NATIONAL RURAL HEALTH ALLIANCE INC.

A Quality Rural Placement System for Health Students

April 2004

Contents

The Rationale for Rural Placements 3

The current situation 4

Deficiencies of the current system 8
Accommodation and other infrastructure 9
Preceptor training and support 9

Designing a Quality Placement System 10

Recommendations 12

Acknowledgements 14

References 14

This Position Paper represents the agreed views of the National Rural Health Alliance but not the full or particular views of all 23 Member Bodies.

Visit 'Publications and News' at www.ruralhealth.org.au for all the Alliance's policy documents on rural and remote health.

A Quality Rural Placement System for Health Students

THE RATIONALE FOR RURAL PLACEMENTS

This Position Paper is about developing a better rural placement system in Australia for students (mainly undergraduate) in the health professions. Such a system would help with the recruitment and retention of graduate Australian health professionals to rural and remote areas. (We use the term 'rural' as an abbreviation for 'rural, regional and remote', to connote all parts of the nation outside the main cities.)

There has been good progress in recent years with the regionalisation of health education, particularly for medical students. Governments and professional bodies are to be congratulated for the resources and support they have given to such regionalisation. One of the next steps required along the road to recruiting and retaining more health professionals for country areas is to give all students access to good rural placements, irrespective of the main location of their training.

A 'rural placement' is a period of experience (usually including clinical training experience) provided to a health undergraduate[1] in one or more health settings in a rural area.

There is a growing body of evidence, largely based on studies in the US and Australia, that the key determinants that make rural practice more likely for a health care professional are rural origin, rural spouse and rural placements, and that these predictors are stronger when they occur in combination.[i] [ii] [iii] There is also some evidence that length of exposure to rural and remote practice during training can predict future rural practice.[iv]

The National Rural Health Policy Forum has identified clinical experience in rural health services as a key element of the educational preparation of health care students for rural practice[v]. It would be valuable to expose all health students - irrespective of rural practice intentions - to the challenges of rural practice but the system cannot accommodate that yet.

There are compulsory placements and elective ones. Both are elements of the whole university curriculum and both have clearly-specified learning outcomes. There are also placements outside the curriculum, such as John Flynn Scholarships that are taken during University holidays.

---

[1] The term 'undergraduate' is used here to mean the first degree for a health professional in a particular discipline. For convenience it includes those who are in 'graduate programs' – particularly in Medicine.

There are two types of rural placement within curricula for undergraduate health professional training. They are generic ones that just happen to be undertaken in a rural or remote area, and specific rural placements (ie targeted at rural exposure and having to be in a rural area).

Forcing students to undertake a rural experience by making it a compulsory part of their course or program requirements is not a sensible option. There is already a risk that the sheer numbers on rural placement will overwhelm the institutions and individuals charged with the responsibility of providing and supporting them. In addition, compulsory placement systems risk creating antipathy.

A more suitable approach is to have a graded exposure to rural health and clinical practice, with all undergraduate health science students required to complete a rural health subject that contains a mix of theoretical and practical content, and encouragement for those students with an interest in rural clinical practice to have quality learning experiences in rural areas.

To be successful, rural placements need to be accessible, well co-ordinated and well-supported. A well-supported rural placement is one in which dislocation is minimized, instructional content is maximized, and costs are covered. If it is a good experience, the student is more likely to look favourably on rural practice when they are trained.

Even if graduates do not end up practising in a rural or remote area, rural placements will sensitise them to both general rural issues and to the issues affecting rural health services. This would help health professionals to take an appropriate approach when working in a metropolitan hospital, for example, and to understand and address the issues involved with such things as discharging a patient home to a rural area.

Overall then, rural placements are important as part of a strategy to increase recruitment and retention of health professionals to rural areas. If planned and supported properly, the mentoring of those on rural placements can contribute to the training and job satisfaction of existing practitioners.

The ultimate goal is to help to ensure that people in rural and remote areas have reasonable access to an appropriate number and mix of health care professionals.

THE CURRENT SITUATION

The Health Reform Summit in August 2003 highlighted the concerns of the States and Territories about the increasing demands placed on them in the delivery of health services. Many of the placements in nursing and allied health occur within the hospital and area health service systems. In some States and Territories the Area Health Services (or equivalent) receive funding for teaching and research as part of their total resource allocation. In recent times the demands placed on acute services (particularly in rural areas) have increased the pressure on practising health professionals to prioritise acute clinical care over teaching or research activity.

For **Registered Nurse** education, clinical placements in rural areas vary widely across the tertiary institutions. Some Schools of Nursing in the capital cities have no compulsory rural placements throughout the whole curriculum, whereas others do. Overall there is increasing pressure on Schools of Nursing to find placement positions, which means that there is increased demand on rural nursing settings to provide them.

No two undergraduate nursing courses in Australia have identical curriculums, so there is great variation between Schools regarding the use of elective rural placements. Given the current lack of formal support, many nursing placements rely on the voluntary commitment of all involved, including members of the rural community.

> "I invite nursing students to stay with us on our dairy farm as it is cheaper for them and they get to see life in the country rather than in a motel or hotel - but they don't get their own bathroom, and the internet could be a little slow." (personal communication from a farmer)

> "I had to go out of town for this placement because I had not been out previously. I asked for X, but got placed in Y instead. I inquired about the possibility of travel assistance because it is about 9 hours by road from the University. I drove here on my own and paid my own petrol costs. Unfortunately there was no assistance available. I'm lucky to be staying in the quarters at the hospital, which is free. I'm the only nursing student at the quarters at present, but there are a couple of agency nurses from New Zealand staying there as well, which is good company. I'm having an excellent placement, and plan to go rural when I graduate. I grew up in the bush, and hadn't really considered working in the city." (personal communication from a student nurse)

> "I had no support getting to A. I got a lift with another student to R and then caught the bus to A, which is about 11 hours by road from the University, and involved an overnight stay in R. I'll be paying the bus fare to get back to Uni. from here. This is my first placement in a rural area and it's hard being away from my family for 6 weeks. I'm staying in the quarters at the Hospital and I hope it's free, but I haven't actually asked. We have to pay for all our own meals. We are able to use the local library for the Internet. It's been an excellent placement, the staff are very welcoming and supportive." (personal communication from a student nurse)

Undergraduate **allied health** courses also vary across Australia as to their requirements for rural placements. For many years rural practitioners and Base Hospitals have taken students on placements for either community or clinical training. Because health professionals in rural settings are frequently sole practitioners and new graduates, the opportunities they provide for rural placements are less than in the better-resourced metropolitan centres with large departments of staff experienced in student supervision, often a designated clinical supervisor and infrastructure like a medical library and good IT access. For staff at the Base Hospital, supervising students may be that one final burden too many.

The resource bases of Universities also vary. Some universities pay for health services to take their students and for other support of student placements, while other more established Universities have a history of placing students with major teaching hospitals in metropolitan centres and have limited need for rural placements. In general, allied health teaching resources are still concentrated in the metropolitan areas. For many rural placements there are no incentives from universities for the training of undergraduate student placements.

The establishment of University Departments of Rural Health (UDRHs) has seen an improvement in student accommodation and access to resources for students on placement – particularly within the UDRHs' regions of influence. For example, for allied health disciplines, universities in Western Australia support the regional travel of Placement Co-ordinators to ensure the preparedness of their rural sites. UDRHs are closely linked to programs in their parent universities and also offer support to students from other universities.

> "The UDRH student housing was greatly appreciated. The four-bedroom house was fully furnished and equipped with four computers with broadband internet connection. The accommodation allowed me to meet other students, therefore developing my network with other future health professionals. The supportive study environment provided an excellent environment for data analysis and report writing.
>
> It would be great if all students had that same experience and opportunities provided by their rural placements. The project became tedious in the final week, with a move into the caravan park as the UDRH student accommodation was not available." (personal communication from a student on a 6-week community placement in a rural regional centre in Victoria)

Currently not all nursing and allied health students have placements that meet these UDRH standards, particularly where accommodation and IT and staff support are concerned. Additional resources are needed to ensure that quality placement options are available to all undergraduate health students in all locations, so that their rural placement is a positive incentive to practise in a rural or remote area after graduation.

For **medical** students, placements are planned, scheduled and recurring during the undergraduate years and integrated between components of the universities (including but not limited to their Rural Clinical Schools and their Departments of Rural Health). Many placements are based on personal networks. Qualified medical practitioners, approved by the universities, tutor the students through learning outcomes that must be achieved and reported upon. These placements are supported through university resources and facilities and are covered by indemnity insurance. GPs are usually paid for taking students, although there is still a significant reliance on volunteers and concessions, such as the altruism that has traditionally been displayed by hospital and home.

> "It is pleasing to note - - that support for the concept of rural and community terms [in medicine] is almost universal among stakeholder groups. The features of high quality terms have been well articulated, and include appropriate attention to training and supervision requirements, clear role definitions and orientation programs, ready access to advice from senior colleagues, consistent and constructive feedback and adequate accommodation and other resources." (personal communication from a medical workforce administrator)

A fourth general group in the health system is comprised of **health service management** students. Quality health service management is an important requirement for any health facility, particularly in rural areas where similar recruitment issues exist as for clinical workers.

In Australia there are limited opportunities for formal health service management placements in rural settings. The schemes in existence are specific to particular professions and industries, and individually funded according to the vision and commitment of particular health services. Furthermore there is very little specific rural or remote health management training. The issues of adequate training for supervisors of rural health service management students, and support for students in accommodation, are similar to those for other health professional groups, except that some of the health service management students are postgraduate.

A formal placement is not usually part of a University health service management course. If such opportunities exist they occur at a postgraduate level and few postgraduate health service management learning experiences are provided in rural settings. Exceptions include the Flinders University Remote Health Management program run by the Centre for Remote Health, and the program conducted through the NSW Branch of the Australian College of Health Service Executives (ACHSE). There is also a scheme in NSW funded by the Commonwealth and State governments co-ordinated by the NSW Aboriginal Health and Medical Research Council and the NSW Branch of ACHSE for the training of Indigenous health service managers, usually for periods of twelve months or two years. The benefits of rural placements in this scheme have been considerable for both mainstream and community controlled health services. It is important that the funding for such schemes is continued at State and Commonwealth levels.

Discipline-specific differences in placements are likely to persist since the opportunities, rights and obligations are determined by the profession and closely governed by university curriculum committees with a responsibility to professional and accreditation bodies.

DEFICIENCIES OF THE CURRENT SYSTEM

The deficiencies of the current rural placement system can be summarised as follows.

- There are no agreed standards or benchmarks across States and Territories, between universities, and among the different health professions; therefore there is no equity between individuals and professions as far as rural placements are concerned.

- Currently the system gives insufficient attention to the needs of the communities, teachers and mentors of the students on placement. The number of undergraduate students on rural placement and the rural placement facilities available are out of proportion. Given that mentors are mostly volunteers who can "pause when they are weary", this is leading to a crisis in the provision of supported clinical placements across all professions.

- There is inequitable access for the different professions to fully-funded placements; there should be parity for students from all health disciplines, so that access and conditions for all students is brought up to the hard-won standard applying to medical students.

- In particular there is currently insufficient support for all students' travel, accommodation and access to information technology.

- There is a need to cater for the needs of greater numbers of mature age students, many with partners and children.

- The access, cost and quality of accommodation for students on placement are extremely variable. There is a strong perception that medical students are given preference over other students for accommodation, thus limiting the opportunities for others and, at worst, encouraging rivalry between professions. (We should be encouraged by the knowledge that things can change so much: people recall how hard it was originally for medical students to be given access to country hospitals' nursing home accommodation.)

- The use of hospital quarters in regional centres for undergraduate students has, in some cases, displaced rural practitioners undertaking refresher courses or updates in the regional centre. This is common where Rural Clinical Schools have been established in regional hospitals and students are now accommodated in the old nursing quarters. This means that rural practitioners may have to pay for alternative lodgings during periods of professional development and training.

- Generally, the current system is poorly co-ordinated; some placements are not well-timed for the parties involved, and very little advantage is taken of the possibility of using rural placements to build inter-disciplinary collaboration and health teams for the future.

- Understaffed health facilities in rural areas lead to overworked clinicians who may not have the capacity or the time to mentor students. This can lead to poor learning opportunities, colouring the views of the student about the placement, and the views of the clinician about students and placements.

- There are insufficient data to ascertain the long-term effect of rural placements. There needs to be a national system of longitudinal tracking of health science students and graduates, to ascertain the impact of rural and remote education and training programs, including placement programs.

- Students on placement often incur additional living expenses as they may be required to maintain rent or lease payments at their normal home. They also find it hard to keep regular part-time or casual work when they have to go on placement.

- Despite some major improvements in information technology services to rural areas[vi], good IT is still spasmodic and not universal. Poor access to information technology still limits the learning experiences students have on clinical placements.

- There is concern about the lack of social support networks, particularly where the student is on placement on their own, and particularly on longer-term placements.

Accommodation and other infrastructure

Infrastructure is an important area requiring attention. An audit is needed of supply and unmet demand across Australia with regard to infrastructure for student placements in rural and remote areas, particularly student accommodation. This would provide the initial evidence base for an ongoing, adequately funded and rational approach to the provision of infrastructure and accommodation based on need, rather than the short term and *ad hoc* initiatives that have been the pattern to date.

Preceptor training and support

There are some schemes that provide funding for medical preceptors (eg RRAPP, JFSS), and specialists in hospitals are likely to be paid for their work with registrars. Overall, however, there is no uniform funding approach to health services taking students. In some States there is no allocation to the Area Health Services for teaching, so that health service dollars have to be used to support the education of students. Clinical staff provide supervision and clinical teaching, and are expected to clear their backlog of patients after the students have left. There needs to be proper recognition of the fact that if a practitioner has a student they will be able to see fewer patients.

Most rural and remote health professionals value opportunities to supervise students and to be involved in teaching. In fact, contributing to student placements can renew and maintain a professional's commitment to rural and remote practice. A reflection of this interest is the demand for seminars, workshops, and short study programs to provide clinicians with skills and knowledge to enable them to be more effective clinical teachers, mentors and supervisors.

DESIGNING A QUALITY PLACEMENT SYSTEM

A quality rural placement system would have the following characteristics:

- it would have agreed national standards or benchmarks, and be of a uniformly high standard across the nation;

- the national standards would be applied to fit regional needs and be co-ordinated at a regional level;

- it would treat all professionals in training equally: whether you are studying Medicine at Monash, Nursing at Newcastle, Dentistry at Darwin, or Podiatry at Perth, the same opportunities, rights and obligations would apply to your rural placement; the system will meet the changing needs of the student population, with more of them now being mature age people with partners and a family;

- it would be 'information-rich': communities and mentors would know who was coming to the town when, communities would have placements when they wanted them, information on vacancies could be advertised nationally, etc;

- there would be perfect communication between and among the key agencies involved: the university schools of health, medicine, nursing, etc; the professional organisations; the individual mentors; and the communities[vii];

- it would be well-resourced and equitable for all health professionals - medicine, nursing, allied health, pharmacy, health service managers, dentists; the students' travel, accommodation and IT needs would be covered, as would the mentors' and communities' costs, and remuneration for time spent by the teachers and mentors;

- it would be stimulating and enjoyable for rural health practitioners and not seen as an additional burden of practice;

- there would be systems for ongoing monitoring and evaluation of the regional and national impact of placements in all health professions;

- communities would benefit from the additional resources provided by regular student placements, and from having current evidence-based practice being taught within their health service facilities; and

- flexible models would be offered that were appropriate to the size of the community and that contributed to the infrastructure and well-being of the host families or communities.

The concept of Rural Centres of Health Education could be advanced where there are rich clinical, social and community experiences available and sufficient resources to manage larger numbers of students over extended periods of time. There also needs to be increased support for clinical teachers – perhaps through dedicated clinical units where students from several disciplines work under direct and indirect supervision with a defined group of clients/patients.

The benefits on the ground of this quality system would be far reaching. Health professionals would have happy rural experiences and be looking forward to returning to a rural area. They would develop relationships with other health professionals that would last them a lifetime and stand them in good stead in clinical and personal terms. The teachers and mentors in rural and remote areas would have reasonable and happy placement loads, for which they would be recompensed and recognised. The universities would turn out better practitioners for the richness of the practice experience which necessarily comes from rural and remote clinical experience. Governments would get good returns on their 'placement dollar'.

Because rural and remote areas need 'whole health teams', the Alliance is interested in the possibility of **joint placements**: medical, nursing and allied health professionals sharing placements together as a learning and working team.[viii] Multi-disciplinary experience is a neglected aspect of student placements. Multi-disciplinary practice and new forms of practice (such as nurse practitioners) are a reality, especially in remote Australia. These make ideal learning settings for students. There are existing examples of innovation in this area. The UDRHs are among those agencies developing and implementing inter-professional education (or "multi-professional learning") programs for health students in rural and remote Australia.

Special attention and additional resources are needed to develop the quality placement system outlined here. While there is recognition of the need for better structures and support for rural clinical experiences in undergraduate education, the tight and competitive economic environment of the universities and the health sector reduce their capacity to provide them. Staff cuts affecting health services in rural areas, and the general maldistribution of health professionals, reduce capacity to provide teaching and supervised learning. The Alliance has called elsewhere for government initiatives to increase the number of university places for health undergraduates.[ix] This will help increase the number of rural practitioners, but it will also further increase the demand for rural placements and put further pressure on the parties involved.

In considering the quality and number of rural placements, proper account must be taken of the role of the communities, the health facilities, and the rural health professionals who will be looking after the students. Being properly looked after is an important part of a positive experience. Rural health services and their staff are already stretched and busy, as are rural health providers in private practice, like GPs and allied health professionals. For them to see the placements as positive experiences, they need to be fully informed about timings and expectations, reimbursed for the reasonable direct costs involved, and given credit for their efforts.

Good mentors are critical for all health students on placement. Financial support for mentors is currently different for different disciplines. For instance in north-western Queensland the medical mentors are remunerated while the nurses are not. Yet according to one correspondent:

> "The students placed on single nurse posts or with nurses in larger places consistently report greater learning opportunities and maintain ongoing contact with their mentors post-placement. I would like to see equitable remuneration for all mentors ie, if they are mentoring a student through a rural placement, they receive recognition of that work to the same value, regardless of what professional group they and the student come from." (personal communication from a nurse academic)

It is clear from first principles that the keys to a successful rural placement system are information and resources. Everyone involved needs to know what's happening and when, and what are the expected activities, reports and acquittal requirements. Good information will ensure that those on placement arrive and stay at times that are not locally difficult. Resources are needed to support travel, accommodation, remuneration and IT services. There must also be work and resources to ensure that the placements are safe for the students involved.

RECOMMENDATIONS

1. National and State Governments should collaborate with student bodies, rural communities, universities and professional bodies to agree on a set of standards for rural placements for health students, to be implemented regionally through government programs and those of the universities and professional associations. The standards would relate to travel, accommodation, financial commitments, community support, evaluation, information and reporting requirements. The standards should be widely publicised so that all parties are aware of them.

2. These same standards should be the basis of funding and other support provided to the rural placement system. The Department of Health and Ageing should work to ensure that financial support is available for students, mentors, supervisors and preceptors for rural placements – in nursing, health service management, allied health and medicine. The resources for student support should be provided through the universities. The resources for mentors, supervisors and preceptors should ideally follow the student and be provided as Commonwealth specific grants or budgetary allocations to the States quarantined only for student teaching in rural sites.

3. A specific paper on placement accommodation should be developed by the National Rural Health Network, circulated to stakeholders for endorsement and presented to the Minister for Health and Ageing for attention. It would include consideration of accommodation available for students across all health professions on rural placement.

4. The NRHA will collate information from its Member Bodies about the preceptoring and career development resources they hold or are developing and, assuming copyright permissions, will make a list of them available.

5. The UDRH network will continue to provide high quality student accommodation that is not discipline-specific, and will work with Rural Clinical Schools and others to maximise access by all students to good accommodation and other infrastructure.

6. Consideration should be given to creation of a national database of student rural accommodation to facilitate priority setting and systematic approaches to meeting gaps at a national, State and regional level. The database would be developed and maintained through joint collaborative action of health agencies, local authorities and universities. It would list details of student accommodation available in rural, regional and remote areas. Funding for the database would be provided jointly by the Australian and State/Territory Governments.

7. Funding should continue to be provided to support the training of Indigenous and non-Indigenous health service managers for placements in rural areas within both mainstream and non-government health services.

8. There should be a protocol prepared relating to IT services and support for students on placement in rural, regional and remote areas. Such a protocol would seek greater uniformity between the Universities and other health training institutions in relation to information technology services provide for students on placement.

9. Consideration should be given to ways in which the taxation system could be used to produce incentives to individuals, local authorities and health professionals involved in the rural placement system. Local investment by Councils and practitioners needs to be recognised and rewarded.

10. As part of the overall evaluation of workforce recruitment and retention initiatives, the Australian Government should support data collection to track students undertaking rural placements.

ACKNOWLEDGEMENTS

Thanks to all of those who contributed to this Position Paper, in particular our 23 Member Bodies and their delegates to Council, and a number of other special friends.

REFERENCES

[i] Simmons D, Bolitho LE, Phelps GJ, et al. Dispelling the myths about rural consultant physician practice: the Victorian Physicians Survey. *Med J Aust* 2002; 176: 477-481.

[ii] Brooks RG, Walsh M, Mardon RE, et al. The roles of nature and nurture in recruitment and retention of primary care physicians in rural areas: a review of the literature. *Acad Med* 2002; 77: 790-798.

[iii] Laven GA, Beilby JJ, Wilkinson D, McElroy HJ. Factors associated with rural practice among Australian-trained general practitioners. *Med J Aust* 2003; 179: 75-79.

[iv] Wilkinson D, Laven G, Pratt N, Beilby J. Impact of undergraduate and postgraduate rural training, and medical school entry criteria on rural practice among Australian general practitioners: national study of 2414 GPs. *Med Educ* 2003; 37: 809-814.

[v] National Rural Health Policy Forum 1999.

[vi] see for example *Rural Telecommunications – Current Status*, A paper for the National Rural Health Alliance, July 2003 – available at www.ruralhealth.org.au

[vii] Baker PG, Dalton L, Walker J. Rural general practitioner preceptors - how can effective undergraduate teaching be supported or improved? *Rural and Remote Health 3* (online), 2003: 107. Available from: http://rrh.deakin.edu.au

[viii] One correspondent writes: "I support fully the principle of inter-professional collaboration. However, it involves deliberate planning and resultant action well before any clinical placement. It does not just 'happen' when on placement. Nursing students attend placement with specific nursing competencies and psychomotor skills that must be achieved, as do other professions with respect to the requirements of their placements and their Course I am sure. The question needs to be asked: What makes rural placement different, so that inter-professional collaboration is more important in those settings that at any other placement? How have students from the different disciplines been socialised to collaborate prior to attending their placement? What outcomes are sought from such collaborative processes? How do these relate to improvements in client care, for example? How is the potential synergy that may result from inter-professional collaboration evidenced - ie in clinical decision making, research activities, organisational models of care and clinical governance, and so on? There are many other issues to discuss re team collaboration and it is important to separate the idyllic rhetoric from the reality. The concept has much to offer, yet I think it has to be presented realistically and in an informed way."

[ix] *Australia & the global supply of health professionals*, Policy Portion 2004(2), NRHA, Canberra, 2004.

Visit 'Publications and News' at www.ruralhealth.org.au for all the Alliance's policy documents on rural and remote health.