AUSTRALIAN MEDICAL STUDENTS' ASSOCIATION

Submission of the Australian Medical Students' Association (AMSA) to the Senate Select Committee into the Abbott Government's Budget Cuts

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Senator Richard Di Natale
Chair
Senate Select Committee into the Abbott Government's Budget Cuts
PO Box 6100
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Dear Senator Di Natale,

The Australian Medical Students' Association (AMSA) is the peak representative body for over 17 000 medical students in Australia. AMSA connects, informs and represents students studying at each of Australia's 20 medical schools. Furthermore, AMSA believes that all communities have the right to the best attainable health, and accordingly seeks to advocate on issues that may impact health outcomes.

AMSA recognises the importance of ensuring that government expenditure is efficient and effective. We are concerned, however, that the 2014 Federal Budget has delivered changes that will ultimately have a negative impact upon the accessibility of both education and healthcare in Australia.

This submission will seek to highlight some of these negative impacts. In particular, we would like to address the following points in the terms of reference of the committee:

1. The impact of the budget on young people and students; and
2. The impact of the budget on households

In our submission, we will separate our major concerns into the following three domains:

1. Higher education reform
2. The introduction of a GP co-payment
3. The impact of abolishing GPET, PGPPP and HWA on medical training

Higher Education reform

The proposed reforms to higher education in the budget, including a decrease in the Commonwealth contribution to higher education, deregulation of university fees and an increase to the interest rate charged on HECS loans, have the potential to reduce equity of access to education. The Bradley Review established that prospective university students from low socioeconomic backgrounds and rural and remote backgrounds in particular already face barriers to accessing tertiary studies [1]. Given there is evidence from the United Kingdom that debt in and of itself is sufficient to deter low socioeconomic groups from higher education [2], it is our fear that this situation will worsen if the reforms are passed.

As a representative body for medical students, we would particularly like to focus on the impact of these proposed reforms on medicine. Here, this issue takes on health workforce implications, as medical education is the first step in producing a future cohort of doctors who, ideally, will meet Australia's lingering health workforce needs.

It is reasonable to predict that university course fees for medicine would rise disproportionately to other courses if fees were deregulated. The demand for medical courses is very high, and moreover the supply of CSP places is capped (for good reason, as the number of medical students nationwide should be matched to the number of available internships and postgraduate training places). This cap does mean that medicine does not operate in a free market. The Grattan Institute predicted, shortly following the budget, that fees for medicine could rise in excess of $37,000 per year [3]. Currently, international full-fee paying students at, for example, the University of Sydney, pay in excess of $60,000 per year for their course fees.

This would undoubtedly deter students from rural and remote, lower socioeconomic, Aboriginal and Torres Strait Islander, and outer metropolitan backgrounds. The Mason Review has shown that one of the key factors in building a future rural health workforce is to recruit students from these backgrounds [4]. If such students are deterred from medicine the health workforce maldistribution would be set to worsen. Many of the students needed by the community would likely pursue other less expensive careers.

There are also consequences further down the medical training pipeline. Evidence from overseas [5, 6], and some evidence from Australia [7], suggests that high graduate debt drives doctors towards more lucrative specialties, and away from general practice. This would also be an unwelcome shift, given Australia currently needs to turn its focus towards general practice.

Ultimately, these higher education reforms would have unintended consequences for the health of households, as well as for opportunity of access to education for young people. These consequences must be mitigated.

The GP co-payment

The government's proposed $7 co-payment has been opposed by a large number of organisations that have a public health interest, including the Australian Medical Association and the Royal Australasian College of General Practitioners. AMSA believes the $7 co-payment will have a significant impact on the health and wellbeing of households around the country, by marking the end to universal health coverage in Australia.

AMSA takes great pride in Australia's history of universal health coverage. This is one of the pillars of Australia's healthcare system. There is evidence to suggest that providing universal health coverage improves the health indicators of a country [8]. Access to healthcare should be equitable and affordable. In terms of equity, AMSA believes all people should have access to a full range of health services, at a quality that will uphold their health and wellbeing. In terms of affordability, the healthcare system must not impose significant financial risk upon those whose circumstances make this risk a source for potential hardship.

AMSA acknowledges that a universal health care system must also be financially sustainable. The GP co-payment threatens what should be the foundation of an efficient and sustainable healthcare system: primary care. AMSA places great value in the training of the future generation of general practitioners, as we recognise that these general practitioners are what the community needs to meet the demands of an increased chronic disease burden and ageing population. Training general practitioners will be futile, however, if the government moves away from easy access to general practice. General practitioners must build strong long-term relationships with patients in order to properly manage the multifactorial burden of chronic disease that may exist – the chance of developing such relationships is impaired if patients are deterred from visiting their GP.

The co-payment deters patients from seeing their GP for vaccinations. The co-payment deters patients from seeing their GP for regular check-ups of chronic yet often asymptomatic conditions like diabetes, hypertension and hypercholesterolaemia. The co-payment particularly erects barriers to the execution of preventive health activities. The application of the co-payment to investigations ordered by a GP, for example blood tests, further deters patients from undertaking due diligence in their own healthcare. These deterrents are nonsensical given, when it comes to healthcare, the patient does not typically have the requisite knowledge to determine whether their consultation is necessary or not.

Evidence from the RAND Corporation suggests that free healthcare systems demonstrate improved health outcomes in areas such as hypertension, vision and dental health [9]. These benefits are lost when a co-payment is added, but the cost saving is minimal [9]. In a study from the United States, increasing primary care co-payments significantly deterred people over the age of 65 from visiting their primary care practitioners, but the costs were essentially transferred to higher inpatient hospital costs [10].

The GP co-payment also threatens the viability of some practices that deal with the particularly vulnerable. For example, practices that bulk-bill Aboriginal and Torres Strait Islander patients provide an invaluable service to a section of the population that historically has experienced poorer health compared to the rest of the country. If these practices choose to waive the co-payment, they will nonetheless have to pay the government its due. Some practices cannot absorb what is essentially a significantly increased level of taxation, and will potentially have to stop offering their services. This would be a great loss to equity and affordability of healthcare for Australia's most vulnerable.

Impact on medical training

The budget will also have consequences for medical training. The number of medical graduates Australia is producing has more than doubled over the last decade. This increase was triggered by fears of an impending doctor shortage, but unfortunately the job was only left half done. Without an internship, and subsequent postgraduate training positions, these graduates cannot become the independently practicing doctors the community needs. In recent years, the number of internships available to medical graduates in Australia has been less than the number of Australian-trained applicants. This has meant that not all Australia-trained applicants could continue their training in Australia, if they wished to. Losing these students overseas is a waste of taxpayer investment, and nonsensical given Health Workforce Australia's *Health Workforce 2025* report suggests Australia has an over-reliance on overseas trained doctors. In future years the problem is set to peak in the postgraduate training years, potentially leaving some doctors unemployed in the midst of their training.

A number of changes in the budget have potentially magnified this situation.

Firstly, the abolition of the Prevocational General Practice Placements Program (PGPPP), for reasons of expense, has resulted in a reduction in the total number of internships offered in some states. This has particularly affected South Australia, where PGPPP placements were used as a key rotation in many existing internships. PGPPP was also the only program by which prevocational trainees could gain experience in rural general practice before choosing their specialty, and so is a great loss to the integrated rural training pathway espoused by the Mason Review.

Secondly, the abolition of General Practice Education and Training (GPET), the government agency which oversaw PGPPP, will have further flow-on effects. In this submission, we have already discussed the importance of general practice in the context of the $7 co-payment. General practice sits right at the core of Australia's future health workforce solutions, but abolishing GPET means a body that is well placed to coordinate and oversee the development of a future general practice workforce is removed.

Finally, the abolition of Health Workforce Australia (HWA) itself, with its functions moved into the Department of Health, threatens to be a setback to medical training. HWA has, over the years, provided robust descriptions of the current and future medical workforce landscape. It was also the body that oversaw the creation of the National Medical Training

Advisory Network (NMTAN), which was responsible for developing a National Training Plan that would aim to resolve many of Australia's long-term health workforce issues. It is AMSA's fear that these projects may stall at a critical juncture as this transition is managed. HWA was also a body that was particularly effective at bringing all stakeholders – from both States and Commonwealth – together to discuss and resolve these difficult issues. AMSA hopes that this function is not lost through the abolition of HWA.

Conclusion

The government's budget cuts have the potential to lead to significant flow-on effects for communities. In summary, some of the key areas under threat are:

- Equity of access to education, particularly for degrees that are likely to have greatly elevated fees, like medicine
- The appeal of general practice as a career for junior doctors who may, in the future, be straddled with large amounts of debt
- Universal health coverage in Australia
- General practice training, particularly for junior doctors
- The availability of sufficient internships to employ the medical graduates Australia's health system desperately needs to retain

As the future doctors of Australia, it is AMSA's view that these threats will undermine Australia's future health care system, and as such should be carefully re-evaluated.

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