



EVALUATION OF THE RURAL HEALTH MULTIDISCIPLINARY TRAINING PROGRAM

Written Submission

Background to the Rural Health Multidisciplinary Training Program

It is well known that there are major inequities in health status for people residing in rural, remote and regional Australia when compared with metropolitan areas. Inequity in access to medical practitioners, allied health professionals, nurses, pharmacists and dentists for rural, remote and regional residents compromises Australia's ability to deliver comprehensive health care to all.

In the late 1990s and early 2000s, the Australian Government established a series of University Departments of Rural Health (UDRH) and Rural Clinical Schools (RCS) to provide an academic network and infrastructure to train rural medical and health professionals with the long term aim of addressing the maldistribution of the health workforce. In 2016 the Department of Health consolidated the UDRH Program, the Rural Clinical Training and Support Program, the Dental Training – Extended Rural Placements Program and the Northern Territory Medical Program into the Rural Health Multidisciplinary Training (RHMT) Program.

Overview of the RHMT Program

The RHMT program now funds a national network of 19 Rural Clinical Schools, 16 University Departments of Rural Health, six dental schools that support rural placements for students across the health disciplines – medicine, nursing, allied health, dentistry as well as 26 regional training hubs. There are 21 universities participating in the RHMT program with current funding of approximately \$200 million per annum supported by the Department of Health until 31st December 2020.

A list of the RCSs and UDRHs funded under the program is available on the Department of Health website:

<https://www1.health.gov.au/internet/main/publishing.nsf/Content/rural-health-multidisciplinary-training>.

The **objectives** of the program are:

- To provide rural training experiences for health students;
- To develop an evidence base for the efficacy of rural training strategies in delivering rural health workforce outcomes;
- To provide support to rural health professionals to improve Aboriginal and Torres Strait Islander health;
- To increase the number of rural origin medical,, nursing, allied health and dental students;
- To maintain well-supported academic networks to enhance the delivery of training to students, junior doctors and specialist trainees.



The RHMT Program Evaluation

KBC Australia has been commissioned by the *Australian Government Department of Health* to undertake an evaluation of the RHMT program. An earlier evaluation of the UDRH and RCS Programs occurred in 2008:

[https://www.health.gov.au/internet/main/publishing.nsf/Content/A3760E61F341B7F5CA257BF0001D73AB/\\$File/udrheval.pdf](https://www.health.gov.au/internet/main/publishing.nsf/Content/A3760E61F341B7F5CA257BF0001D73AB/$File/udrheval.pdf)

The objective of this evaluation is to assess the extent to which the current design and delivery of the RHMT Program is achieving its aim of improving the recruitment and retention of medical, dental, nursing and allied health professionals in rural and remote Australia. The evaluation will also consider the benefits to local health delivery from engagement in teaching and training through the RHMT program.

SUBMISSION

As a component of the evaluation, we are seeking submissions from peak bodies, professional colleges and associations. Please consider the following questions. **Please limit your response to a total of 5 pages and return it to manager@kbconsult.com.au by Friday 6th September 2019.**

NAME_OF_ORGANISATION/PEAK_BODY:_UNIVERSITIES_AUSTRALIA

1. What has been your organisation's engagement and/or experience with the RHMT program to date? Please consider your experience with relevant streams of the program including RCS, UDRH, rural dental training programs and regional training hubs.

Universities Australia (UA) is the national peak body representing Australia's thirty-nine comprehensive universities. UA has engaged with the RHMT program directly through its health professional education and workforce policy and advocacy activities, facilitated by UA's Health and Workforce position. This position works closely with UA's Health Professions Education Standing Group (HPESG – information sheet attached) on matters of health professional/clinical education, workforce development and distribution. HPESG comprises senior leader representatives from all university health professional disciplines and jurisdictions who collectively have experience with all elements of the RHMT program: RCSs, UDRHs, rural dental schools and regional training hubs (RTHs).

UA has a productive relationship and engages regularly with the Commonwealth Department of Health (DoH) which funds the RHMT program. UA also engages on the RHMT program and broader health workforce education, distribution and research issues with multiple health/rural health stakeholders including the:

- Australian Rural Health Education Network (ARHEN);
- National Rural Health Commissioner;
- National Rural Health Alliance (NRHA);
- Services for Rural and Remote Allied Health (SARRAH);
- Rural Doctors Association of Australia (RDAA);
- Regional Australia Institute (RAI); and
- Indigenous Allied Health Australia (IAHA)

2. What is the value/benefit of the RHMT program to your profession or stakeholder group?

The value of the RHMT program is that it supports universities to provide greater rural clinical education experiences for health professional students. This has wider benefits to rural communities and students including: improving workforce distribution; promoting clinical and academic health professional involvement in rural Australia; enabling rural clinical education experiences; and increasing rural health services research.

Education provision in rural areas is costly. The RHMT program helps mediate some of these costs. Without this support, students would miss out on the rewarding experiences of working with rural communities in rural practice. Rural communities would miss out on increased health service delivery, more sustained health workforce, increased grass roots rural health research and the multiple benefits that a university presence in the area brings. These benefits are outlined in more detail in the response to question 5a below.

3. In relation to your engagement with the program, what aspects could be improved?

One area that could be improved is greater funding certainty and transparency for the program. Short term funding adds to the challenge of keeping well trained personnel in rural areas. As outlined in 5a below, there are additional broad-based benefits to rural communities through the strengthened academic presence and infrastructure that the RHMT program affords. These are also put at risk when program funding is uncertain.

Another area for consideration is a carefully managed expansion of the program to international health professional students who commit to working rurally post qualification. (Commitment would be subject to professional registration and Australian residency attainment). Anecdotal feedback to UA from some rural health professional bodies suggests that international students who take up rural positions post-registration are less equipped for rural practice than their domestic counterparts as they generally have less exposure to rural clinical education experiences. A gradual expansion of the RHMT program to international students committed to working rurally could assist.

A further potential area for RHMT program improvement is by enabling closer policy alignment between the DoH and the Commonwealth Department of Education (DoE) to better support their joint policy goals for Australian communities. Universities are undergoing significant change in the current higher education policy environment. A number of these changes have the potential to impact RHMT program delivery including:

- the 2017 funding freeze;
- the introduction of performance-based funding;
- the review of regional education;
- general efforts to encourage more students to study rurally; and
- exploration of international student destination choice (including to rural areas).

UA strongly supports the work and aims of the RHMT program. However, we are concerned that without cross-sector policy development or shared understanding, especially between DoH and DoE, of the broader environment within which universities currently operate and the potential impact this will have, the opportunity for universities to fully maximise the RHMT program benefits may be reduced.

Consideration of possible alignment with, and/or impact on RHMT program delivery from, the range of health workforce programs currently underway in DoH and in DSS (which oversees NDIS workforce policy) is also recommended.

Different jurisdictional approaches can also impact on the delivery of the nationally funded RHMT program, given that many of the health services that students access through the program are state funded. UA recommends exploration of how a more connected COAG approach could assist RHMT program implementation and outcomes.

4. What opportunities are there to strengthen the transition from training in rural locations to working rurally for your profession/ stakeholder group?

A key factor in determining the transition from training to working in rural areas for all health professional disciplines is the availability of sustained, attractive full time employment. A range of factors contribute to this including:

- the availability of dedicated new graduate positions. Beginning practitioners benefit from support and mentoring. However, the small size of some rural health services and existing rural workforce shortages mean this support is often not available;
- options to create full time equivalent (FTE) positions from multiple part-time positions across different sectors (such as aged care, health and disability services). This is particularly the case for certain allied health professions where the patient load in one specific service sector may not in itself support full-time employment but where there is a combined need across different service sectors for an FTE position;
- availability and/or need for certain specialist/sub-specialist skills;
- requirements for certain health professionals to operate in, or at times, establish, private practice models. Rural areas can lack the population base to support viable private practice models. This thin-market issue can be a workforce deterrent.

Policy that helps address these issues could support transition to rural work. Some possible ideas include:

- Extending the regional training hubs (RTHs) to facilitate allied health and nursing, in addition to medical, students. RTHs currently help foster rural employment pathways for medical students interested in rural practice.
- Supporting broader university-health service provider partnerships to foster training and transition to employment pathways
- Working with Primary Health Networks (PHNs) on models where PHNs can employ allied health professionals to work across sectors in the PHN catchment area.

Many ideas to support transition to rural work from training have also been proposed in UA's recent submission to the rural allied health consultation (attached) and UA refers the evaluator to this document.

5. In considering the appropriateness of the RHMT program as a continuing response to addressing rural health workforce shortages and improving workforce distribution:

a) To what extent is the development and maintenance of academic capacity and training infrastructure in rural and remote areas the right approach to improving workforce outcomes for your profession/ stakeholder group? What else is required?

Maintaining the academic capacity and training infrastructure provisioned through the RHMT program is an essential component of enhancing rural health workforce outcomes for the following reasons:

- it improves access to health workforce through increasing the number of health professional academic staff and students in rural areas. A range of additional and/or augmented health services have been made possible by the RHMT program through, for example, student-led clinics, outreach approaches, extra occasions of service;
- it reduces the professional isolation of health and other professionals in rural locations so contributing to increased rural workforce retention;
- it offers enhanced education/upskilling services for existing health personnel to maintain practice currency and evidence-based care delivery;
- it establishes a university presence in rural areas. This is critical to building health professional career aspirations and to showcasing further education opportunities to rural school students. Strengthened relationships with universities also offer the potential for additional academic teaching and research capacity in other areas;

- it furnishes inter professional education opportunities which are important aspects of health professional training and practice;
- it contributes to expanded rural health-services research and adds to knowledge about rural workforce models; and
- while the RHMT program is usually managed under funding agreements with a single host university, each facility often supports student placements from multiple universities. This enables a broader spread of students to experience rural practice.

In addition to these direct health workforce outcomes, the RHMT program infrastructure and academic capacity often boosts rural centres and helps them to prosper more generally. This is consistent with work currently underway through the Regional Australia Institute exploring the role of regional health hubs in supporting economic growth in rural centres.

What else is required?:

Sustained levels of funding are required to support access to accommodation under the program. Accommodation remains an area of unmet need in relation to rural clinical education. While such accommodation has increased with expansion of the RHMT program, multidisciplinary student accommodation is still insufficient: many rural - and particularly remote - areas lack suitable, affordable accommodation. Funding is also required to support multidisciplinary students meet their rural living costs while still paying their home-base rental – and, often, simultaneously giving up their temporary home-based employment income. Without such funding, the number of students able to undertake or complete rural placements is restricted.

National longitudinal data¹ that links university education with future practice destinations across a professional lifespan is also needed. This could explore the impact of rural clinical education experiences on the choice of both established and beginning practitioners to practice rurally. There tends to be a focus on measuring success of rural education programs on new graduates choosing rural practice when arguably such graduates are less well suited to rural practice positions than more experienced practitioners. (See also UA's submission to the rural allied health consultation - attached).

One strength of the RHMT program is that it fosters collaboration. A number of students from non-host universities also use RHMT program facilities. UA recommends that the resource implications, funding adequacy and outcomes for coordination and collaboration activities between host and non-host universities and across RHMT program facilities is explored.

The program also strengthens collaboration between universities and health services. As outlined in UA's submission to the rural allied health consultation, these service collaborations could support expansion of the program's regional (medical) training hubs into integrated multidisciplinary training hubs. Such hubs could support longer multidisciplinary training experiences (as appropriate to different disciplines) and provide

¹ Individual universities have their own longitudinal data showing the positive influence of rural placements on rural career choices. UA refers the evaluator to universities' individual submissions for specific examples.

further multidisciplinary health workforce benefits to rural communities. In relation to this, it would also be helpful to look at the proportions of the different disciplines participating in the program across allied health (including dental), medicine and nursing, especially since the separate RCS, UDRH, rural dental schools and RTH components were combined.

Although outside of the direct remit of the RHMT program, it would also be instructive to examine to what extent the availability of suitable rural employment post-registration has an impact on the ability to translate rural education experiences into rural career choices.

b) To what extent is selection of health students on rural origin or interest, and training in rural locations, the right approach to contribute to rural service provision after graduation for your profession / stakeholder group? What else is required?

Evidence shows that student rural origin and time spent training in rural locations are both factors that make some contribution to a health student's future decision to practice rurally. Robust longitudinal data is lacking. As identified in the 2013 Mason Review, long term national data that tracks activity from university education and beyond must be gathered if information about effective approaches is to be attained.

As mentioned above, other factors also contribute to student decisions about rural practice but are outside of the remit of education providers. These include the:

- availability of rural positions - in general and especially for new graduates;
- need for certain disciplines to practice in (and potentially establish) private practices rather than becoming salaried employees in a public health service;
- insufficient need for particular specialties in rural communities and/or lack of FTE demand for particular services within a single service domain.

UA refers the RHMT program reviewer to UA's recent submission (attached) to the National Rural Health Commissioner's (NRHC's) consultation on rural allied health workforce. Many of the above points are addressed in that submission. UA also recommends that the RHMT program evaluation takes the NRHC's recent consultation into account more broadly given the significant areas of alignment between the two.