MODELS OF RURAL PRACTICE

To me, there are many models of rural practice, rather than just one. One of the key messages from the First International Conference on Rural Medicine in Shanghai was that, despite the great differences between developed and developing countries, many of the crucial issues in rural practice and rural health service are the same.

Even in developing countries, where most of the population is rural, the resources are concentrated in the cities. It also seems that in every country, doctors and other health professionals cluster in the cities, and that there are major difficulties in the recruitment and retention of medical practitioners.

A third global problem is the tendency for city-based health service providers and administrators to view rural health services as second class.

Rural realities

In my view there is a series of key parameters that determines the structure and function of rural health practice and services and how rural practitioners work. I call these the "rural realities".

These rural realities are, in a nutshell, the physical environment; the cultural issues; the patterns of health status, illness and injury; and the availability of resources and personnel. It is these four parameters that provide the framework which determines models of rural practice.

In all countries, the climate and topology of rural and remote areas affect their accessibility. There tend to be clear cultural differences between rural communities and urban areas. In many countries there are significant cultural differences between rural communities. Rural communities are often characterised by loyal and enduring relationships. In contrast, the city and government are seen as distant and antagonistic; bad and inferior to the rural community.

In rural communities social roles and functions are generally clearly defined. Self-sufficiency, self-reliance are highly valued.

However, avoidable death rates and work injuries tend to be higher in rural and remote areas. Work injuries are also more severe than in urban centres. In Australia 40% of work injuries are associated with tractors, although only 5% of the population work with these machines.

In general, lifestyle-related illnesses are more common in rural and remote areas. There is often a higher consumption of alcohol and tobacco and standards of nutrition vary.

Access is a major issue for rural health services. Cities usually have hospitals and emergency services, whereas these cannot be taken for granted in rural areas. This means that rural communities focus on recruiting and retaining doctors and having a hospital in the area. Generally speaking, rural communities prefer to be cared for in their local environment rather than be referred to a specialist in another centre.

Limited funding and lack of other resources have a significant effect on the provision of health care in rural areas. In developing countries, where most of the population lives in rural areas, resources tend to be concentrated in urban areas. In developed countries there is a trend towards reducing funding and infrastructure support for health services in rural and remote communities. These issues are exacerbated by the shortage of doctors and other health care professionals in rural and remote areas.

It is clear that the development and delivery of rural health services need to be specific to the rural context and not simply a "miniaturised version" of urban health services.

Rural practitioners

Research shows that rural practitioners have a heavier work load with a broader range of services than their urban counterparts. They provide procedural services such as surgery and anaesthesia and carry a higher level of clinical responsibility in relative professional isolation.

There are three broad components to rural medicine. The first is broad, all-round general practice/family medicine. The second is procedural care, where dealing with emergencies is an unavoidable part of rural practice. The third is the provision of public health care and education. This includes preventive health care, through immunisation and education on subjects such as hygiene and nutrition.

Characteristics of models of rural practice

The first of three characteristics of models of rural practice is teamwork. In my experience real teamwork is more likely to occur in rural areas than urban. It is encouraged by rural culture and by the special relationship between rural practitioners and their communities.

The second is the relationship between local generalist health care providers and distant specialists. Experience shows that specialists play a useful and productive role when they provide clinical support and teaching for rural practitioners. Co-operation, mutual respect and trust between the specialist and the rural practitioner produce high quality care.

The third characteristic is the use of technology. Rural practitioners learn to be selective in their use of diagnostic and therapeutic technological interventions. In contrast, urban models of practice tend to be specialist-centred, fragmented and more costly. Seen in this light, models of rural practice are clearly not substandard or second class in comparison to urban models of practice.

The potential of information technology

Information technologies have the potential to reduce isolation in rural and remote areas. Satellite links, audio and video conferencing, the Internet and other forms of high speed data transfer provide the means to improve education and support for general practitioners. Specific telehealth applications may provide rural practitioners with rapid access to clinical specialist support.

On the other hand, there is a danger that the development of information technology will be driven by city-based, centralist enthusiasts who have no understanding or respect for rural cultures, health services or practitioners. Effective use of information technology must be based on mutual respect between urban and rural practitioners.

Rewards of rural practice

For rural practitioners there are major professional rewards and satisfactions. These include the variety of practice, ranging from obstetrics and surgery to emergency medicine, the provision of whole-patient, whole-family community care on an ongoing basis and independence. The country environment and outdoor lifestyle, as well as community standing and respect are also cited by rural doctors as important.

Surveys in rural areas show a high level of patient and community satisfaction with localised health care. In general, rural communities prefer local services provided by their own family practitioners.

As we have seen, the specifics of rural health care are determined very much by the rural context. The term "best practice" suggests "one right way" to manage any clinical problem, based on the way a particular problem may be managed in a city teaching hospital. Optimal care is always context specific.

Models of rural practice are determined by rural realities and take many different forms and styles. When compared with urban health services, rural practice models tend to be more diverse, yet more coherent and cost effective. It is critical for the benefit of people in rural and remote communities worldwide that models of rural practice are recognised as distinctive and specific to the rural context. They should not be forced to conform to uniform, urban-derived models and standards. ●

Prof Roger Strasser, Director of the Monash University Centre for Rural Health and Chairman of the WONCA Working Party on Rural Practice