Check for updates

Article

Serving inland rural communities through university clinics

Health Education Journal
70(4) 475–480
© The Author(s) 2011
Reprints and permission: sagepub.co.uk/journalsPermissions.nav
DOI: 10.1177/0017896911403209
hej.sagepub.com

Julaine Allan[a], Rod Pope[a], Peter O'Meara[b], Joy Higgs[c] and Jenny Kent[d]
[a]Centre for Inland Health, Charles Sturt University (CSU), Australia
[b]Paramedic Medicine, Charles Sturt University (CSU), Australia
[c]Education for Practice Institute, Charles Sturt University (CSU), Australia
[d]School of Business, Charles Sturt University (CSU), Australia

Abstract
Aim: To effectively provide clinical placements for students and increase healthcare options for rural communities, an investigation of university clinics was conducted.
Method: This project adopted a consultative inquiry strategy and involved two processes: (1) a review of literature; and (2) interviews with existing health sciences clinic staff.
Results: Low income population groups are more likely to find student-provided services acceptable and have a reliable demand for these services if they are accessible. University clinics reporting high client numbers had a consistent flow of low income clients with chronic problems. Private healthcare providers were often unable to meet the demand from this group. However, multiple methods and flexibility of delivery that fitted in with local services were required rather than single point of access clinics.
Discussion: University clinics are an effective way of providing clinical placements for students and some healthcare for rural communities. Key aspects of the community context that make a university clinic viable are the degree of disadvantage in a community, the population density (or dispersion), the workforce available to supply health services in the public and private sectors, and the types of services that are demanded by policy or lobby groups and not yet supplied.

Keywords
context, rural health, student placements, university clinics

Introduction

The context within which rural healthcare is provided is internationally problematic. Small, dispersed populations around the world have poorer health and more limited access to health-care when compared to urban populations. 'Rural' is considered to be a specific practice

Corresponding author:
Julaine Allan, Centre for Inland Health, Locked bag 588 Wagga Wagga NSW 2678, Australia
Email: juallan@csu.edu.au

context with particular characteristics that include undersupply of health professionals and facilities[1,2]. It is within this external context that Charles Sturt University (CSU) operates. CSU offers a range of clinical science and healthcare qualifications. The employment prospects for graduates are good. However, while course intakes increase and graduate skills are developed, clinical supervision requirements are often identified as the most significant problem limiting clinical placements for students.

University clinics were proposed as one way to increase the number of clinical placements available for students, while simultaneously providing healthcare to rural communities. To inform the development of a model for university clinics at CSU, a research project was commissioned to investigate the ways clinics operate at other universities.

One aspect of the study was examination of the community contexts within which university clinics operate; in particular, demand for healthcare and the way services are supplied. We could predict a greater healthcare need in poor, disadvantaged rural populations who cannot afford to pay for, or travel to, service providers. This need is demonstrated in waiting lists for services and practitioner reports[3]. However, these reports vary from profession to profession and place to place. Information about rural healthcare need is not consistently recorded and is largely anecdotal, although widespread[4].

In addition, need is often confused with demand. The need for particular healthcare services does not always equate to demand. Demand is recorded or noticed by existing practitioners when service requests are made. Local healthcare needs can only be estimated from a combination of population health research and local knowledge. Demand is often the result of successful lobbying and political attention, usually in relation to a specific disease or treatment facility. It is also demonstrated in predictable seasonal and age-related conditions; for example, increases in those seeking treatment for flu or childhood illnesses. Demand does not reflect the total need of a population group[5].

Supply is usually what is measured in health services, rather than need or demand, because it is easier to identify[5]. Supply tends to be historically developed from service locations and funding provided over time. It is also defined by professional roles and activities[4]. For example, in the public sector, when a physiotherapist leaves a position, a new physiotherapist is recruited rather than someone from another profession.

The existing research literature on university clinics contains few references to community need or demand. One clinic was described as delivering healthcare within a 'health service void' in a 'disadvantaged community'[6 p. 84]. Other literature emphasized the role of community engagement or partnership in the establishment and operation of university clinics as a key factor in their success. For example, having a community board involved in management and fundraising[7] and community members on advisory boards[8] were each seen as ways of enhancing understandings of local community needs. No information was provided in these reports about the ways by which needs were identified.

The aim of this study was to identify community needs and markets for healthcare which can be, and are, served by university clinics in Australia and New Zealand. This information could then be synthesized with information regarding the rural context within which CSU is situated, so that the University could plan clinics which would serve the needs of rural communities while providing valuable clinical education for its students.

Table 1. Study participants

Discipline	No. of clinics
Dental	1
Speech	2
Podiatry	2
Physiotherapy	6
Occupational Therapy	1
Audiology	1
Optometry	1
Multidisciplinary	1
Vet	2
Psychotherapy	1
Psychology	1
Human movement and exercise physiology	1

Methodology

The research was conducted by five academics at CSU with expertise in the fields of risk, governance, business models and operations, clinical and fieldwork education, healthcare provision and community development. The research strategy adopted was a consultative inquiry in which the researchers first examined existing documents and literature. The second part of the research strategy involved visits to existing health sciences and veterinary clinics, plus interviews with clinic staff. Twenty existing clinics were identified (17 in Australia and three in New Zealand) that offered both clinical education for students and services to clients. These clinics ranged across a variety of health and veterinary disciplines associated with Australian and New Zealand universities and private sector health service providers (Table 1).

The clinic visit and interview strategy first involved contact with clinic managers to request their participation and access to the clinic. Upon agreement, information about the project was provided and informed consent was obtained for interviews with staff, students, community healthcare providers and one patient. (Only one patient consented to be interviewed. Future research on patients' interests and feedback on clinics is warranted to broaden the perspectives obtained through this study.)

Semi-structured interviews were held onsite at 19 clinics and by phone with one clinic. Questions dealt with the establishment of the clinic, the benefits of the clinic (in particular to students and clients), and barriers to the clinic operation and success. Analysis of the verbatim transcripts of the interviews considered aspects of the contexts, inputs, processes and products (CIPP) of the clinics, based on a CIPP systems framework[8]. A particular focus of the interviews and analysis was the needs and demands of the key stakeholders.

Results

Interview data from the clinic visits suggested that low income population groups are more likely to find student-provided services acceptable and have a reliable demand for these services if they are accessible. University clinics reporting high client numbers had a consistent flow of low income

clients with chronic problems. For example, two Podiatry clinics, a physiotherapy clinic and a dental clinic provided services at no or low cost to public health system clients.

The dental clinic had a target to keep the waiting list for dental treatment to 23 months for routine procedures and to three months for emergencies. At the time of interview, student dental therapists had been working at the clinic for one year and the routine waiting list had been reduced to 15 months. The health service partner representative was optimistic about further reductions in the waiting list but was confident that demand would continue even with increased supply.

> Interviewer (I): Can you see a time when there won't be a waiting list?
>
> Respondent (R): I think, in [town], there's always going to be . . . the demand's always going to be there, there's always going to be a waiting list and if, you know, the students, you know, you might end up with in three years' time, 90 students, but they won't all be here at [town]. But, no, look, the system's great with, in terms of the, you know, treating more patients.

One interview participant worked in a student unit operating within an Area Health Speech Pathology service. The health service employed a grade three speech pathologist who was responsible for student supervision. Demand was constant for speech services. Since the unit had commenced, the waiting list had been eliminated, even though referrals of low income children with complex problems had increased because of government policy changes:

> Since [the] Better Pathways programme started last year [NSW government programme] numbers of clients from very dysfunctional families with complex problems have increased. Students have to deal with this. There are always enough clients for students to see although there is not much voice or feeding work.

Partnerships were described as useful ways to provide a range of student experiences and manage the costs of placements while addressing community need. For example:

> So we have agreements with a couple of the rural health services where they will provide – well the classic is last week in [location]. They fly our students over, plus a tutor, for a week, and we send over three or four students and a tutor and they just work full on for that week, and they see a huge number of the community, clients. And we do that three times a year for these services. And that actually takes, that gets rid of their waiting list, so we're maintaining services for them, providing an absolutely amazing experience for our students in terms of the diversity of experiences. And also, they get to go somewhere different with a group of students. And it, you know, gives goodwill for us for keeping our country placements.

Private service providers who were interviewed all reported high demand for their services and the need for an additional supply of practitioners. However, one rural private practitioner sometimes experienced a lack of clients prepared to see students. She only hosted one student at a time. There had been no public service in the town for the last 10 years so she offered pensioners the opportunity to see the students for free when they were undertaking placements in the practice. The interviewee reported that this approach provided more patients and experience for the students and was good for the private practice. This interviewee reported a greater need for healthcare in the public health system and different client problems:

> Patients in the public system are different generally to private patients. They have chronic problems, tend to be older. The public waiting list means people get better or are chronic by the time they see a physio.

There were two examples of demand created by clinics. A university Speech Clinic offered ‘Clear speech’ courses for people who spoke a language other than English. These were described as pronunciation classes run over a period of weeks for a fee. The courses were described as very successful and ‘good money makers’, and demand for them was high. However, they were not run regularly or frequently because they relied on an academic staff member to organize and run them in addition to the academic’s normal workload.

The second example of created demand was a university Psychology Clinic’s child sleep programme. This clinic activity was a research programme of an academic staff member associated with the clinic. It gave students an opportunity to undertake specialist study and practice. It was also described as the only programme in the area offering a psychological service to families who had children with sleep problems.

Discussion

Given the health status and limited supply of care to communities in inland Australia, it is likely that university clinics are a viable way of providing some healthcare to the population. Demand for rural healthcare exceeds supply, and rural practice exposure increases the take-up of rural positions after qualifying. The challenge for a university providing care as part of student workplace learning is to identify potential patients. Unmet *needs* of the community for healthcare may be the result of a shortage of providers or workforce, isolation or climate of particular locations, or other social barriers. Interestingly, the interviews did not identify community participation as necessary for operating a university clinic. Instead, interviewees described recognizing unmet *demand* and being able to address this unmet demand as what they did in operating a university clinic, rather than identifying and addressing *need*. Government policy could affect demand for services, as in the student speech unit example. Universities would have to accommodate those changes if they are part of healthcare supply.

The areas of greatest need are not necessarily in the regional centres where university campuses are located and therefore may require the provision of outreach services ‘through virtual or periodic visiting services to communities too small to support permanent local services’[9, p. 309]. The very fact that the university produces graduates in the health professions in the regional centres it inhabits means that these centres have stronger workforces and better services than other regional centres. Therefore the university will have a smaller potential client base with unmet needs within these regional centres, and it might have to look to more distant and less well-served communities for a strong client base. Professions that do not require high cost or fixed equipment may be able to offer outreach services to surrounding communities, where there is sufficient client demand.

There is also the opportunity to create demand, as described in the clear speech and sleep clinic examples. While this is likely to rely on the expertise of individual academic staff members, population size will be a critical factor in identifying the niche market. For university clinics, key aspects of the community context are therefore the degree of disadvantage in a community, the population density (or dispersion), the workforce available to supply health services in the public

and private sectors, and the types of services that are demanded by policy or lobby groups and not yet supplied.

University clinics are one way of increasing the supply of care and providing rural practice experience. Universities have to adapt to local conditions and existing healthcare supply to be viable as healthcare providers. Universities can create demand by meeting a population need in a niche market. University clinics can usefully serve inland communities through careful consideration of need, demand and supply.

References

1. Beaulieu J, Berry DE. *Rural Health Services: A Management Perspective*. Fremont, MI: Aupha Press/Health Administration Press, 1994.
2. Bodor R, Green R, Lonne B, Zapf MK. 40 degrees above or 40 degrees below zero: Rural social work and context in Australia and Canada. *Rural Social Work*, 2004: **9**(9): 49–59.
3. Bradshaw J. A taxonomy of social need. *New Society*,1972: (March): 640–643.
4. Allan J, Ball P, Alston M. Developing sustainable models of rural health care: A community development approach. *Rural and Remote Health*, 2007: **7**: 818. Online. Available: http://rrh.deakin.edu.au (accessed: 18 August 2010).
5. Stevens A. *Health Care Needs Assessment: Vol. 2: The Epidemiologically Based Needs Assessment Reviews*. London: Radcliffe Publishing, 2005.
6. Jackson CL, Marley JE. A tale of two cities: Academic service, research, teaching, and community practice partnerships delivering for disadvantaged Australian communities. *The Medical Journal of Australia*, 2007: **187**(2): 84–87.
7. Taylor J, Blue I, Misan G. Approach to sustainable primary health care service delivery for rural and remote South Australia. *Australian Journal of Rural Health*, 2001: **9**: 304–310.
8. Splann Krothe J, Clendon JM. Perceptions of effectiveness of nurse-managed clinics: A cross-cultural study. *Public Health Nursing*, 2006: **23**(3): 242–249.
9. Stufflebeam DL. The CIPP model for program evaluation. In: GF Madaus, MS Scriven, DL Stufflebeam (eds), *Evaluation models: Viewpoints on educational and human services evaluation* (pp. 117–142). Boston: Kluwer-Nijhoff, 1983.