Policy Document

Student Income Support (2026)

Executive Summary

The Australian Medical Students' Association (AMSA) believes that clinical placements are an essential component of medical education, and play a critical role in preparing future medical practitioners for safe, competent, and patient-centred practice. Through placements, medical students develop practical clinical skills, professional competencies, communication abilities, and an understanding of the healthcare system that cannot be replicated within classroom-based learning alone. AMSA believes that participation in mandatory clinical placements should not place students at risk of financial hardship or create barriers to successfully completing medical training.

AMSA recognises the growing financial burden experienced by Australian medical students throughout their training, particularly during mandatory clinical placements. AMSA believes that the current structure of medical education places students under significant financial strain through both direct and indirect costs, including tuition debt, placement-related travel and accommodation expenses, occupational compliance requirements, reduced capacity for paid employment, and the rising costs of living. AMSA further believes that such pressures are particularly acute during clinical placements, where students are often required to undertake full-time unpaid work whilst continuing to meet educational and personal expenses.

AMSA strongly advocates for reform of existing government income support systems that are failing to adequately support medical students. Whilst supports such as Youth Allowance, Austudy, ABSTUDY, Commonwealth Rent Assistance (CRA), and independent or university-based scholarships exist, many students experience substantial barriers to accessing these payments as a result of restrictive eligibility criteria, insufficient payment rates, complex application processes and outdated independence thresholds. It is important to note that medical students with disabilities are ineligible for the Disability Support Pension (DSP) due to the demands of medical school exceeding the Continuing Inability to Work (CITW) criterion limit. AMSA further recognises that many medical students fall between intersections of disadvantage, and may not fit within singular demographic categories despite experiencing significant financial hardship.

AMSA believes the exclusion of medical students from the Commonwealth Prac Payment (CPP) scheme represents a major inequity within higher education and health workforce policy. Medical students undertake extensive mandatory placements comparable to, and often exceeding, those of other health disciplines currently eligible for the scheme, thus making meaningful

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contributions to the workplace. AMSA therefore considers extension of the CPP to medical students to be an immediate advocacy priority.

AMSA recognises that financial burden disproportionately impacts students from disadvantaged and underrepresented backgrounds, including First Nations students, rural and regional students, students with disability, students with caring responsibilities, and students from low socioeconomic backgrounds. AMSA acknowledges evidence demonstrating high attrition rates among First Nations students in tertiary health education, with financial insecurity and lack of adequate income support representing significant contributors to reduced retention and completion. While enhanced financial support would be immensely beneficial, overall long-term focus should turn towards reducing the disadvantage, financial and otherwise, experienced by First Nations students. AMSA also recognises the compounded impacts and structural costs of medical education experienced by students with disability, including those associated with assistive technologies, accessibility requirements, modified transport, specialised equipment, documentation and accessible placement arrangements that are often not recognised or adequately supported by universities or placement providers.

AMSA further acknowledges the significant “hidden costs” associated with medical education, including relocation for placements, transport expenses, compliance requirements, conference attendance, and the social and psychological impacts of financial insecurity. AMSA believes these costs can substantially affect student wellbeing, educational participation, and workforce diversity, particularly for students required to relocate away from family and support networks to complete training. AMSA additionally acknowledges that variation in incurred expenses exists between states, and therefore advocates for standardising and minimising the impact of hidden costs on medical students.

AMSA strongly advocates for coordinated action from all stakeholders to address these inequities. AMSA calls upon the Australian Federal Government to extend the CPP to medical students undertaking mandatory clinical placements on a means-tested basis, with prioritisation for students experiencing financial hardship and students from disadvantaged groups. AMSA additionally advocates for reform of student income support systems, including review of Youth Allowance, Austudy, and ABSTUDY rates and eligibility criteria, increased accessibility of support payments, reduction of HECS-HELP debt burden, and improved scholarship accessibility and flexibility. AMSA also calls upon State and Territory Governments, the Australian Medical Council, medical education providers (MEPs), clinical sites, medical student associations, and health unions to work collaboratively to standardise placement requirements, improve flexibility provisions, reduce unnecessary compliance costs, increase access to paid clinical employment opportunities, and strengthen practical support systems for students experiencing financial hardship.

AMSA believes urgent action is required to address the worsening financial pressures faced by medical students amid rising living costs and increasing educational debt. Without meaningful reform, these pressures risk worsening inequities within medical education, reducing diversity within the future medical workforce, and undermining the long-term sustainability of Australia's healthcare system.

Policy Points

AMSA calls upon:

1. All Stakeholders to:

a. Support advocacy for the extension of the CPP scheme to include all medical students undertaking clinical placement at AMC accredited sites, on a means-tested basis;
b. Recognise the compounded burden of medical school experienced by students from marginalised groups, including but not limited to:
    i. First Nations students;
    ii. Students from LGBTQIASB+ communities;
    iii. Students with disabilities;
    iv. Students with carer responsibilities or dependents; and
    v. Students from regional, rural, and remote areas.
c. Research and identify the factors contributing to financial hardship for medical students on clinical placement; and
d. Ensure all payments or supports offered to medical students provide clear guidance and assistance, such as translators or culturally-appropriate terminology.

2. Federal, State, and Territory Governments to:

a. Expand the current CPP scheme to include all medical students undertaking clinical placement at AMC accredited sites, on a means-tested basis;
b. Prioritise application of the CPP scheme to students from disadvantaged groups, including but not limited to:
    i. Students experiencing financial hardship;
    ii. First Nations students;
    iii. Students from LGBTQIASB+ communities;
    iv. Students with disabilities or carer responsibilities; and
    v. Students from or undertaking placements in regional, rural, and remote areas.
c. Research and publish information related to the efficacy, sustainability, and outcomes of students utilising the CPP scheme;
d. Reform the current state of the income support system for all tertiary students, that:
    i. Implements the recommendations of the Interim Economic Inclusion Advisory Committee;
    ii. Aligns the level of income support available to students with 90% of the age pension in accordance with recommendations from the Interim Economic Inclusion Advisory Committee;
    iii. Aligns the rate of Commonwealth Rent Assistance to the 25th percentile of rents in capital cities to restore historic levels of assistance;
    iv. Includes rent assistance as part of the income support system, with eligibility based on rent paid and income support testing, rather than eligibility for another payment;

v. Increases the income earning threshold before which income support reductions applies to 75% of the age pension amount;
vi. Reviews Youth Allowance Independence eligibility and reconsiders the need for parental means testing, especially for students under the age of 22-years who are completing full-time clinical placements;
vii. Safeguards students from experiencing financial abuse or exploitation;
viii. Supports sustainable financial independence for medical students, particularly for those impacted by partner income testing, and those experiencing domestic and family violence; and
ix. Silos other payments, including but not limited to, Disability Support Pension, Carers Allowance, CPP from income testing for student income support payments.
x. Re-evaluate the scholarship income threshold to ensure income support payments are not reduced when receiving scholarships solely restricted to educational expenses.

e. Expand the ABSTUDY Living Allowance timeframe to support First Nations medical students throughout the entirety of their degree;
    i. Re-evaluate the scholarship income threshold to ensure ABSTUDY payments are not deducted for scholarships that are strictly restricted to educational expenses and cannot be used for living costs.
    ii. Identify and eliminate systemic barriers faced by recipients post-ABSTUDY approval. Implement targeted support strategies that include, but are not limited to:
        1. Providing direct, streamlined reporting assistance; Guaranteeing timely access to dedicated First Nations ABSTUDY representatives; and,
        2. Amending deduction assessments to accurately account for non-annualized payment installments and fortnightly income reporting periods.
    iii. Reform the ABSTUDY eligibility framework by removing arbitrary age, means-testing, and course-level restrictions. This includes:
        1. Eliminating the parental income and assets tests for dependent applicants;
        2. Removing age-based cut-offs and lifetime caps on undergraduate study, ensuring funding extends to subsequent undergraduate degrees; and
        3. Expanding and simplifying access for postgraduate-level qualifications and dismantling rigid "reasonable time" limits on continuous learning.
f. Review the HELP loan limit ceiling to ensure coverage of the entirety of CSP, BMP, and full-fee places in Australian Medical Council accredited medical degrees;

g. Implement a HECS/HELP debt reduction to medical students, particularly those from disadvantaged groups, including but not limited to:
    i. Students with financial needs;
    ii. First Nations students; and
    iii. Students from rural and regional areas.
h. Standardise compliance support from health providers, including flu vaccination and mask fitting costs for students; and
i. Work collaboratively with all stakeholders to implement reforms to the federal income support system, providing standardisation for all medical students.

3. The Australian Medical Council to:

a. Enforce and support flexibility provisions for students, including but not limited to:
    i. Students with disabilities;
    ii. Students with carer responsibilities; and
    iii. First Nations students.
b. Provide comprehensive guidelines to MEPs on requirements for equitable and culturally safe placement;
c. Enforce standardisations across different MEPs to reduce the discrepancy of costs for students at different institutions;
d. Aid MEPs in supporting students who are relocating for short-term regional clinical placements; and
e. Provide comprehensive guidelines for streamlining, and reducing the burden, of occupational health and safety requirements for medical students on clinical placement.

4. Australian Medical Education Providers (MEPs):

a. Implement flexibility provisions as required by the AMC to support student success;
b. Ensure students facing financial burden are engaged with support services;
c. Increase the flexibility of required clinical placement hours where appropriate;
d. Streamline occupational health and safety requirements to reduce barriers for interstate, rural, remote, First Nations, and international students;
e. Reduce the discrepancy of costs for students at different clinical sites under the same institution; and
f. Provide appropriate, specific income support, including CPP and university-based, for students experiencing financial disadvantage due to compulsory relocation for clinical placement.

5. Clinical Sites to:

a. Provide or support the provision of discounted services, or financial support where appropriate, to medical students; and

b. Streamline occupational health and safety requirements to reduce barriers for all students, especially for interstate, rural, remote, First Nations, and international students.

6. Medical Student Associations and Health Unions to:

a. Advocate for the remuneration of medical students on clinical placements;
b. Work collaboratively with other stakeholders to implement reforms that support medical students;
c. Collaborate with students from other institutions and courses to develop solutions to the problem of placement poverty among Australian tertiary students; and
d. Provide or support the provision of discounted services, or financial support where appropriate, to medical students.

Background

FINANCIAL BURDENS FACED BY MEDICAL STUDENTS

Medical students face considerable demands in training to become Australia's future doctors, including structurally constrained programs, stringent academic requirements, and significant financial pressures. Despite the undeniable educational value, unpaid clinical placement is one of the biggest burdens of medical school, typically averaging 2300 hours, with some students required to complete more than 3000 hours.[1,2,3] Although medical education accreditation has required flexibility since 2024, there are limited opportunities for flexible study or part-time pathways.[4,5] The full-time nature of clinical placement limits the capacity to engage in safe, sustainable external employment.[1,2,6] Despite this, over 60% of medical students cannot rely on inadequate government support alone, and have to manage additional employment on top of full-time placement and study requirements.[6,7]

Medical education comes with an array of expenses, extending beyond steep tuition fees alone. Students are faced with substantial direct costs, including accommodation, relocation, travel, and essential medical equipment.[1] Alongside this, medical students pay hidden costs annually to meet the compliance requirements of their unpaid clinical placement, outlined in the For More Information section.[8]

The financial pressures of medical school are additionally attributed to the often overlooked opportunity costs associated with long unpaid periods of study. Medical students not only pay with their time, and their money, but also with their future security, with losses in earnings potential and superannuation accumulation across the 5-7 years of the degree.

REPRESENTATION AND DIVERSITY IN MEDICINE

Structurally, there have been significant global widening access (WA) initiatives aimed at increasing medical student diversity to ensure future doctors represent the patients they serve. This has been supported by increasing student entry from key disadvantaged groups such as First Nations students, rural students, and students from lower socioeconomic backgrounds.[9,10] However, these students still report significant financial concerns and increased reliance on employment when pursuing medical education,[11] demonstrating that institutional support is based around entry, and less so on attrition.[12] Additionally, the over-reliance on demographic profiling fails to account for complex intersections of disadvantage that students may experience, resulting in exclusion from potential support and entry.

Intersectionality provides a framework to understand how systems of power, privilege and oppression come together to shape varying experiences of disadvantage.[13] Medical students who experience the effects of colonisation, racism, ableism, classism, xenophobia and gender or sexuality-based abuse often face compounded financial barriers. While rising living costs ubiquitously impact medical students, these are disproportionately borne by specific groups, usually due to broader structural inequities.[14] First Nations students continue

to experience the effects of colonisation and economic exclusion.[15,16] Students from immigrant and refugee backgrounds may face additional family responsibilities and barriers when navigating culturally unsafe systems.[17,18,19] Students from LGBTQIASB+ communities often encounter economic precarity, unique healthcare costs, and loss of family support.[20,21,22] First in Family (FIF) students may lack both the financial resources and social capital needed to navigate medical education.[23] International students face substantially higher fees and limited access to government support. Moreover, students who relocate, come from regional or remote communities, have dependents, or live with disabilities also incur significant additional costs that can affect both educational participation and wellbeing.[23,24]

Whilst these experiences are diverse and unable to be captured within a single discussion, they collectively demonstrate the need for increased financial support throughout medical training. Addressing these barriers is essential for fostering a diverse medical workforce capable of meeting Australia's complex and evolving healthcare needs.

COMMONWEALTH PRAC PAYMENT

The Commonwealth Prac Payment (CPP) was introduced following recommendations from the Australian Universities Accord as a means of financial support to students undertaking mandatory placements within selected disciplines, including nursing, midwifery, teaching, and social work.[25] Implemented from July 2025, it was developed in recognition of the prevailing issue of “placement poverty”, coined for students experiencing significant financial hardship due to compulsory unpaid placements which limit their ability to seek paid employment.[26] The CPP thus aids in allowing students to focus on their practical studies, whilst targeting the downstream effects of placement poverty, including workforce shortages, attrition, and inequitable access to, as well as lower diversity within, higher education.[25] Eligible students are provided with approximately $388.60 weekly, intended to partially offset lost income and recurring out-of-pocket expenses, including transport, accommodation, parking and associated clinical costs.[27]

The Universities Accord team’s recommendation for selected disciplines was based on existing evidence, taking into account industries with the most severe domestic workforce shortages and lowest graduate starting salaries. Despite meeting the criteria, medical students are not currently recognised by this scheme. There is a clear workforce shortage within the Australian medical space currently, largely due to maldistribution issues which most notably impact regional, rural, remote and low socioeconomic areas.[25,28] For disciplines included within the scheme, there exists substantial documented research quantifying income loss, rising living costs, and the impact of placement-related financial stress on mental health and retention.[29] A study into the benefits of the CPP in eliminating “placement poverty” found that the CPP promoted academic liberation, mental wellbeing, improved learning and retention.[29] Most importantly, this study also demonstrated that the CPP was linked to a decrease in inequitable education access across students of varying financial

backgrounds.[29] In comparison, there remains relatively limited Australian research specifically examining the financial experiences of medical students during their clinical placements, despite the cumulative hours spent in supervisory settings being comparable to or greater than those in other health disciplines. This may potentially be due to longstanding preconceptions regarding the socioeconomic background and future earning capacity of medical students, despite increasing evidence that medicine is becoming less financially accessible to students from lower socioeconomic backgrounds.[30]

The absence of extensive research should not be interpreted as an absence of need. Medical students experience similarly significant financial stress as a result of mandatory unpaid clinical placements, which often exceed 2000 hours throughout their degrees.[31] Studies have shown that almost half of medical students work part-time during their studies, with many students reporting being unable to continue studying without a source of income.[31] For those who must relinquish this work during clinical placement, the loss of earnings can result in issues such as housing-cost stress and food insecurity - experienced by 70.2% of students - particularly when combined with unanticipated placement-related costs.[32]

The resulting loss of regular, paid employment, in addition to accumulating costs including transport, accommodation, relocation, parking and clinical equipment expenses, can have significant consequences which often disproportionately affect vulnerable student groups. Rural and regional placements, whilst important for student clinical experience and for encouraging rural and regional practice post-graduation, additionally exacerbate existing financial difficulties for medical students in the context of poorly available scholarships and income supports with strict eligibility criteria.[33] National and state-level programs, such as the Rural Health Multidisciplinary Training Program (RHMT) and targeted health-workforce scholarships, partially offset some costs but are generally not designed as income-replacement mechanisms and are often restricted by merit, geographic, or service-bond criteria that exclude many students with the greatest financial need.[34] As a result, the exclusion of medical students from the CPP reinforces existing inequities in medical education access, particularly for those from lower-socioeconomic backgrounds, FIF students, and those without access to family financial safety nets.

GOVERNMENT INCOME SUPPORT PAYMENTS

Introduction to Social Security Payments.

Australia's social security system is governed by the *Social Security Act 1991* (Cth), supported alongside administrative rules made through Services Australia and the Department of Social Services. It is designed as the main public safety net for those whose income or family resources are insufficient to meet basic living costs due to varying forms of disadvantage, including age, study, unemployment, carer responsibilities, and disability. At its core, the system is intended to reduce financial hardship and protect wellbeing by providing income support payments based on targeted eligibility rules as opposed to universal entitlement.[35] Means testing, via income and asset tests, is a method of quantifying one's financial capacity, and thus need for assistance. Recipients

may receive the full rate, a reduced rate, or no payment, depending on where their assessment lies relative to the relevant thresholds. The distinction between pensions and allowances is thus important here, as pensions are reduced gradually with an increase in one's assets, whilst many allowances cease once a cut-off point is reached.[36]

Means testing social security payments can create distinctive harms for those experiencing domestic and family violence (DFV) or financial abuse. The Economic Inclusion Advisory Committee's (EIAC) 2025 report found that social security arrangements can discourage victim-survivors from leaving abusive relationships, especially when mutual-obligation rules, discretionary exemptions, and narrow eligibility deadlines make it harder to access and maintain emergency financial support.[37] Economic abuse routinely inflates the victim's apparent financial capacity, including through coerced debt, asset control or the perpetrator's manipulation of income data, such that victims' real-time poverty and risk remain undisclosed.[38] Furthermore, lack of money is often cited as the primary barrier preventing survivors from leaving DV situations, with many not claiming emergency or special-rate payments because the criteria are too restrictive, administered too late, or experienced as traumatising and demeaning.[39] Together, this means-testing can entrap DV-affected individuals in abusive households without sustainable financial independence.

Overall, Australia's social security system combines targeted financial assistance with age-based eligibility, means testing, and participation requirements to balance equity, fiscal control, and labour market participation.

Youth Allowance.
Youth Allowance (YA) provides fortnightly cost-of-living support for students aged 24-years and under.[40] Services Australia considers two aspects for such assessment - a parental income test, assessing parental or guardian income, and a maintenance income test, in which changes to parental or guardian income, as well as siblings' situations can affect payment rates.[41,42] However, the barriers to being eligible for the scheme are inequitable and the maximum fortnightly rate of $677.20 is inadequate in the context of current living costs.[40] One such barrier is the parental means test, which reduces the payment rate received if the individual's parents earn a combined household income exceeding $66,722.[42] This is especially problematic for students from middle-low socioeconomic circumstances, where parental income may disqualify them from assistance, yet their parents carry significant financial obligations of their own, precluding them from supporting a dependent through study. To be considered independent, students must be 22-years and older, or meet strict criteria regarding employment and living arrangements, which is not always practicable in the context of medical education demands. Many younger medical students inevitably find themselves effectively marginalised from meaningful income support entirely.[43]

Austudy.
Individuals aged 25-years or older who are engaged in full-time study or an apprenticeship may be eligible for Austudy under Australian Government income

support criteria.[44] However, its eligibility and payment structures are poorly aligned with the realities of postgraduate medical education. Medical students undertake a program that combines full-time academic study with full-time compulsory unpaid placements, leaving minimal capacity for paid employment.[45] The combination of inadequate income support, compulsory unpaid placements, relocation costs, and high educational debt creates a structural financial barrier within medical education that disproportionately affects mature-aged students with pre-existing financial responsibilities, and undermines equitable access to the profession.[1]

ABSTUDY.

ABSTUDY is the biggest government support scheme which specifically targets the financial needs of First Nations students and apprentices.[46] The complex dimensions of intersectionality exacerbate challenges already faced by medical students and amplify the burden of First Nations students, with many citing financial struggles as a major factor affecting medical school retention.[47] Despite recent rate increases, the maximum range of $418.20 to $1,316.20 per fortnight does not accurately account for the increased disadvantage experienced by these students.[48] Furthermore, the 4-year-limit on ABSTUDY Living Allowance leaves many students with inconsistent support throughout the entirety of their medical degree. These barriers are attributable to the restrictive eligibility and maintenance criteria, fixed parental income thresholds, and repeated evidence requirements. Navigating these requirements can be difficult, especially for students from low-income, rural, or FIF backgrounds, and they add to the time spent contacting departments, gathering documents, and seeking support with applications.[49]

Commonwealth Rent Assistance.

Commonwealth Rent Assistance (CRA) is available for those who receive an eligible payment and have accommodation expenses exceeding a minimum threshold, currently $154.80/fortnight.[50] It is paid fortnightly at 75 cents for every dollar of rent above the threshold, up to a maximum rate of $219.40/fortnight.[50] However, one in three low-income private renters do not receive the CRA, meaning that a significant portion of vulnerable students are unsupported.[51] The EIAC 2025 Report highlights that 75% of students receiving YA and CRA are experiencing rental stress, with no resolution from recent increases in the CRA rate.[37] The CRA is indexed against the general component of Consumer Price Index (CPI), and not the rent component.[52] This measure of indexation means that the increases in the CRA are not reflective of the true increases in housing costs.[52] Moreover, medical students are significantly affected by the upper limit of the CRA payment, as most medical programs are based in large cities where the median rent tends to be higher.[53]

HECS/HELP.

HELP loan schemes include HECS-HELP for Commonwealth-support places (CSP), and FEE-HELP for full-fee paying students, enabling the deferral of tuition fees until an income threshold is exceeded, and indexation occurring annually in line with the CPI.[54,55] Recent Australian data highlights the growing scale of student debt, with 2.93 million Australians holding HECS-HELP

debt in 2023–2024 and total outstanding debt reaching $81.05 billion.[56] Medical students accumulate substantially higher debts due to longer course durations, however the HELP loan limit of $186,544 does not cover the full-fee places.[57,29]

Disability Support Pension.
The Disability Support Pension (DSP) is designed for those with long-term medical conditions or impairments that significantly limit work capacity, and its relevance for students is tied to disability rather than student status alone.[58] Medical students with disabilities often face extra costs that are not well recognised by universities or placement providers, including assistive technology, modified transport, and reasonable adjustments on placement. However, there are minimal supports available for medical students to access. The most recognised payment, the Disability Support Pension (DSP) is designed to support those with long-term medical conditions or impairments that limit work capacity. Unfortunately, the time demands of medical education, despite being unpaid, leave medical students ineligible for this payment.

Moreover, students with disabilities are exposed to substantial learning, compliance, and psychological costs associated with applying for support payments.[59] Higher education providers are relying on multiple, uneven funding streams to support students with a disability, and that the current government and university investment does not necessarily translate into stronger participation or retention outcomes.[60]

OTHER FINANCIAL SUPPORTS

Medical students can access additional support outside of government initiatives, such as university and private scholarships, hardship grants, and rural placement subsidies. However, the availability and accessibility of these supports varies across the medical education sector. University scholarships often have restrictive criteria that may exclude students who are academically impacted by financial hardship. Scholarship availability may be limited due to dependence on donations, increased applications, or outsourced processes, particularly in equity scholarships. This is exacerbated by lengthy application processing times, preventing students from accessing support during periods of acute need.

Private and government-funded scholarships vary in scope and accessibility. NSW Health's Tertiary Health Study Subsidy Program, which provides select students $8000-$12 000 in exchange for a 5-year return of service, leaves students not meeting the restrictive eligibility criteria with little other alternative.[61,62] Notably, this scheme's lack of longevity, being available only from 2024-2026, provides only short-lived utility even for eligible students.[63] Thus even when successful, funding is often insufficient, both in supporting the real-world costs faced by medical students, and in continuity throughout the many years spanned by medical degrees.

Universities and medical education providers often have welfare assistance programs covering emergency financial aid, accommodation, travel

reimbursements, food vouchers, or short-term rural bursaries.[64] These programs fill genuine gaps, but funding capacity and availability vary widely between universities, and fail to account for the chronic financial burden placed on placement-oriented degrees like medicine.

For More Information

The table below has come from the following reference, and highlights the approximate costings of certain compliance checks:

Compliance Requirement	Cost
National (Australian) Police Check	$27.39 ($24.90 + GST)
International Criminal History Check	$174.90 ($159 + GST) $60.50 ($55 + GST) for New Zealand
Working with Children Check	Free in Victoria Free in NSW (volunteers only, $107 for paid workers) Free in TAS (for volunteers only)
Immunisations	$25-$105 (private billing for international students)
First Aid (Radiography and Medical Imaging)	$195 to $225
Medical and Fitness Assessment (Paramedicine)	$450 - $650
NDIS Check	$135.50
Compliance (Mask fit, TB, Sero)	~$200-400

Mandatory compliance. Monash University Australia. Date unknown. Accessed May 24, 2026. https://www.monash.edu/medicine/study/student-services/mandatory-compliance

The Department of Education has publicly available information regarding the Commonwealth Prac Payment eligibility criteria, reporting requirements, and other resources available:

Commonwealth prac payment. Department of Education, Australian Government. Updated May 13, 2026. Accessed May 23, 2026. https://www.education.gov.au/commonwealth-prac-payment-cpp

This source outlines the Rural Health Multidisciplinary Training program (RHMT), its goals, current status and participating universities.

Rural health multidisciplinary training (RHMT) program. Department of Health, Disability and Ageing, Australian Government. Updated May 18, 2026. Accessed June 10, 2026. https://www.health.gov.au/our-work/rhmt?language=en

The source below highlights the eligibility requirements for the DSP with respect to students and the 15 hours of mainstream, unmodified study limit for CITW.

3.6.1.42 Qualification for DSP during study or training - 15 hour rule. Social Security Guide. Department of Social Security, Australian

Government. Updated January 2, 2026. Accessed June 10, 2026. https://guides.dss.gov.au/social-security-guide/3/6/1/42

The sources below highlight various university-specific financial supports available to students, and their respective eligibility criteria.

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Policy Details:

Name: Student Income Support (2026)

Category: C - Supporting Students

History: Reviewed, Council 3, 2026

Vaneeza Kazmi (Lead Author), Amy Luo, Anusha Hasan, Celeste Nicholson, Cher Shi, Jessica Mitchell, Karen Santhosh, Nancy Chi, Victor Nguyen; with Taylor Cabassi (National Policy Mentor), Santi Chua (National Policy Secretary), and Swetha Kumar (National Policy Officer).

Reviewed, Council 3, 2023

Ashley Molloy, Dineli Kalansuriya, En Ning Yu, Sarah Rutledge, Thilini Wijesuriya; with Ebony Layton (National Policy Mentor), Harry Luu (National Policy Secretary), and Connor Ryan (National Policy Officer).

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Reviewed, Council 3, 2014

Adopted, Council 1, 2012