

## Policy Document

# Vocational Training Pathways

### Position Statement

There is currently a bottleneck to doctors entering vocational training pathways in specialist medical colleges, and this is driven by a number of complex factors. There is also a mismatch in available training positions, where training position numbers often do not correlate to the needs of the Australian community, both in respect to location and speciality area.

AMSA therefore believes that:

1. There is a need for increased coordination between the Australian Government, Australian specialist medical colleges and key stakeholders to determine training position numbers based on projected workforce and population needs;
2. A redistribution of specialty training positions with regard to location is required to create a sustainable medical workforce that is able to serve our increasingly ageing population, the difficulties imposed by geographical barriers and complexities of the healthcare system;
3. It is necessary to increase the number of vocational training positions to match the number of medical school graduates entering the workforce and decrease a reliance on unaccredited registrar positions;
4. There is a need for greater transparency with regard to the reasoning for the substantial costs within vocational training pathways, including but not limited to, application costs, exam fees and annual membership and training fees;
5. Locally-trained international medical students should be provided with greater clarity in a timely fashion with respect to their eligibility to join advanced training programs;
6. Flexible training is essential to ensure that there is equal opportunity for a diverse cohort of clinicians, as well as safeguarding the wellbeing of trainees;
7. Due to the insufficient numbers of training positions, there is inflated competition leading to increased levels of professional credentials required for selection into specialty programs;
8. Students should be aware of the importance of generalist training pathways and their role as an alternative to sub-specialisation.

### Policy

AMSA calls upon:

1. The Commonwealth Government of Australia, State and Territory Governments to:
  - a. Collaborate with hospitals and health systems to accommodate the number of specialty training places to sufficiently meet areas of current and future predicted health workforce and community shortages, supported by health care funding where appropriate;
  - b. Involve medical student representatives on Vocational Training review panels and the Medical Workforce Reform Advisory Committee;

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- c. Provide increased funding for positions that promote flexible pathways; and
  - d. Continue to support training positions in extended settings through the Speciality Training Program.
2. Australian Specialist Medical Colleges to:
- a. Increase transparency in published application guides in terms of:
    - i. Assessment procedures;
    - ii. Appeals processes;
    - iii. Accreditation;
    - iv. Reasoning for the costs to be paid by doctors enrolled in training pathways;
    - v. Number of successful applicants each year in each state or territory in the context of how many people applied; and
    - vi. Application and approval process for flexible training positions;
  - b. Minimise costs where appropriate to reduce financial strain of trainees and improve the accessibility of vocational training programs.
  - c. Publish the number of positions available each year and how these numbers are regulated;
  - d. Conduct selection, accreditation, and assessment with integration of the 20 recommendations for best-practice specialty medical college governance from the Australian Competition and Consumer Commission (ACCC);
  - e. Develop and implement academic assessment processes of trainees that grade individual merit as a clinician;
  - f. Better inform locally-trained international medical students regarding their eligibility to enrol in advanced training programs;
  - g. Simplify the administrative process and reducing barriers to applying for flexible medical training;
  - h. Innovate and implement entry and examination options for those experiencing financial hardship;
  - i. Allow extra time to complete training if the trainee is part-time or has experienced extenuating circumstances or illness, or taken parental leave;
  - j. Create training positions that address communities' accessibility to health services, by working alongside State and Territory governments to reduce the maldistribution of trainees; and
  - k. Create training positions that address the bottleneck of junior doctors working to enter specialist training programs with respect to projected future workforce demands.
3. Hospitals and Health Services to:
- a. Work in collaboration with State and Territory health departments and medical colleges to establish appropriate flexible medical training positions that maintain the delivery of high quality healthcare, and provide high quality clinical training; and
  - b. Create training positions that better account for the needs of the community.
4. The Committee of Presidents of Medical Colleges to:
- a. Investigate the equity of the application processes for each Speciality Medical College.
5. Medical education and training providers to:
- a. Provide support for career development and counselling in line with health workforce projections and community needs.

As the peak representative body for Australia's 17,000 medical students, Australian Medical Students' Association (AMSA) advocates on the best possible career opportunities for Australian medical students, in conjunction with building a sustainable medical workforce to serve the community. The training pathways that face medical students after they graduate are a critical issue for the future of AMSA's members, as such, AMSA is uniquely placed to advocate on this issue. Robust and scholastically rigorous vocational training pathways are fundamental to building a quality specialist medical workforce, however this must be balanced with fair and reasonable accessibility to career progression for doctors seeking to specialise, and with equitable distribution of specialist training positions to meet community demand.

## **Applicant and Vocational Training**

### Application Process

Following completion of a medical degree at university and the pre-vocational intern year, doctors who choose to become specialists must gain entry into an accredited training program [1, 2]. These training pathways are accredited by the Australian Medical Council (AMC) and regulated by specialist colleges who dictate the number of places, the requirements for study, as well as the curriculum and assessment [2]. Most training pathways require additional clinical experience in the intended field of study in addition to other aspects of medicine [3, 4]. All training pathways are open to Australian and New Zealand citizens or permanent residents with registration and who have completed their training within these countries. International medical graduates have the ability to apply with additional training and assessment, dictated by the college [3-16].

The application process differs between colleges, however there are two broad mechanisms in which training pathways operate. Within RACP, RACMA, ANZCA, RANZCOG, RCPA, RANZCR and RANZCP, applicants apply to a hospital or health service to obtain an accredited training position before registering with the college [7, 9, 10, 13-16]. The other mechanism consists of applying directly to the college, with the college determining the state or service in which the applicant will work. This is applicable to RACGP, RACS, ACD and RANZCO [3, 5, 8, 11]. ACEM and CICM have a lack of clarity in their application guides [4, 12]. An overview of the application process for each college is in Appendix 1; often including an application and an interview with some colleges requiring a prerequisite exam [3, 5, 8, 13, 14].

The cost of training can be a barrier to commencement and completion of a specialty training program. With non-refundable application fees reaching up to \$1600, annual college and membership fees as high as \$5486, and individual exams costing up to \$8495. Going through a training program can impose a significant financial strain upon an applicant or trainee [8,11]. There is limited transparency into the rationale for these costs, and how this money is distributed. CICM provides a clear breakdown of their exam costs and could be used as a good example for other speciality medical colleges publishing assessment fees. [4]. Some colleges have financial aid programs for those experiencing financial hardship [5]. A full breakdown of fees and transparency for each college can be found in Appendix 1.

Some exams work on standard deviation to determine who is to pass each year, contributing to a high failure and resit rates [11]. This is a point of controversy because, although Australian Specialist Medical Colleges may be admitting trainees at the magnitude recommended by external parties like the Department of Health, they may be unreasonably failing many trainees resulting in a remaining deficit in workforce to meet community demand [17].

### Number of Training Positions & Requirements

Currently, there is a national disparity between the number of vocational training positions and the workforce shortage dictated by community need, despite Australia having a very high number of doctors per capita (average at 3.5 per 1000 population) [18]. While there were concerns that a nationwide shortage of specialists would arise as a result of the ageing medical workforce, the record growth in medical graduate numbers surpassing the Organisation for Economic Development (OECD) average, have tipped the balance towards a 'bottleneck' in certain vocational training programs [19]. Thus, there is a need to increase the number of vocational training positions to match the number of medical school graduates entering the workforce and meet health workforce needs. This is in the context of projected shortages in various specialties including: obstetrics and gynaecology, ophthalmology, anatomical pathology, psychiatry, diagnostic radiology, and radiation oncology, as well as significant geographic maldistribution particularly in rural and regional areas [20]. Appendix 1 provides further detail into the net workforce projections in 2030 across differing medical specialties based on a "no change" scenario in which current policy settings remain fixed [21].

However, the determinants of workforce medical "supply" remain contentious, with the number of training positions for each vocational training pathway largely determined by the respective speciality colleges. Furthermore, the majority of speciality colleges (with the exception of RACS, ACD, RANZCOG and RACP), provide limited information regarding the number of training applications versus number of available posts and level of competition for each speciality area [3-16]. Thus, there is a need for increased transparency with relation to how the number of vocational training positions are determined by each speciality college.

As a result of "poorly coordinated" medical training pathways, Health Workforce Australia (HWA) and the Australian Medical Association (AMA) have called on the Commonwealth, States and Territories to reform the coordination of vocational training pathways to address the mismatch of training positions across differing geographical and specialty areas to meet future community requirements [18, 20]. Despite the projected shortfall of vocational training positions for Australian medical students, some training places are unfilled, with continued reliance on overseas-trained doctors to address areas that are underserved [22]. This highlights the urgent need to develop actionable and sustainable policy that prioritises redistribution of training positions for Australian junior doctors to rectify areas of saturation and depletion. This is essential to not only serve our increasingly aging population and changes in patient expectations, but to support the diversification of the medical workforce, differing needs across geographic locations, and changes in health-care models [23, 24]. Without changes to the distribution of medical training positions, the ongoing imbalance between the number of junior doctors wanting a training position, Australia's specialist workforce, and community requirements will continue to worsen [25]. Cooperation of the government, medical schools, specialist colleges and the profession is necessary to address the forecasted training crisis [23, 24].

### Flexibility in Training

The increasingly diverse age demographic and composition of junior doctors, as well as the shift in attitudes towards doctor wellbeing, has necessitated the requirement to offer flexible training positions [26]. With shortages of specialists still being reported in rural and remote areas, part-time training programs or other alternative training pathways may help to encourage a redistribution of health workforce positions and jobs in areas that lack access to specialist care.

In 2010, it was reported that just 0.3% of surgical trainees pursue a part-time arranged specialty training program, compared to the 33.8% who expressed interest in training arrangements below a full-time equivalency [27].

The Royal Australasian College of Physicians has similarly identified a need to develop flexible training pathways, establishing in 2017, a policy that facilitates the accreditation and approval of alternative pathways that allows training to be undertaken on a part-time basis, through interrupted training or by undertaking a less than full-time position [28].

The National Medical Training Advisory Network reported that in 2018, there were a total of 2,045 part-time advanced trainees, which made up approximately 13.1% of all advanced trainees across specialties [29]. Yet, the proportion of advanced trainees on a part-time schedule in 2018 decreased by 19% compared to 2015, when 16.2% of advanced trainees pursued part-time training [30]. Additionally, for popular specialty programs, such as adult medicine and surgery, only 3.6% and 0.76% respectively were reported as part-time trainees in 2018, emphasising still the lack of flexible training pathways in some disciplines [29, 31].

#### Overseas trained doctors and foreign graduates

International students currently studying at Australian medical schools make up 16.4% of the student population [32]. Despite this, publicly available information on their eligibility for vocational training is very limited.

A number of colleges simply stipulate that candidates have “current registration as a medical practitioner in Australia” or “be a registered medical practitioner” [10, 15]. Prospective general practice applicants that do not have permanent residency in Australia appear to be eligible for entry to the general practice training program [33].

Whilst surgical training candidates are informed that they must have permanent residency in either Australia or New Zealand, this level of detail appears to be uncommon amongst other colleges [34].

#### Unaccredited Registrar Roles

Another area of contention is the abundance of unaccredited registrars, who are doctors not enrolled in a formal training position, but are expected to perform duties at the standard of an accredited registrar [35]. These unaccredited positions predominate in highly competitive specialties (e.g plastic surgery) and are viewed by doctors in training as a gateway into a specialty before applying or reapplying to a vocational training program [35]. These positions have been recognised as a significant source of inefficiency in postgraduate medical training, given the questionable developmental value, lack of formal training, appraisal or supervision [36]. Most concerningly, there are no restrictions on the number of years that doctors can work as an unaccredited registrar, and crucially there is no guarantee of career progression [35]. For doctors with unaccredited registrar positions, the lack of perceived dignity or protection of a formal training position, coupled with elongated training times can increase vulnerability, risk of exploitation and the effects of bullying [35]. Furthermore, specialist medical colleges have limited influence over the management of unaccredited registrars, whose protection falls under their hospitals’ human resources department [35]. One widely publicised example that demonstrates the clear need to reform unaccredited registrars, has been Dr Yumiko Kadota's ordeal as an unaccredited plastic and reconstructive surgery registrar at Bankstown Hospital in Sydney, which provided harrowing insights into the unsafe and unreasonable working conditions of doctors in these positions [35]. Therefore, if a hospital has a clinical need for an unaccredited registrar, then there is also a moral imperative to create an accredited training position to not only fill that clinical need, but ensure welfare and career progression for junior doctors in training [35].

There have been three high profile incidents of units within NSW hospitals losing their accreditation to train registrars due to bullying and harassment within the workplace [37-39]. These were St George and Westmead Hospitals being stripped of their accreditation by CICM to train intensive care physicians as well as the Royal Prince Alfred losing their accreditation from RACS to train cardiothoracic surgeons [37-39]. When a unit loses their accreditation, no registrars on training programs are assigned

to that hospital in the next rotation. This leaves the units short staffed and in reliance of more junior trainees and unaccredited registrars filling the gap in the workforce. This has a negative impact on patient care and further perpetuates unsafe working conditions for unaccredited registrars. Stripping a unit of accreditation forces them to acknowledge and change the culture of the workplace without jeopardising the training of registrars within the training program, however puts vulnerable junior doctors at increased risk.

## Vocational Training and the Community

### Funding models

Imbalances within the medical workforce, including those between rural and metropolitan settings, between various specialities, and between generalists and specialists, are heavily influenced by funding and delivery of training [21]. Medical training takes place in the context of service delivery, and its design must address the needs of the community [40].

The distribution of speciality trainee positions is determined with the mutual consent of Colleges and state governments [40]. As vocational training is traditionally funded through registrar positions in public hospitals, their service requirements influence the number of trainees in each speciality, which can exceed requirements for consultant specialists. It can also overshadow the needs of community and private health sectors [21].

Ultimately, the community bears the consequences of these health workforce imbalances [25]. The maldistribution of adequately trained specialists impedes appropriate healthcare access, leading to long wait times, under utilisation of trained individuals and poor productivity of health services [41].

There are a number of government initiatives seeking to rectify health workforce imbalances. The Specialist Training Program (STP), a Commonwealth grant support program, is designed to address the maldistribution of vocational training positions. It seeks to enhance healthcare sector's capacity to provide high quality training opportunities by extending speciality training into new "expanded" settings, such as private hospitals, specialists' rooms, clinics and day surgeries, and Aboriginal Community Controlled Health Services (ACCHS). These settings aim to create new training positions that complement public hospitals without burdening the public health system. It also addresses the poor distribution of specialist services in rural and regional areas while providing trainees with a bigger range of patient presentations that better encompass the full 'patient journey' [21].

It does this through three complementary streams delivered through thirteen specialist colleges [43]. The three-pronged approach is:

1. Specialist Training Placements and Support, which contribute to 900 positions throughout all specialist medical colleges through salary contribution, rural loading, and administration support. It also contributes to developing training infrastructure and project funding.
2. Integrated Rural Training Pipeline to establish 100 rural training positions by 2018, 26 regional training hubs, and the Rural Doctor Training Innovation Fund. The latter aims to provide rurally based interns opportunity to train in rural primary care settings
3. Tasmanian project, which supports the employment of supervisors and trainees in the Tasmanian public health system.

However, this initiative only accounts for 5-7% of all specialist training positions, with the remainder funded by states and territories [21]. Hence, it cannot, and was not designed to, remedy all imbalances. It also does not support existing training positions funded through another source, post fellowship training or general practice

training [21, 42]. Furthermore, only 90.4% of all STP funded positions in new expanded settings were filled in 2014, resulting in colleges holding collective surpluses in funding. This is likely due to insufficient numbers of trainees accepting positions, the prescriptive nature of the program in deciding appropriate training settings, and the lack of rural/private settings on college reserve lists [21].

The Emergency Medicine Program is another government initiative seeking to increase the health system's capacity to train emergency department specialists and train rural generalists in settings where emergency medicine specialists are less available. In addition to extending emergency medicine training into new settings, it aims to reduce waiting times for patients and improve the quality of rural emergency services [21]. It includes three initiatives:

1. The Emergency Training Program, which financially supports training posts for doctors wishing to become fellows of ACEM.
2. Emergency Medicine Education and Training (EMET) Program, which enables ACEM fellows to deliver training in emergency departments to specialist trainees and other emergency department staff, particularly in rural and regional settings.
3. Emergency Department Private Sector Clinical Supervisor Program, which contributes to the employment of clinical training supervisors or staff specialist training coordinators in private hospitals.

This program sought to fund 129 training positions, however the forecast oversupply of ACEM fellows has led to propositions by the college to reduce funded positions [21].

#### Regulation of training places

The role of Specialist Training Colleges in regulation of postgraduate medical education is the subject of ongoing criticism. There is the potential for serious conflicts of interest if the regulatory body deciding how many doctors enter a certain field of medicine, to serve the community, is run by the same Fellows that stand to financially benefit from a lower supply of these physicians. Specialist colleges, run by Fellows of the college, having the power to restrict the number of trainees and therefore competition of their business is a financial conflict of interest. Specialist colleges have the power to restrict the number of training places, as a means of inflating the profit they can return as specialists [43].

There are a number of stages where conflicts of interest, for the consumer and the prospective trainee, can come into effect. These include but are not limited to:

- Determination of the number of trainees that will be accepted in a given year;
- Selection of the types of people that enter the speciality training positions (diversity);
- Objectivity and procedure of the selection process;
- Areas in which the trainees are permitted to train (metropolitan, districts of workforce shortage, and regional and rural Australia).

The Australian Competition and Consumer Commission (ACCC) has investigated Specialist Training Colleges in the past for potential breaches of the Trade Practices Act (1974). A notable example of this is the investigation of the Royal Australasian College of Surgeons (RACS) during the late 1990s and early 2000s, where the ACCC determined that [44]:

*“... the public detriment from the College's processes is likely to be significant, in particular because: surgeons involved in the College's training and assessment processes possess a conflict of interest; College fellows have the means to restrict entry into surgical practice, and; interested parties, and in particular state and territory governments, had raised sufficient concerns*

*about the College to justify a finding of significant public detriment. The Commission was not satisfied that the public benefit generated by the College's application outweighed the public detriment."*

In this investigation, the ACCC uncovered a number of actions by RACS to restrict entry to their surgical training pathways, which was determined to be detrimental to the health outcomes of the Australian community, including but not limited to [44]:

- The Australian Orthopaedic Association, which administers orthopaedic surgical training on behalf of RACS, ignored the target number of orthopaedic trainees set forth by the then-called Australian Medical Workforce Advisory Committee at the Department of Health;
- Creating concealed barriers to overseas-trained doctors wishing to enter training pathways and practice in Australia, for example but not limited to: not sending applicant information booklets when formally requested, interviews not being held, or multiple interviews being held that imposed prohibitive costs on international applicants.

This behaviour also poses a reputational risk to the Specialist Training Colleges, and to the wider Australian medical profession. If the medical profession is perceived to be regulating the number of trainees for the financial benefit of established Fellows, as opposed to focusing on the needs of the Australian community, this erodes the trust the community has in health sector self-governance and medical practice. Although it is paramount that the best possible candidates are selected for medical specialist training, in order to provide high-quality trainees to the medical workforce, the restriction on these training positions should not come at the detriment of access to timely and financially-competitive specialist care for the Australian community [45].

In 2005 the ACCC conducted a review of the selection, accreditation, and assessment processes of a number of specialty medical colleges. Four key principles were identified that were fundamental to the RACS authorisation: transparency, accountability, procedural fairness, and stakeholder participation. In the 2005 review, the ACCC outlined 20 broad recommendations to the colleges in improving their best-practice governance [17].

The Department of Health Medical Workforce Reform Advisory Committee is the main platform of multilateral discussion of this issue by the key stakeholders, including AMSA. Interaction between the different parties about this issue should aim to be transparent, clearly communicated, centralised, and multilateral - with the primary goals of best serving the healthcare needs of the Australian community and providing doctors with fair and reasonably-accessible pathways to train in their desired medical speciality.

## **Looking into the Future**

### Alternative models of training for applicants

There have been several documented instances where non-traditional training models have been successfully implemented. Accepted models include the job-sharing model (two trainees share a training position) and part-time flexible model including supernumerary positions (6 months on, 6 months off) [31].

A 2001 study of job-sharing in paediatric training showed favourable results for participants. Part-time trainees report that the benefits of job-sharing were decreased tiredness, increased enthusiasm for work and the ability to strike a balance between training and other aspects of life [46]. In addition, they felt that training part-time had no impact on patient care or the quality of their training [46]. However, this system was flawed in that co-workers had to adapt to working with two people responsible for the same tasks [46].



In 2007, the Royal Adelaide Hospital created a stand-alone 0.5 full-time equivalent position, which has proved to be popular with surgical trainees across Australia. Despite concerns that part-time training would impair learning outcomes, the introduction of this position has shown the trainees to be just as capable as their full-time counterparts [25].

These results are supported by an American study of Internal Medicine part-time trainees. Faculty evaluations found that part-time residents scored significantly higher with respect to humanistic skills [47].

In spite of these results, there is limited information about educational outcomes for these trainees and more research is needed to ascertain the effect that flexibility may have on training experience.

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## Policy Details

<b>Name:</b>	Vocational Training Pathways
<b>Category:</b>	E – Medical Workforce
<b>History:</b>	Reviewed, Council 1, 2020

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Adopted, Council 2, 2016

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## Appendix

**Appendix 1:** College breakdown of the cost of fees, application process and transparency of the training program in regards to reasoning for costs and number of placements. The table also includes estimated employment trends.

*This information is accurate as of February 12, 2020 and is subject to change.*

College	Fees	Transparency	Application Process	Eligibility	Department Workforce Forecast for 2030 (21)*	Link to application guide
<b>RACGP</b> (The Royal Australian College of General Practitioners)	<b>Pre-application exam fee</b> \$725 for CAAKT <b>Annual fee</b> \$490/year <b>Exam fees</b> KFP \$2330 AKT \$2330 OSCE \$4770 <b>Estimated minimum total: \$11,625</b>	Transparency of reasoning for costs: none  Transparency of number of placements: none	CAAKT exam Application Interview	Finished 1 year of post educational training	N/A <sup>^</sup>	<a href="https://www.racgp.org.au/education/registrars/fellowship-pathways/australian-general-practice-training-program-agpt">https://www.racgp.org.au/education/registrars/fellowship-pathways/australian-general-practice-training-program-agpt</a>
<b>ACRRM</b> (Australian College of Rural and Remote Medicine)	GPs who want to work rurally - RACGP Rural Doctors who want to work in a rural hospital as a rural generalist - ACRRM Similar processes					<a href="https://www.acrrm.org.au/traininq-towards-fellowship">https://www.acrrm.org.au/traininq-towards-fellowship</a>
<b>RACP</b> (Royal Australasian College of Physicians)	<b>Annual fee</b> \$3646/year <b>Exam fees</b> Written exams \$1986 Basic training clinical exams \$2972 Faculty clinical exams \$2972 <b>Estimated minimum total for BPT: \$15896</b> <b>Estimated total for advanced training: \$15896</b>	Transparency of reasoning for costs: Basic document about where fees go  Transparency of number of placements: Advanced training pathways have number of people who apply and are successful for each year	Find an accredited training position then apply to the college annually  Complete advanced training within 5 years of completing basic physician training	Up to the discretion of the hospital	<b>*Cardiology: 4.40%</b> <b>*Endocrinology: 4.77%</b> <b>*Gastroenterology and hepatology: 15.04%</b> <b>*General medicine: 3.74%</b> <b>*Geriatric medicine: 1.45%</b> <b>*Medical oncology: 8.96%</b> <b>*Nephrology: - 8.79%</b> <b>*Neurology: 3.70%</b> <b>*Paediatrics and child health: - 2.67%</b>	<a href="https://www.racp.edu.au/trainees">https://www.racp.edu.au/trainees</a>

<p><b>RACS</b> (Royal Australasian College of Surgeons)</p>	<p><b>Pre-application exam fee</b> GSSE \$4090 <b>Application fees</b> Registration fee \$575 Selection processing fee \$810/specialty (varies for most specialties) <b>Annual fee</b> \$3195/year <b>Exam fees</b> Clinical exam \$3100 Specialist exams \$2000-4000 Fellowship exam \$8495 <b>Estimated minimum total:</b> \$39240</p>	<p>Transparency of reasoning for costs: none</p> <p>Transparency of number of placements: Very transparent about number of positions and applications each year</p>	<p>GSSE Register interest to apply Apply to specific specialty Interview</p>	<p>Finished 2 years of post educational training</p>	<p><b>*General surgery: -5.53%</b> <b>*Orthopaedic surgery (incl in general surgery): -13.52%</b> <b>*Other surgery: 2.08%</b> <b>*Otolaryngology (incl in general surgery): 25.25%</b> <b>*Plastic surgery: 20.74%</b></p>	<p><a href="https://www.surgeons.org/become-a-surgeon/how-do-i-become-a-surgeon/set-selection-requirements-process-and-application">https://www.surgeons.org/become-a-surgeon/how-do-i-become-a-surgeon/set-selection-requirements-process-and-application</a></p>
<p><b>RACMA</b> (Royal Australasian College of Medical Administrators)</p>	<p><b>Application fee</b> \$1,441 <b>Annual fee</b> \$1093.40/year <b>Workshop fees</b> \$5720 <b>Exam fees</b> Trial exam \$1095 Oral exam \$3339 <b>Estimated minimum total:</b> \$14869</p>	<p>Transparency of reasoning for costs: none</p> <p>Transparency of number of placements: none</p>	<p>Find an accredited training position then apply to the college</p>	<p>Finished 3 years of post educational training</p>	<p>N/A^</p>	<p><a href="https://racma.edu.au/training/fellowship-training-program/apply-for-ftp-candidacy/">https://racma.edu.au/training/fellowship-training-program/apply-for-ftp-candidacy/</a></p>
<p><b>ANZCA</b> (Australian and New Zealand College of Anaesthetists)</p>	<p><b>Application fee</b> \$750 Then \$625/year <b>Registration free</b> \$2435 (then \$625 each year) <b>Annual fees</b> Registration \$625/year Membership \$3295/year <b>Exam fees</b> Primary \$5525 Final \$6145 <b>Estimated minimum total:</b> \$33830</p>	<p>Transparency of reasoning for costs: they advertise an email that answers queries</p> <p>Transparency of number of placements: none</p>	<p>Application Find an accredited training position then register with the college</p>	<p>Finished 1 years of post educational training to apply</p> <p>Finished 2 years of post educational training to register</p>	<p><b>*Anaesthesia: -3.19%</b></p>	<p><a href="http://www.anzca.edu.au/training/application-and-registration">http://www.anzca.edu.au/training/application-and-registration</a></p>
<p><b>ACD</b> (Australasian College of Dermatologists)</p>	<p><b>Application fee</b> \$1,600 <b>Annual fee</b> \$5486/year <b>Workshop and exam fees</b> First year clinical sciences module \$3250 Fellowship exam \$4000 <b>Estimated minimum total:</b> \$37194</p>	<p>Transparency of reasoning for costs: none</p> <p>Transparency of number of placements: have advertised number of places for each year and success rates</p>	<p>Application Interview Assigned state to practice in</p>	<p>Finished 3 years of post educational training to apply</p>	<p><b>*Dermatology: -5.82%</b></p>	<p><a href="https://www.dermcoll.edu.au/for-health-professionals/becoming-a-dermatologist/australian-medical-graduates/">https://www.dermcoll.edu.au/for-health-professionals/becoming-a-dermatologist/australian-medical-graduates/</a></p>
<p><b>ACEM</b> (Australasian College for Emergency Medicine)</p>	<p><b>Application fee</b> \$550 <b>Registration fee</b> \$704 <b>Annual fee</b> \$1601/year <b>Exams fees</b> Primary exam \$4002 Fellowship exam</p>	<p>Transparency of reasoning for costs: none</p> <p>Transparency of number of placements: none</p>	<p>Application If successful, enrol in program</p>	<p>Finished 2 years of post educational training to apply</p>	<p>N/A^</p>	<p><a href="https://acem.org.au/Content/Sources/Training/How-the-FACEM-Training-Program-works/How-to-apply">https://acem.org.au/Content/Sources/Training/How-the-FACEM-Training-Program-works/How-to-apply</a></p>

	\$6012 <b>Estimated minimum total:</b> \$18019					
<b>CICM</b> (College of Intensive Care Medicine)	<b>Application fee</b> Likely exists but not advertised <b>Annual fee</b> \$1670/year <b>Exam fees</b> First exam \$3800 Second exam \$3800 <b>Estimated minimum total:</b> \$17620	Transparency of reasoning for costs: gives detailed explanation for exam fees  Transparency of number of placements: none	Application	Finished 1 year and six months in of post educational training to apply  Also offer training in Hong Kong and Singapore for which you need to be registered there	<b>*Intensive care:</b> <b>1.97%</b>	<a href="https://www.cicm.org.au/Trainees/Becoming-a-Trainee">https://www.cicm.org.au/Trainees/Becoming-a-Trainee</a>
<b>RANZCOG</b> (Royal Australian and New Zealand College of Obstetricians and Gynaecologists)	<b>Application fees</b> Application \$695 Interview \$1075 <b>Annual fee</b> \$4190/year <b>Exam fees</b> Written \$2045 Oral \$3910 <b>Estimated minimum total:</b> \$24485  If adding a subspecialty, another two years and \$16,000	Transparency of reasoning for costs: none  Transparency of number of placements: transparent about how successful applications are on average	Application Situational Judgement Test Interview Get allocated a state and find a job within that state	Finished 2 years of post educational training to apply	<b>*Obstetrics and Gynecology: -</b> <b>10.47%</b>	<a href="https://ranzco.edu.au/training/specialist-training/applying">https://ranzco.edu.au/training/specialist-training/applying</a>
<b>RANZCO</b> (Royal Australian and New Zealand College of Ophthalmologists)	<b>Application fee</b> Likely exists but not advertised <b>Annual fee</b> \$4500/year <b>Exam fees</b> Anatomy and OSPE \$1998 OBCK \$1998 Written exam \$920 Clinical exam \$2760 <b>Workshop fees</b> ~\$2000 <b>Estimated minimum total:</b> \$32176	Transparency of reasoning for costs: none  Transparency of number of placements: none	Application Situational Judgement Test MMI Get allocated a state and find a job within that state	Finished 2 years of post educational training to apply	<b>*Ophthalmology:</b> <b>-14.81%</b>	<a href="https://ranzco.edu.au/home/future-ophthalmologists/vocational-training-program/">https://ranzco.edu.au/home/future-ophthalmologists/vocational-training-program/</a>
<b>RCPA</b> (Royal College of Pathologists of Australasia)	<b>Pre-application exam fee</b> Basic pathological sciences \$700 <b>Registration fee</b> \$110 Annual fees \$1375/year <b>Exam fees</b> Part 1 \$2500 Part 2 \$2500 <b>Estimated minimum total:</b> \$12685	Transparency of reasoning for costs: none  Transparency of number of placements: none	Basic Pathological sciences exam Find an accredited training position then register with the college	Finished 2 years of post educational training to apply	<b>*Anatomical pathology: -</b> <b>3.62%</b> <b>*Other clinical pathology: -</b> <b>13.68%</b>	<a href="https://www.rcpa.edu.au/Pathology-Careers/Becoming-A-Pathologist">https://www.rcpa.edu.au/Pathology-Careers/Becoming-A-Pathologist</a>

<b>RANZCP</b> (Royal Australian and New Zealand College of Psychiatrists)	<b>Registration fee</b> \$702 <b>Annual fee</b> \$1864/year <b>Other fees</b> Unaccessible see "Transparency"	Transparency of reasoning for costs: even costs are not accessible to the public and require a RANZCP login to view  Transparency of number of placements: No numbers but recognise that likelihood of find a job is high	Find an accredited training position then register with the college	Finished 1 years of post educational training to register	* <b>Psychiatry:</b> - <b>8.47%</b>	<a href="https://www.ranzcp.org/pre-fellowship/select-ion-of-trainees">https://www.ranzcp.org/pre-fellowship/select-ion-of-trainees</a>
<b>RANZCR</b> (Royal Australian and New Zealand College of Radiologists)	<b>Annual fees</b> Subscription fee \$2290/year Training fee \$1932/year <b>Exam fees</b> Part 1 exam \$3475 Part 2 exam \$4735 <b>Estimated minimum total:</b> \$29520	Transparency of reasoning for costs: clarity around costs of individual parts of exams but not where the money goes  Transparency of number of placements: none	Application and interview through training sites  Find an accredited training position then register with the college	Finished 2 years of post educational training to register	* <b>Radiation oncology:</b> - <b>63.70%</b> * <b>Radiology:</b> - <b>23.53%</b>	<a href="https://www.ranzcr.com/join-our-professions">https://www.ranzcr.com/join-our-professions</a>

\*Workforce supply forecast for 2030 based on 2016 workforce supply.

The degree of undersupply is assigned a colour by Health Workforce Australia (HWA): red, orange and green. For the purposes of the allocation methodology the department assigned a percentage of undersupply to each colour code: red was assigned 10%; yellow 5% and green 0%.

For those specialties determined to be in balance, that is, the margin is between - 10% and +10%, the number of speciality training posts (STP) posts allocated would not change.

^Specialties that were not analysed by HWA were assumed to be in balance.