

Policy Document

Vocational Training Pathways (2026)

Key Terminology

Accredited Registrars hold a position on a formal training program accredited by a specialist medical college, with a structured curriculum, and well-defined competencies and assessments.

Unaccredited Registrars hold a substantive registrar position, performing similar duties to their accredited counterparts but are not on a formal training program. These positions do not follow the same clear progression as accredited positions.

Career Medical Officer (CMO) refers to a non-specialist appointed to a permanent position without ongoing formal training. They may still supervise junior medical officers and registrars, and are implemented across many specialties, especially those in shortage.

International Medical Graduates (IMGs) are practitioners who have obtained their medical degree internationally (outside of Australia).

Graduates of Australian Medical Schools are practitioners who obtained their medical degree from an AMC-accredited university, irrespective of whether they hold an Australian permanent residency or citizenship.

Executive Summary

As Australia's population grows so too does demand for the continual development and retention of highly skilled medical practitioners to deliver excellent health care. AMSA is committed to working alongside the many stakeholders already addressing this multifactorial issue for the betterment of Australian communities.

Both expansions in funding for Commonwealth Supported Places (CSPs) at Australian Medical Schools and international recruitment have significantly strengthened our prevocational health workforce. Unfortunately, this growth has significantly outpaced expansion of vocational training positions, culminating in a training bottleneck despite ongoing specialist and registrar shortages, especially in rural and remote areas. By 2048, Australia will have 12,812 too few specialists, despite 10,783 junior doctors in surplus. This underutilises a capable talent pool taxpayers have paid to train and recruit. AMSA urgently calls on state and federal governments, specialty colleges and hospitals, to collaboratively increase vocational training position numbers and their allocated funding. AMSA



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calls upon the federal government to tie CSPs to vocational training pathway resourcing and recruitment.

The current lack of comprehensive data oversight hinders strategic workforce planning. This has led to overt geographic maldistribution, high clinician turnover, and reliance on locums and international recruitment, which ultimately direct strategic capacity toward temporary, costly solutions for both patients and health systems, and thus away from training senior clinicians for future demand. AMSA recognises that international medical graduates (IMGs) are essential to Australia's workforce, and bring a rich diversity of skilled clinical and cultural experience to our health system. Current dependence on IMGs as a substitute for national workforce planning incentivises exploitation, creates workforce sustainability risks, and compromises the cultural safety of care for First Nations people, which is further discussed in the Department of Health, Disability and Ageing's National Medical Workforce Strategy 2021-2031.

AMSA calls for the creation of a national training dataset to coordinate resourcing of current and projected health workforce demands from an evidence base, to sustainably produce the correct mix of clinicians for Australian communities. AMSA further urges those stakeholders already engaged in the Medical Workforce Advisory Committee (MWAC) to actively contribute to the implementation of solutions which prioritise accessibility, equity, and efficacy.

Vocational Training selection criteria remain variably inconsistent and opaque between specialty colleges and across application cycles. AMSA calls for transparent, equitable, and financially accessible training pathways for all potential candidates. AMSA urges colleges to publish clear information on selection criteria, applicant numbers and success rates to support informed decision making, especially so that medical students have access to reliable career information. AMSA encourages colleges to refine selection processes so that clinical aptitude and professionalism more significantly outweigh research criteria. AMSA calls for continued recognition of First Nations status and commitment to rural healthcare, as we look to retain culturally competent workforces in places of need.

Unaccredited registrar positions often lack formal training, supervision, and career progression. The growing vocational training bottleneck leaves more junior doctors at risk of exploitation from such positions. AMSA calls upon the Australian State and Territory governments, alongside hospitals and health services, to more strictly govern registrar supervision standards with clear objectives and assessments, provide educational support, and ensure sufficient mentorship for professional development.

Policy Points

AMSA calls upon:

1. All stakeholders to:

- a. Actively collaborate with other stakeholders to rectify the current bottleneck in entering specialist training programs to:
 - i. Increase supply to meet projected future workforce needs;
 - ii. Address the geographical maldistribution of trainees; and
 - iii. Improve the accessibility of health services to the community.

2. The Federal, State, and Territory Governments to:

- a. Establish a national pooled training database that is:
 - i. Independently managed and overseen;
 - ii. Publicly accessible and designed for ease of interpretation;
 - iii. Based on existing Australian Health Practitioner Regulation Agency survey infrastructure, with annual data collection reporting the:
 1. Number of current, and graduating medical students
 2. Number of vocational training applicants
 3. Number of new trainees, fellows, and specialists
 4. Number of continuing trainees, fellows, and specialists
 5. Gender distribution of trainees, fellows, and specialists
 6. Median age of trainees, fellows, and specialists;
 - iv. Presented with geographical distribution statistics per state and nationwide for each specialty; and
 - v. Representative of the current level of reliance on IMGs to fill critical service roles, or areas of shortage.
- b. Utilise the national pooled training database to standardise the content of career guidance resources across all states and territories;
- c. Expand the Specialty Training Program (STP) and Integrated Rural Training Pipeline (IRTP) by increasing the number of specialty training places in priority locations to sufficiently meet areas of current and projected health workforce, supported by additional service resourcing where appropriate;
- d. Ensure adequate ongoing funding of critical training infrastructure, including:
 - i. Increasing the per-place funding for the STP and IRTP to align with inflation;
 - ii. Auditing funding provided through the IRTP and Remote Vocational Training Scheme (RVTS) to ensure it is used rurally; and
 - iii. Continuing to fund and support the Australian General Practice Training (AGPT) program.

- e. Implement the remaining recommendations of the *National Medical Workforce Strategy 2021-2031*; and
- f. Continue medical student representation on the Vocational Training review panel and the Medical Workforce Advisory Committee (MWAC), employing these panels to:
 - i. Investigate and address systemic weakness in responses to ongoing workforce demand;
 - ii. Implement training position minimum quotas for underserved specialties determined by a national pooled database; and
 - iii. Reinvigorate live collaboration for vocational training coordination.
- g. Support hospitals and health services in providing adequate, quality supervision, education, and mentorship to unaccredited registrars.

3. Australian Medical Specialist Colleges to:

- a. Publish clear application guidelines that:
 - i. Provide standardised procedures for assessment, appeals, accreditation, and flexible training positions;
 - ii. Breakdown ongoing college fees for accredited trainees;
 - iii. Stipulate the number, and geographical distribution, of available training positions and the most recent proportion of successful applicants; and
 - iv. Provide detailed and relevant information on the requirements of training programs, including ongoing relocation requirements.
- b. Improve the accessibility of training positions, through actions that:
 - i. Minimise the financial strain on trainees;
 - ii. Innovate and implement entry and examination options for those experiencing financial hardship;
 - iii. Simplify the administrative process and reduce barriers to applying for vocational training;
 - iv. Provide clear and supportive accessibility procedures and reasonable adjustments to trainees with a disability; and
 - v. Empower trainees to utilise flexible program designs, part-time study, and take medical leave for illness, parental leave, and extenuating circumstances;
- c. Develop and implement equitable trainee selection processes which:
 - i. Clearly outline selection criteria, including the relative weighting or scoring of CV domains and other selection components;
 - ii. Grade clinical capability as an individual more favourably than research activity;
 - iii. Uphold the protected attributes under *the Anti-Discrimination Act 1991*;
 - iv. Actively advocate for and endorse First Nations selection initiatives; and

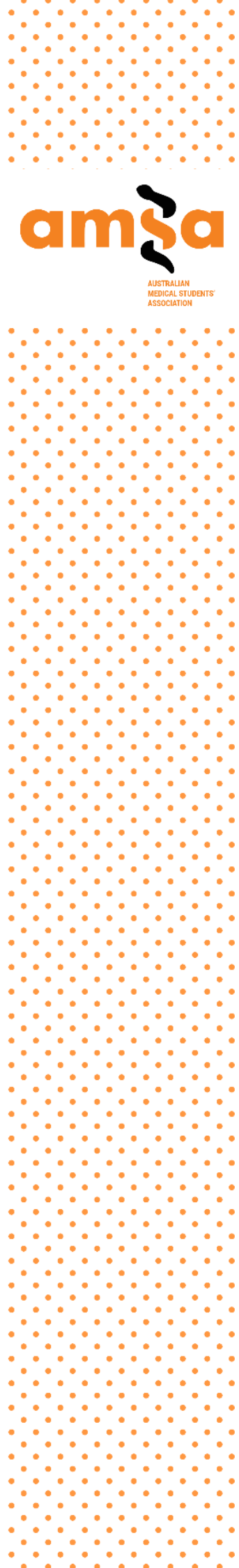
- v. Preference individuals with demonstrable commitment to working rurally.

4. Public and Private Hospitals and Health Services to:

- a. Recruit for appropriately flexible medical training positions which maintain high-quality healthcare delivery and clinical training;
- b. Create more accredited training positions that better account for the specific needs of their local communities;
- c. Fund data collection for contribution to national work-forcing statistics to better inform servicing requirements;
- d. Use funding allocated under the STP to meaningfully enrich teaching infrastructure and supervision to support extended scope of training; and
- e. Ensure protections are in place for mandatory, quality supervision of trainees, that accommodates for all accessibility needs, languages, and cultural contexts.

5. Australian Medical Schools to:

- a. Support students in gaining exposure to undersubscribed specialties, through both curriculum content, and clinical placements;
- b. Provide students with access to Government standardised resources regarding medical specialties, the training pathway, and the specific entry requirements; and
- c. Support students in gaining exposure to rural training pathways, in line with the policy points of AMSA's *Rural Clinical Schools 2026* policy.



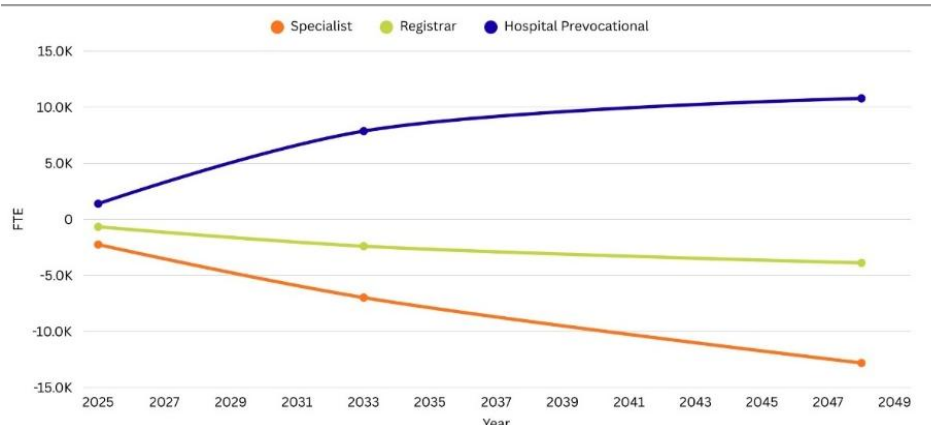
Background

THE MALDISTRIBUTION OF THE AUSTRALIAN HEALTH WORKFORCE

The Shortage of Specialists and Vocational Trainees.

Australia's medical workforce faces a growing shortage of specialist and vocational training doctors. While the government continues to increase medical school places,[1] vocational training positions have largely remained stagnant. In 2025, specialist doctors were already undersupplied by 2,250.5 full-time equivalent (FTE).[2] This deficit is expected to increase to 6,981.1 in 2033 and 12,811.6 in 2048. Registrar shortages are also projected to increase, from 670.1 FTE in 2025 to 2,397.8 in 2033 and 3,884.5 in 2048, which is shown in Figure 1.

Figure 1. Projections of the National Medical Workforce

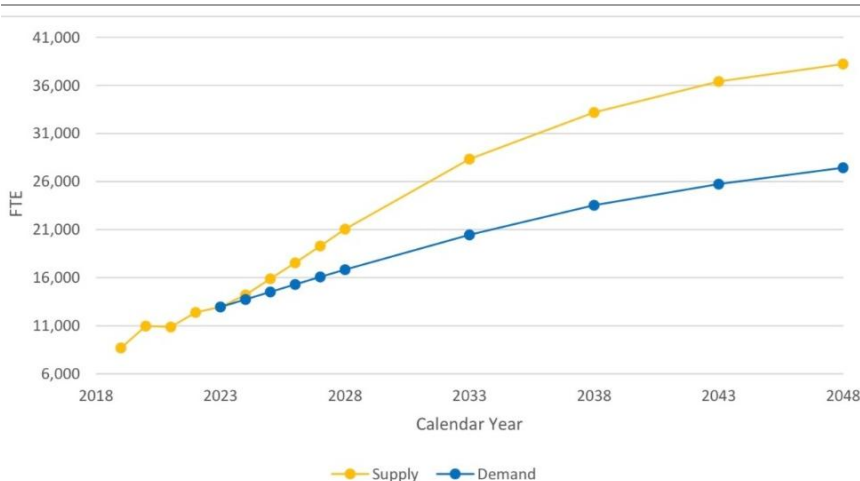


Data derived from Whole of Medical Workforce Supply and Demand Compendium Report.[2]

The Oversupply of Prevocational Doctors.

The Whole of Medical Workforce Supply and Demand Compendium Report projected oversupply of prevocational doctors increasing from 1,391 FTE in 2025 to 7,867 FTE by 2033 and 10,783 by 2048.[2] The average annual transition rate from the hospital prevocational workforce into registrar positions has fallen from 52% in 2018 to 36% in 2024, projected at just 15% by 2048, shown in Figure 2.

Figure 2. National Projections of FTE for Hospital Prevocational Doctors



Source: Dept of Health, Disability and Ageing, Australian Government.[2]

This demonstrates that increasing medical graduate numbers without corresponding expansion of vocational training capacity risks creating prolonged bottlenecks, while failing to address projected shortages of specialists.

Geographical Distribution of Vocational Training Positions.

Geographical distribution of the workforce is an important consideration, as regional, rural and remote areas continue to have substantially fewer medical practitioners per capita than metropolitan areas. In 2023, there were 510.5 FTE doctors per 100,000 population in metropolitan areas (MM1), compared with only 135.5 FTE per 100,000 in small rural towns (MM5).[2]

Training pathways should therefore be coordinated according to future workforce demand, specialty needs, and geographic distribution to prevent both the growing numbers of doctors unable to access training, and shortages in the specialist workforce and underserved communities. Importantly, actions taken to address trainee shortages in regional, rural, and remote areas need to be accompanied by appropriate resourcing and specialist supervision.

SPECIALTY COLLEGE ENTRY REQUIREMENTS

The Specialist Training Bottleneck.

Entry into a specialty college training program remains hypercompetitive due to a mismatch between the large number of junior doctors, and small number of training positions. A large portion of time between graduation and attaining fellowship can be spent in non-training or service roles, contributing to delays in improving clinician competence compared to accredited training positions.[3] Many junior doctors remain in pre-training and unaccredited roles (e.g. unaccredited registrars and resident medical officers) for prolonged periods in order to develop a competitive application for training. While application limits may provide greater career certainty following unsuccessful attempts, they may also unintentionally encourage applicants to delay applying until they consider their portfolio sufficiently competitive, thereby prolonging time spent in pre-training roles.

Positions are influenced by specialist college capacity and hospitals' immediate service needs. As a result, hospitals can require a large amount of registrar-level labour without there being an equivalent need for fully accredited specialists, relegating doctors into unaccredited positions.[4]

The Effect of Selection Criteria on Career Progression.

Of medical students, 76.7% agreed that selection criteria heavily influences their specialty preferences.[5] However, only 14 of the 47 specialty medical and surgical training programs examined had publicly available standardised CV scoring criteria.[6] Additionally, selection criteria varies between specialties and colleges, limiting applicants' flexibility to change specialties or pursue alternative training pathways. Commendably, the Royal Australasian College of Surgeons (RACS) has clear guidelines on selection criteria, including the CV scoring system and relevant weighting of each section.[7]

Conversely, the Royal Australasian College of Physicians (RACP) has a less transparent process for Basic Physician Training, as training position appointment is determined independently from RACP by health services. For subsequent advanced training selection, the RACP identifies several domains in which candidates should demonstrate competence, but does not clearly define the standard required.[8] The RACP's own 2025 evaluation, informed by stakeholder consultations, found that trainees, even within accredited programs, called for clearer selection criteria and progression, as a lack of standardised frameworks contributes to uncertainty around the selection process.[8]

Transparency ideally should include data on application numbers as compared with successful appointments. Despite RACS' considerable transparency reforms,[7] inconsistency between application cycles remains a prevalent issue. Frequent adjustment of selection criteria may result in prospective trainees investing significant time and finances into gaining advantages which potentiate detractions from capacity for quality healthcare delivery, only for these to then be nullified (such as the recent reduced weighting of higher degrees such as Master of Surgery).

The Role of Research in Selection Criteria.

Current selection criteria can promote a "CV arms race", where increasing competition for limited training positions incentivises applicants to maximise every component of their portfolio, with research being a heavily weighted component. Of the 14 programs with publicised CV criteria, all 14 had a component allocated for research, accounting on average for 42.5% of CV points, with research outweighing clinical experience in 10 specialties.[6] Applicants are thus incentivized to pursue research for CV point accumulation rather than out of genuine interest or potential relevance to future practice.

The National Medical Workforce Strategy identified fatigue, burnout, anxiety and other mental health issues amongst applicants as a direct consequence of CV buffing.[3] While other criteria are often easy to 'max out', heavy weighting on research and publications can make them an important focus for a competitive application. Muecke et al. describe this as a 'box-ticking' mentality amongst applicants seeking a competitive application.[6] The National Medical Workforce Strategy revealed that intense competition for vocational training incentivises junior doctors to use prevocational years to pursue specialty-specific work, further qualifications, research and other courses to maximise chances of selection.[3] This pressure often begins as early as medical school, where students may pursue research primarily to improve their competitiveness for specialty training, despite the substantial time demands involved.[9] This compromises the quality of the research being produced. A 2025 study of mandatory research projects among Australian and New Zealand specialist trainees found that 51 trainees felt that the requirements promoted poor-quality research. Of the 27 research reports which were assessed, 24 were rated with having moderate to high risk of bias.[10] This concern is supported by Stehlik et al., who identified specialty selection criteria as an under-recognised driver of

research waste, with research points predominantly rewarding publication authorship rather than research utilisation or training.[11]

The Predictive Validity of Selection Criteria.

Selection processes should identify applicants most likely and capable of becoming competent specialists. However, many common selection criteria have limited evidence in predicting future performance. Across meta-analyses and systematic reviews, common criteria such as research, leadership, volunteering and higher degrees poorly predict future performance, while structured methods such as situational judgement tests (SJTs) and multiple mini interviews (MMIs) demonstrate stronger validity in assessing clinically relevant attributes. This was echoed in the RACP 2025 Evaluation report,[8] and an Australian study following GP Registrars through training.[12] These findings suggest that specialty colleges should find other ways to quantify and reward trainee achievements in clinically relevant domains, so that selection more accurately reflects the skills required to succeed in the specialty.

The Equity of Selection Criteria.

Portfolio-based selection inherently privileges applicants with greater access to resources and opportunities needed to build a competitive application. Many of the activities rewarded in selection, such as higher degrees, conference presentations and extracurricular activities, require financial and time resources which significantly disadvantages doctors living with disability, those in rural towns, those of First Nations status, and those from lower socioeconomic backgrounds. Selection processes should account for applicants with disability, as strict entry requirements can create barriers unrelated to an individual's ability to practice medicine.[13] A 2024 analysis of publicly available CV criteria from 11 programs described how financial constraints and differences between medical programs can limit access to professional achievements. For example, low-income candidates may be less able to pursue unpaid internships or summer research programs.[14]

Access to portfolio-building opportunities may vary geographically, with rural pathways offering different forms of clinical experience from metropolitan training.[15] The strengths developed during rural training specifically, are not consistently reflected in selection criteria. Among the programs with publicly available CV criteria, only 8 formally awarded points for rural exposure, with a maximum weighting of 28.5%, despite it being associated with greater interest in future rural practice, even within non-generalist specialties.[16] The 2025 guidance from the National Rural Health Commissioner and Council of Presidents of Medical Colleges recommend that colleges value rural background and rural placements in specialist selection.[17]

WORKFORCE REFORM

Reinstating National Workforce Planning.

To execute national workforce reforms, Australia must reinstate a national health workforce planning body.[18] Since the disbandment of Health Workforce Australia, the country has suffered from a lack of centralized coordination, leaving workforce planning to fragmented state-by-state approaches. A reinstated national authority is vital to oversee the equitable distribution of training positions and ensure that the medical pipeline is aligned with the long-term health needs of the Australian community.

VOCATIONAL TRAINING PATHWAY TRANSPARENCY

Australian medical students face a persistent difficulty in accessing workforce information that could meaningfully inform specialty selection. Some jurisdictions have made progress in addressing this gap. New South Wales, Queensland, and Western Australia have each developed dedicated career guidance resources that include specialty-specific data such as training numbers, applicant competitiveness, and average consultant hours worked.[19-21] Other states and territories do not currently have an equivalent resource, with Victoria & South Australia's pathway guides providing minimal detail on workforce numbers or long-term specialty sustainability.[22-24] Providing this information allows medical students to factor workforce oversupply or shortage into their career planning in a way that was previously unavailable to them. Comparatively, the English and United States' health systems have already demonstrated that centralised, nationally maintained workforce data is achievable and considered a worthwhile health infrastructure investment. Maintaining specialty recruitment data published annually, and profiling national training requirements, workforce trends, and lifestyle factors.[25-28]

Poor oversight of Australian training data likely contributes to metropolitan overconcentration in some specialist fields and rural shortages in others. Without reliable data, students are unsupported in selecting specialties which fulfil workforce needs, instead choosing based on anecdotal or informal advice. This has a direct equity dimension. Students without established professional or family networks within medicine, including first-in-family and rural background students, are disproportionately reliant on the kind of informal knowledge that a public data resource would otherwise provide.

VOCATIONAL TRAINING POSITION NUMBERS

Medical Graduates and Prevocational Doctors.

Extensive data collection by Medical Deans Australia and New Zealand (MDANZ) highlights the increasing number of medical school intakes over the past 15 years.[29] The number of medical graduates is projected to increase with the new 140 commencing Commonwealth Supported Places (CSPs) and expansion of 6 non-CSP scholarships places through the Northern Territory Medical Program.[2] In 2019, Australia graduated 15.9 medical graduates per 100,000 inhabitants, well above the OECD average, where the UK graduated 13.1, USA 8.1, and Canada 7.1.[30]

Vocational Trainee Maldistribution Across Specialties.

In terms of distribution, psychiatry, general pathology, and emergency medicine are undersubscribed, whereas anaesthesia, cardiothoracic surgery, and dermatology are oversubscribed.[31] Differing characteristics between specialties, such as on-call and procedural work, control over hours and academic research opportunities are important factors associated with variations in specialty oversupply and shortage.[32] Common individual factors include personal values, such as work-life balance, financial factors, and training experiences, such as workplace culture and unbalanced exposure.[32] Common systemic factors are limited training opportunities, limited supervisors, and service models.[3] Major cities had the highest level of employed and registered health professionals (26.8 FTE per 1,000 people) whereas outer regional areas had the lowest (22.2 FTE per 1,000 people).[33] This is in line with the tendency for new medical graduates to prefer metropolitan work, where 72% chose major cities in 2023 compared to 30% who preferred regional, rural or remote locations. In addition to geographical distribution, disparity is also seen in the distribution of doctors in the public and private sector, where over 80% of prevocational doctors and 90% of registrars work in the public sector compared to over 60% of specialists practicing in the private sector.[2]

Determination of Vocational Training Position Numbers.

In Australia, medical vocational training positions are determined and influenced by hospital employers, specialty colleges, state and territory governments, and the federal government. GP training numbers are determined and funded by the Commonwealth through the Australian General Practice Training, with the Independent Pathway providing an alternative for self-funded training through colleges. For specialist training, the state and territory health departments fund training positions, the specialty colleges accredit training posts, and it is ultimately the workplaces and local jurisdictions (e.g. local hospital networks) that have significant influence over training position numbers through their control over funding allocation. However, the lack of independent oversight creates potential conflicts of interest between stakeholders with competing priorities and may limit collaboration to improve workforce strategy.

VOCATIONAL TRAINING FLEXIBILITY

Family Building.

Specialty training coincides with the period in which many doctors begin family building, yet training structures can make these responsibilities difficult to balance with career progression, as training requirements can affect the timing of pregnancy or contribute to delayed childbearing.[34] Protected parental leave, and protections against reproductive discrimination should be foundational to vocational training as per The Universal Declaration of Human Rights.[35] Prevocational doctors therefore may preference training pathways that offer greater flexibility in order to balance their personal commitments. For example, surgical specialties are often least favoured due to longer working hours, on-call and night shift responsibilities.

Rural Training Settings.

Training programs or rotations may not be viable in regional and rural settings due to lack of supervisors, lack of exposure during medical school and the financial or personal costs to doctors required for relocation.[36] A suggested compromise is virtual supervision, wherein senior medical staff oversee a junior doctor's training from a distance, as implemented in the Remote Vocational Training Scheme (RVTS).[37] This can increase the perceived viability of a rural career for prospective medical graduates and allow supervisors to run programs past their geographic capacity in regional or rural areas, however, it creates issues with learning accessibility and opportunity.[38] Conversely, colleges may consider the removal of mandatory rotations that would require doctors to relocate to metropolitan areas, if equivalent skills could be obtained in other, more accessible settings with sufficient case volume.[39]

UNACCREDITED REGISTRARS

A contentious issue is the large number of unaccredited registrars, who despite not being enrolled in formal training programs, are expected to perform at the level of accredited registrars.[40] A lack of national data collection means there is unreliable data on the exact number of unaccredited registrars within the Australian medical workforce. However, these unaccredited positions are particularly common in competitive specialties such as plastic surgery or neurosurgery and are growing in number.[41-43]

Unaccredited registrars have been identified as a significant inefficiency in postgraduate medical training. While they can be a relatively low-cost solution for healthcare systems to address constantly fluctuating workforce demands due to their lower pay and high flexibility, these positions delay career progression and lack formal training, appraisal, or supervision. Capable medical professionals end up trapped in these positions rather than progressing into high-need specialties such as general practice, psychiatry or rural medicine as there are no limits on the time spent as unaccredited registrars and no guarantee of career progression.[44]

For doctors in unaccredited registrar positions, the absence of the dignity and protection of formal training programs increases their vulnerability to exploitation and bullying. While specialty colleges cover accredited registrars, unaccredited registrars lack a representational body to advocate for their concerns and provide oversight.[45] This lack of protection is evidenced by the absence of any national legislation limiting their maximum working hours.[46] For doctors living with disabilities, of First Nations status, or from lower socioeconomic backgrounds, the lack of supervision may result in subpar training and further exacerbate the vulnerabilities faced by unaccredited registrars. Furthermore, because these roles focus on gaining specialty experience and CV building, reliance on referee reports from supervising doctors can contribute to structural power imbalances, which can precipitate bullying, stress and harassment. Dr. Yumiko Kadota's experience involved extreme working conditions with excessively long hours, lack of adequate support, and significant emotional and physical stress to the extent of burnout.[47] Her situation highlights the many

systemic issues within the healthcare system concerning the position of unaccredited registrars.

The position of unaccredited registrars is complicated by the fact that they account for a large proportion of hospital labour, without any penalties. There is no financial incentive for hospitals to convert unaccredited positions to accredited training positions, which require more funding.[42] More broadly, there is limited coordination between state and federal governments, and specialist medical colleges about vocational training pathways as there is no single institution that possess the combined authority, funding and legal mandate to tackle the issue.[48] The 2014 dismantling of Health Workforce Australia has driven the fragmentation of power across these three key stakeholders, creating a responsibility void, stalling any concrete action on the issue.[48]

INTERNATIONAL MEDICAL GRADUATES

Current Reliance and Supply Trends.

The IMG share of the workforce has risen from 21% in 2003 to 32% in 2025.[2] Modelling assumes high levels of international recruitment will continue, with IMGs projected to make up 42% of the total growth in medical practitioner supply from 2025 to 2048, expected to comprise 38% of the total workforce.[2]

Maldistribution, Shortage Areas, and Systemic Risks.

Historically, mechanisms like the District of Workforce Shortage (DWS) for specialists and Distribution Priority Area (DPA) for GPs, which are areas classified as MM 2–7 under the Modified Monash Model (MMM)[2]. Under Section 19AB of the Health Insurance Act 1973, IMGs must work in a DPA/DWS location to access Medicare billing, often without adequate cultural safety training, exposing them to significant risk of exploitation.[49] However, outer metropolitan catchments (MM1) can and frequently do gain DPA status.[50] A 2026 evaluation by the Medical Board of Australia found that only 11% of all Specialist IMGs accepted through the Expedited Specialist Pathway, introduced in 2024, are currently practising in regional, rural and remote areas.[51] This results in prevocational and specialist IMGs clustering in well-served outer-suburban areas of major cities rather than relocating to genuinely rural and remote communities in desperate workforce need.[51] Nonetheless, this pathway increases supervision capacity for vocational training positions, prevents the costly retraining of clinicians with immense clinical expertise who greatly enrich our health services, and makes allowances for cultural safety training.[52] Governance should ensure that expedited pathways do not resource funds from vocational training positions, and that practitioners are directed toward rural and remote areas to expand service and training supervision capacity in these locations.

Service Delivery Pressures and Educational Quality.

Surging service demands and strict college limits on trainee hours have forced hospitals to rely heavily on prevocational doctors, IMGs, and CMOs for out-of-hours coverage.[2] This surge creates a severe workforce bottleneck that

reduces junior doctors and incoming IMGs to mere rostering solutions, ultimately compromising supervision, weakening medical education quality, and posing direct risks to patient safety.

Vulnerabilities in Supply Chain Shocks.

The Australian healthcare system's over-reliance on IMGs creates a brittle workforce supply chain [3] built on temporary migration, thus constantly exposed to geopolitical shifts and migration policy changes, threatening continuous and reliable service delivery for Australian patients.[3] This vulnerability was starkly exposed during the COVID-19 pandemic; when international borders closed, the pipeline of incoming medical practitioners was abruptly severed, leaving regional and rural areas critically understaffed almost overnight.[53]

TRAINING FUNDING

Vocational training funding involves complex stakeholder cooperation at federal, state, and local levels across many clinical environments. Federal funding initiatives broadly incentivise primary care pathways and rural training, however, in the absence of pooled national training data, the 2021-2031 National Medical Workforce Strategy identifies significant challenges in equitable distribution of workforce funding to amend ongoing maldistribution issues.[3] The Commonwealth provides full funding for the Australian General Practice Training (AGPT) program to train junior doctors into qualified general practitioners (GPs).[54] The AGPT absorbed the Rural Generalist Training Scheme in 2026, expanding to deliver over 2500 places annually by 2028.[54] This reform has been accompanied by expanded salary incentives, study and parental leave for GP registrars, resembling existing non-GP arrangements.[55]

State and territory governments provide funding for vocational medical training through their public health service networks, with significant variability between jurisdictions. Federal funding is designed to extend clinical opportunities in public, but especially rural and private hospitals via the Specialty Training Program (STP), an executive grants program involving competitive annual rounds for jurisdictions.[56] This supports 920 training places with a base salary which has grown only 5% since 2015,[56,57] despite Australian Consumer Price Inflation (CPI) compounding 35.9%,[58] and Average Weekly Earnings (AWE) increasing 18.2% during that period.[59] Encouragingly, the rural incentive has risen 25%, though private funding scope remains unchanged.[56,57]

The Integrated Rural Training Pipeline (IRTP) funds 100 vocational training positions for certain medical specialties, with further prevocational and specialist scope to encourage career long engagement in rural locations.[57] Additionally, the RVTS enables remote supervision of 32 generalist trainees.[61] The National Rural Generalist Program and RVTS coordinate funding to strengthen regional training hubs and support longitudinal rural training pathways for vocational training.[61]

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Policy Details:

Name: Vocational Training Pathways

Category: E - Medical Workforce

History: Reviewed, Council 3, 2026
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