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The Hon Dan Tehan MP
Minister for Education
PO Box 6022, House of representatives
Parliament House,
CANBERRA ACT 2600
Email: Dan.Tehan.MP@aph.gov.au
Cc: CGS@education.gov.au

Dear Minister

Go8 response to the Discussion Paper on the redistribution pool of medical places

I am writing to you on behalf of the Group of Eight (Go8) in response to the discussion paper released by your Department on the redistribution of a pool of medical places to support the development of a Rural, Regional and Remote (RRR) medical workforce.

Individual Go8 institutions may make their own responses to the discussion paper, however this collective submission represents the high-level concerns of the Go8 that the redistribution process under discussion will not address the shortage of medical practitioners in RRR areas and indeed may have a detrimental impact.

As such, the Go8 has three main recommendations in response to the discussion paper:

1. **That the redistribution of 2% of commencing medical Commonwealth Supported Places (CSPs) not proceed as currently formulated, including the subsequent (three yearly) rounds of the redistribution pool.**
2. **That the Murray Darling Medical Schools Network (MDMSN) – for which the Go8 is supplying four of the five nodes – be supported as announced in the 2018-19 Budget, including through the provision of 32 CSPs to establish the CSU medical school campus at Orange. These 32 CSPs should be sourced in a way that causes minimal disruption to existing programs.**
3. **That necessary action undertaken to improve the number and geographic distribution of domestically trained medical practitioners in RRR areas should**
    a) **be strategically aligned with the current development of the National Medical Workforce Strategy (NMWS) and the outcomes of the review of the Rural Health Multidisciplinary Training (RHMT) program; and**
    b) **focus on addressing the key bottlenecks in the pipeline of medical practitioners to RRR areas, in particular improving arrangements for intern positions and vocational training for specialist qualifications.**

To be clear, the Go8 fully supports the ambitions of the Government's *Stronger Rural Health Strategy* announced as part of the 2018-19 Budget but is concerned that the redistribution under discussion is fundamentally flawed and will not contribute positively to achieving the desired outcomes of the Strategy.

Go8 contribution to RRR medical training

The Go8 institutions have a significant footprint in RRR medical education and a strong commitment to medical workforce issues. All Go8 institutions operate substantial Rural Clinical Schools and are involved in 17 of the 26 recently established Regional Training Hubs whose mission includes strengthening existing, and developing new, connections with key stakeholders to improve the continuity of training for medical students and trainees.

In terms of their student body, Go8 universities source a substantial percentage of their domestic medical students from an RRR background and commit 28.5% of their CSPs to the Bonded Medical Program which includes a return of service obligation in RRR areas.

In addition to this existing commitment the Go8 will also provide four of the five nodes of the Murray Darling Medical Schools Network (MDMSN) nodes announced as part of the *Stronger Rural Health Strategy.*

This is all part of the broader and coordinated medical education effort which sees the Go8 produce 62% of Australia's medical graduates educated in a research-intensive environment with 7 of the 8 Go8 medical schools ranked in the top 100 in the world.[1]

The impression that Go8 institutions are often considered metropolitan only belies this sizable footprint in RRR medical education. For example, collectively the Go8 conducts health and medical placements in over 550 locations across RRR Australia.

Key blockages in the pipeline of the supply of domestically trained RRR medical practitioners are not at medical schools

Currently, Australian medical schools do generate significant interest in their students to pursue a career in RRR areas. Published evidence shows that RRR "immersion" during medical education at University of Queensland, Monash University and University of Western Australia is correlated with increased likelihood of graduates undertaking a career in RRR areas[2]. More broadly, the 2019 Medical Schools Outcomes Database

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[1] QS World University Rankings by Subject 2019: Medicine. This includes four Go8 institutions in the top 50 globally: University of Melbourne (17), University of Sydney (18), Monash University (32) and University of Queensland (49).

[2] 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.
Playford DE, Evans SF, Atkinson DN, Auret KA, Riley GJ. Impact of the Rural Clinical School of Western Australia on work location of medical graduates. Med J Aust. 2014 Feb 3;200(2):104-7.
and
Playford DE, Nicholson A, Riley GJ, Puddey IB. Longitudinal rural clerkships: increased likelihood of more remote rural medical practice following graduation. BMC Med Educ. 2015 Mar 21;15:55. doi: 10.1186/s12909-015-0332-3.

Report prepared by the Medical Deans of Australia and New Zealand (MDANZ) shows that 36% of medical graduates responding to a survey (of which 68% were from the Go8) have an interest in a career outside of a capital city. This includes 26% of students from a non-rural background also stating this preference.

***Thus, the key to an increased domestically trained RRR medical workforce is to convert the interest in RRR careers generated through medical education to actual workforce outcomes by addressing the key pipeline blockages in a systematic and programmatic manner*.**

As raised in the joint Go8 and Medical Deans of Australia and New Zealand (MDANZ) submission to the 2017 Assessment of the Distribution of Medical School Places in Australia, in the consideration of the supply of medical practitioners to RRR areas the context of medical training pipeline is critical. The period of training for a medical practitioner is long, including entry-level training, prevocational training and specialty training. *What happens all along this training pipeline will influence the geographical location in which a doctor ultimately lives and serves.* Medical school places are in play for part of this journey and can therefore make a useful but necessarily limited contribution to addressing workforce need in isolation.

Many junior doctors interested in working in rural Australia are currently obliged to move back to the city for specialist training. The most important current solution is not another new medical school nor a redistribution of medical school places*. Medical Deans have long advocated that what is needed to achieve a better distribution of doctors in rural Australia is a "flipped" model of regionally based specialist training with rotations back into metropolitan hospitals if needed.*

There is also the issue of medical graduates not being able to secure an intern position in an RRR area and being forced back to metropolitan areas for this part of their training. As a case in point, in 2016 the Orange Health Service received 100 applications for 16 available intern jobs. This is typical of instances around the country where the intention of medical graduates to pursue an RRR career is stymied by chokepoints in the training pipeline. This often means a return to metropolitan centres at a time where students are establishing their life.

The Scoping Framework for the National Medical Workforce Strategy (NMWS) being conducted by the Chief Medical officer for Australia – Professor Brendan Murphy – also reiterates these points. In particular, the Framework lists key contributing factors to the issue including:

- The rural training and career pathway is not cohesive from beginning to end;
- [Accredited vocational] Training positions are predominantly located in urban areas;
- Disparities in earning capacity between rural and urban areas; and
- Training and professional development.

Medical school education is not mentioned as a key factor in this context.

If the ambitions of the *Stronger Rural Health Strategy* are to be realised, then it is these key pipeline blockages – in particular the provision and coordination of intern positions and specialist training – that must be addressed.

Issues with the current proposal for a redistribution of commencing medical CSPs

The Department of Education *Discussion Paper – redistribution pool of medical places* which sets out the options for the redistribution of commencing medical CSPs to improve the recruitment and retention of doctors in rural and regional Australia details little that will actually accomplish these objectives.

In terms of its primary objective of constructively reallocating CSPs, the paper acknowledges that there is not the capability to determine which – if any - redistribution initiatives will be effective:

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. (Page 8)

Nor is there the capacity to track the ongoing progress of initiatives by linking them to the distribution of medical practitioners

… 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. (Page 9)

Not only will there be no evidence-based understanding of which possible initiatives will be effective but the "scattergun" nature of reallocating CSPs will not support new programs at scale (beyond the announced CSU node of the MDMSN) and likely only act to marginally increase the numbers in existing programs.

The proposed redistribution in not addressing the key pipeline issues of intern and specialist training positions (as outlined above) is essentially "tinkering at the edges" of the problem. More significantly than this, the discussion paper does not once reference the National Medical Workforce Strategy (NMWS). The NMWS Scoping Framework dedicates significant space to discussion of the RRR medical workforce issues, contributing factors and setting the framework for the articulation of systems-based solutions.

The CSP redistribution mechanism is currently slated for finalisation in late 2019. This is nearly a year ahead of the scheduled completion of the NMWS with the result that the CSP redistribution will not be linked into the NMWS. Indeed, the CSP redistribution – both the current and future iterations - may serve to distract from the NMWS development and reallocate resources that could be more strategically applied under the NMWS.

Similarly, the design of the CSP redistribution mechanism will not be able to take into account outcomes of the current review of the Australian Government's Rural Health Multidisciplinary Training (RHMT) Program. The RHMT Program supports high quality rural health training and aims to make a measurable impact on addressing the maldistribution of the rural health workforce. This includes initiatives such as the Regional Training Hubs which support the coordination of postgraduate medical training.

While the Go8 acknowledges the need to fully support the MDMSN announced in the 2018-19 Budget with 32 CSPs to be provided to the new CSU medical school campus at Orange, the Go8 has specific concerns with the three options for redistributing an additional 28 places raised in the discussion paper.

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 will require significant work on the part of the sector to apply for a small number of redistributed places – not only in the absence of the National Medical Workforce Strategy (as mentioned above) but also – as acknowledged by the discussion paper – *it is unlikely that sufficient places would be available to reward all proposals with a strong regional commitment.*

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 does not reward *total effort* by an institution in regional medical education but rather relative effort. This would see institutions with a large and significant regional medical education footprint disadvantaged if they also offer metropolitan based medical education. This option also offers no assessment of merit in the redistribution with the discussion paper acknowledging that *no growth opportunities would be available to reward new and innovative proposals through this approach* and that the major attraction of this option would be that it *would be quick to implement.* (Page 13)

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.

There is very little evidence to support that end-to-end fully regional medical programs will on their own be effective in delivering a regional medical workforce. Indeed, the discussion paper itself in support of long-term training in rural areas increasing the likelihood of practice in rural areas upon graduation cites research based on rural immersion during training at Monash University and the University of Queensland (Page 2). A focus on end-to-end training would also require much more resourcing than immersion training to achieve the stated objective of the discussion paper 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.* (Page 9)

Given these issues raised with the proposed redistribution of commencing medical CSPs the Go8 makes the following recommendations.

GROUP OF EIGHT AUSTRALIA

Recommendation 1: That the redistribution of 2% of commencing medical Commonwealth Supported Places (CSPs) not proceed as currently formulated, including the subsequent (three yearly) rounds of the redistribution pool.

Recommendation 2: That the Murray Darling Medical Schools Network (MDMSN) – for which the Go8 is supplying four of the five nodes – be supported as announced in the 2018-19 Budget, including through the provision of 32 CSPs to establish the CSU medical school campus at Orange. These 32 CSPs should be sourced in a way that causes minimal disruption to existing programs.

Coordinated measures to increase the supply of domestically trained RRR medical practitioners

As noted above, the proposed redistribution of commencing medical CSPs is neither strategic nor coordinated with other initiatives currently underway.

As such the Go8 makes the following recommendation.

Recommendation 3: That necessary action undertaken to improve the number and geographic distribution of domestically trained medical practitioners in RRR areas should

a) **be strategically aligned with the current development of the National Medical Workforce Strategy (NMWS) and the outcomes of the review of the Rural Health Multidisciplinary Training (RHMT) program; and**
b) **focus on addressing the key bottlenecks in the pipeline of medical practitioners to RRR areas, in particular improving arrangements for intern positions and vocational training for specialist qualifications.**

Once again, thank you for the opportunity to respond to the discussion paper on the redistribution pool of medical places. If you or your department should have any questions on this Go8 response, then please do not hesitate to contact me at chief.executive@go8.edu.au or on 02 5123 6701.

Yours sincerely

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CHIEF EXECUTIVE