



Discussion Paper – redistribution pool of medical places

Introduction

Establishing a redistribution pool of medical places

As announced in the 2018–19 Budget, the Australian Government is implementing new medical education strategies to better manage the supply of medical graduates and expand opportunities for learning and training in rural Australia. Together with workforce measures through the *Stronger Rural Health Strategy* in the Health portfolio, these strategies will help improve the recruitment and retention of doctors in rural and regional Australia and increase access to medical and health care in these communities.

The medical workforce is expanding, with the Department of Health national modelling predicting:

- a potential oversupply of around 7,000 doctors by 2030
- a shortage of medical specialist training places of more than 1,000 places by 2030
- an imbalance in the distribution of the medical workforce across geography and specialities.¹

Between 2001 and 2008, the number of Australian universities with medical schools almost doubled from 10 to 18. Since then, three more universities have started operating medical schools, bringing the total number of medical schools to 21. Two of these schools offer only fee-paying places and 19 have allocations of medical Commonwealth supported places (CSPs).

Increases in medical schools and medical CSPs in Australia have largely been through Council of Australian Government (COAG) decisions in response to medical workforce shortages experienced in the early–mid 2000s. The establishment of the Curtin University medical school in 2017 occurred bilaterally outside COAG to address health workforce issues in Western Australia, which has fewer doctors per head of population than the rest of Australia.

More broadly, ongoing shortages of doctors in regional, rural and remote communities around Australia are likely to persist, indicating a need for new policy responses.

In the absence of additional medical CSPs, the Government is establishing a small pool of medical CSPs drawn from existing university allocations to provide it with flexibility to support key Government health workforce priorities as they emerge.

¹Health Workforce Australia (2014) *Australia's Future Health Workforce – Doctors*.

The pool will withhold up to 60 commencing medical CSPs every three years, to be reallocated between universities through a competitive process to support health workforce priorities. A pool of 60 commencing CSPs is sufficient to support a major new medical education initiative or a number of smaller initiatives.

The policy priority for the first redistribution pool round for 2021 is to help build the rural and regional medical workforce.

Subsequent rounds, informed by triennial national medical workforce data assessments, will focus on emerging medical workforce pressures and policy priorities.

The outcomes from the first redistribution round will be put into effect through Commonwealth Grant Scheme (CGS) funding agreements with universities from 2021.

As a transition arrangement for the first round only, universities with a net reduction to their medical CSP allocation will be permitted a commensurate increase in their international full-fee paying (IFFP) medical enrolments. Should regulatory controls on IFFP medical enrolments be introduced ahead of 2021, universities would be able to retain this one-off increase.

Policy priority for the first redistribution process for 2021

Shortages of doctors persist in parts of rural Australia. Research evidence shows that enrolling students who undertake long-term training in rural areas increases the likelihood they will practise in rural areas upon graduation². It is internationally recognised that locating health worker schools outside major cities is of value for health worker retention.³

In the 2018–19 Budget, the Government announced funding through the *Stronger Rural Health Strategy* managed through the Health portfolio, to build a sustainable, high-quality health workforce that is distributed across the country according to community need, particularly in rural and remote communities, including:

- the establishment of the Murray–Darling Medical Schools Network (MDMSN) to deliver five ‘end-to-end’ rural medical school programs across the Murray-Darling region of Victoria and New South Wales;
- more opportunities for Australian-trained doctors to work in rural areas, such as through the Junior Doctor Training Program and the More Doctors for Rural Australia Program; and
- an additional 100 General Practitioner (GP) training places from 2021 to support rural generalist postgraduate medical training.

The Government has agreed the first redistribution round will focus on regional medical students and integrated regional training to help build the rural and regional medical workforce.

The initial redistribution will allocate 32 places from the pool to Charles Sturt University (CSU) to establish a new fully regional medical school for the MDMSN at Orange, NSW in partnership with Western Sydney

² Recent research examples:

Kwan MMS, Kondalsamy-Chennakesavan S, Ranmuthugala G, Toombs, M, Nicholson GC (2017) The rural pipeline to longer-term rural practice: general practitioners and specialists, PLoS ONE, July 7, 2017.

O'Sullivan B, McGrail M, Russell D, Walker J, Chambers H, Major L, Langham R. (2018) Duration and setting of rural immersion during the medical degree relates to rural work outcome, Med Educ. 2018 Aug;52(8):803-815. doi: 10.1111/medu.13578. Epub 2018 Apr 19.

³ World Health Organisation (2010) Increasing access to health workers in remote and rural areas through improved retention, WHO Global Policy Recommendations (2010).

University (WSU). This will leave up to 28 remaining pool places for redistribution to align with the round's rural and regional policy focus.

The first round will prioritise support to universities whose medical programs currently serve the needs of rural and regional communities and those committed to delivering a genuine increase in regional medical places. This is discussed in more detail as part of the consultation and issues for feedback process below.

Assessment Framework

A robust and transparent Assessment Framework will set out clear principles to help universities develop proposals for new or expanded medical school programs.

The Department of Education and the Department of Health will establish a panel of senior staff with the relevant expertise to evaluate, rank and recommend proposals for funding. Panel members will have access to external expert advice (e.g. regional, medical education) as required.

The panel will assess university proposals for places from the redistribution pool against all the principles of the Assessment Framework. Proposals must *satisfactorily address* all the Assessment Framework principles to be eligible for recommendation to the Minister for Education for approval.

Proposals seeking places from the redistribution pool will also be considered in the context of the policy priority and associated policy criteria/parameters established for the respective redistribution round. This is discussed in more detail as part of the consultation and issues for feedback process below.

The panel will make recommendations to the Minister for Education for decision, in consultation with the minister with responsibility for medical schools policy within the Health portfolio. This is currently the Hon Mark Coulton MP, Minister for Regional Services, Decentralisation and Local Government.

The Assessment Framework is provided as an attachment to this paper.

Consultation and issues for feedback

The Government recognises the high standard of Australian medical schools programs, which are accredited by the Australian Medical Council (AMC) and approved by the Medical Board of Australia as programs leading to registration to practise in Australia.

The Government aims to work with the university sector to establish a redistribution pool mechanism that provides a genuine opportunity every three years for universities to respond to emerging medical workforce needs with innovative approaches that are supported by additional places from a transparent and fair redistribution process.

The Rural Health Multidisciplinary Training (RHMT) Program administered by the Department of Health provides Commonwealth funding to operate rural clinical schools (RCSs). These RCSs aim to increase rural training and the recruitment of students with rural backgrounds, to address rural health workforce needs.

In implementing the pool, the Government's intent is that any redistribution will not undermine its policy goal of increasing the total number of medical graduates trained outside major cities or supporting long periods of training in rural areas, whether through the RHMT program, the MDMSN initiative, or investment in human resources and infrastructure in rural areas as part of these initiatives.

This discussion paper invites sector feedback on three proposed options for managing the initial redistribution process. These options are detailed below.

The consultation process will also invite sector input to establish specific policy criteria/parameters for the redistribution process. These policy parameters will help universities develop proposals seeking places from the pool and will be used with the Assessment Framework to evaluate proposals.

In conjunction with the consultation process, the department proposes to request data from each university on the volume of regional medical education delivery undertaken during the past three years. This will provide us with a more detailed understanding of each university's regional delivery focus, for consideration with other feedback provided by the sector on the proposed options for managing the redistribution process.

Timeline for developing the redistribution pool approach

It is a priority for the Government to settle the arrangements for the first redistribution round in a timely way, to ensure universities have certainty in forward planning for their medical programs.

Accordingly, the department proposes to finalise the redistribution pool approach and advise universities in 2019 of the process that will be used to determine their 2021 allocations of medical CSPs.

An indicative timeframe for developing the redistribution pool approach is set out below.

23 September 2019	Release discussion paper inviting stakeholder feedback on redistribution pool options. Seek institutional data on current rural medical education training.
25 October 2019	Stakeholder feedback on discussion paper options due. Institutional data on current rural medical education training due.
End-November 2019	Department of Education provides final advice on the redistribution pool mechanism to the Minister for Education.

The approach to creating the redistribution pool (Stage 1)

This stage involves creating a redistribution pool of up to 60 commencing medical CSPs. In the first round, the pool will prioritise support to university medical programs currently serving the needs of rural and regional communities and those with a commitment to delivering a genuine increase in regional medical places.

The process for creating the pool must be transparent, managed fairly across providers, and consistent with the health workforce policy priority to ensure all Australians across the country can access the right mix of health professionals in the right place at the right time and receive high quality health care.

The department recognises that determining the extent of each university's rural/regional contribution is complex, particularly as all medical schools with CSPs have an existing rural presence, made possible through Health portfolio investment.

Providing clinical training experiences across both metropolitan and rural environments is also an AMC accreditation requirement (Standard 8.3.2)⁴.

In addition, medical school programs are diverse, ranging in length from four to six years. Medical courses with a longer duration may increase a university's overall medical load at a regional campus and rural clinical school. A university's rural presence or contribution can be influenced by its overall business model, or its medical program design and operation, including the extent to which each university supports investment in campuses outside major cities.

Table 1 below sets out the projected distribution of medical CSPs and the projected number of domestic medical graduations in 2021 by university medical program. This table uses 2019 allocations and approvals already in place for changes to medical CSPs by 2021.

Table 2 below sets out the projected number of medical CSP commencements in 2021.

As CGS funding agreements do not specify the number of medical CSP commencements for each medical program, the discussion paper uses the projected distribution of Commonwealth supported medical graduations as a proxy for medical CSP commencements. This approach is consistent with the CGS funding assumption of zero attrition for medical courses.

Table 2 adjusts projected medical commencements to reflect approvals already in place for changes to medical CSP allocations by 2021. These include growth in annual intakes during the establishment phase of Curtin University's new medical program and changes in medical places for the universities involved in transfers of medical places to Griffith University for its new Sunshine Coast medical school.

⁴ Australian Medical Council Limited (2012) Standards for Assessment and Accreditation of Primary Medical Programs by the Australian Medical Council, AMC Medical School Accreditation Committee, December 2012.

Table 1: Projected medical CSP enrolments and domestic medical completions in 2021

University	Campus Location	Course duration (yrs)	Total CSP alloc'n ¹	Permitted domestic grads ²
Deakin University	Geelong	4	520	130
Griffith University	Gold Coast	4	785	185
James Cook University	Townsville	6	922	154
Monash University	Melbourne	5	1489	242
	Gippsland	4		75
Australian National University	Canberra	4	360	90
Flinders University	Adelaide and Darwin	4	444	135
University of Adelaide	Adelaide	6	804	134
University of New South Wales	Sydney and Port Macquarie	6	1191	199
		3		
University of Sydney	Sydney	4	907	227
University of Western Australia	Perth	4	820	205
University of Melbourne	Melbourne	4	1005	300
University of New England ³	Armidale	5	300	60
University of Newcastle	Newcastle		536	108
University of Notre Dame Australia	Fremantle	4	640	212
	Sydney			
University of Queensland	Brisbane	4	1084	271
University of Tasmania	Hobart	5	465	93
Western Sydney University	Sydney	5	505	101
University of Wollongong	Wollongong and Nowra	4	279	72
Curtin University	Perth	5	400	0

1. The 'Total CSP alloc'n' column represents the total number of medical CSPs across the medical degree pipeline, not just commencing students.
2. 'Permitted domestic graduates' projections are based on data from the 2018-2020 Commonwealth Grant Scheme (CGS) Funding Agreement with each university and approvals already in place for changes to medical CSPs by 2021. The University of Melbourne and the University of Notre Dame Australia include domestic full-fee paying students, and Flinders University includes Northern Territory Medical Program (NTMP) students. NTMP places are jointly funded by the Department of Health (through the RHMT Program) and the NT Government.
3. The University of Newcastle and University of New England operate a Joint Medical Program. However, each university has a separate allocation of medical CSPs.

Table 2: Projected medical commencements in 2021

University	Projected medical CSP commencements in 2021*
New South Wales	
University of New England	60
University of New South Wales	199
University of Newcastle	108
University of Wollongong	69
University of Sydney	227
Western Sydney University	101
University of Notre Dame Australia (Sydney campus)**	60
TOTAL	824
Victoria	
Deakin University	130
Monash University (5yr)	237
Monash University (4yr)	73
University of Melbourne	250
TOTAL	690
Queensland	
Griffith University	200
James Cook University	154
University of Queensland	271
TOTAL	625
Western Australia	
University of Notre Dame Australia (Fremantle campus)**	100
University of Western Australia	205
Curtin University	100
TOTAL	405
South Australia	
Flinders University	111
University of Adelaide	134
TOTAL	245
Tasmania	
University of Tasmania	93
Australian Capital Territory	
Australian National University	90
TOTAL	2972

* Commencement estimates are based on the number of medical CSP graduates anticipated to be permitted in 2021 Commonwealth Grant Scheme funding agreements, and assume a 100 per cent pipeline. Commencements for the University of Melbourne and the University of Notre Dame Australia (UNDA) exclude domestic full-fee paying medical enrolments. Flinders University commencements excludes NT Medical School Program places as these places are supported by the NT Government and are not CSPs.

** As UNDA operates in both Western Australia and New South Wales, its estimated 160 total medical CSP commencements has been split accordingly between both campuses, based on initial allocations approved for each campus between 2005-2009.

Universities make a significant commitment to rural medical education through their participation in the Department of Health's RHMT program. Every university course that offers medical CSPs, apart from Curtin and Griffith universities, participated in the RHMT program during the 2013–17 period.⁵

RHMT program targets include a requirement for at least 50 per cent of medical CSPs to complete a minimum four consecutive weeks rural clinical training in Australian Statistical Geography Standard-Remoteness Areas-RA (ASGS-RA) 2-5 locations; and at least 25 per cent to complete a minimum 12 months rural clinical training in ASGS-RA 2-5 locations.

As part of their RHMT rural training commitment, universities also agree that 25 per cent of their medical enrolments will be drawn from a rural background (defined as residency of at least ten years cumulatively or any five years consecutively in an ASGS-RA 2-5 area).⁶ Universities are also required to set a growth target, and with the exception of newer entrants, all are currently committed to a target of at least 27 per cent. According to Medical Deans Australia and New Zealand (MDANZ) in 2017, almost 27 per cent of commencing domestic medical students came from a rural background.⁷

The Medical Schools Outcomes Database (MSOD), managed by MDANZ, provides annual survey data from graduating medical students on their rural practice intentions and the proportion of medical enrolments from a rural background. Recent MSOD data⁸ indicates that around 18.4 per cent of those who intend to practise in Australia propose to work outside capital cities/major urban centres in small communities/towns or large towns/regional cities (up to 99,999 population).

Ideally, the approach chosen to create the pool should allow for consideration of a range of factors that influence how a university currently serves the needs of rural and regional communities. These could include the extent of rural presence; engagement with local rural communities; the amount of rural training undertaken; relative length of rural clinical placements by rurality; rural workforce outcomes; and available evidence of success in serving rural communities.

In reality, there is no public, nationally available data at this time that provides comparative evidence that demonstrates direct relationships between particular regional medical education initiatives and improved regional medical workforce outcomes.

Through the department's internal analysis of enrolment data on the current distribution of regional medical load for university medical courses, we anticipate a 2 per cent contribution that preserves medical CSP allocations for universities serving rural communities will potentially reduce the size of the redistribution pool from 60 to around 30 commencing medical places, depending on the approach taken. As 32 pool places are to be allocated to CSU for its partnership with WSU for the MDMSN, this could result in no places being available to support other initiatives for 2021.

To produce a pool of sufficient size to target priorities while making exemptions for universities serving rural communities will mean reconsidering the percentage of commencing places other universities would need to contribute to the pool. The department estimates this could require a contribution of around 4.1 per cent from those universities to maintain the same quantum of places, depending on the approach taken to exempting universities.

⁵ Griffith University joined the RHMT program in 2016 and Curtin University joined the program in 2019.

⁶ Western Sydney University has a lower rural background target than other universities in the RHMT Program. This reflects the university's commitment to pathways for applicants from Greater Western Sydney.

⁷ Medical Deans Australia and New Zealand data published in the Medical Education and Training (MET) Dataset, Department Health Workforce and MET Data Tool, MET 2017, accessed at hwd.health.gov.au.

⁸ Medical Deans Australia and New Zealand (2017) Medical Schools Outcomes Database: National Data Report 2013–17, September 2017.

The process for redistributing places between universities (Stage 2)

The priority for the initial redistribution round will be to increase the overall number of medical students and medical practitioners trained outside major cities, while building on activities currently supported through rural campuses and rural clinical schools. The Government's key objective from this round is to increase the overall number of medical practitioners trained in rural and regional area health settings for two or more years of the medical school program, especially in later clinical training years.

To ensure rural campuses remain sustainable, universities whose main campus is in a metropolitan location will be required to contribute CSPs from that location, and maintain any existing rural based medical CSPs, campuses and programs.

Universities with positive track records serving rural communities, positive rural training track records, strong existing rural training sites, well-developed relationships with local communities and clinical placement providers, and success with rural practice outcomes will be soundly placed to make a case seeking medical CSPs from the pool to strengthen their efforts to grow the rural medical workforce.

As stated earlier in this paper, proposals seeking places from the redistribution pool will be evaluated against, and will need to satisfactorily address, all principles in the Assessment Framework.

It will also be important to establish policy criteria/parameters to ensure places sought from the pool are reallocated across universities to maximise outcomes that will help to strengthen the rural and regional medical workforce.

Options for managing the redistribution process for the 2021 round

Three potential options for managing the redistribution pool for 2021 are set out below as a basis for discussion with the sector.

These options all propose to create a redistribution pool of 60 commencing medical places, using a transparent and equitable process based on each university's share of the national allocation of medical CSPs. The department considers this approach will minimise each provider's contribution to establish the pool.

However, each option proposes a different approach to the way in which pool places are redistributed to providers to support regional medical education initiatives in 2021. Each option aims to strike a balance between rewarding the strongest regional initiatives; minimising changes to programs with strong records of regional medical education delivery; and providing timely advice to the sector of their medical CSP allocations for 2021.

These options are based on the department's internal analysis of enrolment data on the current distribution of regional medical load for university medical courses, with input from the Department of Health. In conjunction with inviting feedback on the discussion paper, the department proposes to separately seek detailed data on regional medical load from each university to validate the accuracy and completeness of this analysis.

This is particularly important as nationally consistent data to demonstrate (or compare) linkages between regional medical education initiatives and eventual locations of medical practice is not available at this time.

Option 1: All universities would contribute 2.03 per cent of commencing medical CSPs to the redistribution pool; and all universities could bid for the 28 places remaining after CSU's allocation of 32 commencing medical places.

This option proposes that:

- all universities would contribute 2.03 per cent of their commencing medical places (rounded) to create a pool of 60 commencing medical CSPs.
- a total of 32 commencing medical CSPs would be allocated to CSU for the MDMSN.
- the remaining 28 commencing medical places would be redistributed using a competitive bidding process based on the Assessment Framework and agreed policy parameters.

This option provides a transparent, equitable process that creates a redistribution pool based on each university's share of the national allocation of medical CSPs. By involving all universities proportionately, this approach minimises the contribution made by any single provider to establish the pool.

All universities would have an opportunity to bid for the return of places they contributed to the pool or to seek additional places, based on their regional medical education focus. Outcomes for this competitive bidding process would be unlikely to be finalised until early 2020.

This option provides an opportunity to reward new and innovative medical education initiatives but does not provide any guarantee that a provider will maintain (or increase) its share of the national allocation. As the limited number of available competitive places would be redistributed to the strongest regional proposals, it is unlikely that sufficient places would be available to reward all proposals with a strong regional commitment.

Table 3 below shows that this approach would result in each university contributing between one and six commencing medical CSPs to the redistribution pool for 2021 (totaling between four and 30 EFTSL at full capacity, depending on the duration of the medical program).

Universities may regain some or all of these places or increase their allocation through the competitive redistribution process. Universities with a net loss of places in the initial redistribution round would be permitted to enrol IFFP medical students to compensate for the reduction in their medical CSP allocation.

Table 3: 2.03 per cent allocation of medical CSPs to the redistribution pool—all providers

University	Medical CSP commencements in 2021*	Places contributed to redistribution pool
New South Wales		
University of New England	60	1
University of New South Wales	199	4
University of Newcastle	108	2
University of Wollongong	69	1
University of Sydney	227	5
Western Sydney University	101	2
University of Notre Dame Australia (Sydney campus)**	60	1
TOTAL	824	16
Victoria		
Deakin University	130	3
Monash University	310	6
University of Melbourne	250	5
TOTAL	690	14
Queensland		
Griffith University	200	4
James Cook University	154	3
University of Queensland	271	6
TOTAL	625	13
Western Australia		
University of Notre Dame Australia (Fremantle campus)**	100	2
University of Western Australia	205	4
Curtin University	100	2
TOTAL	405	8
South Australia		
Flinders University	111	2
University of Adelaide	134	3
TOTAL	245	5
Tasmania		
University of Tasmania	93	2
Australian Capital Territory		
Australian National University	90	2
TOTAL	2972	60

* Commencement estimates are based on the number of medical CSP graduates anticipated to be permitted in 2021 Commonwealth Grant Scheme funding agreements, and assume a 100 per cent pipeline. Commencements for the University of Melbourne and the University of Notre Dame Australia (UNDA) exclude domestic full-fee paying medical enrolments. Flinders University commencements excludes NT Medical School Program places as these places are supported by the NT Government and are not CSPs.

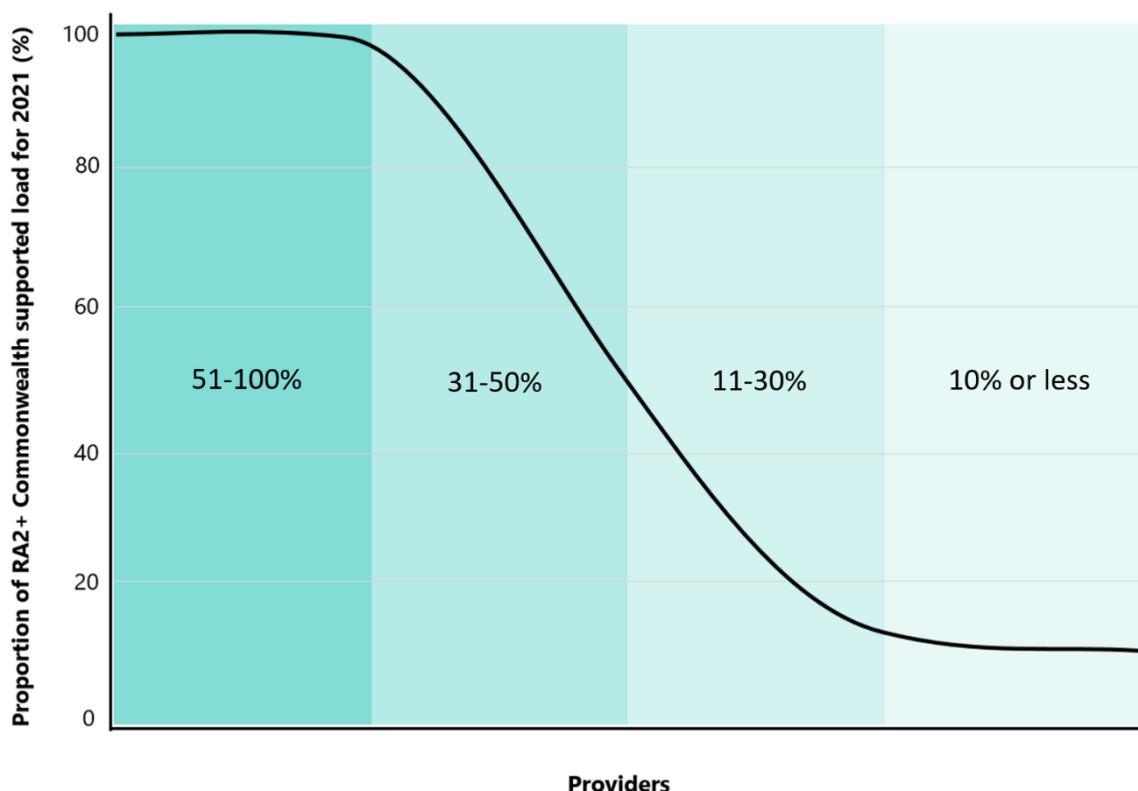
** As UNDA operates in both Western Australia and New South Wales, its estimated 160 total medical CSP commencements has been split accordingly between both campuses, based on initial allocations approved for each campus between 2005-2009.

Option 2: All universities would contribute 2.03 per cent of commencing medical CSPs to create a pool of 60 commencing places; the 28 places remaining after CSU’s allocation would be redistributed across all universities based on the proportion of regional medical education training each institution currently delivers or proposes to deliver.

This option proposes that:

- All medical programs would contribute 2.03 per cent of their commencing medical CSPs (rounded) to create a pool of 60 commencing medical CSPs.
- A total of 32 commencing medical CSPs would be allocated to CSU for the MDMSN.
- The remaining 28 commencing medical places would be redistributed to universities based on the proportion of medical education training they undertake in regional (ASGS-RA2+) locations.

Table 4: Redistribution of medical places based on proportion of regional medical course load



This approach would establish the redistribution pool in the same way as Option 1.

It proposes a transparent, equitable redistribution process to medical programs based on the proportion of regional medical education training each university undertakes, or is committed to undertake, by the initial redistribution round in 2021.

As indicated in [Table 4](#) above, a higher proportion of places would be redistributed to providers with the highest regional medical load and, conversely, a lower proportion would go to providers with a minimal regional focus.

Each provider would receive a proportion of the places it has contributed to the redistribution pool to align with the proportion of its overall medical course delivery in ASGS–RA2+ locations. The proportion of places returned to each provider would depend on its regional delivery bandwidth, as set out below:

Proportion of medical course delivered in ASGS-RA2+ locations	Proportion of places reallocated to a provider from the contribution it has made to the redistribution pool
Over 50%	Up to 100% of contributed places returned
Around 31–50%	Up to 50% of contributed places returned
Around 11–30%	Up to 30% of contributed places returned
Up to 10%	One commencing medical CSP returned

As set out above, regional medical training data each university provides to the department in conjunction with feedback on the discussion paper will help to ensure this approach accurately reflects actual regional medical load.

The number of places returned to an individual provider would not exceed the number of places the provider contributed to the pool’s establishment.

This option would ensure that all providers would receive at least one commencing medical place from the redistribution pool to support their regional initiatives.

Universities with the strongest regional presence would not lose any places in the redistribution process.

The department expects a maximum net loss of around five commencing places to any single provider under this approach, involving metropolitan institutions with the largest medical programs. These universities would be well placed to take advantage of the Government’s transitional measure that permits them to enrol a compensating number of IFFP medical students for any net loss of medical CSPs in the initial redistribution round.

This option would be quick to implement. Outcomes could be finalised before the end of 2019 as a competitive redistribution process involving an evaluation against the Assessment Framework and policy parameters would not be required.

As places returned to any medical program would not exceed the number of places the university contributed to the pool, no growth opportunities would be available to reward new and innovative proposals through this approach.

Option 3: All universities would contribute 2.03 per cent of commencing medical CSPs to create a pool of 60 commencing places; the 28 places remaining after CSU’s allocation would be redistributed only to universities with a commitment to deliver end-to-end fully regional medical programs by 2021.

This option proposes that:

- All medical programs would contribute 2.03 per cent of their commencing medical CSPs (rounded) to create a pool of 60 commencing medical CSPs.
- A total of 32 commencing medical CSPs would be allocated to CSU for the MDMSN.
- The remaining 28 commencing medical places would be redistributed only to universities with a commitment to deliver end-to-end fully regional medical programs to at least a cohort of their students by 2021.

Table 5: Places contributed to redistribution pool by universities with a commitment to deliver fully regional medical programs by 2021

University	Medical CSP commencements in 2021	Places contributed to redistribution pool
New South Wales		
University of New England	60	1
University of New South Wales	199	4
University of Newcastle	108	2
University of Wollongong	69	1
University of Sydney	227	5
Western Sydney University	101	2
University of Notre Dame Australia (Sydney campus)*	60	1
TOTAL	824	16
Victoria		
Deakin University	130	3
Monash University	310	6
University of Melbourne	250	5
TOTAL	690	14
Queensland		
Griffith University	200	4
James Cook University	154	3
University of Queensland	271	6
TOTAL	625	13
Western Australia		
University of Notre Dame Australia (Fremantle campus)*	100	2
University of Western Australia	205	4
Curtin University	100	2
TOTAL	405	8
South Australia		
Flinders University	111	2
University of Adelaide	134	3
TOTAL	245	5
Tasmania		
University of Tasmania	93	2
Australian Capital Territory		
Australian National University	90	2
TOTAL	2972	60

Based on the department's internal analysis of enrolment data on the current distribution of regional medical load for university medical courses and information provided by the Department of Health, the orange shaded cells indicate universities that currently deliver fully regional medical programs, together with those that have funding agreements in place to deliver fully regional medical programs as part of the MDMSN.

* As UNDA operates in both Western Australia and New South Wales, its estimated 160 total medical CSP commencements has been split accordingly between both campuses, based on initial allocations approved for each campus between 2005-2009.

This approach would also establish the redistribution pool in the same way as Option 1.

It proposes a simple redistribution approach where all 28 available places from the pool would be reallocated to universities with a commitment to deliver fully regional programs by 2021.

Fully regional medical programs are defined as end-to-end regional medical courses:

- delivered by a regionally headquartered university, or
- delivered from a regional campus of a metropolitan university to a cohort of its students, or
- where a provider has a firm commitment in place with the Australian Government for full medical course delivery from a regional campus to a cohort of its students by the initial redistribution round for 2021.

Based on the department's analysis of enrolment data on the current distribution of regional medical load for university medical courses and information from the Department of Health, [Table 5](#) above indicates nine universities with a firm commitment to deliver fully regional medical programs from 2021. This includes universities participating in the MDMSN initiative with funding arrangements in place with the Department of Health.

Returning places from the pool to these providers to offset their contribution to the pool as fully as possible would result in no places being left for competitive redistribution and no growth opportunities to reward new and innovative proposals.

This option could be implemented quickly, as for Option 2. Outcomes could be finalised before the end of 2019 as a competitive redistribution process involving an evaluation against the Assessment Framework and policy parameters would not be required.

The department invites stakeholder views on the above three options for managing the redistribution pool and redistribution process for 2021, taking into account the need to ensure:

- **the approach to creating the redistribution pool is fair, equitable and transparent across all universities**
- **the pool provides the maximum number of places to respond most effectively to the goal of helping build the rural and regional medical workforce**
- **the redistribution process supports universities currently serving the needs of rural and regional communities and those committed to delivering a genuine increase in regional medical places.**

Policy parameters for the 2021 redistribution process

Proposals seeking places through the competitive redistribution process envisaged in Option 1 above would be evaluated against the Assessment Framework and agreed policy parameters to maximise regional medical outcomes.

Possible policy parameters that could underpin this approach include:

- only considering proposals for a minimum number of commencing medical CSPs from the redistribution pool. This could include collaborations between universities that enable resources to be shared to deliver sustainable programs in rural or regional locations.
- requiring proposals to build on existing rurally focussed medical programs that support high quality rural and remote training experiences and/or producing rurally practising medical practitioners.⁹ Evidence and data would need to be provided, such as longitudinal workforce outcomes for the university's medical graduates, information about the university's selection and retention processes, and other strategies to grow the rural medical workforce.
- supporting a future medical workforce that has a broad scope of practice, meets the health needs of rural populations, and works well as part of interdisciplinary health care arrangements. Proposals would include strategies and approaches for improving the integration of rural training across the stages of medical training.
- maximising opportunities to support school leavers and graduate-entry students with a rural background and attract those with an interest, intention and aptitude for practising in rural and regional areas once qualified.
- only considering proposals where no additional Commonwealth funding is sought (e.g. for infrastructure), other than the CGS funding associated with any redistributed medical CSPs.
- returning pool places to universities that demonstrate significant viability or sustainability issues for their medical programs resulting from the contribution they have made to the pool's creation, or to universities that already undertaken a large proportion of medical training in rural and regional locations and produce strong rural medical workforce outcomes.
- giving consideration to university approaches that build on existing strategies, to transform medical graduate supply (rather than entirely new strategies) to better meet the needs of rural areas.

The department is aware of the need to consider implications for state/territory health workforce supply, as well as the sustainability of existing rural medical programs and rural training activities funded through the Commonwealth Department of Health. This is important as states and territories guarantee internships for Commonwealth supported medical graduates (COAG 2006) and are the main providers of clinical training for medical students and early career doctors.

⁹ Most publicly available evidence of rural practice outcomes is from published research evidence. A recent review of the literature notes "the evidence about program designs that are most effective remains relatively under-developed" (O'Sullivan et al. *A review of characteristics and outcomes of Australia's undergraduate medical education rural immersion programs*, Human Resources for Health (2018) 16:8 DOI 10.1186/s12960-018-0271-2).

The Department of Health will facilitate advice from state and territory health officials, including implications for post-graduate training of junior doctors and non-GP medical specialists. Feedback could include advice on the following:

- geographic areas where increased clinical training hours could be supported by their local health networks/districts
- any plans for expansion in rural internships or rural specialist training positions
- jurisdictions' expectations about how universities need to engage with them, or their hospital and health services, when developing proposals to be submitted to the Commonwealth,
- likely locations of regional hospital expansion that would support feasible integrated end-to-end rural training pathways.

The department invites stakeholder views on:

- **the suitability of the above policy parameters for the 2021 redistribution process**
- **identification of alternative/additional policy parameters to be applied in the 2021 process to maximise regional medical workforce outcomes**
- **suggestions for policy parameters and/or evidence sources that could inform the triennial review of workforce data and emerging issues for future redistribution rounds after 2021.**

Other feedback

In addition to inviting stakeholder feedback on the matters set out above, the department welcomes views on other issues or approaches included in this discussion paper on the redistribution pool mechanism.

Submissions

Please send your written submissions by **5 pm AEDT on Friday, 25 October 2019** to the department at CGS@education.gov.au.

Unless otherwise agreed with the department, stakeholder views will be published on the department's website.



Assessment Framework

Guiding Notes to support the application of the Assessment Framework

How will the Assessment Framework apply to medical school proposals?

1. This Assessment Framework will apply to all medical school proposals for a new or expanded medical school or medical campus where a university seeks the Australian Government's:
 - a. approval to enrol students in medical Commonwealth supported places (CSPs) at a new medical school campus, or
 - b. allocation of medical CSPs, or
 - c. funding, including capital, transitional, Commonwealth Grant Scheme (CGS) or Higher Education Loan Program (HELP) funding.
2. Proposals that do not address all of the Assessment Framework criteria will not be accepted.
3. National health workforce data and modelling do not support any change to the overall supply of medical graduates at the present time. Accordingly, any medical school proposal that seeks an allocation of new commencing medical CSPs will not be considered. Any medical CSPs required for a proposal must be sourced from within the existing national allocation of medical CSPs.

When will proposals be considered by Government?

4. The Department of Health will undertake a triennial assessment of national medical workforce data to identify emerging workforce trends and priority areas for action. The Government will determine whether to call for proposals in line with this triennial assessment and submissions will be evaluated at that time using the Assessment Framework. Any proposals received outside of this process will generally not be considered.
5. The Minister for Education and the minister with responsibility for medical schools policy within the Health portfolio may jointly revise the Assessment Framework to reflect changing Government priorities over time as informed by the triennial medical workforce analysis.
6. A panel of senior staff established by the Department of Education and the Department of Health will assess all complete proposals. The panel will have the relevant expertise to evaluate, rank and recommend proposals for funding. Panel members will have access to external expert advice when necessary. The panel will make recommendations to the Minister for Education for decision.
7. The Minister for Education is responsible for allocating medical CSPs and consults with the minister with responsibility for medical schools policy within the Health portfolio, on requests for medical places.

Who can bring forward a medical school proposal?

8. The national assessment of medical schools and medical places identified significant establishment and implementation challenges associated with proposals from universities seeking to be new providers of a medical school program. Because of the increased risk, proposals that involve a new medical school provider must be made in partnership with a university that already delivers a medical program.
9. As proposals involving a new provider pose a greater risk, they will be subject to a higher level of scrutiny through the Assessment Framework.
10. In recognition of the established capacity and experience of providers already delivering medical programs (i.e., established curriculum, medical educators, infrastructure and rural clinical training experience), medical school proposals from these providers may require a less comprehensive assessment and will be evaluated accordingly against the Assessment Framework.
11. Small scale proposals, for example, where an existing medical school provider seeks to transfer some of its existing medical places to a new location, may also be subject to a less rigorous analysis against the Assessment Framework.

What information must be contained in a medical school proposal?

12. Medical school proposals must include the following information:
 - a. *Scope of the proposal* – details must clearly identify the scope and footprint of the proposed medical school and its activities.
 - b. *Student numbers* – the number of medical CSPs being sought must be clearly identified.
 - c. *Costs* – information must be provided on how all associated costs with the medical school will be funded. This should identify all funding sources including any funding sought from the Australian Government for the proposal and, if applicable, any associated Health portfolio costs for participation in Department of Health programs.
 - d. *Proposed timelines* – the timing for key aspects of the medical school development such as construction, recruitment, accreditation process and whether a staged rollout is envisaged over time, should be clearly detailed.
 - e. *Evidence of consultation with the Australian Medical Council (AMC)* – the AMC must be consulted prior to submission of any proposal due to the lengthy timeframe needed for AMC accreditation of new medical programs. Proposals should include information about the AMC's preliminary views (see also Assessment Framework principle nine).
 - f. *Flagging an intention to participate in rural training initiatives funded by the Health portfolio* – proposals that flag an intention to participate in rural training initiatives funded by the Department of Health must include detailed plans, consideration of training capacity, an outline of consultations with affected stakeholders and costings associated with the rural training initiatives as part of their proposal and developed following consultations with the Department of Health
 - g. *Assessment Framework* – all elements of the Assessment Framework must be addressed or the proposal will not be accepted for consideration.

Assessment Framework

1. The proposal does not change the national supply of domestic medical graduates

Note: This principle will remain in place until Department of Health medical workforce projections indicate a need for additional medical places.

2. The proposal does not increase the number of domestic or international full fee paying medical students

3. The proposal is either from a university with an existing medical school or from a university partnering with an existing medical school to leverage off the established capacity and experience of an already accredited provider

- a. The proposal leverages existing investment in capital infrastructure within the region to support medical student programs.
- b. The proposal demonstrates collaborative arrangements and partnerships that build on existing primary and postgraduate medical education training initiatives in the proposed region.
- c. For proponents that seek to partner with an existing medical school, the proposal demonstrates how the partnership will leverage off the established capacity and experience of already accredited providers/programs (i.e. their curriculum, medical educators, infrastructure and rural clinical training experience).

4. The proposal increases medical workforce capacity in the region(s) of identified medical workforce need

- a. Evidence clearly demonstrates an undersupply of medical practitioners that the proposal will address.
- b. The evidence base is consistent with national, state, and/or regional medical workforce published data.
- c. The proposal clearly explains why the current medical training model is not addressing the undersupply and demonstrates how the proposed model will address the undersupply.
- d. The proposal includes a detailed rationale for the scale of the proposal which outlines the basis for the number of medical places required.
- e. If the proposed medical school plans to operate in the same region as an existing medical school:
 - i. medical workforce evidence is provided demonstrating the need for additional medical places in the region.
 - ii. the university provides a sound rationale for the need for an additional provider that takes account of potential duplication and/or displacement of existing teaching provision, clinical placement availability and synergies with existing infrastructure and other resources.

5. Any proposal seeking a redistribution of existing medical places demonstrates it will deliver positive medical workforce outcomes that are superior to or cannot be achieved through existing arrangements

- a. The proposal must explain why places cannot be utilised from within the proponents existing allocation of places to implement the proposal.

- b. The proposal demonstrates how its alternative model of medical education will deliver stronger medical workforce outcomes than what is being achieved under existing training models in the region.
- c. The proposal includes a rationale backed by strong evidence detailing how its alternative model of medical education adopts best practice strategies to effect positive changes to the medical workforce distribution in the proposed region compared with current training models, including delivering a better quality, more positive training experience.
- d. The benefits of any proposed additional investment need to clearly demonstrate that the proposed outcomes for medical students, local health services and the local population would be superior to or cannot be achieved through existing arrangements.
- e. The proposal includes a detailed plan articulating how all the transition risks associated with the establishment of the proposed medical school would be appropriately managed and mitigated to ensure minimal or no impact to the provision of existing medical education programs and to the integrity of existing training pathways.

6. The proposal identifies training pathways across each stage of the medical training pipeline from medical student to junior doctor to specialist trainee

- a. The proposal demonstrates the capacity for and evidence of an integrated approach across the medical training pipeline, connecting the medical school program with junior doctor and specialist training in the proposed region.
- b. The proposal demonstrates how it will build on Commonwealth initiatives, such as the Integrated Rural Training Pipeline and Rural Workforce Agency Program, which aim to help retain medical graduates in rural areas by better coordinating the different stages of medical training.
- c. The proposal indicates the state/territory programs in place to ensure continuation of medical education and training in the region(s) of identified workforce need for doctors in training, following completion of the medical degree and provides evidence of support from relevant jurisdiction(s) and their regional health services.

7. The proposal expands opportunities for students from disadvantaged backgrounds

- a. The proposal provides a demographic profile indicating socio-economic disadvantage of the region in which the medical school will operate (including low socio-economic status students, Aboriginal and Torres Strait Islander students, students with a disability, and other disadvantaged groups).
- b. The proposal includes a recruitment strategy, including data, for enrolling students from disadvantaged backgrounds and increasing their participation levels over time.
- c. The proposal describes support structures that will be in place to assist disadvantaged students to complete their medical course.

8. The proposal's student recruitment strategy, training arrangements, and curriculum are tailored to address the region(s) of identified medical workforce need

- a. The proposal details a student recruitment strategy that is targeted to addressing the identified maldistribution of the medical workforce in the proposed region.
- b. The proposal details a targeted clinical training strategy, including the duration and setting of clinical placements, to address the identified maldistribution of the medical workforce in the proposed region.

- c. The proposal indicates how the course curriculum will prepare students to work in the proposed region(s) of identified medical workforce need once their course is completed. If the curriculum is modelled on that of another institution the rationale and local versioning and appropriateness of that must be described in the proposal.

9. The proposal sufficiently details the network of clinical providers who will be engaged in the implementation of the proposed medical program to enable students to complete the course requirements

- a. The proposal includes evidence of in-principle agreement from health providers to provide, at a minimum, the clinical training places required to enable medical students to complete the course requirements.
- b. The proposal includes an assurance from each clinical training placement provider that agreeing to provide the clinical placements will not displace training placements already provided for medical students and doctors in training.
- c. The proposal includes evidence of available supervisory capacity for clinical training placements and details how it will not exacerbate supervisory shortages across all stages of medical training.
- d. The proposal includes an indication that the proposed medical program is likely to meet the Australian Medical Council accreditation requirements concerning the provision of adequate clinical training teaching, places and supervision.

10. The proposal demonstrates effective governance processes and staff recruitment strategies to implement the proposed medical program

- a. The proposal sufficiently details a recruitment plan for clinical academic leadership within the proposed medical program including:
 - i. the formal appointment of a Medical School Dean well in advance of the establishment of the medical program to lead all planning, development, recruitment and transition processes.
 - ii. retention strategies to maintain the required academic workforce across the proposed regions.
- b. The proposal demonstrates robust and effective governance processes, including the ability to effectively coordinate staff and students across multiple campuses and training facilities to maintain consistency in the delivery of the medical program.

11. The relevant state/territory government guarantees support for the proposal, including provision of the necessary clinical training and supervision, internships and specialist training places through each stage of the medical training pipeline

- a. Evidence of strong support for the medical school proposal is provided from jurisdiction/s where the medical school will be located.
- b. Evidence includes a state/territory government guarantee to provide ongoing funding for the required clinical training and supervision, internships and specialist training places required to enable the students to become medical practitioners.
- c. The proposal includes a state/territory government guarantee to provide a funding contribution towards establishing the proposed medical program. This could involve a capital or transitional funding contribution or a commitment to provide land for the medical school site.

12. The proposal is affordable and presents value for money to the Commonwealth

- a. Commonwealth funding towards the proposal represents an effective use of taxpayer money. This could be achieved through:
 - i. Partnership arrangements with existing institutions (co-located facilities with other education/health providers, partnering with research institutes).
 - ii. Co-investment from local /state governments, the private sector, charitable organisations or the university.
- b. Where the Commonwealth has already invested capital funding in the region identified, the proposal:
 - i. Demonstrates how previous Commonwealth investments will be leveraged to minimise the request for additional funding.
 - ii. Identifies how any additional funding sought will deliver improved medical workforce outcomes.
- c. Commonwealth investment provides flow-on financial benefits to the local community in which the medical school will operate.