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Submission to National Health Workforce Agency on Clinical Placements

On behalf of the NRHA and the

National Rural and Remote Health Workforce Roundtable

February 2010

Introduction

The National Rural Health Alliance is the peak non-government organisation working to improve health and wellbeing in rural and remote Australia. It is comprised of 29 Member Bodies, being health provider and consumer organisations, and health professional bodies (see Attachment A).

The Rural and Remote Health Workforce Roundtable (the Roundtable) comprises 20 organisations, 17 of them being members of the Alliance and three others with a strong interest in the development and support of health professionals in rural and remote Australia. These three are the National Farmers Federation, the Australian College of Midwives and the Optometrists Association of Australia.

Members are pleased to have the opportunity to comment on the important issue of support for clinical placements for entry-level health professions and on the provision of facilities for Simulated Learning Environments.

Context

The mal-distribution of the health workforce is an overriding issue for all concerned with equity in accessibility and health outcomes for people in rural and remote Australia. Numbers of medical practitioners, dentists and other oral health practitioners, mental health professionals, other allied health professions and many categories of nurses are significantly lower on a per capita basis than for urban areas, despite the fact that people in country areas have greater health needs, higher levels of morbidity and mortality and face higher health risk factors.

Overall the Australian health system would be far more effective and financially sustainable if its resources were distributed in such a way as to more closely match health need. A better distribution of the health workforce is absolutely pivotal in moving towards an improved system in which there is needs-based allocation. Without the workforce available in high need areas, it is impossible to build the service infrastructure and provide the care required by people there.

In this context it is pleasing to note Commonwealth and COAG-endorsed policies and programs in relation to workforce development that seem to give some recognition to the needs of rural Australia. These include:

- the innovative Clinical Teaching and Training Grants program, designed in part to ensure that students and trainees, especially in rural and remote areas, have access to top quality facilities;

- the Simulated Learning Environment, designed in part to increase equity in access in regional, rural and remote settings; and

- the funding program for clinical training designed to expand training into non-traditional settings.

It is also pleasing to note the recommendation of the National Health and Hospitals Reform Commission that "a higher proportion of new health professional undergraduate and postgraduate places across all disciplines be allocated to remote and rural centres, where possible in a multi-disciplinary facility built on models such as clinical schools or University Departments of Rural Health".

Conversely, the announcement of a $56 million funding package to support additional nursing, allied health and medical clinical supervisors lacked any mention of any special support for improving supervision capacity in rural, regional and remote Australia.

The overall shortage of health professionals in rural Australia means that special efforts are needed to support clinical supervisors in rural and remote areas. This need is made starker by the ageing of the health professional workforce in rural areas. For example, the submission from the Rural Health Workforce Agency to the National Health Workforce Taskforce noted the substantial ageing of the rural GP, with a 72 per cent increase in the number of rural and remote GPs over the age of 54, 113 per cent in the 44-54 category, in contrast to an 18.5 per cent reduction in the numbers under 35. It also noted high levels of GP intentions to retire and proposed that:

> *"As the rural and remote GP population ages, measures will have to be put in place to make student training and supervision more attractive for those doctors coming up."*

The importance of rural and remote clinical placement and training

There are a number of reasons why it is important to have well-supported clinical training available in rural and remote Australia.

Preparation for the challenges of clinical practice in rural settings

Effective rural clinical training will recognise the differences between urban and rural/remote clinical practice and help to ensure that new graduates are job-ready for practice in a range of possible settings.

Extended skill sets are needed by many health professions in rural and remote areas. Research has shown that rural general practitioners, for example, are more likely to be able to provide in-hospital care as well as private consulting room care, provide after hours services, engage in public health roles expected of them by discrete communities in which there are few doctors to choose from, engage in clinical procedures and emergency care, encounter a higher burden of complex or chronic health presentations, and encounter larger proportions of Aboriginal or Torres Strait Islander patients in their overall patient load.

Such important distinctions have resulted in the development of special rural/remote training pathways and packages by health professional bodies such as those in general practice, rural nursing, remote nursing, health service management, and ambulance and paramedic services.

Encouraging students to take up rural practice

Secondly and most importantly, rural clinical placement and training should be seen as part of the package of government policies to recognise and address the mal-distribution of the health workforce and encourage students to choose a career in rural practice. There is some evidence that rural clinical placements, provided that they are positive, influence the choice of rural practice.

In its 2009 Submission to the NHWT on *Clinical Training – Governance and Organisation,* Rural Health Workforce Australia noted evidence that exposing students and young people to the possibility and reality of rural practice can have *some* impact upon their later career choices. For example, a study undertaken of Monash University medical students in 2006 found that rural placements in their first year had “the greatest impact in terms of changing future practice intentions towards rural practice”.

Encouraging rural students to take up and sustain tertiary education in the health professions

Thirdly, people living in rural and remote areas comprise 32 per cent of Australia’s population but only 17 per cent of tertiary student numbers. This under-representation indicates that rural residents are missing out on educational and career opportunities, which impacts adversely on their potential for prosperity, career choices and health and wellbeing.

It is important in terms of equity in access to tertiary education in the health professions that students from rural Australia studying in rural settings such as Rural Clinical Schools, University Departments of Rural Health, rural dental schools, and nursing and allied health degrees at rural campuses have the opportunity, where practicable, to receive clinical training in or close to their region of study.

Stimulating professional leadership and broader professional development opportunities

Finally, the provision of clinical training and placement in rural areas can be important for stimulating and maintaining the interest and involvement of the existing health professionals themselves. Such opportunities to contribute to ongoing training activity adds to the opportunities for health professionals, eg academics, those wishing to reduce their hours of clinical practice, and those wishing to re-enter the workforce on a part time basis. Clinical training and supervision opportunities can also contribute to the clinical leadership, mentoring and professional and career development required by all health professions. These roles are also highly valued by clinical leaders and rural practitioners, giving scope to work within and across teams, to build wider networks, and to engage with specialists and academics in their field.

A systems and outcomes approach

Overall, the provision of high quality clinical training in rural areas and its more equitable distribution requires a 'whole of systems' approach to ensure the availability of well-equipped facilities with adequate space and equipment for training, the availability and funding for clinical supervisors, and funding support for students to meet the costs of being away from their place of study.

It is important that the principles of improved equity and access for rural people are put into practice and that the stated outcomes are achieved. Program aspirations are no guarantee of success, if factors in implementation conspire against rural and remote equity. For example, the Innovative Clinical Teaching and Training Grants program is described as part of a *nationally competitive* (our italics) infrastructure allocation, with Commonwealth *contributions* of between $100,000 and $5 million to be available to public and private organisations for infrastructure projects that are innovative approaches to dealing with the increase in the numbers of people undertaking health professional training and education. The potential difficulty with both competitive processes and with contributions only - rather than full costs of infrastructure - is that the better-resourced institutions are likely to be in a stronger financial and planning position to make such competitive bids for grants, to the detriment of less well established and resourced health services in areas of greater need.

The possible fragmentation of roll-out of system supports, eg the separation of clinical teaching and training grants for infrastructure from the roll-out of funding for supervisors, is also a case in point as health services without adequate financial support for clinical supervision may not seek to bid for infrastructure grants and vice versa.

Finally, quality is crucial. Rural clinical placements, resourced on a shoe string, just for the sake of achieving a rural clinical placement, without regard for its quality in terms of training facility, supervisor or student support or for student accommodation, runs the risk of meeting a short term program objective that actually provides a negative experience. Poor quality rural clinical placements are damaging to the longer term goals of improving the share of health services available to rural and remote Australians.

Overall, therefore, we would argue that all these programs be administered on an outcomes basis, rather than on a competitive and rule-bound allocation process; and that initial processes be established and ongoing processes adjusted where necessary to ensure that increased equity for rural Australia is actually achieved from the outset and on an ongoing basis. If that outcome requires some element of preferential funding to achieve good quality rural clinical training and at very least equitable levels of such clinical placements, then that path must be taken.

Funding for clinical training for entry level students

Adequacy of funding

At the outset, we should raise our considerable concerns about the adequacy of funding for clinical training. While we note that the level of funding is scheduled to more than double, from $134.96 million in 2009-2010 to $280.5 million in 2010-2011 and beyond, we also note figures provided by the Taskforce that show the required numbers of clinical training days is also scheduled to increase substantially, as per the following table.

Table 1: The growing need for training (National Health Workforce Taskforce data)

	Clinical Training Days 2005	**Clinical Training Days 2013**
Medicine	640,705	1,273,405
Nursing	1,123,125	1,736,875
Allied Health	728,763	811,750

The projected funding does not provide for a per capita or per day increase in funding. An increased amount per placement is required to address needs for infrastructure for training, for support for supervisors and to overcome cost barriers in moving clinical training substantially outside the major urban teaching hospitals, and in providing a broader and more varied clinical education experience, as well as to address any existing deficiencies. In this regard, in relation to nurses alone, by far the biggest professional group, the ANF in its 2008-2009 pre-budget submission has estimated a shortfall of about $3,000 per student per year for clinical education.

Funding inadequacy is also highlighted by the fact that university schools for professions such as optometry have not in the past been funded for such clinical training. This situation has to be rectified to give some degree of parity in support for clinical training.

There are also currently large and debilitating gaps in clinical support offered to Aboriginal Health Workers (AHWs), even in the Northern Territory, where they are already subject to accreditation and registration. With nationwide accreditation and registration set for implementation for AHWs by July 2012, all aspects of their clinical training requires immediate planning and funding attention to build a coordinated system of community-based clinical training capacity.

The very small per annum increase (about 1.3 %) in the funding provision for allied health professions is alarming from a rural and remote perspective. The table below shows the relative distribution of allied health professions by region, indicating that serious measures would be required to address shortages in rural, regional and remote areas.

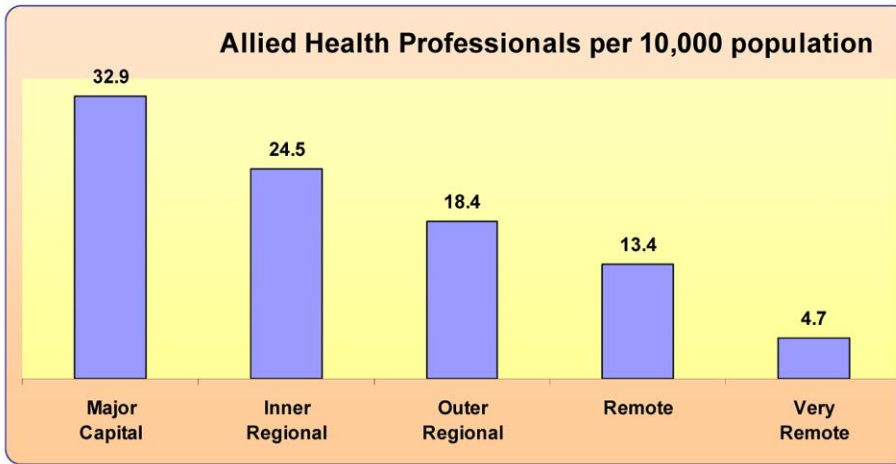

Figure data based on SARRAH *National allied health workforce report* (2004) which is available at: http://www.sarrah.org.au/site/index.cfm?display=65820

The overall funding provision does not augur well for devising a national system of payments for clinical training that equitably meets the needs of the various professions, delivers accredited training, takes into account the many potential expenses of such clinical training, encourages training in other settings and - in the case of rural and remote Australia - takes account of barriers to clinical placements from either service provider/trainer or student perspective. Thus we would strongly argue at the outset for a funding system that has a bias in favour of encouraging students to move outwards from urban and regional settings to rural and remote locations for some of their clinical training.

Accordingly we consider that a range of other programs may need to be expanded to meet these essential prerequisites for clinical training. These include the Commonwealth Rural Education Infrastructure Development (REID) Pool which allows for the development of accommodation for student training as well as for facilities for the provision of that training. Scholarship programs designed to attract and support students in rural clinical placements also offer complementary and targeted means of breaking down barriers to rural placements. These programs include the Allied Health Clinical Placement Scholarship Scheme (AHCPSS), an Australian Government initiative to support allied health and oral health students to undertake a clinical placement in a rural or remote Australian community during their degree. This and other scholarships such as the John Flynn Placement program for medical students are heavily oversubscribed, illustrating the importance of support for clinical training and also offering a blueprint for the nature of required support, with some funding for mentors/supervisors, albeit at honorarium levels, as well as for students.

In terms of clinical placement, the AHCPSS program is to be consolidated into a broader nursing and allied health scholarship scheme in 2010 with a range of objectives and this introduces the risk of a reduction in allocations for clinical placement.

Overall, then, there is a strong case for major increases in funding to meet the demand for clinical placements in rural, regional and remote areas, and to ensure that they are well targeted and well supported from the point of view of both the students and their host sites.

Distribution of funding for clinical placements

We believe that a number of principles should apply to the application of the proposed new funding system.

Equity by region: At the highest level, rural, regional and remote areas should be funded to achieve at the very least their proportionate share of clinical training, taking account of both population and health need, recognising the intention of such training to ultimately provide health services to people throughout Australia and that people in regional rural and remote areas are underserved compared to their urban counterparts. In this regard, it seems anomalous that Rural Clinical Schools are set a target of only 25 per cent rural clinical placements, less than proportionate to the 32 per cent population in rural, regional and remote areas.

Taking this principle further, if training in a particular region can increase the probability of a student returning there to work, the distribution of training places should be on the basis of region-by-region health need.

The work necessary to establish a regional framework for the distribution of support for entry level clinical training would also be useful for the allocation of other health resources. For example, continuing professional development should be made available and supported in proportion to the clinical need being met by the professionals concerned, as well as according to their spatial and logistical need for such support.

Equity by profession: In keeping with moving toward the more coordinated and multi-disciplinary provision of health services, funding for clinical training should also be based on equitable treatment among students of the various health professions, taking into account current and future workforce requirements and areas of shortage. For example, it is difficult to justify widely varying policies on providing accommodation for different professions.

Overall, the objective of funding for clinical training should be to train and develop multi-disciplinary teams of the right composition to best meet the health needs of each community. It would appear that it was with this objective in mind that the National Health and Hospitals Reform Commission made its recommendation that:

> *" a higher proportion of new health professional educational undergraduate and postgraduate places across all disciplines be allocated to remote and rural regional centres , where possible in a multidisciplinary facility built on models such as clinical schools or University Departments of Rural Health."*

Relevance of various settings: To have rural relevance, clinical training should take place within an appropriate context. While some clinical training in a major hospital with its range of patient conditions may be necessary, it is equally the case that clinical training should also expose students to the clinical practice conditions for example in Aboriginal medical services, multi-purpose services, regional health services and other multi-disciplinary settings that are likely to characterise rural health systems in the future. Given that such multidisciplinary models are not yet widespread, it is also important, that student placements in less 'ideal' settings include a strong capacity building component to equip the students with strategies to develop local and regional support and networks to sustain their practice in more isolated settings.

Cost considerations

There are many anomalies in current arrangements, with some professions being paid for clinical training supervision, and other professions not, and only some universities and communities having accommodation available that can be made available free of charge to selected visiting students.

Student costs

In terms of student costs in rural and remote areas, travel and accommodation costs are the key factors.

Travel costs for students are related to the extent of rurality or remoteness from the place of study and should be provided for in setting clinical training subsidies. Given current patterns in favour of clinical training in urban and major regional centres, we consider that any subsidy component for travel should be in favour of travel to rural and remote areas rather than aggravating the existing regional mal-distribution in clinical training.

From a student perspective, the major cost relates to accommodation, where that has to be paid for by the student, and is over and above their expenses for accommodation in their usual place of residence. The cost of accommodation can also vary greatly. It can be prohibitive, if available at all, in some mining boom towns, expensive in some capital and regional cities and perhaps more affordable elsewhere. It may be non-existent in more remote communities. Given the lack of public transport in rural and remote areas, accommodation needs to be close to a student's place of learning.

All these factors suggest that the overall clinical placement system would be much simpler to devise if there was a national policy in place that offered all students free accommodation if away from their usual place of residence and undertaking training in targeted areas. As noted above, the Commonwealth Rural Education Infrastructure Development (REID) Pool allows for the development of accommodation for student training as well as for facilities for the provision of that training, and would need to be very substantially increased to ensure that such an accommodation program was achieved. This program is geared towards construction or acquisition of accommodation, but could be expanded to allow for leasing of accommodation where that was available. Leasing options could be less costly and more flexible having regard to the demographics of the student population, as well as for other trainees such as those undertaking postgraduate and vocational training. In this regard, the ANF advises that the available demographics for commencing nursing/midwifery undergraduate students show that over half are of mature age (20+) and the majority are female, with anecdotal evidence that many are supporting dependant families while studying for their nursing/midwifery degree. Thus there may be some need for student accommodation that is more family-friendly, or for additional programs to support students with caring responsibilities to participate in rural clinical placements. This may become even more important if retraining or upskilling of mature age workers becomes a more significant contributor to increasing the rural health workforce.

An accommodation program could also take account of studies, such as one recently conducted of optometry graduates in Australia and New Zealand, that identified the desirability of several students being placed in practices within the same area, as one means of addressing the disadvantages of being placed in an area away from family and friends.

Failing achievement of the ideal of a national accommodation system, the clinical training program should specifically distinguish between those who are offered free accommodation and those who are required to pay. Subsidies should especially apply for student accommodation for clinical training in areas of greatest health need.

Another cost that students have identified as a barrier to clinical training outside their usual place of residence is the cost of earnings forgone when they cannot continue their usual part-time employment. However, this is not exclusively a rural issue and to take it into account would create administrative difficulties.

Service costs

Health services of different sorts in different places are not all equally well funded. Some are able to make special allowance for students engaged in clinical training - both for the benefit of the student and to ensure minimal disruption of the service to patients. Where services are already overstretched and under-staffed, as is often the case in rural and remote areas, this capacity to accommodate clinical placements is missing.

Programs such as the Commonwealth's Rural Education Infrastructure Development (REID) Pool provide funds for development of service capacity for clinical placements but, as with demand for funding for accommodation, it is heavily over-subscribed. Ideally, substantial increases in REID funding would be used to address facilities' capital requirements, not simply to compensate for current inadequacies through the allocation of recurrent funds.

Centres of excellence also require proper training and support for their supervisors. It is regrettable that the COAG announcement of increased funding for supervisors did not include a particular focus on supervisors in rural and remote areas, as it is in those areas that they have the greatest demands on their time for service provision. This program should be administered to ensure progress towards greater equivalence of clinical training capacity in rural and remote areas compared to their urban and inner regional counterparts.

It is critical that rural and remote clinical training be conducted in services that deliver high quality in both service provision and training, provides a stimulating and well-supported clinical experience, and gives students positive experiences relating to work options for them once they graduate.

In relation to allied health in particular, student supervision is currently provided on a voluntary basis. Training and ongoing local support are critical to sustaining this important activity. Personnel employed to provide this clinical training and support might be funded through appointments of allied health clinical academics linked with University Departments of Rural Health. The development of clinical training supervision for AHWs is another particular need that must be addressed as a matter of priority

Even with adequate training facilities and clinical support, the costs to health practices of providing training in rural and remote areas will be greater than for urban areas. This cost derives from the greater work demands upon rural and remote health services and thus the opportunity cost of reducing patient services as a result of student clinical training. For example, the AIHW survey of the medical labour force in 2006 found that hours of work by primary care clinicians were 2.6 hours more in Inner Regional, 6.1 hours more in Outer Regional and 10.3 hours more in Remote/Very Remote, compared to their metropolitan counterparts. The Optometrists Association of Australia reports that rural practices tend to be more fully booked than their urban counterparts and would certainly need to reduce patient

throughput when providing clinical training. It is a particularly difficult issue for a profession such as optometry where there is no current system in place for payment for providing clinical training.

A clinical training incentive for rural and remote practitioners would be one means of compensating for reduced patient capacities and increased workload. Another measure would be to increase the provision for locum services in rural and remote areas to increase service capacity or to provide some additional time off in lieu for health practitioners taking students.

Overall, special support for the placement activities of clinicians relying on fee-for-service income is one area where a rural/remoteness incentive would be well justified.

The Department of Health and Ageing has introduced a new rural classification system for the provision of incentives for general practitioners in rural, regional and remote areas. This system, the Australian Standard Geographical Classification - Remoteness Area (ASGC-RA) system, groups locations into 'remoteness areas'. The system is based on ABS population data and is therefore subject to periodic updating by the ABS as populations change. More significantly, the Commonwealth incentives applicable by remoteness area are scaled, with greater incentives available with increasing remoteness. We consider that this system - especially its scaling - should be applied to support for clinical training,

Simulated Learning Environments (SLEs)

One of the aims of this program is to increase the capacity of the health system to provide training experiences in rural, regional and remote settings. We support this aim in principle, and the proposal to develop a national plan for developing and operating SLEs.

A national plan should be firmly based on equity in access to such facilities. A national plan for SLE facilities should also take into account the opportunity for such facilities to be utilized for other clinical training, for example in vocational training, specialist training and ongoing continuing education by health professionals. Access to training as locally as possible for all these groups is a crucial element of equitable access to career development and professional and peer support for health professionals who work in smaller and more isolated communities.

The availability of local facilities also enables the utilization of local resources such as visiting medical specialists, and those wishing to work part-time or to re-enter the workforce.

It will be crucial for the ‘curriculum’ for SLEs for rural and remote Australia to be designed specifically with rural and remote needs in mind, rather than to be a mechanistic way of distributing training as if it were a ‘one-size fits all’ commodity. Rural relevance will always be important. Rural and remote practice typically requires a deeper level of inter-professional interaction and offers the opportunity for inter-disciplinary training and the shared use of SLE resources. Especially in remote areas, SLE applications will be of considerable value but substantial research and development will be required to ensure their relevance for each profession.

Accordingly, the national plan should consider the nature of the currently available SLE ‘curriculum’ and make provision as necessary for proposals for the development of new or enhanced rural/remote SLE programs.

Despite acceptance of the important and growing capacity of SLEs, contributors to this paper also expressed strong concern that they be employed judiciously, and not be at the expense of a more patient-centred model of health service provision in which the professional/patient relationship and patient participation in decisions on health care are key. Indeed many saw a more patient-centred approach as a key priority for training and an essential element of the support for and selection of supervisors and of the clinical training of students. In SLE terms, patient-centred care might require more emphasis on role-playing rather than computer-model techniques.

Students need to get some experience of what it is like for the people who live in these rural and remote communities, so that they can relate well to them. SLEs would be more appropriate for people who were on placements to learn about clinical situations that they might not be exposed to in a small town due to small patient numbers, yet may need to respond to once in a lifetime, rather than a way of simulating what it might be like to practise in a smaller town.

Another crucial element of clinical training for practice in rural and remote areas is to build in interaction with other health professionals, including with specialists. In this regard SLEs should include the range of virtual teaching and support opportunities already providing professional development or advice from tertiary specialists, such as satellite case conferencing or participation in grand rounds at a tertiary hospital, or teleradiology and teledermatology advice. Online mentoring opportunities and ways of ensuring that students learn how to keep in touch with their professional peers in rural remote settings once they have passed their student days are also important.

SLEs specially developed for rural or remote environments should also be regarded as an important and cost-effective means for bringing some aspects of rural or remote clinical practice to students in urban areas. For example, CRANAplus, based in Alice Springs, is able through its mobile SLE to bring clinical training such as in remote emergency care and maternity emergency care to groups of students in urban areas. This approach can substantially increase the willingness of urban and regional students to be exposed to aspects of remote health care, and to encourage their interest in other elements of rural and remote clinical practice in those settings.

For them to be most effective for rural and remote areas, SLEs should support training of ‘the whole integrated health care team’. Such training would be based on a special multidisciplinary curriculum, developed as a result of good research on what models of integrated clinical training work well. It would take advantage of the presence of visiting specialists and other potential supervisors.

Overall, contributors were keen to participate in any further consideration of SLE and to comment on the draft national plan when it is developed later in 2010.

Attachment 1: Member Bodies of the National Rural Health Alliance

ACHSE	Australian College of Health Service Executives (rural members)
ACRRM	Australian College of Rural and Remote Medicine
AGPN	Rural Sub-Committee of the Australian General Practice Network
AHHA	Australian Healthcare and Hospitals Association
AHPARR	Allied Health Professions Australia Rural and Remote
AIDA	Australian Indigenous Doctors' Association of Australia
ANF	Australian Nursing Federation (rural members)
APA (RMN)	Australian Physiotherapy Association Rural Members Network
APS	Australian Paediatric Society
ARHEN	Australian Rural Health Education Network
CAA (RRG)	Council of Ambulance Authorities - Rural and Remote Group
CRANAplus	Council of Remote Area Nurses of Australia Inc
CRHF	Catholic Rural Hospitals Forum of Catholic Health of Australia
CWAA	Country Women's Association of Australia
FS	Frontier Services of the Uniting Church in Australia
HCRRA	Health Consumers of Rural and Remote Australia
ICPA	Isolated Children's Parents' Association
NACCHO	National Aboriginal Community Controlled Health Organisation
NRHSN	National Rural Health Students' Network
RACGP (NRF)	Royal Australian College of General Practitioners (National Rural Faculty)
RDAA	Rural Doctors' Association of Australia
RDN of the ADA	Rural Dentists' Network of the Australian Dental Association
RFDS	Australian Council of the Royal Flying Doctor Service of Australia
RHEF	Rural Health Education Foundation
RHWA	Rural Health Workforce Australia
RIHG	Rural and Indigenous Health-interest Group of the Chiropractors' Association of Australia
RNMF of RCNA	Rural Nursing and Midwifery Faculty of the Royal College of Nursing Australia
RPA	Rural Pharmacists Australia - Special Interest Group of the Pharmacy Guild of Australia, the Pharmaceutical Society of Australia and the Society of Hospital Pharmacists of Australia
SARRAH	Services for Australian Rural and Remote Allied Health