Barriers and opportunities to clinical placements in regional, rural and remote settings

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Populations in rural and remote communities would live longer, healthier lives with improved access to health and medical professionals and services in their own communities[1]. This assertion is widely accepted in Australia, and is the reason why geographic maldistribution of the health workforce is a significant priority for governments and for rural and remote communities[2]. Another widely accepted assertion is that, if you expose the right health and medical students to rural and remote practice during their studies, they will be more likely to work in these communities after they graduate[3]. If the students themselves have rural and remote backgrounds they will be even more likely to practice in these settings in the future[4,5,6]. The financial, social, logistical and political challenges associated with sending students on rural and remote clinical placements, however, are numerous and significant. The Federal Government recognises these difficulties, and has introduced several initiatives over the past 20 years to support medicine and health students to undertake regional, rural and remote clinical training opportunities. Despite this, many of the barriers remain the same. The barriers can be summarised with two words—**cost** and **capacity**. Costs are high for universities, health care providers, and students themselves to engage in rural and remote placements. Capacity is also a limiting factor: capacity of individual health providers and clinicians to supervise, capacity of smaller primary healthcare providers to service diverse health and training needs, and capacity of universities to create the frameworks and relationships necessary for safe and reliable rural and remote placement. A number of new barriers and new opportunities have emerged in recent years with changes to healthcare delivery and workforce policy and priorities. This paper argues that a systems approach, backed by core funding and designated responsibilities across multiple interdisciplinary areas is needed to make long-term, sustainable change in addressing old and new barriers.

This paper outlines the experiences, opportunities, barriers and challenges of one regional Australian university, James Cook University (JCU) in northern Australia. JCU made a decision more than 20 years ago to feature rural, remote and regional clinical training as a pillar and priority in all health and medicine Bachelor degrees. The experiences of JCU in seeking to fulfil this aim are not unique; problems and victories are mirrored in other institutions both regional and metropolitan. Significant infrastructure and investment has been required to facilitate meaningful rural placements in JCU degrees, and to identify students who are interested in working outside the cities. Two main enablers—**accommodation provision** and **relationship building**—underpin JCU's rural, remote and regional clinical training for health and medicine students. These two enablers mitigate the known barriers of cost and capacity, and support the University's 'pipeline' approach to health workforce development. JCU and its partner University Department of Rural Health (UDRH), the Centre of Rural

and Remote Health (CRRH) in Mount Isa, have built and leased significant accommodation facilities in small rural and remote towns and communities for students' use. The University has also invested significantly in relationships, developing and growing networks in rural and regional areas that support the implementation of innovative and flexible placement models, such as service learning, tele-supervision and multidisciplinary supervision.

JCU has a history of commitment to developing a professional, work-ready workforce to serve the health needs of rural, remote, tropical and Indigenous Australia. JCU developed the first of the new medical schools in Australia in 1999 and has since rolled out a range of health professional programs from undergraduate to specialist programs in professional areas including Medicine, Dentistry, Nursing, Midwifery, Biomedicine and Allied Health. More than 7000 health and medicine students are enrolled at JCU in the year 2019. The University has an explicit mission to address the health workforce needs of northern Australia. The intention is to create a sustainable pipeline in which students are trained specifically for rural and remote practice, where they might also stay, develop professionally, and train a new generation of practitioners. The pipeline approach is supported most strongly beyond the University in the profession of Medicine in Australia. Federal Government level initiatives include the Integrated Rural Training Pipeline for Medicine, which includes regional training hubs. At JCU, Medicine students in their final three years of study complete their clinical training at one of four rural clinical school sites in Northern Australia, which has been shown to support and feed into the pipeline approach[3].

All JCU health and medicine students begin their degrees with the knowledge that they will spend time in outer regional, rural and remote communities on clinical placement. The rural and remote focus is made clear right from the application process in four of the University's health and medicine disciplines; JCU's selection policy favours rural origin applicants and is used to gauge students' rural and remote practice interests in **Medicine, Dentistry, Physiotherapy** and **Veterinary Science**. In Medicine and Dentistry, students must complete a minimum amount of non-city clinical placement, and further options are available for interested students to spend up to a year working in remote communities. Bachelor of Medicine Bachelor of Surgery (MBBS) students must complete a minimum of 20 weeks rural clinical training with minimum placement duration of four weeks, and Bachelor of Dental Surgery students must complete an 18-week rural placement in Year 5 of their studies. In all other health and medicine degrees at JCU, students are strongly encouraged to undertake clinical placement in rural and remote communities. The University operates a distributed regional education model that provides significant regional, rural and remote clinical placement opportunities for all of health and medicine students. In 2017, JCU worked with more 1900 hospitals, businesses, private organisations and health services around Australia to provide 17,832 clinical placements to its health and medicine students. JCU staff have built up significant capacity and infrastructure for rural and remote placement with the support of Federal and State Government initiatives and programs (for example, Health Workforce Australia, Clinical Training Funding, Rural Health Multidisciplinary Training Program, and the integrated Rural Training Pipeline for Medicine).

Provision of affordable or free student accommodation has been a major component in enabling rural and remote clinical placement for JCU students for at least 20 years. This is supported heavily by the University Department of Rural Health: the Centre for Rural and Remote Health (CRRH). Accommodation can be scarce and expensive in rural and remote locations. Students who complete placements away from home already incur significant personal costs in maintaining their 'home base' accommodation. They might also lose income from part-time jobs. University and CRRH accommodation, therefore, is a key enabler in providing rural and remote placement. CRRH and the University have built, acquired and leased accommodation in more than 12 Queensland towns, including very remote locations like Boulia in Western Queensland: population 301, and Normanton,

a small Gulf country town where the majority of residents are First Nation people. In the outback northwestern Queensland city of Mount Isa alone, where the CRRH accommodation is available to all universities and not simply JCU, CRRH manages five facilities that can house 53 students at any one time. Accommodation is fully furnished and self-contained and, in many cases, subsidised. In some remote locations or disciplines where service needs are great, students do not incur accommodation costs at all. Turning accommodation from a barrier into an opportunity for clinical placement has required significant investment, but a worthy one in terms of addressing workforce maldistribution.

Relationship building is the second major area in which an investment, in this case—of time, has created new or innovative opportunities for clinical placement at JCU. At JCU, the networks and relationships that enable rural and remote clinical placements are built outside the health professional workforce as well as within it. In the Allied Health professions, this is particularly so. Many small communities do not have the capacity—the service need or population base—to support full-time Physiotherapists, Psychologists, Speech Pathologists and Occupational Therapists. Academics who are facilitating placement opportunities in these fields must collaborate with community members, teachers and administrators as well as health professionals. The Speech Pathology (SP) team at JCU has recently completed a research project into its graduate destinations, which has revealed insights into the implications of its dedicated focus on facilitating rural and remote clinical placement. The SP team has a teaching staff member whose role includes key performance indicators related to optimising rural and remote placement opportunities. The team uses service learning models, tele-supervision and inter-professional supervision, sometimes all at once, to enable rural and remote placements. For more than 12 months, they have leveraged professional relationships with Allied Health professionals and teachers across several towns to send pairs of students to work together with children in remote Northern Territory schools. The students work on the ground with a learning disorders teacher who oversees students' interactions in the school. The clinical learning component of placement is supported by an Occupational Therapist who connects with and guides the students via tele-supervision.

Placements such as these have a high degree of complexity and require the building of diverse professional networks rather than professional relationships alone. The SP team is seeing results. In 2018, more than 75 per cent of the 2018 fourth-year JCU speech pathology cohort completed their final eight-week clinical placement in non-city locations. Forty-eight per cent (48%) of fourth-year students went to remote locations: Katherine in the Northern Territory, Cooktown and Mount Isa in Queensland, and 27 per cent of students worked in outer regional towns such as Kingaroy and Ayr in Queensland. Graduates are reportedly adaptable and independent. Contrary to trends in other disciplines, the number of JCU Speech Pathology graduates working in rural and remote areas has been shown by the research team to have increased after the first year out of University. Rather than seeing rural practice as a one-year 'stepping stone', many SP graduates of JCU are settling in to or moving to rural and remote communities beyond their first year of practice. This trend of extended rural practice has a flow-on effect; JCU graduates who have secured positions that are based in or servicing rural areas are themselves providing clinical supervision to JCU students. This flow-on effect, it must be noted, is also a result of changes in the Allied Health workforce landscape that are slowly arising from the rollout of the National Disability Insurance Scheme (NDIS) and other state-based initiatives. Public healthcare might no longer be the only option for rural and remote people as more private providers move, or begin servicing, communities in which there was only public primary healthcare options previously. The mix of Allied Health professionals employed in public and private sectors is expected to change significantly in coming years, which will also change the student clinical placement landscape in Allied Health.

It can be seen that the rural and remote clinical experiences and opportunities for students of the various health professions differ greatly. The rural and remote nursing workforce, which plays a significant role in the provision of health services in rural and remote areas[7], has not received the same concentrated attention as the rural and remote medical workforce in recent years. At JCU, however, the pipeline approach in Nursing Science is very evident. Nursing Science students can complete their entire degree program in a rural or remote location such as Mount Isa, Cloncurry or Longreach as well as engaging in clinical placement in remote areas. Nurses can also continue their professional development through to postgraduate qualification in their rural, regional or remote hometowns as long as they have an internet connection. JCU recently introduced on online Master of Nursing, which has been popular among remote practitioners. Education is one of the majors in the Master of Nursing; the program is targeted at nurses who would like to become nurse educators in a clinical environment. In a pipeline approach, this continuing professional development for rural and remote clinicians is an important factor in creating sustainable clinical placement opportunities, particularly in disciplines such as Nursing, which has stringent accreditation requirements. If the University is helping to develop the capacity of rural practitioners, it is also growing a clinical education knowledge base and strengthening ties between the workforce and the University.

Clinical supervision of students must be viewed as a health workforce issue rather than a University issue. Rural and remote clinical placement is of little value if there is no prospect of employment in these areas for students after they graduate, or if clinicians and graduates are unable to grow and develop professionally in these areas. Most health professionals work in the major cities and Health Workforce data shows the figures have not changed much in the past five years. In 2017, for example, 72.3% of nurses and midwives worked in major cities, 17.8% in inner regional, 7.9% in outer regional and 2.0% in Remote/Very remote locations; the figures were similar in 2014[8]. In Occupational Therapy in 2016, just 7.7% of the Occupational Therapy (OT) workforce worked in outer regional, remote or very remote. The rate of OT practitioners per 100,000 population was 38 in remote areas, 22.7 in very remote areas, and 51 in outer regional areas, compared with the National average of 65.8. A much greater number of OT practitioners (45%), however, had worked in regional, rural or remote locations even though their primary place of work was a major city[9]. In the field of Psychology, the number of practitioners per 100,000 population increased overall in Australia, but decreased in remote and very remote locations[10]. Clinical supervision of students cannot take place, quite obviously, in locations where there are no clinical supervisors.

Changing workforce priorities can be turned into opportunities for rural and remote clinical practice. JCU has contributed to one of these workforce-led initiatives in Queensland, which it is anticipated, will lead to increased opportunities for clinical placement in rural and remote areas in the Allied Health professions. In JCU's home state of Queensland, trials have taken place to expand levels of healthcare support offered by Allied Health professionals in rural and remote areas through the Allied Health Rural Generalist program and the Allied Health Expanded Scope Strategy 2016-2021[11]. These initiatives are underpinned by targeted training. Queensland Health, in collaboration with universities and professional bodies such as the Services for Australian Rural and Remote Allied Health (SARRAH), developed and introduced an Allied Health Rural Generalist Pathway in 2014. This pathway included the creation of designated positions for Allied Health professionals in small towns. Allied Health Rural Generalist training accompanied these positions. The training has since been developed further by JCU and Queensland University of Technology into a degree-level program. The program, known as the RGP, is delivered in modular pieces, and is expected to be backed by an accreditation process in the future, managed by SARRAH to ensure ongoing quality. Queensland's Allied Health Rural Generalist program is run in parallel with the Allied Health Expanded Scope Strategy 2016-2012. One of the four priorities of the latter program is to 'develop sustainable workforce training models'. This program is creating more positions for Allied Health professionals to

work in rural and remote areas. It is providing them with training and support to increase the likelihood they will remain in these positions. It is connecting them with universities through the formal education component of the RGP program. This systems approach, which is supported by employment security and training, is the type of approach that is needed to ensure sustainability of clinical education in rural and remote areas.

The NDIS, the Rural Generalist Pathway, Integrated Training Pathways and other healthcare reforms and initiatives at both the state and federal government levels, represent the potential for both new opportunities and new barriers to rural and remote clinical placement. Whether or not these changes lead to positive or negative outcomes for rural and remote clinical placement and healthcare provision depends very much on taking a systems approach to the issue[12]. Based on JCU's 20-year experience of supporting rural and remote clinical placement in multiple health disciplines, it is argued that sustainable development of rural and remote clinical health training pathways must be done with a systems approach that acknowledges the difficulties, opportunities and barriers of all sectors involved—universities, health organisations, accreditation bodies, professional organisations, and the communities themselves. In every health and medicine practitioner's code of conduct or professional standards, it states that clinicians have an obligation to contribute to the professional development of students and colleagues. In practice, however, fulfilling this obligation can be difficult, especially in rural and remote locations. Universities can send students to rural and remote locations only if there are clinicians available and able to supervise. Clinicians are employed by hospitals, health service and industry, not by universities. Supervisors can take on students only if they have sufficient skills and time to do so. Universities can assist with supervision skills-acquisition but employers must ensure clinicians have the time to train, and to be trained. Allocating set times or making supervision a feature of a health professional's key performance indicators is an effective way to ensure clinical supervision is a priority. All of these factors, and the way they intersect, would be considered in a systems approach. Clinical placement is a significant component in the making of a health professional. It is a pivotal experience and a time during which students set a course for their futures. And that is why rural and remote clinical placements are so important to the development of the workforce in these areas. The rhetoric around health workforce maldistribution in rural and remote areas, and training health and medicine professionals for rural and remote practice remains, in many areas, just that: rhetoric. Pockets of innovation in clinical placement will be unlikely to translate to improved workforce distribution, health, welfare and healthcare for people in rural and remote communities unless the barriers are addressed and opportunities maximised through a systems approach. Health workforce reform that is taking place will be more sustainable if the future workforce—the students—are also considered in the planning and execution of workforce reform. Rural and remote clinical placements might never become 'easy' for universities, the professions and industry, but the benefits to rural and remote communities, students, and to the future of the health workforce make them vitally important.

Recommendation

We call on Commonwealth and State Governments to adopt an integrated health and education systems approach in the vitally important health workforce business of creating and sustaining rural and remote clinical placement for health and medicine students.

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Presenter

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