# RDAA Response to the Department of Education
## *Discussion Paper – redistribution pool of medical places*

*RDAA is the peak national body representing the interests of doctors working in rural and remote areas and the patients and communities they serve.*

RDAA's vision for rural and remote communities is simple – excellent medical care. This means high quality health services that are:

- patient-centred
- continuous
- comprehensive
- collaborative
- coordinated
- cohesive, and
- accessible

and are provided by doctors and other health professionals who have the necessary training and skills to meet the needs of their communities.

### Introduction

The Rural Doctors Association of Australia (RDAA) welcomes the Australian Government's commitment to increasing medical training outside major cities, and thanks the Department of Education for the opportunity to provide input into the consultation on its *Discussion Paper – redistribution pool of medical places*[1]. RDAA identifies a number of key issues in relation to all the options proposed in the paper.

The 'value add' of any redistribution of medical Commonwealth Supported Places (CSPs) in translating university based medical training into rural and remote[2] affiliation will be negligible unless the initiative is part of an adequately funded, cohesive plan that takes into account their future training needs (internship, prevocational and vocational training), and the factors impacting on the desirability of rural communities as desirable places to live and work for the medium and longer terms.

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[1] Australian Government, Department of Education. *Discussion Paper – redistribution pool of medical places*. https://docs-edu.govcms.gov.au/system/files/doc/other/discussion_paper_and_assessment_framework_-_for_wpr_form.pdf. (Canberra: Commonwealth of Australia, 2019). Downloaded 17 October 2019.

[2] In this document the terms 'rural' and 'rural and remote' are used interchangeably to refer to smaller regional, rural and remote communities in Modified Monash Model 3-7. 'Regional" refers to areas classified as Modified Monash Model 2 and above.

As recognised in the discussion paper, rural origin and/or the quality of rural training have a positive impact on the likelihood of working rurally[3]. Care must be taken to ensure that those universities already providing high quality rural training are not disadvantaged by any redistribution of medical CSPs model.

## Key issues

### *Policy priority*

The broader context in which the redistribution of medical CSPs is taking place must be a key consideration in the development of policy and implementation models. Since the early 2000s attempts to redress the shortage of doctors in Australia have failed to deliver those doctors to where they are most needed: rural and remote areas. Whether the continuing establishment of new medical schools will be of any value in this regard is of concern to rural doctors. In particular, the opening of new medical schools in the eastern states is unlikely to be of benefit to Western Australia where almost 55 per cent of rural General Practitioners (GPs) obtained their basic medical qualification overseas[4]. Protecting CSPs for these new medical schools and expanding intake, while increasing the number of Australian graduates, places a burden on other universities competing for the ever-shrinking government dollar.

Although the Australian Government has in recent years announced a number of initiatives to support Australian-trained doctors to work in rural and remote areas, such as the National Rural Generalist Pathway, Junior Doctor Training Program and the More Doctors for Rural Australia Program, their full implementation and effectiveness is yet to be seen. There is still a heavy reliance on Overseas Trained Doctors (OTDs).

Workforce needs in terms of numbers and skills are continually changing with the aging of the population and the burgeoning of chronic conditions, other demographic factors, and the impacts of social, cultural and environmental determinants of health. Systemic agility is problematic. The time lag between identifying and confirming workforce issues and the length of time that it takes to train a doctor, means that:

- all initiatives must be seen as part of a longer-term vision and funded for the current and predicted health needs of Australians (with a particular focus on redressing inequitable access to health care being experienced by rural and remote residents) and be seen as an investment not a cost
- the redistribution of CSPs may not be the best mechanism to achieve the desired "flexibility to support key Government health workforce priorities as they emerge"[5].

Utilising the distribution of CSPs as a mechanism to assist in building the rural and regional medical workforce must be ongoing if it is to have a positive impact. A single redistribution round is likely to have minimal, if any, impact given the length of medical training. All future

[3] Australian Government. *Discussion Paper – redistribution pool of medical places*. p2.
[4] Rural Health West (2019). *Rural General Practice in Western Australia: Annual Workforce Update November 2018*. Perth: Rural Health West
[5] Australian Government. *Discussion Paper – redistribution pool of medical places*. p1.

redistribution rounds for the foreseeable future should be targeted to the rural and remote workforce. Any changes should only occur after a full policy review with input from stakeholders.

There must also be significant and continuing investment in regionally based pre-vocational and vocational training, other recruitment and retention strategies, and in social and community services and infrastructure, to improve the perceived desirability of regional locations as places to live and work for the maldistribution of the medical workforce, both geographic and skills, to be redressed.

These other recruitment and retention strategies must go beyond education and training opportunities for individual doctors. Workplace and employment arrangements, education and work for spouses and children, and social and community infrastructure, services and opportunities that make rural locations more 'liveable' destinations must also be made more attractive.

### *Alignment of medical school places with graduate training capacity*

As evidenced in the discussion paper, the more than doubling of the number of medical schools in Australia over the past 18 years, while potentially oversupplying medical graduates, has not made an appreciable difference to the geographic or skills maldistribution of doctors[6] nor has the trend toward specialisation and sub-specialisation been halted.

Unless any increase in CSPs allocated to universities providing regional medical education is aligned with investment in junior doctor training in regions – Modified Monash Model (MMM) 2 and above – to provide doctors with the skills actually needed by rural communities there will be a minimal impact on the likelihood that graduating doctors will develop rural affiliation.

Regional and rural communities especially need locally based Rural Generalists and non-GP specialists that are generalists in their craft areas (such as general surgeons). Many doctors make their decisions about future career pathways in years immediately following their basic medical degree (post-graduate years (PGY)1 and PGY2). Ensuring that GP, Rural Generalist and non-GP specialist training is provided in the regions, with rotations in metropolitan areas if needed, would increase the likelihood of ongoing rural affiliation and must be a critical part of any approach to reducing rural doctor shortages.

Further, students who express an intention to work outside a capital city or major urban centre in their final year of university-based medical training may not follow through on that intention if they are actively or unintentionally discouraged from doing so by an emphasis on metropolitan general practice, specialist and sub-specialist careers rather than rural careers within the prevocational setting, or by life circumstances, such as the meeting of a partner, during those years.

The Department of Education should work with the Department of Health and with State/Territory governments to ensure that the number of CSPs allocated to regional and rural medical

[6] Australian Government. *Discussion Paper – redistribution pool of medical places*. p1.

programs is matched by an equivalent number of internship places allocated to regional and rural hospitals.

### *Time frames, process and accountability for redistributing medical CSPs*

Three-year Government funding cycles are often used to determine program implementation. However, triennial rounds may not be the best mechanism for achieving positive outcomes in relation to providing the right doctor, with the right skills, in the right location, at the right time.

The timing of redistribution rounds must be informed by how effective universities are in recruiting to and supporting students in their regionally-based programs as well as national workforce data assessments. Universities should be required to provide data on drop out, transfer and failure rates as well as evidence of outcomes by post-graduation location at 1, 3, 5 and 10 years.

Ruling out an increase in medical Commonwealth Supported Places (CSPs) and requiring **all** universities to contribute 2.03 per cent of commencing to the pool in effect disadvantages universities that have existing strong rural medical education and proven outcomes. To mitigate against the possibility that these universities will be worse off, the total number of CSPs should be increased by the 32 to cover places committed to Charles Sturt University (CSU) to establish a new fully regional medical school for the MDMSN at Orange, NSW in partnership with Western Sydney University (WSU).

The redistribution pool should be drawn from metropolitan-based places only and then reallocated to rural programs. Universities with primary campuses located in MMM2 or above should be exempt from contributing to the pool but should be eligible for additional places allocated through the redistribution process.

Preference should be given to universities providing 12-month longitudinal placements in rural general practice within their programs to increase student exposure and experience in rural general practice. This should have a positive effect on the numbers applying for rural GP training.

Any process for allocating CSPs give priority to those universities that currently deliver (or propose to deliver) programs that are based in the MMM2 or above for the total of the training.

### *Transition arrangements*

The numbers of full-fee-paying medical (FFP) domestic and international (IFFP) students at Australian universities has been increasing[7]. This may be due in part to the constriction of government funding to universities (and consequent offsetting of impact by enrolling more FFP students) and to the establishment of new medical programs.

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[7] Medical Deans Australia and New Zealand. *Student Statistics Report: 2017 – 2018 Snapshot of Findings.* https://medicaldeans.org.au/md/2018/12/2018_Student_Statistics_Report.pdf. (Sydney: Medical Deans Australia and New Zealnd Inc., December 2018). Viewed 17 October 2019.

Even the relatively low number of new IFFP students from the one-off allocation to those universities with a reduced CSP allocation as a consequence of redistribution will increase pressure on the system. Many international medical students at Australian universities plan to undertake Australian internships (and seek permanent residency)[8] and there is already a shortfall of internship positions on offer. While internships are guaranteed for CSP students, they are not guaranteed for other Australian medical graduates[9].

Provisions for security of funding for Rural Clinical Schools (determined by numbers of students entering programs) will be necessary to ensure that they are not undermined by any withdrawal of places from their university and/or from a particular state.

Action must be taken to ensure that there are no unintended consequences that place greater pressure on an already stretched system.

### *Assessment*

RDAA strongly recommends that a minimum of twenty percent of the membership of panels assessing proposals should be independent, rural medical practitioners to provide a degree of professional scrutiny of the process

The "volume of regional medical education delivery undertaken in the past three years"[10] is insufficient to give a true indication of a university's regional delivery focus. The quality of that medical education not only in relation to clinical content but also to student experience of rural practice and communities must also be considered.

## Conclusion

Redressing the geographic and skills maldistribution of doctors in Australia will require: long term vision and a cohesive plan; political commitment and leadership; and significant investment at each point along the training pathway and in the broader infrastructure and services that improve the desirability of rural communities as places to live and work.

Ensuring that any model for the redistribution of medical CSPs is cognizant of context and mitigates against possible unintended consequences for universities and Rural Clinical Schools will also be key to effective implementation.

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[8] Lesleyanne Hawthorne and Jan Hamilton. *International medical students and migration: the missing dimension in Australian workforce planning?* Med J Aust 2010; 193 (5): 262-265. II doi: 10.5694/j.1326-5377.2010.tb03903. Published online: 6 September 2010 https://www.mja.com.au/journal/2010/193/5/international-medical-students-and-migration-missing-dimension-australian Viewed 17 October 2019.

[9] Australian Medical Students Association. *National Internship Crisis.* https://www.amsa.org.au/node/861 Viewed 17 October 2019.

[10] Australian Government. *Discussion Paper – redistribution pool of medical places*. p4.