

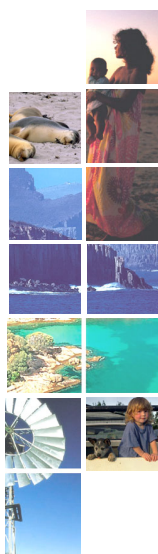
UNIVERSITY DEPARTMENTS OF RURAL HEALTH SYMPOSIUM

Addressing rural and remote health workforce issues: what role for University Departments of Rural Health?

This interactive symposium explored how the eleven University Departments and Schools of Rural Health (UDRHs) across Australia can maximise their contribution to building and maintaining an adequate, skilled, responsive and sustainable health workforce in rural and remote Australia. Over one hundred participants were crammed into the Woolstore Theatre, and many latecomers were unable to get in the door.

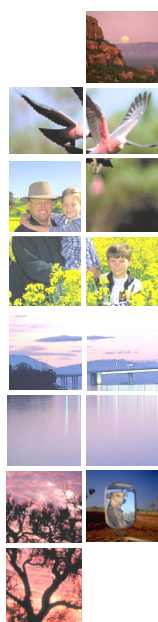
The ARHEN Chairperson, **Professor Judi Walker** (Director, University Department of Rural Health, Tasmania), acted as Master of Ceremonies for the symposium. A panel of speakers from the UDRH sector provided brief keynote presentations to highlight the diversity of Australian rural and remote health and workforce issues. Each panel member explored a different issue and challenge in the health workforce area. The panel comprised:

- **Professor David Lyle**, Director, University of Sydney Department of Rural Health, Broken Hill, who spoke on education and training programs for the rural and remote health workforce.
- **Professor John Beard**, Director, Northern Rivers University Department of Rural Health, Lismore (University of Sydney and Southern Cross University), who discussed how health research in rural and remote areas can contribute to workforce recruitment, retention, and development.
- **Associate Professor Marlene Drysdale**, Lecturer, Monash University School of Rural Health, Traralgon, and **Mr Jason Mifsud**, Indigenous Health Liaison Officer, Greater Green Triangle University Department of Rural Health (Flinders and Deakin Universities), who spoke on workforce issues in relation to Aboriginal and Torres Strait Islander health.
- **Associate Professor Dennis Pashen**, Director, Mount Isa Centre for Rural and Remote Health (James Cook University), who discussed professional support and development programs as a workforce strategy.



These short presentations were followed by interactive discussion between the audience and a panel of University Departments and Schools of Rural Health, around three key questions:

- What are the key factors that get health professionals out to rural and remote areas, and keep them there?
- How can education and training programs, professional support programs, research programs, and Indigenous health programs, make an impact on rural and remote health workforce recruitment and retention?
- How well are the University Departments and Schools of Rural Health working with other key players on workforce issues in rural and remote areas; and how can these working relationships be enhanced?



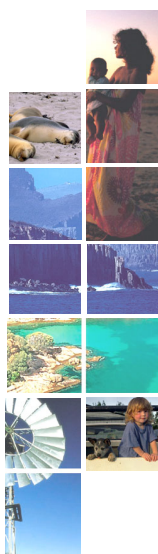
Introduction

Judi Walker, University of Tasmania Department of Rural Health

The University Departments of Rural Health (UDRH) program is a Commonwealth Government initiative focused on expanding and enhancing the rural and remote health workforce through education and training, research, professional support, and service development. Eleven Departments and Schools of Rural Health are now in place, strategically located in regional settings in every State and the Northern Territory. The Departments provide education and training opportunities for medical, nursing, and allied health professionals working in rural and remote areas, and for students to practice their skills in that environment. They also conduct research and development work on rural health and workforce issues.

The Australian Rural Health Education Network (ARHEN) has been established to link and support the UDRHs across Australia. ARHEN aims to optimise the outcomes of the UDRH program by facilitating co-ordination and collaboration between the individual UDRHs, and by adding value to the strategic direction of the program as a whole.

Individually, the UDRHs have already made a significant contribution to addressing health workforce needs in their regions. With the establishment of a national network, the UDRHs now have greater capacity to work together as key players in addressing rural and remote health issues at the national level.



How can education and training programs make an impact on rural and remote health workforce recruitment and retention?

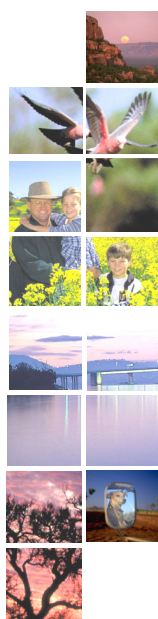
David Lyle, University of Sydney Department of Rural Health, Broken Hill

It is interesting to note that when we talk about what key factors get health professionals out to rural and remote areas and keep them there, we often couch our response in the negative: that professional isolation, social dislocation and lack of succession planning are responsible for people's reluctance to live and work in the country. Examining this question from a positive stance, there is a growing evidence base for specific personal attributes, environmental and other factors that are associated with a decision to commit to rural practice, such as rural origin, improved access to continuing education, and adequate opportunities for leave and locum relief. To these we can add a long list of issues derived from our experiences, personal opinions, hunches and other untested hypotheses, much of which has informed or influenced the development of education and training programs aimed at having a positive impact on the rural and remote health workforce.

Education and training programs and related activities can make an impact in the following ways:

- Facilitating entry of rural residents to medicine and health science courses: Rural background strongly predicts whether a health professional is in rural practice. By increasing the number of rural residents entering the health professions, we should be increasing the likelihood of graduates choosing a career in rural health.
- Making tertiary education more accessible to rural residents: Access to ongoing professional development and further education has been identified as a key issue in a health professional's decision whether or not to go out to a rural or remote area.
- Developing courses that prepare health professionals for rural practice: It is now recognised that health professionals require targeted training to provide them with the broader knowledge and skills base on the range of health conditions found in rural communities than do health professionals in other settings.
- Promoting rural health practice to medical and health science students: The majority of medical and health science students have limited exposure to country life. It has been government policy for a number of years that students undertake some of their training in a rural or remote area to promote rural health practice.

The University Departments of Rural Health are addressing each of these issues in their education and training programs. A summary of some key initiatives is provided below.



Student attachments

Each University Department manages rural placements for medical and health science students coming to their region. Large numbers of students access this program. Last year over 2,000 students were placed throughout the UDRH network. The scope and range of rural placements has grown in the five years since the network was established, and includes general placements, rural intensive programs for discipline specific or multi-professional groups, elective terms, and John Flynn Scholarship Scheme students; and it continues to diversify taking advantage of local opportunities. The students have access to educational resources and support not previously possible in the more remote locations in which many of the Departments are located, thus fostering in students a greater appreciation of, and familiarity with, rural communities and the importance of health care delivery in the rural setting.

Academic programs

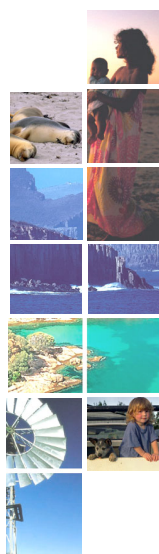
The UDRHs have committed considerable resources to developing courses that prepare health professionals for rural practice, thereby filling gaps caused by lack of accessible or available programs, rather than duplicating existing offerings. With the UDRHs forming an integrated network of academic units across the remote regions of Australia, it is not coincidental that courses such as the Masters of Remote Health Practice and Remote Health Management offered through the Centre for Remote Health at Alice Springs, or the Diploma/Advanced Diploma of Indigenous Primary Health Care and Graduate Certificate in Population Health Research Methods offered through the Broken Hill and Northern Rivers University Departments of Rural Health, have been developed.

Educational infrastructure

Considerable investment in educational infrastructure in the various centres and regions hosting a University Department of Rural Health has also had a big effect. In the centres, campus facilities have been built, including seminar and lecture rooms; which along with library services, computer and internet access, videoconferencing, and regular visits by city-based academics have transformed the health educational landscape in the outback. In other locations such as Tasmania, a number of clinical teaching sites have been established in smaller communities which provide bases for education, research and support, also offering access to the University's library and IT networks and residential accommodation. Provision of comfortable, well-appointed staff and student accommodation is a priority for the UDRHs, and feedback on investments to date indicate that they have made a good impression on students and staff alike.

Academic partnerships and advocacy

UDRHs play an important role in facilitating the delivery of a range of rural experience and placement programs in affiliated health science faculties and departments, in a move towards establishing inter-professional education and research programs and the delivery of jointly supported educational courses to rural practitioners. The UDRH network is also actively advocating for the educational needs



of rural health professionals – to their affiliated universities, with partner health service organisations, and to government.

High schools health careers promotion

The next generation of rural health professionals is still in high school. The UDRHs have joined with other rural health educational and service organisations to promote health careers to secondary students in the country.



The impact of research programs on workforce recruitment and retention

John Beard, Northern Rivers University Department of Rural Health

Research can play a key role in increasing recruitment and retention of clinical staff. This may occur through both the impact of workforce related research that informs workforce planning, and through the direct impact of research capacity itself on existing or potential workforce members.

The key elements of effective workforce related research are to provide accurate information of workforce and health needs and to assess how well the current workforce meets these needs. For example, there are still significant information gaps around the appropriate models of care for rural and remote Australia. Should health care delivery be thought of differently than in urban parts of Australia and, if so, does this mean rural and remote workforce needs are different? Is there a difference in the skills required by clinical staff in rural and remote settings? Once the most appropriate models of service delivery have been identified, research can then explore the gaps between these ideal models, and current distribution.

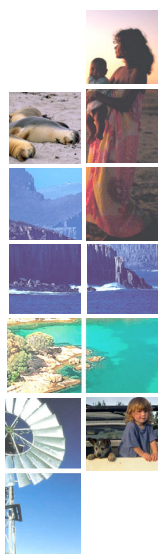
Just as importantly, workforce related research can evaluate innovative solutions to both delivery and workforce problems. A good example here may be the role of nurse practitioners in rural Australia.

Unfortunately, there is still a limited evidence base with which to answer these questions. One of the key strategies that has been developed to address workforce shortages in rural Australia has been the development of University Departments of Rural Health and Rural Clinical Schools to expose students to rural practice in the hope this will lead to many of them returning to rural areas after graduation. While what evidence there is would support these strategies, it is important that they are well evaluated, not least because their cost implications are large.

The *Rural Students Tracking Study* currently being conducted by the University of Tasmania is a good example of such workforce related research. It aims to answer two key questions.

- Are present policies and funding initiatives to increase the supply of health professionals in rural and remote areas effective?
- If undergraduates either come from rural areas or have systematic exposure to rural health issues and experiences during training, are they more likely to choose to spend significant periods of their professional practice in rural/remote areas?

This study is comprehensive and prospective and beyond the scope of this presentation. However, an early component involves a cross sectional study of students looking at such things as their rurality. The early results raise as many questions as they answer. Why is the proportion of students from a rural background much greater in health and life sciences and nursing schools than for medicine and pharmacy? By exploring these and other issues this and other rigorous studies of this



nature will inform future strategies and investments and ultimately improve workforce recruitment and retention.

The other key impact of research on rural workforce is the direct effect of enhanced research capacity in rural areas. An academic presence in rural areas can potentially have a number of significant benefits.

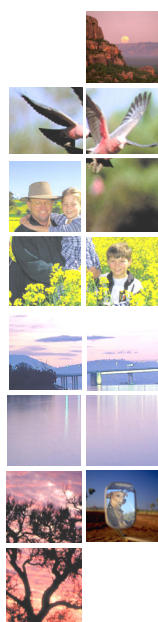
Firstly, a rigorous academic presence can encourage the development of better models of care and improve the quality of health service delivery. Such a presence can also shift the culture of health services towards one of continual evaluation and quality improvement. These are models that are generally accepted in urban areas.

An academic presence can also directly improve recruitment and retention by ensuring clinicians practicing in the country do not have to step off the career escalator. I believe that one of the biggest barriers to recruiting clinicians to rural areas is that at the moment it has become an either/or decision. At one point in their lives clinicians are expected to make the decision to move to the country with little thought to any later reintegration into urban practice. An alternative model that might be worth exploring is where people's careers are actually enhanced by a period of working in rural Australia. In the 1970s, a whole generation of public health professionals were attracted to work in New Guinea and when later applying for Australian positions found this experience was regarded as an advantage rather than a disadvantage. I would challenge whether the same can be said for clinicians working in rural areas. Yet rural areas are often the places where clinicians can gain the broadest experience most quickly.

One of the ways to facilitate such an approach is the use of academic appointments. A clinician with an academic bent may find themselves facing many years of urban practice to progress to a more senior level on the career ladder. One attractive alternative may be for key clinical positions in rural areas to be linked to a senior academic appointment. This would need to be "real" and to encourage links to other centres of excellence as well as involve a local research and teaching program. It may mean, however, that the clinician at a later date could return to an urban area with enhanced career prospects rather the generally diminished prospects they might otherwise expect.

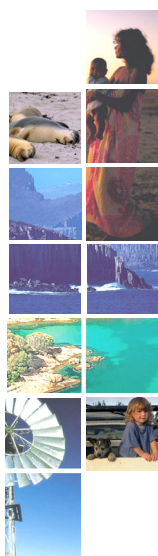
Another way that rurally based research can impact workforce development is by attracting resources. The vast majority of health research grant funding currently spent in Australia is invested in urban areas. By building significant rural research capacity, an increasing proportion of these funds can be directed to rural areas with a significant benefit to local capacity.

Finally, and perhaps most importantly, rigorous research can reorient the external perception of rural areas from that of a problem to that of an opportunity. In many cases, rural areas present research opportunities that are significantly greater than their urban counterparts. Rural communities generally relate closely to clearly identified health services. This is unlike the urban setting where an individual living in the Western suburbs of Sydney may in fact access health services in Northern Sydney. This allows for a far more holistic overview of communities and their health service utilisation, and provides a potential social laboratory for a number of population targeted interventions. Evidence from two trials on the Northern Rivers in



the fields of asthma and hay fever suggests that rural individuals may also be more likely to respond to an invitation to participate in clinical trials.

Rural research may also inform practice far beyond simply the rural setting. One example is the “Stay On Your Feet” program run on the North Coast of New South Wales in the 1990s. This program targeted the regional population of 500,000 people and was intensively evaluated by following cohorts of over 2000 older people in both the study area and a control region. The evaluation clearly demonstrated a significant impact on falls related hospital admissions, which has been sustained over time. These results were a key driver behind current Australian falls prevention policies. It is difficult to visualise how such a study might have been undertaken in an urban area.



Health workforce issues for Aboriginal and Torres Strait Islander people in rural and remote areas

Marlene Drysdale, Monash University School of Rural Health, **Jason Mifsud**, Greater Green Triangle University Department of Rural Health (Flinders and Deakin Universities)

For the Indigenous community, there have been major difficulties in attracting and retaining medical and allied health professionals into the Aboriginal Medical Services or to work in Aboriginal and Torres Strait Islander communities. A key recent report on Indigenous health noted that “One of the biggest things you battle against as a health professional in remote areas, is turnover of staff. It is extraordinarily expensive to be always recruiting and trying to bring people up to speed so that there is safety for them and safety for the people they are looking after” (Commonwealth of Australia, 2000, *Health is Life: report on the inquiry into Indigenous Health*, AGPS, Canberra, p 102).

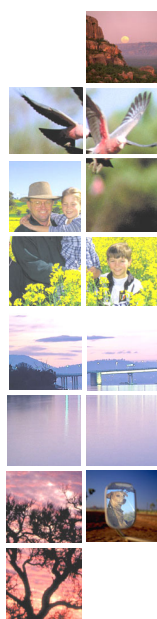
It has also been identified that difficulties in recruiting and retaining staff resulting in inadequate staff numbers, relate to lack of professional support available in remote area, inadequate remuneration, lack of appropriate housing, lack of family support and lack of cultural knowledge.

There is clearly a need to improve the training of the non-Indigenous workforce in cultural matters, to ensure mainstream services are more responsive to Indigenous health needs. At the same time, efforts must be made to increase the number of Indigenous health professionals, including Aboriginal and Torres Strait Islander Health Workers, doctors, nurses, and allied health professionals.

In order to close the current gap between the need for and the supply of health professionals for rural and remote Indigenous communities, the following areas need to be addressed:

- cultural awareness training and proper preparation
- adequate staffing numbers to avoid burnout
- professional support to maintain standards
- adequate staff housing
- organisational stability
- varied and challenging work
- appropriate remuneration and professional recognition.

Indigenous health needs to be recognised as a priority throughout the primary health care sector, and in education and training programs. In addition, a concerted effort is needed to recruit and retain Indigenous medical and health students through incentives such as scholarships, bonded places or priority numbers.



Research methodology, ethics and protocols should be recognised in the context of Indigenous needs and aspirations, with Indigenous researchers being trained by departments to be an integral part of research processes.

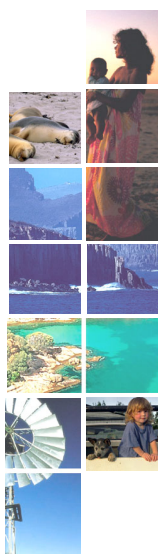
Education and training in Indigenous health and cultural awareness should be a compulsory part of the medical, nursing and allied health programs within our Universities. Cultural awareness training should also be included in professional development sessions for all staff.

Health promotion campaigns should include Indigenous perspectives that have been developed within communities for the target groups, to ensure their relevance and the impact of the messages they seek to convey.

There are often unrealistic demands placed on Indigenous workers, and expectations that the Indigenous community is accessible at all times. University Departments need to recognise and accept Indigenous staff members' commitment and responsibilities to communities, which include the protection of family and community culture and knowledge. Indigenous staff are part of their community and as such there are often demands and needs placed upon the worker from two different sources resulting in high levels of burn out and staff turnover, particularly within Indigenous health worker environments, which then leads to a lack of continuity of programs and fragmented worker-patient relationships.

University Departments and non-Indigenous staff need to recognise and speak for their own culture, not anyone else's. Indigenous people have the knowledge and expertise to speak for themselves.

There is a need to understand the relationship between land and healthy lifestyles. Loss of land, language and culture has led to a sense of helplessness, and this has continued to develop through racism, prejudice and discrimination. Indigenous workers need to be supported by their Departments, and non-Indigenous staff need to understand the historical and contemporary position of Indigenous people, as a prerequisite for culturally safe workplaces.



Professional support programs as a workforce strategy

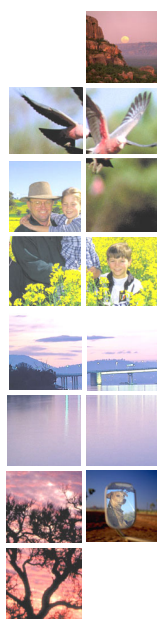
Dennis Pashen, Mt Isa Centre for Rural and Remote Health

The range of professional support programs currently offered by the UDRHs are defined by being multi-disciplinary, and by being vertically and horizontally integrated. Whilst the initial focus of the UDRHs was upon medicine, population health and Indigenous health, they were quickly expanded into nursing and allied health, especially pharmacy. The needs of the communities, their health workforce, and a range of external partnerships with key organisations essentially drove this process.

Current support programs take advantage of associations between individual UDRHs and a range of other agencies, from schools and departments within universities, to external government and non-government stakeholders including Divisions of General Practice, Rural Workforce Agencies, regional GP training consortia, professional colleges and associations, community organisations, and so on. The majority of professional support structures relate to education and research, where grant funding from the Commonwealth in particular is supporting relevant activity. A couple of case models are described below.

Case model 1: Centre for Remote Health, Alice Springs

The Centre for Remote Health (CRH) has an involvement in a number of activities in remote general practice education and support. These activities include their GP Educator working for the local Regional training consortium. These roles include vocational training, encompassing local GP Registrar education, external clinical teaching visits with GP Registrars, GP Registrar workshops, the provision of professional development for GP Supervisors at face to face annual workshops, and preceptor support through the course Introduction to being a GP supervisor in the NT. The delivery of this course by teleconference makes it appropriate for remote GPs. CRH also provides a Continuing Medical Education program for Central Australia, in conjunction with Central Australian Division of Primary Health Care.



Case model 2: Mt Isa Centre for Rural and Remote Health

The Mt Isa Centre for Rural and Remote Health (MICRRH) provides an integrated professional development program for Northern and Western Queensland. The activities include hospital-based Junior House Officer education and training in an integrated curriculum, articulating with the Australian College of Rural and Remote Medicine, involving Post Graduate Year 2-5 intern training; multi-disciplinary Grand Rounds, videoconferenced out to remote communities; a Visiting Specialist Lecture program involving House Officers, General Practitioners and Remote Specialists; procedural workshops for regional health professionals; and a Primary Health Care Research, Evaluation and Development (PHCRED) program for House Officers, Divisional Staff and General Practitioners, encompassing research methodology, evidence-based medicine and practice, literature reviews, and publication skills. In

addition, joint work with other training providers such as the local Division, the regional General Practice Training Consortium, the Rural Workforce Agency, and Indigenous communities and organisations, result in a range of collaborative professional support programs being offered.

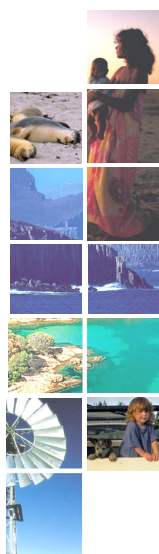
Similar programs exist in most of the other UDRHs, and match the professional support of the local workforce and communities. Many have taken an allied health approach as there have now been co-located Rural Clinical Schools, which tend to focus upon medicine. Other examples of innovation in professional support in the UDRH sector include:

- University Department of Rural Health, Tasmania: The provision of programs including Medication Management for Registered and Enrolled Nursing; Responding Appropriately to Domestic Violence Program; Rural and Remote Midwifery Program; Postgraduate Programs for Allied Health, Allied Health Research, e-Health; suicide prevention programs; and the PHCRED Program.
- University of Melbourne Department of Rural Health, Shepparton: GP Training Consortia Programs, (Bogong); physicians' recruitment program with the Royal Australasian College of Physicians; and research programs including PHCRED.
- Combined Universities Centre for Rural Health (Geraldton): GP recruitment program; Indigenous Health Workers Education Program, offered collaboratively with the Kimberley Aboriginal Medical Services Council (KAMSC); and PHCRED.
- University of Sydney Department of Rural Health, Broken Hill: Education and training programs for Medicine, Indigenous Health Workers; Wilcannia Coordinated Care Trial support and evaluation; Public Health Traineeship through the Faculty of Australasian Public Health Medicine.

As these examples illustrate, the various UDRHs provide support across a wide range of professional disciplines. Whilst they have the usual University roles of providing undergraduate, graduate and postgraduate education, they have a brief to develop health workforce in rural and remote communities. They participate in Regional Training Consortia for rural and remote general practice training, CME activities through relationships with Divisions of General Practice and workforce agencies, and education programs for salaried Junior House Officers and Overseas Trained Doctors.

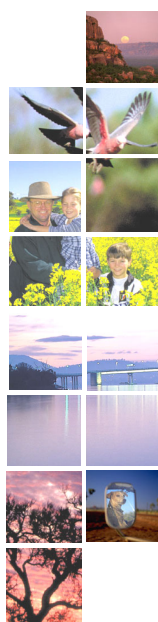
They have approached this task in a variety of ways, which frequently rely upon the unique networks of their local community.

The development of capacity in population health and Indigenous health, research in rural and remote health has required a more lateral approach. Partnerships with local communities and health service providers such as the Wilcannia Coordinated Care Trial allow an academic participation into innovations of health service delivery. This partnership includes NSW Health, the Royal Flying Doctor Service, Wilcannia community, and the Aboriginal Community Controlled Health Service for the area. Integral with this process is the development of Indigenous Health Worker skills and knowledge that is provided by the UDRH in Broken Hill via a degree course in Indigenous Primary Health Care. Similar approaches occur elsewhere: for example, the Kimberley Aboriginal Medical Service Council has an ongoing working relationship with the Geraldton and Mt Isa UDRHs. KAMSC currently provides on



site accredited training programs in Western Australia, and through a partnership with James Cook University and MICRRH, has its curriculum delivered in North Queensland through an alliance called Northern Australian Indigenous Primary Health Education Consortium (NAIPHEC).

The outcomes of the UDRH program are to be subjected to ongoing evaluation both by the Office of Rural Health, and their own organisations. The program is young, with the oldest being six years old, and the youngest only twelve months. Workforce capacity building timeframes are usually measured in decades rather than election cycles, and hence the ongoing commitment of government to the UDRH program has been crucial to the positive outcomes that are just beginning to appear.



Symposium recommendations

As an outcome of lively discussion between the audience and the panel, the following recommendations were drafted from the ARHEN Symposium:

1. A co-ordinated strategic approach to promoting health professional careers in rural and remote areas to high school students, including Indigenous students, is needed.
2. A funded national strategic approach to rural and remote health research is needed, building on the existing infrastructure of academic units in these areas. This approach would include Centres of Excellence for health research in rural and remote areas.
3. All tertiary health professional courses should include a serious, examinable rural health stream, and mandatory time spent in rural and remote areas.
4. Serious efforts are needed to increase the numbers of Indigenous students accessing tertiary health professional education and training. As part of this, every University needs an Indigenous employment strategy.
5. A close working relationship needs to be developed between University Departments of Rural Health and Rural Clinical Schools.

