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SCHOOL OF MEDICINE, SYDNEY

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A/g Deputy Secretary
Department of Education
50 Marcus Clark Street
Canberra ACT 2601

6 November 2019

Dear Mr English

The University of Notre Dame Australia appreciates the opportunity to comment and present our views on the Department of Education's 'Discussion Paper – redistribution pool of medical places' provided to us with your correspondence dated 20 September 2019.

Notre Dame operates two separate Schools of Medicine – based in Fremantle and Sydney – delivering two independently Australian Medical Council accredited and Medical Board of Australia approved medical programs in two very different operating environments. The Deans of these two Schools have prepared the following response and have completed the medical data forms as requested while noting significant concerns about the validity and usefulness of these data (Attachments A and B).

In response to your request for feedback on the discussion paper we provide the following commentary and suggestions including some general observations regarding medical education in Australia relevant to the policy context; comments and caveats on the medical data collected; and specific feedback on the policy framework and options presented in the discussion paper.

Importantly we wish to highlight Notre Dame's demonstrated commitment to building rural medical workforce and to addressing emerging workforce needs in many dimensions.

The School of Medicine, Fremantle (SoMF) has demonstrated commitment to rural and remote medicine as a priority including the innovative Broome Learning on Country (BLOC) initiative which commenced in 2017 as a proof of concept to demonstrate the successful delivery of preclinical medicine in the remote environment. SoMF has also developed an innovative medical education initiative, that it has tabled with the Department of Health, for a rural/remote training pathway based in Broome and the Northwest of WA, however significant funding is required for both capital and operating to make this initiative a reality. With funding, this initiative would be able to deliver an end-to-end fully regional medical program for a cohort of medical students in 2021/22 but this is not recognised in Option 3 because that only applies to existing regional programs.

The School of Medicine, Sydney (SoMS) is very proud of the Rural Clinical School campuses in Lithgow and Wagga Wagga in NSW and Ballarat in Victoria supported by the Rural Multidisciplinary Health Training program. Furthermore the new Riverina Regional Training Hub is progressing very well developing specialist training pathways in Wagga Wagga and the Murrumbidgee area. Prior to the announcement of the Murray Darling Medical Schools Network (MDMSN), SoMS had an MoU with Charles Sturt University (CSU) to provide a pathway to medicine for CSU graduates and a longer term vision of co-delivering the full medical program in the Lithgow/Bathurst and Wagga Wagga regions with CSU. This was tabled as a suggestion with the consultant group engaged by the Commonwealth reviewing the merit of the MDMSN. The outcome of co-delivered medical programs in regional areas is supported by Notre Dame, however we were very disappointed not to have been provided with the opportunity to participate as a partner in that development. We were informed that the selected medical school partners were contributing the CSP places and this was not an option for SoMS given our very small CSP allocation. Our commitment to rural medicine continues with enhancements including a rural stream for students who can undertake both the clinical years in Wagga Wagga, a Rural Medicine research theme available to MD students as an Applied Research Project and participation in BIRCH a research collaborative with other medical schools in the Ballarat area.

General observations about medical education in Australia

Australia educates and trains superior quality medical practitioners underpinning a high quality health system with an excellent international reputation. While all AMC accredited programs have common objectives in delivering graduates well prepared for internship and vocational training, most medical schools offer some distinctive and different elements that contribute to a rich and innovative medical education sector, which enhances the quality and diversity of graduates we produce as a nation. Some Schools focus on biomedical research with prerequisites to entry; some are based in rural and regional Australia; some have a population health focus or social justice emphasis. Changes is Commonwealth support should therefore carefully consider the impact on all aspects of medical education and ongoing innovation.

Notre Dame for example has a unique approach to student selection that attracts a very culturally diverse student cohort with an emphasis on leadership, community service and social justice. Both Schools have a strong commitment to Aboriginal and Torres Strait Islander Health and rural and remote communities including Broome in WA, the Central West and Riverina in NSW and Ballarat in Victoria. SoMF has a focus on delivering graduates to meet the Western Australian medical workforce shortage. SoMS has clinical schools in high-growth, high-need areas placed with hospitals and health services previously without medical schools such as Hawkesbury and Auburn in NSW and the massively growing outer metropolitan corridor in Werribee in Victoria. Other differentiators of our programs are a focus on bioethics – a vital skill for the future medical workforce; climate change and health and sustainability taking a lead role in national curriculum development; and social justice and social action projects embedded within the curriculum. These are relevant to promoting rural practice but are not reflected in rural training hours.

The reason this broader perspective is important is because the policy framework presented in the discussion paper is fairly unidimensional in its focus on the proportion of contact hours in rural training and disregards the many other important outcomes being delivered. The evidence base for the suggestion that proportion of contact hours delivered in a rural setting equates to commitment to promoting rural medical practice is also not clear.

Further the analysis presented in the discussion paper highlights the significant allocation of CSPs concentrated in very few medical schools based on history rather than 'equity' and market forces. In a highly competitive sector the students' views and preferences should perhaps be more appropriately

considered. An important consideration in this context of historic 'maldistribution' and the proposed redistribution is the issue of critical mass or 'size' that enables a sustainable and innovative, quality medical program. Very small reductions in CSP numbers will have a more significant impact on smaller medical schools. Put simply this would not be equitable and could in fact be damaging to specific schools and the medical education sector in unintended ways. While the evidence relating to the 'ideal size' of a medical program is not absolute, from our experience and looking at other schools in Australia, NZ and internationally, we would suggest that medical programs with less than 120 to 130 CSP should be exempt from contributing to the CSP redistribution pool but eligible for applying for innovative proposals.

The assumptions regarding oversupply of medical workforce by 2030 are also worthy of review and further discussion with consideration of International Medical Graduate (IMG) numbers, changing health needs of an ageing population and the changing shape of medical practice and emerging technology including telehealth and other digital technology.

Data Collection – rural/regional medical training

The University of Notre Dame Australia has complied with the Commonwealth's request for the information collected on the templates provided, however we wish to draw to your attention our serious concerns about the purpose of the request and the usefulness of the data provided in particular for comparing medical programs in regard to commitment and effectiveness of delivering graduates with rural practice intent. Concerns and comments relating to this data collection include:

1. Equating contact hours delivered in a regional location with effectiveness of promoting and delivering rural medical workforce is not based on sound evidence.

2. Contact hour definitions may vary across medical schools and additional elements of curriculum hours (e.g. bioethics and social justice projects) may 'dilute' the proportion of contact hours in 'rural training'.

3. The metrics surveyed are 'process' measures and do not relate to outcomes, e.g. uptake of rural internships and continued vocational training and practice in regional and rural areas.

4. Only reporting on Commonwealth Supported Placements would understate the University of Notre Dame Australia's contribution to rural medical education given the School of Medicine, Sydney has approximately 50% Domestic Full Fee Paying (DFFP) students. The University of Notre Dame Australia makes no distinction between students based on fee-type and therefore offers all students the same opportunities for rural training.

5. Given the University of Notre Dame Australia's School of Medicine, Sydney has 50% DFFP students and many of these students are of rural background or have rural intent and take up rural practice, all domestic students have been included in the data provided for SoMS. It is also relevant to that many of the DFFP students are contributing to the rural medical workforce supply without significant direct cost to the Commonwealth for their medical education.

6. Noting the above caveats, these data should not be published or used for any purpose without the consent or involvement of the University.

Comments on Options 1 to 3 as presented

7. Under all Options the loss of 2% of CSPs, and the potential to lose further CSPs, would be particularly detrimental to smaller medical programs (i.e. up to 120-130 cohort size) in terms of the critical mass for efficiency, and would potentially put the ability to innovate and the sustainability of the medical program at risk. This would be further exacerbated for Schools choosing to limit or not to enrol International Full Fee Paying (IFFP).

8. From an investment and policy perspective the discussion paper takes a retrospective approach to CSP gains and penalties. It does not recognise Schools plans and aspirations. Also some Schools, particularly those with less students, could accommodate additional students efficiently. These smaller Schools offer an opportunity to receive redistributed CSPs in underserved areas, e.g. rural or outer metropolitan growth corridors by utilising the significant academic and physical infrastructure already established at those Schools. We note this is a priority for States who are requiring medical and other health professionals to staff new hospitals and health services such as Werribee Mercy Hospital and Health Service in Victoria and Hawkesbury/Windsor in NSW. Opportunities for future end-to-end program delivery could also potentially be delivered in these areas using existing infrastructure.

9. The offer to 'permit' schools with a net loss of CSPs to enrol additional IFFP places is not consistent with current policy or a free market. Not all Schools will, or should, offer or expand IFFP. DFFP may be an alternative but that would expand net medical student numbers.

10. Under Option 2 as presented there are a number of practical implementation issues; for example the return of 30% of a single CSP is not possible. This also demonstrates that applying the redistribution mechanism to small medical programs is impractical.

11. Noting that there was not an open process for application to participate in the MDMSN, the funding and CSP redistribution models presented all provide significant benefits and advantages for the schools and universities involved and therefore disadvantage others.

12. In addition the development of a Murray Darling Medical School Network may benefit rural NSW/Victoria, but does not address other rural and remote regions such as in Western Australia. This is highlighted in Option 3 noting that there are no schools in WA or SA/NT that would qualify for redistribution.

13. The current model does not take into account the contribution of remote medical training above that of regional medical training that may only be a few hours' drive from a capital city; nor does it acknowledge the immediate need in under-resourced, outer metropolitan growth areas.

14. Notre Dame has ambitious plans to consider rural end-to-end medical student training and it is recommended that equitable and transparent opportunities be made available to all interested universities wishing to expand their services noting this did not occur in establishing the MDMSN.

15. While significant new investment was put aside for the Murray Darling Medical School Network through the *train in the regions, stay in the regions* program ($95.4 million over four years), Option 1 in the Discussion Paper offers no new funding for new initiatives in the competitive bidding process proposed. The Commonwealth Government has recognised through RHMT and the *train in the regions, stay in the regions* programs that there are

significant and extra costs to running effective rural training programs and further funding will need to be allocated to the development of new and innovative programs.

16. There are many superior measures or elements that would better justify or provide rationale for CSP redistribution to increase rural medical workforce, including graduate outcomes in taking up rural practice (noting a long time horizon), student feedback, available capacity to support additional students, and areas of growth and community need for service.

17. Regional training hubs are a more significant and effective area for policy focus and investment in our view and should be the priority in advancing rural medical workforce. More than a third of graduates express preference for a future career outside capital cities (Medical Student Outcomes Database). Specialty training is a major barrier to graduates with rural intent continuing and completing their training, and then establishing their future practice in a rural location.

Conclusion

The view of both Notre Dame's School of Medicine, Fremantle and School of Medicine, Sydney is that none of the current three options presented are satisfactory or equitable and therefore the CSP redistribution model should be revisited completely.

The 32 places for the Murray Darling Medical School should primarily be sourced from the participating schools/universities or larger medical programs rather than reducing the critical mass and capacity for innovation of smaller medical programs across Australia.

Any subsequent redistribution of other CSPs needs to be underpinned by an open process for the funding of innovative programs of rural and remote training including, but not limited to end-to-end training. The emerging medical workforce requirements, for example in high-growth, high-need populations in outer metropolitan areas such as Werribee in Victoria and Windsor in NSW, should not be damaged or compromised.

Please contact Professor Christine Bennett on 0467 733 029 or 02 8204 4455 or at christine.bennett@nd.edu.au for any clarifications or further information.

We would be very pleased to meet and discuss these issues and contribute to further policy development that supports the high quality of medical education in its many dimensions and continued vocational training in rural and other high-need areas to address Australia's medical workforce needs.

Yours sincerely

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cc Mr Peter Tranter Acting Vice Chancellor
Mr Julian Smith PVC Strategy and Planning