

Medical Training for Rural Recruitment: Important as Stand-alone Approach

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Short Commentary

Ensuring equal access to health care is increasingly challenged by the growing shortage of rural physicians and the difficulties in recruiting and retaining health professionals in rural practice. Even in countries where the majority of the population lives in rural areas, access is a major health issue. Achieving an appropriate geographic distribution of physicians has proven to be a particularly tough and aggravating problem virtually everywhere in the world. Despite the obvious differences between high-, middle- and low-income countries, the key themes in rural health are surprisingly similar around the globe. The worldwide concentration of health resources in the cities jeopardises universal access to medical care. The fact that practically all countries face shortages of health-care providers in rural and remote areas challenges the global policy goal of achieving universal health coverage and demands for urgent actions.

A considerable array of approaches is being applied all over the world for enhancing the recruitment and retention of physicians and other health professionals in rural, remote and economically underdeveloped areas [1]. In a nutshell, essentially three types of strategies exist for improving the regional distribution of health practitioners, namely:

- Utilitarian approaches such as financial compensation, employment benefits, excellent facilities in order to offset impeding factors;
- Coercive measures like deployment for defined periods in underserved areas as condition of training, financial support or licensure;
- Normative strategies providing mainly symbolic rewards based on personal values or prestige, e. g. through tailored education and training schemes [2].

Many programmes and strategies for recruiting and retaining rural healthcare providers apply a mix of incentives and a match between professional candidates, their families, communities and health facilities. Particular emphasis lies on the potential of medical training and strategies that medical schools can adopt to influence the likelihood of medical students entering primary care practice and contribute to recruit and retain physicians in rural areas [3]. International recommendations for adapting medical training include (i) awarding more places to people from rural areas; (ii) organising medical undergraduate training closer to rural communities; (iii) bringing medical students to rural communities; (iv) matching curricula better with rural health needs and enhance physicians' competencies required in rural setting; (v) and facilitating professional development according to the needs of rural health workers [4]. Some examples of recruitment and retention incentives that encourage health workers to stay in rural or economically underdeveloped

regions include competitive salary and benefit programmes; loyalty bonuses; support for continuing education; opportunities for career advancement; and work-life balance support.

Physicians and advocates of primary health care and rural practice often emphasise individual and subjective factors such as self-confidence and self esteem of rural practitioners as drivers contributing to the recruitment and retention of skilled professionals in remote areas. Initiatives like the Rural Heroes Project 2015 launched by the World Organization of Family Doctors [5] reveal a rather individualistic and narrow-minded approach to solve the increasing need for rural practitioners. In addition, promoters of rural practice use to stress the fact that graduates trained in rural settings tend to rate themselves as better prepared for rural family practice than urban-trained physicians [6,7]. Likewise, rural practitioners organisations and their representatives repeatedly claim for primary health care (PHC) and family practice as the far most important but continuously underrated medical disciplines. Complaints and self-adulation, however, are usually insufficient for convincing others; and self-referential analyses are unlikely to produce innovative ideas and solutions.

Something similar occurs in the research on factors related to improved rural recruitment and health professionals propensity to settle in economically underdeveloped areas. An increasing body of literature suggests that supporting medical careers in rural areas through graduate training is an effective means for overcoming the shortage of rural physicians and preventing severe under supply of medical services in rural areas [4]. Literature reviews tend to confirm former findings that rural medical education and particularly longer rural exposures both at the undergraduate and post-graduate levels have a positive impact on decisions to practice in rural areas [8]. However, a more rigorous assessment of the evidence reveals the strength of these findings being rather weak; causal relationships between medical-school interventions and workplace after graduation are extremely difficult to prove, and high-quality studies are sparse. A large body of research demonstrates the tricky challenge to isolate the influence of rural medical education from confounding factors such as broader healthcare policy decisions and particularly rural upbringing of health professionals [9].

The most often listed favourable conditions associated with later rural practice are rural background, positive undergraduate rural exposure, targeted post-graduate exposure outside urban areas, and stated intent or preference for primary care in general or family practice. These four characteristics, as well as many others, work in a synergistic manner to influence the choice of practice location of physicians rather than acting alone as separate factors [8]. The assessment of the current body of knowledge leads to conclude that quoted evidence is largely based on informed opinions and descriptive

studies. A recent rapid review of available literature on the impact of medical training interventions on rural recruitment and retention revealed a meaningful interrelation: The positive effects of practically all interventions during undergraduate medical training were inseparably associated with students' or physicians' rural upbringing [10].

There is no doubt that professional guidance from an early stage of medical socialisation, purposeful curriculum interventions, training content focussing on family health and rural practice, and similar interventions have a potential to promote rural practice after graduation. Therefore, a comprehensive medical training system is required to provide opportunities to gather rural experience during undergraduate training. This is a major challenge in itself and often hampered by traditional power relations within medical schools that use to favour specialised and high-technology health research and care [11]. At the same time it has to be pointed out that adapting and reforming medical training alone will not be sufficient for overcoming the shortage of rural physicians and achieving equal access to health care.

Despite the growing consensus among health scientists and politicians on the need to re-orientate medical training towards family and rural medicine, a series of systemic, structural, institutional, political and ideological conditions make the necessary reforms and transformations difficult to implement. Medical schools have to overcome the logic of competitive ambitions, reputation or favouritism and prioritise public-health needs and their social accountability mandate. Curriculum interventions have to be embedded in an appropriate political and system context for being effective and sustainable. A multi-pronged approach that goes beyond exposures to rural environments at all levels of the medical education process, along with a set other strategies, is needed as a long-term solution to the problem of geographic maldistribution of physicians [8].

The World Health Organization (WHO) considers PHC and family practice as pivotal to the development of health systems [12]. The other way round, relevant changes towards strengthening primary care and particularly rural practice do imply noticeable measures at health systems level. It has to be stressed that the system and policy context substantially influences the design and implementation of different rural education programmes and determines major challenges to success. After graduation and during medical practice, professional institutions have generally to take care of appropriate reputation and career incentives for rural health professionals. At the same time, they represent corporatistic interests and concerns and play a major role for potential clientelism and other matters of the medical profession.

At the macro level, health policy and the healthcare system as a whole are ultimately responsible for setting the course and strengthening PHC and rural practice. Politicians and stakeholders are required to create job opportunities, implement adequate payment mechanisms, provide financial and other incentives, and systematically reduce existing barriers, which prevent health professionals from practicing in rural and remote regions. With regards to undergraduate training, evidence suggests awarding more places in medical schools to students who grew up or previously lived in rural areas since rural background is the far most reliable predictor of later work in rural practice. However, this might imply a clash with equity concerns on the one hand and vested interests on the other hand.

Advocacy for PHC and particularly for family medicine and rural practice has to surmount the often rather moaning than constructive

discourse of "rural heroes" and develop a more comprehensive and systemic strategy for promoting medical care in rural and remote areas. The commitment for equal access to quality health care in all geographic regions should not be restricted to health care provision and rural practice; promising and sustainable strategies towards recruiting and retaining more health professionals in economically underdeveloped regions have to envisage the education and healthcare systems. Without appropriate and favourable framework conditions, and without partly radical changes in the way how medical doctors are trained, socialised, promoted, supported, hired, committed and embedded in relevant policies, all efforts for safeguarding universal access all over the countries will remain incomplete. A systems approach is needed for appropriate policy planning, and more capacity building required for setting the healthcare systems right in order to ensure countrywide equal delivery of care [13]. Last but not least, adequate funding of health services is crucial for any initiative towards improving rural health. Universal health coverage including access to care for people living in rural and remote regions will definitely depend on public resources. Ultimately this implies a major shift from the prevailing understanding of the healthcare sector as just one branch of industry towards a more needs- and rights-based and less reputation- and profit-oriented system of healthcare provision.

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