Charles Sturt University

DEPARTMENT OF EDUCATION

Redistribution pool of medical Commonwealth supported places

Submission – 25 October 2019

Office of the Vice-Chancellor
Charles Sturt University

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Discussion Paper Review
Department of Education
GPO Box 9880
Canberra ACT 2601

Dear Sir/ Madam,

Redistribution pool of medical Commonwealth supported places

Thank you for the opportunity to provide a submission in response to the discussion paper. We acknowledge that the paper provides the mechanism for the redistribution of CSPs from the already established medical programs to Charles Sturt University as well as the redistribution of a further 28 places.

We would like to reiterate our thanks to the Government for creating a process through which critical health workforce needs for our region can be addressed. We are also grateful for the opportunity to provide input to the broader redistribution discussion.

We note that in the letter received, existing programs were asked to provide a more detailed understanding of regional medical load over the past three years. This is not relevant to Charles Sturt University and as such we have not prepared input in relation to this.

Yours sincerely

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Discussion paper consultation and review

The 2018–19 Budget announced a number of important measures across both the Health and Education portfolios to better manage the supply of medical graduates and expand opportunities for learning and training in rural Australia. One of these strategies will establish a small pool of medical Commonwealth supported places (CSPs) drawn from existing university allocations to give the Australian Government flexibility to support key health workforce priorities as they emerge.

The pool will withhold around two per cent of existing commencing medical CSPs (60 commencing places) every three years for redistribution between universities starting from 2021. The first round for 2021 will focus on helping to build the rural and regional medical workforce.

The department has released a discussion paper inviting stakeholder comments on the establishment and implementation of the redistribution pool. The paper also invites input to help develop specific policy parameters for the rollout of the redistribution process over successive triennial periods.

The discussion paper includes the new Assessment Framework and guiding principles that will support universities developing proposals for new or expanded medical programs. All proposals for new medical schools and/or medical CSPs going forward will be assessed against the Assessment Framework.

Executive Summary

Key Points:

Charles Sturt University has a positive track record of serving rural communities, positive rural health workforce training track records, strong existing rural training locations across our campus network, well-developed relationships with local communities and clinical placement providers, and success with rural practice outcomes for the rural health workforce.

Rural medical and health workforce training located fully in rural areas is relatively more complex and more expensive than larger metropolitan programs but has the best potential return on investment.

A program for growing workforce through any strategy needs to be adequately supported by an integrated approach to education and health funding to ensure this return on investment.

Charles Sturt University supports the policy approach to engage in redistribution to achieve strategic workforce outcomes. Redistribution is supported as a strategy to introduce flexibility and responsiveness into the system without leading to overall growth.

We would argue that any changes need to enable programs to achieve a step change in student numbers to lead to meaningful outcomes. The preferred options should incentivise substantive actions rather than limiting the impacts to a shift of small groups of students between programs.

The policy approach should promote increasing diversity in medical schools according to purpose. It should be acceptable for medical programs to tailor their focus to meet diverse regional community needs. For example not all programs should be expected to become experts in meeting rural workforce outcomes and equally not all programs should need to be experts in highly specialised areas of medical practice.

Charles Sturt University needs a genuine opportunity to grow in a further round of redistribution than covered by this initial program to provide a viable and sustainable return on investment.

We support an initial cycle of 3 years to enable a faster establishment of this priority initiative. There is sufficient evidence that the approach of rural training is a valid means to grow rural workforce and therefore sufficient timely leverage should be applied to achieve the outcome. A 3 year cycle would enable universities to adapt to changes in numbers but not be so long that the potential impact of changes on health outcomes for rural people are further and unreasonably delayed.

Charles Sturt University believes the proposed options in the paper all offer potential benefits. We suggest that the preferred option is combination of 1 and 3 where universities need to clearly articulate their approach, the model promotes diversity of focus and ensures change is associated with a critical mass of change in student numbers.

The assessment framework appears to focus on success factors for a medical school in light of the known medical school delivery challenges. Although important this focus results in relatively less attention given to how the proposed program will strategically deliver on intended outcomes. For example, in this round the proposal should describe how the program will grow the rural health workforce with the associated expectation that this will result in improved health outcomes for rural people.

The assessment framework is under-developed in describing the supporting factors for a positive student experience. It also, unfortunately, refers to key groups by using a language of disadvantage (criteria 7) when these groups could more accurately and respectfully be identified as diverse groups with different needs.

Ensuring that the changes in student numbers achieve meaningful change and sustainable outcomes

We affirm that the intent of this process is to build the capacity and capability of the future and existing medical workforce to meet the needs of Australians living in regional, rural and remote Australia. This process is only of value if it is successful in achieving meaningful change in the numbers of doctors actively working in rural areas.

A current key facet of the proposal is the number of places that are proposed to be redistributed – in this case 2% of the existing CSP's which numbers approximately 60 students. For the number that are over and above the 32 allocated to Charles Sturt it has to be questioned as to what is the need or value in undergoing a redistribution process, unless it allows a significant number to be increased and directly to the target groups.

As general principles we feel that a model should enable economies of scale in terms of viability of medical programs while primarily providing a significant number of additional students. The potential is that if only small increases in the number of students at each medical school occurs then this will be unable to meaningfully change the status quo.

There are a number of important effects of having a critical mass of students as a cohort in rural locations

- Financial viability for the university to deliver medical education
- Improved student experience – cohort identity, access to resources, feelings of substantive value compared to metro centre, improved campus vibrancy
- Local professional staff involvement and community investment in the program
- Contribution to health outcomes and research outputs from locally conducted research
- More students have a positive experience locally – feel it's not better on the other side of the mountains
- Access to interprofessional learning with other students also in a critical mass
- Local prospective students can see a vibrant option for study by maintaining friends and family activities as part of the community, part of sporting teams etc
- Indigenous students have a critical mass and sense of community
- Students support structures are enhanced

Conversely small increases in student numbers leading to small student groups have the potential to have limited impact especially if these promote distributed location, fragmented experiences and lead to small groups dislocated from larger metro group with resultant poorer experiences. We endorse that universities that have successfully achieved positive outcomes for students and graduates should be rewarded for their actions and the model should be able to accommodate these evaluations.

The evaluation of the experience of Charles Sturt under the recently expanded RHMT program, that now includes the Three Rivers UDRH, is that a regionally based university is better equipped to offer a comprehensive student experience.

Principles of a model and consideration of the options (this round and future rounds)

We propose that the model have the following principles

- Targets an area of need
- Drives innovation through providing incentives and therefore incentives need to be signalled into the future to support university planning
- Needs to be able to apply the leverage strongly to start with and then see that the process is working. There should be the potential for more than one cycle of redistribution as the return may take up to 10 years. Sufficient evidence exists to provide confidence in the strategy with strong enough levers and therefore action should not be delayed. Three years is a good time to plan to be able to take on more students.
- The options are all considered to be viable but there is a risk of option 2 and 3 that expediency is being used at the expense of potential outcomes.
- Must be considered in alignment with the evaluation of the RHMT. If there is to be a reduction in RHMT funding in this process or a redistribution of funding how this will shape the landscape?
- An alternative option is to consider if all universities wish to maintain their rural sites. Are there any sites who wish to give up rural clinical schools? The current system which has promoted all programs to have a rural focus has given a broad but fragmented base. Should some schools be targeted to specialise. A redistribution system that enables some differentiation through reallocation of RHMT and CSPs could be an option.
- Consider a model that adapts option 2 that is related to numbers of students and therefore the overall amount of time that students are spending in rural areas. This is distinct from a course design that proposes longitudinal models as a high percentage but there is no evidence of how many students are actually undertaking these options.

Assessment framework

The assessment framework focuses on success factors for a medical school in light of the known challenges. Although important this focus results in relatively less attention given to how the proposed program will strategically deliver on intended outcomes. For example, in this round the proposal should describe how the program will grow the rural health workforce with the associated expectation that this will result in improved health outcomes for rural people.

The assessment framework is under-developed in describing the supporting factors for a positive student experience and also in terms of the processes in place to build student success. The provider should be able to demonstrate the capacity to work effectively with community in the priority areas and with a strong understanding of prospective students.

The assessment framework, unfortunately, refers to key groups by using a language of disadvantage (criteria 7) when these groups could more accurately and respectfully be identified as diverse groups with different needs. Diversity means acknowledging and responding to different needs, understanding aspiration and social capital. This section must identify the targeted student body and how they will be able to be supported to meet the priorities – be it rural, refugees, migrants etc.

The Charles Sturt University situation

For Charles Sturt University we have been currently allocated 32 places and with the Western Sydney University places this will increase to 37. We want to note that as part of the agreement under the MDMSN that Western Sydney University has further agreed to provide 5 additional CSP to Charles Sturt and that this contribution is not referred to in the paper.

The success of the CSU/WSU Joint Program in Medicine will depend upon assuring financial viability. Under the current scheme future viability has been anticipated under the following beliefs

- That there was to be a further round of redistribution in 3 years' time which would provide the capacity to grow to 60 places. Under the current proposal unless option 1 is adopted, options 2 & 3 do not provide any capacity for CSU to grow this round. We have consistently maintained we needed 60 places for financial viability. In one of our earliest submissions to Jim Angus on 13 March 2018 in response to the Murray Darling Medical Network proposals we argued that:

  "*The proposed model for the CSU Medical School will be a six-year undergraduate degree*[1] *that will prepare medical graduates for transition to internship and rural practice. Charles Sturt University will require the allocation of 60 commencing medical training places each year (Commonwealth Supported Places) to deliver a sustainable program. Under a partnership model Charles Sturt University believes an optimal enrolment would be 60 students annually separate to the WSU student load. CSU is prepared to consider a plan to build to these student numbers during the initial years of establishment. The students will be enrolled direct to a CSU campus maximising the recruitment of students of rural origin and minimising the leakage associated with relocation to study in an urban location.*"

- That the relationship with WSU is intended to provide financial viability and access to experience of medical education. The partnership opportunity should result in less need to develop materials, capacity to share resources and collaboratively work with clinical placement providers. Partnerships between metropolitan providers and rural providers/programs should provide this outcome but also secure the outcome under potential changes in focus by the dominant institution. This is not guaranteed in the proposal.

  For Charles Sturt our agreement with WSU needs to provide
  - The curriculum at a cost effective rate
  - Access to economies with organising admissions, assessment, placement coordination
  - Needs access to sustainable intent re the rural priority

- That we would have potential access to RHMT funding which would bring us into line with the resources being provided to other schools with rurally based program and a large economy of scale with a large metro cohort. As it currently stands CSU does not have the same capacity to cross subsidise from a large metro body of CSPs or to draw on RHMT, other than that provided by WSU.

- Unless we can grow through allocation to us we will have no option but to remain tied to WSU, and we would see this as a limit to us achieving the desired outcome of a distinctive and differentiated program to address our rural community needs.

- Growing needs time to scale and planning over a reasonable period of time.

[1] Note that under the CSU/WSU JPM this was changed to a 5 year program.