

Urgent government funding needed for rural curriculum

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New Zealand currently faces a shortage of rural doctors.^{1,2} In recent years we have seen both our medical schools and the government make efforts to address this problem. A recent review³ found that there were four main factors at the undergraduate level that promote rural recruitment and retention:

- Selecting students of rural origin
- Teaching and placements in rural locations
- A curriculum with a primary care emphasis
- Other student support such as rural mentorship and rural health student clubs

In 2004 the government created 40 additional funded places in our medical schools for students of rural origin (i.e. with schooling or other significant life experience in towns of under 20,000 people). Overseas studies show that students with rural backgrounds are more likely to pursue careers in rural medicine.^{3,4} However, "rural recruitment requires far more investment than simply a change in the medical school selection process."⁵ As indicated above, another crucial aspect will be the provision of high quality undergraduate medical education in rural settings and with a primary care emphasis.³ Curricular changes such as these are also important for developing a vertically integrated career pathway for rural practitioners.

Teaching medicine in rural locations is more expensive than in centralized urban teaching hospitals. Additional funding is required for the infrastructure and support that students need on rural attachments, such as transport, accommodation, distance teaching technology, and rural general practitioner reimbursement. There is at present no specific government funding of rural undergraduate curricula in New Zealand medical schools. In 2004, the medical faculties of Auckland and Otago submitted a proposal to Government for \$12 million to fund a twelve month rural curriculum for the rural origin students and a twelve week rural attachment for all students. The full funding was agreed to, and promised in 2004, but has not been delivered.

There is presently a successful and popular seven-week rural GP placement existing at Dunedin School of Medicine, but it is at risk of termination due to funding constraints. This course is enjoyed by students for the practical skills, clinical contact, and community involvement, and students who had never considered rural practice have changed their attitudes following this course.⁶ It is also popular because the essential student support (e.g. accommodation, transport, technology, supervision) are provided by the university and rural stakeholders. The communities and rural doctors themselves benefit from the relationships with students and the medical schools. Rural practice offers not only experience in the primary care, but also extends to secondary and lower tertiary level care. However, the rural programme at Dunedin School of Medicine is operated on a tight budget and depends upon the generosity of many rural general

practitioners. Without extra funding from government, even this seven week course is at high risk of being removed from the curriculum.

The New Zealand Medical Students' Association (NZMSA) supports the development of a fully funded twelve month rural curriculum. The NZMSA will work closely with the universities and other stakeholders of rural health. The NZMSA believes there is a lot of good to be gained from rural medical education - for students, the communities they work in, the rural workforce, and New Zealand as a whole. For rural education to be successful, it must be a positive, well supported experience for students and their rural teachers, and this will require additional funding.

Rural medical education represents an investment in the health system, as well as education. The rural community is an integral part of New Zealand, and deserves health care equity. The rural origin students are entering their fourth year in 2006. Without government funding, our medical schools cannot deliver a rural curriculum. We must convey this sense of urgency to government to deliver this funding.

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The Patient Flow Project: what impact has it had?

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ABSTRACT

As the New Zealand population grows, so too does the demand for health care. Health care providers must service as many people as possible while operating on a limited budget and with limited resources. In June 2002, the Canterbury District Health Board commissioned the *Patient Flow Project Report*,¹ the recommendations of which were later piloted and implemented in May 2003 at Christchurch Hospital. This initiative focused on increasing patient throughput while maintaining an acceptable standard of care. Among its policies was the aim to maximise hospital bed utilisation, and two of the tools used to achieve this included a reduced Average Length Of Stay (ALOS), and early morning discharges. This summer studentship conducted a small-scale literature review to analyse international methods for managing patient flow, and investigated concerns that the increased flow afforded by the *Patient Flow Project* would manifest itself in preventable readmissions, declining patient satisfaction and higher workloads.

KEYWORDS

Patient Flow Project; patient throughput/ flow; Average Length of Stay (ALOS); readmission; discharge planning; patient satisfaction

INTRODUCTION

The changing nature of hospital care to accommodate increasing demand is becoming apparent with a more dominant presence of management organisations in the health care system. One such initiative employed at Christchurch Hospital is the *Patient Flow Project*, which has adopted some of the policies practiced in other countries following their success in better meeting patient demand.

In the United Kingdom the National Health Service (NHS) Modernisation Agency has earned a reputation for its innovative solutions,² which appear to get results. It seems the crux of their approach in aiding the NHS deliver effective health care is to provide "the right skill at the right time in the right place".³ Hence their proposals often involve whole systems analyses for identifying and rectifying potential bottlenecks to patient flow.² Similar tactics have been employed in hospitals in the United States upon the recommendation of the Clinical Advisory Board in Washington DC⁴. Here the focus is on maximising the use of currently available resources. Future expansion of resources may increase capacity, which may meet demand, but in the meantime

Courtney Hore has an interest in Maori Health and hopes to become more involved in this field having enjoyed her first Summer Studentship last year. Courtney feels the exposure she gained to the public health system and its limited resources this early in her medical career was extremely valuable.

increasing patient flow appears to be the most effective way to do this.

The *Patient Flow Project's* key objectives include admission to the correct ward, early morning discharge, discharge planning for provision of support following discharge, and improved communication between health providers. In line with these objectives the aims of the studentship were to review acute medical activity, gauge patient satisfaction, and to report on any associated impact. The preliminary findings may form the basis of future investigations.

METHODOLOGY

Two types of data were analysed; quantitative data and qualitative data.

Quantitative Data

Two data sets of acute medical activity were compiled and processed by Emendo Limited⁵ from January 2002 – November 2004. The raw data was sourced from the Patient Management System (PMS), which records patients' movements through the hospital.

The data sets and the specialties included were:

- The General Medicine ward data set:
General Medicine, Dermatology, Infectious Diseases, Immunology, Gastroenterology, and Rheumatology, (and weekend Otolaryngology activity).
- The Cardiology/Respiratory ward data set:
Cardiology, Endocrinology, and Respiratory.