Medical practitioners: education and training in Australia

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Social Policy Section

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Introduction

Medical practitioners—general practitioners and other medical specialists, hospital non-specialists and specialists-in-training—are a fundamental and vital component of the health workforce. Medical practitioners diagnose physical and mental illnesses, disorders and injuries, provide medical care to patients and prescribe and perform medical and surgical treatments to promote and restore good health.\(^1\)

In 2006, there were an estimated 71 740 medical practitioners registered in Australia, and most of these were working in medicine throughout the country.\(^2\) The overall supply of employed medical practitioners in Australia increased in the period from 2002 to 2006. During the same time, however, the supply of general practitioners decreased.\(^3\)

The overall number of medical practitioners in Australia in 2006 was less than the number of practising doctors in most Organisation for Economic Co-operation and Development (OECD) countries, but more than the numbers of doctors practising in comparable countries such as Canada, the United Kingdom and the United States.\(^4\)

Prior to the mid 1990s, it was believed that there were adequate numbers of medical practitioners to service the needs of the Australian population. As a consequence, the Australian Government placed a cap on the number of university places provided for medical students.\(^5\) In the view of some commentators however, this restriction on places contributed to what was a shortage of general practitioners. In addition, the cap led to shortages at the junior hospital doctor level, in part because there were not enough second-year interns to fill these positions in the public hospital system.

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2. Eighty seven per cent, or 62 425 were working in Australia. The other 13 per cent were on extended leave, not working, working in an area other than medicine or working in medicine overseas. Australian Institute of Health and Welfare (AIHW), Medical labour force 2006, National health labour force series no. 41, AIHW, Canberra, October 2008, viewed 12 March 2009, [http://www.aihw.gov.au/publications/hwl/mlf06/mlf06.pdf](http://www.aihw.gov.au/publications/hwl/mlf06/mlf06.pdf)
3. The overall supply of medical practitioners increased from 271 to 290 Full-Time-Equivalent (FTE) per 100 000 population in the period, and the supply of general practitioners decreased from 101 to 97 FTE per 100 000 population, AIHW, Medical labour force. The FTE measure of supply is based on the total hours worked by a health professional, divided by the hours in a standard working week for that profession. This varies for different professions. For the medical workforce, 45 total hours per week is equivalent to one FTE.
5. See discussion of the student cap later in this paper.
By the end of the 1990s, it was claimed that there were not enough fully registered junior doctors to fill all the training places available in the various specialty programs. Australian Bureau of Statistics (ABS) evidence supported such claims, with figures that indicated between 1986 and 1991 the number of general practitioners grew only slightly, and at a lower rate than the population as a whole. This resulted in a decline in general practitioner to population ratio. Most of the growth in the number of medical practitioners between 1986 and 1991 the ABS attributed to a 48 per cent increase in the number of specialists.

More general questions about whether the supply of doctors was adequate were not raised until the late 1990s when shortages in rural and remote areas of Australia became increasingly noticeable. Initially, however, the consensus was that rather than there being actual shortages in the medical workforce, there was a mal distribution between the bush and metropolitan areas. Following its election in 1996, the Howard Government introduced legislation and schemes intended to address that mal distribution. These initiatives included requiring overseas trained doctors to work in rural and remote areas classified as Districts of Workforce Shortage.

However, despite government initiatives, shortages of doctors persisted in rural and remote areas. Moreover, evidence began to emerge in the late 1990s and early 2000s that shortages were also commonplace in the outer metropolitan areas of the capital cities. At that time, it was argued that government policy initiatives were simply short term solutions, particularly with reference to general practitioner shortages; the introduction of medium and long term solutions was crucial to solving the problem overall. Such solutions, according to one study, included funding more training places for general practitioners. In March 2003, the Royal Australian College of General Practitioners (RACGP) argued also that not only were there grave shortages of general practitioners in outer metropolitan areas, but other specialties in these areas were in short supply.


8. See references to the provider number legislation later in this paper and Appendix E for details of the legislation. Note also that overseas trained doctors are often referred to as International Medical Graduates.


10. Office of the CEO and President, Royal Australian College of General Practitioners (RACGP), The supply of general practitioners in outer metropolitan areas, RACGP, South Melbourne, 31 March 2003.
The Government responded to these types of concerns by raising a cap on medical student numbers that had been announced by the Labor Government in 1995 and introduced by the Coalition in 1996. Under the cap, the number of medical school places had been restricted to approximately 1250 per year. From 2003 until its defeat in 2007, however, the Howard Government approved a number of increases in student places. Since its election in November 2007, the Rudd Government has also committed to increasing the numbers of medical school places as well as clinical training places.

Overall, the number of Commonwealth supported commencing places in medical courses in universities across Australia rose from 1403 in 2003 to an estimated 2544 in 2008. This is expected to rise further to reach around 2600 by 2012. But the results of this change in policy direction will take a number of years to come to fruition, as medical education is a long and complex process which involves many years of study and the input of many players. This background note summarises that process, elaborating upon the roles played by the major providers of medical education in Australia and the pathways taken by students to qualify as medical practitioners. In so doing, the paper illustrates the need for a long term planning approach to medical practitioner supply. This has often not been the case in Australia. Instead, as noted earlier in this section, there have been particular moments where the numbers of medical practitioners have been assessed as either too few or too many to meet the needs of the population. Following from these perceptions, the policy response has been either to restrict or increase medical student numbers. However, such reactions have sometimes had unintended consequences, such as compounding the underlying shortages of practitioners. This has been to the detriment both of patients and practitioners as patients in some areas are unable to access an adequate array of medical services. For medical students this type of approach has also meant that at times there are insufficient places available in medical schools for all those who wish to study medicine. Understanding better how the transformation from student to ‘specialist’ medical practitioner works and the roles of those institutions which contribute to, and influence that transformation may help to lessen the possibility that these types of negative outcomes unnecessarily beleaguer the health system.


12. In 2004, there were 234 new medical places, an additional 246 in 2005, and the largest increase in 2006, when 605 new places were announced by the Prime Minister. J Howard (Prime Minister), More doctors, nurses and allied health professionals for Australia’s health system, media release, 13 July 2006.

Key medical education players

As the Productivity Commission noted in 2005, responsibility for the funding and delivery of education and training for Australia’s health workforce generally is complex and broadly shared. It is particularly so for medical practitioners, with institutions including the Australian and state and territory governments, universities, specialist colleges and other agencies providing various levels of input.14

The Australian Government is principally responsible for policy relating to, and the funding of the university education of medical students. As such, it determines the number of university places available each year for medicine. Part of its commitment to medical student education involves the provision of clinical training component funding to universities, which in turn contract with teaching hospitals for the use of facilities for training purposes.15 The federal government is also responsible for the funding of the Australian General Practice Training Program which provides vocational training for general practitioners (this program is discussed later in this paper).

State and territory governments manage and jointly fund with the Australian Government the public hospitals which provide the bulk of pre-vocational and vocational training for medical students. The state and territory contribution to medical education delivers the important components of hospital infrastructure and on-the-job staff trainers in hospital environments.

Health sector organisations which play key roles in the education and training of medical practitioners include:

• Australian Medical Council (AMC). This independent national standards body for medical education and training accredits the university medical schools and specialist colleges that deliver medical education and training. It also provides advice to governments, medical education providers and medical boards on a range of issues.16

• Specialist medical colleges. The specialist colleges (not including the Royal Australian College of General Practitioners, see the point below relating to this college), in consultation with other relevant bodies, are responsible for determining standards of


16. The Australian Medical Council (AMC) also assesses the qualifications of overseas trained doctors who wish to practise medicine in Australia. The AMC website provides more detailed information on its role and responsibilities, viewed 11 March 2009, [http://www.amc.org.au/](http://www.amc.org.au/)
education and training required for qualification in particular specialties. These colleges also determine the numbers of training places they will provide.

- Royal Australian College of General Practitioners (RACGP). This College supports general practitioners, registrars and medical students by assessing doctors’ skills and knowledge, monitoring professional development activities, developing resources and guidelines and assisting generally with issues that affect practice and accreditation processes. Unlike the other colleges, the RACGP does not provide fellowship training. This is delivered by a government-run organisation, General Practice and Education Training Limited (GPET).17

- Private hospitals also provide and fund a small amount of training to postgraduate medical students.18

- Postgraduate medical councils in the states and the Northern Territory support and develop education and training requirements for junior doctors and hospital medical officers in the prevocational years.19

Box 1 below provides information on the Australian Medical Council, which has traditionally played a vital role in ensuring that the standards of medical education in Australia remain high.

**Box 1: medical school accreditation**

The Australian Medical Council (AMC) currently makes recommendations on the accreditation of Australian medical schools to state and territory medical registration boards (see discussion of impending changes to registration processes in Box 2). The fundamental aim of this process is to ensure that Australian medical school programs meet nationally agreed guidelines for basic medical education. An added aim of the accreditation process is to ensure that graduates of Australian medical schools are competent to practise as interns under supervision and that they have acquired the adequate knowledge and sufficient competency to undertake further vocational training.

The AMC’s accreditation committee comprises nominees of the various medical schools, the Australian Medical Students’ Association, specialist medical colleges, postgraduate medical councils, the Medical Council of New Zealand, the Australian Medical Council and health consumers.

Accreditation of medical schools can be for a period of up to ten years, during which time the schools must submit reports in the second, fifth and seventh years. Schools which make changes to their curriculum during an accreditation period must submit more frequent reports.20

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17. See discussion later in this paper.
Gaining a medical degree

In Australia, there are two pathways to a medical degree—undergraduate and graduate. The first option is mainly taken by secondary school leavers and generally involves a five to six year course, entry to which is based on matriculation results, an admission test and an interview. The second option, graduate entry, requires students to have completed a bachelor degree of any type. Entry to the graduate degree also involves an admission test and interview. Both options are shown in the table below and are discussed in more detail in the following sections.

Table 1: pathways to medical school

Source: AMA


21. Australian Medical Association (AMA), Becoming a doctor and bonded medical school places—a guide for prospective medical students, AMA, viewed 12 March 2009,
Undergraduate medical degree

Selection

Ten of Australia’s 18 university medical schools offer undergraduate degrees. These are five or six years in duration, with the exception of the Bond University degree, which is four years and eight months (see Table 3 below).

Traditionally, entry into medical school was based on final high school year results. In the early 1990s, however, it was felt that this single selection criterion did not take into consideration certain vital qualities people needed to be able to study and practice medicine. These qualities were listed as including: critical thinking and problem solving, an ability to understand people and abstract non-verbal reasoning. Consequently, a number of Australian university medical schools formed a Consortium to commission the Australian Council of Educational Research (ACER) to design the Undergraduate Medical and Health Sciences Admission Test (UMAT). This test is now used to assess students for admission to medical study.

While the Consortium universities use UMAT as part of their entry assessment, each university determines an individual ‘cut off’ score for student acceptance. Additionally, most universities interview candidates as part of their individual selection processes.

22. The consortium also included the Universities of Auckland and Otago in New Zealand.

23. Undergraduate Medical and Health Sciences Admission Test (UMAT) Consortium universities which use the UMAT test in 2009 are University of Adelaide, Bond University, University of Melbourne, Griffith University (no undergraduate entry for medicine), University of Newcastle/University of New England, University of Queensland, Monash University, University of Western Sydney, University of Otago, University of Auckland, University of New South Wales, University of Tasmania and University of Western Australia.

Note: UMAT is also used by universities to assess students for dentistry and other health science courses. See UMAT website for more information, viewed 11 December 2008, http://umat.acer.edu.au/index.php?option=com_frontpage&Itemid=1

24. The University of Melbourne has not included interviews as part of its undergraduate selection process. However, 2008 was the final year of its undergraduate medicine course. The final year of its graduate medicine course is 2009, after which in 2011 it will introduce a new Doctor of Medicine course. A ‘multi mini interview’ will be a selection component. See the Melbourne Model Medicine webpage, viewed 11 December 2008, http://www.medicine.unimelb.edu.au/melbourne_model/ for more information.

The multi mini interview it appears will be similar to that undertaken for example at the University of Western Sydney. This involves applicants being asked a series of questions by separate interviewers at separate interview stations. Applicants have limited time to respond to each question before moving to the next interview station.
Problem based learning

Undergraduate degrees in medicine adopt a problem based learning approach in years one to three of study. This approach is expanded upon in the latter years of the degrees as students undergo placements in teaching hospitals and in the community.

Problem based learning has been described as ‘an instructional strategy in which students confront contextualized, ill-structured problems and strive to find meaningful solutions’.25 This method of learning was first introduced into the study of medicine in Canada in the 1960s after it was noted that medical students ‘were bored and disenchanted when medical education should have been exciting’.26 Consequently, medical faculty educators decided that from its onset, learning for medical students ‘would occur around a series of biomedical problems presented in small groups with the faculty functioning as “tutors or guides of education.”’27

Problem based learning was introduced in Australian medical schools following the publication of the Karmel Report in 1973.28 This report concluded that ‘Australian medical school curricula were too science-oriented, not innovative and neglected primary care’.29

There are, however, arguments for and against the concept of problem based learning and these are summarised in the table below.

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The Universities of Otago and Queensland do not use interviews as part of their selection process.

Table 2: advantages and disadvantages of problem based learning

<table>
<thead>
<tr>
<th>Advantages of PBL</th>
<th>Disadvantages of PBL</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Student centred PBL</strong> – It fosters active learning, improved understanding, and retention and development of lifelong learning skills</td>
<td><strong>Tutors who can’t “teach”</strong> – Tutors enjoy passing on their own knowledge and understanding so may find PBL facilitation difficult and frustrating.</td>
</tr>
<tr>
<td><strong>Generic competencies</strong> – PBL allows students to develop generic skills and attitudes desirable in their future practice.</td>
<td><strong>Human resources</strong> – More staff have to take part in the tutoring process.</td>
</tr>
<tr>
<td><strong>Integration</strong> – PBL facilitates an integrated core curriculum.</td>
<td><strong>Other resources</strong> – Large numbers of students need access to the same library and computer resources simultaneously.</td>
</tr>
<tr>
<td><strong>Motivation</strong> – PBL is fun for students and tutors, and the process requires all students to be engaged in the learning process.</td>
<td><strong>Role models</strong> – Students may be deprived access to a particular inspirational teacher who in a traditional curriculum would deliver lectures to a large group.</td>
</tr>
<tr>
<td><strong>“Deep” learning</strong> – PBL fosters deep learning (students interact with learning materials, relate concepts to everyday activities, and improve their understanding).</td>
<td><strong>Information overload</strong> – Students may be unsure how much self directed study to do and what information is relevant and useful.</td>
</tr>
<tr>
<td><strong>Constructivist approach</strong> – Students activate prior knowledge and build on existing conceptual knowledge frameworks.</td>
<td></td>
</tr>
</tbody>
</table>

Source: British Medical Journal

Graduate medical degree

Selection

An increasing number of university medical schools in Australia have begun to offer graduate medical degrees. Applicants for these medical degrees need to hold a bachelor’s degree. They need also to pass the Graduate Australian Medical School Admission Test (GAMSAT). Like the UMAT, this assessment was developed by ACER in conjunction with the Consortium of Graduate Medical Schools. GAMSAT is divided into three sections: written communication, reasoning in the humanities and social sciences and reasoning in the biological and physical sciences. While applicants do not need a science degree to sit the test, information provided by GAMSAT notes that success in the assessment, which is held annually in March, ‘is

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unlikely without knowledge and ability in the biological and physical sciences, however this [knowledge and ability] is acquired.\(^{31}\)

If applicants are successful in the GAMSAT their applications are sent to the relevant universities which use various internal assessment processes to choose candidates for the interview phase of assessment.

The following table lists the universities which offer undergraduate and graduate degree courses.

**Table 3: medical degrees and course duration**

<table>
<thead>
<tr>
<th>School Leaver Entry</th>
<th>Course Duration (Years)</th>
<th>Graduate Entry</th>
<th>Course Duration (Years)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adelaide</td>
<td>6</td>
<td>ANU</td>
<td>4</td>
</tr>
<tr>
<td>Bond*</td>
<td>4.6</td>
<td>Deakin</td>
<td>4</td>
</tr>
<tr>
<td>James Cook</td>
<td>6</td>
<td>Flinders</td>
<td>4</td>
</tr>
<tr>
<td>Melbourne**</td>
<td>6</td>
<td>Griffith</td>
<td>4</td>
</tr>
<tr>
<td>Monash</td>
<td>5</td>
<td>Melbourne</td>
<td>4.5</td>
</tr>
<tr>
<td>Newcastle/UNE^</td>
<td>5</td>
<td>Monash – Gippsland</td>
<td>4</td>
</tr>
<tr>
<td>UNSW</td>
<td>6</td>
<td>Notre Dame Sydney</td>
<td>4</td>
</tr>
<tr>
<td>Tasmania</td>
<td>5</td>
<td>Notre Dame WA</td>
<td>4</td>
</tr>
<tr>
<td>UWA</td>
<td>6</td>
<td>Queensland</td>
<td>4</td>
</tr>
<tr>
<td>Western Sydney</td>
<td>5</td>
<td>Sydney</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td></td>
<td>UWA</td>
<td>4.5</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Wollongong</td>
<td>4</td>
</tr>
</tbody>
</table>

* Most school leaver-entry programs take students who may have an undergraduate degree
* Bond University operates a three-year program with medical students commencing in second semester (May)
* ** Monash will change to a graduate entry only course from 2011
* ^ Joint Medical Program (JMP) with University of New England from 2008

Source: Medical Deans Australia and New Zealand\(^{32}\)

Each university has a quota for its annual intake of graduate students. The quota includes Commonwealth supported places, bonded places and full fee paying places. The following


Table 4 shows the 2008 GAMSAT estimate of the number of places available for graduates for 2009.

### Table 4: GAMSAT estimated quota of university places for graduate medical students: 2009

<table>
<thead>
<tr>
<th>School places</th>
<th>CSP</th>
<th>MRBS CSP</th>
<th>BMP CSP</th>
<th>Full-fee paying</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>ANU</td>
<td>57</td>
<td>3</td>
<td>20</td>
<td></td>
<td>80</td>
</tr>
<tr>
<td>Deakin</td>
<td>85</td>
<td>5</td>
<td>30</td>
<td>8</td>
<td>128</td>
</tr>
<tr>
<td>Flinders</td>
<td>71</td>
<td>4</td>
<td>25</td>
<td>20§</td>
<td>120</td>
</tr>
<tr>
<td>Griffith</td>
<td>121*</td>
<td>4</td>
<td>25</td>
<td></td>
<td>150</td>
</tr>
<tr>
<td>Melbourne</td>
<td>50#</td>
<td>3</td>
<td>17</td>
<td>5</td>
<td>75</td>
</tr>
<tr>
<td>Monash</td>
<td>33</td>
<td>2</td>
<td>5</td>
<td>10</td>
<td>50</td>
</tr>
<tr>
<td>Notre Dame</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fremantle</td>
<td>73</td>
<td>3</td>
<td>24</td>
<td></td>
<td>100</td>
</tr>
<tr>
<td>Notre Dame</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sydney</td>
<td>57</td>
<td>3</td>
<td>20</td>
<td>32</td>
<td>112</td>
</tr>
<tr>
<td>Queensland</td>
<td>234</td>
<td>11</td>
<td>68</td>
<td>30</td>
<td>343</td>
</tr>
<tr>
<td>Sydney</td>
<td>144∞</td>
<td>8</td>
<td>51</td>
<td>25</td>
<td>228</td>
</tr>
<tr>
<td>UWA</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>60</td>
</tr>
<tr>
<td>Wollongong</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>72</td>
</tr>
</tbody>
</table>

§ includes 5 SA Government sponsored bonded places
* includes 50 Queensland Health bonded places
# includes 10 Extended Rural Cohort places
∞ includes up to 6 places reserved for combined degrees (ie BSc (Adv)/MBBS, BMedSc/MBBS, BA(Adv)(Hons)/MBBS, BMusStudies/MBBS)

These quotas are subject to change.
Applicants are advised that numbers of full fee-paying places are provisional, and may change depending on implementation of Australian Government policy on domestic fee-paying places.
Source: ACER

### Types of medical student places

#### Full fee paying

It is costly to train a medical student—more costly in some universities than others. The cost of a degree at Bond University for example for full fee paying students is approximately $262 559. While eligible full fee paying students for various degrees have been able to gain a


34. See Department of Education, Employment and Workplace Relations (DEEWR), ‘Course Finder’ information on the Department website, viewed 16 March 2009, [http://www.goingtouni.gov.au/Main/CoursesAndProviders/ProvidersAndCourses/CourseFinderDisclaimer.htm](http://www.goingtouni.gov.au/Main/CoursesAndProviders/ProvidersAndCourses/CourseFinderDisclaimer.htm) and Queensland Tertiary Admissions Centre information on Bond
FEE-HELP loan to help pay their tuition fees, these loans have been limited. In the case of medicine, in 2008 the limit was $102,000. After graduation, full fee paying students have had to repay their loan at an amount calculated by the Australian Tax Office once they earn above a certain income.

In the 2008–09 Budget, however, in keeping with a long-standing Labor policy commitment to phase out full fee paying domestic places at public universities, the Government provided funding of $249 million for this purpose from 2009. Under this program universities will be compensated for the loss of revenue they have gained from fee paying places for all domestic undergraduates through the provision of funding for 11,000 Commonwealth supported university places.

Commonwealth supported places

Most domestic university students in Australia are not full fee paying students, however. Their study is subsidised through the Commonwealth Grants Scheme. Under this scheme, the Australian Government provides funding assistance to universities for an agreed number of Commonwealth supported places (previously known as Higher Education Contribution Scheme or HECS places) in various disciplines each year. (See Table 7 at the end of this section which provides a breakdown of the numbers of Commonwealth supported places as well as the other types of student places available to medical students).

35. To be eligible for these loans, students must be Australian citizens, holders of permanent humanitarian visas who will be resident in Australia for the duration of the unit, or the holders of permanent visas who are undertaking bridging study for overseas-trained professionals and will be resident in Australia for the duration of the unit.


Students are also expected to pay a financial contribution towards their education. This contribution is set by higher education providers within a limit imposed by the Government. Students can elect to pay their contribution upfront and receive a 20 per cent fee discount as a result. They can make a partial fee payment of an amount over $500 and receive a discount on the amount paid or they can defer the whole contribution amount. Students who choose the latter option can apply for a HECS-HELP loan. Following graduation, repayment of HECS-HELP loans is required on a scale set by the tax office once graduates earn a minimum income ($41,595 in 2008–09).

The following tables show the Australian Government contribution rates for full time students for medicine compared with other funding cluster disciplines and the ranges of student contribution rates for 2009.

### Table 5: Commonwealth contribution amounts for one equivalent full time student load in 2009

<table>
<thead>
<tr>
<th>Funding cluster</th>
<th>Commonwealth contribution*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Law, accounting, administration, economics, commerce</td>
<td>$1,709</td>
</tr>
<tr>
<td>Humanities</td>
<td>$4,743</td>
</tr>
<tr>
<td>Mathematics*, statistics*, behavioural science, social studies, education*, computing, built environment, other health</td>
<td>$8,289</td>
</tr>
<tr>
<td>Clinical psychology, allied health, foreign languages, visual and performing arts</td>
<td>$10,217</td>
</tr>
<tr>
<td>Nursing*</td>
<td>$11,517</td>
</tr>
<tr>
<td>Engineering, science*, surveying</td>
<td>$14,664</td>
</tr>
<tr>
<td>Medicine, dentistry, veterinary science, agriculture</td>
<td>$18,610</td>
</tr>
</tbody>
</table>

Source: DEEWR

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40. Eligible students are Australian citizens or holders of permanent humanitarian visas.
Table 6: student contribution bands and ranges 2009

<table>
<thead>
<tr>
<th>Student contribution band</th>
<th>2009 Student contribution range (per EFTSL)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Band 3</strong></td>
<td></td>
</tr>
<tr>
<td>Law, dentistry, medicine, veterinary science, accounting, administration, economics, commerce</td>
<td>$0 – $8,677</td>
</tr>
<tr>
<td><strong>Band 2</strong></td>
<td></td>
</tr>
<tr>
<td>Computing, built environment, health, engineering, surveying, agriculture</td>
<td>$0 – $7,412</td>
</tr>
<tr>
<td><strong>Band 1</strong></td>
<td></td>
</tr>
<tr>
<td>Humanities, behavioural science, social studies, foreign languages, visual and performing arts</td>
<td>$0 – $5,201</td>
</tr>
<tr>
<td><strong>National priorities</strong></td>
<td></td>
</tr>
<tr>
<td>Education, nursing Mathematics, statistics and science</td>
<td>$0 – $4,162</td>
</tr>
</tbody>
</table>

Source: DEEWR

Bonded medical school places

Medical students who are Australian citizens or permanent residents are also able to apply for support under the two bonded medical places schemes offered by the Australian Government. Applicants for these schemes need to meet the same entry requirements as other students and selection for all bonded places is undertaken by relevant universities.

The first of these schemes, the Medical Rural Bonded Scholarship Scheme, provides 100 scholarships annually for extra places in medical schools. Scholarship recipients, who must be Australian citizens or permanent residents, receive an annual tax free, non-means tested, indexed payment for as long as it takes them to complete their medical degrees. In 2009, this scholarship payment was $23,686. In return for support under this scholarship, students agree to practice in rural or remote areas of Australia for six years continuously upon completion of their medical and vocational training.

The second scheme, the Bonded Medical Places Scheme, also provides extra university places for students who wish to study medicine. The number of places available to students per year is set at 25 per cent of all students commencing in Commonwealth supported medical places. In return for the opportunity to study medicine, students commit to work in areas where there are workforce shortages (Districts of Workforce Shortage or DWS) for a

43. DEEWR, Information for Commonwealth supported students, op.cit.
period equal to the length of their medical degrees. (See Appendix B for information on DWS). There is no direct funding to students under the Bonded Medical Places Scheme and students are required to pay the full student fee contribution, unless they choose to train or work in a rural DWS. They may then be eligible for the HECS Reimbursement Scheme. This Scheme reimburses one-fifth of HECS-HELP medical fees for each year of rural training or service.45

Other bonded student places

State government places

The South Australian and Queensland State Governments offer bonded scholarships. The South Australian scholarships provide full time undergraduate students with $5000 per year for a maximum for three years. To be eligible for these scholarships, students need to have resided in rural Australia prior to undertaking study in a variety of disciplines, including medicine. They are required to live and work in rural South Australia on completion of their undergraduate degrees for a period equivalent to that funded under the scholarships.46

In 2008, the Federal Government agreed to reimburse Queensland for the costs associated with the training of 235 bonded medical students under the Queensland Health Bonded Medical Scholarship Scheme.47 Queensland Health scholarship holders have their full tuition fees paid to undertake the graduate medical course delivered at Griffith University. They also receive an annual Education Support Allowance of $21 000 for the duration of the course.48

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Australian Defence Force scholarships

The Australian Defence Force sponsors an undergraduate scheme which is available to medicine, dentistry, nursing, pharmacy, radiology, law, environmental health, engineering, Business or Arts students. Under this scheme, students are paid a salary of $33 750 per year while they study, their student debt is paid and they receive free dental and medical benefits. Upon graduation, they are required to serve as officers, in the service of their choice, for the length of their sponsorships plus one year.49

See Appendix D for information on other scholarships available to medical students.

The following table shows the number and percentage of medical students by the category of student places for the period 2004 to 2008.

Table 7: number and percentage of medical students by category of student place, 2004–08 (headcount)

<table>
<thead>
<tr>
<th>Category</th>
<th>2004</th>
<th>2005</th>
<th>2006</th>
<th>2007</th>
<th>2008</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Number</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CSP</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HECS</td>
<td>6,876</td>
<td>6,983</td>
<td>7,144</td>
<td>7,317</td>
<td>7,642</td>
</tr>
<tr>
<td>BMPS</td>
<td>226</td>
<td>434</td>
<td>688</td>
<td>1,242</td>
<td>1,747</td>
</tr>
<tr>
<td>MFRBSS</td>
<td>382</td>
<td>452</td>
<td>406</td>
<td>408</td>
<td>459</td>
</tr>
<tr>
<td><strong>Fee paying</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Domestic</td>
<td>n.a</td>
<td>160</td>
<td>415</td>
<td>678</td>
<td>932</td>
</tr>
<tr>
<td>International</td>
<td>1,749</td>
<td>1,919</td>
<td>2,081</td>
<td>2,153</td>
<td>2,309</td>
</tr>
<tr>
<td>Other(a)</td>
<td>n.a</td>
<td>n.a</td>
<td>35</td>
<td>101</td>
<td>218</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>9,233</td>
<td>9,948</td>
<td>10,849</td>
<td>11,949</td>
<td>13,337</td>
</tr>
</tbody>
</table>

| **Percent**    |       |       |       |       |       |
| CSP            |       |       |       |       |       |
| HECS           | 74.5  | 70.2  | 65.9  | 61.2  | 57.3  |
| BMPS           | 2.5   | 4.4   | 6.3   | 10.1  | 13.1  |
| MFRBSS         | 4.1   | 4.5   | 4.5   | 4.1   | 3.7   |
| **Fee paying** |       |       |       |       |       |
| Domestic       | n.a   | 1.6   | 3.8   | 5.7   | 7.0   |
| International  | 18.9  | 19.3  | 19.2  | 18.0  | 17.3  |
| Other(a)       | n.a   | n.a   | 0.3   | 0.9   | 1.6   |
| **Total**      | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 |

(a) Other includes medical students on state health department bonded medical scholarship.

Source: Medical Training Review Panel\textsuperscript{50}

**International student places**

International students must meet minimum academic requirements in order to study in Australia. They are also required to possess a sufficient level of English language proficiency to gain entry to Australian education and training institutions. According to the Department of Education, Employment and Workplace Relations (DEEWR), courses in medicine are

available to international students at 17 Australian medical schools. It is mandatory for candidates who wish to enter undergraduate medicine courses at Monash University and the Universities of Queensland, Tasmania, Western Sydney and Western Australia to pass the International Student Admissions Test (ISAT), a three-hour multiple choice test.51 Other institutions, such as the Australian National University, require international students to have sat GAMSAT or the United States’ Medical College Admissions Test (MCAT).52

In 2006, there were 2081 overseas students studying medicine in Australia.53

The majority of international students in Australia are full fee paying students who are not eligible for scholarship assistance.54 Tuition fees for these students can range from approximately $142 000 to $327 000 for a medical degree.55

The following table shows the number of students, both domestic and international, enrolled in medicine at the various medical schools in 2006.

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52. Details can be found on the Association of American Medical Colleges website, viewed 3 February 2009, http://www.aamc.org/students/mcat/
53. Calculated from tables in DEEWR, Selected higher education statistics, (All students in a course leading to provisional registration as a medical practitioner by permanent home residence and citizenship) 2006, July 2008. Note: at the time there were 8768 domestic medical students.
55. The University of Wollongong charges $148 400 for a Bachelor of Medicine and Bachelor of Surgery degree. The University of Melbourne charges $327 640 for a Bachelor of Medicine and Bachelor of Surgery/Bachelor of Medical Science degree. See other course details at the following website, viewed 19 December 2008, http://www.studyinaustralia.gov.au/Sia/en/CourseSearch/InstitutionList.aspx?Sectors=&States=ACT,NSW,NT,QLD,SA,TAS,VIC,WA&FoEBroad=06&FoENarrow=0601&FoEDetailed=060101&Institution=&Course=&CRICOS=&Foundation=False&Component=False&LevelOfStudy=Bachelor+Degree
Clinical experience

Clinical training is an essential part of a medical degree. As the Medical Deans Australia and New Zealand note, this training is necessary for students to ‘contextualize and further explore the clinical problems and systems learned in the classroom and skills labs’. In the initial


57. Medical Deans Australia and New Zealand, *National clinical training review*, op.cit.
years of a degree clinical training often occurs in general practice or community settings and may consist only of observation, although in recent times, early clinical training has included experience in clinical skills training laboratories. Clinical skills laboratories are considered to provide flexible, controlled learning environments that allow junior students to make mistakes, while avoiding risks to patients.\textsuperscript{58}

Senior medical students traditionally undertake their clinical placements in hospital settings. While some private hospitals provide these types of placements, overwhelmingly this clinical experience is provided in public hospitals. Students generally rotate through a number of specialties as part of their clinical experience.

For some time there has been concern that the number of clinical training places has been insufficient to cope with increasing numbers of medical students. Professor James Angus from Medical Deans Australia and New Zealand argued in September 2008 for example:

\textit{By 2012 there will be nearly 60 per cent more medical school graduates than that expected in 2008 … However there has not been a commensurate increase in clinical training places. There is very little point in training Australian medical graduates if there is no significant increase in the number of clinical placements to cater for these students and the quality staff to train them. Students can’t learn by looking over the shoulders of 10 others.}\textsuperscript{59}

In response to such concerns about the adequacy of clinical training places for medical students, an additional $500 million for undergraduate clinical training places, which includes increasing the clinical training subsidy to 30 per cent for all health undergraduate places, was agreed to at the Council of Australian Governments’ (COAG) meeting on 29 November 2008.\textsuperscript{60}

\textbf{Pre vocational Training}

All Australian medical graduates are required to complete at least one year of supervised medical experience as interns (this is known as PGY1) once they have obtained their medical degree.\textsuperscript{61} Usually this training takes place in a public teaching hospital. Graduates are able to choose the hospital where they will undertake their internship, and mostly, students choose a hospital in the state where they completed their degree.

\begin{itemize}
\item \textsuperscript{58} Medical Deans Australia and New Zealand, \textit{National clinical training review}, op.cit.
\item \textsuperscript{59} Medical Deans Australia and New Zealand, \textit{Clinical training at risk if not funded by Healthcare Agreements}, media release, Sydney, 8 September 2008, viewed 3 February 2009, \url{http://www.medicaldeans.org.au/media_090808.html}
\item \textsuperscript{61} During prevocational training graduates are usually referred to as Resident Medical Officers or Residents.
\end{itemize}
National training and assessment guidelines for junior medical practitioners recommend that the intern year provides:

- a learning environment in which interns are supported and supervised in the development of professional values and identity
- opportunities for interns to consolidate and develop knowledge, skills and professional attitudes acquired during undergraduate years
- experience of a range of medical practices and advice in career options
- assistance in developing a sound basis for life-long education
- allocation to units where registrars and consultants have a demonstrated commitment to the training of junior medical officers
- supervision by an experienced medical practitioner
- appropriate rostering and after hours supervision
- sufficient contact between supervisors and interns to permit an adequate assessment of performance and to ensure early warning of the need for remediation and
- supervisors with an outline of their responsibilities and regular feedback about their performance as supervisors.62

Successful completion of the intern year allows medical graduates to have unrestricted registration through one of eight state or territory based Medical Boards. However, the national training and assessment guidelines for junior medical doctors note that ‘completion of the intern year is insufficient preparation for independent practice of medicine’.63

Postgraduate Medical Councils (PMCs) in each state and the Northern Territory are responsible for developing prevocational education and training requirements. Currently, the range of responsibilities of the various PMCs in developing education and training curricula varies. However, there are moves towards developing a national approach and a draft national Prevocational Medical Accreditation Framework (PMAF) was released for consideration in


63. Advisory Committee for the National Guidelines for Junior Medical Officer Training and Assessment, National training and assessment guidelines, op.cit.
November 2008. The Confederation of Postgraduate Medical Education Councils noted at that time that the PMAF:

… aims to increase consistency across the jurisdictions of accreditation practices, align prevocational accreditation practices with other appropriate local and international benchmarks, reduce duplication of work required in each PMC (or its equivalent), and provide increased transparency of accreditation practices. The project has been recognised by the Medical Training and Review Panel (MTRP) as a national priority in prevocational medical education. It also fits in with COAG initiatives towards achieving national registration and accreditation in the health professions.64

See Box 2 for more discussion of the COAG national registration and accreditation scheme.

PMCs also provide support to junior doctors, to overseas trained doctors who work in junior medical positions in Australian hospitals and to career medical officers (those doctors who choose not to undertake vocational training, but to remain working in the public health system).

On completion of the intern year, graduates in PGY2 ‘continue to work under supervision with increasing levels of responsibility, in a broad range of health care settings, many of which are training positions deemed acceptable for basic training by colleges’.65

Box 2: Medical Registration Boards and the move towards a national registration scheme

Medical Registration Boards are state and territory statutory authorities, funded through medical registration fees. They are independent of government and the medical profession. The primary objectives of the boards have been to protect public health and safety by ensuring that only properly trained people are registered to practise as medical practitioners, and that those registered as medical practitioners maintain proper standards of conduct and competence.

Under the existing system of medical registration in Australia, to practise medicine in any state or territory a person must be registered with the medical board in that state or territory. The Mutual Recognition Act 1992 (Cth), however, entitles persons who are registered in an occupation, such as medicine, in one state or territory, and who lodge notice to seek registration in an equivalent occupation with the registration authority of another state or territory, to be registered in the second jurisdiction in that equivalent occupation.66

In its 2005 report on the health workforce, the Productivity Commission recommended the establishment of a single national registration and accreditation board for health professions. The Commission advocated this consolidation to ‘lock in national standards based on qualification requirements’ and to improve mobility for the professions.67

In response to the Commission’s recommendations, the Council of Australian Governments (COAG) decided in March 2008 to establish a national registration scheme which is to commence operation in July 2010. The Queensland Government was given responsibility for the development of a legislative template which other states and the territories will follow in introducing the scheme. Legislation was passed in Queensland in 2008 to begin the implementation processes for the scheme.

Under the scheme, profession-specific boards will be established for the medical, nursing and midwifery, pharmacy, physiotherapy, dental, psychology, optometry, osteopathy, chiropractic and podiatry professions. These national boards will approve accredited courses, oversee registration and the assessment of overseas trained health professionals and undertake investigations into conduct and competence, as well as conditions imposed on the practice of health professionals.68

67. Productivity Commission, Australia’s health workforce, op.cit., p.xxv.
The Australian Medical Association (AMA), the Committee of Presidents of Medical Colleges and the Royal Australian College of General Practitioners (RACGP) have expressed concern about the scheme arguing that it may amount to government interference in the setting of professional standards. The RACGP has suggested further that under the scheme the Government would set skill requirements for the professions and that this may lead to the lowering of professional standards.

On the other hand, Professor Peter Brooks, Executive Dean of Health Sciences at the University of Queensland, argues in favour of the scheme and considers that opposition from the medical profession is simply about maintaining its power base.

Deborah Paltridge has criticised what has been labelled an ‘apprenticeship model’ of post graduate training. Paltridge argues:

Increased patient throughput, reduced lengths of stay, increased patient complexity and workforce shortages are threatening the ability of the apprenticeship model to address all the learning needs of PGY1 and PGY2 doctors. Patients have become more knowledgeable about their conditions and more demanding about the standard of the health care they receive.

The apprenticeship model relies on senior clinicians to monitor junior doctors’ competencies. An important question is whether the supervision given to junior doctors is adequate to ensure that competency is established. Most of the supervision by senior clinicians is provided by sessional Visiting Medical Officers (VMOs), the great majority of whom also work in the private sector. It is not these individuals, but registrars, who undertake the bulk of day-to-day work-related supervision. Mid-term and end-of-term formal feedback by supervisors is a general requisite of accrediting postgraduate councils. However, anecdotally, Medical Education Officers and Directors of Clinical Training report varying levels of compliance with this in most hospitals, particularly for PGY2 trainees.


End-of-term global rating scales of generic attributes are the usual tools used to provide feedback on the progress of individual PGY1 or PGY2 trainees to the hospital.\textsuperscript{72}

The move towards a more consistent national approach to postgraduate training currently being considered by PMCs may go some way towards addressing Paltridge’s concerns. These include that supervising authorities are left to their own devices to determine:

- the knowledge, skills and attitudes that junior doctors should have
- how these are best learnt, by what stage, and what level of supervision is required and
- assessment procedures required to determine competency.\textsuperscript{73}

Not everyone agrees with Paltridge’s view. The AMA argues in favour of the apprenticeship model: ‘[t]raining should be an apprenticeship which is patient focused and skills based. The apprenticeship model remains the most effective one for training doctors’. At the same time, the AMA makes the point that hospitals and senior clinicians have an obligation to put in place appropriate mechanisms to ensure that quality training is offered to junior doctors.\textsuperscript{74}

Generalist training issue

In 2006, the AMA argued against suggestions that the generalist nature of the medical training which practitioners undergo in postgraduate years one and two should be replaced by ‘early streaming’ into specialist training.\textsuperscript{75} The AMA argument endorsed an earlier assessment by the Medical Training Review Panel (MTRP) that the initial postgraduate years should aim to achieve a well rounded generalist orientation, which prepared medical doctors for their postgraduate training. The AMA considered that the shortage of medical practitioners was to blame for this advocacy for change and, while noting that in some instances this approach may work, generally:

\ldots the complexity and subtlety of the [medical training] process can be too easily missed in the rush to shorten training times and meet pressing workforce needs. Time spent with patients and with mentors cannot be replaced by fast track teaching methods. The growth of ‘medical professionalism’, which underpins the vocation of medicine, occurs best across a range of settings and medical disciplines, so that varied streams of medical knowledge and practice can be related and understood as part of an integrated whole. Graduates need time to be inducted into professional practice and need time to develop those attributes and skills that only come from time spent with direct patient care and through mentoring by senior

\textsuperscript{72} Paltridge, ‘Prevocational medical training in Australia’, op.cit.

\textsuperscript{73} Paltridge, ‘Prevocational medical training in Australia’, op.cit.


This view was supported by evidence from a 2005 Australian Medical Workforce Advisory Committee (AMWAC) report which revealed that only 18 per cent of doctors had decided at the end of medical school what specialty they wanted to pursue and even at the end of their intern year, only 36 per cent had made that decision.77

**Vocational Training**

Many medical practitioners undertake vocational training to achieve a fellowship qualification in a chosen specialty immediately following their pre-vocational years. Other medical doctors elect to remain in salaried positions in the health system or to work in non-clinical positions.78 The table below summarises the postgraduate experience for those practitioners who undergo training in a specialty discipline.

<table>
<thead>
<tr>
<th>Medical school (4-5 years)</th>
<th>Provisional registration</th>
<th>Intern (1 year)</th>
<th>Medical registration</th>
<th>Resident Medical Officer (1+ years)</th>
<th>Registrar (3-8 years)</th>
<th>College Fellowship</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-vocational Training</td>
<td></td>
<td>Vocational Training</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Postgraduate Training</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Source: AMA79

There are twelve major specialist medical colleges in Australia (see Box 3 below and Appendix B). These colleges determine the standards of education and training required for

76. AMA, Early streaming into specialty training, op.cit.


78. Note: pre-vocational doctors are defined as those in postgraduate years one (PGY1) and two (PGY2), but this term also refers to medical staff in subsequent years who are not enrolled in a specialty training program (PGY3+). Those doctors enrolled in vocational training programs are required to take up registrar positions in the specialty of their choice. These doctors are known as registrars. Registrars are qualified doctors, who are able to take medical histories, order tests, make diagnoses, provide treatment, make referrals and write reports. Depending on the medical needs of patients and the experience of registrars, they may be able to undertake these tasks without help or with the assistance of supervising specialists.

79. AMA, Becoming a doctor and bonded medical school places, op.cit.
medical practitioners to obtain fellowships, and in most cases, the colleges also determine the number of training places they will provide (numbers for general practice training are determined by the Australian Government; this issue will be discussed later in this paper). Each of the medical colleges has its own particular training program and structure, and college training periods range from three to seven years, depending on the specialty. (There are some differences which apply to general practice. See the relevant section later in this paper.)

Once trainees have been accepted into a specialist training program, they are required to apply for hospital registrar positions which have been accredited by a relevant college. These positions are generally in public hospitals. Advanced training is mostly undertaken in hospitals, except for general practice training, which occurs in general practice training practices. Once they have completed their training, specialists generally can opt to work as staff specialists in public hospitals or other health facilities, engage in private practice only, or combine work as visiting medical officers at one or more hospitals, with private practice.

There have been suggestions for a number of years that various colleges have adopted an ‘old boys club’ mentality with regards to the allocation of training places; that is, that they deliberately restrict entry. These types of allegations led the Australian Competition and Consumer Commission (ACCC) to consider if the trainee selection practices of one college, the Royal Australian College of Surgeons (RACS), were in breach of the Trade Practices Act 1974 (Cth). Following a series of investigations, in 2003, the ACCC was reportedly ‘aghast at the mean-spirited way surgeons limited people entering the profession—such as by not sending information booklets to foreign applicants when requested’. At the same time however, the regulator granted the college an exemption from prosecution because its selection practices were deemed ultimately to be in the public interest.

In 2006, the issue surfaced again when the Australian Health Ministers’ Conference asked the ACCC to reconsider its earlier decision and to force RACS to provide extra basic training for overseas trained doctors who wish to practise as specialists in Australia.

A registrar is defined as a registered doctor who is undergoing a training programme in a chosen specialty in order to obtain qualifications in that specialty.


places.\textsuperscript{84} RACS argued however, that it was not the college to blame, but the states and territories which did not provide enough training places in hospitals.\textsuperscript{85}

A number of sources considered that this dispute illustrated it was time for governments to be more creative about medical training by encouraging university medical schools to provide alternative options for specialists.

Some university medical schools are already thinking about it, and have been since the ACCC decreed the RACS training system was anti-competitive, but authorised it on public benefit grounds. It’s not brain surgery. State governments provide the training funds, and register the specialists that emerge. There’s no law that says the medical colleges have to provide the oversight. It would not even involve excluding the colleges. States could simply put their training requirement out to tender, inviting both the colleges and university medical schools to bid.\textsuperscript{86}

At the time, the AMA dismissed the idea as a university ‘cash grab’; \textsuperscript{87} it has yet to come to fruition and specialist colleges remain the providers of specialist training.

**Specialist colleges: training and assessment**

A summary of specialist college training and assessment requirements to obtain fellowship status is included in Appendix B.

**Box 3: specialist medical colleges**

| Australian and New Zealand College of Anaesthetists (ANZCA) |
| The Australasian College of Dermatologists (ACD) |
| The Australasian College for Emergency Medicine (ACEM) |
| The Royal Australian College of General Practitioners (RACGP) |
| The Royal Australasian College of Medical Administrators (RACMA) |
| The Royal Australian and New Zealand College of Obstetricians & Gynaecologists (RANZCOG) |
| The Royal Australian and New Zealand College of Ophthalmologists (RANZCO) |
| The Royal College of Pathologists of Australasia (RCPA) |
| The Royal Australasian College of Physicians (RACP) |
| The Royal Australian and New Zealand College of Psychiatrists (RANZCP) |
| The Royal Australian and New Zealand College of Radiologists (RANZCR) |
| Royal Australasian College of Surgeons (RACS) |


\textsuperscript{85} Branchley, ‘Push to scrap doctors’ monopoly’, op.cit.

\textsuperscript{86} Fels and Brenchley, ‘An unhealthy monopoly’, op.cit.

General practice: training and assessment

General practice as a specialty

As medical academics David Weller and James Dunbar note, Australia was slow to recognise general practice ‘as a specific and defined discipline in medicine’.88 Formal training for general practitioners was introduced in the 1970s by the Royal Australian College of General Practitioners (RACGP) under a Family Medicine Program funded by the Australian Government. Training for fellowship of the RACGP was voluntary under this program however, and it remained that doctors who were not specialists, were by default, general practitioners. Indeed, ‘going into general practice was seen to be the inevitable last resort for those who could not succeed as a specialist’.89

In 1988, following a dispute about whether general practitioners should be allowed to bill based on the content of a consultation, as opposed to the time spent in that consultation, the RACGP and the Government agreed to consider ways by which experienced general practitioners would be allowed to bill on content-based descriptors. These discussions eventually led to the introduction of a general practice vocational register in 1989. From that time, general practitioners with recognised (specialist) qualifications or experience were able to attract higher Medicare rebates for their services.90

Upon its election in 1996, and in response to the perception at the time that Australia had too many general practitioners, the Howard Government introduced legislation that restricted the issue of Medicare provider numbers. These were issued from that time only to those who had completed a recognised course of post graduate training leading to the award of a fellowship, (see Appendix E for an explanation of these provider number restrictions).91 While this legislation did not affect previously recognised ‘specialists’, for general practitioners it meant

90. A vocational register was created which listed these practitioners with the Health Insurance Commission (now known as Medicare Australia). From 1994, no more doctors were accepted on the register. Following the introduction of the provider number legislation, doctors who were not on the register were not eligible for ‘grandfathering’ as vocationally registered practitioners.
91. A Medicare provider number uniquely identifies a medical practitioner and the location where he or she provides medical services. There are different types of provider numbers which are dependent on the category of medical board registration of doctors or the legislative requirements to which they are subject.
that those not vocationally recognised and new medical graduates were unable to access higher Medicare rebates (A1 rebates) unless they gained fellowship qualifications.\footnote{The 1996 legislation was controversial. Many argued that it led to injustices for those doctors who had not applied for vocational registration (for a variety of reasons) and for those who just missed out on experience qualifications. Similarly, it was argued that the legislation unjustly treated medical students who had commenced studies before the introduction of the legislation. This was because these students had commenced study with the expectation that they would be able to access Medicare rebates without having to obtain a general practice fellowship.}

This means that generally, non-vocationally registered medical practitioners are still eligible for Medicare rebates, but at lower rates. However, under a series of programs to encourage doctors to practice in areas where there are workforce shortages, non-vocationally registered practitioners are able to bill Medicare for general practice services at the A1 schedule rate. These programs include the Rural Other Medical Practitioners Program.\footnote{The Department of Health and Ageing website has more information on the Rural Other Medical Practitioners Program, viewed 16 March 2009, http://www.health.gov.au/internet/main/publishing.nsf/Content/work-pr-romps}

**General practice training**


These two recommendations were adopted, and in 2001, a new program, the Australian General Practice Training (AGPT) Program, to deliver training in the general practice specialty, was introduced. The program is conducted by an independent, government-run organisation, General Practice and Education Training Limited (GPET). In 2009, twenty-one regional providers delivered the AGPT Program on behalf of GPET.\footnote{A list of training providers and links to their websites can be found on the Australian General Practice Training Program (AGPT) website, viewed 4 February 2009, http://www.agpt.com.au/TrainingProviders/TrainingProviderLinks/}

Fellowships for general practitioners continue to be awarded by the RACGP. From April 2007, fellowships are also awarded by the Australian College of Rural and Remote Medicine. Trainees can be allocated places on either a general or rural pathway to fellowship. General
pathway trainees complete most of their training in metropolitan areas or in large regional centres. Rural pathway trainees complete all their general practice terms in rural and remote locations.96

Trainees for both pathways are chosen after an assessment of three structured referee reports and an interview. Trainee preferences are also taken into account when allocating training places. Training is provided in accredited medical practices in urban and rural areas, in hospitals and in specialised medical areas over a period of three years full time for metropolitan registrars and four years for rural and remote registrars.97

All registrars must complete some training in rural and remote areas—at least six months for those enrolled in the general pathways and 18 months for those in the rural pathway. Registrars training in the state capital cities and Canberra are also required to spend six months in an accredited training practice in an outer metropolitan area placement.98

Assessments of trainees are undertaken by regional training providers throughout their training period, but the award of fellowship is dependent on passing final clinical and written RACGP examinations.

The Australian Government imposes a quota on the number of general practitioner training places available each year.99 This ‘cap’ has made entry to general practice training competitive. In recent times, concern over declining numbers of general practitioners has led

96. Note: overseas trained doctors, who are permanent residents and affected by provider number restrictions introduced by the Howard Government in 1996 and who choose to undertake training for a general practice fellowship, are only eligible to apply for the rural training pathway.


to a number of increases in the training places cap, but not to any real moves to remove the
cap altogether.\textsuperscript{100}

In 2008, the Government provided $86 million to provide 212 additional ongoing general
practitioner training places (as well as 73 additional specialist training places in the private
sector). This increase means that there will be over 800 training places available from 2011
onwards.\textsuperscript{101}

Table 10 below provides an outline of the fellowship training pathways for general
practitioners.

\textsuperscript{100} It could be argued that the AMA would be most likely to call for a complete removal of the
cap, but the comments by the organisation have been ambiguous. While it has called for the
cap to be ‘lifted’, this could be interpreted as a call to raise the numbers of places, rather than
completely removing the cap. AMA, \textit{Urgent need to train more GPs}, media release,

\textsuperscript{101} K Rudd (Prime Minister) and N Roxon (Minister for Health), \textit{A stronger health workforce—
more doctors and nurses}, media release, 30 November 2008, viewed 17 March 2009,
\url{http://www.health.gov.au/internet/ministers/publishing.nsf/Content/mr-yr08-nr-
nr165.htm?OpenDocument&yr=2008&mth=11}
Continuing education/professional development

Obtaining a fellowship qualification is not the end of the education process for most medical practitioners; medical education has become a continuing process. As one study notes:

"The amount of biomedical knowledge available doubles every 20 years. Therefore, a doctor’s practice could become rapidly outdated without activities allowing a clinician’s knowledge and skills to remain current. Continuing medical education (CME) is the..."

Source: AGPT\textsuperscript{102}

mechanism by which doctors keep their practice up-to-date and is defined as ‘any and all the ways by which doctors learn after formal completion of their training’. At present, there is no legislation in Australia which compels medical practitioners to participate in continuing medical education, or what has more recently been labelled as professional development. However, some state medical boards impose this requirement and hospitals and area health services often require practitioners to demonstrate that they participate in ongoing learning to obtain or retain posts.

Continuing professional development (CPD) is based on the concept of adult learning and on the principles shown in Table 11 below. These involve self directed learning, taking responsibility for learning outcomes and ideally, according to one source, demonstrating that learning has improved performance and the subsequent health of patients.

CPD activities are classified on three levels which reflect the ability to effect change in practitioner behaviour and patient outcomes. First level activities are considered to be those which provide information. The level of demand on practitioners created by participation in these activities, which include meetings and workshops, self assessment tests and reading of journal articles is considered relatively low.

Level Two activities can include preparation for, and taking part in practice reviews, clinical audits or critical incident monitoring. They can involve adopting new approaches or techniques in practitioners’ clinical practise and participating in workshops, quality control studies and patient satisfaction surveys. Adopting new approaches and techniques are also considered level three activities; at level three, these additionally involve evaluating outcomes.


Some Australian colleges impose fellowship conditions in relation to CPD. The Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) has one of the most rigorous of the continuing professional development programs. It requires its fellows and sub specialists to accrue 150 points in continuing professional development activities per three year cycle. Practitioners keep their own records of professional development activities undertaken and report these to the College each year. The College undertakes a random verification exercise annually.106

Table 12 below provides a detailed example of a continuing development program; it shows the RACGP requirements for general practitioners in that College’s Quality Assurance and Continuing Professional Development program.

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Medical practitioners: education and training in Australia

Table 12: 2008–2010 RACGP requirements for continuing medical education

| 2008–2010 RACGP QA&CPD Program requirements (Note: new or modified elements indicated in bold) |
|---|---|---|
| Category 1 options | Category 2 options | Unaccredited activities |
| Active learning module (40 points) | Endorsed or accredited provider Category 2 activities (each activity capped at 30 points) | Self recorded activities (minimum of 10 hours education for 20 points for the triennium) |
| Clinical audit (40 points) | | |
| Evidence based medicine (EBM) journal club (40 points) | | |
| GP research (40 points) | | |
| • principal investigator | | |
| • GP research participant | | |
| Learning plan (one per triennium capped at 40 points) | | |
| Rapid ‘Plan, Do, Study, Act’ (PDSA) cycle (40 points) | | |
| Small group learning (40 points) | | |
| Supervised clinical attachment (40 points) | | |
| Higher education relevant to general practice (Australian qualifications framework – accredited): | | |
| • Graduate certificate (60 points) | | |
| • Graduate diploma (90 points) | | |
| • Masters degree (120 points) | | |
| • Doctor of Philosophy degree (PhD) (150 points) | | |
| RACGP assessment activities (150 points) | | |
| • FRACGP by examination | | |
| • FRACGP by practice based assessment | | |
| • FARGP | | |
| Basic CPR course | | |
| • Must meet Australian Resuscitation Council (ARC) guidelines | | |
| • Can be a Category 2 activity or part of a Category 1 activity | | |

Source: RACGP107

There has been some question about the extent to which pharmaceutical companies are involved in, and influence CPD. Drug companies sponsored 18 060 events, such as seminars, conferences and symposia for doctors and other health care professionals, in Australia in the period 1 July to 31 December 2008. These events were attended by nearly 445 000 people.108 According to a 2008 Australian Broadcasting Corporation (ABC) report, it is not uncommon


for the drug companies to suggest speakers who may be sympathetic to their products to attend educational conference sessions.¹⁰⁹ One view is that for this reason the sponsored events are ‘marketing masquerading as education’.¹¹⁰ Some findings suggest that the prescribing habits of medical practitioners are indeed influenced by the information provided at such events.¹¹¹ However, another view is that it is logical that the producers of drugs deliver information to the medical profession and that drug companies are only part of the continuum of medical education.¹¹² The issue remains topical and controversial.

Conclusion

It is a long and arduous road from student to medical practitioner—one upon which, students engage with many players. This brief has noted the involvement of many of these players. These include: governments, which develop education and training policies and provide infrastructure; universities and medical colleges, which provide education, training and mentoring, and a number of other organisations, which monitor processes and provide advocacy on behalf of students and the medical profession. The brief has illustrated the complexity of the transitional processes for students, and noted that becoming a medical practitioner is not the end of the road; lifelong learning is an integral part of being a medical professional.

The length and difficulty of the medical training road, however, has ensured that ‘products’ of the Australian medical education and training are among the best in the world and more than sufficiently skilled to meet the challenges of twenty first century medicine.


Appendix A

Basic outline of medical training in Australia

Source: Productivity Commission, *Australia’s health Workforce*, Research report, Canberra, 22 December 2005, p. 365 (Figure B.8).
Appendix B

Specialist colleges: training and assessment

A summary of specialist college training and assessment requirements to obtain fellowship status is included below.

**Australian and New Zealand College of Anaesthetists**

Anaesthesia involves the administering of various medications, which allow a range of surgical procedures to be undertaken without causing undue distress to patients. Anaesthetists are also involved in other fields, such as critical care medicine and pain medicine.

The Australian and New Zealand College of Anaesthetists notes that anaesthesia has increasingly become more sophisticated, with the ‘development of monitoring devices, the application of computer technology and the advent of drugs with fewer undesirable side effects’. It adds also that the specialty is progressively challenged by the ageing population, who present with co-morbidities of increasing incidence and severity.113

Trainees for this specialty need to complete a full time five-year program to gain fellowship. The program consists of two years of basic training and three years advanced training. Trainees are assessed progressively and must complete curriculum modules, primary and final examinations and either an Effective Management of Anaesthetic Crises or Early Management of Severe Trauma course or equivalent.114

**Australasian College of Dermatologists**

Dermatology is concerned with the diagnosis, treatment and prevention of diseases of the skin and its appendages.

To achieve the Fellowship of the College of Dermatologists, full time trainees undertake two years of basic training followed by two years of advanced training. Assessment involves passing clinical science and clinical pharmacology examinations before proceeding to advanced training and the passing of a final examination.115

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Medical practitioners: education and training in Australia

Australasian College of Emergency Medicine

Emergency medicine is the branch of medicine concerned with the prompt diagnosis and treatment of injuries or trauma or sudden illness. The Australasian College describes it as:

… a field of practice based on the knowledge and skills required for the prevention, diagnosis and management of acute and urgent aspects of illness and injury affecting patients of all age groups with a full spectrum of episodic undifferentiated physical and behavioural disorders; it further encompasses an understanding of the development of prehospital and inhospital emergency medical system and the skills necessary for this development.116

Training for an Emergency Medicine Fellowship is undertaken over seven years on a full-time basis. The first two years involves basic training. This is followed by one year provisional training and four years advanced training. The first two years of basic training usually include PGY 1 and 2 (see the discussion of early streaming into specialist education in the body of this paper). Trainees are required to gain 18 months experience in approved non emergency department disciplines during their advanced training.

To gain fellowship, trainees need to pass a primary examination prior to undertaking advanced training and an examination in the final year of training. They also need either to publish a paper or present it at an approved forum.117

Royal Australasian College of Medical Administrators

The aim of the Royal Australasian College of Medical Administrators (RACMA) is to promote and advance the study of health services management by medical practitioners. The College program is based on the assumption that combining skills acquired in the study of medicine with the knowledge and techniques of management ‘uniquely qualifie[s] medical practitioners to ensure that the highest standards of medical care are maintained’.118

College Fellowship is obtained after three years full time training and completing three years full-time or equivalent of supervised medical management experience in a recognised workplace, formal academic studies at an Australian or New Zealand university in a Masters degree (or equivalent), which contains core subjects required by the College and satisfactory completion of the RACMA training program. This program involves participation in College

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workshops, submission of a Management Practice Portfolio, oral presentation and assessment of a case, submission of Preceptor Reports and annual oral examinations.\textsuperscript{119}

**Royal Australian and New Zealand College of Obstetricians and Gynaecologists**

Obstetrics and gynaecology is the specialty of medicine concerned with the care of women during pregnancy and the management of conditions specifically experienced by women.

Fellowship of the Royal Australasian College of Obstetrics and Gynaecology requires completion of six years of full time training. This comprises four years of general obstetrics and gynaecology study and two years in which trainees can pursue particular interests, such as a subspecialty.

Assessment involves written and oral examinations. The written assessment, which may be taken in year three of training, comprises multiple choice and short answer papers. A structured oral examination can be taken in the second half of the fourth year of training.\textsuperscript{120}

**Royal Australian and New Zealand College of Ophthalmologists**

Ophthalmology practice includes the prevention of blindness, promotion of eye health and the rehabilitation of those with visual disability.\textsuperscript{121}

Training for Fellowship of the Royal Australian and New Zealand College of Ophthalmologists involves two years of basic training after which trainees need to demonstrate skills and knowledge in the subjects of Ophthalmic Sciences and Ophthalmic Basic Competencies and Knowledge.\textsuperscript{122} This is followed by two years advanced training. Trainees are required to pass examinations and online assessments of subjects studied in the first two years and in the advanced training years, an on-the-job-assessment and clinical and pathology examinations before becoming eligible to complete a final year. The final year is

\textsuperscript{119} See College website, viewed 8 January 2009, \url{http://www.racma.edu.au/}. Note: a preceptor is an experienced medical professional who provides training, observation and support for a less experienced trainee.


\textsuperscript{121} Royal Australian and New Zealand College of Ophthalmologists (RANZCO), *Ophthalmology as a career*, RANZCO website, viewed 4 February 2009, \url{http://www.ranzco.edu/aboutus/college-information/career}

\textsuperscript{122} The Ophthalmic Sciences are anatomy, physiology, optics, clinical ophthalmic pharmacology and emergency medicine, genetics, microbiology and epidemiology.
intended to broaden their experience and is spent preferably at a different institution from the one at which they complete their first four years.\textsuperscript{123}

**Royal Australian and New Zealand College of Psychiatrists**

Psychiatry involves the diagnosis, treatment and prevention of mental illness and emotional problems.\textsuperscript{124}

To acquire a fellowship of the Royal Australian and New Zealand College of Psychiatrists requires three years basic and two years advanced training. Basic training focuses on the acquisition of knowledge and skills in phenomenology, interviewing, clinical assessment and the principles of management planning in the first year and the development of knowledge and skills in clinical management and teamwork in the second and third years. Basic training assessment is ongoing and includes assessments by supervisors, case histories, written examinations and clinical vivas. Advanced training can involve generalist or approved program work which involves experience in mandatory training areas. Assessment also involves supervisor reports, a research project and a final report.\textsuperscript{125}

**Royal Australasian College of Physicians**

In Australia and New Zealand, physicians are specialists in adult internal medicine, paediatrics and child health and associated subspecialties. Physicians practice in areas such as cardiology, geriatric medicine, haematology (diseases of the blood) and thoracic medicine (diseases of the lungs).\textsuperscript{126}

Learning assessment for a fellowship of the Royal Australasian College of Physicians is ongoing and involves regular feedback exercises and meetings with supervisors. To be eligible for fellowship, trainees need to complete three years of basic training and to pass written and clinical examinations. Basic training involves broad-based training in internal medicine disciplines as well as options to undertake internal and non internal medicine rotations. Advanced training involves a further three years in-depth training in a chosen field

\textsuperscript{123} Royal Australian and New Zealand College of Ophthalmologists (RANZCO), *Vocational training program*, RANZCO website, viewed 4 February 2009, [http://www.ranzco.edu/training](http://www.ranzco.edu/training)


\textsuperscript{125} RANZCP, Information on basic and advanced training for fellowship, RANZCP website, November 2003, viewed 6 February 2009, [http://www.ranzcp.org/fellowship/general-training.html](http://www.ranzcp.org/fellowship/general-training.html)

and ongoing assessment. Fellowship can be awarded once final written and clinical examinations have been passed.  

**Royal Australian and New Zealand College of Radiologists**

Radiology involves the scanning of radiographic images of the body using medical imaging techniques, advanced computers and other equipment that allows radiologists to see inside the body. Radiation Oncology involves the care of patients with cancer and the use of radiation treatment, often in combination with surgery and/or chemotherapy.

Training for fellowship in this specialty takes five years full time. A maximum of one year of this training must be taken overseas. This College notes that in order to be awarded fellowship, a trainee must obtain experience in all imaging modalities available in Australia and New Zealand. Assessment in radiology involves a two-part examination; part one in anatomy and applied imaging technology and part two in radiology and pathology for radiologists. A two-part examination is also undertaken for students studying radiation oncology. Part one is in anatomy, clinical radiobiology and radiotherapeutic physics and part two in radiation oncology and pathology. 

**Royal College of Pathologists Australasia**

Pathology is concerned with the study of the nature and causes of diseases. It underpins all aspects of medicine and involves a broad spectrum of work from diagnostic testing and monitoring of chronic diseases to genetic research and blood transfusion technologies.

Pathology training takes a minimum of five full time years. Training can be undertaken in: General Pathology, Anatomical Pathology (including Histopathology, Cytopathology and Forensic Pathology), Chemical Pathology, Clinical Pathology, Forensic Pathology, Genetics, Haematology, Immunology and Microbiology (including Virology).

To achieve fellowship, students must pass a basic pathological sciences examination followed by a first discipline-specialty examination (usually in the third year of training), and a second

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discipline-specialty examination (usually in the final year of training). The latter two examinations involve written, practical and oral components.\textsuperscript{130}

**Royal Australasian College of Surgeons**

Surgeons treat injury, disease and deformity through operations. Many surgeons perform general surgery, while others specialise in areas such as orthopaedic surgery (the treatment of the musculoskeletal system).

In 2007, the Royal Australasian College of Surgeons introduced a new training program, Surgical Education and Training (SET). This program combines basic and specialist surgical training. Trainees are selected directly into one of the nine specialty training programs. The earliest point at which students can apply for the first year of the SET program is during Postgraduate Year Two. Entry to the program is in Postgraduate Year Three. SET assessment involves a generic surgical science examination, a specialty-specific surgical examination and a clinical examination.

Trainees then complete specialty training and examination in a number of disciplines, such as general surgery, cardiothoracic surgery, neurosurgery and plastic and reconstructive surgery. The length of further training depends on the specialty area. Paediatric surgery for example, requires three years of general surgery training and three years of paediatric specialty training.\textsuperscript{131}

**Appendix C**

**Areas of need/ districts of workforce shortage**

**Areas of need**

Area of need (AON) is a state and territory classification related to health workforce shortage. AON refers to any location in which there is a lack of specific medical practitioners or where there are medical positions that remain unfilled even after recruitment efforts have taken place over a period of time. AON can apply to both public and private sector positions.


\textsuperscript{131} Royal Australasian College of Surgeons (RACS), education and training pages, viewed 5 March, \url{http://www.surgeons.org/Content/NavigationMenu/EducationandTraining/EducationandTrainingoverview/default.htm}
Districts of workforce shortage

District of workforce shortage (DWS) is an Australian Government classification of health workforce shortage. DWS refers to any areas in which the community is considered to have less access to medical services than that experienced by the population in general. This restriction on access can be because of the remote nature of the community or because there is a lack of services available in the area, or a combination of these two factors.

DWS are calculated by the Department of Health and Ageing and determined with reference to the geographic areas (metropolitan or rural Statistical Local Areas known as SLAs) immediately surrounding specific practice locations. The Department uses a doctor-to-population ratio based on recent Medicare billing statistics and a ‘full time equivalent’ measure (FTE) that takes into account Medicare billing in an area, irrespective of whether medical practitioners work in a part time or a full time capacity, to assess if there are practitioner shortages in particular areas.

In addition, a delegate of the Minister for Health examines material relevant to the population need for professional services required in districts before making decisions about conferring DWS status.

A preliminary assessment of areas in relation to their DWS status can be requested from the Department of Health and Ageing. Requests need to provide relevant reasons and supporting documentation. Reasons may include:

- population need
- the special nature of the patient group (for example, a large Indigenous population)
- demonstrable changes in the workforce since the most recent quarterly statistics (for example, a significant population increase) or
- the special nature of services to be provided (for example, after hours services).

While for some time only rural and remote areas were eligible for consideration as DWS, it is now recognised that many outer metropolitan areas suffer medical practitioner shortages and these may be eligible for consideration as DWS.

Appendix D

Other medical scholarships

John Flynn Placement Program

The John Flynn Placement Program was established in 1997. It is administered by the Australian College of Rural and Remote Medicine on behalf of the Australian Government.
Medical practitioners: education and training in Australia

Medical students who are Australian citizens or permanent residents and who are enrolled in accredited medical courses at participating universities can apply for a place in the program. From 2009, 300 new placements will be available each year. The program offers medical students placements in the same rural and remote communities, country towns or regional centres for a minimum of two weeks each year over a period of four consecutive years. Students need to complete the program requirements before they finish their medical degrees.

Each John Flynn program participant works closely with a rural doctor in a wide variety of health settings, and each experiences one-on-one mentoring. This type and level of mentoring for students supplements the experience of a university clinical rotation in a hospital or general practice. The program also encourages students to interact and become involved with local communities.

An amount of $500 per week is paid to students while on placement.

**Rural Australian Medical Undergraduate Scholarship**

Established in 2000, the Rural Australia Medical Undergraduate Scholarship (RAMUS) scheme assists selected students from rural and remote areas to undertake medical degrees. To be eligible for RAMUS, students must have lived in rural or remote areas for a minimum of five consecutive years or eight cumulative years (commencing from the age of five). RAMUS assists students to meet accommodation, living and travel costs incurred while undertaking medical degrees in urban areas.

Scholarships awarded under RAMUS do not bond students to work in rural areas, however. Efforts are made instead to reinforce student ties to the bush through a rural mentorship program and compulsory membership of university student rural clubs.

Each year, approximately 100 new scholarships are awarded under the RAMUS scheme. This maintains an annual total of 550. Scholarship holders receive $10,000 a year during the completion of a standard medical degree at their chosen university.

**New South Wales Rural Resident Medical Officer Cadetships**

The New South Wales Government offers 12 Rural Resident Medical Officer Cadetships annually. To be eligible, students must be Australian or New Zealand citizens or permanent residents and enrolled in the second year of a medical degree at the Universities of Sydney, Wollongong, Notre Dame or the Australian National University, the third year of study at the Universities of Newcastle or Western Sydney or the fourth year of study at the University of New South Wales. New South Wales and Australian Capital Territory residents studying in another state must be enrolled in their second year graduate medical degree or third last year of an undergraduate medical degree.
Students chosen for the cadetships need to demonstrate an understanding of rural medical practice and display a commitment to, and interest in rural practice and lifestyle. They need to work for two years after graduation at rural base hospitals in either, Tamworth, Wagga Wagga, Orange or Dubbo.

The cadetships are valued at up to $15 000 each year, depending on other income received by recipients. Cadets are also eligible for a relocation allowance to help with costs associated with moving to the country. Cadetship recipients cannot also hold a Rural Australian Medical Undergraduate Scholarship (RAMUS) or a Medical Rural Bonded Scholarship.

**Assistance for Aboriginal and Torres Strait Islander Students**

There are a number of scholarships and bursaries awarded exclusively to Aboriginal and Torres Strait Islander students. These include:

- **Australian Medical Association Indigenous Peoples’ Medical Scholarship**

  To be eligible, students must not already hold a scholarship. They must be enrolled in an Australian medical school and have successfully completed their first year of a medical degree. Applicants must also be eligible for ABSTUDY.

  Scholarships are awarded on the recommendation of an advisory committee appointed by the Australian Medical Association (AMA) Indigenous People's Medical Scholarship Board of Trustees. Selection of scholarship recipients is based on satisfactory academic performance and reports from referees and statements provided by applicants. These statements are required to describe applicants’ purposes in studying medicine and their intentions on graduation.

  The AMA scholarships are awarded for a full course of study, subject to review at the end of each year. The value of the scholarship in 2009 was a maximum of $9000 per annum.

- **Puggy Hunter Memorial Scholarship Scheme**

  The Puggy Hunter memorial scholarship scheme was established by the Australian Government in 2002 to recognise the contribution made by Dr Arnold ‘Puggy’ Hunter in the field of Aboriginal and Torres Strait Islander health.

  The scheme provides financial support mainly to undergraduate Aboriginal and Torres Strait Islander students in health related disciplines. However, support is also extended to students in graduate entry medicine.

  Scholarships are awarded on the recommendation of a selection committee which considers the community involvement and leadership of students as well as their commitment to
improving Aboriginal and Torres Strait Islander health. Scholarships are not bonded and are valued at $15 000 annually for the duration of the course being undertaken.

Appendix E

Health Insurance Act 1973(Cth): provider number restrictions

Section 19AA

In 1996, the Howard Government introduced amendments to the Health Insurance Act 1973 (Cth) to impose minimum proficiency requirements that new medical practitioners must meet before the services they provide are able to attract Medicare benefits. These amendments were made under section 19AA of the Act.

Section 19AA states that medical doctors who were first recognised as practitioners on or after 1 November 1996, are unable to attract Medicare benefits, unless they are recognised general practitioners, specialists, consultant physicians, or persons undertaking approved placements under section 3GA of the Act (programs under this section of the Act include the Rural Locum Relief Program). Recognised general practitioners are either vocationally registered general practitioners or persons who hold Fellowship of the Royal Australian College of General Practitioners (that is, a postgraduate qualification).

The impact of section 19AA on medical practitioners without postgraduate qualifications depends on their residency status.

Permanent residents or Australian citizens

In order to be eligible to provide services that attract Medicare benefits, medical doctors who are permanent residents or Australian citizens must meet one of the following criteria:

- have been recognised as medical practitioners under the Act, prior to 1 November 1996. This means that before 1 November 1996, the doctors must have:
  - been permanent residents or citizens of Australia, and
  - completed their internship or period of supervised training (for AMC purposes), and
  - been registered with an Australian Medical Board.

- They must have been recognised as medical practitioners under the Act on or after 1 November 1996, and they must be:
  - recognised under the Act as specialists, consultant physicians or general practitioners, or
– in approved placements under section 3GA of the Act.

Temporary residents

Temporary resident medical practitioners are also subject to section 19AB of the Act. From 18 October 2001, section 19AB contains a provision that temporary resident medical practitioners who hold what are called section 19AB exemptions (see explanation below) are not affected by the restriction on Medicare access contained in section 19AA.

Most temporary resident medical practitioners who were registered in Australia prior to 1 January 1997 were no longer subject to Medicare restrictions under section 19AB from 18 October 2001. As the majority of these doctors had acquired postgraduate qualifications, they were not subject to qualification restrictions under section 19AA. However, temporary resident doctors who were no longer affected by Section 19AB after 18 October 2001, but have not gained relevant postgraduate qualifications, continue to be subject to section 19AA restrictions.

These doctors are eligible to access Medicare after 18 October 2001, only if any postgraduate qualifications they possess have been recognised by a relevant Australian medical college, or if they are undertaking approved placements (that is, if they are on training or workforce programs as specified under section 3GA of the Act).

Section 19AB

Section 19AB of the Act imposes restrictions on doctors who did not obtain their primary medical qualifications in Australia. This includes doctors trained in New Zealand. These doctors are known as overseas trained doctors or International Medical Graduates.

Permanent resident or citizen overseas trained doctors

Under the 1996 amendments, Medicare benefits are not payable for professional services rendered by permanent resident overseas trained doctors for a period of ten years from the time they first became medical practitioners, as defined under section 3 of the Act.

Permanent resident or citizen overseas trained doctors are not subject to section 19AB restrictions if before 1 January 1997:

• they were registered with an Australian Medical Board or

• they were eligible for assessment of their medical qualifications by the Australian Medical Council and they had made application for that assessment.

For doctors registered before 18 October 2001, the ten year restriction applies from their first recognition as medical practitioners, as defined under the Act. For doctors first registered after 18 October 2001, the restriction applies from the time they were granted permanent residency.
Temporary resident overseas trained doctors

Temporary resident overseas trained doctors are subject to restrictions under section 19AB of the Act for an indefinite period.