Australian Government

Office of the National Rural Health Commissioner

5 September 2023

Professor Mary O'Kane

Chair

Australian Universities Accord Review Panel

Re: Submission in response to the Australian Universities Accord Interim Report

Dear Professor O'Kane,

Thank you for the opportunity to respond to the Australian Universities Accord Interim Report.

The National Rural Health Commissioner is an independent, statutory office holder, appointed under Part VA of the Health Insurance Act 1973 (the Act). The Office of the National Rural Health Commissioner works with regional, rural and remote communities, the health sector, universities, specialist training colleges and across all levels of government to improve rural health policies and ensure there remains a strong focus on the needs of rural communities.

Approximately 7 million people live outside of Australia's cities. These communities make an enormous contribution to the national economy and are the fabric of our national identity. The government's commitment to a thriving regional, rural, and remote Australia comprises keeping communities healthy, by ensuring they can access health services when they need them, and as close to home as possible. Australians deserve access to high quality health care services, no matter where they live. This requires close collaboration with the education sector to ensure an appropriate workforce is trained and distributed to areas of highest need.

More levers can be utilised to manage Australia's current health workforce maldistribution. For example, most of Australia's health training models are primarily delivered in metropolitan centres, geared towards enrolling metropolitan students, producing health professionals who are most likely to practise in high density metropolitan centres within familiar, well-resourced health systems. Evidence demonstrates that these training models are not producing the necessary numbers of rural and or remote health workforce/s required to service the health and wellbeing needs of rural, remote, and very remote communities (Hays, 2001; Smith, et al., 2006; Woolley, et al., 2020). To address this, the Office of the National Rural Health Commissioner encourages the Accord Review Panel to consider the provision of greater support to universities that are genuinely committed to increasing the rural and remote workforce, such as increasing the number of Commonwealth Supported Places for these universities.

Please find attached a submission responding to the Australian Universities Acord Interim Report

Yours Sincerely,

Adjunct Professor Ruth Stewart

National Rural Health Commissioner

Executive Summary

The Office of the National Rural Health Commissioner (ONRHC) recognises the importance of the Australian Universities Accord and Interim Report and welcomes the opportunity to contribute to this work.

The Office of the National Rural Health Commissioner broadly supports several principles described in the Interim Report, particularly:

- Putting First Nations at the heart of Australia's higher education system
- Growth for skills through greater equity
- Equity in participation, access, and opportunity
- Serving our communities
- Research, innovation, and research training
- Strengthening institutional governance

Whilst the Interim Report encompasses the whole Australian university system, the ONRHC Executive Summary focuses primarily on strategies and considerations for building a sustainable rural and remote health workforce and increasing equitable access to tertiary education for rural and remote people and communities. The attachments provide specific strategies to achieve system shifts and actions described in the Interim Report.

Considerations

1. Building a sustainable rural and remote health workforce

Attracting more people from rural communities to train as professionals is an important and broadly adopted strategy in building a sustainable rural and remote workforce (National Rural Health Alliance, 2004). Few will understand the life and the needs of rural and remote communities better than those from these communities, including First Nations communities.

Managing health workforce distribution concurrently with the changing health profile of Australians requires policy design to be flexible and innovative to meet these changes and challenges accordingly. Through the investment and implementation of the Rural Health Multidisciplinary Training (RHMT) program, Australian universities have demonstrated targeted strategies can effectively improve the percentage of health professional graduates choosing to work in rural and remote communities (For more information please see Attachment 1).

Increased retention rates of rural practitioners occurs when there is identification, engagement and recruitment of rural origin students, and when students and junior doctors are given early and well supported rural and remote clinical placements (Courtney, et al., 2002; Dunbabin & Levitt, 2003; Ogden, et al., 2020; Playford, et al., 2020). This approach applies to health professionals who have lived experience in rural and remote communities; they are more likely to make the decision to work rurally. Rural placements offer opportunities to increase interest and exposure to these underserved areas and high value placements can result in positive clinical and social experiences that are likely to influence early career decisions of students and new graduates. Work ready placement programs such as those currently delivered by University Departments of Rural Health (UDRHs), that increase opportunities for longer-term rural placements and end-to-end rural training have a positive impact on developing a sustainable rural workforce and viable and healthy communities.

This year the ONHRC has released The National Rural and Remote Nursing Generalist Framework 2023-2027 and Ngayubah Gadan (Coming Together) Consensus Statement: Rural and Remote Multidisciplinary Health Teams as key frameworks to build and support the rural and remote workforce. The frameworks were developed in collaboration with key rural and remote stakeholders, universities and peak body representatives and a number of Australian universities have begun implementing them within their curriculum. Embedding these frameworks within health professions curriculum will enable students to learn the skills necessary to serve the needs of rural and remote communities. (For more information please see Attachment 2).

2. Increasing numbers of graduates from priority groups

There is a growing international trend to improve demographic representation in university student cohorts through the university intake process premised on the population that the university seeks to serve (Razcak, et al., 2015). Some argue this impedes on selection processes driven by traditional academic factors (Razcak, et al., 2015). However, there is growing evidence to show that the impacts of such measures, i.e. enrolling students from priority groups, may deliver workforces with greater intentions to work with underserved populations (Larkins, et al., 2015). The Training for Health Equity Network (THEnet) (2023) monitors the return on investment of social accountability strategies through the international network, which includes one Australian university provider. Learnings from this leading international network can shape the Accord's intent on social accountability, charters and mandates and the returns that they can deliver to underserved communities. It is recommended that within social charters and mandates, that there is a strong focus on broader factors, beyond academic, when articulating pathways, considering admissions and supporting entry into tertiary education.

Consideration into increasing cohort numbers from priority groups such as First Nations students and those with rural and remote backgrounds also needs to occur. Some universities do this through specific rural quotas, equity adjustments or specific rural selection tools such like interviews and personal statements (Larkins, et al., 2015; McGrail, et al., 2023). The James Cook University medical school provides an example of how universities can produce graduates committed to practising with underserved populations with a selection process preferentially favouring First Nations applicants and those from the local region (Woolley, et al., 2021) (For more information please see Attachment 3). For further information on supporting First Nation students please see Attachment 4.

3. Addressing barriers facing rural and remote students

There is a clear link between training rural origin students and increased recruitment and retention rates for rural health practitioners. Despite this, many rural students face significant barriers accessing tertiary education. Cost is a major hurdle for rural and remote students when considering tertiary education. For students experiencing disadvantage cost is often an impenetrable barrier. For many rural and remote people, relocation to a metropolitan centre for education can be untenable for reasons such as cost, social connection and caring responsibilities.

Cost barriers can also limit tertiary student opportunities to experience rural clinical placements and potentially their decision to choose rural careers. Consideration should be given to student oncosts such as outreach travel i.e. support for commercial transport or accommodation costs for rural clinical placements. Well-funded public services may support student's transport and accommodation costs, but this is often not feasible for private and other non-government services operating on thin profit margins.

There is a need to expand opportunities particularly for allied health student placements in private and not-for-profit rural and remote settings. There is currently limited scope to accept students in these settings due to the cost incurred by clinics who often operate with thin profit margins. Private and not-for-profit clinicians require financial support to compensate for any loss of income they

experience while supervising students on placements. Providing support to supervisors to host longer service-based learning placements would ultimately be of greater economic benefit to the host clinics and potentially provide greater opportunities for rural placements.

Additionally, as it stands, the balance and presence of university infrastructure is urban-centric and therefore relies on regional, rural and remote students to relocate to urban campuses. Building the infrastructure of regional and rural campuses across Australia and investing in the growth of Regional University Centres can provide intermediary solutions for study access options (Department of Education, 2023).

4. Strengthening pathways to universities

A stronger emphasis in rural and remote communities to formalise Vocational Education and Training (VET) pathways into university courses would likely see an increase in a highly skilled rural and remote workforce with strong connections to rural and remote regions. Development of articulated pathways from high school into VET programs and onto regional universities with dispersed models of delivery would increase the number of professionals who are already connected to rural communities.

Barriers for rural and remote origin students to enter undergraduate university courses are high and considerably higher for First Nations students. Existing responses, such as the Indigenous Allied Health Australia (IAHA) Health Academy model, that create supportive, community-led local pathways into tertiary training, directly work towards increasing the number of First Nations allied health graduates. This model is a successful educational pathway program that provides wrap around culturally safe education for First Nations students. The expansion of this model across and into all states and territories of Australia will reshape the way education and training pathways are designed and delivered for Aboriginal and Torres Strait Islander high school students (For more information please see Attachment 4).

In South Australia, the Yorke and Northern Local Health Network (YNLHN) and Rural Support Service (RSS) have partnered to tackle allied health workforce challenges in regional areas through a pipeline of multifaceted strategies focusing on attraction and selection, training, support and recognition (Miller, 2023). YNLHN has developed a training pathway beginning with an allied health cadetship, offering students employment as an Allied Health Assistant while studying locally, with a commitment to ongoing employment on completion. Evaluation specific to each pipeline strategy.

Additionally, models of Service-Learning formalise and expand student roles in service delivery. Students provide services to the community in a carefully structured and supervised environment and thus expand the available services in a community and the learning opportunities available therein. This is particularly applicable to final year and post graduate students. University Departments of Rural Health funded under the RHMT program are increasingly providing such opportunities to the benefit of communities and students.

5. Rural and Remote Health Research

There is growing awareness that there is inequitable funding for rural and remote health research (Spinifex Rural Health and Medical Research Network, 2020). To improve the delivery of health care in rural and remote communities, quarantined research funding for rural and remote-based clinicians is needed so they can build local partnerships and collaborations with their respective communities. There needs to be improved understandings of health outcomes and acceptable and effective interventions and models of care.

Investments in UDRH and Remote Clinical Schools are helping to grow the collective knowledge of rural and remote health, but not at the rate needed as research funding has traditionally been developed for metropolitan-based researchers. While inroads are being made, for example the

Medical Research Future fund is taking considerable steps in their approach to support rural and remote communities in getting a better share of research funding, more targeted investment strategies are needed. Opportunities for rural and remote-based clinicians to conduct research can act as powerful incentives for health professionals and academics to remain working in rural and remote locations. Creating research pathways for rurally based health professionals and academics helps to build skills and capabilities, expand employment prospects and support career progression, all of which assists with workforce retention. For rural and remote communities, research by and from their community members can leverage important investments and improve resource allocations. In doing this, networks of rural and remote clinician researchers will be able to develop new capabilities and overcome rural and remote health issues.

Concluding remarks

Structured yet flexible training pathways can create rural-ready workforces that will meet the needs of rural and remote Australia. More investment is required. Rural and remote communities need a workforce who want to work in rural Australia and are specifically equipped to do so.

Rural and remote Australia has always been a site for innovation – often born of necessity - and carried forward with commitment and vision. More than any time in our recent history, this innovation will be needed to cope with the impact of pandemics, drought, floods and bushfires. The potential for collaborative, cohesive, interconnected networks of training and service provision exists across regional, rural and remote Australia. We need to recognise this potential and take a strength-based approach to policy development that nurtures and builds on the considerable existing strengths of rural communities and the professionals and structures that serve them.

Attachment 1: Rural Health Multidisciplinary Training (RHMT) Program

Commonwealth and state governments have responded to evidence of the importance of rural origin enrolment strategies and rural exposure during training and with significant investments in programs to increase these aspects in training programs such as those funded by the Rural Health Multidisciplinary Training (RHMT) program.

The Rural Health Multidisciplinary Training (RHMT) program is one of several Commonwealth rural health workforce programs aiming to increase the number of health professionals working in rural, remote and regional Australia. The RHMT program supports a network of Rural Clinical Schools (RCSs), University Departments of Rural Health (UDRHs) for medical, nursing and allied health students. It also supports six metropolitan based dental schools to provide rural placements for dental students through the Dental Training Expanding Rural Placement Program (DTERP). Twelve universities offer dental and/or oral health courses in Australia, eleven of which receive funding through the RHMT program.

In May 2020 the Australian Government received a commissioned independent evaluation of the RHMT program. The evaluation states 'The RCSs and UDRHs have established a university presence in rural communities across Australia, built new capital infrastructure, developed local academic and professional networks, enabled the teaching and supervision of health students beyond the confines of the city, developed rural and remote research capacity and expertise, and strengthened clinical service delivery across Australia' (Battye, et al., 2020).

Investing in the growth of Regional University Centres (RUCs) can provide intermediary solutions for study access options (Department of Education, 2023). A strong focus on the RUCs' evaluation and any recommendations must be considered within the development of this Accord, alongside the recommendations from the National Regional, Rural and Remote Tertiary Education Strategy (Department of Education, 2019) too. However, it is only when larger innovative investments are sought in rural and remote communities, such as the growth of UDRHs, RCS and RUCs, that bold targets (e.g. lifting the bachelor degree attainment percentage rate of rural and remote origin students to that of metropolitan students) can be met.

The ONRHC recommends inclusion of the University Departments of Rural Health and Rural Clinicals schools in this priority action to align with the broader system shift.

Attachment 2: Relevant work of the Office of the National Rural Health Commissioner

The ONHRC has released 'The National Rural and Remote Nursing Generalist Framework 2023-2027' and 'Ngayubah Gadan (Coming Together) Consensus Statement: Rural and Remote Multidisciplinary Health Teams' this year as key documents for the rural and remote workforce. The documents were developed in collaboration with key rural and remote stakeholders and peak body representatives. Embedding these frameworks within the curriculum of health professions will enable students to earn the skills necessary to serve the needs of rural and remote communities in multidisciplinary teams.

The National Rural and Remote Nursing Generalist Framework 2023-2027

The National Rural and Remote Nursing Generalist Framework is underpinned by the Nursing and Midwifery Board of Australia's Registered Nurse Standards for Practice, the Framework describes the unique context of practice and capabilities for rural and remote Registered Nurses practice.

The Framework recognises that rural and remote nurses often provide primary health, acute and aged care in small teams, or in isolation, at times being the only available health professional. It acknowledges the legacies of prior rural and remote health service delivery with limited resources, and the effect of this on current rural and remote health outcomes.

Implementation is well underway to realise the full potential of the Framework across University Departments of Rural Health, regional universities, state and territory governments and employers to further develop a skilled rural and remote registered nurse workforce.

The Framework promotes culturally safe practice to support Closing the Gap. Over the coming year, the ONHRC will work with the sector to continue to embed and evaluate the Framework's uptake and identify areas to support further use.

Nurses, and CRANAplus have actively promoted the Framework via their own publications and social media. The La Trobe University, James Cook University and Flinders University Northern Territory have been leaders in applying the Framework into rural nursing programs and rural nursing micro-credentials.

The uptake of the Framework by the tertiary education sector, Registered Nurses and their employers will be evaluated during the 2023-2024 period using a process evaluation approach to ascertain a baseline uptake of it within the sector. This will help to identify any changes that can be made to support future and ongoing uptake of the Framework amongst stakeholders, and to support attraction and retention of a skilled rural generalist nursing workforce in rural and remote Australia.

Ngayubah Gadan (Coming Together) Consensus Statement: Rural and Remote Multidisciplinary Health Teams

The Ngayubah Gadan Consensus Statement (the Statement) defines Rural and Remote Multidisciplinary Health Teams (RRMHT) within the contemporary Australian context. The Statement recognises the contribution of the health workforce in meeting the unique health needs in rural and remote communities and describes the system enablers that allow them to thrive and deliver high quality care.

The National Rural Health Commissioner and health stakeholders have led this work and the Statement has been endorsed by 56 key rural and remote health training, service and peak organisations.

University signatories include:

- Curtain University
- Flinders University
- James Cook University
- La Trobe University
- Monash University
- Southern Cross University
- The University of Sydney
- University of South Australia

Other notable signatories:

- Australasian Council of Deans of Health Sciences
- Federation of Rural Medical Educators
- Medical Deans Australia and New Zealand

The intention of the Statement is that it will be used as a key reference document by government, policy makers and fundholders, workforce planners, training, service and peak organisations, universities, health professionals and workers, and communities when addressing rural and remote health workforce, training, and service needs.

Attachment 3: James Cook University (JCU) medical school increasing numbers of graduates from priority groups

The James Cook University (JCU) medical school has a mission to produce graduates committed to practising with underserved populations (Woolley, et al., 2021).

The objective of the program and curriculum is to produce medical graduates who are 'fit for purpose', socially accountable with an awareness of broader population health inequalities. Key learning modules of the six-year undergraduate program focus on rural and remote health, Indigenous and tropical health, health inequities and social determinants of health. Trainees undertake a minimum of 20 weeks of rural and remote community placements and cultural immersion.

The JCU selection process preferentially favours First Nations and local rural and remote applicants, recognising that once graduated, these students are likely to practise in areas of need, including rural areas.

The JCU medical program is delivered regionally in its entirety, with clinical training and placements delivered in a combination of acute and community care settings. The program and academic staff have close links with local health services who host students and provide mentoring, JCU in turn provides *supervisor education* workshops and offers a Certificate in Clinical Supervision for local rural and remote clinicians.

'As recruiting medical applicants who are attracted to rural lifestyle and rural practice is known to improve rural health workforce outcomes (Keane, et al., 2011; Viscomi, et al., 2013)*, the JCU medical school has a selection process (* Sen Gupta, et al., 2012) *preferentially favouring Indigenous applicants, and those from the local region or rural Australian towns (Principle 2). The JCU medical program is delivered entirely regionally, with a distributed model that includes an extensive program of community-based placements, with clinical teaching in the last three years in Clinical Schools.*

The JCU medical school's mission, student selection policies, curriculum content, and clinical experiences are all consistent with the principles of 'socially-accountable' health professional education (SAHPE) (Larkins, et al., 2013; Ross, et al., 2014)*. Following these principles has resulted in JCU being one of a number of medical schools worldwide which promote altruistic values such as community service and serving disadvantaged populations, as well as emphasizing the importance of primary care and generalist doctors to health systems* (Ross & Couzos, 2019)*.'*

Please also see: Woolley T, Sen Gupta T, Paton K. Mid-career graduate practice outcomes of the James Cook University medical school: key insights from the first 20 years. Rural and Remote Health 2021; 21: 6642. https://doi.org/10.22605/RRH6642

Attachment 4: First Nations at the heart of higher education.

It is essential the Accord highlights the value and importance of developing the First Nations workforce by reviewing university policies and developing networks to increase culturally safe employment and career development opportunities for First Nations academics, professionals and students and the inclusion of First Nations administrative staff. Equally as important is embedding locally contextualised, cultural competency and responsiveness training into all university courses, prioritise building regional capacity, community responsiveness and reciprocity in preparing Australia's current and future workforce.

Some universities have implemented the Aboriginal and Torres Strait Islander Health Curriculum Framework (the Framework) (Commonwealth of Australia (Department of Health), 2014) into their health courses. However, there is a need for universal and comprehensive application. In order for the Framework to be effectively embedded and implemented, support needs to be demonstrated by program coordinators that cultural competency training is core to course curriculum. This can be ensured by implementing mechanisms for impact such as the inclusion of relevant cultural capability exam questions. For this to happen good governance for implementation of the Framework needs to be in place to ensure academic leaders in First Nations education are involved in design of curriculum including development of assessment and exam criteria.

Increasing the number of First Nations health graduates requires a whole- of-training collaborative approach. A dedicated inter-professional training and education network of leaders can facilitate this collaboration. The Leaders in Indigenous Medical Education Network (LIME) for medical schools and Leaders in Indigenous Nursing and Midwifery Education Network (LINMEN) for Nursing and Midwifery demonstrate this and the Commissioner recommends expanding this to other disciplines. In addition, increased recruitment of First Nations health professionals to academic roles would enhance the integrity of teaching in relation to culturally safe and responsive service delivery and provide role models and opportunities for mentorship. First Nations-led course development is essential for optimising graduate capability in the delivery of effective health services that are responsive to the needs of First Nations people. The availability of First Nations educators provides students with mentorship through access to role models with correlating cultural identities.

Barriers for rural origin students to enter undergraduate university courses are high and considerably higher for First Nations students. Existing responses, such as the Indigenous Allied Health Australia (IAHA) National Aboriginal and Torres Strait Islander Health Academy model, that create supportive, community-led local pathways into tertiary training, directly work towards increasing the number of First Nations allied health graduates.

The IAHA Health Academy is a community-led learning model focused on academic achievement and re-shaping the way training pathways are co-designed and delivered with First Nations high school students. The Academy aims to embed culturally safe curricula and to be inclusive of local cultural aspirations for successful outcomes where social, cultural and environmental determinants are addressed with wraparound supports. Students undertake a School Based Traineeship in Certificate III in Allied Health Assistance alongside their year 11 and 12 qualifications. They also undertake a work placement in a health or related sector provider to gain on the job training and experience in their preferred career pathway (Indigenous Allied Health Australia, 2019).

The Academy has First Nations higher education health students and graduates supporting them as role models and as mentors, sharing their journeys into health, experiences in further education and the opportunities which exist. The Academy is promoting all health careers inclusive of allied health, nursing, medicine and Aboriginal and/or Torres Strait Islander Health Workers/Practitioners. The Academy promotes the diverse health and related settings where the health workforce is required

including disability, aged care, community services, community- controlled health services, hospitals and pharmacy (Indigenous Allied Health Australia, 2019).

The expansion of IAHA's Health Academy model across and into all states and territories of Australia will reshape the way education and training pathways are designed and delivered for First Nations high school students. By embedding culturally safe learning environments, culturally relevant curricula, wrap-around mentoring and links with local health services and training providers, appropriate, safe and supported pathways will be available to Indigenous Australians to participate in the allied and broader health workforce.

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