Recruiting and retaining a rural medical workforce: the value of active community participation

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Overseas experience offers insights into providing sustainable health care for remote communities

In this issue of the *MJA*, Playford and colleagues report research which found that undergraduate rural clinical school immersion increases the likelihood that students who begin medical school intending to practise in rural areas will actually enter the rural medical workforce after graduation. The authors conclude that: "Rural background, rural intention and rural experience during medical school all need to be factored into programs for redressing deficits in rural workforce levels programs."[1] This report provides evidence that supports recent Australian government initiatives aimed at strengthening the education and training pathway to rural practice.[2]

Most countries face the same challenge as Australia: training, recruiting and retaining health professionals with the skills and commitment for providing care where it is most needed, particularly in underserved remote, rural, and indigenous communities. Like Australia, many countries have implemented evidence-based education and training initiatives. In addition, Health Canada and Canadian medical schools committed themselves in 2001 to social accountability, defined by the World Health Organization as "the obligation to direct their education, research, and service activities towards addressing the priority health concerns of the community, region and the nation that they have a mandate to serve".[3]

Located in a vast rural region of Canada, the Northern Ontario School of Medicine (NOSM) opened in 2005 with a social accountability mandate focused on improving the health of Northern Ontarians.[4] Consistent with social accountability, NOSM developed distributed community engaged learning (DCEL) as its distinctive model of medical education and health research. Community engagement, consisting of active community participation, involves interdependent partnerships between the School and the communities that benefit all partners.[5] Community engagement guided the development of the comprehensive life cycle approach of NOSM, beginning in high school and extending through to continuing medical education. The NOSM admissions process seeks to reflect the population distribution of Northern Ontario, specifically promoting applicants from Northern Ontario or from similar backgrounds. Community members play a vital role in selecting students for the 4-year medical program, in educating students by serving as standardised patients, and by providing local support for students during their community placements.[6]

Twelve years since its official opening, NOSM is recognised for its success in fulfilling its social accountability mandate: 92% of all NOSM medical students grew up in Northern Ontario, while 8% come from other remote and rural parts of Canada; 62% of NOSM graduates (almost double the Canadian average) have chosen predominantly rural general practice training; and 94% of the doctors who completed undergraduate and postgraduate education with NOSM are practising in Northern Ontario (33% in remote rural communities). Many NOSM graduates are now faculty members, and an increasing number have taken on academic leadership roles. The socio-economic impact of NOSM on Northern Ontario communities includes new economic activity totalling more than CAN$100 million in 2016, more than twice the School's budget; rural communities that had previously struggled to attract physicians have a full complement of NOSM-trained doctors and have greatly reduced their spending on recruitment; and there is a sense of empowerment in participating communities that is largely attributable to NOSM.[7]

Like Australia and Canada, the northern regions of European countries experience considerable difficulty recruiting and retaining health care workforces. Communities, health services and academic organisations in northern Sweden, Norway, Scotland, Iceland, and Canada (NOSM) are therefore implementing the European Union-funded "Recruit and Retain" project. The first Recruit and Retain phase created a network of communities linked by a common purpose and commitment to successful health workforce recruitment and retention in remote rural areas. The current phase, "Making it Work", implements the seven-step business model developed during phase one in five jurisdictions; in Canada, this means replicating the success of NOSM in the Arctic territory of Nunavut.[8]

Earlier this year, the first World Summit on Social Accountability, with its focus on "Improving the impact of educational institutions

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on people's health",[9] highlighted the value of both health care and socially accountable health workforce education designed and delivered with active community participation.[10] This is consistent with the experience of both the Recruit and Retain project and NOSM. Recruit and Retain also found that people in remote rural communities have more in common with similar communities in other countries than with people in the major population centres of their own countries. These international experiences suggest that a sustainable remote and rural medical workforce in Australia is more likely to be achieved by policies that encourage active community participation.

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