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Australian Rural Health Education Network

SUBMISSION TO THE SENATE SELECT COMMITTEE ON HEALTH FROM THE AUSTRALIAN RURAL HEALTH EDUCATION NETWORK (ARHEN)

1. Introduction

The Australian Rural Health Education Network (ARHEN) welcomes the opportunity to make a submission to the Select Committee on Health which has been established to inquire into and report on health policy, administration and expenditure.

As the peak body for Australia's 11 University Departments of Rural Health (UDRH), ARHEN (www.arhen.org.au) has a particular interest in the **Committee's Terms of Reference which cover improvements in the provision of health services, including Indigenous health and rural health, and health workforce planning (see part 3 of this submission).**

ARHEN notes that while submissions are due by 19 September 2014, the Select Committee does not provide a final report to the Senate until 20 June 2016. We would therefore welcome the opportunity to be further involved in the process as the Committee develops its report and recommendations.

2. Background

The University Department of Rural Health (UDRH) Program is a very successful program funded by the Commonwealth Department of Health (DoH) as a rural health workforce strategy since the late 1990s. There are currently 11 UDRHs in every State and the Northern Territory (see *Attachment 1*). ARHEN, the peak body for the UDRHs, was established in 2001 and currently receives core funding from DoH.

UDRHs enhance and expand the rural and remote health workforce through multidisciplinary education and training, research, professional support and service development. They are the only rurally based academic units that work with all health disciplines at undergraduate and postgraduate levels and with the existing workforce.

As a group, UDRHs have a commitment to ensuring that the health workforce needs of rural and remote areas are addressed by national strategies. In summary, UDRHs:

- Offer clinical placements and teaching activities to provide rich, authentic learning experiences which prepare students for professional practice in distinctive remote and rural settings.
- Undertake research focused on rural and remote health problems; and develop and test original solutions, including research which may have national and international significance. This research informs the development of accessible and sustainable health services for Australia.
- Work with their communities to build capacity to respond effectively to contemporary challenges in rural and remote health.

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UDRHs operate in situations where workforce shortages are common. Additional resources are always needed to ensure health sciences students are appropriately supervised and supported in these environments. Some examples of how UDRHs build the rural and remote health workforce are at *Attachment 2*.

At the same time, UDRHs recognize that they are an important component of a broader health workforce strategy which has many connected players. They also recognize the importance of connecting new structures such as Primary Health Networks and Rural Training Providers to UDRHs to ensure maximum integration and avoid duplication and gaps. UDRHs train in and for rural and remote communities and will need to continue to build their capacity, including infrastructure and services, in areas less served.

3. Improvements in the provision of health services, including Indigenous health and rural health, plus health workforce planning

The Australian Institute of Health and Welfare reports that:

> *People living in rural areas tend to have shorter lives and higher levels of illness and disease risk factors than those in major cities. It is also true that, on average, people living in rural Australia do not always have the same opportunities for good health as those living in major cities. For example, residents of more inaccessible areas of Australia are generally disadvantaged in their access to good and services, educational and employment opportunities and income.*
>
> *Health outcomes, as exemplified by higher rates of death, tend to be poorer outside major cities. The main contributors to higher death rates in regional and remote areas are coronary heart disease, other circulatory diseases, motor vehicle accidents and chronic obstructive pulmonary disease (e.g. emphysema). These higher death rates may relate to differences in access to services, risk factors and the regional/remote environment.* *(AIHW http://www.aihw.gov.au/rural-health/)*

A lack of health services constrains community growth, with the availability of adequate health services being key to improved health outcomes. It follows therefore that ensuring an adequate multidisciplinary health workforce is vital to achieving accessible heath care in rural and remote Australia. Following are strategies that ARHEN recommends would assist in achieving this outcome.

- ***An education pipeline leads to a rural-ready health workforce***

One of the biggest challenges in rural and remote health is how to develop an available and work-ready workforce. The concept of an education 'pipeline' provides a framework for understanding and developing a rural-ready workforce. Rural background and educational experience are two important inputs to the pipeline and valuable predictors for taking up rural practice. This forms part of the concept of a rural training pipeline or 'joined up' approach which to date has referred mainly to doctors.

The rural health pipeline:

- commences in school, with health careers promotion in primary and high school
- progresses to the tertiary level
- continues with undergraduate followed by postgraduate training with new graduate employment and specialty training for those with intent to practise rurally.

There is a link between longer rural placements/rotations and rural recruitment for internships and other new graduate employment. Rural curriculum and exposure help develop a 'rural-ready' workforce that is prepared for the challenges, isolation, variety – and satisfaction - of rural and remote practice.

- ***Service learning is consistent with a pipeline approach and translates into a much needed work-ready rural and remote health workforce***

The principles of community engaged learning and teaching and student-led clinics provide a framework for the development of a new approach to clinical placements – also referred to as service learning. This innovative approach to the delivery of nursing and allied health clinical training aligns student placement programs to areas of local health need through strong partnering with community organisations and local service providers. It results in improved community access to health care as well as enhanced student learning.

Service learning opportunities are already in place in several UDRHs, with Broken Hill UDRH offering national leadership and international engagement around this vital workforce strategy. The inclusion of service learning programs across rural and remote Australia would result in UDRHs influencing the clinical training, professional development and career choices of an increasingly large proportion of students in the health sciences.

- ***An extended clinical placement program for senior dentistry students who provide services facilitated by an Oral Health Academic (Dentist) would provide a foundation for the future development of an oral health workforce in remote and rural areas.***

There are three times as many dentists practising per 100,000 population in Major Cities (59.5 per 100,0000) as in Remote/Very Remote areas (17.9 per 100,000). At the same time, the maldistribution of the dental workforce impedes timely and affordable access to services for groups such as remote, rural and Indigenous people *(Report of the National Advisory Council on Dental Health, 23 February 2012, pp31-32).* Final year dental students are a major contributor to public dental services across metropolitan Australia. Lack of qualified supervision is the prime rate limiter in placing and utilising students in remote and rural areas.

The establishment of an extended clinical placement program for senior dentistry students would provide supervised clinical training for 4-6 dentistry students on placement with a UDRH for 12+ weeks at a time throughout the academic year. Clinical training would occur in the public dentistry service and students would deliver services facilitated by a qualified dentist.

With funding, UDRHs could employ a rural Oral Health Academic (Dentist) to develop the service learning program, supervise students, establish a Voluntary Dental Graduate Year Program as well as contribute to service delivery in their own right. Access to infrastructure

funding would also be required to expand public dentistry facilities for the program and to meet the relocation costs for the Oral Health Academic. Once established, the new Program would provide a foundation for the future development in remote and rural areas of an oral health workforce.

- ***Develop Aboriginal and Torres Strait Islander Health Academic Leaders in rural and remote Australia who work with communities and regions to build a health workforce and increase the use of culturally safe practices.***

Aboriginal and Torres Strait Islander people are under-represented in the health academic workforce in universities. The Indigenous Higher Education Advisory Council has cited the postgraduate gap between Indigenous and non-Indigenous students and the impact of this on measures to close the health and socio-economic gap for Indigenous Australians, noting specifically that:

'*To achieve parity of participation the number of Indigenous doctoral students needs to more than triple and completions need to increase by more than 600 percent. The task is formidable.*' *(Indigenous Higher Education Advisory Council, Submission to the Review of Australian Higher Education, 31 July 2008, pg 4)*

Our vision is for a generation of rural and remote Aboriginal and Torres Strait Islander academic leaders who:

- work with communities and regions to build a health workforce
- support and lead educational activities, research activities and community capacity building to ensure the delivery of culturally appropriate health care and increase the use of culturally safe practices.

The overall outcome over 10 years would be 11 Aboriginal and Torres Strait Islander health academics with academic capability and skills for leadership roles in health related areas within universities and also the government sector. Such a program would also make a major contribution to the generation of new knowledge about Indigenous health issues in rural and remote Australia, the development and evaluation of health services for Aboriginal and Torres Strait Islander communities, and provision of enhanced education about Indigenous health and culturally competent health practice for the 5,000 plus students and health staff who access training through the UDRH network each year.

- ***Establish a nationally agreed approach to infrastructure investment to support government plans for training and development to meet future health workforce needs***

The UDRH program has a proven record of achievement for over 15 years in rural and remote health education and research and has supported more than 36,000 students to undertake clinical placements in rural and remote locations around Australia. Adequate infrastructure is essential to continue the delivery of high quality health education in rural and remote areas and for rural health research.

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Good facilities – both for student support and for teaching - underpin the most effective programs. Health sciences students on clinical placement in rural areas need access to high quality, safe and affordable accommodation; computers and reliable internet; and transport. Facilities should include access to clinical teaching areas with a range of training and computer and telecommunications equipment.

Achieving a critical mass of students both provides for a more vibrant student and learning culture, and is a more cost effective way to deliver rural health education. It makes sense to build upon the existing expertise of the UDRH program to enhance high quality support for allied health, nursing and also medical students in rural health.

- ***Establish a rural and remote Integrated Health Research Centre (IHRC) to build much needed rural health research capacity***

UDRHs are well positioned to join with other established organisations to form a virtual IHRC. An IHRC would:

- be formed by rurally based organisations
- have an emphasis on applied and translational research and research capacity building
- be focussed on achieving improvements in rural and remote health with a focus on health workforce, population health and health service improvement.

The McKeon Report (2013) noted that, given that rural and remote communities experience significantly worse health outcomes than metropolitan populations, research capacity should be built to better understand/address this gap with a national integrated network or virtual IHRC to lead these efforts. The IHRC would have '*links to other IHRCs and leverage national data platforms for research, streamlined clinical trials processes, and patient record management*', with building Indigenous research capacity as a core role (Recommendation 7).

UDRHs are uniquely embedded within their local health systems and can address health outcomes at community level in ways relevant to the health professional and health service patterns of those communities. This opportunity would take advantage of their demonstrated track record in research, with several punching well above their weight in relation to health research effort.

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Attachment 1

UDRH LOCATIONS AND MAP

UDRH	Locations	University
New South Wales		
Broken Hill University Department of Rural Health	**Broken Hill** Bourke	**University of Sydney**
University Centre for Rural Health, North Coast	**Lismore** Murwillumbah, Grafton, Ballina	**University of Sydney** **Southern Cross University**
University of Newcastle Department of Rural Health	**Tamworth** Armidale, Moree, Taree	**University of Newcastle**
Victoria		
Rural Health Academic Centre	**Shepparton** Ballarat, Wangaratta	**University of Melbourne**
School of Rural Health – Department of Rural and Indigenous Health	**Moe** Mildura, Bendigo, East Gippsland, Gippsland	**Monash University**
Greater Green Triangle University Department of Rural Health	**Warrnambool** Hamilton, Mt Gambier, Burwood	**Flinders University** **Deakin University**
Queensland		
Mount Isa Centre for Rural and Remote Health	**Mount Isa** Longreach, Cloncurry	**James Cook University**
Western Australia		
Western Australian Centre for Rural Health	**Geraldton** Perth	**University of WA** **Murdoch University** **University of Notre Dame** **Curtin University** **Edith Cowan University**
South Australia		
University Department of Rural Health; Division of Health Sciences	**Whyalla** Pt Augusta, Booleroo Centre, Pt Pirie, Minlaton, Maitland, Pt Lincoln, Clare, Kadina/Wallaroo	**University of South Australia**
Northern Territory		
Centre for Remote Health	**Alice Springs** Katherine, Darwin	**Flinders University** **Charles Darwin University**
Tasmania		
Centre for Rural Health	**Launceston** Hobart, Burnie	**University of Tasmania**

Attachment 1

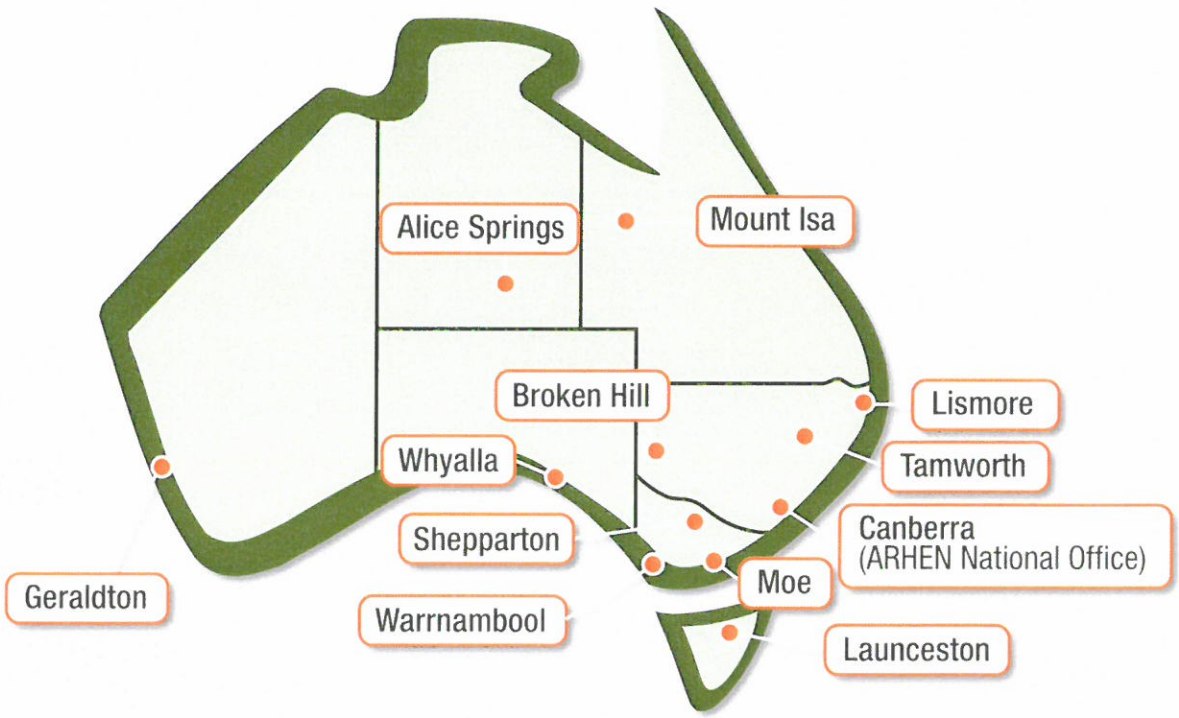
ARHEN

Linking and supporting UDRHs across Australia

Vision - Achievement of better rural and remote health through learning.

Guiding Purpose - To lead and initiate the rural and remote health agenda in the areas of education and research.

ARHEN HAS 11 MEMBER UNIVERSITY DEPARTMENTS OF RURAL HEALTH (UDRH) IN EVERY STATE AND THE NT



ATTACHMENT 2

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HOW UDRHS BUILD THE RURAL AND REMOTE HEALTH WORKFORCE

Workforce is key to accessible healthcare in rural and remote communities. Building a rural and remote health workforce is core business for UDRHs who provide more than 5,000 clinical placements per year in rural and remote Australia. For example:

1. Broken Hill UDRH, NSW

- A long term focus on service learning[1] means this UDRH offers national leadership and international engagement around this vital workforce strategy.
- Service learning opportunities are now available for more students across an even wider range of disciplines than ever.

2. Western Australian Centre for Rural Health, Geraldton, WA

- A new focus on service learning is adding value to clinical placements in rural/remote areas by establishing partnerships to improve healthcare opportunities for residents while enhancing student experiences.
- New infrastructure including the recently opened Education Simulation Centre is providing state- of –the-art opportunities for both students and staff.

3. Mount Isa Centre for Rural and Remote Health, Queensland

- New infrastructure, increased teaching capacity and a focus on service learning has contributed to an increase in both student placement numbers and placement weeks.
- Service learning has also resulted in services such as community rehabilitation for neurological conditions being offered for the first time.

4. UDRH, Rural Health Academic Centre, Shepparton, Victoria

- Developed a pathway for local Aboriginal health professionals to undertake the University of Melbourne Masters in Health and Social Science without leaving their community.

5. University Centre for Rural Health, North Coast, Lismore, NSW

- Significantly increased professional development opportunities for clinicians. This is critical to ensuring students are supervised by professionals operating under contemporary best practice models.
- The approach includes simulated teaching models using staff from residential aged care facilities, the local health district, acute care hospital practitioners, as well as General Practices.

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[1] Service learning aligns student placements with health need through partnerships with community organisations resulting in improved community access to healthcare and enhanced student learning.

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6. Centre for Remote Health, Alice Springs, NT

- A focus on building clinical placement weeks and student numbers has resulted in a doubling of these undergraduate student numbers in the past 2 years.
- Postgraduate student numbers and placement weeks have also increased significantly, further boosting the potential supply of rural and remote health professionals.

7. University of Newcastle Department of Rural Health, Tamworth, NSW

- The quality and quantity of student experiences have been significantly boosted by year-long placements in Physiotherapy, Nutrition and Dietetics, Medical Radiation Science and Medicine.
- This approach also provides time for community engagement, inter-professional learning and core curriculum outcomes.

8. Greater Green Triangle UDRH, Warrnambool, Victoria

- Along with their clinical placement program, also recognised by the Register of Australian Research (ROAR) as Australia's most productive primary healthcare research organisation.
- The Director is Australia's most productive primary health care researcher.

9. UDRH, Whyalla, SA

- Delivers 3,000 educational hours for 500 students undertaking a rural/regional clinical placement each year.
- Developed strategic alliances with other universities, secondary health care providers, Medicare Locals, non-Government organisations and industry to assist in delivery of regional evidence-based health care.

10. Centre for Rural Health, University of Tasmania, Launceston, Tasmania

- Increased research volume output (knowledge dissemination) by a third over three years.
- Won Vice-Chancellor's award for outstanding community engagement, reflecting work with rural and remote communities to improve health services.

11. School of Rural Health, Monash University Department of Rural and Indigenous Health, Moe, Victoria

- Secured almost $3 million additional income over the past 4 years. This has been achieved through rural workforce inter-professional training projects and a State government grant to develop an Australian-first recovery model for parents in Victorian mental health and family services, won by the UDRH Mental Health Academic.