Background

The Australian Medical Students' Association (AMSA) is the peak representative body for medical students in Australia.

Analysis by the Medical Deans of Australia and New Zealand (Medical Deans) demonstrates that it costs between $50,727 and $51,149 per year to train a medical student.[i] Currently universities only receive a proportion of this required funding from the Federal Government. Therefore universities must find alternative sources of funding to meet the difference.

Medical Deans state that universities are now required to meet a shortfall in funding of approximately $23,500 per year per medical student to supplement the inadequate base funding provided by the Federal Government. This figure does not take into account unpaid teaching, which comprises a very significant proportion of medical education particularly in the clinical years of each medical program.[i]

Funding arrangements

There are a number of funding arrangements for different medical student places in Australia. Commonwealth supported places include Higher Education Contribution Scheme (HECS) only places, Bonded Medical Places (BMPs), and Rural Bonded Medical Scheme (MRBS) places. There are also full-fee medical student places.

The majority of places available are Commonwealth supported places. In 2010 Commonwealth supported places represented 77% of all medical student places. More specifically 56% of all medical student places were HECS only places, 17% were BMPs and 3% were MRBS places.[ii]

HECS only places are funded by the Federal Government as well as by the student. This arrangement is commonly referred to as a combination of public and private contributions. There are three components to the funding provided for HECS only places: Commonwealth Grant Scheme public base funding, Commonwealth Grant Scheme medical student loading, and student contributions.

Base funding

In Australia the public contribution is via the Commonwealth Grant Scheme and is dependent on which of the eight funding clusters the discipline belongs. The Commonwealth Grant Scheme was introduced in 2005 and considers medicine as a cluster eight course. In 2012 this classification translates to Commonwealth base funding of $20,284 per medical student per year. This contribution is indexed annually according to the Higher Education Indexation Factor (HEIF).[iii]

Medical student loading

In addition to the public base funding contribution via the Commonwealth Grant Scheme, universities also receive a further payment known as 'medical student loading'. This payment is ostensibly for the provision of funds to teaching hospitals that help to deliver medical programs.iv In 2010 this amount was $1,180 per Commonwealth supported student, again indexed from $1,111 per year according to the HEIF and section 5 - 6 of the *Higher Education Support Act 2003.*[v]

Student contributions

The maximum private (i.e student) contribution for a course is defined by the *Higher Education Support Act 2003.* This is indexed annually according to the HEIF. For medicine in 2012, this is a maximum of $9,425.[vi]

Student Contributions

Each medical student contributes 32% of the $30,889 of external funding available annually to a university for their place. The other 68% is provided by the Federal Government under the Commonwealth Grant Scheme, as is detailed above. However the real cost of basic medical education in Australia is much greater than this. Medical Deans approximate that $23,500 per student per year is required in addition to the funds available from the Commonwealth and students.

Australian public contribution to tertiary education is low when compared to other Organisation for Economic Cooperation and Development listed countries. Approximately 76% of the total funding for New Zealand medical students is provided by the New Zealand Government. In Canada, government contribution comprises 82% to 86% of total funding. This equates to contributions ranging from $67,000 to $87,500 per medical student per year. A similar situation exists in the United Kingdom, with government contributions being vastly greater than those provided in Australia.[vii] This impacts the ability of some potential students to participate in basic medical education in Australia.

Equity of access

Universities classified as 'Table A Providers' under the Commonwealth Grant Scheme are not permitted to offer full-fee places to domestic students beginning an undergraduate course.[viii] However post-graduate courses are exempt from this legislation. This permits masters-level courses (such as 'Doctor of Medicine' [MD] programs) to circumvent the ban on domestic undergraduate full-fee places.

The University of Melbourne was the first public Australian university to exploit this loophole to supplement deficient Commonwealth funding with private student contributions. In 2012 its novel MD program will cost students $53,056 per year, with an estimated total cost of $228,678 for the four year course.ix Considering the substantial financial benefits, it is unclear how many other Universities will follow the example of the University of Melbourne and also implement full-fee domestic places in MD programs.

These developments will clearly impact the capacity of some potential students to participate in basic medical education in Australia. In particular this will affect access for students from lower socioeconomic backgrounds as well as Aboriginal and Torres Strait Islander students, for whom increased access was a priority of the Bradley Review of Australian Higher Education and subsequent legislation.[x]

FEE-HELP is a scheme which assists students in payment of their tuition fees if the student is a domestic student and is not receiving any contribution from the Commonwealth for their place (i.e domestic full-fee paying students). However the maximum FEE-HELP available to medical students is $112,134,[xi] which does not cover the cost of studying as a full-fee paying medical student.

Fee deregulation

Full fee places were introduced at Australian Universities in 2003. Following the passage of legislation in 2007, domestic undergraduate full fee places have been progressively phased out,

however, postgraduate full fee places continue to exist. Most current postgraduate students (see figure 6) are in full-fee places with market-set prices.

Entry to medicine is highly competitive. Further deregulation of student contributions to medicine are likely to lead to major increases in course fees. Government investment in higher education has immense benefits to society including, but not limited to, increased productivity, returns from research, labour participation and export income from education services.[xii, xiii]

High student contributions and graduate debt would act as a significant barrier to equity of access to medical programs.[xiv] Furthermore, high levels of graduate debt affect career decisions (often made soon after graduation). Increased graduate debt is associated with an increased tendency for graduates to preference specialties with higher earning capacities rather than electing careers in primary care, which is essential to meet population health needs.[xv, xvi]

International students

Universities may supplement their external income by accepting full-fee paying international students. In 2010 international students comprised 16% of medical students at Australian universities.[ii] Perverse incentives arise from the enrolment of international students to alleviate university funding pressures. These can contribute to exploitation of international students, who are not guaranteed an internship in Australia upon graduation. AMSA addresses some of these issues in its *International Medical Student Internship Policy*.

Increasing student numbers

The issue of inadequate funding for basic medical education is being further exacerbated by recent increases in student numbers. Australia has witnessed the recent introduction of nine new medical schools over the last decade. There will be a predicted 171% increase in the number of medical graduates between 1999 and 2015. This correlates to an increase in graduates from 2,380 in 2009 to 3,794 by 2015.[ii] This growth is placing increasing demands on relatively fixed overheads like infrastructure and clinical training capacity.

Conclusion

The significant discrepancy between base funding and the real cost of basic medical education is placing major strains on the training of future doctors in Australia. Inadequate funding is negatively impacting on infrastructure, teaching resources and clinical training capacity. Inadequate Commonwealth funding threatens the quality of medical education and public safety.

Position Statement

AMSA believes the current discrepancy between Federal Government base funding of medical programs and the actual cost of medical education must be addressed promptly to maintain quality training of medical students.

Policy

AMSA believes that:

1. Funding for basic medical education must be significantly increased to:
   - 1.1 maintain the quality of basic medical education in Australia;
   - 1.2 retain clinical teachers; and
   - 1.3 ensure the provision of adequate infrastructure for medical education.

2. There should not be any increase in medical student numbers without:
    2.1 a significant increase in funding for current medical student places;
    2.2 confirmation of funding for any new medical student places; and
    2.3 strong evidence that current educational quality will be maintained or improved upon.

3. Equity of access to medical education should be protected by:
    3.1 ensuring the real value of medical student contributions to the cost of their education does not increase;
    3.2 prohibiting public Australian universities from offering domestic full-fee medical student places; and
    3.3 increasing the maximum loan available to medical students via FEE-HELP to reflect the total cost of a full-fee medical degree, whilst such places remain in existence.

4. Student contributions to higher education should continue to be regulated by government in all disciplines including medicine.

AMSA calls on the Federal Government to:

1. significantly increase the base funding it provides for each medical student place in Australia;
2. undertake timely reviews of its funding of higher education to ensure it reflects the real cost of basic medical education;
3. extend the current legislative ban on domestic undergraduate full-fee paying places to encompass postgraduate medical programs; and
4. continue to regulate student contributions to higher education funding in all disciplines, including medicine.

AMSA calls on universities to review their funding structures to:
1. sustain the quality of medical education they provide;
2. ensure funding of medical programs takes into consideration any increases in student numbers; and
3. ensure all increases in full-fee international student numbers which aim to address funding discrepancies are done in a responsible and sustainable matter, taking into account the current junior doctor training capacity.

Actions

AMSA Council directs the Executive to:
1. continue to advocate to the Minister for Tertiary Education, Skills, Jobs and Workplace Relations to affect an increase in Commonwealth funding for basic medical education;
2. establish joint efforts with Medical Deans to advocate on the issue of funding for basic medical education;
3. work with the Australian Medical Association in advocating for increases in Commonwealth funding for basic medical education; and
4. assist willing Medical Students' Societies to advocate to Australian universities to ensure funding of medical programs optimises educational quality.

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