Policy Document

Domestic Full Fee Places (2024)

Executive Summary

The cost of medical education in Australia is a topic of intense debate, with the funding options available to students significantly affecting the accessibility and feasibility of medical training. The cost of Domestic Full Fee Paying places currently far exceeds the HELP loan limit that is available to domestic students to delay the paying of their tuition fees. The reality of this funding arrangement is discussed from multiple perspectives in this policy paper, encompassing student considerations, structural disadvantages, the HELP loan system, and future health workforce needs. The paper demonstrates the harmful links that exist as a result of unequal opportunity in medical programs, connecting structural advantages enabled by Domestic Full Fee Paying positions with the development and distribution of a future health workforce that is failing to meet the needs of the Australian community.

Policy Points

AMSA calls upon:

1. The Australian Federal Government to:
    a. Implement an equitable funding program for medical education in Australia by:
        i. Allocating funding to replace all currently enrolled Domestic Full Fee Paying places in all Australian Medical Council accredited medical programs with Commonwealth Supported Positions;
        ii. Enacting legislation restricting the accreditation of medical programs that provide DFFP places in medical programs, without reducing the overall number of medical school places available to domestic students;
    b. In the interim, assist those in Domestic Full Fee Paying positions by:
        i. Establishing legislation placing a cap on the tuition fees able to be charged to students at an equivalent figure to the combined student and Commonwealth Grant Scheme contribution of Commonwealth Support Places;
        ii. Removing the HELP limit currently applied to students;
        iii. Establishing legislation limiting the number of Domestic Full Fee Paying places in medical programs to ensure parity between graduate and internship numbers;

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c. Promote, communicate and collaborate with medical institutions and all levels of government in regards to;
    i. Aligning graduate outcomes with Australia's future health workforce needs;
    ii. Ensure equitable access to medical education.

2. Australian Universities to:
    a. Implement an equitable funding program for medical education in Australia by;
        i. Ceasing any further enrolment of Domestic Full Fee Paying places in all Australian Universities without reducing the overall number of medical school places available to domestic students;
        ii. In the interim, setting DFFP students tuition fees at an equivalent figure to the combined student and Commonwealth Grant Scheme contribution of Commonwealth Support Places;
    b. Disclose annually the number and type of medical school enrolments at their respective institutions and any fees and costs associated with that enrolment;
    c. Regularly conduct research and publish findings on the cost of medical degrees and training across Australian medical schools, with a focus on:
        i. Student characteristics and intersectional factors, such as First Nations status, socioeconomic background, rurality, LGBTQIASB+ identity, disability status, and other equity groups;
        ii. Enhancing transparency in medical school revenue and expenditure, including how funds are allocated and utilised;
    d. Promote, communicate and collaborate with other medical institutions and all levels of government in regards to;
        i. Aligning graduate outcomes with Australia's future health workforce needs;
        ii. Promote equitable access to medical education;

3. Australian Medical Association and MDANZ to:
    a. Collaborate with all stakeholders to implement an equitable funding program for medical education in Australia by:
        i. Petitioning the Australian Federal Government to allocate funding for transitioning all currently enrolled Domestic Full Fee Paying places in all Australian Medical Council accredited medical programs with Government Subsidised Positions;
    b. Innovate and conduct research on themes including:

i. Incentives that promote medical students and doctors to choose in-need specialties;
ii. Incentives that promote medical students and doctors to study and work in areas with relatively unmet or underserved healthcare provision;
iii. The impact of funding on the allocation of medical school fee places;

c. Promote, communicate and collaborate with other medical institutions and all levels of government in regards to:
i. Aligning graduate outcomes with Australia's future health workforce needs;
ii. Promoting equitable access to medical education;

4. The Australian Medical Council to:
a. Work with Australian Universities and the Australian Federal Government to:
i. Enact legislative changes that transition DFFP students to Commonwealth Support Positions through an updated accreditation process that recognises these changes;
b. Promote, communicate and collaborate with other medical institutions and all levels of government in regards to;
i. Aligning graduate outcomes with Australia's future health workforce needs;
ii. Promoting equitable access to medical education;

Background

Student Costs in Attending Australian Medical Schools

On 1 January 1974, the Whitlam government, in order to make tertiary education more accessible to the working and middle class, introduced free university education for all Australians. Within three years, this led to a 25% increase in higher education enrolment rates and was particularly impactful for women deciding to attend university. [1] However, due to the continued increase of enrollment over the next decade and the demand placed on infrastructure and teaching staff, Australian political parties consensually agreed that fees should be reintroduced to sustain university education. As a result, in 1989, the Higher Education Contribution Scheme (HECS) was introduced by the Australian government as part of the Dawkins Revolution in tertiary education. The scheme aimed to shift the cost of higher education from the government to students and their families. Under HECS, students were required to contribute to the cost of their education, but they could defer payment until they started earning above a certain income threshold. Initially, HECS fees were relatively modest, and students could repay their contributions through the tax system once their income reached a certain level. Under this scheme, all students were charged an annual fee of $1,800, for which payment could be deferred and repaid when the student's income eventually reached a certain threshold. [1]]

The HECS system has survived to the current day, albeit with a number of changes since its introduction in 1989. In 1996, the Howard government increased HECS fees by an average of 40%, as well as introduced a tiered system. [2] Tiers were established by which students were charged based on the expected income of their job following university; for example, medicine students were charged more than nursing students. Following this, the *Higher Education Support Act 2003* came into effect, allowing universities to increase HECS fees by up to 25%, which was widely implemented. [3] In 2005, alongside HECS-HELP, FEE-HELP was introduced to assist students in paying for fee-paying courses. Unlike HECS-HELP, which was for Commonwealth-supported places, FEE-HELP covered full-fee-paying students

Domestic Full-Fee Paying (DFFP) places are a type of non-commonwealth-supported enrollment in Australian universities, where domestic students (Australian citizens or permanent residents) pay the full cost of their tuition without receiving any government subsidies. DFFP were introduced for medical degrees in 2005. [4] In 2008, a change to the *Higher Education Support Act 2003 (Cth)* banned DFFP for undergraduate degrees at public universities.[4] To better align the number of medical students with workforce demand, the Australian Government has proposed controlling full-fee paying enrollments. [5] However, postgraduate degrees and private universities remain outside of these regulations. Since 2009, many universities have shifted to offering master's programs in medicine, allowing them

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to enrol DFFPs, despite opposition from groups like the Australian Medical Association (AMA), who argue this creates inequities in access and contributes to an oversupply of medical graduates. Nevertheless, DFFP enrollment has risen from 1.6% in 2005 to 9.6% in 2024. [6]

In 2017, there were major changes proposed as federal university funding was decreased by 2.5% and HECS fees were increased by an average of 7.5%, however these changes did not end up being implemented. [7] Also, in 2017, the income at which HECS repayments would begin was reduced from $55,000 to $42,000. The decreased funding of universities by the Government has made tertiary education less accessible to Australians, and has placed a significant financial burden on individuals wishing to receive a tertiary education. [8] This shift has taken place despite evidence suggesting that having a more educated society, particularly in healthcare, will lead to a more economically and socially prosperous society. [9,10] In 2015, CSP medical students in Australia finished their degree with an average of $36,000 - $63,000 worth of debt prior to accounting for added financial difficulties from cost of living pressures, which has undoubtedly increased over the last decade with increases to medical program fees, and a limit placed on HECS/HELP loan amounts. [11]

The number of CSPs in medical schools are set and restricted within funding agreements between the Commonwealth and the university. In 2024, CSP represented 73.8% of all medical student places, with non-Commonwealth supported places comprising 26.2% of medical student places, with 16.6% international and 9.6% DFFP. [6] Currently, the number of CSPs are distributed between primary medical schools and are intended as a means to address geographic shortages of medical graduates and doctors, and any other needs identified by the Ministers and departments of health and education. Further subsidies are available through Bonded Medical Places, Australian Defence Force (ADF) scholarships and other state-based rural scholarships. These require a return of service in areas of need or government allocation.

Position	2024	
	Number	%
CSP	9823	52.2%
BMP	4066	21.6%
International FFP	3129	16.6%
Domestic FFP	1814	9.6%
Total	18 832	100%

Table 1. 2024 Medical School Enrolments by Funding Allocation - Medical Deans Australia and New Zealand

The Commonwealth Grant Scheme (CGS) subsidies tertiary tuition costs via taxpayer contributions, with the extent of funding dependent upon the 'funding cluster' as determined by the Australian government. [12] Medicine is considered to be a 'cluster four' course, thus translating into Commonwealth base funding of $30,395 per medical student per year in 2024, which is indexed annually according to the Higher Education Indexation Factor (HEIF). [13,14] In 2024, medical students paid $ 12,720 for each of the 4 to 6 years of medical tuition via the HECS-HELP scheme (Higher Education Contribution Scheme, Higher Education Loan Program). Whilst these figures represent government funding for Commonwealth Supported Places (CSPs), the 2008 Amendment prohibits public universities receiving Commonwealth grants from offering full-fee places for undergraduates but does not apply to postgraduate courses. [4] There is the possibility for international students who gain permanent residency or Australian citizenship during their degree to switch to a government-subsidised position at the university's discretion. However, many universities often choose not to offer these government subsidised positions, instead transitioning these students to domestic full-fee payments places. [15] As a result, students in full-fee places often pay significantly more than this for their tuition, up to $85,088 per year in 2024. [16]

In Australia, Bond University and Macquarie University are the only institutions that offer exclusively full-fee medical places. Bond University, a private institution, provides DFFPs in its undergraduate program. [17] Macquarie University, a public university, introduced a new postgraduate medical program of only DFFPs in 2018, despite significant opposition. Macquarie is seen as running a de facto private medical program while posing as a public institution, potentially worsening the already strained medical training pipeline. [17] Since Bond and Macquarie Universities private medical programs are independent of government funding, they are not subject to current government regulations. This limits the Department of Health's ability to control the number of medical places according to workforce needs. These programs can also set their own tuition fees, with costs reaching over $419,440 at Bond University and $67,980 annually at Macquarie, totalling around $271,920 for the entire degree. [18,19] These fees far exceed the available FEE-HELP loan cap for DFFP medical places.

The DFFP Effect: Making Medicine Even More Inequitable?

Significant financial barriers to medical training exist across the entire entry, education and training process for prospective future doctors in Australia. In the admission process, the most pressing issue is a growing inequity in access to medical school for socioeconomically disadvantaged students. The cost of aptitude tests required for admission (UCAT, GAMSAT) has been increasing steadily over the

years. In 2024, the UCAT costs $325 to register for, while the GAMSAT costs $549. [20,21] Adding on the additional burden of private preparatory material, it imposes inaccessibility for financially disadvantaged students. Further costs are often incurred for psychometric tests required for admission to some programs. The total cost for students preparing for the UMAT in 2018 was estimated at a median explicit cost of AU$1,063 per applicant and a median implicit cost of AU$2,586 per applicant, AU$803 and AU$2,326 more than the advertised 2018 cost of the UMAT: AU$260, respectively. [22]

Australians are struggling with an increasing cost of study and debt, with identified equity groups being disproportionately impacted. Current equity-specific funding for higher education is limited in scope, focusing only on undergraduate studies for public universities, leaving postgraduate studies and other providers underfunded. The current scale of funding has also been shown to be inadequate to sufficiently increase higher education participation and attainment of students from identified equity groups. [23] Furthermore, once students have reached medical school, they are often "priced out" of clinical placements and certain further specialisation routes, increasing inequity and a lack of diversity in the medical workforce. [24,25] Further detailed discussion of the costs facing medical students and prospective doctors is available in the AMSA policy *Student Income Support (2023).*

Ideally, in an equitably accessible medical education system, newly commencing medical students would represent Australia's population on multiple measures, such as socioeconomic status, rurality, family income, culturally and linguistically diverse status, and First Nations status. However, medical schools are often dominated by students of high socio-economic status, which is a universal problem. [26] Students studying medicine at private universities under DFFPs are more likely to be of high socio-economic status, given the associated costs of the degree. Puddey et al. discovered that medical students who were living in the 8 lower socio-economic deciles prior to or upon entry to medical school are more likely to work within the lower 8 socio-economic deciles 5 or more years following graduation ($p<0.001$). [26] Hence, recruiting medical students from diverse socioeconomic backgrounds will likely increase the distribution of the medical workforce to where they are most needed, increasing supply of doctors in currently underserved areas. [26]

A fundamental issue in discussing the impact of DFFP is the lack of complete, consistent and detailed data on the issue. At present, there is only limited data available on students' socioeconomic position, rurality, relative disadvantage status and whether students come from minority backgrounds. [28] The only relatively complete data, showing data on Medical students from all Australian Medical Schools is from 2018. This data only reports on whether students are from a Rural

background or identify as First Nations. [28] More recent data are available from MDANZ, who publish annual reports on commencing medical students. However, the data is an incomplete picture of Australian Medical students, as rural background data on the 137 domestic students from Bond is not included, and First Nations status is not stratified by university or domestic fee type. [27]

Being from a rural background or identifying as First Nations are identified equity groups and correlate strongly with a more disadvantaged decile as per the Socio-Economic Indexes for Areas (SEIFA) Index of Relative Socio-Economic Advantage and Disadvantage (IRSAD). [23,29,30] As the only complete data available is from 2018, conclusions about the socioeconomic position, structural disadvantage and the relative advantage or disadvantage of students can only be made by correlating how a rural background or identifying as First Nations relates to social disadvantage and socioeconomic position. This can provide insight into the overall characteristics of students who can enrol in Medicine and, specifically, domestic full-fee payment placements, as can be seen in Figure 1 and Tables 2, and 3. [27]

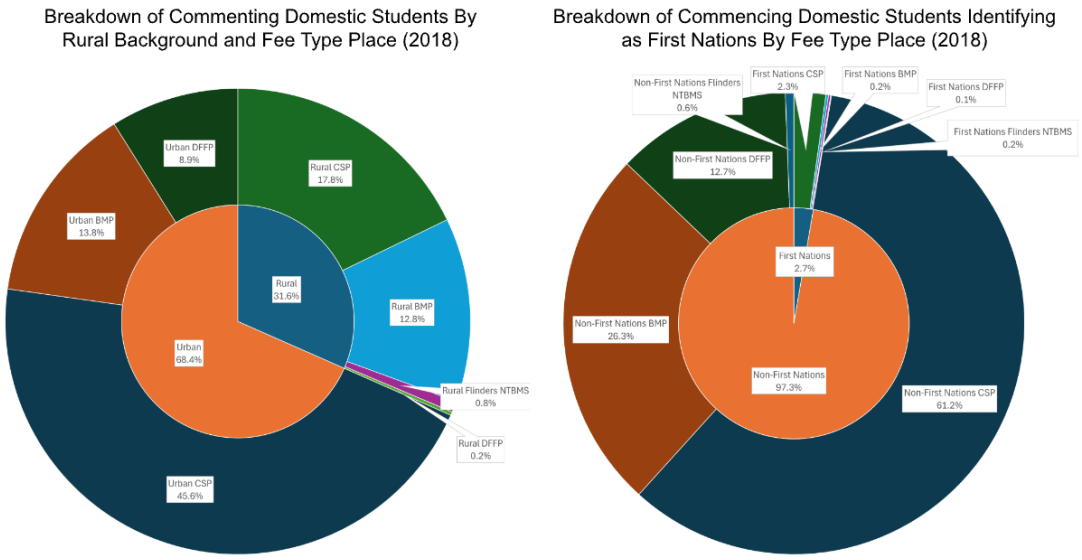

Figure 1: Breakdown of Commencing Domestic Students in 2018 by Student Fee Type and Identified Equity Group[a]

Table 1: Rural Background Status of Commencing Domestic Medical Students in 2018, by Student Fee Type (2018)[a]

	n of CSP (%)	n of BMP (%)	n of Flinders NTBMS (%)	n of Overall Government Subsidised Positions (%)	n of DFFP (%)	Total (%)
Rural Background	579 (28.1%)	415 (48.0%)	25 (100%)	1019 (34.5%)	8 (2.7%)	1002 (31.1%)
Non-Rural Background	1483 (71.9%)	450 (52.0%)	0 (0%)	1933 (65.5)	290 (97.3%)	2223 (68.9%)

Table 2: Commencing domestic medical students identifying as First Nations by student fee type (2018)[a]

	n of CSP (%)	n of BMP (%)	n of Flinders NTBMS (%)	n of Overall Government Subsidised Positions (%)	n of DFFP (%)	Total (%)
First Nations	75 (3.6%)	6 (0.7%)	5 (20%)	86 (2.9%)	2 (0.7%)	88 (2.7%)
Non-First Nations	1990 (96.4%)	855 (99.3%)	20 (80%)	2865 (97.1%)	299 (99.3%)	3164 (97.3%)

a: Note that rurality data was missing for two DFFP students commencing at James Cook and one student at UNSW. Similarly, note that DFFP data are available for Monash, Notre Dame Fremantle, Queensland, and WSU, when the universities do not offer DFFP. This is likely due to students who were offered international full-fee payment placements before becoming citizens and recognised as domestic students, who therefore become DFFP students instead of starting on a government-subsidised fee type.

It is important to compare this data to the 2018 estimate of First Nations people in Australia (933,207 people, which represents 3.7% of the total Australian population). [31] Similarly, the rural data should be compared to the 2016 census data on the rural population (approximately 2.86 million people living in a remote area other than major cities of Australia, representing 29.9% of the total Australian Population). [32].

It is interesting to note that while the overall number of students in medical cohorts is roughly representative of Australia's population of people from a rural background and people who are First Nations, identified equity groups are accurately represented or over-represented in the government-subsidised positions and disproportionately under-represented in the DFFP positions (Tables 2 and 3). Indeed, some of these relationships can be found to have a strong correlation strength and significance, as seen in Figure 2, where the proportion of DFFP places in a school was found to have a strong inverse correlation to the proportion of students coming from a rural background (R2 = 0.9425, p = 0.0292). Meanwhile, the proportion of government-subsidised positions within a school had a weaker but still significant correlation to the proportion of medical students from a rural background (R2 = 0.2212, p = 0.0314). No significant correlations were found in the First Nations dataset, perhaps due to the size of the dataset (81 students identifying as First Nations) not having enough statistical power.

The accurate reflection of the population in the Government-subsidised positions is likely due to the Government's allocation of subsidised positions to students of rural backgrounds and many universities having direct entry pathway options for students who identify as First Nations, part of an equity drive, attempting to achieve a cohort of medical students and a future medical workforce which represent Australia. [33]

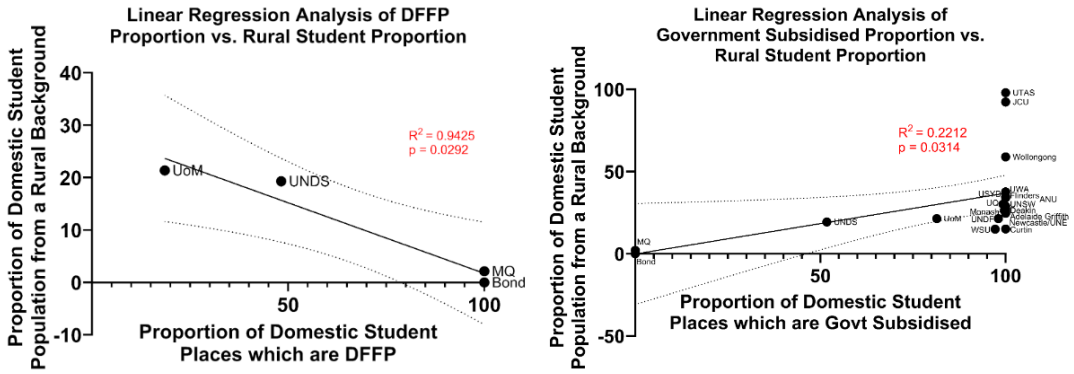

Figure 2: Regression Analyses on the Impact of Fee Types on the Proportion of Commencing Rural Students (2018)

a: Note that rurality data was missing for two DFFP students commencing at James Cook and one student at UNSW. Similarly, note that DFFP data are available for Monash, Notre Dame Fremantle, Queensland, and WSU, when the universities do not offer DFFP. This is likely due to students who were offered international full-fee payment placements before becoming citizens and recognised as domestic students, who therefore become DFFP students instead of starting on a government-subsidised fee type.

This data shows that there are capable students from identified equity groups who have the capacity to study Medicine, only when certain barriers are removed. Figure 2 shows that Universities with more DFFP positions are more likely to be less

equitable and less representative of the Australian population. This is likely due to the excessive cost of entering and studying medicine being even greater in these DFFP positions, further limiting individuals from low socioeconomic statuses or identified equity groups from studying at these Medical schools. Currently, in 2024, there are a total of 1,815 DFFP students studying Medicine in Australia. [6] Based on the discussed data, it is highly likely that these 1,815 DFFP students are more likely to be from affluent, urban backgrounds and not First Nations peoples, putting further strain on the government to increase equity allocations to government-subsidised positions to ensure our future medical workforce accurately represents the diversity of Australia.

Impacts on the Health Workforce

Internships and Prevocational Training

The current Commonwealth legislation concerning the regulation of CSP and medical program funding means that some Australian public universities choose to supplement the income they receive from the Commonwealth by extracting higher fees from DFFP and international students. A more detailed discussion of this topic is available in the AMSA policy *Funding of Medical Programs (2024).* This is of relevance now more than ever given the government's planned caps on international students, which could lead Universities to further increase the number of DFFP students across all degrees. [34]

The two universities offering private post-graduate medical degrees (Bond and Macquarie University) are exempt from funding restrictions which regulate CSP, meaning the number of DFFPs is uncapped. [35] This is of concern as it not only places a significant financial strain on medical students, but it also may impact the availability of internship positions after medical school completion. The 2017 Report on the National Audit of Applications and Acceptances found a net excess of 393 graduates from all fee classes compared to the number of internships available. [35] Although the number of internships available has now changed from 2017, if the number of DFFP increases due to international student capping or alternative reasons, it may increase pressure on the number of internships available. Indeed ongoing financial strains on public universities present today potentially encouraging them to increase DFFP, the shortage in positions available for Australian medical graduates may worsen. [36] In support of this, the most recent and available government data shows an estimated surplus of at least 4,494 doctors by 2030 due to the addition of 6 medical schools over the last two decades. [37] Further detailed discussion of the issues regarding internship numbers and allocation can be found in the AMSA policy *Internships and Prevocational Framework* (2023).

In turn, shortages of doctors in rural, remote and regional areas are evident and likely to continue. [38] In response to this, in 2021, the Department of Education, Skills and Employment drew a pool of CSP from existing university allocations with the plan of redistributing them amongst universities every three years. [38] The medical programs that the redistributed CSP are allocated to aim to serve the needs of rural and regional communities; however, the schools losing these positions are required to internally address their loss of revenue. [38] It is postulated that this could be compensated by increasing the number of DFFPs and international places. In fact, the number of DFFPs has increased from 1223 in 2018 to 1815 in 2024. [6] Should any increase in international tuition fees deter students from studying in Australia or recent caps on the numbers of international students planned by the government, universities may be compelled to increase the number of DFFPs, thereby increasing the number of local graduates and potentially putting further strain on the availability of quality internships.

Despite this, the 2022 Group of Eight Medical Workforce Roundtable recommended that an increase of 1,000 CSPs is required over four years to secure the 2030 Australian Medical Workforce needs. [39] The Roundtable, however, did not consider a similar large-scale increase of DFFP students, nor did it consider that these positions could more equitably be filled by CSP as well. There is currently no mechanism to ensure the availability of internships is compatible with the number of medical graduates. [39]

All Australian States and Territories have guaranteed internships for graduating domestic CSP students. [40] States including Victoria, Queensland and New South Wales have extended this guarantee to DFFP students and students with New Zealand citizenship or Australian permanent residency. [41] However, without Federal government oversight, individual State and Territory health systems control the number of internships and may also prioritise graduates by fee class. Additionally, Federal government pressure may exist to prioritise internships for domestic graduates in order to repay HECS-HELP loans in the shortest time frame, to alleviate graduate concerns and to alleviate the current $74 billion HELP debt crisis. [42] South Australia is the only state or territory that prioritises CSP graduates (priority 1.2) over DFFPs (priority 1.3) for graduates from a South Australian university. [43] A prioritisation of CSP over DFFP graduates for internships is inequitable and is not supported.

General Practitioner Shortages

Not only does the financial burden of DFFP influence the demographics of students entering medical schools, but it also has implications for the vocational direction of the graduates that schools produce. This is of particular concern now, given that there is a predicted undersupply of 10,600 general practitioners (GP) by 2031-32. [44] Despite this, there is controversy over the potential oversupply of approximately 7,000 doctors by 2030. [38] This demonstrates a significant disconnect between the supply of doctors and the later distribution of specialists within the health workforce, to the detriment of primary care practitioner numbers and locations.

DFFP students are both more likely to choose a top five income specialty as their first preference and less likely to choose an in-need specialty by a greater magnitude than their international full-fee-paying counterparts.[45] Relevantly, there is a predicted shortage of over 1000 medical specialist training positions by 2030. [38] Additionally, high medical student debt levels have been found to drive medical students towards choosing higher paying specialties, in an attempt to make up for the significant burden of their debt on their future. [46] Reducing the likelihood of these students practicing in areas of most need across Australia. Hence, if the number of DFFPs continues to increase, it will exacerbate the current surplus of prevocational doctors aiming to complete particular specialist training programs with insufficient places to accommodate them. [6]

Rural Doctor Shortages

There is a shortage of doctors working in rural Australia. [31] Data from the Australian Institute of Health and Welfare suggests that approximately 20% of Australians living in remote areas do not have access to a GP nearby, while 60% do not have access to specialists. [47] There are large discrepancies between the need for doctors to work rurally and the number of doctors working rurally. DFFP students are less likely to choose to work in more rural areas and, hence, less likely to resolve the shortage of rural doctors currently facing Australia. [45]

A study by Kwan et al. found 2 years of rural clinical experience to be a strong predictor in longer-term rural practice in GPs and specialist doctors. [48] Furthermore, medical graduates with a rural background are more likely to start their career in, move to and remain working in rural practice. [49,50] CSP contracts regulate the number of rural rotations completed and rural-origin intake; however, these initiatives do not exist in private DFFP medical programs. [51,52] The lack of rural exposure and placements combined with the lower numbers of students from rural backgrounds studying at private medical schools may further exacerbate the undersupply of rural doctors.

Moreover, DFFP students are 3.36 times more likely to preference practising in urban settings than their CSP counterparts ($p<0.001$), indicating that increasing the number of DFFP is unlikely to be successful in addressing medical workforce maldistribution. [11] The resultant maldistribution is also reflected in the number of international medical students (currently 45%) practising rurally and remotely despite them being half as likely to be practising rurally 15 years after medical school regardless of Distribution Priority initiatives. [52,53] When international medical graduates leave rural practice it further exacerbates the undersupply and maldistribution of doctors seen in rural Australia. Thus, initiatives must be taken to increase the desire for medical students and graduates to practise rurally. Initiatives could include both public and private medical schools commiting to rural education and placements in order to ensure exposure with the hope of enhancing the motivation of medical students to work in the rural medical sector.

9.5% of all Australian medical school places are DFFPs. Currently, DFFPs make up a minimal proportion of the medical student population, however, if the numbers continue to rise it could have drastic effects on the medical workforce distribution, internship availability and diversity within the medical field.

A Safe and Representative Health Workforce

The impact of DFFP on the current medical school cohort, and the makeup of the future health workforce can only be understood in the context of the already discussed barriers and challenges to diversity and the delivery of safe healthcare in Australia. An intersectional approach to this process can facilitate the critical examination of the relationship between systems of power, privilege, and advantage in medicine. Intersectionality was first theorised as a method of understanding and detailing systems of oppression, analysing the interplay between gender and race, and more recently has been used to shed light on the multiple marginalised identities that can compound forms of discrimination that cannot be conceptualised solely in their constituent components. [54]

Historically, Australian doctors have been drawn largely from privileged classes in society, especially those with financial, racial and social privilege. [55] While recent efforts to improve diversity within medical schools have attempted to address these trends, there remains significant progress to be made, and which cannot be separated from existing medical school funding structures. [31] The continued allocation of DFFP is anathema to efforts to address inequality in medical school providing places exclusively to those who can afford the exorbitant fees. Given Australia's long and enduring history with institutional racism and inequality in healthcare, the persistence of unequal structures like DFFP challenges further

progress to be made, especially the inclusion and growth of marginalised communities within the health workforce. [57–60]

Many medical students are diverse in positionality and lived experience, occupying varied intersectional identities. [56,59] These students are significantly more likely to have lived experience of systemic oppression such as ongoing colonisation, racism, sexuality, sex characteristic and/or gender-based oppression, ableism, classism and xenophobia. [54] This intersectionality not only impacts entry into medical school, but also presents challenges and barriers to participation, engagement, opportunities and sustainment during study medical school, and are directly related to financial considerations and the funding of medical programs, especially DFFP. [59,60] Each of these groups of people will experience disadvantage differently, and the scope of this paper pertains only to a limited discussion of some of the challenges. Nonetheless, that a significant proportion of medical student places are offered only to those with the financial privilege required to afford them, prohibits the entry of more students with these diverse lived experiences. When these groups are systematically excluded from participation in medical education, it inhibits the safe practice of healthcare by diverse clinicians who are able to engage with their patients from a position of lived experience, providing culturally safe, well informed and driven by social justice. [53–55,61–63]

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Policy Details:

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