

# Perceptions of work-integrated learning in rural health and human services under the National Disability Insurance Scheme in Australia

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The impact of Australian disability policy reform, known as the National Disability Insurance Scheme, on the capacity of rural health and human service organizations to facilitate higher education has been poorly investigated. This study explored how health professionals perceive the impact of the National Disability Insurance Scheme on nursing and allied health work-integrated learning (WIL) in rural host organizations during the scheme's implementation in Victoria, Australia. Data collected from 20 health professionals across rural Victoria were thematically analyzed and mapped onto WIL dimensions. This process revealed themes relating to shifts in WIL purpose, context, nature and responsibilities. The findings suggest the National Disability Insurance Scheme may have limited rural organizational capacity to host students undertaking WIL, and in turn, contributed to a decline in rural health education during the implementation phase. Thus, WIL partners may need to pay greater attention to the policy framework surrounding rural WIL opportunities.

Keywords: health and human services, higher education, National Disability Insurance Scheme, rural health workforce, work-integrated learning (WIL)

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Work-integrated learning (WIL) is a higher education concept that has been widely adopted by different fields in Australia and internationally (Cooper et al., 2010; McRae & Johnston, 2016). The term WIL broadly refers to formal learning opportunities in real world contexts (Effeney, 2020), although other terms are often used to refer to WIL, such as student placements in the field of rural health (Playford et al., 2020; Smith, Sutton, et al., 2018). For some time now, WIL has been considered an important mechanism for improving the Australian rural nursing and allied health workforce (Maloney et al., 2013). Rural nursing and allied health WIL opportunities in Australia, while diverse, tend to follow the professional program model of WIL where discipline professional bodies and universities set placement requirements to meet strict registration policies (Cooper et al., 2010; Universities Australia and Professions Australia, 2016). A key focus of the rural health literature in recent years has been on the learning environments shared between universities and learning sites. The context of WIL, including broader health policies that can shape WIL opportunities and outcomes, has received less attention. This paper focuses on the experiences of rural health and human service employees that host students undertaking WIL, in light of disability policy change in the rural Victorian, Australian context. Cooper et al.'s (2010) WIL dimensions are used to explore these experiences and to identify the particular areas where policy change has impacted on rural health higher education facilitated by rural organizations.

Cooper et al. (2010) identified seven dimensions that interact to support WIL planning: 1) purpose of WIL, 2) the WIL context, 3) multi-level integration, 4) workplace curriculum alignment, 5) reflective learning opportunities, 6) partnership work, and 7) student and host organization support. The dominant purpose for WIL in rural contexts has been to expose students to aspects of working and living in rural areas and encourage them to work rurally following graduation (Keane et al., 2012). WIL

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opportunities allow rural host organizations to contribute to the development of the rural health workforce generally, and aid their own recruitment efforts (Australian Government Department of Social Services, n.d.). WIL opportunities require workplace curriculum to be developed in a way that supports the intended student learning outcomes (Cooper et al., 2010). Health professionals employed by rural host organizations often work with students to design discipline-related WIL curriculum tasks (Maloney et al., 2013), and tasks that also expose students to the generalist, interconnected nature of service provision in rural contexts (Smith, Cross, et al., 2018). Rural health professionals often enable students to reflect on these experiences through supervision (Thomasz & Young, 2016).

Host organizations require differing levels of support to provide WIL opportunities, identified through ongoing partnership management between educational institutions and industry (Cooper et al., 2010). This is particularly the case in rural areas where there are workforce shortages and a lack of other resources to ensure quality WIL experiences. Australian Government investment in rural health workforce initiatives, such as the University Departments of Rural Health, have supported rural organizations to host students, and have led to an increase in the inclusion of WIL opportunities across rural Australia over the last decade (Australian Rural Health Education Network, 2019). Innovative partnerships with a range of health services have enabled quality WIL experiences for students in rural and remote settings (Worley, 2020). However, the context in which rural host organizations facilitate WIL can be impacted by policy and other reforms in areas outside of education and health (de Zwart, 2015). One such policy area is disability, which has undergone significant reform over the last decade in Australia with the introduction of the National Disability Insurance Scheme.

The National Disability Insurance Scheme (referred to as the 'scheme' at times herein), which commenced full roll out in 2016, reflects the international trend toward the personalization agenda aimed at affording people with disability choice and control over supports to live in their community (Carey et al., 2018; National Disability Insurance Scheme Act, 2013). The scheme has significantly increased the number of people with disability using formal services in Australia, and is expected to provide individualized funding and services to 500,000 scheme participants by 2023 (National Disability Insurance Agency, 2019). The scheme has changed the nature of funding available to rural health and human service organizations, from mostly block funding to individualized fee-for-service funding (Australian Government Productivity Commission, 2017). Along with this latter funding model, registered scheme service providers including hospitals, community health services, private allied health practices and disability services, compete to provide services to scheme participants within the scheme service price limits (Green et al., 2018; National Disability Insurance Agency, 2020; National Disability Insurance Scheme, 2020b). The scheme service prices incorporate an overhead amount to cover many non-direct service activity costs incurred during service delivery, including staff professional development and supervision (National Disability Insurance Agency, 2020). However, in rural Victoria, some rural scheme service providers have reduced non-direct or non-billable service activities because they felt scheme funding did not adequately cover these activities (Quilliam & Bourke, 2020).

How WIL partners integrate at a systems level to adjust WIL opportunities in response to contextual shifts driven by disability service policy is yet to be fully understood. The federal government has suggested scheme service providers continue hosting students undertaking WIL by using supervised students to deliver scheme funded services, offering scheme participants additional services or charging for services with student involvement at a reduced price (National Disability Insurance Scheme, 2020a). Some professional bodies have encouraged rural host organizations and universities to adapt WIL models to better suit the scheme's funding arrangements (Hewat et al, 2018). However,

there is little evidence of collaboration between WIL partners, such as universities and rural host organizations on a systems level, to identify and address any contextual changes to WIL opportunities created by the scheme. Any impact to the nature of rural health WIL opportunities is important to understand given these opportunities play a prominent role in contemporary approaches to training and recruiting the rural nursing and allied health workforce (Lyle & Greenhill, 2018). Given health professionals are typically involved in the process of hosting students, they are well positioned to provide insight into any changes that have occurred to WIL supported by rural host organisations, or to the organisational supports required to host students under the scheme. This exploratory study aimed to understand how health professionals perceive the impact of the National Disability Insurance Scheme on nursing and allied health WIL in rural health and human service organizations during the implementation of the scheme in rural Victoria, Australia.

## MATERIALS AND METHODS

This study employed a post-positivist epistemological paradigm that assumes research processes and findings are 'neither totally objective nor unquestionably certain' (Crotty, 1998, p. 40). The initial issue of the impact of the scheme was identified by a University Department of Rural Health team facilitating WIL. Further, given the sense of uncertainty raised by the scheme in rural organizations (Dintino et al., 2019; Quilliam & Bourke, 2020), evidence of changes to WIL opportunities resulting from the scheme was needed to inform University Department of Rural Health strategies to support rural scheme funded health and human services to host students. Researchers set to explore this issue from the perspective of service providers and wanted detailed experiences which aligned with the use of semi-structured, qualitative interviews.

A range of rural health and human service organizations, at least partially funded by the scheme, were identified using a purposive sampling technique (Liamputtong, 2012), drawing on local knowledge and publicly available information on the internet. Forty-five providers were telephoned with the aim of contacting employees responsible for managing the scheme transition process, employee professional development, or facilitating student placements. Fourteen organizations did not respond to the phone calls. Fifteen organizational representatives, including potential participants, declined participation for reasons including insufficient time due to the scheme or feeling they had little to contribute to the study. The sample ( $n=20$ ) was drawn from 16 rural Victorian scheme service providers, including community health services ( $n=6$ ), hospitals ( $n=4$ ), disability services ( $n=3$ ), and private allied health practices ( $n=3$ ), located across the Goulburn, Ovens Murray, Loddon, Central Highlands and Western District regions. The authors agreed that a sample of 20 participants from a range of service providers in different rural Victorian regions would likely yield sufficient data to gain exploratory insight into the impact of the scheme on WIL, while maintaining confidentiality. At the time of data collection, the scheme was approximately six-months from implementation in one region included in the study and had been implemented for approximately six to nine-months in other regions. This meant the services that employed the participants had recently transitioned or were transitioning to the scheme. Potential participants were given a verbal explanation of the study via telephone and invited to meet face-to-face with researchers at a suitable time and place. Participants signed a consent form before participating in the study. The participant sample comprised program managers and directors ( $n=9$ ), student, volunteer coordination and staff professional development coordinators ( $n=7$ ), practice managers ( $n=2$ ), and direct allied health service providers ( $n=2$ ).

Author CQ used a semi-structured interview protocol comprising seven main questions and further prompting questions prepared by author LB to expand on participant answers during interviews

(Seidman, 2013). The main questions within the protocol related to the barriers and enablers to hosting students, impact of the scheme on the organization and service provision, impact of the scheme on WIL, and ways to support organizations to host students. The interviews were between 25 and 90 minutes in length. With permission from participants, interviews were audio-recorded and transcribed verbatim. Identifying data was removed from the transcripts prior to analysis.

Braun and Clark's (2006) thematic analysis techniques and Cooper et al.'s (2010) WIL dimensions were used to analyze the data. Author CQ carried out the four phases of Braun and Clarke's (2006) thematic analysis process. This process involved becoming familiar with the data by deidentifying and reading interview transcripts, generating initial codes and collating data relevant to the research question. Codes and relating data were then mapped onto Cooper et al.'s (2010) WIL dimensions. The remaining three phases of Braun and Clark's (2006) analysis techniques, including reviewing themes to ensure they reflected the broader data set, defining and naming themes and drafting and finalizing the findings in a manuscript, were conducted by both authors and discussed over regular meetings, until agreement was reached that the themes were relevant to the data and study aim. Data illustrating the themes are presented in the findings section, and the relationship between the themes, codes and Cooper et al.'s dimensions are summarized in Table 1. Findings from a preliminary analysis of the data were captured in a written report (Quilliam & Bourke, 2019a), and verbally presented at a rural health forum to ensure the findings resonated with rural health professionals (Quilliam & Bourke, 2019b).

#### *Ethics Approval*

The study protocol written by author LB gained ethics approval through The University of Melbourne in 2017 (ID: 1750733.1, 1750733.2).

## RESULTS

Participants described a range of impacts that the National Disability Insurance Scheme had on how rural scheme funded organizations hosted students to undertake WIL during the scheme's implementation. The impacts related to four themes: shifts in hosting motivation, shifts in the placement context, shifts in placement nature, and shifts in placement responsibility. These themes mapped across Cooper et al.'s (2010) WIL dimensions, although integrated and emphasized some dimensions more than others (see Table 1).

TABLE 1: Themes and exemplar codes mapped to Cooper et al.'s (2010) WIL dimensions.

<b>WIL dimensions</b>	<b>Themes</b>	<b>Exemplar codes</b>
Purpose	Shifts in hosting motivation	Organizations prefer local-origin students
Context	Shifts in WIL context	Staff focused on transitioning service users
Learning, Curriculum, Support	Shifts in WIL nature	Fewer opportunities for student engagement in direct service provision
Partnerships, Integration	Shifts in WIL responsibilities	Partners need to work collaboratively

*Shifts in Hosting Motivation: 'Local Students in First'*

The first theme related to shifts in organizational motivation to host students undertaking WIL during the scheme's implementation. Participants considered hosting students as an important organizational activity for meeting two functions. First, rural WIL provided host organizations with an opportunity to expose and educate future rural health professionals in disability practice and develop the rural health workforce. Second, rural WIL supported organizational recruitment practices by providing an opportunity to gauge student capacity for employment following graduation:

Disability is not a prime area that [health] students go to when they're looking at their future careers. But, I think once you have students go through our sector they become more interested and they can really see that they can do a lot of good work... If [students] don't get that exposure, [they] may not think about it. (Disability service employee)

Student placements allow us to, a) support a person in their studies, but, b) to give us time to see how a person fits [with the organization]. And to show them what the organization's like, and maybe, instill a desire to come here [to work]. (Community Health service employee)

However, the scheme seemed to shift organizational motivation to host students. Participants noted their organization was now in competition with others to recruit qualified health professionals in rural locations and was more driven to host students to meet their recruitment needs. Thus, participants explained how their organizations looked to host students who would likely work for the organization following graduation: "We've just agreed to take on a speech placement because another agency pulled out... They're a local person, and maybe they would like to work in disability in the future" (Disability service employee). Students of rural origin—particularly those from towns within the organizational service footprint, were offered placements before students from other areas: "We now, 99% of the time, only take local students" (Community health service employee).

*Shifts in the WIL Context: 'Not Sure Where Students Can Fit'*

The second theme related to shifts in the context in which rural organizations hosted students undertaking WIL during the scheme's implementation. During this time, rural health professionals focused their attention on supporting service users to transition to the scheme, training employees in new organizational procedures and bureaucratic processes, and addressing workforce challenges, such as the scheme-related demand for qualified rural health professionals. Participants explained how continuous changes to the scheme rules during the implementation period resulted in health professionals spending significant time adapting their practices, and less time undertaking tasks peripheral to this focus, including non-direct service activities such as supporting students undertaking WIL:

At the moment, a lot of their [health professionals] work is really just helping clients to go through that planning process. ... In the past I've had a social work student, nursing students ... And none of those [students] are going in there at the moment ... Because they're [health professionals] just head-down, bum-up, getting [scheme] plans done. That's all they've got time for. (Community health service employee)

Participants explained how the shift to a fee-for-service funding model highlighted the generous allocation of organizational funding toward WIL-related activities prior to the scheme and made it difficult for rural host organizations to reconcile these costs under the scheme. Participants explained

that even minor reductions in organizational resources due to the scheme was problematic because organizations relied on these resources to conduct time-intensive WIL-related tasks, such as completing pre-placement administration and student supervision. The individualized service model emphasized the choices of each service user and created further administrative tasks for organizations when hosting students:

When you live in a grant funded world, there's fat... In a fee-for-service world, there isn't any fat, so I can't have my staff doing anything but billing those five hours every day to cover their wages and our corporate costs. (Community health service organization)

For each of those clients you'd have to get permission to take a student with you. ... Some families will probably be really good. Others, you know, would be sitting there saying, "No," just because they either don't understand or don't feel like being [observed]. (Community health service organization)

*Shifts in WIL Nature: 'We've Changed the Placements That We Offer'*

The third theme related to shifts in how host organizations approached student learning during the scheme's implementation, including to the nature of WIL and supports offered to students. Many participants emphasized their personal and their organization's ongoing commitment to providing good quality rural health higher education, in particular the provision of structured opportunities that support students to engage in experiential learning:

If you're going to have a student, you need to be fair to them. You need to give them a proper education, supervision, experience, a range of activities. You can't just have them sort of shadowing you; you have to actually put the time in. (Community health service employee)

However, apparent shifts in the nature of WIL relating to the number and range of placements offered, type of activities students engaged in, and to the type of supports provided to students somewhat contradicted this commitment. One notable shift was the decision made by organizations to halt WIL opportunities. Participants suggested this decision benefited students because they were not offered "half-baked" learning experiences, and benefited the organization by freeing up resources typically used to host students to transition to the scheme:

We have always offered student placements, up until last year ... We made a conscious decision to not offer student placements in 2017 because we were transitioning to the National Disability Insurance Scheme and needed all our time and energy focused on that transition rather than on student placements. (Disability service employee)

Organizations that continued to host students during the implementation period carefully managed the number of students undertaking WIL to reduce impacts on the organization: "It's a pretty major difference ... we have done that deliberately. And [we are] just being very strategic in offering the placements ... so we haven't got three students here at one time" (Disability service employee). Organizations also changed the range of WIL opportunities offered, particularly by hosting students that required fewer organizational resources. WIL placements comprising high levels of observational, independent activities or clear university commitment to manage student assessment were preferred over those requiring student-client interaction or intensive student supervisory support:

We've ... actually looked at [offering a WIL placement to] a fourth-[year] student rather than a second-year student because they're more independent, so there's less time required [from the organization] ... The really easy ones [to offer] are the first-year placements, which are observational. [The student will] just come in, spend a day with someone and observe what's going on. ... Then the other ones are probably fourth-year placements, where we would expect them to be more independent, and be up and running and having a clinical case load. (Disability service employee)

The type of activities that host organizations felt comfortable with students engaging in appeared to shift slightly to reflect the competitive nature of the scheme, and in a way that narrowed opportunities for experimental learning. Participants felt the National Disability Insurance Agency had been unclear about if and how students could partake in scheme funded services. As a result, some participants were hesitant to host students within teams providing scheme funded services: "It's sort of almost back to the dollar—what can we charge if a student is running a session ... when technically the participant is charging for that time?" (Community health service employee). Others were concerned student mistakes during service delivery could impact future business in a competitive service market that requires rural organizations to maintain a positive reputation. Participants explained that organizations negated these risks by limiting student involvement in service delivery, for example, to supporting people requiring somewhat routine service:

The complex clients you have on your caseload for a long time. ...For a student—that could be a really challenging caseload. I'm not saying that we need to protect our students from the [service users requiring] complex [supports]... But you don't want to give them [students] something that's too challenging. ...Parents are paying private money for somebody that's not qualified... If someone's paying privately, you're only as good as your last session, really... So, if you've had the student and it's been a particularly bad session, they might go "oh, we can't rebook." (Private practice employee)

*Shifts in WIL Responsibilities: 'There's Much More of a Decision-Making Process Now, About How Much We Can Do'*

The fourth theme related to shifts in perceptions about responsibilities for WIL as a mechanism for rural health higher education. While participants looked forward to hosting students beyond the scheme's implementation period, they were also concerned about the capacity of rural organizations to realistically do this. Some participants noted their organization would likely host fewer students on the basis that the scheme would continue to shape the nature of service funding and provision, and therefore organizational capacity to support WIL opportunities:

All organizations now funded under the National Disability Insurance Scheme will need to be looking at their financial viability and [thinking]... "can we afford to offer student placements?" ...We've set a target of 70 percent of our day needs to be billable... There's a whole lot of other things that need to fit into those billable hours. So, whilst we're still committed to it [hosting students], we are probably likely to offer less placements than we have in the past for that reason. (Disability service employee)

Participants described how their organization was now hesitant to assume responsibility for a broad range of tasks associated with hosting students. They suggested a shift in approach to WIL was required to reflect the transformed service context and to acknowledge rural scheme service providers

may not have capacity to assume these responsibilities in the future. Many suggested universities, government bodies, and allied health professional bodies collaborate with rural host organizations to address scheme-related WIL barriers, and assume more responsibility for WIL activities so that WIL remains a viable rural health workforce mechanism: "This is an issue that the sector needs to take responsibility for, and not just leave it up to organizations, because organizations won't be able to fill in the gaps" (Disability service employee). Participants proposed WIL tasks be reallocated so rural organizations need only to contribute to WIL aspects that require minimal resources: "We could provide the environment ... clients [to work with] ... We would certainly embrace [students] in a team environment and they could certainly sit alongside us" (Community health service employee). Participants also suggested the National Disability Insurance Agency clarify their role in the development of the rural health workforce through rural WIL or other mechanisms, offer financial incentives to encourage rural organizations to host students, and provide clear policies on involving students in scheme funded service provision that accounted for the impact of day-to-day student involvement on future business:

Everyone always is talking about development of the workforce and demand for the workforce in the disability sector ... The National Disability Insurance Agency needs to look at how it can support the development of the workforce in the sector as well. (Disability service employee)

In the long term, there has to be a financial exchange ... They're [rural organizations] providing a service to ... participants of the National Disability Insurance Scheme, but they're also providing a service to [students]. That's been managed through goodwill and commitment to partnerships and good practice ... in the past, but there's something else that's just been thrown in there. And there's no getting around that. (Disability service employee)

Many participants, however, saw universities as being ultimately responsible for preparing students for rural health practice. They suggested universities assume more responsibility for preparing students for WIL experiences, supervising and assessing student work, completing WIL-related administration, and rethinking the nature of activities expected of students undertaking WIL:

They're [universities] the ones asking us to do the placements ... Are they going to pay the *real* cost to do the placements? ... The real cost of providing student supervision is high. ... Someone [has] got to take responsibility [for students] on a day-to-day basis ... [to make] sure that that student is here and they have appointments scheduled, and [they are] following up on the appointment and making sure it all went smoothly, or if it didn't go so well. (Disability service employee)

It's perhaps about universities looking at what their requirements are in a placement. What is it that they absolutely, as a benchmark, must have? And maybe they need to revisit that now in National Disability Insurance Scheme land ... Maybe it's about their students doing more observational work and more self-reflective work and taking that back to their uni supervisors, rather than expecting our therapists to be that person for them. (Community health service employee)

Many participants noted WIL partners including universities, government bodies, allied health professional bodies and rural host organizations could work collaboratively to renegotiate WIL responsibilities:

We can't work in silos, you know? ... There has to be more linkages and I know often when something's new like the National Disability Insurance Scheme, there is going to be a bit of that silo [approach] because they've got to get off the ground and get it up and running ... We know [the scheme] will take time to mature and get right ... but it doesn't mean we can't try and connect the dots a little bit more now. (Disability service employee)

## DISCUSSION

This study used Cooper et al.'s (2010) WIL dimensions to explore how health professionals perceive the impact of the National Disability Insurance Scheme on nursing and allied health WIL in rural health and human service organizations during the scheme's implementation in Victoria, Australia. Perceptions of rural health professionals in this study suggest the scheme has impacted WIL opportunities offered by scheme funded rural host organizations, across all seven of Cooper et al.'s WIL dimensions, albeit in an integrated manner. Health professionals described shifts in organizational purpose to host students and shifts in the context in which organizations offered WIL opportunities to students. They described shifts in the nature of WIL that impacted curriculum offered to students, and in particular, opportunities for experiential learning and supervision. Health professionals described shifts in perceptions about WIL responsibilities and suggested WIL partners, particularly universities and rural organizations, are yet to integrate and respond to the challenges to rural health higher education posed by the scheme. These findings suggest Cooper et al.'s (2010) WIL dimensions are helpful for discerning how the scheme has impacted the capacity of rural organizations to contribute to rural health higher education, and to identify potential strategies to support rural organizations to continue to work closely with universities to host students undertaking WIL within the changed disability policy context.

In response to the scheme, health professionals described a narrowing of the organizational purpose for hosting students, from contributing to the education and development of the future rural health workforce generally and meeting individual organizational recruitment needs, to a focus on the latter. The purposes for organizations to host students will of course differ to that of other WIL partners (Cooper et al., 2010), although of interest here is that rural scheme funded organizations may now be driven to host students for slightly different reasons than prior to the scheme's implementation. This shift makes sense given rural scheme funded organizations may struggle to recruit qualified health professionals to meet service demand (Quilliam & Bourke, 2020). However, this shift in hosting motivation may require universities to acknowledge changes in their relationship with hosting organizations brought about by the scheme, and as suggested by Choy and Delahaye (2011), seek out tacit knowledge held by hosting organizations to support WIL opportunities to continue. Universities may wish to consider this shift particularly when approaching rural scheme funded organizations to host students from particular disciplines, or students from outside their service footprint or those that may not directly support organizations to meet their own recruitment demands. Further, rather than expect rural organizations to host students for the benefit of contributing to the education of the rural health workforce, universities could give greater consideration to the WIL notion of reciprocity (Fleming et al., 2018). Universities could offer host organizations industry and contextually relevant resources and supports (Ferns et al., 2016) by, for example, providing additional funding or assuming additional WIL responsibilities, to acknowledge hosting efforts within the changed conditions. However, Australian universities are not currently well positioned to address the impact of the scheme on WIL through additional financial contributions (Universities Australia, 2020). This suggests more thinking is required to explore how to best support nursing and allied health students to learn rural disability practice in a way that acknowledges the changed hosting capacity of rural organizations.

Rural host organizations offered fewer opportunities for students to gain experience delivering services under supervision during the scheme's implementation. Experiencing service provision and reflecting on practice with a health professional are important components of rural nursing and allied health WIL. Fewer reflective opportunities for students is particularly concerning because the nature of supervision impacts student placement satisfaction and student intention to work in rural areas following graduation (Smith, Sutton, et al., 2018). Further, a decrease in WIL within rural disability practice, if only for the duration of the scheme's implementation period, could result in a cohort of nursing and allied health students with little opportunity to consolidate relevant classroom learning in a rural context, and in turn, a cohort of health professionals with minimal experience in rural disability practice. This potential reduction in exposure to rural disability practice for nursing and allied health students comes at a time when rural areas face challenges in recruiting qualified health professionals to the disability workforce, as noted by the State Government of Victoria (2016). The shifts in the nature of WIL opportunities, combined with the slow integration of other WIL partners to understand and respond to the changed disability service context, suggest that it may be difficult for rural host organizations to offer WIL placements within the professional placement model under the scheme. Thus, the suitability of other WIL models, particularly service learning, may need to be further explored in this context. Students could undertake service learning placements aimed at meeting the service needs of particular groups of people with disability outside of the scheme, including direct service provision to children in school settings or capacity building of teachers to promote inclusive educational settings (Jones et al., 2015; Salter et al., 2020).

Finally, the findings illustrated that rural nursing and allied health WIL opportunities, and the roles of WIL partners, such as host organizations and universities, can be enabled and constrained by broader policy frameworks. The educational role undertaken by rural health and human service organizations prior to entering the scheme appears to be particularly susceptible to policy impacts. In this study, changes to the broader disability policy framework accentuated the tension between the competitive service context in which students gain practice experience and the risks that inexperienced students pose to organizational reputation. This policy impact on service competition and reputation is concerning for rural organizations in particular, because word-of-mouth is a common source of information about rural services (Bourke & Lockard, 2000). If local reputation and interested business diminish for these organizations, they may find it difficult to market services to those beyond the local context. Maintaining good reputation is therefore particularly important for rural organizations, and those concerned with reputational risk under the scheme may stop hosting students or only host students from within their service footprint. This potential reduction in student placements due to concern with reputational risk could make it more difficult for rural organizations to address existing workforce challenges. The National Disability Insurance Scheme's (2020a) guidelines on involving students in service provision, which were available at the time of data collection, fail to address this tension, and places rural scheme service providers in the difficult position of having to reconsider their involvement in the provision of rural health WIL experiences. The federal government could address this oversight, and also acknowledge its role as a powerful stakeholder with capacity to enable or constrain WIL opportunities in rural health and human service organizations, through the establishment of policies and government programs that impact the relationships between other WIL partners, namely universities and rural host organizations. Sustainable university-industry relationships are foundational to ensuring rural nursing and allied health WIL opportunities continue in the future. Effective communication, along with commitment and capability, are considered key principles to supporting sustainable development of WIL relationships (Fleming et al., 2018; Jeffries & Milne, 2014). The findings of this study suggest the federal government could play a greater role in

supporting universities and rural host organizations to communicate effectively. Through this communication process, universities and rural host organizations could explore current and potential impacts of the scheme on rural health WIL, re-establish expectations and develop a sense of reciprocity, particularly around resource allocation and responsibilities to support learning for students of a range of geographical backgrounds, within the changed policy context. University Departments of Rural Health are federally government funded through the Rural Health Multidisciplinary Training program and are well positioned to facilitate rural WIL partner communication at a local, regional and national level. However, the government may need to emphasize this facilitative role within the program guidelines to ensure it is recognized broadly in practice.

#### *Limitations and Strengths*

This study was small, excluded the experiences of service users and students, and only captured a snapshot of health professional perspectives in 2018 in rural Victoria, Australia, when rural scheme funded organizations were transitioning to the scheme (which has since been implemented). The initial impacts from the scheme's implementation as experienced by rural scheme funded organizations may linger for some time, although further research is required to explore the impact of the scheme on organizational hosting decisions beyond this period. This study offers some approaches for continuing WIL in rural scheme funded organizations, for example, increasing adoption of the service learning WIL model in disability services and using University Departments of Rural Health to facilitate WIL partner reciprocity, communication and integration. Further, this study has demonstrated how disability policy change, underpinned with a personalization agenda, can impact rural WIL in Australia. Given the international trend toward personalization in disability policy, future research could explore and compare the ongoing impact of this policy trend on rural nursing and allied health WIL in Australia and beyond. This research could involve a range of other stakeholder perspectives including people with disability living in rural and remote locations, students, university coordinators, government bureaucrats and allied health professional body professionals.

#### CONCLUSIONS

Australian disability policy reform known as the National Disability Insurance Scheme, has had some negative impacts, albeit unintendedly, on the capacity of rural Victorian scheme funded health and human service organizations to host students on WIL during the scheme's implementation. Health professional perspectives suggest the scheme shifted organizational motivation for hosting students, the context in which rural WIL occurs, the nature of WIL placements, and the perception of WIL responsibilities. University and rural host organization efforts to facilitate WIL are important, although what is required is a greater awareness of the impact that WIL partners working at the policy level, such as government bodies, can have on WIL opportunities in rural areas. WIL partners need to integrate to better understand the impact of the scheme on rural organizational capacity to facilitate nursing and allied health WIL, and to identify suitable WIL models and reimagine WIL responsibilities to suit the disability service context, going forward.

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