THE UNIVERSITY of ADELAIDE

2015/216

Dom English
Acting Deputy Secretary
Department of Education and Training
GPO Box 9880
CANBERRA ACT 2601

c/o cgs@education.gov.au

23 October 2019

Dom,

Dear ~~Mr English~~

Redistribution pool of medical places – Discussion Paper

Thank you for your letter of 20 September 2019. The University of Adelaide welcomes the opportunity to provide feedback on the Redistribution Pool of Medical Places Discussion Paper and our response is enclosed.

As requested, further information is also provided on the amount of medical education the University has delivered regionally in the last three years.

Please let us know if you require any additional detail to this submission.

Yours sincerely

Peter

PROFESSOR PETER RATHJEN AO
Vice-Chancellor and President

cc: Director, Learning and Quality Support

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Redistribution pool of medical places – Discussion Paper

University of Adelaide Submission

Background

The number of universities with medical schools has almost doubled in the last two decades. Expansion of medical school CSPs was in response to medical workforce shortages in the 2000's. Currently Australia produces three times more medical graduates than the OECD average, but the maldistribution of doctors persists, with roughly half the doctors per capita in rural compared to metropolitan areas. Almost all medical schools, including Adelaide, have a significant rural clinical school (RCS) footprint. Data from the Medical Deans of Australia and New Zealand (MDANZ) Medical Schools Outcome Database has shown that the rural origin selection into medical schools and longitudinal rural training has substantially increased the preference for rural practice in graduates.

Despite having a state where less than 18% of the population lives outside of the capital city, the University of Adelaide has consistently admitted more than 25% of its domestic medical students from rural areas.

The Adelaide Rural Clinical School has been providing clinical placements across rural South Australia for more than 10 years. Along with Flinders University, we have pioneered a successful longitudinal integrated program for students in the 5th year of their studies. In this program students work alongside rural GPs and specialists for a year, learning throughout about maternal health, child health, aged care and indigenous health in a primary care setting, instead of the conventional tertiary care series of discipline-based rotations. During this year students become part of the communities where they are based, contributing in a real way to the delivery of services.

In addition to the year 5 program, all of our students undertake a minimum of four weeks experience in rural areas and we provide placements in surgery in year 4 and in general practice in year 6 of the program.

The University of Adelaide's Rural Clinical School program has been consistently identified as one of the best educational experiences of our program, with students who undertake this more confident and better prepared for the transition to internship and more likely to express an intention to work in rural areas after graduation. We have data from our alumni showing that 20% of students who complete the year 5 longitudinal program are now working in regional or rural areas. Importantly, two thirds of these rural alumni are working in RA 3-5 locations, which is the medical workforce required for the geography in South Australia.

In addition to the support we provide for undergraduate training, members of our rural clinical school have played a leading role in the setting up of postgraduate medical training including most recently the provision of new intern training positions. Furthermore, the network of University educational facilities and staff we have developed across the state now provides a base for the further development of postgraduate medical training in these areas.

We strongly support the importance of addressing the rural medical workforce shortage and believe that the medical schools including ourselves have demonstrated this commitment by the high quality of rural experience that we have provided for our students and our commitment to supporting postgraduate training. We note the substantial evidence supporting such a multifactorial approach to delivering a rurally-inclined and prepared graduate doctor.

We also wish to bring to the attention of the Commonwealth the significant challenges of delivering end to end medical school training in rural South Australia. The University is currently undertaking a feasibility study for such a program in rural SA, the greatest challenge to which is the geographic spread of the State's population. Unlike all other mainland states, South Australia does not have significant population centres outside of the capital. Only 18% of the population live in rural areas and the majority of towns in Adelaide Rural Clinical School footprint are less than 10,000 people, with small GP-led hospitals.

South Australia's commencing medical students are predominately from South Australia or the Northern Territory (more than 70% of domestic students from SA and the NT study medicine in SA compared to 61% of NSW who study in NSW). Currently the proportion of total medicine CSPs in SA reflects the overall proportion of population of SA and the NT in Australia – combined, SA and NT represent 8% of the country's population and South Australia has s 8% of commencing medical students. Given this, a change in the distribution of medical places would likely reduce the number of SA and NT school leavers able to study medicine.

We would argue that the main impediment to increasing the rural doctor workforce now is the lack of postgraduate training pathways in rural and regional Australia and not the number of graduates leaving medical school wishing to practice in rural areas. We note for example that the results of medical schools' outcomes database report for 2018 indicated than 36% of current medical graduates expressed an intention to work outside of a capital city and 18% in smaller regional, rural or remote communities.

The University of Adelaide acknowledges the Government's commitment to providing 32 places to Charles Sturt University to support the establishment of Orange Campus as part of the Murray Darling Medical Schools Network, as announced in the 2018-19 Budget. However, we would contend that the justification for the redistribution of the additional 28 places is not clear and that supporting this by removing places from existing programs risks undermining the intent of the policy by disrupting existing and effective initiatives and programs.

Establishing a redistribution of medical places

Given the work underway already reviewing the RHMT program and the National Medical Workforce strategy, both of which were commenced subsequent to this policy's announcement, the University believes that the policy should be suspended as it stands to allow time for this to benefit from the opportunity to learn from the outcomes of these reviews.

The University of Adelaide currently has 134 CSP per year and a 6 year program. As indicated in the document under the proposed redistribution of 60 CSPs, this would involve the removal of be 3 places per year from the University. This would mean a reduction of 3 CSP across the whole program in 2021, 6 CSP in 2022 etc to a total of 18 CSP by 2026 representing an annual loss of income for the medical program of nearly $900k. This would have a significant impact on our ability to deliver our current program for domestic students, including those from rural backgrounds. In addition, this would mean that we would have five fewer opportunities for students from rural backgrounds to be studying medicine with us across the program by 2022.

Long term, we believe that supporting the redistribution of medical places by removing places from existing programs will negatively impact the rural doctor workforce in South Australia. It will result in net migration of medical training out of the state, exacerbating the current maldistribution of doctors in this State.

The proposed increase in international students to compensate for this loss of income would be counterproductive to the aim of increasing rural intention to practice as, under the current RHMT funding conditions for rural clinical skills, international students are precluded from studying in rural placements.

We note also that the discussion paper indicates that a further round of 2% redistribution could take place in 2024, before even allowing a single cohort to complete their 6 year program, making meaningful evaluation of the impact of the policy impossible.

We believe that all of the three options proposed in the Discussion Paper to manage the redistribution of 28 CSPs, based on the Assessment Framework, would be a poor investment for universities and the Government and cannot see how these would produce the desired outcome of an immediate need for increasing the number of doctors in rural practice. Indeed, any change in medical school admissions will by definition take many years to have an impact on workforce.

There will be a significant cost required from universities to develop a proposal that incorporates all the required elements, particularly in the extremely short timeframe alluded to.

Additionally, Government would also bear significant cost and resource to properly assess the proposals, monitor and evaluate their progress and repeat this process triennially without any longitudinal benchmarks to measure improvement against the desired policy outcomes.

The process for redistributing places between the universities
The University of Adelaide believes that none of the options protect schools like Adelaide which are successfully delivering students who want to work in regional or rural areas, and who are working in local partnerships to support the end point of their graduates ending up in a rural career, from potentially losing CSPs or having to expend a significant amount of resource on the chance of retaining their current allocation

Option 1
As yet there is no clear indication of what the process would be but it is likely that this would involve significant administrative work with no guarantee of 'regaining' any of the places lost. Indeed, by definition the University of Adelaide would be competing against all 19 other schools, some of which have significantly greater track records in rural health and clearly with only 28 places out of the 60 removed available most schools would still have a loss of places.

Option 2
The University of Adelaide currently has 25% of its students undertaking 2 semesters in the rural clinical school in year 5 with some additional clinical placements in years 4 and 6. Overall, we have approximately 14% of our total student weeks spent in rural/regional settings. The discussion document suggests that this would place us in the second lowest 'band' for redistribution with a possible one place being 'returned'. If we doubled the proportion of time in rural to 30%, we would not get any additional places in this proposal and if we *reduced* the rural experience for our students we would still have one place returned. In any case this focus on a single quantitative measure of rural experience disregards the evidence that all successful work in delivering a rurally-inclined and prepared graduate doctor requires a multifactorial approach, in particular the quality of the rural experience is vital. We believe this approach would reward initiatives that go against this evidence.

Option 3
The Adelaide Rural Clinical School has recently had agreements from the Commonwealth to use some of its unspent funding for 2016-2018 to undertake a feasibility study for an end to end medical program in rural SA. However, it appears that this option relates only to schools who have already agreed to set up end to end programs as part of the new MDMSN or have existing courses that fit this definition and therefore Adelaide would have no opportunity to compete for places in this proposal. Further more this option focuses solely on one strategy (end to end training) without regard to learning from evidence of what has been effective. Should this option be implemented, it would impose a disproportionately high proportion of CSP losses on a small number of universities such as Adelaide, which would cause significant and harmful disruption, and again potentially impact on our ability to deliver a strong outcome of rurally-interested graduates.

Summary
The University of Adelaide acknowledges that the Government has the right and responsibility to review the distribution of medical places. However, we believe that the proposals included in the policy paper will not achieve the desired outcome for the rural medical workforce and have the potential to make the situation worse by undermining current successful initiatives by the medical schools.

We believe that the proposed timeframe to implement the policy is unrealistic and highly unlikely to be achieved, particularly given the Assessment Framework requires substantial and detailed information from a range of different sources, including the jurisdictions. Much of this will be outside the schools' control and would not provide sufficient time for Universities such as Adelaide to prepare a response that would meet any of the options outlined in the discussion paper. We believe that it would be inherently unfair to penalise University of Adelaide on this basis.
Changing rural medical workforce is a complex problem in which changes to medical school training are only one factor which, we would argue, is already being addressed, and where further changes without changing the rest of the training pipeline will not be effective.