8th November, 2017

Dear Anna.

The authors would sincerely like to thank you and the reviews for their valuable comments. Their insight has enabled us to look at the paper with fresh eyes and ultimately, to strengthen what we have written.

Specific comments are below

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| The central comments I would offer would be to make the purposeof the paper more explicit, it is not clear to page 4 as to what the paperis about. Similarly as a ‘report of considerations of HTAG members’ italso provides ‘aims’ and ‘objectives’ which blur the direction andreason for the paper.  | Amended to Abstract to remove aims and objectives and to show the purpose of the paper  |
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| The paper authors clearly have experienced a certainset of UHC relationships between industry and higher education however froma national perspective such opportunities may not always apply; this couldat least be acknowledged. | Addressed  |
| Given the insights of the HTAG the opinions within the paper are directed tolocal relationships and structures, with some tacit acknowledgment of national bodies TEQSA, however I suggest the value of the paper would be to ascribe to a higher set of national principles, ones that could inform a wider audience as to the benefit of UHCs. Given the paper title I would also provide a much clearer (bolded) definition of what a UHC is – two definitions (pages 4-5) are provided along with an acknowledgement that guidelines to inform structures are not clear. | This has been amended  |
| Finally the HTAG could be much clearer as to what financial model they areeither proposing, recommending or describing for the conduct of a UHC.  Forexample if UHC take on a cost recovery or income generating role, is this tooffset clinical placement charges in other hospital settings? | We appreciate this comment, but at this stage of our work we are not prepared to make any recommendations. Perhaps we will after more knowledge is gathered.  |
| *Some comments and suggestions are offered below.* |  |
| Page 1 1.      In doing so, UHCs provide an opportunity to operationalise theuniversities’ strategic plans- to demonstrate the axiom:  University forthe common good2.      The University of Calgary, Canada adopt the view that student-run clinicscontribute…3.      …programs provide valuable health services to community groups who maynot be able to afford regular care while also providing valuable learningexperiences for students. | All corrected  |
| Page 2 4.      Is there a more recent reference than (Barnett et al., 2008)?5.      UHCs complement clinical education6.      The phrase ‘internships’ may be confused with the more widelyaccepted term of clinical education or clinical placements 7.      Many health professions allocate a substantial number of the hours toclinical learning within a UHC – there is no basis provided for this claim– the comment above is that this writing represents a ‘generalhypothesis’ | 4. No. 5. adjusted the grammar6. amended 7. As a group we know this - so this has been restated.  |
| Page 3 8.      Unlike external businesses who are required to sustain economicviability, the goal of UHCs are more likely to be non-profit – suggestingthey are cost neutral does not consider the provision of academic staffsupport, any administrative costs, even within a university framework theUHC will still have indirect costs such as insurance, space, equipment,governance….an argument might be made for the role of the UHC to offsetthe cost/s of an externally sourced placement. | 8. Excellent point – now included for clarification.  |
| Page 49.      It is not explicit until page 4 ‘This report introduces theconsiderations of the HTAG members..’ as to what the paper is directed todo. Prior to this statement an aim and objective of the HTAG is provided butthis is distinct to the purpose of the paper.  10.     See comment 8 regarding the description of the financing of UHC. Thepaper has both cost neutral and then identifies that some may need afinancial imperative to be viable. The author will need to clarify thedescription of costs and modelling associated with a UHC. 11.     There needs to be a clearer definition of ‘University hospital’provided. This label may not articulate with other Australian states where a different relationship of ‘teaching’ hospital has a different meaning or indeed where hospital may not have an explicit or implied relationship with any health education.12.      there is a primary expectation | 9. This is now addressed in the Abstract10. Clarified. 11. ClarifiedThe definition has been strengthened  |
| Page 6 13.     because all clients understand and are respectful of students’ need to learn…..It is not clear as to how the claim that all clients understand and are respectful of students needs to learn can be made. | 13. This statement was in reference to work of Barro and McKimm and Bostick et all  |
| Page 7 14.     Learning activities15.     overall function of a clinic and it’s complexity,…16.     The resultant development of a broad skill base is considered by the HTAG members, a response to students being…17.     This sentence doesn’t make sense ‘In UHCs of during SLCS students often work alongside…  | 14. Corrected15 Corrected16. Corrected17. Corrected  |
| Page 8 18.     These are, as stated earlier,  are clinics which are similar in nature to those for SLCS in UHCs…19.     They wrote…? | 18-19 Corrected.  |
| Page 9 20.     This sentence is awkward to read ‘In Australia, UHCs rely on clients who are prepared to self-fund treatments because third-party payments from for example: Department of Veteran Affairs, Motor Vehicle Accident, WorkersCompensation, Medicare’…21.     ‘students. conversely’ – full stop incorrectly placed or capitalmissing22.     The relative benefits to clients and the negative aspects of student learning could be separated more clearly in the sentences ‘SLCS can provide a solution for these clients. This does mean students are not orientated to different clinical funding models for service delivery. Similarly, they do not always have an opportunity to learn real… | 20-21 Corrected 22. Clarified.  |
| Page 10 23.     What is the ‘going rate’ – is this a co-payment, the full nonsubsidised cost, the normal Medicare fee…. | 23. Clarified |
| Page 1124.     Also, a sustained commitment to the clinic by the University– might not make money to begin with but over time can reach a sustainable level – again this seems at odds with the label or identification of a cost neutral (or not for profit) financially model. I suggest the HTAG could make a much clearer statement as to either supporting a standard model financial model to underpin the establishment and maintenance of a UHC or the HTAG canacknowledge the need for a more diverse set of founding principles. For example arguing for a nationally consistent approach to the funding and management of UHC through clinical training funds, as an element of HECS costs, as a protected component of clinical placement costs etc etc | This is excellent feedback and we have included the point.  |
| Page 12 25.     relations ship is mutually | 25. Amended  |
| Page 14 26.     the university aspirations to provide quality clinical placementexperiences and provide healthcare delivery to communities – is the role of university to provide health care delivery to communities or to ensure graduates are most capable of providing this care? The distinction is made as the locus of responsibility in this argument needs to be carefully and clearly articulated. | 26 Amended |
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