AUSTRALIAN MEDICAL STUDENTS' ASSOCIATION

25 November 2012

Ms Jenny Mason
Chair
Review of Health Workforce Programs
Department of Health and Ageing

Dear Ms Mason,

RE: Review of Commonwealth Government Health Workforce Programs

On behalf of the Australian Medical Students' Association (AMSA), thank you for the opportunity to provide further feedback to the Department of Health and Ageing's Review of Health Workforce Programs following the Education Round Table session at Scarborough House on 21 November 2012.

AMSA's priorities for the Review are two-fold: working towards a new balance of programs to tackle medical workforce maldistribution and addressing challenges in medical training capacity.

There are currently a multitude of workforce programs designed to address medical workforce maldistribution, including:

- Commonwealth bonding schemes, including the Bonded Medical Places Scheme (BMPS) and Medical Rural Bonded Scholarships (MRBS)
- The Rural Clinical Schools (RCS) program, which operates at 17 of Australia's medical schools, and rural-background entry schemes
- Section 19AB of the *Health Insurance Act (1973)*, commonly referred to as the 10 Year Moratorium
- Other rural mentoring schemes, including the Rural Australian Medical Undergraduate Scholarship (RAMUS) and John Flynn Placement Program (JFPP)

I will assume that you are familiar with the design of each of these programs, and will therefore focus on the specific areas of these schemes that AMSA believes warrants attention as part of this review. In this letter, the term 'rural' is used to encompass regional, rural and remote locations.

<u>Commonwealth bonding schemes</u>

AMSA is concerned that there is insufficient evidence to indicate that either of these schemes will produce a long-term increase in the numbers of doctors practicing in rural areas and calls for their removal, in favour of greater support for evidence-based programs including the RCS program and recruitment of students with a rural background.

Issues affecting the BMP and MRBS schemes include:

- potentiation of stigma of rural practice, through association with these programs, which is likely to damage students' and new graduates' perceptions of the value or rural practice;
- exploitation of prospective students, through capitalisation on the high demand for medical programs at a time in which it is extremely difficult for under-informed students to foresee the effects of the schemes on their future life and career choices, many of which will be affected only from 15 years or more after signing contracts;

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- the lack of positive incentive associated with the BMPS; and
- significant uncertainty for those with future return of service obligations, due to the variable use of rural classification systems, including RRMA and ASGC-RA, and the use of the Districts of Workforce Shortage system which is subject to change.

Failing abolition of these schemes, AMSA calls for the following modifications to be made to the BMP and MRBS programs, to improve their acceptance, fairness and effectiveness:

- enable participants in both programs to complete return of service obligations at any stage of post-graduate training, such that graduates may be rewarded for voluntarily undertaking training in rural areas;
- change the MRBS return of service obligation to be commensurate to length of medical degree, to align the MRBS program with recent such changes to the BMPS program;
- provide positive incentives with the BMPS program, such as providing these places HECS-free;
- provide participants in both programs with mentoring and opportunities for enhanced exposure to rural practice;
- remove harsh Medicare Provider Number penalties associated with withdrawal from both schemes;
- provide more comprehensive standardised advice to potential medical students, prior to enrolment, regarding both programs' impact on future life and career choices, including on vocational choice; and
- expand existing program support schemes, such as the bonded support program administered by ACRRM, over time with increasing program participants.

Evidence-based approaches to rural workforce programs

The RCS program is supported by local and international evidence that early, positive exposure to rural practice leads to greater recruitment of practitioners to rural areas after graduation. In addition, AMSA is aware of unpublished data from the Medical Students' Outcome Database that the length of these placements positively correlates with likelihood of rural practice in early postgraduate years. AMSA supports the Commonwealth's continuing investment in the RCS program, via the Rural Clinical Training Support funding scheme.

AMSA supports other Commonwealth, State and national schemes which provide positive rural mentoring opportunities for medical students, including the RAMUS and JFPP schemes.

Similarly, local and international evidence indicates that students of rural origin are more likely to practice in a rural area upon graduation, but face significant barriers to medical school entry compared to students from a metropolitan background. AMSA supports the Commonwealth's target, set in the Rural Clinical Training Support funding scheme, of 25% of medical school places quarantined for students of rural origin. In 2011, though the national average was 23.6%, only 8 of 21 medical programs reported having met this target[1].

Crucial to development of an effective rural medical workforce are opportunities to undertake pre-vocational and vocational training in rural areas, consolidating positive experiences gained during medical school and allowing graduates to build lives in rural areas at a time of significant personal and professional development. Currently, the only positive incentive for rural practice during early post-graduate years is the HECS Reimbursement Scheme and expansion of training capacity in rural areas will be essential for capitalising on increased medical graduate numbers.

[1] Commonwealth Department of Health and Ageing Medical Training Review Panel, 15th Report, 2012

Section 19AB restrictions

Section 19AB of the *Health Insurance Act (1973)* places geographic restrictions on the location of practice of Overseas Trained Doctors (OTDs) and Foreign Graduates of Australian Medical Schools (FGAMS) for a period of 10 years following registration, known as the '10 Year Moratorium'.

AMSA believes that the application of Section 19AB restrictions to Australian-trained medical graduates is unnecessary and discourages retention of graduates in the Australian health care system. HWA's workforce modeling indicates that maximal retention of Australian-trained medical graduates will be needed for a sustainable health workforce by 2025, and that Australia is likely to remain dependent on the importation of significant numbers of overseas-trained doctors each year.

Failing exclusion from the Section 19AB restrictions, AMSA believes that the following changes to legislation be made:

- change the definition of FGAMS from residency status at enrolment to residency status at time of registration, to take account of those students who gain permanent residency during medical school;
- halve the length of provider number restrictions to five years, broadly consistent with the recommendations of the Parliamentary Inquiry Report, *Lost in the Labyrinth*; and
- provide more comprehensive advice to potential FGAMS, prior to enrolment, regarding the impact of restrictions on future life and career choices.

Expanding medical training capacity

The rapid and sustained increase in the number of medical students, which has doubled since 2001 to 16,868 in 2012, has placed significant strain on clinical training capacity. Combined with significant and chronic underfunding of medical programs, identified in the *Higher Education Base Funding Review* to be more than $23,500 per Commonwealth-supported place per year, these increases pose a threat to the quality of Australian medical education.

In 2012, there have been significant challenges in identifying and funding sufficient numbers of internships for Australian-trained medical graduates, such that at the time of writing there exists a shortfall of approximately 45 places. Medical graduates cannot practice independently, and are not fully registered, without an internship. HWA's workforce modellying predicts a significant shortfall vocational training places by 2016 and pressure is already evident in the availability of further pre-vocational posts.

AMSA welcomes HWA's work towards nationally-consistent workforce planning, underpinned by robust data modeling and efforts to improve the mechanisms for coordination of the medical training pipeline.

In light of these challenges, AMSA urges that there not be any further expansion in medical student numbers, whether associated with new or existing medical schools, until capacity for further training can be demonstrated. Total numbers of medical students, including full-fee students, must be centrally regulated and the chronic underfunding of medical programs must be alleviated through increased Government 'base funding'.

In order to realize significant public investment and 'convert' medical graduates into independent practitioners, there must exist sufficient capacity at all stages of medical training. Commonwealth programs, such as the Prevocational GP Placements Program, the Specialist Training Program and the recent (one-off) investment in internships in private settings must be maintained and, subject to accreditation to ensure quality, expanded.

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Providing expanded programs for experience in private and non-traditional settings achieves the dual purposes of providing educational exposure to a more broad case-mix than is available exclusively in traditional settings and allows Australian-trained graduates to continue training and serve their communities.

I thank you once again for your work in chairing this important review. Should you wish to further discuss AMSA's feedback, I encourage you to please contact Ms Helen Jentz, AMSA CEO, on (02) 6140 4556 or via ceo@amsa.org.au.

Yours sincerely,

James Churchill
President