The RIPENing: advancing rural interprofessional education in Australia

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Abstract

For several decades there has been growing international recognition that health professionals need better preparation and support for effective collaborative practice. For a range of reasons this is especially the case with rural health workers. So far, however, interprofessional education (IPE) has been slower to emerge in Australia compared to our peer countries. A major cause of this tardiness is an apparent uncertainty about how to position and manage IPE at policy levels. Without a clear articulation of related needs, vision and purpose, IPE has largely remained outside of the strategic planning and funding cycles necessary for implementation as ‘core business’ across various sectors and levels.

For some time Australian universities involved in rural health education have recognised the need for IPE and continue to develop a variety of related projects and programs. In 2005 the Rural Interprofessional Education Network (RIPEN) was formed to promote IPE as an integral component of rural-focused health professional education in Australia. Network objectives include performing collaborative IPE research and sharing teaching and other resources between sites and stakeholders.

RIPEN shows that, despite relatively scarce resources, the rural health sector has again been an ‘incubator’ for developing innovative models that can be transferred to non-rural areas. It is not new for such ‘bottom-up’ practice to lead some way ahead of relevant government and institutional policies, but this does heighten the need for IPE to be centrally incorporated within ‘top-down’ policy processes. There are some growing signs that vindicate optimism.

This paper draws on international experience and collaboration to emphasise the need to complement innovative, rural IPE practice with supporting policy, specifically to maximise the quality of future rural health care delivery.

Background

The concept of boosting interprofessional education (IPE) to improve interprofessional practice (IPP) is not new. Evidence that this has formed an explicit area of study stretches back more than three decades, for example Harsh, Fewell and Casto.1 This is not an isolated example: in 1973 the WHO initiated the worldwide movement in IPE, stating that IPE would improve job satisfaction, and encourage a holistic response to patients’ needs.2 This has been backed up by numerous subsequent studies and projects, for example WHO.3 Nor is IPE, as claimed by some such as Campbell and Johnson4 a passing ‘fashion’ or ‘fad’. The National Health System (NHS) in the UK has mandated that IPE be a compulsory and core feature in the training of all health professionals.

In recent years, other developed countries such as the US, Scandinavian nations, South Africa and Canada have also made long term commitments to develop IPE programs to improve IPP. In these settings, recognition of the need for better collaboration and communication amongst health professionals has taken the form of mainstream education and training policy initiatives and substantial government funding commitments to facilitate associated program and curriculum redevelopment. IPE and IPP are thus recognised as practical necessities in response to pressures for greater efficiency and effectiveness of team-based, interdisciplinary health care delivery.

There is now a substantial base of research evidence that shows improvements in interprofessional practice in a wide range of health care contexts can lead to significant improvements health outcomes (a selection of related references is provided in Appendix 1). The benefits are particularly apparent in areas that have been identified as being poorly addressed within traditional models of health care
delivery. These include conditions that are chronic and complex such as the management of diabetes, asthma, cardiovascular disease, emergency procedures, rehabilitation, aged care, and Indigenous and mental health. These challenges are even greater, and more important to address, in sociodemographically underserved populations such as those rural areas.

Improving IPP has also been shown to increase the effectiveness of interprofessional communication and reduce the prevalence of miscommunication, tension and preventable adverse events associated with clinical error. IPP is also seen as an effective response to a range of workforce issues in both rural and other settings, for example, by reducing workplace stress and increasing job satisfaction. Such beneficial effects are of particular pertinence in rural health care where the perennial workforce shortages are projected to worsen over the next several decades.

Recurring key recommendations from conferences of the National Rural Health Alliance (NRHA) and the National Undergraduate Rural Health Network (NRHN) highlight the need for Australian health professional students to have regular opportunities to experience IPE. For example, a recent NRHA recommendation follows:

State and Federal Ministers for Health and Higher Education should immediately inform higher education institutions and health professional bodies that undergraduate health professional curricula must be changed to incorporate and/or address the need for interprofessional education and future clinical practice.

For several years prior reports have carried similar messages, as well as frustration at the persistent lack of recognition of the need for greater levels of IPE. It is essential for the responsible Ministers to address the critical need to fund the strategic development of IPE-specific teaching and learning initiatives within the budgetary framework. In doing so it must be recognised that the current university funding model does not provided the necessary flexibility to support these developments.

A recent health professional development event (getGP 2005) in East Gippsland, Victoria, highlighted the strong potential benefits of interdisciplinary training and regional collaboration. One of the key disincentives for health professionals considering rural practice is the perceived professional and social isolation associated with these settings. While there are typically diverse ranges of professional communities and activities in this and other regions, there is no co-ordinating mechanism to ensure efficient sharing of resources and expertise due to the traditional mono-disciplinary arrangements and structures that prevail. Boosting interprofessional, in-service learning (IPL) opportunities was recognised as a practical, achievable and much needed response to help address the perennial issues of both workforce recruitment and retention. This anecdotal observation is complemented by a range of research that strongly suggests effective IPE and IPL will improve both patient health outcomes and workplace satisfaction.

In Australia there has so far been relatively little policy and funding commitment to the IPE field. Despite significant international developments in IPE, there have only been a relatively small number of pilot IPE initiatives, involving small numbers of students. Examples include Smith, Williams, Lyons and Lewis and McNair, Stone, Sims and Curtis. These are typically isolated, mostly rural-based, short-term initiatives that in themselves have limited scope to effect the lasting, systemic change that is needed. More optimistically though, they do offer a solid basis from which IPE may be integrated into mainstream health professional undergraduate and postgraduate education.

The push towards health care innovation is intertwined with changes in educational practice. We should not expect greater flexibility in service delivery and in role delineation, unless there is change towards educational approaches that will support such innovation and community-responsive practices. What is now needed is national recognition that IPE and IPP are essential prerequisites for optimising the effectiveness of scarce health care services and human resources. This recognition would need to be manifest in policy commitment, project funding and medium to long-term change management strategies, necessarily shared by local, state and commonwealth health authorities and by the university and VET education sectors.
In the international educational research community there is evidence that Australia is acquiring a reputation for being an ‘interprofessional backwater’:

[Interprofessional learning in Australia] is currently limited in size and scope by non-recurrent funding due to a policy vacuum in this area at university, state and national government levels. Curricular reform requires forward planning to fit in with review and development cycles of several years: this is precluded with last minute, year-to-year funding arrangements … This lack of support at the ‘top’ contrasts sharply with the growing and passionate support for IPE at student, teacher and practitioner levels.

Therefore a major challenge is to engage in effective advocacy to bring IPE from the margins to the mainstream. IPE has earned far greater recognition in our peer countries … These international developments and achievements offer inspiration and a range of models, research and experience that we can blend with our own to help Australia make progress on this very important issue.

Coming from what is a relative hive of interprofessional development, and probably at the international forefront of interprofessional activity in the UK, Thistlethwaite seems surprised that a nation such as Australia, that prides itself on progressive approaches to health care and related education and training, has allowed such a costly oversight to continue for so long.

In a section on Workforce Innovation (p.41) the recent Productivity Commission Position Paper includes amongst the key points:

There has been considerable change and innovation in health workforce deployment across Australia in recent years … (and) growing use of inter-disciplinary and multidisciplinary approaches to patient care. However, the evidence suggests that many opportunities for more significant workforce innovation, including job redesign and changing scopes of work, have not been progressed, or even properly evaluated.

There are a number of very promising pilot and other interprofessional projects taking place in this country. However, they are taking place in the context of a policy vacuum and are thus destined to be of limited impact and sustainability. While the importance of interprofessional learning and practice is slowly becoming evident at some levels, mostly within the areas of applied health care education, training and practice, it appears that the greatest barrier is a lack of government and institutional support as well as commensurate strategic planning.

There are a number of positive signs that suggest cause for modest optimism. In collaboration with the University of New South Wales, ACT Health has recently secured substantial funding to conduct a four-year project to ‘interprofessionalise’ their state health system. For the first time (known to the authors) a national conference has recently focused squarely on ‘Interdisciplinary Learning for Interprofessional Practice’ including more than 30 sessions on a range of projects and initiatives, mostly from across this country but also from abroad. A number of universities have established, or are establishing interprofessional teams to support IPE and, in the longer term, the development of IPP competencies within and across different health discipline departments.

Another example is the Productivity Commission’s recent reports on Australia’s Health Workforce which recognise the huge and preventable risks and costs of continuing to maintain such a highly fragmented health care system. One recommendation is to consolidate national health profession regulation and accreditation frameworks. Related initiatives are under way and, if successful, will allow and encourage IPE to be built in at system level to support emerging IPE practice on the ground.

These are all promising developments, but their progress will be limited unless IPE is addressed within all meaningful phases of policy cycles Curran’s model (Figure 1 below) is useful in articulating major elements of strategic change management needed to move IPE forward.
Waller (et al.)\textsuperscript{17} have used this model to describe policy fragmentation as a possible cause for difficulty implementing IPE in Australia. However, as with most models, there is a risk that the associated challenges can be represented too simplistically to reflect the dynamism and complexity of real life multiple systems interacting in unpredictable ways. This model is a condensed version of the work of Tarlov\textsuperscript{18}, whose original approach may be useful to consider. Tarlov\textsuperscript{18} offers four public policy frameworks with which to improve population health. One is particularly useful with respect to IPE which by definition involves multiple complex systems:

Linear effects models and multiple independent effects models fail to yield results that explain satisfactorily the dynamics of population health production. A different method (complex systems modelling) is needed to select the most effective interventions to improve population health. (p281)

Thus implementing IPE requires accepting even greater levels of complexity and uncertainty than in ‘normal’ major positive change management.\textsuperscript{19} Expecting relatively simple, linear (or circular) approaches to achieve significant gains may condemn such endeavours to be labelled or dismissed as failures when they do not (and probably cannot) deliver what appears to have been promised.

The future development of effective IPE and IPP will clearly require both ‘top-down’ and ‘bottom-up’ approaches.\textsuperscript{20} Without fundamental policy change and funding support the local achievements of innovative service providers, clinical teachers and academics will necessarily remain limited to the margins. RIPEN for example, operates largely on the assumption of goodwill and professional commitment, the constituents get little if any official recognition for their work. Such goodwill cannot be sustained indefinitely in a ‘policy-vacuum’.\textsuperscript{17} It is essential to call this urgent need to the attention of health authorities and education providers at the highest administrative echelons, as well as consolidating support for, and learning from the good IPE work that is already being done.
References


Appendix 1—Selected references


**Presenters**

**Nick Stone** is Senior Lecturer, School of Primary Health Care at Monash University, Victoria. He is co-ordinating the establishment of interprofessional education (IPE) initiatives involving allied health and nursing students. Previously he managed the Rural Interprofessional Education (RIPE) project for more than five years at the University of Melbourne. He is an active member of the Australian Rural Health Education Network (ARHEN) IPE Group. He has conducted and published work related to a range of IPE related research and educational activities. Nick has a background in education and training and is completing a PhD “Assessing intercultural effectiveness in management”.

**Tony Smith** is a radiographer of some 30 years’ experience. Although having been an academic for many years he has always been clinically active. He has been involved in teaching various health professionals, including nurse and GP remote x-ray operators. He has recently completed his PhD on this topic.