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Committee Secretary  
Senate Education and Employment Committees  
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Dear Committee Secretary

**Re: Higher Education and Research Reform Amendment Bill 2014**

I am writing concerning the above Bill, particularly the Government's decision to deregulate university fees and to reduce the subsidy for Commonwealth Supported Places by an average of 20 per cent, and the potential impact this will have on medicine.

The AMA is concerned about the impact of these policy changes on medicine for a number of reasons. There is good evidence that high fee levels and the prospect of significant debt deter people from lower socio-economic backgrounds from entering university<sup>i</sup>. We also know in relation to medicine that a high level of student debt is an important factor in career choice – driving people towards better remunerated areas of practice and away from less well paid specialties like general practice<sup>iiiiiv</sup>.

One of the strengths of medical education in Australia is diversity in the selection of students, including those from lower socio-economic backgrounds and to this end entry to medical school must continue to be based on merit rather than financial capacity. If we are to deliver a medical workforce that meets community needs, it is also important that we strike the right balance in who is selected for medicine so as to ensure that people from different backgrounds are well represented.

Medicine is a much sought after qualification and there is significant potential under the Government's policy for an explosion in the costs of a medical degree. The University of Sydney, for example, currently offers the Doctor of Medicine program. This is a four-year postgraduate medical degree and, for international students, the current indicative cost is \$66,100 per year of full time study, or \$264,400 over the life of the degree.

Entry to the above course also requires a bachelor level degree with a Bachelor of Medical Science being an obvious choice for students. For an international student the current indicative cost of this program is \$40,400pa or \$121,200 over the life of the degree.

It is not unreasonable to suggest that the same fee structures could be applied to domestic students, particularly for medicine and the courses that are required for entry into graduate medical programs. With high demand for places there is no reason to think that competition will keep fees under control.

Under the Government's deregulated funding model, the subsidy for Commonwealth Supported Places for medical science and medical studies will also be reduced to \$18,067 pa. If the above fee structures were to be adopted for domestic students, this would leave a medical student with a debt of over \$259,000 plus interest once they have completed both degrees. On any measure, this is a significant debt and no matter what upfront loan assistance is provided, it will deter students from low-income backgrounds from entering medicine.

The above level of debt also needs to be considered in the context of the modest salaries earned by doctors in training during their initial years after graduation from medical school. Very little student debt would be repaid during these years and the accumulating interest would be significant, making the task of repayment even more daunting.

The former Health Workforce Australia (HWA) published medical workforce projections through until 2025. While these show that by 2025 the overall medical workforce will be very close to being in balance, there will be geographic shortages as well as shortages in specific specialties. Encouraging doctors to work in these areas and specialties will be much more difficult if they are saddled with high levels of debt, undermining the significant effort that has been made by the Commonwealth to expand doctor numbers as well as attract graduates to work in underserved communities and specialties.

The Higher Education Base Funding Review: Final Report highlighted the urgent need for further investment in primary medical education. It identified medicine as a discipline that was under funded, both in terms of the resourcing required and in comparison with the funding provided internationally for medical schools. This reflects the very high costs of clinical placements, and above average teaching and learning costs, with the costs of teaching and scholarship alone exceeding the base funding received.

The Report also identified that students from low SES backgrounds are under-represented in Australian higher education and are particularly under-represented in medicine. Based on international comparisons and the available costing information, the Panel considered that the base funding rate for medicine should be increased significantly. The Review made the case for additional Commonwealth funding and highlighted to us the dangers of passing more costs on to students.

It remains the AMA's strong position that the Commonwealth should be providing additional support for primary medical education, not less. We do not see fee deregulation as a solution to funding problems, particularly because of the significant issues that we have outlined above.

The Government has flagged a willingness to negotiate its reforms through the Senate. If there is to be a compromise on fee deregulation, then robust protections must be put in place to prevent an explosion in the costs of degrees and to avoid the types of impacts we have highlighted. In relation to medicine, we would urge the consideration of a percentage cap on course fees, linked to an appropriate benchmark such as the subsidy for Commonwealth Supported Places.

This type of option was contemplated in the Regulatory Impact Statement (RIS) accompanying the Bill, although it was rejected. We do not agree with the conclusions reached by the RIS, which did not have sufficient regard for the operation of the cap on places for domestic medical students and the distorting effect that this cap will have on fees under the Government's model. We also support the retention of existing indexation arrangements for HELP debts, based on CPI movements.

In the absence of meaningful change, the AMA believes the reforms as they stand should be opposed.

Yours sincerely

A/Prof Brian Owler  
**President**

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<sup>i</sup> Callender C, Jackson J. Does the fear of debt deter students from higher education? J Social Policy. 2005;34(4):509-40.

<sup>ii</sup> Grayson MS, Newton DA, Thompson LF. Payback time: The associations of debt and income with medical student career choice. Med Educ. 2012;46(10):983-91.

<sup>iii</sup> Moore J, Gale J, Dew K, Simmers D. Student debt amongst junior doctors in new zealand; part 2: Effects on intentions and workforce. N Z Med J. 2006;119(1229):21-8.

<sup>iv</sup> Sivey P, Scott A, Witt J, Joyce C, Humphreys J. Junior doctors' preferences for specialty choice. J Health Econ. 2012;31(6):813-23.