Executive summary

Urbis was commissioned by the Department of Health and Ageing to conduct the evaluation of the University Departments of Rural Health (UDRH) Program and the Rural Clinical Schools (RCS) Program. This joint evaluation of the two Programs has two objectives:

1. to evaluate the current effectiveness, and future role, of each Program within the context of the current national approach to improving rural and remote health services in Australia; and
2. to evaluate the degree to which RCSs are satisfying RCS Program parameters and UDRHs are achieving UDRH Program objectives.

Extensive consultation and data analysis took place between May and August 2008. Approximately 530 people were consulted in the course of the evaluation, either face to face or over the telephone. In addition, published literature, Program datasets, and a range of Program documentation were analysed. Overall, the Programs were found to be meeting their objectives and contributing to enhancing the rural health workforce. Seven themes and 25 recommendations were identified for strategic consideration in the future. These themes are:

- 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.

University Departments of Rural Health

The UDRH Program has been well established, ten years from its inception, and all eleven UDRHs are meeting the objectives of the Program. Nationally, the UDRHs have made significant contributions to rural clinical training, rural health service innovation and population health research, and increased rural community engagement with health promotion and population health awareness.

There is anecdotal evidence that rural student placements reinforce student intentions to practice rurally, and also evidence that some practitioners have been recruited to rural practice because of the presence of the UDRH. There is also evidence that the UDRHs have influenced rural and remote practitioners to remain in practice, through providing additional professional and personal networking and support, professional development opportunities, access to university resources, and incentives to undertake research.

Overall, UDRHs have demonstrated strategic leadership and vision in creating a rural university infrastructure which can influence the development and improvement of rural health services, and have increased communication and knowledge transfer through increased information technology. Challenges to the Program include funding constraints, disciplinary silos, and difficulties in recruiting staff and ensuring the capacity for clinical placements. However, each UDRH has sought to minimise these limitations and to maximise their capacity to strengthen the rural health workforce.
Rural Clinical Schools

The RCS Program has now enabled the creation of 14 dedicated rural clinical schools, with the establishment of significant tertiary infrastructure in rural Australia and the development of a strong network of academic rural clinicians. A number of alternative clinical training models have been piloted and found to be beneficial, including the Flinders University Parallel Rural Community Curriculum and other community-based training approaches. The successful provision of clinical training in the rural environment, evidenced by the academic results of RCS students in comparison with their urban counterparts, has demonstrated the validity of rurally-based clinical training.

It is too soon to determine whether this extended rural exposure through the RCSs has influenced medical students’ actual decisions to practise rurally. However, there is anecdotal evidence that the presence of the RCSs has influenced the recruitment of new clinicians to rural practice, and also assisted with retention of current rural medical practitioners. Evidence of student career intentions is also encouraging. The early cohorts of the RCSs will soon be establishing themselves in medical practice and over the next few years it should be possible to analyse whether the number of RCS-trained, rural doctors is increasing. Student tracking surveys should also enable longitudinal data to be collected with regard to RCS students and their later career decisions.

Challenges to the RCS Program, as for the UDRH Program, are the capacity of the health system to accommodate increasing student numbers, as well as recruitment of staff. The RCS Program faces an additional challenge due to the nature of medical training, as the number of rural internships, pre-vocational placements, and vocational training opportunities remain limited, potentially undoing the positive influence of the rural experience gained through the RCS placement if students find themselves spending extended periods back in the urban environment for pre-vocational and vocational training. The need to address this lack of capacity is pressing if the investment in the RCS Program is to be realised in terms of increasing the rural medical workforce.

Recommendations

Strategic leadership and vision

**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. (see section 6.3.1 for further discussion)

**Recommendation 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. (see section 6.3.3)

Program management

**Recommendation 3**: That core funding for UDRHs be increased to accommodate increased staffing and operational costs, including continued annual indexation. (see section 6.4.1)

**Recommendation 4**: That the Department clarify with universities the responsibility for funding infrastructure maintenance. (see section 6.4.1)

**Recommendation 5**: That funding support for UDRH students in nursing and allied health be increased, including accommodation and transport costs for student placements. (see section 6.4.1)

**Recommendation 6**: That RCS funding levels be maintained, and that efforts continue to achieve a more equitable distribution amongst RCSs. (see section 6.4.1)

**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. (see section 6.4.2)

**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. (see section 6.4.3)

**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 map in Appendix E).

Expansion considerations should include whether to increase the size and capacity of current universities or whether to include additional universities. (see section 6.4.4)

**Recommendation 10:** That the Department maintain the two Programs as separate initiatives. (see section 6.4.4)

**Maintaining the culture of innovation**

**Recommendation 11:** That the Department continue its current approach to the Programs, characterised by flexibility and openness to innovation. (see section 6.5)

**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. (see section 6.5)

**Health system capacity to absorb increased training requirements**

**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. (see section 6.6)

**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. (see section 6.6)

**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. (see section 6.6)

**Partnerships**

**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. (see section 6.7.1)

**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. (see section 6.7.1)
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. (see section 6.7.2)

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. (see section 6.7.2)

Recommendation 20: That opportunities to streamline some of the student support funding streams be explored. (see section 6.7.2)

Community impact

Recommendation 21: That the role of advisory boards for both Programs be assessed by RCSs and UDRHs to define their purpose and potential. (see section 6.8.1)

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. (see section 6.8.2)

Implications for the local workforce

Recommendation 23: That the UDRH Program continues to increase its research capacity building assistance to rural health clinicians. (see section 6.9)

Recommendation 24: That the RCS Program increases its focus on research capacity once the medical teaching infrastructure and curriculum are established. (see section 6.9)

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. (see section 6.9)