Australian Medical Students' Association
Level 1, 39 Brisbane Avenue
Barton, ACT 2600
April 2023

Dear Members of the University Accord Panel,

The Australian Medical Students' Association (AMSA) thanks the government for the opportunity to present the following submission to the Accord regarding the published discussion papers.

As the peak representative body for Australia's future medical workforce of over 18,000 medical students, AMSA has focused this submission on the three themes listed below.

1. The Geographical and Speciality based maldistribution of the health workforce and subsequent health workforce shortage.
2. Increasing accessibility and diversity within medicine.
3. Upholding a high quality of medical education via appropriate and varied placement opportunities for medical students.

AMSA has answered select questions from the discussion paper that highlight the challenges experienced by medical students across the nation and spaces for improvement within the medical education sphere.

Please contact us if your colleagues or yourself would like to discuss the content of this submission in further detail.

Sincerely,
On behalf of the AMSA National Advocacy Team,

[redacted]

Tisshapaa Sivagnanan
AMSA President
President@amsa.org.au

[redacted]

Gabrielle Dewsbury
AMSA Vice President External
Vpe@amsa.org.au

HEAD OFFICE
LEVEL 1
39 BRISBANE AVENUE
BARTON, ACT 2600

POSTAL ADDRESS
PO BOX 6099,
KINGSTON, ACT 2604

ABN
67079 544 513

EMAIL
INFO@AMSA.ORG.AU

WEBSITE
WWW.AMSA.ORG.AU

Challenges and Opportunities for Australia

Q4 Looking from now to 2030 and 2040, what major national challenges and opportunities should Australian higher education be focused on meeting?

One of the greatest challenges facing Australian society today is the evidenced geographical and speciality based maldistribution of doctors across the nation. The present-day lived experience of consumers of the healthcare system and future modelling highlights the concurrent geographical and specialty-based maldistribution of doctors paired with the simultaneous oversupply of doctors. Data forecasting projects an over-supply in areas such as Emergency Medicine and Anaesthetics and undersupply in areas such as Psychiatry, Ophthalmology, and General Practice.

As a result, Australia's remote and rural population continues to be a highly vulnerable population to the growing gaps within the healthcare system, facing inequity in accessing services. Rural Australians are more likely to defer access to healthcare due to cost, significant travel distances, and/or extended wait times.

However, recent times have highlighted the pressures faced by the primary healthcare system of Australia, which are increasingly being felt by not only rural communities but regional and outer metropolitan areas. Modelling has suggested that by 2032, we will have a shortfall of over 10,000 GP's.

The Australian higher education system must strive to implement changes to ensure that community needs are being met.

Q5 How do the current structures of institutions, regulation and funding in higher education help or hinder Australia's ability to meet these challenges? What needs to change?

The Australian medical force is an integral part of the lives of all Australians, facilitating good health by providing high-quality healthcare. However, inadequate coordination between stakeholders and the subsequent implementation of ad hoc strategies in workforce planning, in the absence of quality data to guide decision-making has resulted in discordance and maldistribution of the medical workforce. For instance, the isolated increase in Commonwealth Supported Places in medical education without adequate capacity building over the last two decades has amplified bottlenecks within the medical training pipeline

Evidence-based and longitudinal strategic planning is needed to ensure that the medical education sector is striving to meet population needs. AMSA supports the funding and establishment of a Joint Medical Workforce Planning and Governance body with the authority to advise, direct, or make decisions on the size and

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LEVEL 1
39 BRISBANE AVENUE
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67079 544 513

EMAIL
INFO@AMSA.ORG.AU

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structure of the entirety of the medical workforce pipeline. This will allow medium to long-term planning and resource allocation to align the workforce with demand. Concurrently, the funding of a National Medical Workforce Data Strategy will enable evaluation of the efficacy of training models implemented by medical schools and speciality colleges, better-informing stakeholders via the facilitation of data driven decision making and modelling of workforce planning.

Challenges and opportunities for the higher education system

Q9 How should Australia ensure enough students are studying courses that align with the changing needs of the economy and society?

There is evidence that observing and witnessing individuals with your own background increases your interest in the same fields they work amongst. Role models are essential for people to see themselves doing similar work. Increasing the frequency, breadth and locations of early exposure to medicine and healthcare is essential for diversifying the workforce and reaching population parity for Aboriginal and Torres Strait Islanders, rural and regional communities and those from lower Socioeconomic backgrounds. This not only reduces the inaccessibility but improves the long term, workforce distribution and quality of care

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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. The initial entry examination to enter medicine, is 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. Additionally, tutoring that allows students to 'get a leg up' is provided by external organisations and costs up to $3000 per student - making it seemingly impossible for those from disadvantaged backgrounds to compete for a spot in medicine.

This could be addressed by reviewing the use of entry examinations such as GAMSAT or UCAT and their purpose in ranking students, rather; furthering social stratification. If remaining as an entry requirement, they scholarship programs or discounts for students from disadvantaged backgrounds must coexist. Secondly, universities should have well-known and transparent entry programs and scholarship programs for students from disadvantaged backgrounds

Once students from diverse backgrounds have entered the medical degree, further support needs to be in place to retain them and ensure they are successful throughout their studies. Strategies to support this may include financial support, providing opportunity to undertake parts of or the entirety of their training in rural and regional areas, and ensuring there is access to expensive student equipment such as stethoscopes, manual blood pressure cuffs, scrubs and so on.

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Q12 How should an adequate supply of CSPs be sustained and funded, as population and demand increase?

The rapid increase of CSPs and medical schools is estimated to cause an oversupply of doctors while simultaneously failing to address the geographical and speciality-based nationwide maldistribution of doctors.

While there are many strategies that medical schools could employ to increase student interest in generalism, it is essential that universities are incentivised to implement them. 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.

Additionally, we request that the government refuse to fund any scheme which directly or indirectly increases the number of Australian medical students. Further, to ensure the efficient use of health and education spending, we request that the government refrain from supporting or funding any new medical school proposals unless guided by evidence-based modelling to address workforce needs.

Q13 How could an Accord support cooperation between providers, accreditation bodies, government and industry to ensure graduates have relevant skills for the workforce?

Management of the medical training pipeline currently lacks top-down coordination and data-driven decision-making. Ad hoc implementation of strategies paired with a lack of outcome focussed evaluation are further exacerbating workforce maldistribution, worsening healthcare and economic burden.

The funding and establishment of a Joint Medical Workforce Planning and Governance body with the authority to advise, direct, or make decisions on the size and structure of the entirety of the medical workforce pipeline will allow medium to long-term planning and resource allocation to align the workforce with demand. Concurrently, the funding of a National Medical Workforce Data Strategy will enable evaluation of the efficacy of training models implemented by medical

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LEVEL 1
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schools and speciality colleges, better-informing stakeholders via the facilitation of data driven decision making and modelling of workforce planning

Q14 How should placement arrangements and work-integrated learning (WIL) in higher education change in the decades ahead?

As a minimum standard barriers to quality clinical placements should be identified and appropriately addressed. These barriers include inadequate support, training, and resources for clinicians at teaching hospitals, as well as a lack of proper exposure, supervision, guidance, infrastructure and standardisation across teaching sites

More specifically, continued exposure to primary health care throughout the medical degree is essential to increase medical student interest in a generalist career and for medical education to successfully address community needs. Currently, an overwhelming majority of medical students' time is spent in hospital settings, with one often short GP placement being a make or break exposure to whether or not a student will choose GP as a career.

Increasing the amount of time students spend in general practice, will increase their familiarity with the career opportunities, their awareness of the important role GPs play in our healthcare system, and will enable them to gain access to mentors for further research and study opportunities.

Systemic quality improvements in the execution of General Practice teaching should also be considered, focusing on the emphasis placed on General Practice within the medical curriculum, the depth and breadth of teaching across both pre-clinical and clinical years.It is recognised there may be finite capacity in some general practices, especially in the context of increasing placements in general practice for junior doctors, AMSA believes this can be overcome by increasing incentives for GP Registrars to teach, as well as placing students in GP led community care placements such as in aged care, community mental health, and Aboriginal Medical Services.

Creating Opportunities for all Australians

Q28 What is needed to increase the number of people from under-represented groups applying to and prepared for higher education, both from school and from other pathways?

There is evidence that observing and witnessing individuals with your own background increases your interest in the same fields they work amongst. Role models are essential for people to see themselves doing similar work. Increasing the frequency, breadth and locations of early exposure to medicine and healthcare is essential for diversifying our workforce and reaching population parity for our Aboriginal and Torres Strait Islanders, rural and regional communities and those

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from lower Socioeconomic backgrounds. This not only reduces the inaccessibility but improves the long term, workforce distribution and quality of care.

Q29 What changes in provider practices and offerings are necessary to ensure all potential students can succeed in their chosen area of study?
Q30 How can governments, institutions and employers assist students, widen opportunities and remove barriers to higher education?

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. 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. Additionally, tutoring that allows students to 'get a leg up' is provided by external organisations and costs up to $3000 per student - making it seemingly impossible for those from disadvantaged backgrounds to compete for a spot in medicine.

This could be addressed by reviewing the use of entry examinations such as GAMSAT or UCAT and their purpose in ranking students, rather; furthering social stratification. If remaining as an entry requirement, they should have scholarship programs or discounts for students from disadvantaged backgrounds. Secondly, universities should have well-known and transparent entry programs and scholarship programs for students from disadvantaged backgrounds

Q31 How can the costs of participation, including living expenses, be most effectively alleviated?

The extensive hours of expected study hours and the demand of compulsory placement leaves many medical students time-poor and with an unpredictable time-table. This means many students aren't able to secure or maintain employment and thus a steady income. Compiled with the costs of studying, fuel, equipment and everyday costs, many students are financially stressed. This could be alleviated through strategies such as;

- Subsidised accommodation and transport
- Increased support payments
- Flexible study pathways and options to ensure that people have capacity to support themselves while studying
    - Ensuring recorded lectures are available etc.
- Support through free or subsidised mental and physical healthcare and social services
- Ensuring access to expensive student equipment such as stethoscopes, manual blood pressure cuffs, scrubs etc
- Providing opportunity to undertake parts of or the entirety of their training in rural and regional areas
- Payments to support the pursuit of recreational activities

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Quality and Sustainability

Q39 What reforms are needed to ensure that all students have a quality student experience?

1. Research into optimal educational setting

There is limited literature exploring the teaching capacity of doctors and optimal ratios for medical student clinical education. Little published data exists, especially in the Australian context of student to staff ratios, both ideal and realistic. One publication on teaching suturing skills in 2006 highlighted an optimal ratio of 1 clinician to 4 students.Distorted ratios negatively impact student learning experiences, with fewer individualised learning opportunities. Altered clinician to student ratios, for example in resource-deprived environments, can therefore be challenging environments to develop professional skills.The literature does, however, highlight the importance of students developing clinical skills and competencies with complexity associated with physician lead teaching and communication.

Anecdotally, the number of students on a medical team has continued to increase within Australia. This issue has been exacerbated in the post-COVID era, where staff are moved between wards to mitigate workforce shortages. There is literature documenting that COVID-associated reductions in placement time and clinical opportunities are associated with a personal lack of confidence in students' own skills, stemming from reduced patient exposure and physician clinical teaching time.

2. Standard Setting between Universities

The 'experience based learning' model suggests students exposed to a greater range of situations, with appropriate support and assistance when placed in situations beyond their comfort zone, are better prepared and safer clinicians when entering the workforce. This idea is backed by data associating participation in a greater diversity of clinical settings with increased medical student confidence.Standardising clinical placements to provide all students exposure to this breadth of teaching is necessary to optimise preparation of the next generation of medical professionals.
Student satisfaction differs between Australian universities. However, there is limited literature on the source of these inequalities in student satisfaction within the Australian clinical placement context. Anecdotally, clinical schools often differ in the quality of student support and organisation. Clinical schools also often differ in the level of engagement of clinical educators and number of opportunities for meaningful feedback

Q40 What changes are needed to ensure all students are physically and culturally safe while studying?

1. Free Access to Mental Health First Aid for Medical Students

HEAD OFFICE
LEVEL 1
39 BRISBANE AVENUE
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POSTAL ADDRESS
PO BOX 6099,
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ABN
67079 544 513

EMAIL
INFO@AMSA.ORG.AU

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Medical students are at a higher risk of mental illness and suicide than the general population. Furthermore, medical students are more likely to be approached by colleagues, friends, or family in distressed or pre-distress states. Mental Health First Aid training is invaluable in facilitating early intervention by training students to identify and respond to crisis scenarios in themselves and others.

AMSA commends the government for the $690,000 Mental Health First Aid (MHFA) funding for medical students in 2020-21 to complete the online component of MHFA training. We request the Federal Government provide further funding over 2023-24 and beyond, to ensure this invaluable training is to remain freely available to Australian-based medical students. This is especially important as MHFA training certificates last 3 years, while medical school is between 4 and 6 years, and continual access will ensure MHFA training, and the associated skills, cover the entirety of medical school.

2. Increased access to Cultural Safety training for students and staff in the health sector.

Increasing cultural competence in medical students and staff is essential to creating structures and support systems that ensure that medical students are adequately supported throughout the degree. A paradigm shift in Australian medical curricula to promote strengths-based education and community-led intervention is necessary to develop self-reflexive and culturally competent individuals.

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HEAD OFFICE
LEVEL 1
39 BRISBANE AVENUE
BARTON, ACT 2600

POSTAL ADDRESS
PO BOX 6099,
KINGSTON, ACT 2604

ABN
67079 544 513

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INFO@AMSA.ORG.AU

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