

**Medical Deans Australia and New Zealand Submission to
Driving Innovation, Fairness and Excellence in Australian Higher Education
25 July 2016**

Medical Deans Australia and New Zealand (Medical Deans) is the peak professional body representing entry level medical education, training and research in Australia and New Zealand. Medical Deans is committed to improving the health of Australians and New Zealanders through the continual development and advocacy of medical education and research leading to high quality, work ready medical graduates and excellence in research. Medical Deans welcomes the opportunity to make a submission to the Australian Government discussion paper “Driving Innovation, Fairness and Excellence in Australian Higher Education.”

While many of the issues raised in the discussion paper have implications for medical schools and faculties, Medical Deans are limiting comments in this submission to the issues raised on p 19 of the paper on the relativities between disciplines of funding clusters.

“The Government also seeks the views of the sector on the relativities between disciplines of funding clusters in the context of its overarching objectives. It is proposing to work with Universities Australia and the higher education sector to investigate the relative cost of delivery of higher education. Based on this work, Commonwealth and student contributions could be adjusted to reflect a more streamlined framework that better reflects these costs, teaching method, infrastructure required, and potential value to students.”

“Driving Innovation, Fairness and Excellence in Australian Higher Education” p 19

There are other issues in the Government’s Discussion Paper which are also of relevance to medical schools, however it is expected they will be covered in individual university submissions or peak body submissions. Currently medicine is in the highest funding cluster along with veterinary science and dentistry. Medical Deans understanding of medical schools operations means it is well placed to contribute to the discussion regarding the funding clusters and their relativities.

The Government’s Discussion Paper also raises the possibility that an evaluation of the level and relativities of funding clusters could occur through an efficient pricing review. Should this be the case, Medical Deans would wish to be consulted in this process.

The Changing Environment of Medical Education

The current framework of eight levels of government grants and three different levels of student contributions was introduced in the 1990’s. Medical education has significantly changed since the Relative Funding Model was developed and the model has not kept pace with these changes. The next section addresses these changes.

There has been a rapid expansion in medical school capacity in the past two decades to address the shortage of doctors evident in the late 1990’s and early 2000’s. Between 2005 and 2015 there has been a 131% increase in the number of graduating domestic medical students, increasing

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from 1,320 students in 2005 to 3,055 in 2015. In the same period there has been a 72% increase in commencing domestic medical students, increasing from 1,871 in 2005 to 3,210 in 2015.

The increase in capacity has been achieved through new medical schools with nine new medical schools established between 2000 and 2009, the expansion of existing medical schools and the establishment of rural clinical schools, with 17 rural clinical schools associated with 16 universities now providing opportunities for medical students to experience extended rural placements.

The expansion in capacity has been accompanied by new models for medical education, including the emergence of graduate entry medical degrees. New models have required substantial investment by universities involving changes to course content, student entry and selection processes and the mix and skills of teaching staff.

There have been changes to the teaching and learning of medical curricula to incorporate approaches such as problem based learning and scenario based learning. As this involves a stronger focus on learning through small groups, it has major implications for the staffing and resourcing of medical education. This has meant an increasing emphasis on evaluating the effectiveness of approaches to medical education, with the establishment of units focussed specifically on medical education and its evaluation.

These changes have had an impact on both the complexity and cost structures of medical schools and have not been matched by adequate growth and indexation in Commonwealth funding for teaching and learning. Despite the separate stream of funding that has been provided for rural clinical schools, there is still a relative funding gap in medical education

Clinical training has also impacted on the cost of medical education. Medical schools have seen an expansion in work integrated learning through clinical training occurring much earlier in the medical degree and in a wider range of community based settings. Historically clinical education occurred in the final three years of a medical degree however it is now increasingly being integrated into all years of a medical degree. There is also considerable geographic diffusion of clinical education through distributed models of training. The expansion in the number of medical students has also meant a significant increase in the cost burden of clinical training.

The costs associated with clinical education are one of the most significant factors contributing to the cost structure of medical education. This has been exacerbated since the Government abolished the Clinical Training Fund at the end of last year through the Mid-Year Financial and Economic Outlook. This fund was established by Health Workforce Australia to support increased clinical training and its cessation was announced in December 2015, with very little notice for schools who had built the money into their 2016 Budgets.

Cost of Medical Education

In a previous submission to the 2011 Base Funding Review, Medical Deans demonstrated the relative funding gap in medical education in Australia through two means: the disparity in funding levels for medical students between Australia and New Zealand and benchmarking the expenditure of Australian medical schools. Updated figures since that submission show the relative funding gap remains.

1) Disparity in Funding Between Australia and New Zealand

Combined government and student base funding of New Zealand medical students is on average, about 57% higher than for Australian medical students - see table below. This largely reflects the

New Zealand Government’s decision to significantly increase its funding contribution in 2007, based on submissions from the two New Zealand medical schools.

	Base CSP Funding - Australia 2016	Base Funding – New Zealand 2016
Government Contribution	\$22 472	\$38 929 (averaged across years)
Student Contribution	\$10 440	\$12 701
Total	\$32 912	\$51 630

The Higher Education Base Funding Report 2011 (Lomax-Smith Review) also found that Australian funding for medicine was relatively low stating:

“While it is difficult to make precise comparisons between different jurisdictions, there is evidence that Australian funding for medicine, dentistry and veterinary science remains relatively low by international standards.”

Higher Education Base Funding Report, 2011

2) Benchmarking the Expenditure of Australian Medical Schools

Medical Deans has undertaken a detailed benchmarking project across Australian and New Zealand medical schools. The benchmarking project involves measurement of existing expenditure levels rather than real costs as it does not incorporate elements such as the costs of pro bono teaching, clinical training in an expanded range of settings, and required investment in new technology.

The 2014 Medical Deans operational benchmarking study (most recent study) found the average teaching expenses were \$58 318 and the combined base Commonwealth Government and student contribution was \$31 792 leaving a gap between expenses and funding of \$26 526.

Medical Deans Benchmarking Project 2009 (as per submission to 2011 Base Funding Review)

Source and year	Measure	\$ per medical student
Medical Deans Benchmarking Project 2009	Expenditure on teaching	\$50 938
DEEWR – 2009	Base Funding (CGS and student contribution)	\$27 287
	Difference (Expenditure less Base Funding)	\$23 651

Medical Deans Benchmarking Project 2014

Source and year	Measure	\$ per medical student
Medical Deans Benchmarking Project 2014	Expenditure on teaching	\$58 318
DET – 2014	Base Funding (CGS and student contribution)	\$31 792
	Difference (Expenditure less Base Funding)	\$26 526

Findings of Earlier Higher Education Funding Reviews

There have been a number of previous reviews of higher education that have examined relativities between the funding clusters and found that medicine along with some other disciplines is underfunded.

The Higher Education Base Funding Report, 2011 (Lomax-Smith Review) found that the current funding clusters no longer reflect the costs of delivery of teaching, scholarship and base research capability in all disciplines. The Report's research identified some areas of underfunding for particular disciplines and also indicated the prevalence of internal cross-subsidisation.

The Report identified three groups of disciplines of concern:

- accounting, administration, economics and commerce
- **medicine**, dentistry, agriculture, veterinary science, and visual and performing arts
- law and humanities

It made the following recommendation:

“The Australian Government should address the identified areas of underfunding in the disciplines of accounting, administration, economics, commerce, medicine, veterinary science, agriculture, dentistry, and visual and performing arts, and should consider increasing the funding level for humanities and law.”

Higher Education Base Funding Report, 2011

The 2014 Review of Demand Driven Funding System (Kemp Norton Review) also made recommendations about the discipline cluster funding and noted that health related disciplines all have problems with the clinical training component of their courses, with the traditional pro bono models of providing clinical training breaking down as health services have to deal with more patients and more students.¹ The Kemp Norton Report also drew upon the costing studies completed for the Higher Education Base Funding review and recommended:

“Maximum per Commonwealth supported place funding rates in engineering and health disciplines should be reviewed in the light of cost pressures.”
2014 Review of Demand Driven Funding (Kemp Norton Review)

¹ 2014 Review of Demand Driven Funding System (Kemp Norton Review) – p91

Conclusion

Increased number of medical students, changes in the way medical education is delivered and the expansion of clinical training have all contributed to the increasing cost of medical education and the combined Government and student funding has not kept pace. Medical Deans recognise that the current consultation on higher education is taking place within the parameters set by the Government where it is trying to preserve “equity of access while meeting the financial sustainability savings outlined in the budget.”² The issue of overall funding for higher education will be determined by many factors, and Medical Deans understands the funding of medical education does not occur in isolation from other university wide financial and operational imperatives.

However Medical Deans are in a position to contribute to the discussion about the relativities between disciplines of funding clusters. While the current framework of eight funding clusters and three different levels of student contribution was introduced in the 1990’s and there has been significant change since then, it is still the case that that base funding relativities are fundamentally driven by different modes of teaching.

The mode of teaching for medicine involving problem based learning, laboratory work, the centrality of clinical training placements and high level infrastructure including simulation facilities makes it more expensive to deliver relative to other disciplines. Previous studies have found that Medicine is underfunded. It is clear that in an environment where existing Government and student funding combined does not meet the cost of providing medical education, medicine must remain in the highest funding cluster relative to other disciplines. Medical Deans would be happy to provide any further information required by the Expert Advisory Group and reiterate our desire to be involved in any subsequent efficient pricing review of funding clusters.

² Consultation Paper – Driving Innovation, Fairness and Excellence in Australian Higher Education – p5