**Professor Vlado Perkovic**
Dean, UNSW Medicine

25 October 2019

Dom English
A/g Deputy Secretary
Commonwealth Department of Education
By email: CGS@education.gov.au

Dear Mr English,

**Re: UNSW feedback on the discussion paper of redistribution pool of medical places**

UNSW Sydney is grateful for the opportunity to provide feedback on the Discussion Paper, and as requested, has also attached the completed form of regional medical load data.

UNSW supports the need for addressing the issues of medical workforce shortages in regional and rural areas and is an industry leader in delivering undergraduate medical education in rural and regional locations.

Our submission consists of three main sections. Part 1 summarises UNSW's record in providing medical training in regional and rural Australia. Part 2 sets out our views on the establishment of redistribution pools. Part 3 contains our response to the Commonwealth Supported Places (CSPs) redistribution options as outlined in the Discussion Paper.

**1. UNSW's contribution and commitment to regional and rural medical training**

UNSW Medicine's contribution to the improvement of medical workforce in regional, rural, and remote Australia commenced more than 20 years ago with the establishment of UNSW's Rural Clinical School. Across our campuses at Albury-Wodonga, Coffs Harbour, Griffith, Port Macquarie and Wagga Wagga, UNSW Medicine now delivers its full six-year undergraduate medicine program, manages three major rural Regional Training Hubs and hosts specialist college training programs and examinations, making it one of the largest and most geographically distributed medical training models in the country. Through our Rural Student Entry Scheme into UNSW Medicine, approximately 28% of each cohort is from a rural background.

UNSW Medicine's commitment to rural medical education is evident by the significant academic and staff investment within our rural campuses and the proportion of Commonwealth supported course load undertaken regionally. In 2018, 26% of course load was conducted across UNSW ASGS-RA2+ locations. This has grown from 22% in 2016. We expect this to rise significantly from 2021 onwards as we commence delivery of the full six-year undergraduate Medicine program from Wagga Wagga.

**2. Establishment of pool**

Whilst we recognise the purpose of the Discussion Paper is focussed on options related to the redistribution of CSPs, we feel that it is equally important to discuss the establishment of the CSPs pool itself. A genuine

intent to increase the number of rural medical graduates would mean positioning the number of places to accommodate the needs of the area's medical training.

Creating the pool by removing CSPs from universities who are already delivering and committed to delivering a significant portion of their medical training in rural and regional areas (including true end-to-end medical training programs) appears counterproductive. Removing CSPs from such medical schools means taking away places already allocated to students of rural origin and compromises the feasibility of delivering training in multiple locations.

From 2021, UNSW Medicine will be delivering its full six-year undergraduate Medicine program at two separate regional locations, Wagga Wagga and Port Macquarie in NSW (UNSW commenced its full six-year program in Port Macquarie in 2017). To do so, UNSW Medicine will need to redistribute up to 50 of its existing 199 CSPs across the two separate locations. This inevitably presents logistical and financial challenges. Arguably, CSPs already committed to full end-to-end medical education in rural areas should not be considered in the same way as CSPs used for predominantly metropolitan-based medical education. Running an entire medical program across multiple locations sustainably requires a guaranteed, or indeed a growing, stream of CSPs and resources into the future.

No scheme should disadvantage universities already committed to rural and remote training of medical students. UNSW would prefer to see the Government create and fund additional places dedicated to rural and regional training and directly addressing the issue of attracting students and medical professionals to rural and regional areas.

We fully support a fair, equitable and transparent approach to rural and regional medical education and believe those universities with a demonstrable commitment to building the training pipeline for the rural medical workforce should be duly supported.

**3. Response to CSPs redistribution options**

As requested, our response provides specific feedback relating to each of the options and policy parameters presented in the Discussion Paper. Whilst we acknowledge these options as possible courses of action, fundamentally we do not believe any of these will achieve the Commonwealth's overarching objective, because they deal with only one aspect of the medical training pipeline. Any new policy or procedure must consider an integrated training pipeline involving postgraduate training.

Accordingly, UNSW has been very active in this space through our Regional Training Hubs as well as developing rural training pathways and opportunities in collaboration with Local Health Districts, Specialist Colleges, Training Institutes, other Universities and rural health providers and Specialist Training Programs.

Nevertheless, we are committed to working with the Commonwealth and our fellow medical schools across Australia to address the maldistribution of the existing medical workforce in rural and regional areas. The following feedback is provided in that spirit.

<u>Option 1</u>

This option is unclear as to how the redistribution of CSPs will be determined. With the absence of a 'fixed' formula, the redistribution pool may not be fair, equitable and transparent across all universities. At best,

the metrics required to judge the redistribution of CSPs will be difficult to obtain and might not be equitable for all medical schools. Moreover, this system would encourage medical schools to structure their programs to favour methods that would improve these metrics.

Statements such as "the limited number of available competitive places would be redistributed to the strongest regional proposal…" does not clearly explain how many schools would be given additional places and how these additional places would be fairly distributed.

The bidding mechanism requires medical schools to compete for places that have been used as a foundation of their existing programs. Given the high cost of delivering medical education, eroding places from any program ultimately compromises its feasibility over time.

However, this option does provide a growth opportunity for 'untouched' rural areas, as the competitive bidding process allows universities to have different views on which regional or rural areas to focus. Nevertheless, the short timeframe may prevent innovative proposals from being funded, as the proposals would only be accepted if the implementation is feasible by 2021. In addition, building infrastructure for a new program may be problematic within a two-year timeline.

- **Response to Policy Parameters**

UNSW is concerned with some of the policy parameters for the 2011 distribution process included in the discussion paper. For example:

A. "Only considering proposals for a minimum number of commencing medical CSPs from the redistribution pool. This could include collaborations between universities that enable resources to be shared to deliver sustainable programs in rural or regional locations."

Committed universities with excellent records in providing medical training in rural areas may lose CSPs that have supported their activities. In addition, the variation in CSPs from year to year at medical schools impacts on long term planning, considering students may be allocated to a rural clinical placement 12 months or more before they have to attend.

B. "Requiring proposals to build on existing rurally focussed medical programs that support high quality rural and remote training experiences and/or producing rurally practising medical practitioners. Evidence and data would need to be provided, such as longitudinal workforce outcomes for the university's medical graduates, information about the university's selection and retention processes, and other strategies to grow the rural medical workforce."

Retrospective data collection, for example, to depict the longitudinal workforce outcomes for the university's medical graduates, may be challenging to complete within a short timeframe. In addition, many postgraduate medical practitioners change hospitals on an annual basis and even rotate to rural sites from city hospitals. Therefore, collection of accurate data may be problematic.

- **Response to the Assessment Framework**

Almost all elements of the Assessment Framework are clearly defined and suitable for the 2021 redistribution process. However, the second element (i.e. "The proposal does not increase the number of domestic or international full fee-paying medical students") is unclear because it is not congruent with the compensation intimated in the Discussion Paper for those medical schools who lose CSPs. A clearer explanation for the second element is recommended.

Option 2

Basing the redistribution merely on the quantity of regional training may disregard another dimension of medical education, i.e. the quality of the program. Under this option, medical schools will be rewarded for teaching most of their program at a rural campus, without regard to the quality and breadth of education provided.

Research supports the proposition that the *quality* of the rural experience is as important as the quantity of the experience in rural health settings. For example, students may receive excellent teaching about neurosurgery in a rural campus. However, to gain a broad understanding of the discipline, students should also be exposed to tertiary referral neurosurgery in a city hospital. This option would discourage medical schools from allowing students to return to metropolitan campuses for even a brief exposure to tertiary referral services. This might not be the most effective means to meet rural medical needs, as it would not:

- address the medical workforce shortage in areas lacking medical schools;
- allocate CSPs directly to rural medical training; and
- increase the retention ratio of medical graduates in rural areas.

The proposed 'compensation' permitting medical schools to enrol more international full fee paying (IFFP) to compensate the net loss of CSPs might negatively affect:

- the diversity of students enrolled in medical programs; and
- the demographic balance of medical students undertaking clinical placement training.

Option 3

This option offers 28 remaining CSPs to universities who have committed to deliver end-to-end fully regional medical programs by 2021, thus expanding the infrastructure and facilities to provide learning and teaching opportunities in regional and rural areas.

Although, on the one hand, this option restricts uncommitted universities from seeking places, it rightly rewards universities who have already invested significantly in rural and regional medical education. This approach may encourage the nine universities to continue to improve their programs and incentivise other universities to plan regional or rural medical programs for the next CSP redistribution process.

However, rewarding a small pool of medical schools by this option would be perceived as inequitable by the majority of medical schools, who have also committed considerable resources to medical education in rural and remote areas.

Furthermore, the total number of places contributed to the redistribution pool by the nine universities is larger than the number of additional places available. As shown in Table 5 of the discussion paper, the 28

places available for redistribution cannot fully compensate the 29 places already contributed by the participating universities.

**4. Conclusion**

UNSW believes that the draft policy to redistribute CSPs is not an adequate solution to address the shortage of rural medical workforce as it does not directly affect the retention of medical graduates in rural areas. Whilst we do acknowledge these options as legitimate courses of action, fundamentally we do not believe any of these will achieve the Commonwealth's overarching objectives to address training bottlenecks for medical practitioners in rural and regional areas, in particular improving opportunities for internships and specialist training.

Furthermore, the establishment mechanism for the pool of CSPs for redistribution should be reconsidered to take into account the fact that many universities have invested heavily over a long period in rural medical education. The feasibility of these programs is dependent on CSPs. No scheme should disadvantage universities already committed to rural and remote training of medical students.

We would be welcome the opportunity to meet and discuss further our response or to provide additional information or assistance if required.

**Professor Vlado Perkovic**
Dean, UNSW Medicine