Increased Student Numbers Policy

Background

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

Doctor Shortage and Response

The Australian medical workforce is comprised of Australian-trained doctors and international medical graduates (IMGs). By manipulating the number of each of these, Australia may tailor its workforce size to meet the demand for health services.[1] The creation of new fully-qualified Australian-trained doctors takes 10 to 15 years, and as such there is a significant delay between adjusting the number of medical students and its impact on the workforce numbers. Adjusting the numbers of temporary and permanently migrating doctors represents another way to address workforce numbers, but is beyond the scope of this policy.

In the recent decade, the Commonwealth Government increased medical student numbers to help alleviate a forecasted doctor shortage in urban areas, and a known shortage of doctors rurally.[2] This shortage however was created in part by the Government’s actions of the 1980’s and 1990’s, when the Commonwealth reduced medical student numbers to address an oversupply of doctors.[2] There is evidently a need for careful consideration and planning of medical student numbers.

Quality Clinical Placements

As of 2014 there are 16,837 medical students including domestic and international students.[3] This represents a 56% increase from 2006 numbers, or an additional 6,067 students.[3] The annual number of medical graduates has more-than doubled from 1,503 in 2004, to 3,441 in 2013.[3] Medical student numbers are at an all time high, slated to grow further until 2017.[4] This has serious implications for the quality of medical student training and on the government’s ability to guarantee internships for domestic students.

Quality medical student placements are required to reinforce biomedical science education undertaken in the pre-clinical phase, practice basic clinical skills, and to develop analytical skills.[5, 6] It is difficult to comment on the impact of increased student numbers on the quality of medical education due to a lack of correlative objective measures. There are however concerns about the health system’s ability to provide clinical placements in light of increased numbers.[7]

In 2008, Medical Deans Australia and New Zealand was commissioned by the Department of Health and Ageing to develop a report on the national status of clinical training in light of the increase in student numbers.[8] It found that existing capacity for medical student training in all settings was concerning with particular emphasis on paediatrics, emergency medicine, general practice and psychiatry.[8] It also highlighted a number of barriers to expanding clinical placements, including the availability of suitably trained health professionals to supervise clinical placements and the lack of appropriate infrastructure to support medical education in clinical settings.[8] It made subsequent recommendations to improve clinical placements. A follow-up report to evaluate the current state of clinical education has not been conducted, but medical student numbers have increased further since then.[3, 8]

Regulation of Medical Student Places

The regulation of medical student places is complicated, and is dependent on: the level of the degree, the nationality of the student, and source of funding. The three broad categories are:

- Domestic full-fee paying students
- International full-fee paying students
- Commonwealth Supported Places (Domestic students)
  - Undergraduate students
  - Postgraduate students
Domestic and International full-fee paying students fund the majority of their own medical degree costs. The number of such places available are not regulated by legislation, but are subject to various agreements made between individual universities and the Commonwealth Government.

Commonwealth Supported Places (CSP) are available to Australian and New Zealand students only and are heavily subsidised by the Commonwealth Government [9].

The coordination of the medical workforce, including recommendations on the total number of medical student places, used to be the responsibility of Health Workforce Australia (HWA) before its abolishment. The Department of Health and Ageing are to now manage the essential functions of the HWA, however no reports of a similar nature have yet been released.[10] This national planning is essential for ensuring that graduate doctors are able to advance in their training.

NB: Due to a lack of regulation on the number of domestic full-fee places for postgraduate medical degrees, there is a risk that as medical schools transition from an undergraduate to postgraduate medical degree student numbers may be increased. AMSA however has received assurances from the Commonwealth Department of Industry, Innovation, Science, Research and Tertiary Education that the transfer of existing CSPs from an undergraduate level to a postgraduate masters (MD) level program will only be approved if the University agrees to not enrol any domestic full-fee paying students in the MD program. In addition, existing MD programs were “capped” at their current number of domestic full-fee places.[11]

Internships and postgraduate training
Internships are a necessary part of qualifying as a medical doctor. These are guaranteed for domestic CSP students, but not for full-fee paying domestic or international students. It is therefore imperative that any increase in medical student numbers is coupled with an equivalent increase in the number of internship places available to all students. This is not occurring; in 2014, the National Medical Intern Data Management Working Group advised that the number of Australian medical graduates that would not receive a state or territory intern position in 2015 could be as high as 240.[12]

To ensure that the investment made in training junior doctors is not wasted, it is also necessary that capacity at all stages of the medical training pipeline be increased. This includes the availability of resident medical officer, non-vocational, and vocational positions. Whilst it is prudent to delay increasing capacity in the pipeline until increased numbers arrive, it is important to begin planning for this at the earliest possible stage.

Adjusting medical student numbers is a necessary component of healthcare planning.[1] Doing so, however, has a number of consequences that must be considered and mediated. These include: impacts on the availability and quality of medical student clinical training, the availability and quality of internships, and downstream impacts on the availability of postgraduate positions. Failure to do so could result in a wastage of human resources, and a significant loss on financial investments by the various governments.

It is also important that health-care planning should be nationally coordinated, taking into account the vertical nature of the training pathway. In order to achieve this, it requires strong input from all relevant stakeholders, including but not limited to, the federal and state governments, higher education providers, healthcare providers, and the regulatory bodies of the health sector.

Position Statement
AMSA believes that regulating the total number of medical students in Australia is essential to maintaining quality clinical training, ensuring that graduates are trained to a high standard, and that the total number of medical students should be commensurate with internship, prevocational and vocational training capacity.

Policy
AMSA calls upon:

1. The Federal Government:
   a. To ensure that changes in medical student numbers only occur:
i. within proportion to Australia’s need for doctors;
ii. with extensive prior evaluation and planning to ensure that the educational and clinical resources (including availability of clinical placements) required to provide a high quality of medical education are available;
iii. if adequate funding and infrastructure has been made available to provide enough quality pre-vocational and vocational training places, including internships, in accredited centres.

b. To ensure that any changes to medical student numbers should involve consultation of all stakeholders, including but not limited to: State Governments and their planning bodies, Federal Government and their planning bodies, state-based postgraduate medical councils, Australian Medical Council, Medical Deans Australia and New Zealand, and the AMSA.

c. To develop predictive models of the medical workforce, including net consequences of immigration and emigration of temporary and permanent international medical graduates. This should be used to develop and implement solutions to maintain the quality of education, prior to any planned increase in the number of students, to alleviate any potential bottlenecks for entry into vocational training.

d. To regulate the number of international medical students with consideration to the total number of medical students in Australia.

e. To reestablish an independent body whose purpose is to deliver a national, coordinated approach to health workforce reform, including the development of workforce modelling.

f. Ensure that modifications in medical student numbers occur incrementally to ensure that teaching clinical facilities are able to:
   i. Maintain high quality teaching (both formal and informal);
   ii. Sustain the necessary educational resources, including but not limited to, libraries and IT infrastructure.

g. To, if seeking to increase student numbers, decline proposals to establish new medical schools until the capacity of existing medical schools to host increased numbers are fully explored, particularly if these new medical schools seek to utilise clinical training facilities already offered to students of existing medical schools.

2. Australian Medical Schools to:
   a. Ensure that all Australian medical students have sufficient exposure to an extensive range of medical specialties and clinical settings irrespective of medical student numbers. This is including, but not limited to: public and, where appropriate, private hospitals; rural clinics; community health care facilities; and general practice.

3. All stakeholders in medical education to:
   a. Collaborate to ensure that a sufficient number of appropriate clinical training, intern and further training places are available to students and graduates. Such stakeholders include but are not limited to: Australian medical schools, the Australian Medical Council, and state and federal governments.

References


Policy Details

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