities, including the need for treatment facilities, diagnostic facilities, an adequately trained workforce and the means to support local disease prevention, health promotion activities..

5.2.2 The need for dedicated funding for the support of rural health care practitioners must be recognised.

5.2.3 Allocation of financial resources in rural areas should target funding to areas of need. *Example, reducing the negative impacts of globalisation*.

5.3 Strategies to increase rural health research

Rural research designed by rural health practitioners is an essential pre-requisite for developing specific answers to rural health problems based on sound evidence within a framework defined by rural stakeholders.

Research is needed to inform rural health initiatives and to monitor progress in rural health care. Technical, personnel and financial support for rural research is scarce and much essential rural research is not done because there are insufficient skilled people available to do it. In many instances, we do not know what are the needs and problems of rural health services and of rural people.

The defined population of rural communities provides a unique opportunity for health research. Research should be encouraged to develop specific answers to rural health problems based on sound evidence within a framework defined by rural stakeholders.

Sound rural health policy requires sound rural health research. An essential first step is to develop research infrastructure which includes a skilled workforce to conceptualise rural health research as a particular discipline capable of elucidating rural health issues, proposing solutions, and evaluating rural health programmes.

Strategies

5.3.1 Priority issues for rural health research are:

- workforce issues
- health service delivery models
- management of specific clinical problems
- technology applications
- health care outcomes
- evaluation of successful models
- locally based participatory action research

5.3.2 Rurally-based medical education and research centres should be established in each country in rural areas with the aim of co-ordinating undergraduate education, postgraduate vocational training, and continuing medical education for medical practitioners, as well as rural health research. Such centres will greatly facilitate implementation of all previous recommendations. An important consequence of establishing rurally based medical education and research centres is the development of reciprocal links between country hospitals/practices and medical schools/teaching hospitals.

5.3.3 There should be appropriate academic positions, professional development and financial support for rural doctor-teachers to encourage rural health research and education.

5.3.4 The Wonca Working Party on Rural Practice should collaborate with the Wonca Research Committee to develop workable models for rural practice research.

5.3.5 There should be an international network of rural health research facilitated through the establishment of a WHO Collaborating Centre on Rural Health

5.3.6 The development of research projects, especially those that are participatory, at Wonca rural conferences should be encouraged.

5.4 Strategies to enhance development of rural doctor issues

A commitment is sought to the affirmative action in the Durban Declaration. The health status, morbidity and mortality patterns of people in rural and remote areas vary from country to country. However it is generally true that avoidable death rates are substantially higher in rural areas when compared with the cities. Despite this, rural health services are substantially under-resourced compared with urban health services. To remedy this it is essential that rural health service providers contribute to the development of health policy and programs through international, national and local forums.

Wonca has already reinforced its commitment to rural health through the establishment of the Working Party, the support of the international rural health congresses and the adoption of the Policy on Training for Rural Practice. Additional support and new initiatives are needed from Wonca and its member organisations to address the needs of rural doctors, the diversity of their roles, and the ongoing drive to develop the rural health workforce. This will demonstrate commitment to the affirmative action sought in the Durban Declaration.

Strategies

5.4.1 Future international conferences on rural health must be structured to ensure the participation of as wide a spectrum of rural doctors as possible.[covered below]

5.4.2 Future Wonca regional meetings and world congresses should contain a strong rural component.

5.4.3 Particular attention must be paid to the involvement of women in the planning, organisation and programs of conferences. A substantial amount of time should be included in conference programs to discuss gender-related issues, including but not restricted to consideration of personal, family and professional relationships for male and female physicians, and this should include presentation of issues at plenary sessions.

5.4.4 Issues in women's health should be highlighted in the clinical sessions at future rural conferences.

5.4.5 Child care and programs for children of delegates should be provided at all rural health meetings and conferences.

5.4.6 Every possible effort should be made to ensure that participants at conferences include all ethnic groups of the country. This should include planning, organisation and program development.

5.4.7 Conferences on rural health should involve all relevant rural health professionals

5.4.8 Conference venues should be rotated through different geographical regions to ensure adequate representation and cross fertilisation of ideas.

5.4.9 Wonca and member organisations' policies should specifically address the needs of rural doctors.

5.4.10 There should be international recognition of the medical implications of forced migration, whether due to political conflicts or natural disasters.

5.4.11 A global approach to diseases such as tuberculosis, with the involvement of rural doctors in the formulation of this approach should be encouraged.

5.4.12 In our advocacy role, rural doctors should take a positive attitude to rural practice

wherever possible in the media and in education.

5.5 Strategies to enhance representation of rural doctor issues

Rural practice is a particular field which requires representation in national and international policy making bodies if the continuing serious disadvantage in rural health and rural health services are to be overcome. It is essential that the voice of rural health be included directly in policy, including policy developed by Wonca.

Strategies

5.5.1 The Wonca Working Party on Rural Practice should be given the mandate to facilitate the formation of a Wonca International Network on Rural practice, including inputs from rural doctors groups and Wonca member bodies, to ensure representation of rural views to Wonca Council, and through council to other organisations around the world. Any such future network should be encouraged to work with Wonca.

5.5.2 The recommendations of the Wonca Policy on Training for Rural Practice and the Wonca/WHO document “Making Medical Practice and Education More Relevant to People’s Needs: The Contribution of the Family Doctor” should be implemented by Wonca and its member organisations.

5.5.3 Wonca should develop a policy to ensure equitable representation of women doctors on all decision-making bodies.

5.5.4 A Wonca Rural Advisory Unit be established to visit individual countries to assist them in enhancing their rural health services.

6. Future

It is envisaged that the Wonca Policy on Rural Practice and Rural Health will provide national, professional, and government bodies with a useful template for the development of national initiatives in rural health. Many of the strategies have been tested while a number await testing. Some may not suit the needs of individual countries but most will find that the multifactorial approach suggested in these recommendations will be better that a single strategy or few “quick fixes”.

The Wonca Working Party on Rural Practice strongly encourages the documentation of the achievements of individual strategies to improve rural health and rural health services.

The ultimate test will be an improvement in the health status of rural people.

Wonca Working Party on Rural Practice

The Wonca working party consists of up to 20 members with at least two representatives from each of the world's regions: Europe, Asia, Africa, North America, South America, Australasia/Pacific. These members are identified through Wonca member associations in each region with a requirement that each member be a rural practitioner or has a close association with rural practice. The Working Party is committed to achieving gender equity.

The chair of the Working Party is elected by the Working Party members for a three year term commencing in the year of each Wonca World Conference.

Vision

Health for all rural people around the world.

Mission

Improving rural health care around the world

Objectives

1 To facilitate communication between and networking of rural general practitioners around the world both individually and through rural family doctors' organisations and interest groups

2 To represent rural family doctors within Wonca, to Wonca Council, Standing Committees, Working Parties and Member Organisations.

3 Through Wonca to liaise on rural health issues with the World Health Organisation and other relevant international bodies.

4 To collaborate with organisations of rural doctors

5 To address issues of importance to rural family doctors including developing effective

- 5.1 Rural health care systems with appropriate funding to meet community needs
- 5.2 Integration of the family doctor into primary health care approaches for rural health care delivery
- 5.3 Community participation including a multisectorial approach to health care and health promotion in rural communities
- 5.4 Strategies to improve the status and health of rural women around the world
- 5.5 Rural health workforce models.
- 5.6 Recruitment, retention and support strategies for rural practitioners.
- 5.7 Education and training for rural medical practice
- 5.8 Research in rural health and rural practice including building research and development partnerships involving individuals and organisations in different countries

Members of The Wonca Working Party on Rural Practice

Professor Roger Strasser (Chair)	Australia	Dr Peter Newbery	Canada
Dr Bruce Chater	Australia	Dr M K Rajakuma	Malaysia
Dr James Rourke	Canada	Professor S H Lee	China (Hong Kong)
Dr John Wynn Jones	Wales	Professor Gu Yuan	China
Dr Tariq Aziz	Pakistan	Dr Chris Simpson	United States of America
Dr Neethea Naidoo	South Africa	Dr Berta Nunes	Portugal
Dr John Macleod	Scotland	Dr Elisabeth Swensen	Norway
Dr Ijaz Anwar	Pakistan	Dr Shatendra K Gupta	Nepal