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EDITORIAL

Medical schools must contribute to rural health care in South America

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Contrary to popular belief, only 13% of South America's 350 million inhabitants live in rural areas, and this number is decreasing. Uruguay and Argentina have the lowest rural population (7.5% and 11.4%) and Ecuador the highest (36%). Moreover, besides this demographic difference, South America is the region of the world with the greatest inequity in income distribution, after Central America and the Caribbean[1]. It is a continent heterogenous in sociodemographic terms. However, there is a great disparity in the realities among different countries and within each country, and this implies that rural healthcare policies and delivery are necessarily diverse. In educational terms, the response of every country to student exposure to rural health differs, from very structured and mandatory undergraduate experiences, to the most flexible and elective in others.

Despite these differences, there are three common obstacles to effective rural healthcare delivery. First, there is a lack of information concerning health conditions in rural areas. Statistical, demographic and epidemiological information is often insufficient or badly organized, making life difficult for rural health planners. Second, the national healthcare systems of some South American countries are not yet fully developed, and are at different stages of organization. Rural healthcare provision is seldom a real priority. Third, health ministries and medical schools frequently have different agendas and no common projects. This implies a difference between the human resources needed and those available.

However, recently in many South American countries there has been a sustained effort to improve the situation. Resources have been invested in the collection, organization and analysis of health-related data, and on designing centrally planned health systems that respond to each region's health needs, and to bringing medical schools closer to local health needs. In recent times, South American governments, universities and national and international health organizations have recognized the need to improve and expand healthcare delivery in rural areas. Many universities and accrediting bodies require that medical schools arrange some kind of rural health experience for their students. In this editorial I will focus on the role of the

university in promoting rural health care in South America. Although there are a few rurally oriented medical schools, I will refer mainly to those that are the majority: highly specialized large urban institutions.

How can universities contribute to change?

While government healthcare agencies have to build conditions to enable the best rural health possible, the role of the university is to train and teach those who are going to be the health promoters and providers at the graduate and post-graduate level. How can medical schools accomplish this objective? I suggest there are five areas to consider: students, faculties, interdisciplinary work, policy development, and research.

Students

International research has shown that placing students in rural contexts is a partially effective way to promote rural medicine and to recruit physicians for rural areas[2]. However our schools need to incorporate and integrate rural health teaching in the curriculum. We don't need a new course (there are enough courses already in our often overloaded curriculum) but should include some essential rural health topics in the existing courses. Latent interest in rural health care in our region must be fostered, and we must give our students the opportunity to consider rural health as an option. Raising students' interest in rural health may be sufficient at this stage of our evolution. This can be done by the effective strategy of bringing those students who have worked in a rural setting back to school to share their experiences with their peers.

Faculty

Most medical school faculty have had very little or no contact with rural health, therefore they cannot contribute to teaching it. Those who know about rural health are located far from the central medical schools and the tertiary care university hospitals where students spend most of their time. Rural healthcare providers and preceptors must be invited to medical schools to lecture on rural health topics and to interact with medical students. As part of this equation they must be rewarded and supported by medical schools, and there are many different ways doing this[3]. For example, educational support may include developing preceptorship and teaching skills in a rural context; setting rotation objectives in advance; and improving continuous evaluation of students and programs, giving feedback and developing supervising strategies.

Interdisciplinary work

Unlike large urban hospitals where there is cooperative work among medical specialties, what is needed in the rural setting is interdisciplinary work with an emphasis on considering and dealing with socioeconomic problems, cultural differences and characteristics. These influences are very easily recognized in rural health care settings[4,5], and students can benefit from experiencing them personally.

Policy development

Medical schools need to be involved in national policy decisions about their country's health care. Importantly, those schools serving rural areas must raise their voices and lobby at government level to promote rural-oriented health care by providing evidence of its necessity and effectiveness.

Research

Universities can contribute with one essential element: fostering, promoting and engaging in relevant research. To be useful, the research topics must be selected locally and not in a central highly specialized urban office or hospital. Research collaboration between local physicians and nurses, epidemiologists, students, and sociologists, among other disciplines related to health provision, will be invaluable. Medical schools can contribute greatly by providing methodological expertise, especially in population-based and qualitative research studies.

Conclusion

Rural health is often undervalued in our region, and unfairly considered to be second-class medicine. Medical schools have an essential role to play in reversing this situation. What is needed may not be large curricular changes or ambitious rural health programs, although they would be welcome. Rather, what is needed is a sustained, gradual change, based on committed faculty and students, and the decision of each school's authorities to support the development of rural health, or at least not to marginalize it. The five areas discussed in this Editorial can be brought together in a concrete, realistic, feasible and affordable way of commencing change.

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