



## Rural health turned upside-down

*The UK needs to revitalise metropolitan medicine as Australia has done for rural medicine*

With over half of the world's population living in cities and towns, one of the great challenges of the 21st century is to define and deliver effective and affordable health and social care to urban populations. In the United Kingdom, this is nowhere more apparent than in the deprived parts of its great metropolitan areas. Here, the ratio of general practitioners to population numbers is significantly lower than the national average, there are more solo-doctor practices, and these practices frequently lack the critical mass required to support a full range of services. Overall, inner-city general practice has been a running sore for the National Health Service. To make matters worse, many of the principals of these practices are within cooe of retiring.

The looming crisis in metropolitan medical manpower has thrown into focus a general difficulty in attracting health professionals of all kinds to work specifically in primary care, but also in other parts of the NHS serving the big cities. As ever, London is the most extreme case, but it is not unique. The combination of low wages, expensive accommodation, and difficulties in out-of-hours travel (underground trains stop soon after midnight and buses are then infrequent) leaves one far short of Dr Finlay's idyllic country practice, as depicted in A J Cronin's books and the TV series. If you are a general practitioner in Harris, in the Outer Hebrides, your nearest specialist in a particular discipline might be in Aberdeen, on the other side of Scotland, but your life and work will have other personal and professional compensations, starting with a beautiful environment, neighbours you know and a stable population of patients.

In 2001, the UK government launched a program of "teaching" primary care trusts (PCTs), eventually conferring this status on one trust in each of the 25 strategic health authority areas in England and Wales and making equivalent arrangements in Scotland. Curiously, the background documents for this initiative stressed not education but recruitment and retention of health professionals to work in primary care. Although this seemed a *non sequitur*, eventually the penny dropped — metropolitan medicine in the UK is, in effect, rural health in Australia turned upside-down. Many of the difficulties faced by practitioners in the two settings are virtually identical: long working hours, often in solo practice; lack of suitable pre-placement training; limited locum cover for holidays and professional development activities; and major concerns about housing, education for children, jobs for partners, and transport.

What is not the same is the systematic effort and investment to make a virtue out of necessity. Going beyond early experiments in protected quotas for students from country areas, many Australian medical schools have created departments of rural health, and there are vibrant undergraduate student societies supporting this interest. There are now dedicated postgraduate training schemes

for both GPs and specialists seeking a career in the bush, and the profile of the *Australian Journal of Rural Health* is growing steadily. While medical schools worry that a mismatch between political enthusiasm and dollars invested has increased competition for limited resources, and *outer metropolitan* areas struggle to attract doctors, country practitioners in Australia from all health disciplines have a growing sense of pride in themselves and their work and are rediscovering the independence and ingenuity that the nation holds as central to its self-image.

The UK badly needs to revitalise metropolitan medicine in the same way, but, apart from some dedicated appointments of GPs made under a new system of contracts, this is not happening. The "teaching" budgets of the teaching PCTs are tiny and time-limited, and the university-affiliated hospitals of the biggest cities have one eye on solving the problems referred by their local district general hospitals and the other on research. Any sense of serving a "patch"

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is much more about defining the geographical boundaries of legitimate referrals than mutual "imprinting" between institution and community. Providing primary care services to their local, inner-urban populations via accident and emergency departments is an inherited responsibility descended directly from giving alms to the poor — a form

of *noblesse oblige*. The features of urban populations that make metropolitan practice exciting — their youth, mixture and mobility — are seen as a source of complication, not stimulation.

Nor are the medical schools showing heightened interest. Outside academic departments of primary care, which have been leaders in research on ethnicity, poverty and health, UK medical schools have mostly been lukewarm in their response to requests from government to improve the breadth of access to medical training to include more mature students, entrants from poorer socioeconomic groups, and members of black and other ethnic minorities. The last, in particular, are far more prominent in the large UK cities. In a manner akin to Australian initiatives to attract and graduate rural and Indigenous students, some medical schools have actively recruited from the nominated target groups to new, in-house "foundation programs" to help bridge any gaps between secondary and tertiary education.<sup>1</sup> Other schools have "outsourced" such activities to less prestigious universities eager to boost their more modest reputations as higher-education institutions. While that might be a win-win solution for both parties — as well as for the students — it does highlight a stark difference in degree of connection with pressing issues in the wider community and health service.

Australia might have been short-sighted in cutting numbers entering medical training in the early 1990s, but, in trying to limit the contraction, several medical schools responded by earmarking places for students of rural or Indigenous origin. The lead-time is very long, and we can not yet be sure about the careers these pioneers will follow, but the seeds were sown and the trees are

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growing. Britain, by contrast, has been agonising about metropolitan medicine since at least the late 1970s,<sup>2,3</sup> but has taken a decade longer even to begin preparing the soil. Conceivably, recent by-election victories by the Liberal Democrats in economically poor, immigrant-rich urban constituencies might lead the other two major political parties to realise that “things need not be forever thus” and prompt some real reform.

### **Konrad Jamrozik**

Professor of Primary Care Epidemiology  
Department of Primary Care and Social Medicine  
Imperial College of Science, Technology and Medicine, London, UK  
k.jamrozik@sph.uq.edu.au

### **David P Weller**

Professor of General Practice, Department of General Practice  
Division of Community Health Sciences  
University of Edinburgh, Edinburgh, UK

### **Richard F Heller**

Professor of Public Health, Evidence for Population Health Unit  
School of Epidemiology and Health Sciences  
University of Manchester, Manchester, UK

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1 Department of Health. Medical schools: delivering the doctors of the future. London: DoH, 2004.

2 General practice in Inner London. *BMJ* 1978; 1: 221-222.

3 Morrell D. Inner London general practice — is there a solution? *BMJ* 1981; 282: 162-163. □