Joint Medical Program (JMP)

Bachelor of Medical Science and Doctor of Medicine

The JMP (University of Newcastle and University of New England) submission on the Department of Education *"Discussion Paper – redistribution pool of medical places"* dated 23th September 2019.

We welcome the opportunity to respond to the Departments discussion paper and acknowledge the need to address medical workforce shortages within rural Australia.

Executive Summary

The Joint Medical Program was established in 2008 as a unique and innovative strategy to embed an undergraduate medical education program within an existing rural academic centre, providing prospective students with the opportunity to commence medical training in a rural area and providing the impetus for the expansion of a comprehensive and rurally focused medical education pathway. This was built on the University of Newcastle's (UON) history and established record of achievement as Australia's first regional medical school dating back 40 years, and the University of New England's (UNE) expertise and outstanding record as a rurally based provider of high quality tertiary education across a range of health and science disciplines.

The Joint Medical Program is innovative in its unique governance model, representing a partnership Between two Universities(UON and UNE) and two Local Health Districts (Hunter New England and Central Coast). This provides a network that ensures students have experience across a comprehensive range of rural and regional health services, along with those in more urban centres. UNE's leadership in establishing the School of Rural Medicine within a comprehensive Health Faculty and the partnership with the University of Newcastle has provided the necessary foundation for a range of achievements in rural medical education and growth in rural academic capacity in medicine. The opportunity for students to undertake their foundational years in medical education at UNE has been instrumental in the achievements of the JMP, and its place as a driver for future innovation in rural medical education.

The following represent the views of the JMP leadership regarding the Discussion Paper and the options presented. Our shared record demonstrates our commitment to rural medical education and to providing the long-term, sustainable growth in rural medical workforce that rural and regional Australia requires. The problems underpinning these workforce challenges are complex and the solutions are not simple. It is critical that policy reform in this area is based on long-term engagement, and collaboration with, the Universities, health service providers and communities.

On the basis of this experience and commitment we suggest that the following steps and strategies be considered:

1. The Department instigate a comprehensive in depth review of the current medical programs initiatives and achievements in meeting medical rural workforce needs.
2. A revision of the proposal with a focus on measures of quality and an appraisal of capacity in the rural and regional health services ability to support expanded medical education.
3. Steps be taken to address the inconsistences and inaccuracies in the discussion paper relating to "end to end" training
4. A review of the use of ASGC-RA classification as opposed to the Modified Monash Classification, given that the latter better aligns to the delivery of rural health services.
5. Refocus on the quality of rural and regional medical education rather than the quantity of time spent in rural and regional areas.

6. Policy reform requires acknowledgement that medical training requires integration across post graduate education career pathways in rural areas and should not just focus on the initial medical training of 4, 5 or 6 year medical degree programs.
7. The three year redistribution model be ceased, given the potential adverse impact that will, we believe, provide little demonstrable impact on the key barriers to achieving the goals in rural medical workforce development.
8. It is our strong recommendation that the requirement for 32 CSP's to support the Murray Darling Medical Schools network (MDMSN) be met by a re-distribution of existing CSPs from within the Universities participating in the MDMSN.
9. A long term perspective is required for any policy reform in this area. It is our view that the evaluation of this CSP redistribution take place with an appropriate timeline, of at least 10 years, to demonstrate the effectiveness of the redistribution on the rural medical workforce

Background

From the outset, the JMP vision has been to enhance the medical workforce within regional and rural NSW through an integrated, innovative approach to the training of medical students. This vision saw the establishment of the first Australian Joint Medical Program (JMP) in 2008. This JMP is a partnership between the Universities of Newcastle and New England with two health districts– Hunter New England and Central Coast Local Health Districts. Over the past 10 years we have successfully integrated our rural and metropolitan clinical schools by embedding a student-focused, strengths-based approach to training across the NSW Hunter, New England and Central Coast footprints. In its initial phase, the JMP was underpinned by UON's experience of delivering a medical program and sharing that knowledge with UNE. In more recent years the partnership has been enhanced by the delivery of rural medical education aligned with the experience of UNE. The economic viability of the partnership is sustained by the sharing of many resources which in younger and smaller medical programs is neither feasible nor manageable.

The JMP is proud of our achievements in training medical students, we lead the nation in the education of Aboriginal and Torres Strait Islander students, representing over 10% of the current student cohort, and with a cumulative total of over 100 Indigenous medical graduates to date. Almost half of our graduating medical students show a desire to work in, and make a difference to, rural communities; with two thirds expressing an intention to practice outside capital cities (Medical Student Outcomes Database 2019).

UNE is renowned for its ability to drive change and enhance student experiences. The introduction of a medical degree delivered at Armidale and development of the UNE School of Rural Medicine has ensured that the JMP provides a robust and sustainable model of rurally-based medical education that is delivering on key outcomes for rural and regional Australia. This includes UNE's success in establishing a rurally-based School with its related links to rural communities and health services, in addition to the assembled academic capacity and infrastructure needed to support an end-to-end training model. Furthermore, effective targeted outreach programs have been developed to build opportunities for rural and regional residents to undertake medical education. A robust partnership with Local Health Districts to support clinical training and a rurally-themed curriculum has facilitated the engagement of students in future rural practice, with the JMP exceeding national figures in this regard. Our students are supported via rural education hubs and targeted rural accommodation enabling vertically-integrated clinical teaching in rural facilities. This ensures early exposure to a rural experience along with the challenges and rewards of rural practice as well as the meeting the needs of rural and remote communities. The two Universities together work constructively

towards these common goals, the outcomes of which reflect the unique strengths and capabilities of each University within this Joint framework. Each is able to achieve the goal of quality rural medical education through this partnership model.

From a resourcing perspective, UON has a proven capacity to respond to government initiatives, the most recent featuring the transfer of 30 existing CSPs per annum from Newcastle to the Central Coast at Gosford Hospital Health and Wellbeing Precinct, to establish end-to-end training within the new Central Coast Clinical School. This initiative was stimulated by the the needs of the Central Coast community, which is an underserved region with low educational attainment (only 67% of 19 year-olds completing HSC in 2016, compared with 80.3% in metropolitan areas) as well as a significant and growing need for local health workers. This internal redistribution will require major change processes that UON is prepared to accept in order to meet the requirements of government and the local community. Interestingly, this approach to supporting areas of need was also undertaken in establishing the Sunshine Coast Medical Program under the auspices of Griffith University.

If the funding of additional CSPs is not supported by a majority of stakeholders, we recommend a similar model of internal redistribution of existing CSPs from within those medical schools participating in the MDMSN (Sydney, Melbourne, Monash, UNSW and UWS) as a strategy to meet the requirement for 32 CSPs in 2021.

Options

We view the three options and the triennial approach to redistribution of Medical CSP's counterproductive to the underlying intent. We believe that a redistribution pool of medical places approach will place an unnecessary burden upon the government and medical schools with limited, and perhaps no, achievement of the desired outcomes. For the first round, the desired outcome is:

> *"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."*

We propose that an appropriate initial step in the focus on medical schools and rural medical workforce needs, would be a comprehensive, in-depth review of the current programs, initiatives and achievements in this area. This should entail a more comprehensive approach to the full scope of the longitudinal pathways of rural medical workforce development (from medical school through to post graduate opportunities and career pathways) including health services, specialist Colleges, key bodies such as the Medical Deans of Australia and New Zealand, and of course, the Universities.

Such a strategy also requires a more specific focus on measures of quality, a realistic appraisal of the capacity of rural and regional health services to support expanded medical education (including early foundational studies in medical school settings, along with stable clinical placement capacity), the strategies needed to enhance the necessary academic workforce in those regions, and a more nuanced approach to the evaluation of any interventions including timeframes and metrics to assess outcomes at a service and community level.

Furthermore we wish to respectfully highlight critical inconsistencies and inaccuracies in the proposal and background documentation. The categorisation of Universities by their regional focus and current delivery of end-to end programs is, we believe, inaccurate. This is best illustrated in Table 5, in which the University of Newcastle is included among those programs not offering end to end rural training, while University of New England is treated as a separate program.

This portrayal is inaccurate as the Joint Medical Program is integrated across the two Universities and while students are enrolled at one or other University, the educational framework is integrated across the two Universities and our six clinical schools. The 'end to end' training of UNE-enrolled students requires their integration with UON students, shared facilities, academic and professional staff resources and clinical placements across the broad JMP network of LHD partners. The curriculum has evolved to reflect and capitalise on the strengths of each University, including expanded rural research opportunities, innovations in rural clinical placements, and a dedicated pathway of curriculum content and placement experience in rural health, in addition to the elements of a rurally-informed core curriculum. It is our firm and shared view that the JMP needs to be considered as a single program when evaluating rural performance and focus since it is only through our close collaboration that the JMP can offer a quality end-to-end rural medical educational experience.

Inconsistencies also exist in Table 5 with the clustering of some Universities as currently offering end-to-end training in rural areas when this is chiefly reliant on the proposed redistribution itself.

The use of the ASGC-RA classification methodology also fails to accurately reflect the rural and regional focus argued in the proposal. Whilst no classification system is perfect, the use of ASGC RA allows universities to claim training as rurally-based, when the population base allows access to tertiary hospital services (see below).

These inconsistencies reflect the need for a more granular understanding of the current activities, achievements and challenges in medical education in rural and regional Australia. For example, the proposal does not reference initiatives or achievements of certain medical schools that understand the importance of supporting rural workforce development. This is reflected in the national MSOD data indicating the high level of interest among new graduates in working outside capital cities, including those from non-rural backgrounds (up to one quarter of the latter). The Joint Medical Program itself (and its links to a Regional Training Hub and RHMT through the University of Newcastle's UDRH) is a case study in innovative models of supporting longitudinal pathways in rural medical education. We draw the Department's attention to the very real challenges that exist in post graduate education career pathways in rural areas. While Universities such as those within the JMP are committed to supporting such pathways, this involves variables beyond the control of Universities, residing within specialist Colleges and health service employers. A complex strategy such as that outlined in this proposal and the 3 options, involves substantial potential disruption to the medical school sector, underestimates the existing commitments of many medical schools to quality rural education and in our opinion will have little, if any, impact on the key drivers that impact long-term rural workforce development.

We cannot support either the redistribution model or the three-year timeframe for such redistribution. The rationale for the proposed 2% redistribution is unclear and inconsistent with the stated objectives: why are 60 places required to support the 32 places for the CSU initiative? If the plan is to redistribute the remainder, does this not mean that some will gain additional CSP places through this process, even though the proposal clearly refers to no Universities gaining additional places (option 2 and 3). 28 CSPs would be insufficient for any single new program to be established, hence the rationale for this policy initiative is unclear and unsubstantiated.

The justification for a three year timeframe is also not clear and is potentially highly disruptive without the prospect of generating significant corresponding benefit. Medical school programs vary from four to six years in duration. The prospect of varying policy drivers influencing a three year cycle of redistribution as a method to drive medical education priorities, does not acknowledge the time frame of medical curricula, the necessary planning for any such curricula change and most importantly the time frame required to evaluate any such changes. The impact on smaller programs will be substantial with, every three years, the prospect of further reduction in CSPs and the consequences for planning and managing programs. Furthermore for the scale of potential disruption to the stability of the sector,

the relatively small number of CSP places proposed at a national level is unlikely, in our view, to provide the return on investment required to administer such a process.

The proposal to offer additional international places to those Universities that lose places in this model presents a number of concerns. Currently international medical students are not assured internship places on graduation. Any increase in international medical student numbers would require the support from state health services and relevant jurisdictions to address this issue. Furthermore such an approach would favour those Universities with the greatest established capacity to attract international students; i.e those located within a metropolitan setting.

Issues

In addressing the issues we have used the framework outlined on page 15 of the paper as the basis of our response:

1. "the approach to creating the redistribution pool is fair, equitable and transparent across all universities"

The proposed redistribution potentially disadvantages Universities with a track record in rural and regional medical education. Table 5 within the paper indicates those medical schools deemed to provide "fully regional programs". We note that UON is not one of those programs and yet, since 2008, UON and UNE have provided a comprehensive joint rural program that has been used as the model adopted for the MDMS in establishing rurally based CSPs through a partnership with established medical programs. We respectfully ask how the table was devised and request that the evidence be provided in support of those schools deemed to provide fully regional programs as there appears to be inconsistencies in allocation.

Option 3 refers to "end-to-end training" without a clear definition of what would constitute such training. In addition, the proposal needs to be realistic about the practical limitations in accessing stable, essential quality clinical placements for students in many rural and regional localities where the critical mass of clinicians is smaller and inherently more fragile.

If it is assumed that "end to end" training in rural regions represents 80% of the students' education occurring in rural regions, the JMP provides such training to 60 students per year through the Joint Program. While the CSPs are allocated to each University, it is more appropriate to consider the total CSP for the JMP since the students undertake an integrated, jointly managed program that draws on the resources and expertise of both institutions, and was based on the premise that the UON curriculum and resources would support the establishment and sustainability of the medical program.

The models proposed would disadvantage those, such as the Joint Medical Program, that have:

- consistently demonstrated a commitment to rural education
- demonstrated positive outcomes including graduates committed to working in rural and remote regions
- demonstrated high retention of junior medical staff to partner rural and regional local health districts
- provided quality clinical placements in rural areas

Furthermore the program has a robust history of developing academic capacity in regional areas from the earliest establishment of the University of Newcastle as Australia's first non-metropolitan medical school in 1978 to the subsequent development of substantial teaching and academic facilities and resources in locations such as Tamworth, Taree, Maitland, Orange and across north west NSW. These achievements have only been made possible by an effective partnership between UNE and UON to establish the country's first Joint Medical Program, with its inherent focus on rural medical education.

As indicated above, our joint program would also be disadvantaged through the models' reliance on RA classifications as the basis for defining rural focus and location. The ASCGC_RA classification system has limitations when used as a comparative tool in assessing medical education sites. The move to the Modified Monash Classification has been more effective in allowing locations to be comparatively assessed in rewarding commitment to rural medical education. Generalist training sites are more prevalent in MM3-7 locations. Whilst no classification system is without complexity, the use of ASGC RA allows universities to claim training as rurally based when the population base allows for tertiary hospital services.

The redistribution model focuses solely on **quantity** of time in rural locations. It is our view that the predictors of long-term rural practice relate to the overall **quality** of education in rural locations, and that quantity alone without quality is unlikely to demonstrate short- and long- term outcomes relevant to rural health services and rural communities.

Furthermore medical graduates require an understanding of the full spectrum of health care services in order to be "work-ready" for rural locations and be competent to provide the best possible care to patients. In our view this means experience in **both** urban and rural settings.

Evidence indicates that the quality of student rural experience (rather than duration per se) as well as the opportunity for a breadth of post graduate rural training are key factors influencing subsequent practice in rural areas. The current proposal does not address these issues.

2. *"the pool provides the maximum number of places to respond most effectively to the goal of helping build the rural and regional medical workforce"*

The rationale for the number of redistributed places is unclear (i.e. a total of 60 places in the first instance that requires 32 of these CSPs to be reallocated). Additionally this policy is ongoing so in order to be transparent and evidence based it would be important to see the correlation between the disruption of removing CSP places and long- term outcomes. The gestation of a fully trained medical professional is long with markers of successful program outcome likely to be 10 years in development. Such periodic redistribution does not acknowledge the timelines relevant to planning medical curricula, the identification and support of appropriate clinical placements in rural areas, and the important requirement for accreditation approval when significant changes in curricula are required. Periodic redistribution targets would also need clear evidence that short term changes were likely to build long term sector wide sustainable reform /change. Unintended consequences could include a reduction in long term commitments to sites and programs so as to provide the "nimbleness" required.

It is our view that the building of a rural and regional workforce will be ill-served by this strategy and what is required is a broader set of strategies, specifically focusing on the career pathways in rural locations for medical graduates, building on the model of regional training hubs and strengthening RHMT models, promoting links between medical schools and the local health services and monitoring short and longer term outcomes of these initiatives. *Periodic redistribution will have the effect of destabilising the future planning of medical school curricula and resourcing, without a commensurate gain in real outcomes for rural health workforce.*

We are committed to improving rural training experiences and curriculum in this field, having introduced a two-year in-depth, dedicated curriculum theme in rural health for students wishing to gain specific expertise in this area above the existing rurally influenced core training for all students. This is one of the key strengths of the JMP – that we are able to address the medical workforce issues across a significant rural and regional footprint. By periodic

redistribution this strength will be significantly weakened through the uncertainty of long term CSP.

3. *"the redistribution process supports universities currently serving the needs of rural and regional communities and those committed to delivering a genuine increase in regional medical places."*

As indicated above, the options will significantly impact on a number of Universities currently serving these needs and with a track record of achievement in these areas. The Universities of Newcastle and New England through their Joint Medical Program have demonstrated a sustained commitment to increasing regional places. This is evidenced through the support of 60 new rurally based CSPs from year one of the program at UNE, with around 40% of the total cohort of the JMP (approx. 170) CSPs receiving 80% or more of their training in rural and regional areas.

We believe that the return of investment in this discussion paper will be low or non-existent and that the opportunity to ensure valid and valuable future long-term outcomes can only be ensured with a comprehensive evaluation. It is the view of the JMP that the allocation of 32 CSP's to Charles Sturt University for the Murray Darling Medical School Network come from the academic institutions comprising the network, thereby allowing medical schools outside the network to continue to operate within a climate of certainty around CSP medical funding.

Whilst we recognise the intent behind the three options outlined in the redistribution proposals, we believe that the objective of the redistribution via any of these options cannot be met.

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THE UNIVERSITY OF NEWCASTLE AUSTRALIA

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