The Royal New Zealand College of General Practitioners
Te Whare Tohu Rata o Aotearoa

Failing to thrive: academic rural health in New Zealand

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In this edition of the Journal, Dr John Burton reflects on a recent visit to the Northern Ontario School of Medicine (NOSM), and asks whether New Zealand (NZ) should follow the lead of Australian and Canadian Universities in establishing a school whose principal focus is rural medicine.[1]

Rural practice can be exciting and immensely rewarding but there is no doubt that much of NZ's rural medical workforce remains in a slow chronic crisis, something that has become almost normalised. Shortages persist, the rural workforce is aging and continues to be reliant on International Medical Graduates.[2,3] For such a significant part of the NZ population to be so underserved, for so long, is indicative of a fundamental problem in way we select, train and support doctors to work in these communities. We are not alone in this regard. Australia, Japan, Scandinavia, Canada, the USA and the UK all have problems attracting and retaining rural doctors. However, Canada and Australia, in particular, have resourced innovative rurally based programmes that we have much to learn from.

NZ participated in the early discussions aimed at addressing shortages in the rural medical workforce. In 1998, the late Pat Farry organised a rural medical education summit in Invercargill that brought together the universities and the rural health sector. Around the same time John Burton along with Ron Janes and Martin London were publishing papers advocating for a similar direction.[4–6]

It felt, for a while, as if progress was being made in rural medical education. In 2002 the NZ government funded 40 medical school places specifically for rural origin students. In 2008 Otago established a rural longitudinal integrated clerkship (Rural Medical Immersion Programme) and Auckland established their provincial program in Northland (Pūkawakawa) following a substantial increase in medical student funding to the two Universities.[7,8] At the same time the first steps were taken towards developing postgraduate pathways for rural general practice and hospital medicine. But progress in NZ has since slowed.

NOSM is Canada's newest medical school, a community engaged and socially accountable institution whose focus is unashamedly rural, generalist and the indigenous and Francophone communities of Northern Ontario. It has been led through its formative years by Roger Strasser, an Australian rural health pioneer and academic. John was clearly impressed by what he saw, but likely disappointed to see the extent to which NZ has failed to keep pace in two important areas in particular.

NOSM places considerable emphasis on engagement with its rural communities. All students spend prolonged periods of their training in rural areas, including during a Longitudinal Integrated Clerkship.[9] The communities and their health services are active parts of a medical school that sees its campus as encompassing the whole of Northern Ontario. Genuine community engagement is at the heart of successful rural health professional education. This is much more than hosting students for clinical attachments and includes involving communities in the design of programmes, co-governance of programmes at the community level and the university being accountable to the community with respect to mutually agreed outcomes.[10]

The second critical area in which NZ appears to have fallen behind is the development of the academic discipline of rural health. Not only was the Dean of NOSM a rural GP, rural generalists can be found at all levels of the faculty. Seeing rural doctors in senior academic roles increases the influence they have on students and their career choices and helps raise the status of rural medicine. The importance of these academic posts goes beyond teaching to provide the research and leadership that is needed to support and sustain high quality rural health services, in the same way academic activity supports urban branches of medicine. John quite rightly emphasises the importance of creating the opportunity for rural doctors to take up academic roles without having to leave rural practice or the communities they serve. He also makes the point that the rural context is a good place to learn medicine, regardless of final career choice. This is borne out by the success NOSM graduates have when applying for specialist training positions.[11]

There are several reasons why academic rural health has failed to thrive in NZ. The most important may be the lack of recognition by central government of rural health as a health priority. This may be because we have not demonstrated the rural (versus urban) disparities in health outcomes and access to services that have been demonstrated in comparable countries. It is hard to imagine these do not exist. NZ's rural towns have overall the lowest socioeconomic status and the highest proportion of Māori of any of our geographic categories, and likely the poorest access to health services. But the research has not been done, because rural health has not developed as an academic discipline, a classic 'catch-22'. The territorial nature of our health services and medical schools is a further barrier hindering the creation of a critical mass of rural health expertise. The expectation that rural health can be resourced by a trickle-down approach through multiple urban based university departments and District Health Boards (DHBs) has not been met. Medical Schools (and DHBs) inevitably pull resources to the centre and this can be overcome only when they establish dedicated rural health entities and a strong commitment to dispersed models of medical education. Rural medicine differs from general practice in metropolitan and provincial centres because of the additional skills generalist rural doctors need to practice competently at a distance from specialist services. Extended scopes of rural generalist practice therefore need explicit recognition in medical education and training.

John concludes by calling for the existing institutions and professional groups to cooperate to find the best model for NZ.[1] He rightly points out this needs to be done by engaging and involving our rural communities. He suggests central government facilitate this process, but to date such appeals have fallen on deaf ears. We hope that the Health and Disability System Review which has been consulting widely has heard the voice of rural communities and their health professionals and will help facilitate a new community engaged approach to our rural health workforce crisis.

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