Policy on Rural Practice and Rural Health

www.wonca.org
links to the Rural web site from there

1. Preparation for rural practice

1.1 Strategies for increasing student interest in rural practice

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

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

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

2.1 Strategies to increase skills through rural vocational training

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

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*
- 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

3.1 Strategies to enhance financial incentives

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, spousalallowance to compensate for loss of career opportunities*

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

3.2 Strategies for sustainable work practices

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

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

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

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

4.1 Strategies to achieve balanced gender mix

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

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

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 multi-professional 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

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 & 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, computerized 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*

5. A framework for rural health care

5.1 Strategies to establish rural health administrative structures

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 coordinate 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

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

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 coordinating 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

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

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.