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AUSTRALIAN MEDICAL STUDENTS' ASSOCIATION

Australian Medical Students' Association
December 2022

Professor Mary O'Kane AC
Chair, Australian Universities Accord Panel

Re: Review of Australia's Higher Education System - Accord Panel

Dear Professor O'Kane

Thank you for the opportunity to provide a submission to the Australian Universities Accord Panel pertaining to the higher education review being conducted. We write on behalf of the Australian Medical Students' Association, the peak representative body for Australia's 18,000 medical students at 23 universities.

Our submission has been presented in line with the terms of reference of the Accord Panel and structured as such. The terms of reference most relevant to our organisation and the students we represent are:

1. Meeting Australia's knowledge and skills needs, now and in the future;
2. Access and opportunity;
3. Access and affordability; and
4. Governance, accountability and community.

The key areas in which we have provided recommendations are in regard to: the quality and content of medical education, increasing diversity of people selected into medical schools and the contribution of medical schools to producing the medical workforce that Australia needs.

We look forward to further engaging with you during the process of the education review. Please do not hesitate to contact us should you have any questions, or if there are any further opportunities for consultation. .

Kind regards

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1. Meeting Australia's knowledge and skills needs, now and in the future

Background

Australia's medical workforce suffers country-wide maldistribution, both geographically and with respect to the need for certain specialist doctors, bearing significant economic and health implications. This maldistribution is driven in large part by a lack of coordination between actors at various stages of the medical training pipeline, as well as the lack of data driving decisions made regarding workforce training models.[1]

In particular, there is a shortage of medical students entering careers in general practice and psychiatry, as well as the ongoing need to increase the amount of doctors recruited to, and retained in, rural and remote Australia.[2]

There has been a rapid increase of medical schools in Australia from 15 in 2006 to 23 in 2022, and an almost doubling of medical student numbers.[1] Despite this, there is still significant maldistribution, highlighting that increasing Commonwealth Supported Places (CSPs) or Full-Fee Places (FFPs) is not an adequate tool to create the types of doctors we need, in the areas we need them, now, or in the future. There is no workforce modelling to suggest that we have a shortage of medical school graduates, highlighting that the focus needs to be on selection, high quality exposure, and creating training pathways and opportunities that are appealing and accessible in the areas and specialties where we need doctors.

Of particular concern, only 15% of graduating medical students are interested in a career in General Practice. Modelling has suggested that by 2032, we will have a shortfall of over 10,000 GP's.[3] On August 11th 2022, AMSA held a Roundtable on the topic: Medical Student Interest in General Practice - Reversing the Trend. The meeting was attended by peak national bodies for health workforce, medical education and student advocacy. Both Government and Opposition were represented by the Hon Mark Butler MP, Minister for Health and Aged Care and Senator the Hon Anne Ruston, Shadow Minister for Health and Aged Care. Following the roundtable, AMSA released a report of recommendations for Government, Universities and the GP Specialist Colleges. You can read the full report here.[4] Recommendations 4 and 5 are experts specifically from the GP Roundtable Report, with background information available in the report itself.

Recommendations

1. Fund a Data Strategy to collect data on the medical workforce, and establish a Joint Medical Workforce Planning and Governance Body, in

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line with the recommendations of the National Medical Workforce Strategy;
2. Refuse to fund any scheme which directly or indirectly increases the number of Australian, especially international, medical students, and refrain from supporting or funding any new medical school proposals unless guided by evidence-based modelling addressing the workforce need;
3. Provide increased funding for vocational medical training options in rural and regional Australia via continuation and expansion of the Specialist Training Program;
4. Provide funding to teaching primary care centres to increase their educational capacity and improve the appeal of a career in General Practice; and
5. Tie Commonwealth Supported Places (CSPs) at universities to outcomes of producing a generalist and rural workforce (this recommendation is further elaborated on in section 4 of this submission).

2. Access and opportunity

Background

Representation within the health workforce is paramount in the creation of a stronger and safer health system. Initial steps have been taken by key stakeholders within the Medical Education system to acknowledge and address the shortcomings in terms of diversity, equity and inclusion. These changes are most evident when reviewing incentives and programs established to encourage students from rural backgrounds to pursue higher education and efforts to encourage women into STEM disciplines.[5]

However, studies persistently demonstrate significant gaps in medical education regarding the recruitment and retention of minority groups. In particular, Torres Strait Islander and Aboriginal students and students with disabilities.[6] Alongside this, although making up a significant portion of Australian medical graduates, International Students are significantly disadvantaged in their placement experiences, and face discrimination in accessing work opportunities.[7]

Medicine now has reached gender equity in medical student enrolments, and some medical schools have reached population parity in admission of Aboriginal and Torres Strait Islander medical students.[2] Despite these achievements, there is still significant barriers for women in accessing certain specialties post medical school, and we are doing very poorly in retaining and graduating population parity of Aboriginal and Torres Strait Islander students.[6] There is a lack of data on how many medical students have a disability, with suggestions from overseas suggesting the

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representation is poor, and that there is a need for targeted strategies to increase the representation of people with disabilities in medical schools and the health profession more widely.

Recommendations

1. Continue programs to encourage women, rural and remote background, and Aboriginal and Torres Strait Islander students to pursue a career in medicine;
2. Universities to have specific disability entry pathways for enrolment of students with disabilities in medicine;
3. Universities to have specific First Nations and Disability Support Units;
4. Scholarship programs for disadvantaged background students;
5. Enable international students to do rural placements funded by Government; and
6. Enable international students to have access to a guaranteed medical internship in Australia.

3. Access and affordability

Background

Medicine has a background of being a university degree historically only accessible to those of very privileged backgrounds. Although the demographic of medical students has changed over time to become more diverse and gender equitable, the course is still very inaccessible for many students.

Barriers exist from as early as the initial entry examination to enter medicine, known as either the UCAT for undergraduate medicine, or GAMSAT for postgraduate medicine. These courses range in cost from $300 to $600 AUD per sitting, with students from disadvantaged backgrounds possibly being more likely to need to sit the examination on multiple occasions.[8]

For students who are eligible to enter medical school, additional financial barriers continue to exist, particularly in clinical placement years, where students are required to be full time on placement, with placement hours frequently in excess of 40 hours a week. On Top of this, students are required to do additional lectures, tutorials, and self-directed study. This leaves little time for medical students to have part time or casual jobs, with most resorting to tutoring jobs that are unstable and inconsistent in their pay.[9] This most significantly affects students from low socioeconomic backgrounds. Work programs such as the Assistants in Medicine (AIM) roles for final year medical students to be paid for their work in hospitals are a step toward reducing these barriers.[10]

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Recommendations

1. Universities to revise their use of entry examinations such as the GAMSAT or UCAT;
2. Entry examinations such as GAMSAT or UCAT should have scholarship programs or discounts for students from disadvantaged backgrounds;
3. Universities to have entry programs and scholarship programs for students from disadvantaged backgrounds; and
4. Universities and hospitals should introduce paid work opportunities for students to apply for whilst they are in their clinical placement years.

4. Governance, accountability and community

Background

Medical schools are mainly accountable through the accreditation standards set by the Australian Medical Council (AMC), these standards are currently under review, and AMSA has been a significant contributor to ensuring that these new standards are modern, inclusive, and ensures universities will be accountable for their curriculums and outcomes.[11]

Where accountability is lacking, is in regard to universities graduating doctors that fulfil workforce shortages. As explored under section 1 of this submission, there is a shortage of medical students interested in careers in general practice and psychiatry, as well as maldistribution of doctors between metropolitan and rural and remote areas. A policy lever that has not been adequately utilised, is the tying of Commonwealth Supported Places to outcomes of universities. Data collected by Medical Deans can match graduating cohorts to their fellowship, enabling the speciality choices of university cohorts to be analysed. This is an accurate and meaningful measure of how effective different universities are at creating students who ultimately pursue generalist careers.

The Commonwealth Government could use this data to inform funding for CSPs at universities through a quota system. In this system, universities would not be granted new CSPs or could lose some of their CSP allocation if they fail to reach a threshold of graduates interested in, or entering generalism. This could be used to encourage universities to seriously consider the representation of general practice within their curriculum and placements. A system like this would require a long implementation period to allow universities to make changes and see those take effect.

Recommendations

1. Tie Commonwealth Supported Places (CSPs) at universities to outcomes of producing a generalist and rural workforce.

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