Medical Deans
AUSTRALIA AND NEW ZEALAND

25 October 2019

The Hon Dan Tehan MP
Minister for Education
Via email: Minister@education.gov.au

Dear Minister Tehan,

Re: Medical Deans' response to the Discussion Paper – redistribution pool of medical places

Medical Deans Australia and New Zealand (Medical Deans) appreciates the opportunity to provide our views on the Department of Education's *Discussion Paper – redistribution pool of medical places* that was released on 23 September 2019.

We strongly support the need to address the maldistribution of the existing workforce in rural and regional areas, and recognise that government should have the capacity and flexibility to redistribute Commonwealth Supported Places (CSPs) if this would support the desired policy outcomes and better meet community needs.

However, we are concerned that the policy as announced in April 2018 and the options outlined in this Discussion Paper will not deliver on the desired outcome, will lead to unintended consequences, and is a significant amount of unproductive work – for both medical schools and government.

Doing nothing is not an option though. Since the announcement of this Budget measure in early 2018, a number of universities have made commitments based on the understanding that it will be implemented. Whilst we do not support this proposed approach, not progressing with any policy to address the maldistribution of doctors is likely to adversely impact those universities and medical schools who have progressed in their planning and work, and risks losing momentum within the sector of working towards achieving these aims. However changes must be well-considered and well-balanced, be based on what is known to be effective, and be focused on the outcomes it is aiming to achieve.

It is vital that any new policy to drive and support greater regional training take account of and integrate across the training pipeline. Changes focused on one stage of the training pipeline only, will invariably worsen the current bottlenecks. Whilst we understand the current Discussion Paper is solely focused on utilising the 'reward' of CSPs to achieve the Government's policy objectives to strengthen the rural medical workforce, this long-term outcome is impossible to achieve without the right structures in place and effective support and incentives dispersed right across the medical training pipeline; from student, to intern, to trainee, to specialist medical practitioner.

CSP redistribution policy

We strongly recommend that the CSP redistribution policy be suspended as it currently stands, and be further developed learning from the outcomes of the evaluation of the Rural Health Multidisciplinary Training (RHMT) Program and align and connect with the National Medical Workforce Strategy (NMWS) Framework, both of which were commenced subsequent to this policy's announcement.

Medical Deans acknowledges the Government's commitment to providing 32 CSPs to Charles Sturt University to support the establishment of the Orange Campus as part of the Murray Darling Medical Schools Network, as announced in the 2018-19 Budget. We suggest the Government focus on options that would enable that, in a way that doesn't undermine what is trying to be achieved, and that doesn't disrupt existing and effective medical school initiatives and programs.

We urge the Government to work with the medical school sector and other key stakeholders to further develop this proposed policy in line with the proposal and recommendations provided by Medical Deans to you and your Ministerial colleagues in the Health and Regional Services portfolios – attached to this letter.

All options proposed in the Discussion Paper are highly likely to impede the policy's intent

We are concerned that the approaches outlined in the Discussion Paper present the situation and the proposed policy outcomes with a high degree of false precision. Rural workforce planning, especially in the case of healthcare, is complex, multifaceted and long-term – none of these considerations are reflected in this policy and the proposed options.

Using a redistribution of medical school placements as the sole lever for workforce changes will have a significant lag time before any impacts can be felt. The impending retirement of much of the current rural workforce makes more urgent measures – such as reforms further downstream – the only way to get the outcomes desired before we are faced with a potentially irreversible loss of senior rural clinicians needed to supervise regionally-based students and doctors in training.

We recognise the Government's commitment to fiscal responsibility and the need for policy proposals to provide value for money and if possible, be cost-neutral. All three options proposed to manage the redistribution of 28 CSPs, based on the Assessment Framework, would be a poor investment of time and money for universities and the Government. Specifically, 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 resources 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.

Fundamentally however, we are unable to see how any of the options proposed would achieve the desired outcome of Government, namely increasing rural doctors. There is no option that protects schools who are already successfully delivering students who want to work in regional or rural areas,

and who are working in effective local partnerships to support their graduates towards a rural career, from potentially losing CSPs or having to expend a significant amount of resource on the chance of retaining their current allocation. All the proposed options have flaws and are likely, in various ways, to undermine the intent of the policy.

- *Option 1*: is a blanket approach. Irrespective of the outcomes a medical school is achieving, they will lose places and be required to invest a substantial amount of time and resource to develop a proposal – with no guidelines on how this will be assessed – with the hope that they might secure back the places they've given up, and possibly gain a small number more. As noted in the Discussion Paper, it is practically guaranteed that some schools will lose places despite a strong proposal that would support the policy's intent. There seems a strong likelihood that schools will invest significant time and resources to only end up in the same, or slightly worse, position.
- *Option 2*: is focused solely on one measure – that of the quantum of regionally-based training within the medical curriculum. This completely disregards the evidence that all successful work in delivering a rurally-inclined and prepared graduate doctor has been delivered through a multifactorial approach. In particular it is known that the *quality* of the rural experience is vital. This option seems to be encouraging and rewarding initiatives that actually go against the existing evidence.
- *Option 3*: again focuses solely on one aspect of policy – that of an end-to-end training model (where all of the medical curriculum is delivered in a non-capital city location) – without regard to other factors vital to building rural intention and preparedness, and so similarly goes against the evidence of what's been shown to be effective. Should this option be implemented, it would impose a disproportionately high proportion of CSP losses on a small number of universities, which would cause significant and harmful disruption, and again potentially impact a medical school that is delivering a strong outcome of rurally-interested graduates through their other initiatives and approaches.

We have concerns that the options all assume that there will be no other 'special cases' argued locally, for example previously agreed transfers of CSPs to the Sunshine Coast, the need for sufficient graduates to fill rosters in metropolitan areas of workforce shortage and/or population growth, or existing arrangements with some schools. If this were to be the case, then – as with option 3 – this would mean that a greater number of places would need to be taken from a smaller number of medical schools.

It is also the case for some states that the number of their medical school places is proportionate to their state populations and any removal of places would reduce the opportunities for local students to study medicine locally, unfairly penalising them and forcing them to apply to schools further away with the additional cost that that involves, and potentially where their eligibility may be impacted.

As 28% of CSPs are students from rural backgrounds, any reduction in places could actually reduce the number of rural students in a given state.

The lack of clarity in the document on what criteria the proposals will be judged against is very concerning, and the transparency of the process is not evident.

We note the proposed timeframe to implement the policy and believe this to be both 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. Accessing and collating much of this information will be outside the schools' control and it would be inherently unfair to penalise a medical school on this basis.

Rushing this process would only further undermine the intent and transparency of the policy. The motivation to rush the implementation of something that would result in a significant change for medical schools and Government is unclear, especially given the amount of influential and co-dependent factors present, such as the RHMT Program evaluation and the development of the National Medical Workforce Strategy.

Central to our concerns that this policy will not deliver on its intended outcomes, is the fact that it does not address a fundamental barrier to establishing a rural career – that of the postgraduate and specialty training programs still primarily being based in and driven by, large city-based hospitals.

Medical Deans' alternative policy proposal

Attached to this response is a proposal developed by Medical Deans as requested by yourself, the Minister for Health, the Hon Greg Hunt MP, and the Minister for Regional Services, Local Government and Decentralisation, the Hon Mark Coulton MP.

Central to our proposal is the desired outcome of the Government – a clear and measurable plan to increase the medical workforce in regional and rural areas. Achieving meaningful change to meet this challenge requires each stage of the training pipeline to be addressed in unison. Policies that address only one aspect of training will further embed an ineffective, wasteful, and siloed approach.

Our recommended approach is centred on measuring outcomes that can be achieved through a regionally-based integrated model – from medical school through to specialist career – not solely the geographical placements of medical students in their initial education and training. In contrast to the approach outline in the Discussion Paper, our approach allows the Government to leverage the existing and long-standing investment in medical education infrastructure in rural areas, Regional Training Hubs and the Specialist Training Program in a more strategic way to provide a more cost-effective and, outcomes-focused approach.

We would be pleased to meet with you to discuss our proposal in greater detail or to provide any further information or assistance where necessary.

Yours sincerely,

Professor Ian Symonds
President, Medical Deans Australia and New Zealand