6 Discussion and recommendations

6.1 Overview of outcomes

Overall, there is clear evidence that the UDRH Program and the RCS Program have achieved their initial aims of establishing a functioning educational infrastructure in rural Australia and of increasing support for and, to some extent, capacity within the current rural health workforce. The earliest sites for the Programs have moved past the establishment phase to become more mature agencies of training and research, and in some places innovative partnerships are developing which are enhancing health service delivery. The annual reports for each site and regular reporting mechanisms demonstrate that the sites are fulfilling their obligations according to the requirements which have been made of them through their Program parameters or objectives.

The UDRH and RCS Programs have been described as part of a ‘rural health education revolution’ (Wing 2007:344). The result of this ‘revolution’ has been the creation of a rural health infrastructure where none existed, with resulting opportunities for students, academics, and clinicians to contribute to improving rural health services. The benefits which have accrued can be summarised broadly as the following:

- increased number of health students gaining exposure to rural health services and rural health issues;
- the establishment of educational infrastructure, with facilities which are available to a range of health providers and community groups as well as teachers and students;
- some recent nursing and allied health graduates choosing to take up rural employment as a result of their exposure through a UDRH, and some medical students seeking rural internships or vocational training placements as a result of their exposure through an RCS;
- some clinicians – nursing, allied health, and medical – choosing to remain in rural employment as a result of any of the following: new opportunities to teach or train, ability to undertake research and/or postgraduate studies, perception of increased practical, social or professional support, and/or ability to take an academic appointment while remaining in rural clinical practice;
- some clinicians – nursing, allied health, and medical – choosing to relocate from the city because of the opportunity to accept a joint academic and clinical position;
- enhanced visibility of rural health and its challenges within the university environment;
- increased number of publications with a rural or remote focus;
- new partnerships for innovation in service delivery and health system research; and
- enhanced visibility of the university sector within rural and remote Australia.

Many of these statements cannot be quantified at a national level, and indeed, many cannot be quantified at a local level either due to the fact that the influences on people’s decision-making (regarding choices of career pathway, or decision to remain in rural practice or conversely to leave it) is not always publicly known.

However, sufficient anecdotal evidence exists to suggest that there is an impact on rural workforce capacity through recruitment and retention of health professionals, and through influencing health students’ perceptions of rural health careers. The objective of increasing the workforce through encouraging students to return to the country has been met, to the extent that without a target goal even one student returning to practise in a rural area could increase the workforce. While it was noted by several respondents that it will be impossible to prove causality across either the RCS or the UDRH Program with regard to increasing the rural health workforce, to the extent that the UDRHs and the RCSs have retained or attracted clinicians through opportunities to take up clinical and teaching appointments, the rural workforce has been sustained or increased. The reported increases through recruitment or retention are unlikely at the current level to be sufficient to compensate for rural
workforce decline, but the stories of new graduates seeking rural careers, or of experienced clinicians choosing to remain in the country, do give cause for hope that in time the Programs will contribute significantly to overcoming the current workforce shortage.

Other contributions to a vibrant rural health sector are more amenable to measurement, and such indicators as publications, research projects, or partnerships in health service innovation have been reported by the UDRHs particularly, in their annual reports to the Department as well as in journals, conferences, and other professional fora. There is scope for these activities to increase and every expectation that they will do so as the Programs mature. In order to effectively assess the impact of these Programs longitudinally it will also be important to consider such secondary benefits as:

- improved perceptions of rural health services across the health system through students receiving greater exposure and understanding of the challenges of rural health care, whether or not they return to the country to practice themselves;
- enhanced communication amongst rural and remote practitioners through greater information technology infrastructure, increasing professional and personal support to remote practitioners;
- enhanced clinical and educational opportunities including increased availability of interprofessional education;
- increased number of joint academic and clinical positions, attracting highly qualified and dynamic professionals; and
- overall community benefits such as innovations in health service delivery, increased numbers (or maintenance of stable numbers) of health practitioners, and greater availability of health promotion and population health information and activities.

Each Program has contributed to these secondary benefits, and has made a contribution to the strength of the rural health workforce through engagement with and support for existing clinicians as well as students.

Table 10 overleaf summarises the findings of the evaluation applied to the original hierarchy of outcomes of the evaluation framework. Use of the hierarchy of outcomes may assist in future strategic planning to ensure that progress continues to be made towards ultimate outcomes, and that progress can be monitored.

The remainder of this chapter discusses the key strategic issues emerging from the evaluation and makes recommendations for the future.
<table>
<thead>
<tr>
<th>Hierarchy of outcomes</th>
<th>Achievements to date</th>
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</thead>
<tbody>
<tr>
<td><strong>Ultimate outcomes</strong></td>
<td></td>
</tr>
<tr>
<td>Increased workforce capacity</td>
<td>Contributed – see 4.4.1, 5.4.1, 5.4.2</td>
</tr>
<tr>
<td>Increased training and support</td>
<td>Yes – see 4.4.2, 5.4.1, 5.4.2</td>
</tr>
<tr>
<td>Increased rural health research capability and output</td>
<td>Yes – see 4.4.3, 5.4.3</td>
</tr>
<tr>
<td>Integrated rural health training and support programs</td>
<td>To some extent – see 4.4.2, 5.4.4</td>
</tr>
<tr>
<td><strong>Intermediate outcomes</strong></td>
<td></td>
</tr>
<tr>
<td>Increased recruitment and retention of health practitioners in rural and remote areas through the provision of a positive rural health education experience</td>
<td>To some extent – see 4.4.1, 5.4.2</td>
</tr>
<tr>
<td>RCSs and UDRHs engage with other programs/initiatives within local, State, Territory and Commonwealth Governments</td>
<td>Yes – see 4.4.4, 5.4.4</td>
</tr>
<tr>
<td>There is increased and effective collaboration between UDRHs and RCSs, and also with local educational institutions and health service providers</td>
<td>Yes – see 4.4.3, 4.4.4, 5.4.4</td>
</tr>
<tr>
<td><strong>Immediate outcomes</strong></td>
<td></td>
</tr>
<tr>
<td>Research into rural and remote health issues is taking place</td>
<td>Yes – see 4.4.3, 5.4.3</td>
</tr>
<tr>
<td>Appropriate and effective support provided to health professionals currently practising in rural and remote settings</td>
<td>To some extent – see 4.4.2, 5.4.2</td>
</tr>
<tr>
<td>More rural and remote health practitioners are engaged in education and training opportunities</td>
<td>Yes – see 4.4.1, 4.4.2, 5.4.2</td>
</tr>
<tr>
<td><strong>Activities/Outputs</strong></td>
<td></td>
</tr>
<tr>
<td>Rural Clinical Schools Program – targeted education, training and support for medical students in rural and remote health, and development of support infrastructure</td>
<td>Yes – see section 5</td>
</tr>
<tr>
<td>UDRH Program – targeted education, training and support to enhance opportunities for medical, nursing and allied health students in rural and remote health, and development of support infrastructure</td>
<td>Yes – see section 4</td>
</tr>
</tbody>
</table>
6.2 Policy challenges for the two Programs

At present there are a number of policy challenges which have implications for both Programs. One major consideration is the sizable ‘bubble’ of an expanded cohort of medical students that will be making its way through the training system for the next five years. Resulting from Federal policy decisions made in the 1990s, ‘the figures paint a clear picture: the wave of students flowing into the Australian medical workforce represents substantial growth, and we must plan carefully – now – if we are to ride the wave, rather than being swamped by it.’ (Joyce et al 2007:310) Many stakeholders around the country are aware of this approaching wave, from the NSW Medical Student Council which called upon the Federal Government to stop increasing medical student placements until more internship positions have been created (Wallace 2008) to the RDAA which has called for increased investment at the level of internship and vocational training (RDAA 2008), to Schwartz (2008) who has suggested that market forces should be allowed to influence the numbers of medical practitioners.

As Joyce and others point out, the consequences of policy decisions can be felt for decades. Both the UDRH and the RCS Program have required significant infrastructure investment and to ensure that the investment which has already been made is realised, the medical training pathways, including the capacity of State/Territory-funded health services, require urgent consideration to accommodate the projected increase of medical students into the system. This poses a challenge for the RCSs in particular, as they will seek to accommodate a growing demand for clinical placements in rural hospitals, Aboriginal Medical Services, GP surgeries and other health service settings at the same time that pre-vocational and vocational placements are being increased within many of the same settings. However, the expected expansion of medical students through the system will also impact upon the capacity of the UDRHs to maintain the programs of training and support for nursing and allied health while being faced with increasing demands to accommodate placements for a greater number of medical students.

A second policy challenge which faces both Programs is the requirement to deliver on a workforce initiative within an educational setting. Each RCS or UDRH serves two masters, to the extent that they are accountable to their university faculty for delivering educational outcomes (with commensurate reporting and administration) while also being accountable to the Department of Health and Ageing for delivery of a suite of activities designed to support and sustain the rural health workforce (also with its own reporting and administration). Ensuring that the goals are clear and that all parties are cooperating towards a common end should assist to streamline some of the administration requirements of each Program without loss of transparency.

A third policy challenge arises from a long-standing concern of many doctors to develop a dedicated rural training pathway. This dream of integrating the various levels of rural medical training, from student placements through intern and postgraduate years to vocational training, has been on the rural medical agenda for some time and a number of organisations are already exploring options to streamline training pathways. The extent to which RCSs can play a leadership role in this – for instance whether RCSs have the infrastructure available to accommodate oversight of intern and postgraduate years, and whether they should do so – is still to be resolved. Some informants considered that the RCS should continue to focus on its original mandate of delivering the university medical curriculum, while others argued that the RCS structures and facilities are well-placed to become an integrated provider of all levels of medical training. This latter view has been promulgated most recently by the RDAA and the NSW Medical Student Council (RDAA 2008). Regardless of who provides the various levels of rural medical training, as with the previous two challenges it appears clear that urgent dialogue and cooperation are required to develop a pathway which will accommodate the increasing numbers of students who are likely to seek rural pre-vocational and vocational training.
The remainder of this chapter discusses the key strategic issues emerging from the evaluation and makes recommendations for the future. This discussion is grouped into seven themes:

- strategic leadership and vision – including succession planning and structural sustainability;
- program management – including funding levels, parameters and objectives, monitoring and operational expansion;
- maintaining the culture of innovation;
- the capacity of the health system to absorb increased training requirements;
- partnerships;
- community impact - including Indigenous health; and
- implications for the local workforce.

6.3 Strategic leadership and vision

6.3.1 Leadership

People in leadership positions in RCSs and UDRHs play a crucial role in three important arenas:

- Leaders represent and advocate for new models of training which challenge the long-established metropolitan models of the professions and the university (a particularly critical issue in medical training, but also relevant in nursing and allied health).
- Leaders inspire and support rural practitioners to participate in the program as trainers and supervisors, and have sought to develop academic opportunities such as joint appointments so practitioners have an additional motivation to stay in the rural location.
- Leaders build collaborative relationships with the State/Territory health services (at a clinical and management level), with local private health providers (including Aboriginal Health Services), and with community stakeholders such as Shire councils, Rotary clubs, etc.

_The biggest asset is also the biggest risk – people._ (UDRH academic)

As with any organisation, the capability and capacity of its people and their ability to work together as a highly functioning team determine the organisation’s long-term success. As discussed throughout this report, the leadership within the Programs has been critical in building up the individual sites across the country. It is reasonable to expect that some of those who have been key champions or pioneers of the Programs will choose to move on from their current positions within the next five to ten years if they have not already. Accordingly, it is essential that plans are in place to ensure that relationships with external partners are embedded within the organisation rather than resting with the personal credibility of individuals.

One of the ways in which the Programs can do this is to build on their organisational learning culture, encouraging professional development and capacity building within their own staff. This has the secondary effect of developing a cohort of leadership capacity within rural communities, which has the potential to benefit the rural health sector, the university sector, and the local community. Developing leadership capacity within the ranks will also contribute to succession planning.

One of the strengths of both Programs, but particularly the UDRH Program, is the variety of ways in which the UDRHs and RCSs have responded to and adapted to local circumstances and challenges. The ethos of each site is slightly different and determined as much by the way in which the leadership have responded to their mandate in the local context as to the national Program objectives or parameters. Organisational vision is highly influenced by the leader of the organisation, and there is a natural risk to both Programs of losing the early passion and vision of the founders as the individual UDRHs and RCSs become more established. Developing and articulating a strategic vision for the national Program (discussed later in section 6.4.2) will assist in ensuring stability as leaders change.
At the same time, strategic leadership within the potentially isolated contexts in which RCSs and UDRHs operate is difficult, and universities can provide structural and professional support to assist those in leadership positions who are in the process of creating new and innovative rural health training systems, to avoid burnout and to encourage others to follow in their footsteps. This is not a financial obligation of the universities as much as an opportunity to embed the Programs further in the structures of the universities in order to ensure UDRH and RCS staff are integrated into the larger enterprise of health education and training.

**Recommendation 1:** That the universities support and encourage the professional development of RCS and UDRH Program staff to ensure stability and the mentoring of new leadership.

### 6.3.2 Succession planning

Recruitment for UDRHs and RCSs is as difficult as it is for health services in rural areas; this is an indication of the challenges currently faced across rural Australia and is likely to remain so for some time. However, UDRHs and RCSs have the additional attraction of offering joint academic and clinical appointments which may be attractive to a cohort of students already pre-disposed to rural practice. The ability to attract younger, academically oriented people to take positions was a concern for many informants.

‘Research funding isn’t enough to attract them, we need a broader range of investments’. (UDRH academic)

‘A major psychological issue in rural areas is critical mass - you need to know there’s back-up, if you want to take any time off, to not be on call all the time. You will get doctors coming to rural areas if you can offer them an academic package.’ (RCS academic)

In other words, the Programs need to continue to be innovative in order to be seen as an attractive career opportunity for young researchers and early career clinicians. Opportunities for ongoing professional development as well as lifestyle benefits were named as some of the factors in Program staff’s career decisions.

It has also been noted that flexibility with the expenditure of funding is required; sometimes funding is received for positions but a time lapse ensues before implementation due to the difficulty in recruiting an appropriate person to undertake the role. In some cases it has taken a year or more to recruit a suitable person to fill an academic and/or clinical appointment. (Refer to the case study ‘Border Medical Recruitment Taskforce’ in section 5.4.2 for an example of regional recruitment strategies.)

The challenges of recruitment reinforce the need for UDRHs and RCSs to collaborate with area health services and other agencies to develop strategies for attracting high-quality people to take up rural appointments, for the benefit of the Programs as well as local health service delivery. This point is discussed further in sections 6.6 and 6.7.2 below.

### 6.3.3 Structural sustainability

The participating universities have benefited from Commonwealth funding for the Programs to establish a university presence in regional and rural Australia. The Department of Health and Ageing has provided funding for infrastructure which would not have been available to universities otherwise (such as office and teaching space, accommodation, clinical simulation laboratories, and information technology facilities).

This infrastructure has had broad benefits not only for the health sector, but also the educational sector, heightening the universities’ visibility within communities and engendering a positive response towards the university through their presence in the local community. External stakeholders have expressed community perceptions that the rural environment is valued by the university because of this tangible investment in the provision of rural university sites.

However, there are questions regarding the sustainability of the current arrangements. A number of UDRH staff pointed out that there is no funding for maintenance of capital works, so that when maintenance is required it impacts upon core funding. Some informants reported a perception that,
because of the external funding source of the Programs, the university did not feel the same ownership of the Programs as they might for other, metropolitan-based departments.

'It's been more like a growth on the university than a growth of the university.' (UDRH staff member)

As noted in sections 4.4.2 and 5.4.2, senior university informants universally believed that the Programs were making a positive contribution to the rural health workforce, and that the Programs had benefited the universities by allowing them to develop academic infrastructure which enhanced their visibility and credibility within rural and regional Australia.

One senior university representative stated that the continuity of Commonwealth funding was critical in order to achieve the scale of operations which the Programs currently undertake. A senior representative of another university also stated that 'DoHA has a better understanding of workforce issues', and that it was preferable for the Programs to be funded through the Department rather than through DEEWR as the workforce priorities of the Programs differentiated them from the rest of the university sector. One UDRH Head commented that:

‘the UDRHs are a hybrid group – not standard education providers because they are service-oriented. They need not to be put into [the education sector] solely because they are also providing research and service improvements. Their strengths are operating at both levels’.

This perception of being 'embedded into local services' was considered by most UDRH and RCS leaders to be a critical component of their ability to support the rural workforce. While they are not necessarily easily defined because of this straddling of both the educational and workforce sectors, this dual nature may in fact be the key to their sustainability, informing the education sector regarding health system needs and facilitating ongoing educational and professional development within the health sector. Maintaining this delicate balance of identifying with both the academic sector and the professional health sector appears to be crucial for both UDRHs and RCSs to bridge the gap between training students for clinical practice and sustaining an effective and functioning rural health system.

Most university informants considered that the Programs would not be sustainable without continued funding from the Department, both because of the financial investment required but also because of this dual nature of the Programs as both workforce and educational initiatives.

Recommdation 2: That the Department maintain its current funding arrangement of the two Programs, maintaining the Programs as distinct health workforce initiatives within the academic sector.

6.4 Program management

6.4.1 Funding levels

Each UDRH receives the same amount of core funding each year ($1.66 million exclusive of GST in 2008-2009). This amount has not increased since the Program's inception, and an annual indexation was only approved in 2004-5, meaning that the real value of the Program's funding has effectively declined in the last ten years in terms of purchasing power.

UDRHs have been innovative in gaining additional funding from a range of other sources (through grant funding, research collaborations, and partnerships with local health services), and have been active contributors to health system development as well as health student education. Many UDRHs have been able to employ additional staff only because of particular grant and research money which they have acquired, and have used such contracts to employ staff who can also contribute to their core activities of teaching and professional development. Some UDRHs have been more proactive than others in seeking external funding sources. However, in the current competitive employment environment, the UDRHs' ability to continue their activities could be constrained without incremental annual increases to the core funding as well as annual indexation, putting at risk the significant investment which has been made to the Program to date. As was noted in chapter 4, attracting
qualified people to rural locations is often difficult, and the levels of salary and incentives required to attract health professionals to the country (often raising the bar of what is considered a reasonable salary package) are a pressure for UDRHs to meet (and also for RCSs).

In addition, recent increases in costs of petrol and transportation, with corresponding increases to other costs of living such as food, make the organisation of placements more costly for both RCSs and UDRHs. In rural locations which are experiencing significant growth due to the mining industry, costs of housing have increased while availability of adequate housing has decreased, impacting both students and staff who might consider relocation. While RCSs have been able to acquire long-term accommodation for students, either through lease or purchasing agreements, accessing short-term accommodation for UDRH students undertaking placements is more difficult; although capital funding has been available to UDRHs from the Department, the extent to which it has been used for student accommodation varies. Infrastructure maintenance was also mentioned by several UDRH stakeholders as an expense for which they do not have adequate funding, and it would be useful to clarify between the Department and the universities where the responsibility lies for maintaining capital works which have been funded by the Department but whose ownership resides with the university.

Increasing levels of support available from UDRHs for accommodation and transport costs of placements would encourage students to undertake placements who might currently be deterred due to the costs of doing so, and thus provide additional encouragement for students to be exposed to rural practice. Increasing the investment in the Program would also signal that increasing nursing and allied health professionals in rural locations is a workforce priority.

The differential in student support available through the UDRH and RCS Programs is also significant and noted by students (see section 4.5.2). The Programs run a strong risk of structurally inculcating a privileging of medical students and a distinction in value between the health disciplines which the students themselves question. This has the potential to impede the ability for interprofessional education opportunities and also the development of a rural teamwork ethos which could be grounded in students even before they qualify. While recognising the importance of increasing the number of doctors in the workforce, many stakeholders also noted that in order to function doctors need nursing and allied health providers available: ‘they need someone to refer [a patient] to.’

It has been almost universally acknowledged that one of the factors in the RCS Program’s success to date has been the level of funding, so it does seem reasonable for funding to continue at this level. In the foreseeable future at least, the need for funding will not diminish once the establishment phase of the RCS Program has been completed, due to the steadily increasing number of students who will require placements, accommodation, administrative support and teachers.

If RCS funding were to be reduced, it is likely that the length of time a student could be subsidised to study in a rural location would be reduced accordingly. As the whole impetus of the Program to date has been to increase the amount of time a student could spend outside of metropolitan areas, this would seem a retrograde step. As stakeholders consistently emphasised, ‘The experience has to be long enough, and it has to be positive’ for rural exposure to influence a student’s career choices.

The cost per student ranges widely across RCSs: four operate on less than $40,000 per student, while five run at over $100,000 per student. These discrepancies are partly explained by age, size (with corresponding efficiencies of scale) and geography (remoteness and catchment area), but there are anomalies beyond these factors. Some students are keenly aware of the different amenities which universities are able to offer, and perceive that there are disadvantages which may accrue to them as a result of choosing one university over another. Accordingly, it would be of benefit to the Department, the universities and the RCSs to explore a more evenly distributed allocation across Program sites. It is recognised that the latest funding round did partially address the discrepancy in funding across universities.
Recommendation 3: That core funding for UDRHs be increased to accommodate increased staffing and operational costs, including continued annual indexation.

Recommendation 4: That the Department clarify with universities the responsibility for funding infrastructure maintenance.

Recommendation 5: That funding support for UDRH students in nursing and allied health be increased, including accommodation and transport costs for student placements.

Recommendation 6: That RCS funding levels be maintained, and that efforts continue to achieve a more equitable distribution amongst RCSs.

6.4.2 Parameters and objectives

Many stakeholders believe that the Department has shown wisdom in the way in which the Programs are managed, and that the supportive and flexible approach of the Department has been a key factor in the success of the Programs to date. For each Program, the original aims have largely been achieved, with established infrastructure, staff and educational, training and research programs. At this point in time it seems appropriate to re-define the Programs’ goals for the next ten years, seeing each Program as a long-term addition to national rural health workforce strategies. The reasons for this differ for each Program.

- For the RCSs, the current funding parameters are properly seen as contractual requirements rather than ongoing objectives or outcomes. Each RCS reports regularly on their student numbers, curriculum requirements, research and other activities as well as on budgetary matters. Now that most RCSs have moved out of their initial establishment phase, developing objectives which describe what outputs and outcomes the Program is seeking to achieve would assist in future evaluation of the Program. These objectives should be linked to a strategic vision for the Program as a whole, including secondary benefits additional to the workforce distribution changes which it seeks to influence. Objectives for the next ten years might include challenges such as tracking students (already a focus of FRAME’s attention), developing vertically integrated training pathways, and increasing the level of research activity.

For instance, it was acknowledged by most RCSs that the priority to date has been to establish a credible medical education training program in a rural environment. However, research is also recognised as important and many sites have developed a research program, with research activity tending to be more extensive the longer the RCS had been established. Most sites had plans to increase their research activity in the future. Including in the objectives the secondary benefits which the RCSs are widely considered to provide, such as the level of rural clinical research and innovation, contributing to recruitment and retention, and promoting rural health careers through the presence of the university in rural locations, might also be a means to recognise these achievements as legitimate aims of the Program.

- The objectives of the UDRH Program are broad; this has been determined to be a strength in encouraging innovation and a locally relevant approach. As with the RCS Program, the UDRHs report regularly to the Department on the number of placements, level of research activity, collaborations, publications and budget. The KPIs which are currently monitored are largely process measures, and potentially could be more closely aligned with the strategic aims of the Program to assess short, medium and longer term impact on the local workforce and population health.

‘The KPIs have improved but they are sometimes a bit irrational, there should be fewer KPIs and more strategic direction.’ (senior university administrator)

As with the RCSs, developing a strategic long-term vision for a Program which has now moved past its establishment phase will assist in ensuring its effectiveness as a workforce initiative. This would require developing measurable indicators which focus more on outcome than process measures; for instance, seeking to measure the impact of publications in influencing Australian
health policy and clinical practice rather than simply the number of publications (perhaps using the DEEWR Higher Education Research Data Collection specifications which universities already use to quantify their research output).

At the same time, the development of targets for nursing and allied health placements (discussed in section 4.4.2), would reinforce the importance of these placements as a workforce initiative, and might assist in raising the profile of rural health careers in these disciplines.

Some administrators have suggested that the reporting requirements are already onerous, with one Head of School suggesting that a .5 FTE position was dedicated to fulfilling reporting requirements for the Department and the host university. Developing Program-wide strategic objectives should not add an additional level of reporting burden on to individual sites. Rather, for each Program, FRAME and ARHEN, in consultation with the Department and their universities, might consider developing objectives which focus on national strategic direction rather than operational measures such as throughput which are ongoing contractual requirements. This could assist with more clearly defining the impact the Programs are seeking to have on the rural health workforce, and to measuring their success in meeting those objectives. A logical framework approach may be helpful in assessing what goals are actually measurable and attributable to the Programs, as opposed to those to which they contribute, such as influencing students’ ultimate career choices.

**Recommendation 7:** That the Department, in consultation with ARHEN, FRAME and the universities, define long-term strategic priorities and objectives to reflect the Programs’ aims more clearly, and incorporate these into reporting mechanisms.

### 6.4.3 Monitoring and policy research

The lack of longitudinal and consistent data regarding students and clinicians hampers the Department’s ability to monitor the extent to which the Programs are influencing the rural health workforce. The difficulties of monitoring and evaluating student and clinician career decisions is well-recognised, and MDANZ and FRAME have both made efforts to create a process which will provide consistent data in the future. This evaluation has relied on reported personal experiences, anecdotal reports regarding workforce impact, published literature from the RCSs and UDRHs, and the few tracking studies or research projects which individual sites have conducted into their own local impact or contribution. While this provides an evidence base for a process evaluation of the Programs, assessment of the long-term impact of either Program will be dependent upon rigorous and continuing monitoring. Each UDRH or RCS is already evaluating its own performance on a regular basis in reports to the Department as well as through a variety of research projects. Developing mechanisms for assessing national Program impact would require an overarching, collaborative framework based on such objectives as described above in section 6.4.2.

Data available through such studies could inform a continuing quality improvement process for each Program so that problems may be addressed and changes incorporated before the next generation of policy assessments are made. It is acknowledged widely that the Programs will not see the outcomes of their efforts for some time to come; however if, as reported by Health Workforce Queensland (2008), only 4% of Queensland medical graduates since 1990 are operating in RRMA 4-7 locations, it is evident that there is a need to demonstrate that the Programs are increasing the rural health workforce over time. As one informant stated with regard to the dependence of the Programs on rural clinicians and health services, ‘the problem is being asked to be the solution’, and it will be essential to assess whether that strategy is bearing fruit over time.

In order to be able to both identify emerging challenges to the health system and design innovative models for addressing them, building on the academic culture of critical analysis to incorporate ongoing monitoring and evaluation will strengthen the capacity of each Program to respond to their operating environment. It will also assist in the identification of areas for future innovation as well as models of best practice.
Recommendation 8: That FRAME and ARHEN, in collaboration with the Department and the rural workforce agencies, continue to develop mechanisms for national monitoring of each Program’s workforce outcomes, including the existing FRAME tracking survey and the MDANZ student tracking database.

6.4.4 Geographic coverage and operational models

There is scope for the UDRH Program to be expanded to cover geographical areas not currently serviced by the program. Whether this should be through expanding the current UDRHs or through creating new ones is not clear. A strategic mapping process should be undertaken which looks at current coverage of the UDRHs, the needs of communities not currently serviced by UDRHs, the capacity and interest of host universities, and projected needs for services in the future. A transparent process would then need to be undertaken with universities to determine where expanded or new UDRHs should be based.

One viewpoint expressed by some informants is that now would be a good time for the UDRHs or RCSs to expand because of the difficulties facing many rural communities due to drought or loss of services. Expansion would provide additional services to communities which may be struggling and promote a sense of hope that rural health services will continue or improve. It would bring academic clinicians to new locations and thus also increase the local workforce. To be effective, expansion also needs to include ownership from local communities, as the current sites have clearly demonstrated. Equally, there are some who would like to see the current model be proven before additional expenditure is made for either Program.

There are a range of operational models currently extant within the RCS Program, developed according to the medical structures in place within the local region (e.g. GP-run hospitals, regional hospitals, GP surgeries, AMSs) and curriculum requirements of the university. As each model has demonstrated its capacity to fulfil the contractual requirements of the Program, there does not seem to be any need to develop one common unified operational model.

Currently, the greatest number of RCSs reside in the States with the greatest population base: four in NSW, two each in Victoria, Queensland and South Australia, and one each in the other States and Territories. At the moment, it appears that these 14 RCSs are able to accommodate their current demand for RCS student places; although many are receiving more applications than the available number of places allow, some see this as a positive opportunity to ‘cherry pick’ the best students rather than having to fill positions with less enthusiastic candidates as sometimes happened in the early years. At the same time, the number of medical students is expected to continue to grow and whether the current number of RCSs can expand to accommodate these numbers or whether new RCSs are required will need to be determined through careful strategic and statistical modelling, which should include those universities who are already in discussion with the Department about establishing Program sites.

Most RCSs are now able to meet the target of accepting 25% of Commonwealth-funded medical students into their Program (Parameter 1, see section 5.2), and some regularly exceed this target. Increasing the target, say to 30%, would allow RCSs to claim additional funding as their student numbers would increase. However, the ability of RCSs to meet this target overall is unclear and an expansion of the target should be subject both to funding and capacity constraints. For now, 25% is slightly less than the proportion of Australians who live rurally39, any consideration of expanding the target should be considered carefully as the additional burden could potentially be significant on RCSs.

The two Programs, while having similar long-term aims, each have different operational models, the RCS focussing on delivery of the medical curriculum, the UDRH focussing on a broader range of teaching and training activities, as well as research and health service development. The level of activity undertaken within either UDRHs or RCSs is significant, through teaching and clinical training.

39 According to the Australian Bureau of Statistics, the percentage of the Australian population of Australia living in regional or remote settings in 2006 was 32%. (cat 4102.0’) (www.abs.gov.au)
through student placements and community engagement, through research and publications, and through health service delivery and innovation. Their different approaches to addressing the workforce shortage suggest that there would be no net benefit, but potentially an overall loss, to integrating the two Programs as one. While there may be a natural integration in various locations over time, as for instance in those universities which have unified the two Programs into one School of Rural Health, this decision has been taken at a local level and for the aim of best accommodating local circumstances and the long-term vision of the particular university/ies. Overall, there seems to be no national benefit to integrating UDRHs and RCSs at a Program level at this time.

**Recommendation 9:** That the Department consider expansion of the Programs only after careful strategic demographic profiling targeted to areas of population growth, taking account of:

- the capacity of current RCSs and UDRHs for expansion;
- the capacity of regional, rural and remote health infrastructure and workforce to accommodate increased student numbers;
- local population needs;
- the demonstrated interest of the host university;
- infrastructure requirements; and
- the current coverage of UDRHs and RCSs (see maps in Appendix E).

Expansion considerations should include whether to increase the size and capacity of current universities or whether to include additional universities.

**Recommendation 10:** That the Department maintain the two Programs as separate initiatives.

### 6.5 Maintaining the culture of innovation

One of the factors in the success of the Programs to date has been the Department's approach to the Programs in their implementation. Departmental staff were considered to be approachable, flexible and understanding when operational challenges arose, and this was believed to be appropriate in fostering the establishment of ambitious and fledgling Programs which had not been trialled before. The continuity of Departmental staff overseeing the Programs over time has also been noted favourably. For both Programs this approach has encouraged the enthusiasm and innovation which have characterised the development of the Programs nationally. Some stakeholders expressed concern that a change in the Department's approach, for instance away from openness and flexibility, would inhibit the ability of the Programs to be responsive to their local environments and the needs of their communities.

Some stakeholders were aware of the need for the UDRHs and RCSs to maintain their ability to innovate and create new opportunities or risk losing the level of financial and professional support that has been critical to the success to date.

> ‘[we need] to add value in a whole range of different ways; simply teaching alone as an activity is not enough of an activity for a rural clinical school nor is it likely to produce the kind of workforce impact. We have got to be involved in service development and involved in the services in a whole range of different ways so that our role infiltrates both practice and teaching. So there’s a very important dual role and I think that’s a critical sustainability issue. I don’t think we can just sit here as teachers, I think we have to be very, very involved in the overall development of health services throughout the region and I think we’re doing that to some extent.’ (RCS academic)

Along these lines, a recent study (Edmondson 2008) analysed the difference between efficiency and learning in organisational practice. The author argued that organisational cultures that are focussed on efficiency risk losing the ability to remain competitive, or (for hospitals and other complex not-for-profit systems) to retain best practice, because they stop focussing on the learning and reflective practices
which lead to innovation and development. Similar arguments have been put forward by other education scholars, notably Schon (1991) with his analysis of reflection-in-practice. The common thread of these approaches is the importance of making space for reflection and the consideration of novelty within the daily execution of the organisation’s mandate. A culture of innovation is largely what has characterised the establishment of both Programs to date.

Edmondson identified four steps to enculturating ‘execution-as-learning’ into an organisation:

- provide process guidelines;
- provide tools that enable employees to collaborate in real time;
- collect process data; and
- institutionalise disciplined reflection. (Edmondson 2008:65-67)

One way for UDRHs and RCSs to retain their ability to be proactive in identifying and meeting the needs of the rural health workforce is to develop process guidelines which are clear protocols for high performance; support for collaboration; ongoing monitoring mechanisms; and structured opportunities to reflect and learn from their performance. All UDRHs and RCSs are already doing this to some extent, but it is admittedly a challenge to retain the cutting edge in the midst of demanding schedules, university and Program reporting requirements, and continual change and development in both staff and program activities. FRAME and ARHEN each contribute to their members’ learning and reflective practices already by providing mechanisms and events in which members can share experiences and ideas, and develop new ways of thinking about common challenges.

An additional way in which the Department could encourage this quality approach would be to provide incentives for innovative exploration of new models for health service delivery. Creating a pool of innovation funding would provide an incentive for partnerships between academic entities but also could include local service providers and services. It would recognise the opportunity for the UDRHs and RCSs to become leaders in rural health service development and in doing so would advance both the workforce goals of the Programs and the teaching and research aspirations of the universities. The Department could structure the funding selection criteria in such a way that the applications reflect the kinds of partnerships and activities that are of particular relevance to the Australian Government’s rural health workforce strategic aims.

**Recommendation 11:** That the Department continue its current approach to the Programs, characterised by flexibility and openness to innovation.

**Recommendation 12:** That the Department, in order to encourage collaboration and innovation, create a dedicated pool of funding which could be available on a competitive basis to RCSs, UDRHs and other university rural health institutions, for practical and applied health service delivery and workforce research and innovation.

### 6.6 Health system capacity to absorb increased training requirements

The ability of both Programs to deliver their stated objectives is heavily dependent upon the capacity of the health system to absorb the projected increase in the number of medical students, as well as nursing and allied health students. This in turn is dependent upon the ability of Federal and State/Territory health services to recruit and retain high-quality clinicians.

In the long term, the sustainability of both Programs will rely on an interdependent relationship with Federal and State/Territory-funded health services in which the Programs nurture potential rural clinicians and support existing ones, while the health services provide the environment in which those clinicians (both potential and existing) can flourish.

> ‘It’s all very well turning out graduates, but it’s no good if there are no postgraduate intern positions. We need a better vision for a rural pathway.’ (clinician)
Success for the RCSs could be measured in the number of rural interns and registrars; however it is not possible to measure success with these parameters when the placements for those segments of medical training are not available in rural areas. In addition, a significant factor in the RCS Program’s potential to impact on workforce is the development of vertically integrated rural pathways. Medical students spend another 5-7 years in postgraduate training programs following their RCS experience, before they become qualified to practise in their own right; these are years where significant life choices are made, wedding vows are exchanged, mortgages are signed and families are started. The more that postgraduate and vocational training requires extended metropolitan placements, the greater risk that rural intentions fostered by the RCS Program may be eroded and replaced by metropolitan intentions. The Australian General Practice Training Program has already been regionalised (by the same Minister for Health who oversaw the launch of the RCS and UDRH Programs); the same progress has not yet been made for surgical or physician training.

Recent calls to re-examine the number of Commonwealth-funded medical student places (Wallace 2008), to increase the number of rural hospital intern placements and to restore the PGPPP funding for general practice intern placements (RDAA 2008), and to consider a market-based approach to the determination of workforce levels (Schwartz 2008), are symptomatic of a heightened awareness that the lack of integration across all levels of medical training will potentially limit the intended benefits of many of the Australian Government’s rural health workforce strategies, including the RCS and UDRH Programs.

The need for integration across training levels will require collaboration across training providers, as well as across State/Territory and Federal health systems in providing clinical placements within hospitals and other service delivery environments. As the ability of the RCS and UDRH Programs to deliver their workforce outcomes will be hampered by the lack of availability of placements for students within community or hospital settings, as well as the lack of capacity of rural health professionals to take on preceptor responsibilities, it seems essential for both Programs to be represented in national and State/Territory-based discussions on resolution of a vertically integrated rural training pathway. In addition, the development of clear clinical academic pathways, so that clinicians could be supported to develop from clinical supervisor to clinical educator over a career, could be an additional contribution to the recruitment and retention of GPs as well as specialists.

**Recommendation 13:** That the Department, in collaboration with State/Territory-funded health services, explore alternative partnership arrangements with State/Territory health systems, such as joint appointments, sharing of clinical training facilities, and creation of new clinical training places, to provide stability in training systems for both Programs.

**Recommendation 14:** That at national and State/Territory levels the Department encourages vertical integration opportunities to link more closely RCS, postgraduate and vocational training systems, including the implementation of a rural medical career pathway, in close collaboration with universities, professional colleges, workforce agencies, State/Territory governments, and FRAME.

**Recommendation 15:** That the Department, in collaboration with State/Territory-funded health services, assist both Programs to develop additional incentives, training and support mechanisms for clinical supervisors and trainers, including exploration of alternative remuneration structures.

### 6.7 Partnerships

#### 6.7.1 Universities

Lyle et al (2007:232) point out that even with the dedicated investment of the Department of Health and Ageing into the RCS and UDRH Programs, universities do not easily produce internal structures and processes which will facilitate rural health workforce choices amongst students. The authors suggest that increased collaboration across university health science departments and faculties might improve the level of promotion of rural health careers. Jones et al (2005:274) suggest that RCSs need to educate medical faculties and university academics to inculcate a positive perception of rural training. Influencing the medical and health system culture towards a more positive understanding of rural health services has been evident through the UDRHs and RCSs. Developing internal university systems which
encourage health students to consider rural careers could be considered an in-kind contribution from the universities to the broader rural health workforce agenda.

‘There seems to be a perpetual undermining of rural health by people in the city, people get here and realise how great it is and are surprised. This will be hard to overcome, I am not sure how.’ (UDRH administrator)

Because the Programs receive dedicated funding from the Department of Health and Ageing, it has been suggested that some universities do not feel as much ‘ownership’ over the UDRH or RCS as they might if the school or department were fully part of the DEEWR-funded university structure. At the same time, other senior university stakeholders have emphasised the importance of the UDRHs and RCSs as components of their medical or health faculties.

While it was commonly understood that universities’ funding is tightly stretched, the universities themselves contribute to the functioning of the RCS and UDRH Programs in many ways through infrastructure and institutional support, and it might be useful to explore ways in which their in-kind contributions to Programs can be measured. As the Programs mature and the individual sites become more embedded within their regions, heightening the universities’ collaborations with RCSs and UDRHs would benefit the universities, the RCSs and UDRHs, and local communities. There would potentially be additional opportunities to promote further the universities’ engagement in the rural context.

**Recommendation 16:** That the host universities be encouraged to explore new ways of promoting rural health careers, and particularly the opportunities available through the UDRH and RCS Programs, in collaboration with their UDRH and/or RCS.

**Recommendation 17:** That the host universities explore, in collaboration with the Department, ways in which the in-kind contribution of the host universities might be recognised and quantified nationally.

6.7.2 Other workforce and training programs

Rural clinical schools and UDRHs also have partnerships with a range of stakeholders outside the university sector. As has been noted, both Programs are reliant on a network of alliances across the Federal and State/Territory-funded health services as well as within rural communities. It appears that all Program sites have made great efforts to make a positive contribution to the local community as well as to be seen as an enabler and support mechanism for the rural workforce. These efforts should continue in order to retain the sense of both Programs being embedded in the life of rural and remote Australia.

Integration with other training systems is primarily an issue for the RCS Program, concerning vertical integration of medical training. However, within the UDRH Program there is probably room for greater integration with other funding initiatives; in particular, funding mechanisms from the Department could probably be streamlined. For example, the processes of the various funding and scholarship initiatives could usefully be examined.

RUSC funding, while a medical initiative primarily affecting RCSs or university departments of general practice, in some instances is administered through the UDRH and creates a substantial additional workload. This is, however, substantially a local issue as each university determines how their RUSC funding is managed and expended. Questions were raised among some informants as to the effectiveness of the RUSC funding, which was generally considered to be insufficient funding in light of the increasing number of rural medical student placements which were required each year. It was recognised that the RUSC Program had contributed greatly to increasing the level of awareness of rural health careers amongst medical students, and that its support for rural health clubs and short-term placements had been crucial in exposing a majority of medical students to the context of rural health practice. However, the RUSC requirements were considered to be onerous for the level of funding received, and some wondered whether the original aims of RUSC had been subsumed into the more recently-developed RCS Program.

There is great potential for the RCS and UDRH Programs to collaborate further, particularly in the area of interprofessional education. Some sites have developed significant shared training opportunities across disciplines, while others have preferred to maintain a separate and collegial relationship but not
to integrate their students formally. In those places where, for instance, joint clinical training using simulation laboratories is available, students and academics perceived that the benefits were greater than simply the imparting of clinical knowledge; students learned to work together across disciplines and to understand what each discipline has to offer. Similar experiences were noted in places where short interdisciplinary placements were supported and students were brought together to spend a week in a rural location, exploring local health issues and learning how rural practitioners addressed population health issues. Most students – nursing, medical and allied health – considered that these types of interdisciplinary training opportunities were very important in preparation for rural health practice.

However, relationships have evolved organically between UDRHs and RCSs over time, sometimes dependent upon the personality and operating style of the Program leadership. It appears that encouraging collaboration rather than mandating partnership allows each Program partner to recognise the other’s distinctiveness and to find where they can each best add value to the other.

The PHCRED Program appears to work well with the UDRH Program, and was favourably mentioned by most informants. The various scholarship opportunities (RAMUS, RAHUS, John Flynn Placement Program) were also mentioned favourably by students, with several saying that the fact that there were a number of opportunities to get rural exposure meant that a student was provided with a variety of experiences and perspectives.

There may be scope to streamline these various mechanisms to support rural student exposure, however it is outside the scope of this evaluation to determine how best this might be realised. There may be efficiencies to be gained, however, from integrating co-ordination of the many funding streams; one example of this which has already been discussed (see section 6.4.2) is the centralising of student placement co-ordination.

**Recommendation 18:** That both Programs be encouraged to collaborate and increase partnerships in training, research, and interprofessional clinical training, while recognising the independence of each Program and their different aims.

**Recommendation 19:** That consideration be given to the future of the RUSC Program and whether its activities should be wholly absorbed by, and managed through, the RCSs.

**Recommendation 20:** That opportunities to streamline some of the student support funding streams be explored.

6.8 Community impact

6.8.1 Broad community impact

At least three levels of community impacts are evident from the two Programs:

1. **Affirmation of rural Australia (and therefore of rural Australians): ‘that [the university, the Government] thinks it's worthwhile investing in rural Australia.'** This ‘feel-good’ factor has a benefit in that it predisposes community members to be more supportive of the Programs and their place in the community.

2. **Contribution to local services:** Some have indicated that the mere presence of students increases the workforce capacity in providing an extra pair of hands: ‘The students are actually useful'; medical students help out in surgery at the hospital, take patient histories in the GPs’ surgery, test for blood pressure and sugar at the local agricultural show; and

3. **Contribution to workforce retention through opportunities for clinicians in research and teaching.**

Additional community impacts may be a general increase in social capital in rural Australia, and an economic contribution through employment and the purchase of goods and services.
DISCUSSION AND RECOMMENDATIONS

While many have seen the growing university infrastructure as an inspiration to rural schoolchildren and as a contribution to the economic, social and health infrastructure of the country, others have sounded a note of caution, and of weariness:

‘I would like to see Australian-trained doctors coming out here. We are putting immense resources into this and not getting anything back – I mean the government, taxpayers – I would like to see something coming back… There’s no evidence that we’re making any impact.’ (RCS staff member)

Each RCS is required to establish a Community Advisory Board to facilitate communication with local community representatives in the areas where RCS training sites are located. UDRHs are also required to establish advisory boards. In the establishment phase of the Programs, the Community Advisory Boards have assisted with promoting the Programs to the community, listening and responding to community concerns regarding health services and providing support to students on placements. Stories abound of the ways in which local committees have worked to ensure that medical students were made to feel at home, including providing welcoming parties, amenities such as bicycles and BBQs, and opportunities to get involved with community activities.

Many of the RCSs have now established a two-tier advisory process, with local advisory committees at each training site, who send representatives to the larger, yearly Community Advisory Board meeting. It appears that this local community engagement has been crucial to the RCS and the university being welcomed into the rural environment, particularly during the early years when the university and RCS were trying to introduce themselves and establish working relationships with community members.

While Community Advisory Board members consider community consultation still to be important, the mechanism of a yearly meeting is considered by some informants to be an ineffective mechanism for consultation. It might be useful to consider whether there are alternative ways for the Programs to interact with the community once the initial establishment phases are completed, or whether the advisory boards could be developed further. While the advisory boards are not intended to function as management or governance bodies, some advisory boards are involved in strategic planning and informing direction for the organisation. Others rely on more informal consultation with community members. Without seeking to prescribe a structure for all sites, there might be scope for encouraging RCSs and UDRHs to consider whether new consultation mechanisms could prove more useful than the established structure.

**Recommendation 21:** That the role of advisory boards for both Programs be assessed by RCSs and UDRHs, in consultation with the Department, to define their purpose and potential.

### 6.8.2 Indigenous health

It is difficult to ascertain the impact of either Program on Indigenous health. A number of indicators are present which may result in improved future provision of health services for Indigenous Australians. These indicators include:

- the number of Indigenous students studying for health careers;
- the number of Indigenous people employed within RCSs or UDRHs;
- the extent and quality of Indigenous cultural training, including training in cultural safety for non-Indigenous students and clinicians;
- the extent of research on topics relevant to Indigenous health and the increase of an evidence-base for health service development; and
- the involvement of UDRH and RCS students and academics in the delivery of health services through AMSs and other facilities.

There is no longitudinal research in this area, however as part of an improved monitoring and research component of the Programs it would be useful to assess the impact of the Programs on the improvement of health service provision to Indigenous people. This is especially relevant for UDRHs, which have Indigenous health explicitly named within their objectives as an area of focus.
DISCUSSION AND RECOMMENDATIONS

There were some comments received regarding perceptions that the *reciprocity* of relationships could be improved between some Program sites and local AMSs. Accordingly, structural mechanisms for ensuring a continuing open dialogue with local Indigenous communities should be embedded within the structures of the organisation, rather than relying on particular individuals or leaders within the RCS or UDRH. Appropriate consultation mechanisms with local Indigenous communities, including identification of existing structures such as COAG structures, need to be identified and formalised by each RCS and UDRH.

The RUSC parameters provide direction to universities in terms of encouraging Indigenous students to take up health careers and providing support to them throughout their training, as well as providing Indigenous cultural awareness training to all medical students. All RCSs and UDRHs have some engagement with the recruitment of Indigenous staff and students, and of supporting existing professionals working in Indigenous health services. It is likely that more could be done to promote rural health careers to Indigenous students, and to support them as they undertake their training. A useful first step would be to analyse the parameters of all the workforce programs, including the RCSs and UDRHs, and to determine whether there is overlap between the RUSC parameters and the funding parameters of other Programs such as the UDRH and RCS.

Recommendation 22: That strategic objectives be reviewed for the Programs with regard to their contribution to Indigenous health, in consultation with local Indigenous leaders, health service providers and communities.

6.9 Implications for the local workforce

Over time there are a number of future benefits that are likely to accrue to the rural health workforce. These include:

- likely increases in the amount of research and capacity building which should deliver a return in the future;
- likely increases in the numbers of people willing to spend some time in the country over the period of their career;
- likely improvements in the perceptions of urban-based clinicians who will have a greater understanding of issues faced in country areas; and
- likely ongoing growth of networks and social support which can reduce isolation and pressures of work.

A benefit which has already been demonstrated is that of increasing the skills and knowledge of local practitioners, due to their involvement in teaching and supervision. A number of doctors and nurses noted that teaching requires them to hone their own clinical skills and knowledge, and that the presence of students encourages greater diligence in reading the professional journals and keeping up with recent research. This should lead to an increased level of evidence-based practice in the rural environment, and a continuing improvement in the quality of the health care available to consumers. The UDRHs in particular have actively contributed to the research capacity and output of rural clinicians, and the role of UDRHs as an enabler of research and development has been noted by many.

An additional benefit, noted by some clinicians, is the increased satisfaction and affirmation which teaching provides. A sense that one does actually know quite a lot, or does one’s job well, was named as bringing renewed interest and enthusiasm to the work. Some doctors noted that this had assisted them to remain in their current position when they might otherwise have burnt out and re-located to the city.

However, as already noted, increasing numbers of students moving through the rural health services over a period of time may lead to burnout or inability to provide sufficient training and supervision. Both RCSs and UDRHs tend to ‘trade’ on goodwill and favours with local health service providers (who unless delivering lectures/tutorials are often unpaid), and there is some concern that overloading them will eventually erode goodwill. This could be addressed through ensuring that the health system has
the capacity to provide sufficient numbers of clinicians willing to take on training responsibilities, thus sharing the burden amongst a greater number of people and lessening the demands on any one individual. Recommendations 13 and 15 above are especially pertinent here, as the interdependence of these two Programs with the rural health services means that cooperation is required to ensure that over time the impact of the Programs on the rural health workforce is positive rather than negative.

At this point in time, however, it can be said that there have been some positive impacts on the local workforce through additional opportunities for teaching, research and professional development. The keys for the future will be continuing to develop means for supporting and encouraging rural health practitioners, and demonstrating that students who train through the RCS or UDRH Programs do in fact return to ease the burden currently facing rural health services.

**Recommendation 23:** That the UDRH Program continues to increase its research capacity building assistance to rural health clinicians.

**Recommendation 24:** That the RCS Program increases its focus on research capacity once the medical teaching infrastructure and curriculum are established.

**Recommendation 25:** That the RCS and UDRH Programs, in consultation with the Department, State/Territory-funded health services, and workforce agencies, develop additional mechanisms for supporting and nurturing rural health practitioners, such as an increasing involvement in professional development and continuing education, as a means of retention.