Policy Document

Medical Schools and Medical Student Numbers (2025)

Executive Summary

AMSA believes that the health of the Australian population relies upon the quality education of the medical workforce, which begins with medical school. Stricter regulations on both the number of medical students and the inception of new medical programs are essential to ensuring good quality pre-clinical education, clinical training, and integral in promoting a sustainable workforce that has access to sufficient quality training opportunities during and beyond medical school.

Medical student commencement in Australia has increased drastically over the past two decades, with commencement numbers nearly doubling from 2005 to 2024. Different stakeholders have also recently called for the Australian government to fund up to 1,000 additional CSP medical places.

Moreover, several new medical schools are soon to be launched or are being planned as of 2025, including the Queensland University of Technology's medical program planned to commence teaching in 2027. Without proper oversight and planning, these new medical schools may compete for limited preclinical and clinical training capacity, affecting the delivery of high-quality medical education.

The absence of a singular, stable, and long-term medical workforce planning body has further led to inconsistencies in medical workforce planning.
AMSA's position is that proposals to increase medical school CSPs must be based on evidence-based long-term medical workforce projections. AMSA also urges the Federal Government to coordinate stages of medical training via a joint medical workforce planning and governance body.

There is a limited supply of pre-vocational and specialist training positions in Australia, and this has caused a bottleneck in the medical training pipeline. This bottleneck is being exacerbated by the increasing medical students' commencement and graduate numbers.

AMSA urges the Federal government to match any increases in medical student numbers with a commensurate investment in downstream prevocational and specialist medical training places.

While increases in medical student numbers may be needed to address growing healthcare needs in Australia, key maldistribution, within geographic distributions and within specialities, in the medical workforce remains despite the growth of medical student numbers and medical schools. The simplistic suggestion that

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increasing medical student numbers is the sole solution to healthcare's multi-faceted problems is false and irresponsible.

AMSA believes that increasing the number of medical school places without adequate support for preclinical education and clinical placements, long-term medical workforce planning, and downstream investment in post-medical school pre-vocational and specialist training to be ineffective in alleviating current medical workforce issues, and would negatively impacts the quality of education for current and prospective medical students.

AMSA further believes that accreditation and approval of new medical schools should be conducted with appropriate consultation with relevant stakeholders, to safeguard the quality of clinical placements and uphold the standard of medical graduates. Existing and prospective medical schools should not prioritise economic incentives and benefits of increasing medical student numbers over the potential implications such changes could have on medical education quality and medical workforce planning.

The funding of increased CSPs and/or new medical schools should only occur with evidence-based workforce modelling that demonstrates the increase can address a current or future medical workforce maldistribution in geography or within medical specialities. Rather than diverting funds to increasing medical student numbers, AMSA asserts that resources should instead prioritise investing in more pre-vocational and specialist training for existing postgraduate doctors, rural training opportunities for medical students and postgraduate doctors, and targeting postgraduate training capacity in needed areas and specialities.

Overall, AMSA believes medical school places should be allocated based on population health needs and long-term, evidence-based workforce projections.

Policy Points

AMSA calls upon:

1. **The Australian Commonwealth Government to:**
    a. Refrain from establishing new medical schools or increasing medical student numbers, without:
        i. Consultation of the relevant bodies, including AMSA, AMA, MWAC, state and/or territory health departments;
        ii. Evidence-based workforce modelling that demonstrates the increase in medical schools or medical student numbers can address current or future medical workforce maldistribution in geography or within medical specialities
        iii. Modelling these changes to ensure such plans do not exacerbate existing bottlenecks in the medical training pipeline, including in the pre-vocational and specialist vocational training space; and
        iv. Providing a commensurate increase in funding for downstream prevocational and speciality training positions.
    b. Support:
        i. Conducting annual reviews of medical workforce modelling to inform adjustments to medical school intakes based on new data;
        ii. Investigating employment patterns and career intentions of prevocational doctors to align the training of existing doctors with national needs; and
        iii. Prioritising policy work of a long-term joint medical workforce planning and governance body;
        iv. Coordination in stages of medical training via a centralised permanent medical workforce planning committee, of which there is currently none;
        v. Redistribution of existing resources to address medical workforce maldistribution via the redistribution pool of medical CSPs
    c. Implement a permanent and centralised medical workforce planning committee
    d. Ensure rural clinical schools under the redistribution pool of medical CSPs are given enough resources to ensure equal quality of medical education in metropolitan and rural settings;
    e. Conduct studies investigating the effects of increases in medical student numbers and/or medical schools on the quality of pre-clinical education and clinical placements;
    f. Consider legislative change to put caps on domestic and international full fee-paying medical places to ensure a cap on overall medical student enrolment numbers;
    g. Appropriately match any increase in CSP funding with increased JDTP funding;
    h. Reform bonded programs (BMP) to offer more flexible, attractive, and viable return-of-service options that align with student career aspirations and actual rural workforce needs; and
    i. Provide direct funding incentives for state and regional health services to

expand rural internship and PGY3+ positions, especially for graduates of full-rural or regional programs.

2. **Australian State and Territory Governments to:**
    a. Guarantee internships for all Australian-trained medical graduates;
    b. Partner with health services and colleges to fund and expand accredited training posts (Specialist Training Pathways) beyond metropolitan hospitals; and
    c. Study and invest in incentives and infrastructure to support retention in rural and remote areas.
3. **The Australian Medical Council and Medical Deans Australia and New Zealand (MDANZ) to:**
    a. Continue investigating the effects of increases in medical student numbers and/or medical schools on the quality of clinical placements;
    b. Continue advocating for innovation in curriculum design to better prepare students for future workforce roles, especially in generalist and rural practice; and
    c. Continue conducting and improving data collection and reporting on student enrolment categories, training outcomes, and rural workforce retention to guide evidence-based policy.
4. **The Australian Medical Council (AMC) to:**
    a. Ensure the accreditation and approval of new medical schools occur after proper consultation with the relevant stakeholders in order to safeguard the quality of clinical placements and uphold the standard of medical graduates
5. **Specialist Medical Colleges to:**
    a. Increase the number of training positions and supervision capacity in under-supplied specialities and geographic regions;
    b. Ensure transparent, equitable and merit-based selection processes for training applicants;
    c. Collaborate with government and universities to support early exposure and outreach programs to priority specialities; and
    d. Advocate for GP terms for PGY1 and PGY2 junior doctors to increase exposure to general practice outside of medical school.
6. **Australian Medical Schools to:**
    a. Advocate for the reallocation of their medical places if it is evidenced to be beneficial towards improving workforce mal-distribution;
    b. Refrain from lobbying the Federal Government for an increase in their CSP funding without prior future workforce modelling to support this;
    c. Not prioritise the economic incentives and benefits of increasing student numbers to institutions over the potential implications such changes could have on graduate quality and workforce planning;
    d. Include medical workforce maldistribution and its impacts on both medical students and workforce in the core curriculum;
    e. Ensure rural training programs are adequately resourced, not just in student numbers but in clinical supervision, accommodation, and long-term workforce planning.
    f. Ensure appropriate student-to-teacher/clinician ratios in both pre-clinical and clinical education;

g. Strengthen support for international students, including by lobbying for equitable access to internships and supporting navigation of complex visa and workforce systems.

7. **Australian Medical Students' Association (AMSA) to:**
    a. Advocate for a moratorium on enrolment increases until clinical training and workforce infrastructure are scaled proportionally.
    b. Advocate for guaranteed internships for all Australian-trained medical graduates;
    c. Engage in national conversations on the sustainability of medical education and the long-term workforce pipeline.
8. **All stakeholders in medical education and training to:**
    a. Engage in data collection and sharing in all stages throughout the medical training pipeline to support evidence-based, up-to-date workforce modelling to inform future changes in medical student numbers
    b. Base advocacy and policy making on medical student numbers and/or medical schools on evidence-based workforce modelling.

Background

REGULATION OF MEDICAL SCHOOL ENROLMENT

Australia's medical education sector continues to expand, driven by growing demand, policy shifts, and institutional financial incentives. Medical school enrolments are broadly classified into domestic and international cohorts, and further divided by funding categories: Commonwealth Supported Places (CSP), Bonded Medical Places (BMP), and Full-Fee Paying (FFP) positions.

Domestic vs International Enrolment.

In 2024, 4453 students commenced studies at Australian medical schools. Of these, 3629 were domestic students (81.5%), and 824 were international students (18.5%). Although international students represent a smaller proportion, their commencement numbers have seen faster growth (45.6%) in the decade since 2015 compared to domestic commencements (14.2%). Overall, from 2015 to 2024, total medical student commencement increased by 18.91% (Refer to Table 1 for details). The rapid rise in total and international student numbers is concerning, and risks negatively impacting and diluting the quality of medical education under unrestricted growth in total medical student numbers.

Year	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024
Domestic	3210	3215	3211	3252	3389	3411	3533	3485	3552	3629
International	572	613	645	664	651	646	620	707	750	824
Total	3782	3828	3856	3916	4040	4057	4153	4192	4302	4453
Increase from previous year	37	46	28	60	124	17	96	39	110	151

Table 1: Australian medical student commencement numbers by student type from 2015 to 2024, categorised by domestic and international students (1).

Types of Medical School Places.

Among domestic places, three primary funding categories exist (2):

- Commonwealth Supported Places (CSP): These are subsidised by the Australian Government and form the majority of domestic medical school enrolments.
- Bonded Medical Places (BMP): A subset of CSPs, BMPs require a return-of-service obligation in designated rural or remote areas. In 2024, BMPs accounted for over 25% of CSPs (1).
- Domestic Full-Fee Paying (DFFP): These are unsubsidised places, where students pay the full tuition cost. Although relatively small in number, DFFP places have grown by 67.6% since 2015, raising concerns about accessibility and socioeconomic diversity in medicine. (For detailed numbers, refer to Table A in the Appendix)

All international medical students are FFP and are not eligible for CSPs or BMPs. They face barriers in transitioning to the Australian medical workforce due to internship priority systems and a lack of guaranteed training positions.

Medical School Expansion.
Several universities are expanding medical training, aiming to address workforce shortages in primary care and rural areas. A notable example is the Queensland University of Technology (QUT), which will open its medical school in 2027, offering 48 new CSP places annually (3).
This new medical school is stated to have an emphasis on primary care to encourage graduates to become GPs, targeting Aboriginal and Torres Strait Islander peoples and rural and remote students (4).

However, there are concerns that funding a new medical school may not contribute to filling rural workforce gaps as QUT is a metropolitan-based university. There are also concerns that medical education and clinical placement quality in Queensland may be diluted, as QUT would be Queensland's 5th University to have a medical degree, and as such there is high competition with other Queensland universities for teaching hospital and GP placements (5, 6, 7).

Therefore, the current structure of medical school enrolment in Australia — across domestic and international categories, funding models, and institutional expansion — has created a system where graduate supply is outpacing training capacity, as will be explored later. Increasing the number of medical schools or places alone will not solve workforce shortages, particularly in rural areas.

Policy must shift from simply growing numbers at the front end to investing in sustainable training pipelines, particularly by expanding pre-vocational and speciality training opportunities and supporting rural career pathways for both domestic and international graduates.

MEDICAL STUDENTS AND THE AUSTRALIAN HEALTH WORKFORCE

Bottlenecks in the Medical Training Pipeline.

Medical training in Australia is a multi-phase journey (8), as outlined in Figure 1. Progressively increasing funding is required throughout the medical training pipeline for a commencing medical student to progress to independent clinical practice.

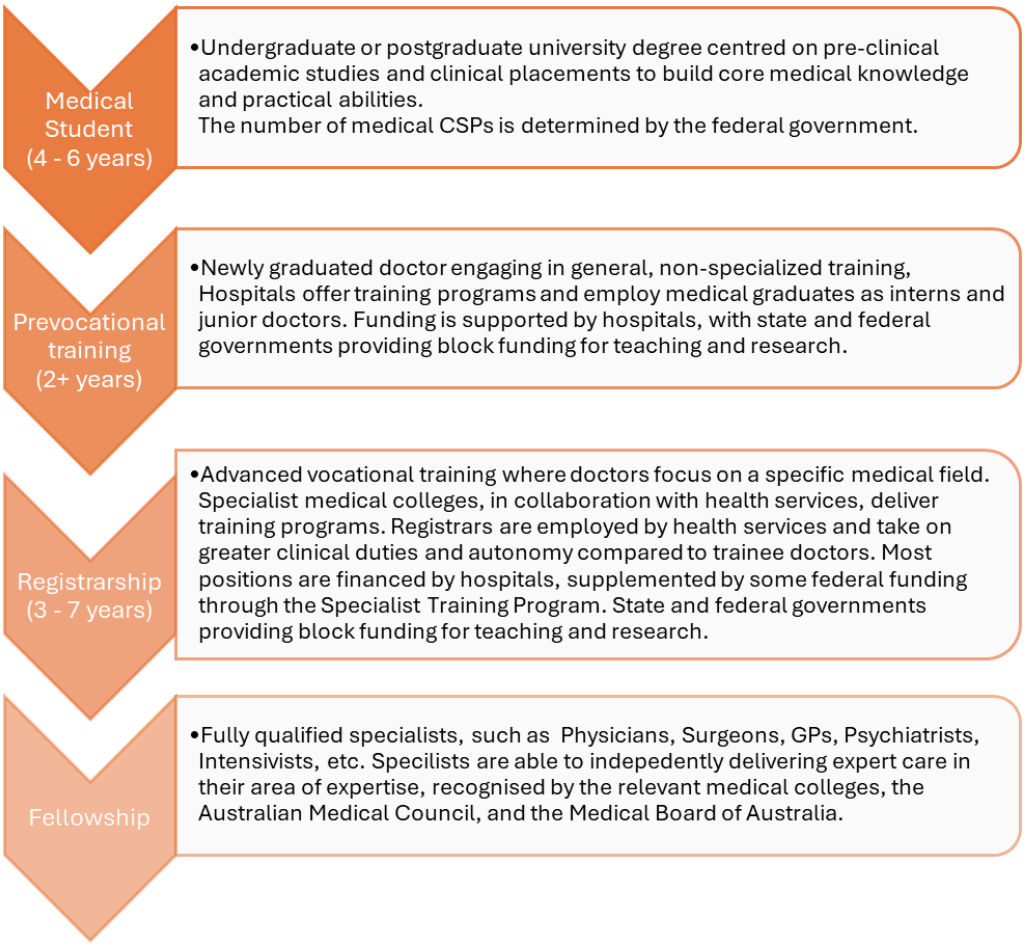
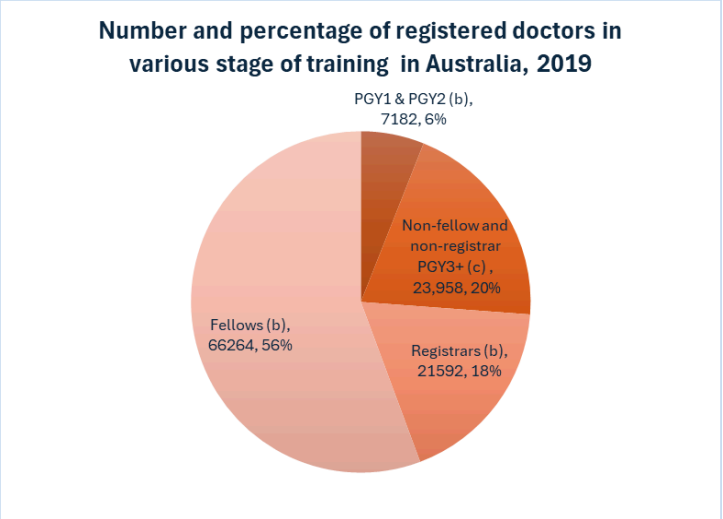


Figure 1: Training pathways for Australian doctors (9)

There is already an existing and widening bottleneck where many PGY3+ doctors become stuck in "non-training service roles" as unaccredited registrars, as shown in Figure 2. An increase in medical schools and student numbers alone is insufficient to address health workforce problems, and may instead increase the number of doctors in prevocational training and in PGY3+ unaccredited registrar positions, exacerbating training bottlenecks for specialist vocational training.



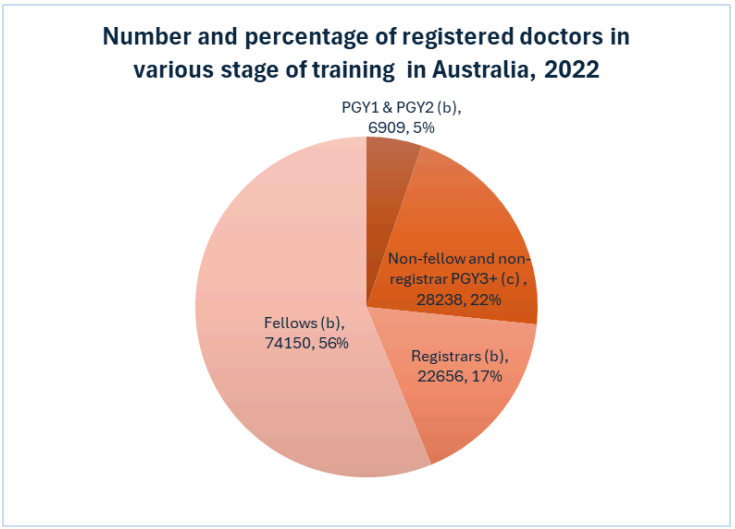


Figure 2: Australian doctors' progression through medical training in 2019 and 2022. [a] The total number of AHPRA registered doctors in 2019 and 2022 is 118996 and 131953, respectively. Data derived from AHPRA Annual reports (10, 11) [b] Data derived from Medical Education and Training (MET), 7th Edition (2023) (12) [c] Data extrapolated from [a] and [b] and may not be an exact figure. The figure for PGY3+ doctors is extrapolated by subtracting the number of PGY1 doctors, PGY2 doctors, registrars, and fellows from the total number of AHPRA-registered doctors of the same year.

Inconsistencies in the Medical Training Pipeline.

A lack of an independent permanent medical education and workforce planning body has also led to inconsistencies in the stages within the medical training pipeline. The Medical Workforce Advisory Collaboration (MWAC), currently responsible for medical workforce planning, has been preceded by various different organisations (13).

At the pre-vocational training level, internship positions are coordinated at the state/territory level, while medical student numbers are regulated at the federal level (2), potentially leading to a mismatch.

At the registrar training level, specialist training programs are run by 16 AMC-accredited medical colleges (14). This fragmented governance may limit responsive workforce planning at the vocational training level.

Moreover, while medical school places have grown, vocational training positions have not kept pace. From 2018 to 2023, medical student commencement and total enrolment numbers rose 9.86% and 7.07% respectively (1), while basic and advanced specialist medical trainee numbers only rose 4.42% and 6.78% respectively (12) (for detailed number comparisons, refer to Table B in the Appendix). This shows that the increase in medical student numbers has been disproportionate to the increase in downstream vocational training numbers.

The Australian medical workforce is also increasingly dependent on international medical graduates (IMGs). In 2022, 32% of Australia's medical practitioners were internationally trained (15); and in 2024, 5717 IMGs were registered by AHPRA (16) while there were only 3725 Australian medical school graduates in the same year (1) (for detailed number comparisons, refer to Figure A in Appendix). Increases in IMGs coupled with increases in medical student numbers without adequate workforce planning and vocational training positions could lead to an exacerbation of training bottlenecks.

Imbalance in the Australian Medical Workforce.
Despite a rise in medical students and IMGs, imbalances within geographic distribution and within specialities are projected to continue (17). The simplistic suggestion that increasing medical student numbers is the sole solution to healthcare's multi-faceted problems is false and irresponsible.

Regarding rural maldistribution, the majority of the medical workforce works in major cities (18), despite people living outside major cities having poorer health status and outcomes (19). Without addressing the geographic distribution, the influx of medical students would only continue to overcrowd metropolitan regions rather than addressing the underserved rural and remote areas.

Regarding speciality maldistribution, there is an oversupply in specialities such as emergency medicine and cardiothoracic surgery, whereas persistent shortages remain in GP and psychiatry (20, 21, 22). The GP shortage is of particular concern and the focus of the government's effort, with a shortage of 3900 full-time equivalent (FTE) GPs projected for 2028, increasing to 8900 by 2048 (21).

Increasing Medical Student Numbers Diverts Funding Away From Other Initiatives.
The main challenge for the medical workforce is an imbalance in supply rather than a shortage. As shown in Figure 2, the current number of PGY3+ suggests that Australia has enough PGY3+ to fill all vocational specialist training spots. Rather than diverting funds to increasing medical student numbers, resources should target vocational training and the imbalance in the workforce.

Increasing rural and First Nations training opportunities and reducing financial barriers for low SES medical students, as opposed to increasing medical student

numbers, could better increase the likelihood of graduates practising rurally and address geographic maldistribution (23). Targeted implementation of regionally based specialist training instead of focusing on medical school places with no consideration of medical graduates could target rural maldistribution at the specialist training stage (24).

For the first time in years, the RACGP has filled all places in the GP training program in 2025 (25). Despite the increase in medical student numbers, without ensuring sufficient funding for prevocational and vocational training, existing bottlenecks in the medical training pipeline could be further exacerbated, and would fail to result in a well-trained workforce responsive to the needs of Australians. Rather than diverting funding to additional university medical places, increasing funding for primary care exposure during preclinical education and clinical placements for existing medical students, and continuing increases in GP training places provided by the RACGP could help improve rural primary care coverage and GP access in a shorter time frame.

GOVERNMENT POLICY & FUNDING

Recent Government Plans Regarding Medical Schools and Medical School Places.

As of 2025, there are currently 25 Medical Universities in Australia, with a further 3 medical schools being planned or proposed; the Queensland University of Technology (QUT) Medical School (3, 4), Charles Darwin University Menzies School of Medicine (26), and the University of the Sunshine Coast medical school (27).

In recent years, there have been calls to increase medical CSPs from different stakeholders. In the 2025-2026 Budget, the Australian Government proposes to fund 100 new medical CSPs a year from 2026, increasing to 150 from 2028 (28). The MDANZ, in their 2025-2026 pre-budget submission, has proposed an increase of an additional 1000 CSPs by 2030 (29). In a 2022 report, the Group of Eight (Go8), comprising Australia's leading universities, has also recommended increasing medical CSPs by a minimum of 1,000 over four years (30). While these plans are intended to address workforce maldistribution, these abrupt plans to increase medical school places are of particular concern due to their potential impact on the medical training pipeline discussed previously, and the impact on medical education, which will be discussed in a later section.

In addition, the increase in medical school places alone may not be able to address the workforce geographical and speciality maldistribution. A majority of medical schools are based in urban areas where current students lack exposure to regional and remote areas and general practice.

Recent Government Plans Regarding Rural Reallocation of Medical School Places.

Several schemes aim to reallocate CSPs to rurally located medical schools and campuses to alleviate rural doctor maldistribution. These schemes include the Murray-Darling Medical Schools Network (MDMSN), and End-to-end Rural Training Pathways.

The first round of redistributed CSPs went towards the establishment of the MDMSN. The Federal Government re-allocated up to 60 current medical Commonwealth Supported Places, including Bonded Medical Places, every three years. The MDMSN follows an 'end-to-end' rural and regional medical education experience, which aims to immerse medical students in regional and rural areas to positively influence and increase the distribution of medical graduates towards these underserved areas. (31-35)

There has not been limited modelling on the MDMSN, with the possibility that reallocation of these CSPs will not actually increase the rural workforce (36). However, this scheme, backed by the Federal Government, does allow for more lobbying of extra CSPs by the MDMSN institutions and opens up the pathway for more FFP medical school positions to be implemented to compensate for the loss of numbers at established medical schools (36).

MDMSN Institution and Program	Year Started	Location
University of Melbourne/ La Trobe: Combined Bachelor of Medical Science (Medical) and MD	2019, first medical cohort in 2022 (37)	Shepparton, Vic
Charles Sturt University/ Western Sydney University: Joint Program in Medicine MD	2021	Orange, NSW
University of New South Wales: Bachelor of Medical Studies/ MD	2021	Wagga Wagga, NSW (38)
The University of Sydney: MD	2022	Dubbo, NSW
Monash University: Bachelor of Medical Science/ MD	2021, first medical cohort in 2024 (39)	Bendigo and Mildura, Vic

Table 2: Institutions participating in the MDMSN

The Australian Government has also invested $90 million into an extra 160 medical students for end-to-end rural medical training at six new medical school programs in rural communities beginning from 2024 (40).

The development of the new facilities and programs will include:

- 30 medical students in Ararat and Warrnambool, Victoria - Deakin University
- 20 medical students in Broome, Western Australia – University of Notre Dame
- 20 medical students in Rockhampton, Queensland – University of Queensland
- 30 medical students in Nowra, New South Wales – University of Wollongong
- 20 medical students in regional Tasmania – University of Tasmania
- 40 medical students in regional South Australia – Flinders University

While 160 CSP medical students will begin rural end-to-end training under this scheme, the funding only supports 80 new CSPs, and participating universities have to redirect an equivalent number of their existing placements to the new rural programs (40).

This funding model currently lacks transparency about where these universities are reallocating these extra placements from, and also raises questions about whether the quality of medical education would be affected for both medical students under the new funding and for those funded under the traditional way.

IMPACT OF PROPOSED POLICY ON MEDICAL EDUCATION

What remains a priority is the wellbeing and satisfaction of current Australian medical students. Many studies recognise the crucial role played by the quality of teaching as well as an environment of support within the medical school (41). This goes in tandem with effective clinical learning - quality supervision, increased participation in the workplace, and sufficient opportunities to practice procedures and skills allow for flourishing student environments (41). Increasing the number of medical students would increase the ratio of student numbers to teachers, clinicians, and patients, reducing individual student exposure (42). Indeed, students find having a bigger student pool, leading to overcrowding, a negative experience on placement (43).

As mentioned previously, the efforts to recruit and encourage medical students to pursue the General Practitioner pathway have been successful, given that the 2025 trainee positions have been full (44). The issue lies with retaining these clinicians post-training. Currently, while there are adequate GP placements for medical students within medical school, placements after graduation are almost exclusively in hospitals (44). Therefore, graduates are not able to continue the longitudinal learning within the GP environment, which could contribute to dwindling interest and increasing barriers. Additionally, directing investment away from establishing more medical student numbers would allow governing bodies to address the pay gaps between GPs and other specialities (44).

Retention, not lack of initial interest, is also the main issue when it comes to reduced numbers and maldistribution of health practitioners in rural areas (45). Analysis shows Bonded Places show poor retention, while a reduction in the HELP loan seems promising (45, 46). Additionally, the implementation of the Australian Remote Vocational Training Scheme (RVTS) makes a case for investing in rural remote teaching in order to retain and provide for practitioners already there and encourage newer entrants (47).

Hence, AMSA's stance is that increasing the number of medical schools and medical students does not address the issues the Federal Government is trying to resolve, in particular the shortage of rural clinicians and General Practitioners in the nation.

For More Information

To learn more about how Australian Government funding works for university medical places, please see here:

> *Ferguson H. Australian Government funding for university medical places. FlagPost [Internet]. Canberra: Parliamentary Library, Department of Parliamentary Services; 25 May 2022 [cited 2025 Jul 29]. Available from: https://www.aph.gov.au/About_Parliament/Parliamentary_Departments/Parliamentary_Library/Research/FlagPost/2022/May/Medical_places*

The AMA in 2023 released a position statement regarding CSPs and medical workforce distribution. They discuss in a similar vein of our policy the concerns of increasing medical student spots without an increase in specialty training capacity. Furthermore, they also call upon the Government to implement an independent health workforce modelling and planning body.

> *Australian Medical Association. Commonwealth Supported Places and Medical Workforce Supply and Distribution: Position Statement [Internet]. Canberra: Australian Medical Association; 19 October 2023 [cited 2025 Jul 29]. Available from: https://www.ama.com.au/sites/default/files/2023-10/Commonwealth%20Supported%20Places%20and%20Medical%20Workforce%20Supply%20and%20Distribution%20Position%20Statement.pdf*

The Department of Health and Aged Care in February 2025 submitted an impact analysis to The Office of Impact Analysis describing a proposed strategy in meeting Australia's GP healthcare needs. Key components of their proposal includes increasing CSPs as well as increasing GP specialty training capacity. To read more about their proposed strategy, please see below.

> *Office of Impact Analysis, Department of the Prime Minister and Cabinet. Building the General Practice Workforce to Strengthen Medicare: Impact Analysis [Internet]. Canberra: Office of Impact Analysis; Published 23 February 2025 [cited 2025 Jul 29]. Available from: https://oia.pmc.gov.au/published-impact-analyses-and-reports/building-general-practice-workforce-strengthen-medicare*

Please see the below links for other sources of information and data that was discussed throughout this policy:

- Medical Workforce Supply and Distribution 2023
- Medical Deans Australia and New Zealand: Data Dashboard
- Medical Education and Training (MET), 7th Edition
- Special treatment: Improving Australians' access to specialist care
- Securing the Future of Australia's Medical Workforce
- 25-26 Federal Budget Factsheet - Medical places

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Appendix

Year	2015	2024	Percentage change 2015 - 2024
CSP	2116	2273	7.42
BMP	835	922	10.42
DFFP	259	434	67.57

Table A: Australian domestic medical student commencement numbers by funding, 2015 - 2024.
Note: Data derived from MDANZ Data Set (1)

Year	2018	2019	2020	2021	2022	2023	% Change 2018 - 2023
Medical Students Commencement [a]	3916	4040	4057	4153	4192	4302	9.86%
Medical Students Total Enrolment [a]	17146	17586	17884	18157	18223	18359	7.07%
Vocational Training Total Enrolments [b]	21483	21592	22642	23445	22656	22801	6.14%
of which Basic trainee Total [b]	5858	5656	5822	5650	5703	6117	4.42%
of which Advanced trainee Total [b]	15625	15936	16820	17795	16953	16684	6.78%

Table B: Australian medical student numbers and medical specialists vocational training numbers, 2018 - 2023.
Note:
[a] Data derived from MDANZ Data Set (1)
[b] Data derived from Medical Education and Training (MET), 7th Edition (2023) (12)

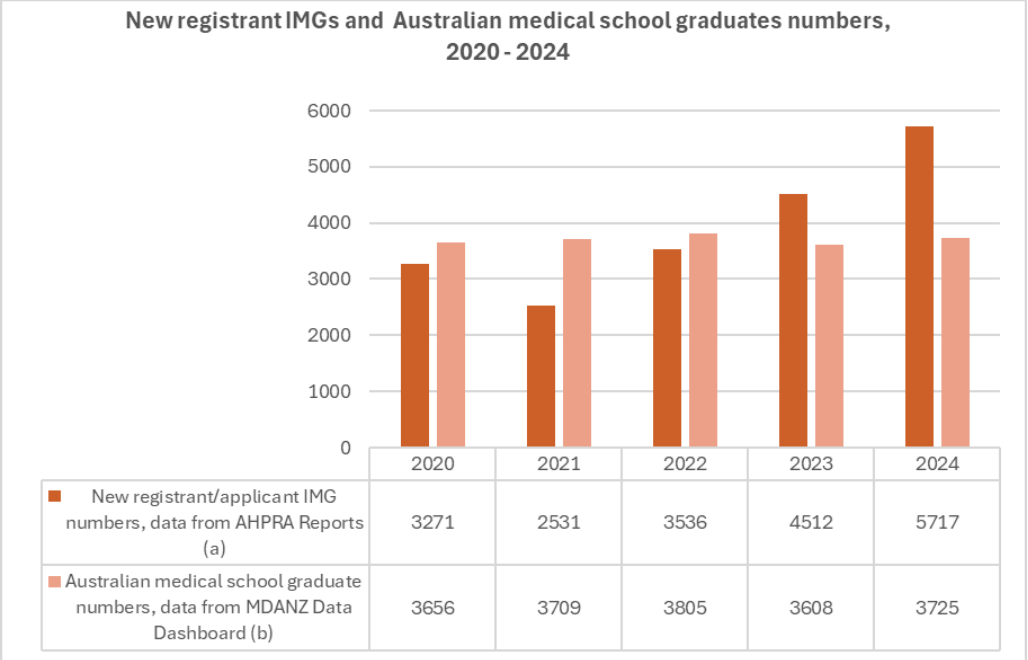

Figure A: New registrant/ applicant IMGs and Australian medical school graduates numbers, 2020 - 2024.

Note:

[a] Data derived from AHPRA reports (11, 48 - 50). Data from 2020 - 2022 are IMG registrant numbers; data from 2023 - 2024 are IMG registrant numbers.

[b] Data derived from MDANZ Data Set (1)

Policy Details:

Name: Medical School and Medical Student Numbers

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Category: E - Medical Workforce

History: Reviewed and Adopted as an amalgamation of Increased Student Numbers and New Medical Schools, Council 1, 2021

Orkojeet Banerji, Ragavi Jayejumar, Varshini Chandrasekar, Jonathan Greenberg, Tanmay Gupta, Ally Yates, Fergus Stafford (Policy Officer)

Increased Student Numbers

Reviewed and Adopted, Council 1, 2019

Fergus Stafford, Stephanie Li, Bridget Rodkin, Audilia Sujana, Elizabeth Suo, Daniel Zuo (Policy Officer)

Reviewed and Adopted, Council 1, 2015

Reviewed and Adopted, Council 1, 2011

Adopted, Council 1, 2007

New Medical Schools

Adopted, Council 3, 2017

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