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Update on a pandemic: junior doctor debt in New Zealand

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Four and a half years ago, I wrote an editorial for this journal discussing original research that surveyed medical student debt at New Zealand medical schools.[1] In this issue of the *Journal*, I have the dubious honour of editorialising further research that surveys student debt amongst New Zealand junior doctors.[2,3]

In 2001, I likened the relatively new phenomenon of medical student debt to a novel disease-process taking hold in New Zealand. Four years on, the new breed of medical graduates is exhibiting the sequelae of infection with this disease. The survey reveals that first-year house officers have an average debt of $65,000; with 10% owing more than $100,000.[2] In addition, those graduates with higher debt levels are more stressed by their loan, and experience more difficulty gaining additional finance from (for example) commercial banks.[2] Those with higher debts are also more likely to find their student loan debt influencing intentions to have children.[2] These are the palpable and unpleasant personal costs of lumbering medical students with the cost of their education.

The second paper from the survey reveals that 80% of respondents intend to spend the bulk of their careers in New Zealand.[3] This statistic almost sounds positive until one realises that the reciprocal is also true: 20% of our graduates intend to emigrate. Surely this is an unacceptable rate of attrition. The survey also documents that doctors with higher debt are more likely to consider their debt level and the financial opportunities available to them, when they decide whether or not to leave New Zealand.[3] The same is true when doctors contemplate choice of specialty.[3]

This survey therefore vindicates the fearful forecasts made years earlier. Our medical graduates are indeed lumbered by the cost of paying for their education, and the greater the millstone the greater the effect on their decisions about the future.

By documenting these findings, the survey also inadvertently underlines its own importance as an information gathering tool, providing much needed data to back-up anecdotal evidence. Consideration must be given to undertaking similar surveys on a regular basis so that the shape and direction of our graduating medical classes can be monitored in perpetuity. The Medical Council of New Zealand's annual workforce survey would be the ideal vehicle to continue such monitoring. I hope the Council gives due consideration to fulfilling this role.

Of further concern is the apparent mismatch between what our graduates 'want to be' and what we 'need them to be'. A quarter of respondents to this survey want to be surgeons, and only 10% want to be general practitioners.[3] In previous studies of medical students, this mismatch in career intentions was tempered by the fact that medical students' career intentions are subject to the passage of time and accumulation of experiences before they manifest as actual decisions about career pathways. The respondents in this survey, however, are first-year house officers, some of whom will already be registered trainees on the Basic Surgical Training program, so a mismatch at this stage is that much more concerning. The specific lack of interest

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in general practice as a career has been previously documented[4] and is perhaps the most out of kilter—foreshadowing an impending general practitioner workforce crisis.

Clearly the development of the medical workforce is an incredibly complicated and multi-faceted scenario. Many factors are involved in shaping individuals' career choices, and many of these factors will not be reversible. What these two papers clearly document, however, is that within the morass of competing influences there is a component—medical student debt—that has at least some influence on individuals' preferences, and is reversible.

The present Government will point to several steps undertaken recently that will hopefully have some effect in attenuating the accumulation of medical student debt. These steps include the inflation of the trainee intern grant from $16,000 to $26,000 per annum for final year students; the institution of *Step-Up Scholarships* that are available to those students who already qualify for the student allowance, and provide a significant subsidy to tuition fees; and the yet to be implemented policy of making all student loans interest free (whilst resident in New Zealand).

Though it is important to acknowledge these policies as progress, and to acknowledge that the full impact of these policies will not be reflected in present data, there are also policy failures to take into account. Reduction, or at least stabilisation, of medical student fees is clearly a fundamental tenet in any policy to address medical student debt. Unfortunately, tuition fees at both medical schools increased 10% in each of the last 2 years—this situation was made possible by the universities successfully applying for exemptions from the Government's fee-capping rules. As usual, positive change is incremental, and it is a case of two steps forward, one step backwards. The reality for the average medical student graduating last November is that they will have benefited from the increase to the trainee intern grant, but probably did not qualify for a *Step-Up Scholarship*, and were stung by the hike in tuition fees.

An example of how not to do things is close at hand. Across the Tasman in Australia we have seen the introduction and subsequent expansion of domestic full-fee-paying medical students.[5] Australian public universities are now taking, alongside publicly subsidised medical students, a cohort of exclusively privately funded students, who are required to pay the A$200,000 tuition fee for their degree. Clearly, students graduating with that kind of student debt will be forced to act according to financial, not philanthropic, incentives. This two-tiered system also mounts a strong challenge to the principle of equal access to education. There will clearly be students who qualify for unfunded places on the basis of academic merit, but will be unable to attend due to personal financial constraints. Their places will be taken by people further down the list who have the financial wherewithal to undertake the massive investment in their education. This is not a system we should contemplate for New Zealand.

A further burgeoning medical workforce problem not elucidated by the current survey is the advent of a prolific locum house-officer market in New Zealand. Junior doctors are invited to "live the lifestyle" in locum agency advertising promising "top rates".[6] The accompanying photo depicts a group of scantily-clad young people cavorting on a beach—not a stethoscope in sight!

At this stage, an assessment of the influence the locum doctor market in New Zealand is purely speculative. Clearly, locum arrangements do allow hospitals to fill vacancies

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at short notice with experienced doctors. For the doctors themselves the pay is very competitive (especially it would seem for those with large student debt), and the flexibility is obviously an attraction for some individuals. Having a large proportion of the junior doctor workforce engaged in such employment practice is probably inefficient, however, as they are expensive for DHBs, and most locum doctors are not engaged in a vocational training pathway. Furthermore, when one hears of contracted junior doctors using annual leave or rostered days off to locum in other parts of the country, one has to question their commitment to work-life balance and maintaining safe practice.

The challenge is to provide permanent (though flexible) and well-remunerated training positions for house surgeons and registrars in our hospitals and communities. The importance of a healthy work-life balance for this new generation of doctors should not be overlooked. And finally, as the papers published in this issue of the *Journal* attest, any steps taken to lower medical graduate debt will help doctors stay in New Zealand and make decisions about their future that align with our needs as a nation.

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