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Providing health services to rural and remote communities

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ABSTRACT The provision of health services, including specialist medical services, to rural and remote communities may require a different approach to the increasingly sub-specialised, centralised and consumer-orientated systems prevailing in urban centres. The close links between health services and viability of communities introduces an additional political dimension to health planning in these settings. New models of care and new technologies will require specific training for rural settings. International experience must be used to mutual benefit in developing services of appropriate standard, which comply with local needs and are staffed by appropriately trained, supported and accredited clinicians.

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BACKGROUND

Provision of health services to rural and remote communities is increasingly recognised as a challenge in both developed and developing countries. In the developed world, health services in general are facing demographic changes, an increasing prevalence of chronic illness, increasing expenditure, uncontrolled diffusion of medical technology, issues of prioritisation, and a trend towards a consumer based approach, the latter particularly in urban settings. In the UK, major changes in the nature and working practices of medical practitioners have occurred, driven partly by European legislation. In rural and remote communities, these trends are compounded by geography and climatic conditions. Health and health services are also inextricably linked with the viability of rural communities, and current changes are therefore liable to impact more significantly than in urban communities.

The Royal College of Physicians of Edinburgh has recently published a number of reflections from clinicians working in rural Scotland,[1] and this issue of *The Journal* contains an interesting description of the Australian approach to addressing specialist medical care for rural and remote communities.[2] The recent publication of the Kerr Report[3] in Scotland provides an outline strategy to address rural health provision in Scotland, and is mirrored in strategic documents from other countries, such as the USA.[4] Common themes can be drawn from international comparisons of approaches to rural health care, though some important differences between countries exist.

Worldwide, there is a general tendency towards poorer health in rural, compared to urban, communities as, for example, in Australia.[2] This reflects a combination of socio-economic deprivation, complex issues surrounding indigenous people and migrant workers, and poorer access to health services. In contrast, in Scotland, rural people have enjoyed as good or better health than their urban counterparts and have rated their satisfaction with health services, both primary and secondary care, highly.[5] Unlike Australia and North America, our rural health services have been delivered almost exclusively by a publicly funded system with only a miniscule private sector. However, within our training systems for medical and other health care personnel, we have not until recently recognised a need for training which is specific to those working in rural and remote settings. This situation is about to change.

Rural and remote communities in many countries face similar demographic patterns: increasing elderly population; out migration of younger, economically active individuals; and loss of other services such as banks, schools etc. The relative contribution of health services to the economy and social capital of these communities is greater than in larger towns or cities, and thus the political impact of proposed changes to services may be felt more strongly in such communities. How then are we to approach provision of services in rural communities?

A well-defined concept in procedural medicine (less well articulated in diagnostic medicine) is the volume/quality relationship, i.e. the notion that improved outcomes are likely to be delivered where more procedures are performed, in turn leading to

centralisation. This provided some of the thinking behind the Acute Services Review carried out in Scotland in 1998.[6] However, more recent work has begun to indicate that while this holds true for certain more complex procedures, there may be other simpler procedures which can be delivered to a high quality at relatively low volume.[7] The Australians have a long and continuous history of providing procedural medicine. Such practices largely died out in the UK during the past 30 years, but a renewed emphasis on developing GPs with a special interest may reverse that trend.

The Kerr Report[3] describes a number of strategies for the future of rural and remote health care in Scotland, which could have wider international application. These include extended roles for primary care; enhanced Community Hospital services; tiered emergency responses; defined roles for networked Rural General Hospitals; appropriate training regimes for rural health professionals; and the development of a School for Rural Health Care. To deliver this successfully, a blurring of the boundaries between traditional primary and secondary care provision will be essential, as will coordinated working between health and social care and other agencies such as transport providers.

We can draw on a number of international models to inform these developments. For example, experience from Critical Access Hospitals in rural USA and District Medical Centres in Northern Norway can inform the development of both Community Hospitals and the Rural General Hospitals, particularly in relation to definition of core services and standard setting. Rural Clinical Schools, well established in Australia and developing in Canada (e.g. the Northern Ontario Medical School), can point the way to tailored rural clinical training. The growing network of rural health research and policy centres around the world can contribute to the necessary robust evidence base for the development of rural services.

In the UK, as in Australia, there will be an important role for the Colleges, in association with universities and NHS educational organisations to define, deliver and quality assure appropriate curricula for generalists and specialists working in rural and remote settings. These curricula will reflect the generalist nature of rural practice, the critical importance of emergency care in remote settings, the need for clearly defined interfaces and communication between levels of care, and the appropriate use of e-health, including internet-based and other telemedicine systems. The skills gained within such curricula could be highly exportable to developing countries, from whom important lessons could also be learned, particularly in relation to working within local cultural norms, a feature of rural and remote health provision in almost all countries. By sustaining and developing health provision, we will contribute to the maintenance of rural and remote communities worldwide, and indirectly therefore to social and cultural diversity, arguably as important as biodiversity in our shrinking planet.

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