

RURAL UNDERGRADUATE SUPPORT AND CO-ORDINATION (RUSC) PROGRAM GUIDELINES 2002-05

Introduction

These guidelines have been developed to provide university and co-ordination unit staff involved in the implementation, administration and financial management of the RUSC Program with a broad understanding of the program. The guidelines cover:

- the basis on which the Program has developed;
- the requirements of universities under funding agreements; and
- the reporting and accountability framework.

The guidelines are intended only for the projects which provide ongoing funding to medical schools for achievements against the RUSC targets and to co-ordination units for student curriculum placements. They do not cover national or one-off projects.

Background

The Rural Undergraduate Steering Committee (RUSC) Program was developed as part of the Rural Incentives Program as a strategic long term initiative to increase the number of medical graduates adopting a career in rural and remote practice. The Program was, and continues to be, based on the premise that selection of students for medical school from rural locations, increased exposure to rural medicine during the undergraduate course and enhanced support for students and rural educators would lead to more doctors adopting a career in rural medicine.

Further detail on the development of the Program is at Appendix 1.

The RUSC Program review

A full review of the program was undertaken in 2000. The aim of the review was to evaluate the RUSC Program and make recommendations on how the program might be better shaped to meet its objectives in future. Within the review, while there was some emphasis on evaluating the extent to which medical schools had met the nine key targets, the report also evaluated the program as part of a continuum of medical education, training and career choice.

The RUSC Program Reference Group

One of the key recommendations of the review was that a Reference Group be established to provide a forum for key stakeholders to have input to the program and to provide advice to the Minister through the Department on RUSC strategic directions and activities.

The Reference Group was established for this purpose in 2001. The Reference Group membership provides national representation from the Deans of Medical Schools, University Departments of General Practice, the Australian Association of Academic General Practice, University Rural Health Units, RUSC Co-ordination Units, rural General Practitioners, an Aboriginal health representative and medical students. In addition, the General Practice Branch Department of Health and Aged Care is represented on the Group.

Components of the Program

Rural medical education and support

The RUSC Program provides resources to Departments/Disciplines of General Practice, through medical schools, to facilitate and enhance change in three key areas – student selection, educational experience and support systems for students and staff (academic and rural GP educators). This is achieved through specified targets which support:

- ♦ rural student selection
- ♦ curriculum design and assessment
- ♦ rural placements
- ♦ rural teachers and academic support
- ♦ student support
- ♦ rural medicine as a career
- ♦ Indigenous health
- ♦ gender awareness

Student placement co-ordination

The RUSC Program provides resources to Departments/Disciplines of General Practice, through medical schools, for the co-ordination of curriculum placements. Schools may elect to provide the co-ordination directly or manage the activities through a state-based co-ordination unit. In addition, because the two co-ordination units in the Northern Territory manage placements for students from all universities, they are funded separately under the Program.

Co-ordination funding is to assist with arranging curriculum placements and paying related travel and accommodation expenses.

National projects

The RUSC Program provides limited funding for national projects, i.e. initiatives which impact on all medical schools and enhance progress in bringing about changes consistent with Program goals and targets.

The RUSC targets

Student selection

At least 25 percent of students enrolled in medical schools are of rural origin (, currently RRMA 3-7, with at least five years rural residence (consecutive or cumulative) from commencement of primary school) and a minimum of 15 percent are from more isolated communities (RRMA 4-7). The selection process is undertaken by staff with a rural background and understanding of rural issues. This target acknowledges geographic and demographic differences between states/territories and that some medical schools may far exceed this target while others may have difficulty achieving this goal.

Curriculum design and assessment

A rural focussed curriculum that promotes and integrates rural practice and is designed by people who understand rural health, with delivery commencing early in the course. The curriculum highlights the rural context by focusing on learning needs about rural health, the rural social environment, clinical skills and decision making appropriate to rural practice, and avoids the use of case study stereotypes.

Appropriate assessment to match curriculum objectives is undertaken by rural practitioners and academics with experience of rural practice.

Rural placement

A minimum of 8 weeks structured residential rural placement for every student. This is to be undertaken throughout the curriculum to maximise training opportunities and breadth of experience, and commence early in the course. A substantial part is in rural general practice and the remainder in rural hospital or community service, with a minimum of 50 percent community experience overall and a minimum of 50 percent community experience in the early placement.

Rural teachers and academic support

The educational development and support for teachers in rural areas is developed further and improved by:

- investigating and implementing the most appropriate form of support; and
- utilising regionalised training programs linked to GPET regions, clinical schools and UDRH

Student support

Rural GP academic and administrative support for students through rural health clubs is maintained and improved through designated funding provided from the core RUSC grant. The grant is set at \$10,000 p.a. or 15% of grant, whichever is the greater.

Rural medicine as a career

Each medical school maintains a program which promotes rural medicine as a career option to rural secondary school students and/or potential rural origin graduates, and provides appropriate information and support activities.

Indigenous health and indigenous student recruitment

Suitable curricula in relation to rural indigenous health are implemented which address local and national needs. As part of the rural curricula, all students undertake appropriate cultural awareness training and increase their awareness of indigenous health issues.

Support mechanisms are established and maintained to assist in the selection and retention of rural Indigenous Australian medical students.

Gender awareness

Gender awareness training, covering broad gender issues and with particular focus on issues for women in rural general practice, is included in the curriculum.

Student placement co-ordination

The function of student placement co-ordination is to:

- co-ordinate, facilitate and support curriculum placements for students. Placements may only be in , currently RRMA 3-7 (with preference for RRMA 4-7);
- work in co-operation with the other medical school/s in their state, Rural Clinical Schools, University Departments of Rural Health and (when appropriate) the Northern Territory Co-ordination Units and the administering agency for the John Flynn Scholarship Scheme, Rural Workforce Agencies and Divisions of General Practice in co-ordinating student placements;
- streamline placements to ensure that rural practices, where possible, are not contacted direct by multiple organisations;
- have an appropriate infrastructure in place to facilitate the co-ordination processes and personnel required to undertake the task;
- encourage more rural doctors to provide placements;
- provide financial subsidies to Department of Employment Science and Training (DEST) funded students participating in placements. The subsidy level provided will be dependent on placement requirements;
- liaise with senior academic staff in Departments/Disciplines of General Practice, Rural Clinical Schools and University Department of Rural Health to better focus activities;
- provide appropriate cross cultural awareness programs and comprehensive orientation procedures, especially for those students placed in indigenous communities; and
- have appropriate data collection procedures in place to capture information about placement of medical students.

The accountability and reporting framework

Rural medical education and support – the RUSC targets

The framework in which accountability and reporting sit is made up of three elements:

- the eight RUSC targets;
- the funding agreement requirements; and
- annual workplans submitted by each university which detail proposed achievement of the requirements in each academic year.

Universities should have regard for all these elements in their reporting, particularly focusing on achievements against their workplans.

An important feature of the Program is that requirements set out in the funding agreements are flexible, enabling universities to remain responsive to the local medical education environment and the needs of their state rural areas. To this end, the proportion of funds to be spent against each of the targets (with the exception of student support) is not prescribed, and although encouraged to do so, universities are not required to report detailed expenditure against the targets individually.

In maintaining this flexibility, the Department has recognised that the rate of progress against RUSC Program targets varies across universities.

National database

A national database will be developed by the RUSC Reference Group, incorporating a unique student identifier, as the basis for improved program evaluation through:

- assessing the effectiveness of specific RUSC targets in contributing to the likelihood of graduates taking up rural practice;
- tracking students over time in order to assess the effectiveness of RUSC targets in achieving the overall RUSC aim; and
- facilitating a major longitudinal student cohort study.

An interim minimum data collection is attached to the reporting proforma at Attachment 1.

Performance indicators

In establishing the contribution of the Program to the support of rural general practice, the performance indicators describe how the funding contributes to the achievement of the targets and how RUSC integrates with Rural Clinical Schools and University Departments of Rural Health.

A reporting proforma has been developed which provides for a mix of quantitative and qualitative information against each target and against which each university should report on their achievements. The proforma is at Attachment 1.

Funding agreement requirements

To support the achievement of RUSC targets and student placements, funding agreements between the Commonwealth of Australia (through the Department of Health and Aged Care) and each university provide for the payment of prescribed funding. Separate agreements are made with the two co-ordination units in the Northern territory.

Funding agreements cover a three year period, subject to the provision of annual reports and acquitted financial statements within the stipulated timeframe.

Universities are to direct all RUSC Program funding outlined in the agreement towards the support and development of general practice in a rural context as an academic discipline. It must be used solely to support rural general practice initiatives and not broader rural health initiatives.

Funds must be managed by staff within the department/discipline of general practice (or its equivalent).

Evaluation

There are two components to the Program evaluation. The provision of nationally consistent quantitative and qualitative information against the targets and the national database will facilitate ongoing monitoring, contribute to the Program's accountability requirements and provide baseline data for the evaluation.

An evaluation of the RUSC Program will be undertaken in the third year of funding (2004/05) to assess the outcome of the Program as a strategic long term initiative to increase the number of medical graduates adopting a career in rural general practice. The evaluation will examine achievements against the RUSC targets, the effectiveness of the targets, the reporting and accountability framework and the co-ordination function.

Development of the Program

The Rural Incentives Program

The 1992 Budget announced a major strategy to improve access to general practitioner (GP) services, to encourage better links between general practice and the rest of the health system and to enhance the quality of general practice. The Rural Incentives Program (RIP) was a key element of the strategy which has implemented measures to encourage rural general practice and address the maldistribution of GPs by providing better access to GP services for rural Australians. RIP comprised a series of grants for GP relocation, training, continuing medical education and locum support, rural undergraduate education support and remote area support. Funding was made available under RIP for the rural undergraduate component to encourage medical students to seek a career in rural general practice.

The Rural Undergraduate Steering Committee final report

The Rural Undergraduate Steering Committee (RUSC) was established in 1993 to provide advice on innovative strategies for increased recruitment of medical students to rural practice, to assess options and make recommendations for the implementation of the undergraduate component of RIP.

The Committee presented its final report in 1994 and recommended a series of strategies to increase: the number of rural-based students enrolling in medical schools; the rural component of medical school courses; and the infrastructure support systems.

It proposed that:

- the majority of funds be made available to medical schools on the condition that the schools meet a range of targets and achievable outcomes;
- funds be made available to the states and Northern Territory to provide direct student support and co-ordination of community resources; and
- the balance of funds be allocated to projects of national significance and to those medical schools demonstrating significant progress towards achieving the targets.

RUSC mid term review

The review was conducted in 1997 with two broad objectives:

- to further monitor the progress of individual medical schools and the extent to which the overall performance of medical schools reflects the aims of the RUSC Program; and
- to take account of the changing context of rural health education and to ascertain how this may affect the overall implementation of the RUSC Program.

The report found an overwhelming consensus that the Program had been and remained an important catalyst for change, and that the nine RUSC targets were generally accepted as appropriate for improving undergraduate rural experience. Through its focus on rural

practice and the need for appropriate medical training, RUSC had contributed to a change in culture and a move away from traditional training and teaching models. It had contributed to increased awareness of the need for a more integrated program of medical education for rural practice and a focus on the nature and quality of rural experience.

The report acknowledged that the outcome-based nature of the program provided medical schools with the flexibility to develop strategies which were appropriate to their individual circumstances to achieve the targets.

The report also found that the rate of medical schools' progress in implementing change and their commitment to rural health varied considerably as did the relationship between medical schools and their state co-ordination agency. The report queried the effectiveness of continuing funding support for underperforming medical schools and the appropriateness of continued separation of the support and co-ordination grants from medical schools.

The report identified actions which were critical to the continued development of the program:

- defining rural origin;
- stimulating a commitment to teaching of Indigenous health and support for the development of appropriate curriculum resources; and
- providing appropriate remuneration for general practice teachers.

The RUSC Program evaluation

A full review of the program was undertaken in 2000. The aim of the review was to evaluate the RUSC Program and make recommendations on how the program might be better shaped in future to meet its objectives. Within the review, while there was some emphasis on evaluating the extent to which medical schools had met the nine key targets, the report also evaluated the program as part of a continuum of medical education, training and career choice.

The evaluation found that the Program has had a considerable impact, for a relatively small outlay, on increasing the quality of rural medicine education and the rural experience for students. It has acted as a catalyst for change and deserves to be enhanced and receive continuing support.

In terms of achieving the Program objectives, the evaluation found that there has been significant progress across universities in:

- increasing the number of rural origin students;
- increasing the number of students seriously considering rural practice as a career option; and
- improving the integration of rural health issues in medical curricula.

In addition the evaluation found that rural health clubs have supported and raised the profile of rural medicine and that support for students and GP educators has assisted in integrating medical education more closely with rural practice.

The report made recommendations on future directions to ensure the Program remains applicable to rural undergraduate medical education and relevant to the wider environment of

rural health. The recommendations provided for significant improvement in the accountability of the Program and a greater focus on achieving outcomes.

In summary the recommendations focused on six broad directions:

- the continuation of the Program as a specific program with core funding available to each university, directly at departmental level, for activities relating to student selection, placement, mentoring and support for local GP educators;
- the funding should require medical schools to meet quantifiable targets based on consistent data definitions for student selection, placement and academic support;
- additional program specific funding should be available on application to assist with long term strategic projects, such as a national high schools liaison and awareness project;
- a Reference Group should be established to provide overall direction on the Program, monitor achievement against the targets, promote the Program and make recommendations on proposed projects;
- the separation of the roles of the Department of Education, Training and Youth Affairs and this Department to distinguish between activities which are core university business (curriculum, assessment and clinical placement experience) and affirmative programs directed towards workforce training goals; and
- the establishment of a nationally consistent minimal student data set to aid tracking and monitor outcomes.