

COMMUNITY HEALTH TEACHING AND RESEARCH PROJECT (CH TARP)

BACKGROUND PAPER

Introduction

DHS and the Australian Institute for Primary Care (AIPC) at La Trobe University have agreed to release the following summary of an unpublished report *Teaching and Research in Community Health Services* commissioned by DHS and completed by AIPC in 2005. The excerpts are provided as background reading for the statewide Forum to be held by DHS at 50 Lonsdale St on 5 February 2007.

Key Messages

- ✓ Most Community Health Services in Victoria already provide some placements to undergraduate students from one or more health related disciplines, with the number of placements per annum estimated to be between 1000 and 2000. A smaller number of CHSs also employ GP Registrars.
- ✓ Stakeholders see a number of advantages in student placements in CHSs. From the university perspective these include the need to provide learning experiences relevant to the shift from inpatient to ambulatory and community care, the need for more interdisciplinary training, and the imperatives of finding an adequate number of placements for all enrollees. For CHSs the benefits include a role in recruitment and retention, helping clinicians to stay abreast of new trends, a potential to add to the clinical and/or research capacity of the organisation.
- ✓ However, CHS student placements are rarely organised or recorded centrally according to a formal policy. Instead, student placement tends to be a decentralised function arranged at the discipline level, often although not always in an ad hoc fashion.
- ✓ There is enthusiasm among all key stakeholders (universities, CHS, GP training authorities) for moving the placement and teaching of undergraduate and postgraduate students in Community Health Services into a more formalised program.
- ✓ It would be feasible to implement a program that would better meet the needs of all stakeholders while recognising the funding constraints in both the education and health sectors.

1. Background

This project takes place within the broader context of an ageing Victorian population, leading to rapidly expanding demand for the provision of health services in community and ambulatory settings, and a health education system which is under considerable pressure as it attempts to produce sufficient numbers of health practitioners to meet community demands and which still relies predominantly on the acute sector to provide placements for students.

Community Health Services (CHS) provide a range of health services to nearly 200,000 registered clients each year and comprise about 20 per cent of the Victorian primary health care sector¹. Within Victoria they are a major platform for the delivery of State-funded, population-focussed, community-based health services². With the demand for community health services increasing, the sector is experiencing severe workforce shortages especially in rural and some outer metropolitan areas. Moving to community-based ambulatory care will require recruitment and transfer of staff with more specialised clinical skills, while retaining specialist health promotion skills.

2. Methodology and Summary of findings

The following project activities were undertaken between January and June 2005:

2.1 Project Reference Group

A Project Reference Group was established including senior university staff from a range of health disciplines, GP Registrar training providers, Community Health Services, students, consumers and government departments (see Appendix 1 for list of Reference Group members).

2.2 Literature Review

A literature review was undertaken. It provides useful background information for designing and implementing community based placement, particularly those that reflect the growing trend towards interprofessional education of health professionals.

2.3 CHS Placement Survey

Because very little was known about current student placements in Community Health Services, a survey was sent to all 100 CHSs in January 2005, asking them to report on their student (and GP Registrar) placements during 2004 (see Appendix 2 for questionnaire). Just over half (54) of the CHSs responded to the survey. The sample was reasonably representative, comprising 36 rural services (67%) and 18 metropolitan services (33%). Just over half (54%) of those sampled were stand-alone services and the remaining 43% were integrated. Of the CHSs sampled that employed dentists, more metropolitan services (20) employed dentists than rural services (15). Twenty three (43%) of the CHSs surveyed employed general practitioners.

Despite the representativeness of the surveyed CHSs, the data was of limited value, with most CHSs finding it very difficult to provide accurate reliable data on student placements. However, the survey did provide a useful insight into the ways in which student placements are currently handled by CHSs.

¹ Australian Institute for Primary Care (2002) Unpublished report on primary health care workforce for DHS.)

² *I.b.i.d*

2.4 Key Stakeholder Interviews

Just over 40 key stakeholder interviews were undertaken: 25 university staff across four universities and nine disciplines, eleven CHS CEOs³ and representatives of GP training authorities and government departments concerned with development of the health workforce. Interviewees were chosen from those CHSs that had responded to the survey, and were selected to achieve a balance across rural and metropolitan areas and stand alone and integrated services. The project reference group also provided valuable input.

The semi structured interviews aimed to follow on from the survey, identifying issues including barriers and incentives to student placements. The interviews covered existing placement requirements and practices, attitudes towards CHS placements, barriers and enablers to student placements.

Findings:

There was a high level of consistency between stakeholders, including the two largest stakeholder groups, universities and community health service providers.

- All stakeholders recognised the importance of student placements and the need to respond to future workforce requirements.
- GP Registrars were perceived as particularly attractive by CHSs because in addition to providing real clinical skills they were more or less cost neutral and had a longer length of stay than other types of students.
- All stakeholders acknowledged the limited financial resources available to deliver student placements. Resourcing issues arise for both universities and CHSs providing placements. Both are under increasing financial pressure with services having the additional difficulty of student placements not being their 'core business', and thus lacking the capacity to cater for medical students requiring long placements and large numbers of nursing students.
- All stakeholders saw CHSs as valuable learning environments for students, and there was a high level of interest in CHSs playing a larger role in the training and education of health professionals in the future.
- CHSs also felt very strongly that their sector could play a unique and substantially larger role in research, but that their potential contributions in this area were not currently recognised by either government or universities.
- There was general recognition that current processes for arranging CHS placements are not optimal. Overall, there was enthusiasm among all key stakeholders for moving the placement and teaching of undergraduate and postgraduate students in Community Health Services into a more formalised program.

Section 9 elaborates on the views expressed specifically by the university sector, the community health sector and by GP training authorities.

3. The Community Health Context

3.1 Community Health Services in Victoria

Community Health Services (CHSs) play an important role in providing a range of health services to many Victorians and comprise about 20 per cent of the Victorian primary health care sector⁴. A workforce of around 8,000 people provides primary health care services from 100 CHSs across more than 250 sites⁵. CHSs fall into two organisational types: 39 are independent Community Health Centres and the remainder are mainly units or

³ These interviewees were chosen from those CHSs, which had responded to the survey, and were selected to achieve a balance across rural and metropolitan areas and stand-alone and integrated services.

⁴ Australian Institute for Primary Care (2002) Unpublished report on primary health care workforce for DHS.)

⁵ *Ibid.*

divisions of larger health services, such as Metropolitan or Rural Health Services and hospitals. CHSs provide primary health and support services to nearly 200,000 registered clients each year, and are a major platform for the delivery of State-funded, population-focussed, community-based health services within Victoria⁶.

Programs provided by CHSs vary according to local needs and funding arrangements and can include:

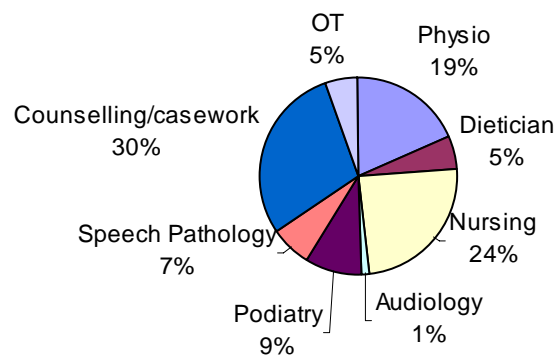
- Allied health
- Community nursing
- Counselling/casework
- General Practice
- Dental
- Health promotion
- Social support and coordination of volunteers
- Drug treatment
- Mental health
- Youth services
- Disability services
- Rehabilitation services

CHS clients are concentrated among people on low incomes, older aged people, and children. More than 80 per cent of clients are Health Care Card holders. Most clients suffer from, or are at risk of, chronic and complex conditions⁷.

CHSs have combined annual budgets (from multiple program areas) estimated at about \$400 million. The Community Health Program funds only 25 per cent of the services provided by CHSs: about \$75 million for direct services (allied health, counselling and nursing) and \$30 million for health promotion. Other important funding sources include the Home and Community Care (HACC) program, the Community Dental Program, Disability Services and Drug Treatment Services⁸.

The figure below shows the distribution of direct service hours for nursing, allied health and counselling/casework in CHSs in 2000-01.

Figure 1: Distribution of Allied Health Direct Service Hours, 2000-01 within CHSs



Health practitioners employed in CHSs (and relevant to this project) include:

3.2 General Practitioners

GPs have worked in CHSs within a multidisciplinary environment since their inception in the 1970s. Although the numbers of GPs declined after the State Government discontinued direct funding for GPs in CHSs in the early 1990s, in 2001-2002, there were

⁶ *Ibid*

⁷ Department of Human Services (2004) **Community Health Services – creating a healthier Victoria**

⁸ *ibid.*

still around 97 EFT GPs delivering medical services from 29 of the 100 CHSs. These services were all funded through Medicare income. Just over half of these CHSs employed salaried GPs. Other arrangements included private co-located practices and income sharing⁹.

GPs in CHSs generally deliver services through a social model of health by:

- Responding to the complex needs of disadvantaged clients;
- Applying a holistic approach to assessment and care planning, incorporating biomedical, psychological, social and cultural factors impacting on health status;
- Frequently collaborating on an informal basis with allied health professionals to deliver integrated care.

Dental Practitioners

CHSs are the major provider of public dental care. There are 50 community dental clinics operating from 43 CHSs. Placement of dental clinics in CHSs allows dental care to be integrated with other primary health services, especially with health promotion. This has improved access to care and allowed services to reach more marginalised population groups¹⁰.

Most of this work is funded through the Community Dental Program operated by Dental Health Services Victoria (DHSV) with funds from DHS. The Community Dental Program provides services for Health Care and Pensioner concession card holders and their dependants. There are also an increasing number of co-location arrangements, with government funded pre-school and school dental services delivered from CHSs¹¹.

3.3 Nursing

CHSs are major providers of community-based nursing services funded primarily through the Community Health and HACC programs. Nursing is provided at services, in the home and from other community sites. It may involve clinical care, early identification and intervention and health promotion. Community nurses will often work with a focus on one or more population health issues. This might include working with particular at-risk groups, such as adolescents or socially isolated older people, or it might involve a health focus such as diabetes, asthma or sexual health¹².

3.4 Allied Health

All CHSs provide a range of allied health services. These can vary between CHSs but include physiotherapy, occupational therapy, speech therapy, audiology, dietetics and podiatry. With evidence from the field suggesting that around one-third of referrals to CHSs arise in acute service settings, the availability of allied health in CHSs is critical to reducing demand for acute services and supporting people post-discharge. For many low-income people, CHSs offer the only affordable venue for allied health treatment¹³.

3.5 Counselling and Casework

As shown in Figure 1, counselling/casework accounts for the largest number of CHS direct service hours, data indicates that community health counselling services up to 7.5% of Victorians seeking help for non-psychotic health problems, including anxiety, depression and family and relationship conflict. Counselling in community health represents the most systematic effort to provide intervention for this population¹⁴.

⁹ Department of Human Services (2004) **General Practitioners in Community Health Services Strategy**

¹⁰ Department of Human Services (2002) **Towards a Community Health Policy Framework: discussion paper**

¹¹ *ibid.*

¹² *ibid.*

¹³ *ibid.*

¹⁴ Department of Human Services (2002) **Review of Counselling Services in Community Health: a discussion paper**

In addition to Community Health Program funding, many CHSs receive funding from other State or Commonwealth programs to provide more specialised counselling, including drug and alcohol, problem gambling and family support¹⁵.

3.6 Health Promotion

Health promotion and illness prevention have been core functions of CHSs since their inception. All CHSs are required to undertake planned and integrated health promotion programs and campaigns, and to submit formal health promotion plans. It is widely recognised that CHSs have a wealth of knowledge and experience in community-based health promotion. In particular, they work actively on integrated health promotion initiatives with other primary care providers in their catchment areas (including local government) through the Primary Care Partnership strategy.

3.7 Policy Context

The State Government's Community Health Policy, launched in September 2004, sets out five major strategic directions for Community Health Services over the next decade:

1. Strengthen CHSs to be a major platform for delivery of primary health care
2. Coordinated community-based disease management and ambulatory care
3. Expanded primary medical care
4. Increased focus on child and family health
5. Leadership in health promotion¹⁶.

Workforce development is identified as one of the key enabling strategies required to further develop and expand the role of Community Health Services. The policy document points out that there are already challenges in recruiting health practitioners, especially in rural and some outer metropolitan areas, and that moving to community-based ambulatory care will require recruitment and transfer of staff with more specialised clinical skills, while retaining specialist health promotion skills. The workforce development initiatives set out in the policy document include examining options to establish 'teaching Community Health Services' in both metropolitan and rural areas to provide increased access to primary care settings for medical, nursing, dental and allied health students.

Within the context of its broader Community Health Policy, the State Government has a separate and specific General Practitioners in Community Health Services Strategy¹⁷. It is believed that more well-positioned GP services in community settings will reduce primary health-type presentations in Emergency Departments, and link these patients to a broader range of primary health care services. The 2004-2005 State Budget provided \$8million over four years for the GPs in CHSs Strategy.

The State Government's *Care in Your Community* strategy is a planning framework for integrated community-based ambulatory health care. One of its key principles is to configure the workforce to deliver integrated health care, and to have a future workforce that is flexible and multi-skilled, and able to deliver care in a variety of settings including community and home based settings.

¹⁵ Department of Human Services (2002) **Towards a Community Health Policy Framework: discussion paper**

¹⁶ Department of Human Services (2004) **Community Health Services – creating a healthier Victoria**

¹⁷ Department of Human Services (2004) **General Practitioners in Community Health Services Strategy**

4. The Number of Student Placements in CHSs

Although core funding provided to CHSs through the Community Health program is intended to include provision for supervision of students undertaking placements, service delivery data provided by CHSs can not distinguish (and hence enable quantification of) student supervision as opposed to other activities. As a result, available information about the role of CHSs in providing student placements is largely anecdotal.

As described above, the project undertook a survey of student placements in CHSs to provide a firmer knowledge base. Unfortunately, the data was of limited reliability, largely due to the fact that at present student placements are generally not managed (or recorded) centrally by CHSs, but are arranged at the individual discipline level. However, the survey data does provide some information about student placements:

- The 54 CHSs which completed and returned a survey reported a total of 720 students undertaking placements in: Audiology, Dental, Dietetics, Medicine, Nursing, Occupational Therapy, Physiotherapy, Podiatry, Social Work and Speech Pathology.
- In 2004, most of these CHSs (74%) placed nursing students and
- About half the CHSs placed social work students (52%).
- Fewer than half the CHSs that responded placed physiotherapy students (43%), dietetic students (43%) and occupational therapy students (44%)
- Just under a third accommodated podiatry (30%) and medical students (31%).
- Twelve CHSs took in speech therapy students (22%),
- Seven (13%) of CHSs employed General Practice Registrars, with another two planning to employ GP Registrars in the near future.
- Six placed dentistry students
- Two placed audiology students (4%).
- The clinical disciplines with the most students placed were nursing and podiatry.

The number of student placements reported by CHSs ranged from none to 91, with only two not placing any students during this period. However, data is unreliable because high reported numbers were often the result of CHSs accepting large groups of students visiting for short (sometimes one day) observational visits. However, some CHSs did not count these visits as placements, reducing their reported placement numbers by comparison.

Arriving at any meaningful conclusions about current student placement numbers in CHSs on the basis of the survey is problematic. Although the 54 CHSs which responded to the survey were representative of CHSs overall in most respects, it is possible that they were more heavily involved in student placements than non-participating CHSs. Further, follow up interviews with CEOs from CHSs that had returned the survey suggested that at least in some cases their returns undercounted the numbers of student placements. This generally related to the decentralised nature of student placement activity in CHSs.

On the basis of this limited data, we can come to a very general conclusion that almost all CHSs take some students on placement, and that there are currently between 1000 and 2000 student placements in CHSs each year in the disciplines covered by the survey.

Data provided by the VUHRC project indicates that an estimated 11,680 Victorian university students currently require approximately 139,292 placement weeks annually (not including dental and social work). On this basis, it would appear that CHSs may take approximately ten percent of students undertaking placements each year. However, it is clear from the survey data that CHSs do not take anything approaching ten percent of the student placement weeks required annually. This could be due partly because of the lack of capacity of CHSs to cater for medical students requiring long placements and large numbers of nursing students.

5. Health Workforce Education in Victoria

According to Commonwealth Department of Education Science and Training data, in 2003 there were 15,043 undergraduate students undertaking health related courses across eight Victorian universities, with 3,321 students completing their courses at the end of the previous year¹⁸. This section of the report contains some basic information about course provision and clinical placement requirements for each of the health disciplines included in this report.

5.1 Medicine

Medical undergraduate education is provided in Victoria by the University of Melbourne and Monash University. Each has an intake of approximately 300 students per year, making a total of around 600. Both schools are located within metropolitan Melbourne and have a number of associated 'clinical schools' based in teaching hospitals. Historically, these teaching hospitals have been located in metropolitan areas. Rural placements have been introduced more recently. However, in the main, these country hospitals have not had the academic staff appointments or teaching resources of metropolitan hospitals¹⁹. Both medical schools have also taken initiatives to increase the proportion of time that students spend in primary and ambulatory care placements.

From the primary care perspective, medical training is unique in that payments for undergraduate placements with General Practice are made through the Health Insurance Commission, which administers Medicare. Accredited practices eligible for Practice Incentive Payments (PIP) can claim \$100 per training session if they meet the following criteria:

- sessions must be a minimum of three hours duration;
- maximum payment of two sessions per medical student per calendar day;
- the medical students must be enrolled in an Australian Medical University and the session must be part of the curriculum for the student; and
- the relevant university must have asked the GP to be responsible for the student's learning experience, even if it occurs outside the GP's surgery.

5.2 Dentistry

The University of Melbourne has been the only school for dentists in Victoria. It also trains oral health therapists, while RMIT trains dental prosthetists, dental assistants and dental technicians. The Bachelor of Dental Science course is a fixed, five year program which enrolls approximately 68 new students each year. Junior students are placed at the new dental hospital which has 140 chairs for student placements, both dental students from Melbourne University and dental technician students from RMIT. Placements for final year students are virtually full time for six weeks.

Although there have been informal arrangements previously between the university and some community health services, other opportunities for placement of dental students in community health services have recently been created around the new dental hospital. This has involved, where possible, building clinics in some CHSs which include space (dental chairs) for additional dental students.

At the recently established University of Melbourne Rural Dental Clinical School in Shepparton, students will be placed through a twelve chair clinic at Goulbourn Valley Health and two chairs at Rumbalara Aboriginal Co-operative.

¹⁸ This data does not include information on physiotherapy students, although it does include student numbers for several disciplines not covered by the current project, such as pharmacy and psychology

¹⁹ Victorian Universities Rural Health Consortium (VURHC), (2002) Clinical Placements in Victoria: Issues affecting co-ordination in nursing and medical education. Available from www.vurhc.org.au

5.3 Nursing

Nurses make up the largest group of health students, with 4,149 undergraduates enrolled in general nursing courses in 2003. This was twice as many as the next largest group of students, those studying medicine. Undergraduate nursing training is available from eight Victorian universities: Australian Catholic University, Ballarat University, Deakin University, La Trobe University, Monash University, RMIT, University of Melbourne and Victoria University. All except Victoria University have nursing schools at rural campuses.

The larger nursing schools tend to have formal contractual (exclusive) arrangements with agencies placing students. The majority of these are hospitals although they include other organisations such as the Royal District Nursing Service (RDNS). Outside these arrangements the placement process for students varies around expressions of interest and personal contacts. The models of placement vary in payment requirements for supervisors, and the timing and duration of placements. Hospitals, however, are more likely to charge for placements than CHSs.

5.4 Allied Health

These are generally four year undergraduate degree courses, with substantial placement requirements. The exception is audiology (a two year postgraduate course following a relevant undergraduate degree). The table below shows the approximate number of first year students for the allied health professions included in this project, by university:

	Physio	OT	Podiatry	Speech	Dietetics	Audio (post grad)
Deakin		60			35	
La Trobe	115	148	40	80		
Monash					35	
Melbourne	100					33
Total	215	208	40	80	70	33

5.5 Counselling/Casework

Although current CHS counsellors have a variety of qualifications, there is a growing emphasis on the need for tertiary education and where possible postgraduate counselling qualifications.²⁰ The current project has chosen to concentrate on social work because it appears that significant numbers of CHS counsellors have a social work background, and because undergraduate social work courses train large numbers of students, all of whom require placements during their courses and some of whom will go on to become counsellors in the health sector. In 2004, there were 1,838 social work students in Victoria, spread across six universities: Deakin, La Trobe, Monash, RMIT, Melbourne and Victoria University.

The majority of university social work student placements in the metropolitan area are allocated through a combined schools student placement database which is currently being managed by Monash University. Universities must pay \$25.50 for each placement requested from the database and each university is guaranteed 60% of the placements requested. Additional placements required may come from agency partnerships involving a variety of contractual or less formal but still regularised arrangements, or from personal contacts.

Placements are undertaken in a broad range of agencies. In some cases where supervision by a social worker is not available on site a task supervisor is used and specific social work

²⁰ Department of Human Services (2005) **Counselling in Community Health Services: future directions and guidelines for quality counselling; public consultation draft**

supervision provided at the university. The models of placement vary including payment requirements for supervisors, level of students being placed and the timing and duration of placements.

5.6 General Practice

The project was also asked to look at training for General Practitioners, which is a postgraduate qualification.

In 2001, the Commonwealth Government established General Practice Education and Training (GPET), to implement and foster regionally provided general practice education and training program across Australia²¹. General Practice Registrars generally undertake a three year training program consisting of paid placements (with some on site clinical training) and formal education programs off site, leading up to the Royal Australian College of General Practitioners (RACGP) Fellowship examination. RACGP undertakes the accreditation of teaching general practices and supervisors according to standards which relate to physical infrastructure, teaching and educational resources, experience and training of supervisors, release for educational activities and general support of registrars.

The national annual GP Registrar intake is currently 600, of which Victoria has been allocated 155 places. Across Victoria there are five providers, four in regional areas and one metropolitan based.

There are several grants and other incentive payments, which are available to boost general practice training, particularly in rural and remote areas.

6. Current Health Workforce Initiatives

Some of the initiatives described below aim to increase the numbers of students being educated in particular health disciplines, others to recruit workers (including new graduates) to particular geographic areas, and still others to retrain and/or retain existing health workers.

Major initiatives identified as being potentially relevant to the current project included:

6.1 Rural Workforce Strategy

The State Government has committed \$6 million over 4 years to the Rural Workforce Strategy to address the significant health workforce shortages in rural and regional Victoria. The key objective is to improve recruitment and retention of health professionals, including doctors, nurses, physiotherapists and other allied health workers in rural and regional Victoria.

6.2 Overseas Trained Doctor (OTD) Rural Recruitment Scheme

Operated by the Rural Workforce Agency of Victoria on behalf of the Victorian Government, this is a program to attract, assess, place and support overseas trained general practitioners in rural and regional Victoria.

6.3 Rural Clinical Schools

In 2001, the Commonwealth Government committed \$117.6m over 4 years to establish Rural Clinical Schools (RCS) attached to university medical faculties. In Victoria, the Victorian Government is contributing \$4.5m over 3 years to each of the University of Melbourne and Monash University for teaching infrastructure and student accommodation.

²¹ Trumble, S. (2003) "Changes to training for General Practice in Australia" *Asia Pacific Family Medicine* 2:171-174

University of Melbourne sites are located at Shepparton, Ballarat and Wangaratta. Monash University sites are located at Traralgon, Bairnsdale, Sale, Warragul, Bendigo and Mildura.

6.4 Victorian Universities Rural Health Consortium

VURHC undertook a DHS funded project to develop sustainable rural health placement models for medical, nursing and allied health students across Victoria. The project follows from a review undertaken for VURHC in 2002, which identified a need for:

- A coordinated approach to rural clinical placements for all health professional students
- Mapping the availability of placements and accommodation
- A centralised co-ordination between the venues and the universities to oversee the success of the rural placements of health science students²².

6.5 Prevocational General Practice Placements Program

As part of the *Medicare Plus* package, junior doctors are offered new opportunities to work in general practice in outer metropolitan, regional, rural and remote areas. The measure provides up to 280 GP placements per year nationally, with the average placement being 12 weeks in duration. Junior doctors who are undertaking hospital training, but not yet enrolled in a specialty, are the target group. Generally they will be in postgraduate years 2 and 3, but there is some flexibility to include later postgraduate years and interns.

This program is managed by RACGP, which has called for applications by training collaborations, which may consist of a number of local General Practices, health services that provide General Practice services, General Practice supervisors, hospitals, universities, local Divisions of General Practice and a fund holder.

4.6 Update from DHS (not in the original AIPC report)

Two further initiatives worth mentioning are:

Clinical Placements

The Department of Human Services has developed the Clinical Placements Strategy to provide a more cohesive and sustainable approach to addressing the range of issues identified by health services, universities and other stakeholders with regard to undergraduate clinical education.

The broad Strategy aims are to ensure over the long term that sufficient undergraduate clinical training capacity exists in Victoria, and that training models are effective and efficient and produce quality outcomes that meet evolving service and community needs and expectations. A range of initiatives are being progressed as part of this Strategy, for example, the department is funding 17 pilot innovative approaches to the organisation and delivery of clinical placements.

These projects aim to identify more efficient and effective training models, promote interdisciplinary and multidisciplinary training models, expand overall clinical placement capacity, and increase the number of suitable placements to incorporate growth across Victoria. In doing so, the goal is to promote an optimal alignment between training models and service and patient needs, and identify opportunities for broader implementation across Victoria.

Rural & Remote Area Placement Program (RRAPP)

This program is designed to provide postgraduate Year 1–3 doctors with a 10-13 week placement in a rural general/community practice. This is a Commonwealth initiative to which the Department is contributing \$25,000 for each of the two Victorian pilots in West Gippsland and North-west Victoria.

7. Student Placement Models

The project investigated the potential to expand and/or utilise existing innovative student placement models designed to increase the numbers of practising health professionals,

²² Mahnken, J. (2002) **Clinical Placements in Victoria: issues affecting co-ordination in nursing and medical education.** VUHRC

particularly but not only in rural areas. Information about each of these models was collected through interviews with relevant staff and examination of available literature. These models provided valuable information about possible challenges, for example, sourcing accommodation for students, appropriate preceptors and host health services; and requirements such as the need for formal assessment and accreditation of student placements in developing a successful model.

7.1 Rural Interprofessional Education Project (RIPE)

This program was established in 2001. It was managed by the Department of General Practice at the University of Melbourne, funded through the Department of Human Services and steered by a consortium of 14 university departments from eight universities. The project aimed to improve students' understanding of other health disciplines and increase interest in rural health practice²³. Students from a variety of health disciplines (medicine, nursing, physiotherapy and pharmacy) volunteered to attend a two week clinical placement in a rural primary health care service, during which they worked with another student, from a different discipline, on a community based project. Accommodation was funded and there was a limited allowance for travel to and from the placement. The RIPE project officer reported that sourcing accommodation for the students on placement was very difficult, and that students sometimes had to use motels or backpackers accommodation, at a high cost to the program.

Health professionals with an interest in interprofessional education were sourced to supervise and coordinate students, and paid an honorarium. Sourcing appropriate preceptors and health services was time consuming and often needed repeat visits to ensure enthusiasm and appropriateness of the placement. However, the project coordinator reported that the preceptors found the placements satisfying, and often participated in the program more than once.

Some students received some credit points towards their courses for participation in RIPE, while others do not. In general, the voluntary dimension of the project was seen as an advantage, because those students who volunteered were typically highly motivated and self-directed, and intrinsically interested in community-based/rural based practice²⁴. On the other hand, the lack of formal assessment or accreditation resulted in a lack of commitment from some students, which risked compromising the value of placements for students and placement sites. The project officer suggested that as a compromise students have a choice of elective work units, including a rural interprofessional placement, but that having made that decision, they would need to fulfil their commitment in order to gain required assessment credits. However, university timetabling arrangements do not appear to allow for this at present.

7.2 Six Cluster Project

Six clusters of health service providers in north and north-east Victoria participated in a project which aimed to support publicly funded rural and regional health service providers to effectively and efficiently supervise clinical placements for undergraduate medical, nursing and allied health students of all universities in North and North-east Victoria.

The project commenced in June 2004 and was funded by the Department of Human Services for one year. Funding enabled services within each cluster to source up to \$5,000 per year to support the placement of students at their service. Clusters were based on geographic proximity and historical affiliations. A central contact person (coordinator) was nominated for each cluster and was usually located at the local hospital. The coordinator was responsible for invoicing for service providers for activities consistent with criteria

²³ RIPE Website www.gp.unimelb.edu.au/research/ripe/ June 2004

²⁴ Stone, N & McNair, R. **The time is RIPE for community-based interprofessional education** (Paper presented at 7th National Rural Health Conference, Hobart, 1-4 March, 2003)

developed and at a pre determined rate. Payments were to be associated with services to students such as supervision, logistical support and accommodation, training of supervisors including transport costs and back-filling of positions and purchasing equipment for teaching undergraduate students. Central administration of the program was through the Department of Rural Health at the University of Melbourne although all universities were encouraged to participate.

7.3 Rural Clinical Placements in Allied Health (La Trobe University)

La Trobe University school of physiotherapy has established a cooperative arrangement with a group of health service providers in the Bendigo area in response to a perceived need to more reliably place students particularly in rural areas. A self funding joint appointment between the university and the Bendigo Health Care Group was created as a central coordinating point. The position is located at the hospital which provides office space and teaching facilities. The arrangement is seen as of mutual benefit in that the university is provided with student placements and the Group is able to address serious recruiting problems.

Services receive \$100 a week for each student from the university. Although La Trobe university charges for training supervisors, services can use the money from the arrangement to pay for this. It is also used to pay for other professional development activities such as conferences etc. The relationship between the university and the Group is very close with the coordinator providing a range of services for staff including PD, acting as a locum when required, assisting with research projects and mentoring. Services also benefit from service staff offering sessional lectures, access to the university library and computers and through sharing of some equipment when it is not being used by students.

Accommodation is not an issue in this model as most students live locally. When they go on placements in the city they exchange accommodation with city students who have their rural placement at Bendigo. Students can rotate through a number of parts of Bendigo health to get both breadth and depth of experience. Multidisciplinary experience is encouraged.

8. Literature Review

The literature review consists of three sections:

1. The teaching hospital, the traditional model for clinical placements of health students.
2. Existing models of community and primary care placements.
3. The growing emphasis on inter-professional education and placements.

It should be noted that the available literature tends to focus mostly on medical education.

8.1 Teaching Hospitals

Historically, teaching hospitals were affiliated with medical schools. This involved direct treatment of patients under the supervision of experienced doctors with patients being cared for by a team of doctors, students and nurses (Stevens 2004). The concept of the teaching hospital now encompasses clinical placements for a range of health professions. According to McColl (2003), teaching hospitals have four main functions: to provide a culture of "lifelong learning" and education, deliver the highest quality undergraduate and postgraduate teaching, and support health-related research. Victoria's history of teaching hospitals is outlined by Walker (1994).

The major teaching hospitals have been critical to Australia's training for health professionals (Brooks, 1999). However, funding problems and the suitability of teaching undergraduates in this environment have issues confronting teaching hospitals (McColl 2003; Prideaux, 2001). According to Prideaux (2001), medical schools are finding it progressively difficult to resource and organise medical education effectively due to reductions in funding of teaching hospitals. Universities do not have the capacity to provide additional funding to support programs run in teaching hospitals.

Teaching hospitals cost more to run than other public hospitals, not only due to the cost of teaching, but also because they tend to treat more complex cases and carry out more research (Duckett, 1994). The Royal Australian College of Physicians estimates that teaching hospitals require 10-20% additional funds, and that the capacity of hospitals and medical staff in Australia to offer high quality training for students has been hindered due to diminishing funding and shifting health funding systems. According to the RACP, this has affected the quality and capacity of medical training (RACP 2002).

Reduced hospital stays and increased throughputs have made it difficult for trainees to spend valuable clinical time with patients. Critical aspects of patient management are now executed outside the hospital system (at outpatient level), particularly with some sub-specialities like rheumatology and endocrinology, so trainees often fail to benefit from training in these areas of medicine (RACP 2002).

The change to casemix funding systems and increasing cost constraints has also impacted training opportunities within teaching hospitals (RACP 2002). Reduced funding has resulted in hospitals concentrating on clinical service delivery. Hospitals have begun to question their involvement in teaching and research, despite having a considerable component of their budgets that acknowledges their teaching function (Prideaux 2001, p497). Contracting out pathology and diagnostic imaging by hospitals has led to trainees not having access to consultants in these fields and missing out on vital instruction. Furthermore, restraints in funds have limited trainee overtime and have reduced patient contact and "loss of continuity of care" (RACP 2002). Outpatient clinics have also been shut down or privatised therefore removing a valuable pool of patients from contact with trainees (RACP 2002).

Another major issue facing the teaching hospital system is that while most health students do clinical placements in hospitals, most patients receive their health care in community settings (Anderson, Lennox & Peterson, 2003; Worley, Silagy, Prideaux, Newble & Jones,

2000; Wasylenki, Cohen & McRobb, 1997; O'Keefe, White, Spurrier & Fox, 2001). As a result, students only receive experience in a fraction of clinical conditions and in particular may not experience the treatment of chronic illness in a relevant environment (O'Keefe et al, 2001; Oswald, Alderson & Jones, 2001). With declining inpatient numbers, shorter hospital stays and more specialised care being provided in the community, there is a growing need for medical education to incorporate primary care training (Howe, Crofts & Billingham, 2000).

8.2 Student Placements in Community Settings

The literature refers to a number of initiatives and studies managing clinical placements in the community in both Australia and internationally. Unfortunately, however, this literature is confined to student evaluations of their experiences and the short-term effects of community placements. The following is a brief summary of models of teaching students in the community.

Australia

The South Australian Centre for Rural and Remote Health (SACRRH) and the **Adelaide University Department of General Practice** have developed a primary health care model for rural areas (Taylor, Blue & Misan, 2001). The model combines University involvement in running a practice and placements for undergraduate health care students. The model generally consists of a family medical practice, staffed by GPs, who usually hold a fractional academic appointment, co-located with an allied health team, hospital or accident and emergency service. Each practice was managed by a community board. Agreements and memorandums of understanding were developed to cover roles and financial responsibilities. About 85% of the students were studying medicine, with the remainder being allied health students (Taylor et al, 2001). Students were all exposed to a broad range of clinical and community activities in a rural multidisciplinary environment.

The **University of Adelaide and Flinders University** collaborated to provide a single coordinated community child health placement (O'Keefe et al, 2001). The University of Adelaide coordinated all placements, although agencies were approached in writing on joint letterhead. The universities encouraged the students to see the agency through the eyes of the client. Students identify a patient from their allocated agency and then follow that child through a multitude of agencies over the placement term (6-8 weeks). The authors found that the placements with community agencies were most successful with small student groups, and hence a large number of agencies had to be recruited and negotiated with. A number of problems were identified including difficulty maintaining effective communication between the agency and the university. They also found that the large numbers of agency staff involved, and staff turnover, meant an ongoing need for programme orientation (O'Keefe et al, 2001).

In the **University of Queensland's Community Attachment Program** third year medical students have a chance to interact with people with a range of health needs and in a variety of community settings as part of the General Practice and Community Rotation. During the 6-8 week attachment, students become familiar with health-related activities involving individuals, families, social networks, organisations and communities. The attachment offers an opportunity for students to extend their learning beyond the clinical and hospital setting and gain a deeper understanding of people's experiences of health and illness. There are benefits to both students and community organisation. Community organisations obtain knowledgeable, skilful and experienced medical students. Students gain valuable interaction skills, practice and knowledge as well as a better awareness and understanding of particular health issues and insight into their impacts on individuals and families (University of Queensland, 2005). Organisations are not required to take on a demanding teaching role, or assess the students. At the conclusion of the attachment, as part of course assessment, students are required to complete a report and share their

experience with other students. Placements are organised through the registration of interested community organisations and student preferences. A Community Liaison Officer is responsible for arranging the attachments. (University of Queensland, 2005)

United Kingdom

The UK has developed a model for medical education in primary care settings and enabling medical students to develop skills and competencies in patient centred teamwork (Anderson et al, 2003). A consortium of a university and health providers developed the model in 1998, for third year medical students to spend one month working in a community setting. Students are supervised by student nurses, and undertake in-depth patient case studies in pairs. The model draws on the experience and skills of frontline staff, who have rarely contributed to medical education (Anderson et al, 2003). Key factors for the success of this model include the need for close partnership between the medical school and the service. Firm management structures need to be formed between the university and health services and the priorities of the health service must be reflected in the learning opportunities provided to the students. Staff must also be supported and trained to help the students learn, as they may have had little experience in teaching medical education (Anderson et al, 2003).

Canada

The **University of Toronto** has formed partnerships with community agencies to provide first and second year medical students with learning experiences in patient's homes and community organisations (Wasylenko et al, 1997). The program aimed to give students the opportunity to see patients in their homes and experience in population health, health determinants and health promotion. The university formed links with four established networks, representing 150 community agencies. The networks then recruited community agencies within their area to host student placements. The university and the networks work closely to develop a system for selecting and coordinating placements. Agencies involved either have experience hosting student placements, or retain an organisational structure that could accommodate the introduction of placements. The authors emphasise the importance of effective liaison between the university and the community agencies; acknowledging the needs of the community agency; and allowing the community agency to provide significant input into the development of the planning and evaluation of the placements (Wasylenko et al, 1997).

The **Family Medicine Residency Program of the University of British Columbia** is a community-based compulsory rotation for postgraduate physicians. Residents spend a minimum of 64 hours per week for 16 weeks (in Year 1 & 2) with their designated family practice (UBC, 2005). The program combines mentorship, independent learning, one-on-one direct clinical supervision, learning in direct patient care, and small group seminars and formal course work. Residents partake in weekly community based elective units where they learn a range of community services that are accessible to assist in patient care (UBC, 2005). At the end of each elective, the resident has experienced a number of patient-centred care activities such as observing a supportive day care education program and life skills training for 'teen moms' who wish to continue their education; observing the care of patients being followed by a chiropractor in relation to musculoskeletal problems; and spending a day with nurses visiting palliative care patients in their homes (UBC, 2005). The program was founded to meet the training requirements of physicians considering practice in the mid-sized Canadian city. The city of Chilliwack, the hospital and the medical staff constitute support and training for this program (UBC, 2005).

United States

The **Pennsylvania Area Health Education Centre (PA AHEC)** coordinates community-based health professional education and training for medical, dental, nursing, physical therapy, pharmacy and public and allied health students. Working with over 48

community health centres and health centres, the Centre fosters clinical training experiences of working with at-risk populations and teaches the knowledge and skills required to provide quality care in communities with limited resources (PA AHEC, 2004). These students are primarily recruited to train in underserved communities within the Commonwealth (PA AHEC, 2004). Each Pennsylvania AHEC region is matched with a cooperating medical school, setting up associations between participating service providers and universities. This relationship allows for improvement of the providers' skills in patient care by providing opportunities for continuing medical education and training provided by the university. This unit serves to enhance the skills of physicians and other primary care providers in rural and underserved areas. Training is offered at low or no cost to the professional who acts as a preceptor to the health students. Third year medical students are scheduled for 12 one month clinical rotations in community based training sites, usually physician offices or clinics (PA AHEC, 2004).

Clear management structures need to be established between the university and health service, and effective communication between both parties is essential. The literature identified the importance of allowing the community agency to provide significant input into the development and evaluation of the placements and for the priorities and needs of the health service to be foremost. Community agencies can benefit from retaining knowledgeable, skilful and experienced students which in turn can improve patient care. Physicians and other primary health care professionals can also benefit from the experience, but priority must be given to training physicians who take on a teaching role as they may have had little experience in teaching medical education.

By participating in community-based placements, students have an opportunity to experience the social, organic and psychological dimensions of health, sickness and disease and develop a population perspective (Dowell, Crampton & Parkin, 2001; Parry & Greenfield, 2001; QLD, 2005). Students also have the opportunity to engage in collaborative work with other professionals and observe their roles within a clinical setting; students become more aware of other professionals and their roles. This can encourage future collaboration (Leaviss 2000; Howe, 2001; O'Sullivan, Martin & Murray, 2000; Thistlethwaite, 2000).

8.3 Interprofessional Education and Learning

Modern health care demands that practitioners provide an increasingly specialised service (Hall & Weaver, 2001), but this often results in a decrease in interdisciplinary exchange (Loseke & Cahill, 1986). This can lead to increased coordination costs, inefficiency and problems of continuity of care (Duckett, 2005). Interdisciplinary exchange or interprofessional collaboration becomes more necessary as no one health and social care professional can meet and manage the complexity of modern services alone. It is therefore crucial that practitioners have the skill and motivation to work collaboratively with other health professionals. Interprofessional learning (IPL), as defined by the UK based Centre for the Advancement of Interprofessional Education (CAIPE), refers to the occasion when 'two or more professions learn from and about each other to improve collaboration and the quality of care' (Barr, 2001). The literature demonstrates a number of potential benefits of introducing interprofessional learning into student education, but while there is a variety of literature on this topic, there is no research evidence supporting long-term impacts on patient care and educational outcomes.

Most program evaluations have found students were generally positive and enthusiastic about working collaboratively with other disciplines (Wahlström, Sandén & Hammar, 1997; ILI, 2004; Reeves, 2000; Reeves, Freeth, McCrorie & Perry, 2002). However, this depended on whether all students could successfully engage in placement activities (Reeves et al, 2002); whether students had motivation to learn (Reeves, 2000; Dunn & Hansford, 1997); whether the placement impinged on students' other course commitments (Reeves, 2000) or the learning of their own discipline's requirements (ILI, 2004).

Negative stereotyping within the workforce can impede successful collaboration. The literature is divided on the impact of interprofessional learning on breaking down stereotypes. Some studies found that interprofessional placements had no impact on changing negative attitudes (Leaviss, 2000; Reeves, 2000) and other studies found that interprofessional education assisted in overcoming these barriers which were usually learnt from course tutors (Reeves, 2000). Leaviss (2000) recommended introducing interprofessional learning early on in the undergraduate experience to help curb the development of negative attitudes.

In the UK, Reeves, Freeth, McCrorie and Perry (2002) piloted a program at the **Royal London Hospital** to promote interprofessional teamwork in a clinical setting. Six supervised interprofessional teams of students (medical, nursing, occupational therapy and physiotherapy students) covered an orthopaedic and rheumatology ward for a 2 week period. Students carried out profession-specific care duties and also assisted with the nursing duties, such as making beds, to encourage students to work closely together, working morning and afternoon shifts. Students also updated one another by interprofessional team handovers at the beginning and end of their shifts, and attended reflective sessions by university staff where they were able to consider their learnings and experiences (Reeves et al, 2002).

Reeves (2000) also refers to the importance of informal collaborative social activities, such as catching up for coffee. These informal meetings were helpful in consolidating the students' learning and also unpacking issues around developing professional identities. The ILI (2004) also cited the importance of regular contact between students particularly in relation to running regular ward meetings where students can interact with other disciplines and contribute collectively to decision-making regarding patient care and management. Attendance at weekly ward meetings was cited as a crucial feature for students to feel engaged and for teams to function effectively (ILI, 2004).

Also in the UK, **the Family Welfare Association** was funded to report on the feasibility of setting up interprofessional placements in primary care for students in community nursing, social work and occupational therapy. Universities, GP practices and other primary care agencies were consulted in relation to interprofessional learning within placements. Organisational issues were reported as potential barriers to coordinating placements for even a small number of students. There were wide disparities between courses in the timing and duration of placements, and even if students were on placement over the same weeks, the days would not always coincide. Additionally, methods of assessing the skills in interprofessional working acquired by students would need to be identified. Hard pressed staff in primary care services raised doubts about the amount of time, energy and commitment that would be required in order to set up and maintain placements (Cook, Davis & Vanclay, 2001).

In Australia, an **Interprofessional Learning Initiative (ILI)** has trialled the introduction of interprofessional clinical placements in hospitals. The program was conducted at Royal North Shore Hospital (Sydney) and included Medical, Nursing and Allied Health students from the University of Sydney and the University of Technology, Sydney. Students from four courses (medicine, physiotherapy, occupational therapy and dietetics) took part in organised team activities in the Cardiothoracic and Respiratory wards and observed assessment/treatment procedures of other team members (ILI, 2004). At completion of the program students stated that they had a better understanding and appreciation of other disciplines and their roles in patient care, particularly because it gave them the opportunity and confidence to approach other disciplines for advice or information. This impact has also been cited in a number of other studies (Leaviss, 2000; Reeves, 2000). The authors referred to a number of logistical problems including difficulty in coordinating interprofessional placements for students from different disciplines and coordinating ward sessions for student discussion and input into patient care decision-making (ILI, 2004).

An Australian example of a community based interprofessional placement program is the **Rural Interprofessional Education Project (RIPE)**, discussed in the previous section.

Successful interdisciplinary placements rely to a considerable extent on the guidance and teachings provided by the preceptor. Most senior practitioners are now required to adopt the role of educator in the clinical setting, but the literature identifies workload pressures and lack of experience and training as educators as problems faced by placement organisers. Reeves (2000) reported that most preceptors felt under-prepared for the demands of teaching interprofessional groups, especially in making their sessions equally relevant to each professional group. All felt some form of prior training would be helpful. At the same time, students' experiences of placements have been reported as more fulfilling when educators are supportive, have faith in the student's abilities and are themselves competent team members (Hilton and Morris, 2001). Finding appropriate preceptors can be difficult, particularly with time and workload pressures.

Conclusion

Overall, the literature demonstrates that students are generally positive about their interprofessional learning experiences, providing they are motivated and able to successfully engage in placement activities. Reasons for unsatisfactory IPL experiences were due to the participation compromising the learning of an individual discipline and impinging on students other course requirements. However, as a result of working collaboratively in a team, students reported gaining a better appreciation of other professionals' roles in patient care, and, as some studies showed, negative attitudes towards other professions/professionals were reduced.

There are a number of logistical and organisational issues. Timetabling is complex even for small groups of students. Finding a universal method for assessing students' developed skills in IPL is a potential problem. The length of placements and the size of inter-professional teams require consideration; in particular, placements for longer than a two week period (Wahlström, Sandén & Hammar, 1997; Reeves et al, 2002) and interprofessional teams should be kept to a minimal size (Reeves et al, 2002; ILI, 2004).

While there is a lack of specific literature on student placements in community health services, there are examples of models for teaching students in the community and in interprofessional working environments. These models are varied, and none can be transferred directly to fit the specific situation of Victoria's Community Health Services.

Nevertheless, there are valuable lessons from the literature, which confirms an international trend towards providing more primary and community based placements in health to balance the traditional hospital placements, and that interprofessional education is becoming an important feature of health workforce development.

At a practical level, the literature indicates that effective planning, commitment and communication between universities, agencies/hospitals and staff involved in supervision can help ease the pressures of organising student placements.

There are benefits for community agencies in teaching students, such as increased motivation and work satisfaction for staff, which in turn can affect the quality of client care. Student exposure to the community health setting gives students an opportunity to engage in collaborative work with other professionals and observe their roles within a multidisciplinary clinical setting.

9. Stakeholder Views

Section 2.4 provides a summary of the overall views expressed by stakeholders. This section elaborates on the views expressed specifically by the university sector, the community health sector and by GP training authorities.

9.1 Universities

University informants stressed the difficulties associated with providing adequate numbers of student placements for the student numbers and expressed concerns that this was likely to be exacerbated as numbers increase. They reported increasing competition between universities for available placements and that in some cases the shortage of placements is limiting admission numbers. This is occurring within the context of changes to the way universities are financed, with a greater reliance on full fee paying students (including international students) for many courses. Many staff were primarily concerned about how they could improve (or even maintain) the quality of placements in this environment.

At the same time, they recognise that they must educate students to meet changing demands in health. These include an ageing population, the shift from inpatient to ambulatory and community care, and the greater emphasis on managing chronic conditions. Staff involved in curriculum planning were aware of the need to provide more interprofessional education in the health disciplines. Despite the many practical difficulties involved, staff were keen to at least set up the physical and organisational infrastructure for this to occur. From this perspective, CHSs are seen as a particularly attractive placement option because they are multidisciplinary, community based, and focussed on clients with chronic and complex conditions.

However, CHSs were seen as minor players in terms of their capacity to place large numbers of students. CHSs are small organisations, and not all employ practitioners across all disciplines. Additionally, in some disciplines CHSs were seen as being somewhat limited in the kinds of experiences they could provide. This was particularly true for disciplines such as medicine and physiotherapy.

Some university staff also felt that their placement options were being unreasonably limited by inflexible and out of date professional registration bodies. Adding a community health placement to existing placement requirements was generally not seen as possible because of the crowded nature of the curricula in most health sciences.

Despite these qualifications, university informants in general responded very positively to the possibility of opportunities for student placements (or additional placements) in community health services, particularly if the logistics could be streamlined.

9.2 Community Health Service CEOs

CHS informants recognised that participation in the education of health professionals in general, and providing student placements in particular, was an important part of their role. In discussing their reasons for accepting students, CHS CEOs frequently mentioned their responsibility to the future, as well as the fact that having students encouraged clinicians to stay abreast of new trends. Students were also seen as bringing new ideas and enthusiasm into the workplace, although this was tempered by the reality that the quality and attitudes of students varied considerably. Some senior students and (even more so) graduate and postgraduate students were seen as adding to the overall capacity of the CHS because of their ability to either take up a clinical load or to undertake work which was useful but which none of the existing staff had time to do, such as reviews, evaluations and needs studies.

GP Registrars were seen as being particularly attractive because they provide real clinical skills, were financially more or less cost neutral and had a longer length of stay than other types of students. As young GPs, Registrars were seen to provide very positive role models for undergraduate medical students who might be encouraged to consider going into General Practice (and possibly even community health). In general, student placements were seen as a workforce recruitment strategy, particularly in rural areas. Some CHSs also reported that providing student placements improved retention rates by providing senior clinicians with an opportunity to undertake clinical supervision and thus adding to the diversity and quality of their working lives.

CHS informants felt strongly that CHSs could also play a unique and substantially larger role in research, but that this potential contribution was not currently recognised either by government or universities. As a result, they saw an opportunity through enhanced student placements of increasing the understanding of the role of community health services more generally. CEOs stressed the unique role that their services played in the health sector and consequently the value of the experience provided by CHS placements.

At the same time, CEOs argued that their financial resources were extremely limited, and that current funding arrangements did not actively encourage them to participate in teaching or student placements. Their priority was the delivery of services. Financial assistance with student placements would assist with reimbursing the cost of supervision and planning. However there was great enthusiasm for expanding opportunities to develop stronger and more equitable relationships with universities including better coordination of student placements, active involvement in research and opportunities to improve professional development arrangements for CHS staff.

9.3 GP Training Authorities

Those involved with the training of General Practice Registrars saw CHSs as having the potential to play a greater role in the education of GPs at graduate and postgraduate level, although this was to some extent dependent on the success of the GPs in Community Health Strategy in increasing the numbers of GPs either employed by or working in close collaboration with CHSs.

Among the advantages which could be offered by CHSs were the opportunity to work in an egalitarian team relationship with clinicians from a number of disciplines, the greater exposure to clients with serious chronic and complex conditions, the flexibility offered by a funding model which was not necessarily purely fee for service in nature, the cultural and socio-economic diversity of the client group, and the possibilities for adding a practical population health perspective to the Registrars' experience of General Practice. They saw an environment in which CHSs had close relationships with universities and were actively involved in teaching graduates and postgraduates from a range of disciplines as being attractive to GP Registrars (and possibly also Registrars from other medical disciplines such as paediatrics). Informants also saw participation in the GP Training program as providing benefits for CHSs in terms of the provision of supervisor training for existing GPs, recruitment of GPs, and access to training resources and new ideas.

References

- Anderson E.S, Lennox A.I. & Peterson A. (2003). Learning from lives: a model for health and social care education in the wider community context, Medical Education, v37, pp.29-68.
- Barr, H. (2001). Interprofessional education: Today, yesterday and tomorrow, a review, London: CAIPE.
- Brooks, P.M. (1999). Privatisation of teaching hospitals, The Medical Journal of Australia, v170, pp.321-322.
- Combined Universities Interprofessional Learning Unit (CUILU) (2004). Combined Universities Interprofessional Learning Unit, accessed on 09/05/2005 at www.sheff.ac.uk/cuilu, London, UK.
- Cook, A., Davis, J. & Vanclay, L. (2001). Shared learning in practice placements for health and social work students in East London: a feasibility study, Journal of Interprofessional Care, v15, n2, pp185-190.
- Department of Human Services (DHS) (2002). Towards a community health policy framework: Discussion paper, Community Health Unit, DHS, Victorian Government, Melbourne.
- Department of Human Services (DHS) (2004). Community Health Services: Creating a healthier Victoria, Primary and Community Health Branch, DHS, Victorian Government, Melbourne.
- Dowell A., Crampton P. & Parkin C. (2001). The first sunrise: an experience of cultural immersion and community health needs assessment by undergraduate medical students in New Zealand, Medical Education, v35, pp.242-49.
- Duckett, S.J. (1994). Reform of Public Hospital Funding in Victoria, School of Health Services Management, University of New South Wales, Sydney
- Duckett, S.J. (2005) Health workforce design for the 21st century, Australian Health Review v29(2), pp201-210
- Dunn, S.V & Hansford, B. (1997). Undergraduate nursing students' perceptions of their clinical learning environment, Journal of Advanced Nursing, 25, pp1299-1306.
- Hall, P. & Weaver, L. (2001). Interdisciplinary education and teamwork; a long and winding road, Medical Education, 35, pp867-875.
- Howe, A. (2001). Patient-centred medicine through student-centred teaching: a student perspective on the key impacts of community-based learning in undergraduate medical education, Medical Education, v35, pp.666-672.
- Howe, A., Crofts, D. & Billingham, K. (2000). Can nurses teach tomorrow's doctors? A nursing perspective on involvement in community-based medical education, Medical Teacher, v22, n6, pp.576-581.
- Howe, A. & Ives, G. (2001). Does community-based experience alter career preference? New evidence from a prospective longitudinal cohort study of undergraduate medical students, Medical Education, v35, i4, pp391-398.
- Interprofessional Learning Initiative (ILI). (2004). The Interprofessional Learning Initiative: Report on the 2004 program, An educational program for the Northern Clinical School, University of Sydney and Royal North Shore Hospital in conjunction with the University of Technology, Sydney.
- Leaviss, J. (2000). Exploring the perceived effect of an undergraduate multiprofessional educational intervention, Medical Education, v34, pp.483-486.
- Mathers J., Parry J., Lewis, S. & Greenfield, S. (2003). What impact will the 'conversion' of two district general hospitals into teaching hospitals have? Views from the field, Medical Education, v37, pp.223-232.
- McColl, G. (2003). Introduction to possible private hospitals as teaching hospitals. Presentation at University of Melbourne Planning and Strategy Conference, 9-11 October 2003.
- Mennin, S. (2000). Community-based medical education: toward the health of the public, Medical Education, v34, pp.503-504.
- O'Keefe, M., White, D., Spurrier, N. & Fox, N. (2001). An inter-university community child health clinical placement programme for medical students, Medical Education, v35, pp.384-390.

- O'Sullivan, M., Martin, J. & Murray, E. (2000). Students' perceptions of the relative advantages and disadvantages of community-based and hospital-based teaching: a qualitative study, Medical Education, v34, pp.648-655.
- Oswald, N., Alderson, T. & Jones, S. (2001). Evaluating primary care as a base for medical education: the report of the Cambridge Community-based Clinical Course. Medical Education, v35, pp.782-788.
- Parry, J. & Greenfield, S. (2001). Community based teaching: killing the goose that laid the golden egg? Medical Education, v35, pp.722-723.
- Pennsylvania Area Health Education Centre (PA AHEC) (2004). Community-based health [accessed on 07/02/2005 at: <http://www.nwpaahcec.org/combase.html>].
- Petchey, R., Williams, J. & Baker, M. (1997). 'Ending up a GP': a qualitative study of junior doctors' perceptions of general practice as a career, Family Practice, 14, 3, pp194-198.
- Prideaux, D. (ed) (2001). Country report: Australia, Medical Education, v35, pp.495-504.
- Reeves, S. (2000). Community-based Interprofessional education for medical, nursing and dental students, Health and Social Care in the Community, 8, 4, pp269-276.
- Reeves, S., Freeth, D., McCrorie, P. & Perry, D. (2002). "It teaches you what to expect in future ...": interprofessional learning on a training ward for medical, nursing, occupational therapy and physiotherapy students, Medical Education, 36, pp.337-344.
- Royal Australasian College of Physicians (RACP) (2002). Health financing: response to the senate inquiry into public hospital funding [Accessed on 01/02/2005 at www.racp.edu.au/hpu/finance/senate/funding4.htm].
- Stevens L.M. (2004). Academic health centres, The Journal of American Medical Association, v292, i9, pp.1134.
- Stone, N. & McNair, R. (2003). The time is RIPE for community-based interprofessional education, (Paper presented at 7th National Rural Health Conference, Hobart, 1-4 March, 2003)
- Taylor, J., Blue, I. & Misan, G. (2001). Approach to sustainable primary health care service delivery for rural and remote South Australia. Australian Journal of Rural Health, 9, pp.304-310.
- Thistlethwaite, J.E. (2000). Introducing community-based teaching of third year medical students: outcomes of a pilot project one year later and implications for managing change, Education for Health, v13, n1, pp.53-62.
- University of British Columbia (UBC) (2005) Department of Family Practice: Chilliwack Residency Site, Canada [Accessed on 08/02/2005 at: <http://www.familymed.ubc.ca/chilliwack/curriculum/familymedicine.htm>].
- University of Queensland (2005). Building Partnerships Program: Community Attachment Program, Queensland. [Accessed on 08/02/2005 at: http://www.sph.uq.edu.au/CPHC/BPP/programs_comattach.html].
- Wahlström, O., Sandén, I. & Hammar, M. (1997). Multiprofessional education in the medical curriculum, Medical Education, 31, pp425-429.
- Walker, C. (1994). The emergence of the hospital system in Melbourne: 1846-1975, La Trobe University, Melbourne.
- Wasylenki, D.A., Cohen, C.A. & McRobb, B.R. (1997). Creating community agency placements for undergraduate medical education: a program description. Canadian Medical Ass'n Journal, 156(3), pp.379-83.
- Worley, P., Silagy, C., Prideaux, D., Newble, D. & Jones, A. (2000). The parallel rural community curriculum: an integrated clinical curriculum based in rural general practice, Medical Education, v34, pp.558-65.

Appendix 1

Project Reference Group

Professor Meg Morris
School of Physiotherapy, Faculty of Health Sciences, La Trobe University

Dr Hanny Calache
Dental Health Services Victoria

Ms Maureen Williams
Inner South Community Health Service

Associate Professor Hannelore Best
Director of Nursing, University of Ballarat, Horsham

Professor Olga Kanitsaki
Division Head, Department of Nursing and Midwifery, RMIT University

Professor Teng Liaw
Director, Department of Rural Health, University of Melbourne, Shepparton

Professor Leon Piterman
Head of School of Primary Health Care, Faculty of Medicine, Nursing and Health Sciences
Monash University

Ms Kaye Cole
Board Member, Health Issues Centre

Mr Michael Reardon
Victorian State Manager, Department of Education, Science and Training

Alex Wightman
Medical Student, University of Melbourne

Demos Krousos
CEO, North Richmond Community Health Service

Dr Rod Wellard
CEO, Gippsland Education and Training for General Practice

Vicky Mason
CEO, Darebin Community Health Service

Assoc Prof Lynne Adamson
School of Health and Social Development
Faculty of Health and Behavioural Sciences, Deakin University

Jeff Young
Family Therapist, Bouverie Centre, La Trobe University

Sue Clarke
CEO, Bendigo Community Health Service
(invited to join final meeting)

Appendix 2

Agency Questionnaire

COMMUNITY HEALTH SERVICE STUDENT PLACEMENTS 2004

Service/CEO name

Clinical Discipline	Year Course of	Number of Students	Total placement duration (weeks)	Hours per week
Audiology				
Dental				
Dietetics				
Medicine				
Nursing				
Occupational Therapy				
Physiotherapy				
Podiatry				
Social Work				
Speech Pathology				

Does your Service employ GP Registrars?

Would you be willing to take part in a follow-up interview?

Please return completed form by Friday 11 February 2005