25 October 2019

Dr Michelle Bruniges AM
Secretary
Commonwealth Department of Education and Training
GPO Box 9880
Canberra ACT 2601

Dear Dr Bruniges,

The University of Melbourne welcomes the opportunity to respond to the Department of Education and Training's Discussion Paper on the redistribution of medical places.

The University acknowledges the need to address ongoing shortages of doctors in regional, rural and remote (RRR) communities. We commend the Australian Government for seeking out policy responses to this problem. The University of Melbourne has itself been active in seeking to address RRR medical workforce challenges, most obviously in our partnership with La Trobe University to deliver end-to-end rural training as part of the Murray Darling Medical School Network (MDMSN), with the first cohort of students commencing in 2019. The initiative has required the internal reallocation of 30 CSP from the University's Melbourne campus to its Shepparton campus. This is in addition to the 20 CSP the University has reallocated to help establish Griffith University's medical program at its Sunshine Coast campus. In total, around 20 per cent of the University's commencing CSP has been reallocated already to boost RRR medical training. Consequently, the University should not be subject to a further re-allocation of medical places.

While we join with the Government in recognising the need to respond to the uneven distribution of medical practitioners, the University of Melbourne has significant concerns with the reform direction suggested in the Discussion Paper. In broad terms, there are two major problems with the Discussion Paper's proposals:

1. As noted in both the Medical Deans of Australia and New Zealand (MDANZ) and the Group of Eight responses to the Discussion Paper, the proposed approach to redistribution does not address the key factor that inhibits otherwise willing graduates from pursuing a career in a RRR location – the lack of regionally-based specialist training at the postgraduate level. This draws students from regional to metropolitan locations at a crucial formative stage of their lives, making it difficult for RRR areas to attract and retain trained medical professionals. Failure to develop a targeted response that deals with this issue will inevitably lead to policy changes that fail to deliver the intended outcomes for RRR communities.

2. Two of the three options identified for reallocating CSPs (options 1 and 2) are highly problematic. They would entail considerable administrative effort and lead to funding allocations that are unfair, while failing to address the factors the drive the uneven distribution of Australia's medical workforce. These options do not take into account those universities that have already allocated a significant number of places to deliver end-to-end rurally-based medical training.

In view of these problems, the University of Melbourne does not support the redistribution of medical places as proposed in the Discussion Paper. We recommend that the Government not proceed with this approach, and that it instead explores the possibility of the more targeted approach outlined in the MDANZ policy proposal. Notwithstanding our concerns with the proposed approach, we recommend that option 3 (focused on a commitment to end-to-end medical training) is the best available approach to redistribution, *if* the Government persists with the Discussion Paper's proposals.

The comments below discuss the problems with the Discussion Paper's approach in more detail. Before coming to this, we briefly outline some of the measures the University of Melbourne is already taking in support of medical workforce provision in RRR areas.

University of Melbourne and rural medical training

The University of Melbourne has had a longstanding commitment to supporting the RRR medical workforce. The University's Department of Rural Health, based at our Shepparton Campus, provides professional health education and research training in a rural context, and has taken an innovative approach to tackling workforce challenges. It has major nodes at Ballarat and Wangaratta, and associations with nearly 40 smaller towns in rural Victoria. The Department of Rural Health has been in place for 20 years, clearly demonstrating the University's long-term commitment to RRR training.

The Regional Training Hub initiative was first developed by Monash University, Deakin University and the University of Melbourne to support postgraduate medical training in regional areas. Due to its success, this initiative has since been expanded to all other States. The University of Melbourne's Goulburn Valley Regional Training Hub is managed by the Department of Rural Health.

Currently, 28 per cent of students selected into the UoM's existing Doctor of Medicine program are of rural origin and 28 per cent spend at least one year at the Rural Clinical School. A further 62 per cent of this group complete all three years in a rural environment.

Our partnership with La Trobe University to deliver end-to-end medical training as part of the MDMSN further demonstrates our commitment to RRR training. The partnership was launched within a year of being announced in the 2018 Budget, with the first cohort of students commencing in 2019. Students from La Trobe's new Bachelor of Biomedical Science (Medical) program will articulate into the University of Melbourne's four-year Doctor of Medicine, with the entire undergraduate-postgraduate pathway delivered in north-eastern Victoria. This program has been accommodated by the University of Melbourne internally redistributing 30 CSPs (from metropolitan placements).

We also note that the University of Melbourne has contributed 20 CSPs to help establish Griffith University's medical program at its Sunshine Coast campus. These places will contribute 40 per cent of the Sunshine Coast medical program's allocation of CSPs. The reallocation of places commenced in 2019 with five commencing CSPs, with an additional five to be reallocated each year until 2022. We note that the resulting reduction in CSPs has not been reflected in the number of medical commencements attributed to the University in the Discussion Paper. The University of Melbourne's commencing medical CSPs will fall to 240 by 2021, i.e. lower than the 250 commencing CSPs claimed in the Discussion Paper.

The University of Melbourne has already contributed around 20 per cent of its commencing CSPs to support medical training in RRR locations, when combining the impact of the re-allocation of places to Griffith University and the internal redistribution of places to the Doctor of Medicine in Shepparton. This is significantly more than the Discussion Paper is proposing for the sake of establishing a redistribution pool. Having already made a major contribution to medical training in RRR locations, the University of Melbourne should not subject to a further re-allocation of medical CSPs.

Comment on the Discussion Paper

General approach to redistribution

The Discussion Paper proposes enacting a 2.03 per cent reduction in commencing CSPs from all medical schools to establish a redistribution pool. This represents a blunt instrument approach that fails to address the key points in the medical training pipeline that currently inhibit medical graduates from pursuing a career in rural and regional locations. Consequently, the approach is likely to result in considerable administrative effort and disruption to existing programs without also disrupting the factors leading to the maldistribution of Australia's health workforce.

For those inclined to pursue a medical career in a rural or regional location, the lack of regionally-based postgraduate training represents a significant barrier to doing so. Students – including those who have completed a Bachelor of Medicine at a regional campus – are often forced to undertake specialist training in a metropolitan location. The result is that students are drawn to our major cities in their formative years, i.e. at the point when they (in many cases) meet their life partner, buy a home, start a family and so on. It becomes much less likely that they will then relocate to a RRR location upon completion of their training.

The MDANZ has proposed a "flipped model", where students undertake specialist postgraduate training in a regional location with rotations through metropolitan hospitals where this is needed. This would help to attract or retain students to, or in, RRR areas at the key point in the medical training pipeline. This approach targets the parts of our medical training system that are failing to deliver graduates to rural and regional communities. This contrasts with the approach proposed in the Discussion Paper, which would likely shift CSPs between medical schools without consideration of how this will address bottlenecks in the rural and regional medical training pipeline.

We should note the progress already made in this area. Rural Training Hubs help to connect the government's existing investment in University Departments of Rural Health and Rural Clinical Schools with the vocational phase of medical training. Nonetheless, Australian universities' educational expertise is yet to be brought to bear on the health sector. Innovation in online delivery offers potentially significant benefits. A range of models exist that would allow universities to better support rural specialist training through the provision of high quality, online programs, enabling more training placements in rural and regional centres. The University of Melbourne's current Master of Psychiatry and Master of Medicine (Radiology) stand as examples in just two specialties. The Master of Internal Medicine – jointly developed by the Universities of Melbourne and Sydney – is another example. Targeted investment in innovative models such as these promise to deliver further gains.

Redistribution options

The University of Melbourne has major concerns with the options for redistributing CSPs proposed in the Discussion Paper. For each of the three options identified, all universities would contribute 2.03 per cent of commencing medical CSPs to create a pool of 60 places, 32 of which would be allocated to Charles Sturt University to facilitate its new medical school. The options differ in how the remaining 28 places would be redistributed:

- **Option 1:** the remaining 28 commencing medical places would be redistributed using a competitive bidding process based on the Assessment Framework and agreed policy parameters.
- **Option 2:** The remaining 28 commencing medical places would be redistributed to universities based on the proportion of medical education training they undertake in regional (ASGS-RA2+) locations.
- **Option 3:** The remaining 28 commencing medical places would be redistributed only to universities with a commitment to deliver end-to-end fully regional medical programs to at least a cohort of their students by 2021.

Options 1 and 2 are highly problematic. The competitive bidding process proposed in option 1 would impose a considerable administrative burden on medical schools, with little clarity as to the assessment criteria that would be used. As noted in the Group of Eight response to the Discussion Paper, it is very likely that universities with a strong commitment to regional medical training would nonetheless suffer a reduction of CSPs due to the small number of places available.

Option 2 is especially problematic in that it proposes to use regional *intensity* (i.e. the proportion of a university's medical training delivered regionally) rather than *absolute* regional contribution (i.e. the total amount of medical training delivered regionally). There is no policy rationale for this approach. It would effectively penalise universities who operate medical programs at both metropolitan and regional campuses, and whose proportion delivered regionally is therefore diluted by metropolitan enrolments.

Of the options floated in the Discussion Paper, we argue that option 3 – which would redistribute places based on a commitment to end-to-end regional medical programs – is the best available. Importantly, this approach is reflective of the measures the University of Melbourne has taken in internally redistributing CSPs to support the Shepparton portion of the MDMSN. Having made this commitment – and having contributed places to support Griffith University's Sunshine Coast medical school – the University should not be subject to a further re-allocation in medical places.

Issues that impact attraction and retention of a rural medical workforce

There are a range of reasons doctors do not choose a career in a rural setting. The Centre for Research Excellence in Medical Workforce Dynamics[1] has found in an investigation of the role of financial incentives and non-financial factors in doctors' workforce participation decisions that financial incentives alone are unlikely to address supply shortages. For female doctors, as with women in other occupations, the presence of young children is the most important factor influencing labour supply. In a slightly different context, the CRE team has shown that in encouraging doctors to rural locations, non-pecuniary factors such as the amount of on-call, the ease with which a locum doctor can be arranged, the social interactions that are available in a location, access to ongoing professional development, availability of schools and employment opportunities for partners are all important.

We also note the research undertaken at the Melbourne Institute through the 'Medicine in Australia: Balancing Employment and Life' (MABEL), a national longitudinal survey of doctors in Australia. The survey contributes to the evidence base for the range of challenges to maintaining Australia's rural medical workforce, which extend well beyond the funding of medical CSPs.

The University is proud to play its part in the education of high-quality medical graduates and will continue to work to ensure rural students, and those interested in a rural medical career, have every opportunity to succeed, including the choice to study in a rural setting.

[1] Solving Australia's rural medical workforce shortage, https://melbourneinstitute.unimelb.edu.au/__data/assets/pdf_file/0010/2635048/MABEL-policy-brief-no-3.pdf

Recommendations

The University of Melbourne recommends that:

- the Government not proceed with the approach proposed in the Discussion Paper, and that it instead explore the possibility of the more targeted approach outlined by the MDANZ; and
- if the Government proceeds with the proposed approach, it implement option 3 (focusing on end-to-end regional programs), given the considerable problems with options 1 and 2.

For further information or to discuss this submission please contact Professor Shitij Kapur, Dean of the Faculty of Medicine, Dentistry and Health Sciences, at shitij.kapur@unimelb.edu.au or on (03) 8344 9577.

Kind regards,

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Cc: The Hon Dan Tehan MP, Minister for Education