Dear Ms McCauley,

Discussion Paper: Rural Health Multidisciplinary Training Program Redesign

The University of Sydney welcomes the opportunity to provide input on the Department of Health’s draft proposal to consolidate the administration of the four programs that currently make up the Rural Health Multidisciplinary Training Programme (RCTS, UDRH, DTERP and JFPP) under a single scheme.

The University currently contributes approximately 30% of NSW’s health workforce graduates annually across arguably the broadest range of disciplines offered by an Australian university. In addition to our substantial presence across the Sydney metropolitan basin, we have a longstanding and substantial multidisciplinary education and research presence in rural and remote NSW through our School of Rural Health at Dubbo and Orange and through our involvement with the University Department and Centre of Rural Health based at Broken Hill and Lismore respectively. Many of the University’s research centres are also focused on rural health issues, including the particular challenges facing Aboriginal and Torres Strait Islander communities in regional and remote areas.

Our attached submission in response to the Discussion Paper’s consultation questions has been prepared by the University’s faculties and schools responsible for educating health professionals in the disciplines of Medicine, Nursing, Dentistry, Pharmacy, and all allied health fields offered by our Faculty of Health Sciences and others (Attachment A). As such, the submission represents the shared views of senior educators and researchers from across the University with rural health expertise.

The University strongly supports the key policy objectives that underpin the proposed changes the Rural Health Multidisciplinary Training (RHMT) program including: simplifying funding arrangements and making them more flexible; reducing duplication, reporting and regulatory burdens; encouraging innovation; enhancing the focus on outcomes; and improving data and evidence to inform future policy and practice.

We are concerned, however, that some of the proposed reforms need to be thought through carefully as we are doubtful that they will contribute substantially or efficiently to the achievement of these worthy goals. In some cases, we fear the proposals could work against the policy intent by being ineffective or having unintended consequences.
The objective of a single coherent funding and administrative scheme that encompasses all disciplines is a worthy one, which we strongly support, so long as administrative and funding flexibility remains in relation to the individual components. This approach aligns well with the University’s internal structures and the commitment of our health faculties and schools to work together in relation to clinical placements through our rural sites and our recently established University-wide Office of Clinical Education Support.

Reconceptualising all components of the RHMT into a multidisciplinary scheme is also an appropriate reflection of the nature of contemporary rural and remote practice in health, and we are particularly pleased to see the explicit inclusion of allied health education and research in all aspects of the new scheme.

We are concerned to note, however, the focus on increasing rural origin quota targets for medicine and introducing them in all other health professions. Evidence that rural origin influences the location of practice is weak. In fact, our research has shown that other key initiatives, such as long-term rural placements, are the determining factor in increasing rural workforce retention for medicine, pharmacy and dentistry. We also note that these quota/target aspects of the proposal, along with those proposed for Aboriginal and Torres Strait Islander participation and completions, are inconsistent with the deregulatory policy directions the Minister for Education and Training is currently pursuing for the Government.

Much of the proposed redesign is also based on the assumption that the recruitment and retention factors in rural practice for the medical workforce are likely to apply to the nursing and allied health workforce. Recent research suggests, however, that retention factors may be different for allied health professionals and doctors, while no evidence exists on rural nursing retention.

Given the breadth and potential implications of the reform proposals, and the scale of the University of Sydney health education (including rural and remote) activities, we would value the opportunity to arrange a meeting between the Departmental officials responsible for the design and implementation of the reforms, and relevant experts from across our faculties, schools and rural and remote campuses.

I would be grateful for your advice about how we might best proceed to arrange such a meeting.

Yours sincerely,

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Dr Michael Spence
Vice-Chancellor and Principal


Executive Summary

The University of Sydney supports continuation of the Rural Health and Multidisciplinary Training (RHMT) program to address the uneven distribution of the health workforce between metropolitan and rural sites, improve rural health, and increase capacity in health and medical research relevant to the rural population. The University's interdisciplinary, experiential learning approach is aligned with policies that encourage all faculties of health professions to work together for education, research and external engagement. As such, we support the proposal to reconceptualise the RCTS, UDRH, DTERP and JFPP program into one multidisciplinary scheme. This is an appropriate reflection of the nature of health service delivery whether in metropolitan or rural and remote communities.

It is vital, however, that the move to a consolidated RHMT program has flexibility around site-specific, and discipline/profession-specific requirements, so as to enable rural centres to respond to their own community needs and to accommodate multiple university providers and multiple health disciplines. While the University of Sydney is well placed to administer and report on programs at the institutional level, we are concerned that amalgamating reporting requirements for diverse programs and sites under one university provider will reduce the availability of data and evidence for regional benchmarking and the potential responsiveness of these programs to local needs.

The University is strongly opposed to an increase in, or adoption of, rural origin enrolment targets for all health disciplines. There is good evidence of the success of the University's own and other initiatives in increasing rural health workforce through long term quality placements for medicine, dentistry and pharmacy without such targets, and relatively poor evidence that rural origin alone is a predictor of where graduates choose to work. We also note that there are profession-specific differences in rural retention factors, with allied health professionals influenced by different factors than medical professionals. There is limited evidence to inform the development of policy for other disciplines, such as the rural nursing workforce.

The University is deeply committed to increasing the participation of Aboriginal and Torres Strait Islander people in higher education, and in the health professions in particular. This is shown by our integrated Wingara Mura – Bunga Barrabugu strategy and the progress we are making on many fronts under this University-wide plan. While we currently have institution-wide Aboriginal and Torres Strait Islander participation targets in place under our compact agreement with the Commonwealth, we note the Government's intention to abolish these agreements in recognition of their limited effectiveness as a policy tool and the regulatory and reporting burdens such approaches impose on providers. We further note the policy inconsistency apparent in the Department of Health’s plans to introduce rural origin and Aboriginal and Torres Strait Islander enrolment and completion targets at a time when the Department of Education and Training is seeking to deregulate the higher education sector to, among other things, promote competition and diversity between providers.

Enhancing rural health workforce education and research experiences is strategically aligned to the philosophy of the University of Sydney. We are committed to providing all students with a suite of health education opportunities by broadening the impact of health education to faculties and expertise outside traditional health spheres such as Business, Information Technology and the Arts. As part of this, we are keen to see students and staff at our rural sites included in this richer set of educational experiences, and our students from
non-clinical disciplines participating in multidisciplinary team-based learning experiences in rural health workplaces and communities.

Finally, we note that any expansion of the proposed parameters for rural placement weeks across all health professions will require appropriate lead time for negotiation and assessment of the implications for rural sites and for universities. Provision will also need to be made to support increases in student costs (and ensure consistency in support between disciplines which does not exist currently), as well as for administration and the increased demands that will be placed on academic and support staff based at rural placement sites.
Question 1. Do the proposed parameters sufficiently capture the activities currently supported by the RCTS, UDRH and DTERP programs? Please identify any areas of concern.

Rural multidisciplinary and dental training (core requirements 3a and 3b)

There are no activities undertaken by the University of Sydney affiliated Rural Clinical School (RCS) and University Department of Rural Health (UDRH) related to medicine that are not encompassed by the proposed parameters. However, it must be emphasised that not all activities occur at each site or for each profession. The University of Sydney places students at multiple rural campuses, with different placement opportunities for health professions at each site. Some professions (e.g. nursing) have limited engagement under current programs. Programs which the University of Sydney medical school administers (e.g. the Lismore University Centre for Rural Health (UCRH), and the Broken Hill UDRH) have up to 15 other universities placing students of various disciplines included in our UDRH/UCRH programs. This places limitations on placements available due to local university requirements for places. These successful collaborative programs have been developed and driven by the local community in response to their needs. As a result of these and other factors, we strongly support flexibility in the proposed arrangements across sites and providers.

The expansion of undergraduate and postgraduate courses to all professions at all sites would pose some difficulties for University of Sydney programs under current funding arrangements as there is no onsite academic support to cover additional professions. Expansion of these courses would therefore require additional funding and expansion to the UDRH or RCS budgets to provide preceptors from health professions.

DTERP programs at the University of Sydney

Parameter 1 ensures placements are of a length that supports genuine engagement with the community, in line with our own and others’ evidence on improved rural dental workforce retention. This shows that high quality placements of four weeks or longer significantly increase the likelihood of a graduate relocating to a rural site for employment. Whilst we are open to considering lengthening the average duration of these placements, we believe the focus should not be on duration at the expense of scope of clinical experience, which is key to a student’s ability to graduate, practice independently and feel embedded in a rural and remote community.

Increases in dental rural placements also need to take into account financial and capacity limitations. The administrative burden of the current DTERP program is high due to numerous students going to multiple sites throughout the year, all requiring clinical supervision. The University is currently exploring additional rural locations to place students (Orange and Wagga Wagga) but expansion is limited by access to adequate clinical supervision and academics at these sites.

Financial hardship for students

We note with concern the removal of the parameter that students should not be financially disadvantaged by rural placements. Financial support for student accommodation and travel is critical to allow them to study in metropolitan and rural settings (UCRH, UDRH and medical short term rural placements) which necessitate a move away from their normal places of residence.
We also note that current programs provide student support inconsistently both across programs (e.g. UDRH/DTERPP vs. RCS) and across professions. For example, pharmacy students have funding available to cover the cost of travel and accommodation for rural placements while allied health students do not.

We recommend that provisions for financial support be included in the RHMT for all mandated placements, and that this be equitable and transparently provided to students regardless of their disciplines.

**Interdisciplinary learning**

While the program is titled “Rural Health Multidisciplinary Training Program” there is no requirement to provide interdisciplinary training. The current proposal requires the participants to support health students to undertake rural placements and removes the rural health club, which develops interdisciplinary learning, and is currently a prerequisite of Parameter 6 of the RCTS program. Multidisciplinary interactions are key skills to develop in the health workforce overall, and in the rural workforce in particular. The redesigned program should consider requiring students to learn, work or live together to facilitate these interactions and cross-disciplinary learnings.

**Question 2.** We note that the application of consistent parameters across the RCTS, UDRH and DTERP programs will result in some additional requirements applying to some streams of activity, for example, the application of the Aboriginal and Torres Strait Islander Health parameter to the DTERP program. Please identify any areas where the university would experience difficulty in meeting these additional requirements.

**Rural origin quotas (parameter 3, core requirement 2d and 3d)**

The University of Sydney does not support the proposed increase to the rural origin target to 30% for medicine, or the adoption of rural origin targets for other health professions. We strongly disagree with the underlying assumption based on the paper of Kondalasamy-Chennakesavan et al. (quoted on page 3 of the Discussion Paper) and see significant potential for unintended and unforeseen adverse impacts arising from the adoption of such an approach.

As stated in our rebuttal to this publication (Arnold MH, in press MJA 2015), it is likely that each university operating a rural clinical school will have different outcome data based on its program (undergraduate vs. postgraduate), course duration and student demographics. The proposed 30% rural origin target for medicine is not achievable for metropolitan university providers and will likely create a competitive environment between universities for a small pool of candidates, rather than increasing the pool as a whole. It may also place pressure on providers to reduce entry standards to health courses for students from targeted backgrounds, with flow on consequences in terms of success and completion rates. In allied health, the University believes we have already achieved maximal rural enrolments through the E12 scheme.

In addition, the proposed alteration to the residency period, especially the 5 year requirement, is restrictive for metropolitan higher education providers, which offer postgraduate entry programs, as students may have moved from regional areas for undergraduate studies or for work.
We have recently published evidence that other key initiatives, including long term placements rather than rural origin, are the determining factor in increasing rural workforce retention for medicine\textsuperscript{1}.

The extrapolation of medical data to other health professions is problematic, as there is evidence that these rural retention determinants differ by profession\textsuperscript{6,7}. Our Faculty of Health Sciences, for example, has demonstrated that factors predicting rural retention are different from those for doctors\textsuperscript{7}. We have also found that rural internships are critical factors for the pharmacy workforce\textsuperscript{6} and data collected by our Faculty of Dentistry has shown that, through DTERP, the trend of migration from rural to metropolitan areas has been reversed by offering metropolitan students a rural experience\textsuperscript{2-5}.

Rural origin quotas would be difficult to achieve for the Sydney Nursing School, which has a large Master of Nursing (Graduate Entry) program in addition to a Bachelor of Nursing program. Regional universities are often strong in nursing, their students originate locally and are employed locally on graduation. Student profiles are quite different in these cohorts and there is no evidence base to support rural origin for rural health retention in nursing.

Pharmacy has had a rural entry scheme in place for a number of years, offering an ATAR reduction, but this has not resulted in more than one or two students per year. There is also a Rural Pharmacy Scholarship Scheme which funds at least 30 rural pharmacy students per year (\$10,000 per student). We are not privy to the statistics of this scheme but it would be interesting to know how successful it has been in attracting rural students to pharmacy programs nationally. In part this is restricted by strong ‘rural’ criteria that mean we cannot use regional hospitals (whose clientele and practice is quite different from urban hospitals) as part of this experience.

**Rural multidisciplinary training targets (core requirement 3a)**

The University of Sydney does not support introduction of the proposed parameters to all health professions across all programs and sites without further evaluation of capacity and cost. There also needs to be some consideration for the local training providers and the students who are required to train in a rural clinical capacity. The rural University of Sydney sites work closely with their university partners to ensure the needs of the community are met.

It is difficult to determine the specific requirements for nursing and allied health students within the current draft RHMT.

Many of these parameters have not previously applied to health professions other than medicine and dentistry and the impact of these changes on current RCSs and UDRHs needs to be considered and costed. Specific issues could include the need to increase accommodation, academic support and pastoral care for all health professional students on extended clinical placements within these programs, and the funding of such support. As our DTERP, UDRH, UCRH and RCS programs are not co-located, many of these parameters have not applied to specific sites (e.g. Dubbo/Orange RCS would need to be funded and placement capacity determined if it were to take on the additional role of promoting and supporting health professional placements other than medicine). As discussed above, current inconsistencies in the availability of funding and access to accommodation across programs and disciplines would also need to be addressed.
The capacity to increase training placements may be limited at some sites given the current shortage of supervisors within the rural health workforce. The capacity to increase training placements for a metropolitan university such as Sydney may also be limited where there are local university providers. This could create an environment where there are multiple providers at rural sites competing for the same placements and/or pool of students. University-specific targets need to be flexible for each site and profession so that we can consider the individual capacity of the rural sites to increase clinical placements for each profession.

For nursing in particular, there is a high proportion of students with children which impacts on both the availability of the student to travel and their accommodation options. There are also limitations in the number of appropriate rural placements nursing can source (for example rural paediatric places are limited) and the timing of placements in current programs may cause issues, as a significant number occur early and it may be inappropriate to send inexperienced students to some locations.

For pharmacy, even with the current availability of a financial cost recovery system, it is difficult to encourage large numbers of students to participate in rural placements. Availability of rural placements with appropriate supervision in a highly competitive environment is also a major issue.

**Application of Aboriginal and Torres Strait Islander stream to DTERP**

Please see response under question 3.

**Question 3.** The new framework introduces university-specific targets for some activities, namely multidisciplinary training and Aboriginal and Torres Strait Islander student enrolments and graduations. Do you agree with this approach? If yes, do you have any other comments? If not, can you suggest an alternative way of specifying training outcomes for the program?

**Linking Aboriginal and Torres Strait Islander enrolments and graduation targets to the RHMT**

The University of Sydney strongly supports initiatives to increase Aboriginal and Torres Strait Islander student enrolments and graduations in health professions. The University’s integrated institution-wide Wingara Mura – Bunga Barrabugu strategy, launched in June 2012, expands Aboriginal and Torres Strait Islander education, research and engagement so that it is core to all of the University’s activities. However, we do not support linking Aboriginal and Torres Strait Islander student enrolment or graduation targets to RHMT (core requirement 4b). The majority of Aboriginal and Torres Strait Islander people live in metropolitan areas, and the premise that retention of these students in rural sites will be improved if they have the opportunity to do a rural clinical placement is untested. We also note that the Department of Education and Training plans to abolish Aboriginal and Torres Strait Islander participation performance targets by abolishing the current compact funding agreements with universities as part of proposed deregulatory reforms to the higher education sector.

Sydney-based universities will find it difficult to meet targets for increased enrolments of Aboriginal and Torres Strait Islander students (whether of rural or metropolitan origin) for a number of reasons (parameter 6). In the University of Sydney’s case, many of our health
degrees are postgraduate entry courses, and there is currently a small pool of suitably qualified Aboriginal and Torres Strait Islander graduates from which to select. At the current time, there is also a very small cohort of Aboriginal and Torres Strait Islander school and non-recent school leaver candidates from which to satisfy enrolment targets for undergraduate programs and the University is working closely with schools and communities to increase the numbers of Aboriginal and Torres Strait Islander students completing and achieving well at high school.

**Alternative training outcomes**

Improving Aboriginal and Torres Strait Islander health workforce outcomes must be approached holistically and framed in a long-term perspective. This requires support for school programs, often provided through UDRH initiatives and our UDRHs, to identify and support capable Aboriginal and Torres Strait Islander students.

Cultural competency and awareness training for the existing health workforce and our students still needs improvement.

**Graduation targets**

Irrespective of linkage to the RHMT, we strongly support the objective of improving completion rates for Aboriginal and Torres Strait Islander and all other students, without diminishing academic standards. For reasons discussed in our response to Question 2, we do not, however, support the imposition of completion targets by the Government as an effective method of achieving this policy goal. It is improper to offer Aboriginal and Torres Strait Islander students a place at university unless there is a reasonable likelihood of their completing the program, and appropriate support mechanisms in place to assist students who require academic and pastoral support. The University of Sydney already has very strong completion rates for Aboriginal and Torres Strait Islander students, achieved through focusing on selection, support and program design, not the setting of arbitrary targets.

**Extend DTERP program to undergraduate oral health programs**

We suggest that the DTERP program needs to be extended to include undergraduate oral health student enrolments in addition to dentistry students to increase the rural oral health workforce. The University of Sydney has run a rural placement program for third year Bachelor of Oral Health students since 2007. This program, along with the Oral Health Graduate Year Program, has effectively doubled the proportion of oral health students who decide to work in a rural location upon graduation (from approximately 15 to 30 percent).

**Question 4. Please describe the current university structure in relation to funded programs (RCTS/UDRH/DTERP) i.e. the faculties under which these programs currently sit. Please advise the extent to which university-level funding and reporting will be supported by current structures. Do you foresee any issues in moving to university level funding and reporting?**

The current university structure of our funded programs is that the RCTS sits directly under the Sydney Medical School (SMS). The University Department of Rural Health (UDRH) at Broken Hill and University Centre for Rural Health (UCRH) at Lismore sit within the School of Public Health, which is part of SMS. The UDRH includes allied health placements from the University of Sydney. DTERP sits under the Faculty of Dentistry. Current dentistry student
placements include Bowral, Ballina, Dubbo, Cessnock and Central Tablelands. Sydney Nursing School does not have specific funding for rural placements under these or any other programs, and as a result only 4% of nursing students currently undertake rural placements. The Faculty of Health Science also does not currently receive any specific funding for rural placements.

The current structures of the University of Sydney such as the University's Divisional Structure, and the Office of Clinical Education Support (for those disciplines not included in the Division of Health) will support university-level funding and reporting if there was appropriate recurrent funding provided. We will be better able to make this assessment once full details of the administrative expectations under the proposed consolidated model (and timeframes for implementation) are available.

The University of Sydney does foresee some issues with university-level funding and reporting. Consolidation to a single RHMT grant to the University of Sydney for all health students (medical, dentistry, nursing, pharmacy and other allied health) would only be able to be implemented if there was clarity about distribution of funds to faculty/site specific programs. This would include specification of funds allocated to provide long term placement in each facility (including administrative and academic support), and flexibility to accommodate local training site capacity for different professions and their needs. Without this, we foresee considerable risks to current programs that are highly successful in achieving their current goals and key performance indicators.

**Question 5.** The proposed reporting arrangements involve a summary of parameters and specific reporting against the core requirements. How could the reporting arrangements be designed to reduce the burden on universities while providing an appropriate level of evidence to justify funding and inform future policy development?

The University of Sydney recommends that reporting requirements for each program undertaken by a university be reported for each setting, as the distribution of parameters, health professions and outcomes that could be met at each site would be different. We advise against integration of reports from each setting by provider, as it will hinder evaluation of outcomes for each site (particularly where there are multiple universities). It is also time consuming to rewrite reports from each program into an integrated report. We would, however, see value in working with the Department to develop options for consolidating (rather than integrating) site specific reports into a single university report, according to an agreed template.

There should also be a mechanism by which sites that host a collaboration of medical and other schools can consolidate reports from each provider by discipline.

A reporting template that outlines the key information required by the Department would assist with report preparation. This type of template would allow for aggregation of all the reports and data. There would need to be some space provided to enable each site to report individually with its region’s respective outcomes and capacity.

Reporting longitudinal rural workforce outcomes of graduates by individual providers would be difficult to achieve, costly and likely of low yield, particularly for professions that do not have national registration (e.g. speech pathology and exercise physiology in the allied health disciplines). Instead, data from AHPRA could be used to track place of practice of professions and linked with data from individual providers.
Question 6. The proposed framework requires universities to develop a rural health workforce research plan, in consultation with the department. Do you agree with this approach? If yes, do you have any other feedback? If no, can you suggest an alternative way of better coordinating and directing research activities funded through the RHMT program, towards rural health and workforce priorities?

The University of Sydney supports the need for evidence to inform rural health service delivery and training policy development and the conduct of high quality research and evaluation to produce this evidence and analyse it.

The University’s divisional structure is well positioned to coordinate these research activities and report to the Department of Health. However, the University does not believe development of a university specific ‘rural health workforce research plan’ (core requirement 5a) for each of the three rural departments of the University is either necessary or desirable given existing structures and programs already in place. The proposed plan could stifle research driven by regional needs by introducing a top down approach, and add additional administrative burden that would require additional resources. Academics located at the three rural departments (UCRH, UDRH and RCS) affiliated with Sydney Medical School already work with their local communities and local partners (health and non-health) to develop research projects that are beneficial to the local communities. These projects include rural health workforce, rural health service delivery and address local health issues.

We support the requirement for students placed at rural sites to be offered rural research opportunities where possible. For example, our newly developed MD research project in Sydney Medical School is one example of these opportunities (core requirement 5b). However, we believe that research relevant to rural health and workforce issues need not only be conducted by rural staff. The University’s metropolitan health faculties have a strong track record of conducting successful research relevant to rural health workforce outcomes 2-5,7.

The scope of rural research detailed in core requirement 3b appears to be limited to health service delivery models and workforce sustainability. Rural research core requirements would be better expanded to include all issues relevant to rural health, such as inclusion in clinical trials and service delivery. The high quality translational research undertaken by health researchers at University of Sydney affiliated rural sites has had application not only to the region, but has also led to metropolitan, national, and international benefits. A broader research perspective would enable the attraction of research-focused members of the health workforce to rural areas, especially where they could be supported and mentored in an adjunct capacity by the local RHMT research teams.

The following alternative approach to research based in rural areas and rural research could be considered.

- Site-specific reporting with additional requirements for universities to provide evidence of enhancement of a site’s research outcomes through inclusion in broader strategic initiatives (for example, the University of Sydney’s Charles Perkins Centre’s disease initiatives with Broken Hill UDRH), and research workforce capacity building schemes (such as mentored Early Career Researcher programs).
- Research outcomes measured against a set of national priorities for rural research rather than a university research plan.
- A targeted call for funding for rural health, and multidisciplinary rural health workforce research, for example through the NHMRC for project grants, establishing a Centre
of Research Excellence, or dedicated funding PhD scholarships located in rural areas.

Question 7. The framework proposes that universities will take on responsibility for the John Flynn Placement Program (JFPP), with universities providing support for current JFPP participants, but future placements up to the discretion of universities. Do you agree with this approach? Do you foresee that you would support vacation placements as part of your university’s placement activity? If not, to what extent could your university provide some of the positive elements of the JFPP, such as mentoring or the opportunity of students to build a longer term relationship with a particular community?

The University of Sydney would support taking over the responsibility for administration of John Flynn Placement Program (JFPP) on the condition that additional recurrent funding will be provided to support the administration of this program. It is envisaged the placements can be incorporated into the medical program, ensuring both that the curriculum needs are met, and that medical students gain critical exposure to rural general practice.

Shifting responsibility for the administration of the JFPP to universities would benefit rural general practices by reducing the administration costs incurred by streamlining and better managing requests for rural placements.

The RCS and UDRHs already work with the local communities in the same way that the Australian College of Rural and Remote Medicine (ACRRM) currently does to ensure the students have a successful placement and are immersed in the local community. The local UDRHS and RCS are better placed to do this as they are already immersed with GP practices and communities planning students currently and have strong networks of alumni that can assist with the assimilation of students into the community.

Question 8. There may be an opportunity for the administration of rural clinical placement scholarships to be transferred to universities, with a view to simplifying the application process for students. Would there be benefit in this approach?

Transferring the awarding and administration of other rural clinical placement scholarships to the University is also a welcome proposal. With adequate resources, we could adopt a consistent, simplified, transparent and equitable approach to all health faculties including medicine. There would be an administration cost for administering these scholarship programs, but given the student administration processes that are already in place within the university we can see potential for efficiency gains from this proposal.
Question 9. Parameter 3 of the proposed framework discusses the establishment of a ‘rural stream’ within university medical programs. To what extent does this already exist within your medical program? Do you agree with this approach? Can you suggest an alternative way of aligning training activities to support better rural workforce outcomes?

Creation of a rural stream (parameter 3, part 2)

There is not a specific rural stream within the Sydney Medical School. Instead, we encourage and enable students with an interest in rural health to identify themselves in year two of the course. These students are then mentored for a career in rural health, and by self-nomination given a long-term placement at one of the four rural campuses in year three or four of the four year program.

The University is supportive of the concept of providing a ‘rural pathway’ but we do not believe this should be focussed on the medical program alone. One of the major barriers to providing a rural stream and pathway for students is the requirement for an internship post-graduation and then vocational training. Both internships and vocational training places are recruited and administered by parties external to the University, and in the main, postgraduate year two vocational pathways are based around metropolitan training facilities. This reduces students’ practical exposure to postgraduate rural practice. Changing this will require negotiation with the NSW Ministry of Health and the Speciality Colleges to enable rural vocational training pathways to be established and appropriately supervised in rural locations (expanded in response to question 10). Another major concern is that these highly effective and resource intensive clinical placements are currently underfunded.

Rather than creating a separate rural stream, content should be embedded across all health curricula so that all students are educated about rural health issues and challenges, as well as experiencing interdisciplinary models of learning and service delivery which are essential at rural sites.

Question 10. Are there any other areas within the RHMT program where reforms could deliver positive outcomes for rural training? For example, efficiency gains, better collaborations between disciplines?

Other reforms within the RHMT program which could delivery positive outcomes for rural training include integration of pathways from undergraduate to post professional (vocational) training, coupled with increased employment opportunities.

Increasing the numbers of health graduates who intend to work in rural locations will not achieve the desired increase in workforce unless there is an integrated approach to retain and develop the workforce post-graduation. This must include increased employment opportunities and programs to support the continuing professional development of the current health workforce, though specific needs differ for each profession.

For medicine, the positive benefits programs such as ours (RCS, UDRH) are not being maximised due to a lack of rural internships and training positions in all vocational disciplines. A reversal of the hub and spoke model of postgraduate training is needed. Medicine has three phases of training: undergraduate, pre-vocational and vocational, which are each managed by a different body. The current metropolitan focus of pre-vocational and vocational training that exists for all disciplines other than General Practice, Rural
Generalist/ACRRM accreditation means that the path to rural practice is paved with laudable but unrequited rural practice intentions. The University has had extensive discussions with all other NSW and Victorian universities last year and came to an agreed approach. The implementation of this requires the assent of the various Royal Colleges, which has not been forthcoming. Unless the respective medical training colleges can provide a greater number of training places, and integrate more closely with undergraduate programs, efforts to translate rural training to long term rural commitment will remain compromised.

As presented to government in 2014 by existing Victorian and NSW medical schools, we propose an alternative program of vocational training administered through the Rural Clinical Schools and University Department of Rural, which would:

“coordinate integrated rural training pathways by working closely with the various stakeholders including RTPs, colleges and health services including remote community practices; utilise existing government training and infrastructure investments in hospitals and community practices; further develop e-learning and e-health programs; take a leadership role in addressing professional and educational isolation of rural health practitioners and mentoring rural junior doctors; and use current expertise to develop regional programs to address chronic health issues.”

For many other health professions, the limiting factor is the lack of local jobs. For the nursing profession, only 80% of graduates at all sites find employment, with lower rates at rural sites due to reduced retirement rates. Similarly, there is insufficient funding to establish allied health positions. On the other hand, for the pharmacy workforce, Australian data has shown that the strongest indicator for future practice location was a pharmacist’s internship location.

The entire program depends on the capacity, resilience, expertise and willingness of the rural health workforce. Continuing to support those clinicians with locally based professional development opportunities is critical, as is preserving good working relationships with local regional universities.

There is a risk that the proposed redesign will fail to capitalise on the potential for multidisciplinary and cultural competency skills development in students. Allied health students in particular would benefit from exposure to alternative service delivery models, for example working with allied health assistants, Aboriginal and Torres Strait Islander health workers and telehealth models of service delivery. Better programs for continuing professional education at rural sites for all health professions is also essential.

Question 11. Are there any other issues you wish to raise in regard to the draft framework?

Retention of 50% CSP placements for medical students as short term (< 4 week) placements

It is unclear why short-term CSP medical placements have been retained given that evidence shows rural placements shorter than 4 weeks do not increase rural workforce intentions. We recommend that the program seeks to make all funded CSP medical placements long-term. This should free up funding to increase investment in long-term placements of the large pool of metropolitan medical students who may not otherwise have considered a rural career.
Given the breadth and potential implications of the reform proposals, the scale of the University of Sydney’s health education (including rural and remote) activities, we would see mutual benefit in having the opportunity for a roundtable discussion between the departmental officials responsible for the design and implementation of the reforms, with University experts from across the disciplines and our various rural sites.

References


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