NSWMSC

New South Wales Medical Students' Council

Representing 6500+ medical students from medical schools across the NSW & ACT.

Domestic Graduate Prioritisation

Training the Doctors We Have Already Paid For.

A national framework for domestic-graduate prioritisation in specialty training (July 2026)

NSW Medical Student Council

Position Statement

NSWMSC holds the position that:

1. Australia has a duty to the medical graduates it has publicly funded to train, and the completion of their training to fellowship is the natural and necessary return on that public investment;

2. The principal challenge facing Australia's medical workforce is not an absolute shortage of doctors but a structural bottleneck at entry to specialty training, and this bottleneck is widening;

3. Graduates of Australian medical schools must be **prioritised** for selection into specialty training ahead of newly arrived international medical graduates (IMGs), with appropriate grandfathering of IMGs already serving in the Australian health system;

4. Prioritisation is necessary but not sufficient, and must be paired with a commensurate expansion of accredited training places and a pause on further medical-school expansion until downstream training capacity matches graduate supply;

5. IMGs are a valued and essential part of Australia's medical workforce, and overseas recruitment should be directed to genuine areas of geographic and specialty need;

6. Continued reliance on international recruitment to fill the specialty-training pipeline is inconsistent with Australia's own National Medical Workforce Strategy and its stated objective of national self-sufficiency; and

7. The absence of a permanent, independent medical workforce planning body has produced these foreseeable failures and must be remedied.

Policy Points

NSWMSC calls upon:

1. The Australian Commonwealth Government to:

a. Legislate a domestic-graduate prioritisation framework for entry to specialty training, modelled on the United Kingdom's Medical Training (Prioritisation) Act 2026 (1), under which graduates of Australian medical schools and doctors with substantial Australian service are prioritised at shortlisting and offer, with grandfathering of IMGs already practising in Australia;

b. In addition, make Specialist Training Program (STP) funding conditional on specialist medical colleges adopting domestic-graduate prioritisation within their selection processes, achieving the same end without legislating across every college individually;

c. Refrain from further increasing medical-school Commonwealth Supported Places (CSPs) or establishing new medical programs, *until* accredited prevocational and specialist training capacity demonstrably matches domestic graduate supply (2);

d. Match any increase in medical student numbers with a commensurate increase in funding for accredited prevocational and specialist training positions (2,3);

e. Expand accredited registrar training places by at least approximately 1,150 per year (about 20% above current intake), phased in from 2027, to close a projected specialist shortfall of at least 12,812 full-time-equivalent specialists by 2048 (4,5);

f. Direct overseas recruitment to genuine areas of need (rural, regional and undersupplied specialties) (6);

g. Re-establish a permanent, independent national medical workforce planning body, with a mandate to model and publish graduate-origin progression data;

h. Fund additional public staff-specialist and clinic positions to absorb new fellows, and preference domestically trained candidates at the post-fellowship appointment stage;

i. Building on the 2006 Council of Australian Governments (COAG) commitment that guaranteed internships for Commonwealth-supported graduates, work through National Cabinet to guarantee every Australian medical graduate a funded, accredited prevocational and specialty-training pathway (7); and

j. Subject any prioritisation framework to independent review after each of its first three selection cycles, and at least every three years thereafter, with published reporting of competition ratios, PGY-at-intake, rural and specialty distribution, and IMG outcomes.

2. Australian State and Territory Governments to:

a. Partner with the Commonwealth and specialist colleges to expand accredited training places to meet current and projected geographic and specialty need (8);

b. Convert service-registrar (unaccredited) positions into accredited training positions where the underlying service need is genuine and ongoing (9);

c. Preference domestically-trained candidates for public staff-specialist appointments where clinical merit is equivalent.

3. Specialist Medical Colleges to:

a. Implement domestic-graduate prioritisation within selection, consistent with any Commonwealth framework or STP funding condition;

b. Publish, by specialty and jurisdiction, the number of eligible applicants, places offered and success rates, together with transparent CV-scoring and selection criteria (8); and

c. Review selection criteria to remove requirements that do not reflect clinical aptitude and that disadvantage candidates without the means to accumulate research and additional qualifications (8).

4. The Australian Medical Council and Medical Board of Australia to:

a. Align IMG assessment and recognition pathways with demonstrated workforce need, prioritising areas of genuine shortage; and

b. Maintain rigorous, college-led standards while reducing avoidable duplication and delay in assessment (6).

5. Medical Deans Australia and New Zealand (MDANZ) to:

a. Align published medical-student intake projections with downstream prevocational and specialist training capacity; and

b. Continue and expand the public reporting of graduate numbers, origins and career outcomes (10).

6. Universities to:

a. Support legislative caps on domestic and international full-fee-paying medical places, so that total enrolment is governed rather than uncapped (2,3); and

b. Ensure that any growth in Commonwealth Supported Positions (CSP) or Bonded Medical Positions (BMP) is matched by clinical-placement and teaching capacity.

7. NSWMSC and the medical-student community to:

a. Advocate for the above reforms to government, colleges and universities;

b. Maintain and extend independent modelling and data collection on competition ratios and training progression; and

c. Support medical students and early-career doctors navigating an increasingly competitive training environment.

Background

THE BOTTLENECK HAS LED TO THE SHORTAGE

The Commonwealth's *Whole of Medical Workforce Supply and Demand Compendium Report* (June 2026) projects that the medical workforce will remain "balanced" (within ±3%) for 25 years (5, p.3). That headline conceals a structurally broken pipeline. The report projects the hospital prevocational workforce to more than double, from 15,900 to 38,222 full-time equivalents (FTE) between 2025 and 2048, while the registrar workforce grows by only about 10% (5, p.17). The annual rate at which prevocational doctors progress into registrar training is projected to fall from 36% in 2024 to 15% by 2048 (5, p.19); the report states elsewhere that this rate has already fallen from 52% in 2018 to 33% in 2024 (5, p.25).

This is not a new or unforeseen problem. Australia's own *National Medical Workforce Strategy 2021–31* identified the oversupply of prevocational doctors, the growth of unaccredited service registrars, and the resulting competition and career uncertainty more than five years ago, observing that increased junior doctor numbers from medical school expansion had "exacerbated this situation, by increasing competition and bottlenecks for training places" (9). The Australian Medical Association (AMA) likewise attributes the bottleneck to increases in CSPs "without a commensurate investment in specialist medical training places" (3), and the Australian Medical Students' Association (AMSA) has stated plainly that the suggestion that increasing medical-student numbers is the sole solution to workforce problems is "false and irresponsible" (2).

The strain is being driven into the system from the front. Australia graduated 15.9 medical students per 100,000 population in 2019, well above the United Kingdom (13.1), the United States (8.1) and Canada (7.1) (11), and domestic graduate numbers nearly doubled from 1,544 in 2007 to 3,066 in 2020 (3). Medical Deans data show that growth is locked in to continue: domestic commencements in 2026 (approximately 3,812) imply continued graduate growth of around 16% to 2031, independent of any further expansion (10).

THE PUBLIC INVESTMENT IN AUSTRALIAN GRADUATES

Training a specialist is among the largest investments the health system makes in any individual. The National Medical Workforce Strategy estimates the total investment from student to qualified specialist at between approximately $1 million and $2.6 million, accumulated over 10 to 20 years of medical school, internship, prevocational years and vocational training (9). The Australian taxpayer funds the great majority of this education and training.

Yet the system increasingly fails to see that investment through. The Compendium reports that over 80% of prevocational doctors and over 90% of registrars work in the public sector, while over 60% of specialists ultimately practise in the private sector, and names directly the resulting "growing concerns around the return on investment to training a specialist in the public system" (5, p.26). NSWMSC's position is that the appropriate response is not to employ IMG consultants past a domestic queue, but to complete the training of the graduates Australia has already paid for and to fund the public positions needed to retain them.

None of this was unforeseen. As early as 2007, as the Commonwealth expanded medical-school places, the profession warned that accredited training would need to roughly double (from about 6,000 to 12,000 prevocational positions) to absorb a graduate cohort projected to grow from 1,348 in 2005 to over 3,000, observing that at that time "there are currently many more accredited prevocational training positions than local graduates" (12). The graduates arrived; the commensurate expansion of accredited training did not. Governments expected the strain to be temporary: the 2013 National Medical Intern Summit recorded the states' and territories' view that "the demand for international medical graduates will decline" as more Australian-trained graduates progressed (13). The opposite occurred: overseas entry has grown, not fallen, confirming that the bottleneck is a foreseen policy failure that will not self-correct.

THE PIPELINE IS BEING FILLED AT THE TRAINING GATE BY OVERSEAS RECRUITMENT

Overseas entry to the profession now exceeds domestic graduate production: in 2023–24, 5,717 IMG registration applications were approved against 3,110 domestic graduates of Australian universities (5, p.2). Indeed, first-time international registrations have outnumbered domestic graduates in each of the past three years (Figure 1) (10,14). The IMG share of the workforce has risen from 21% (2003) to 34% (2023) and is projected to reach 38%, accounting for 42% of all workforce growth to 2048 (5, p.2).

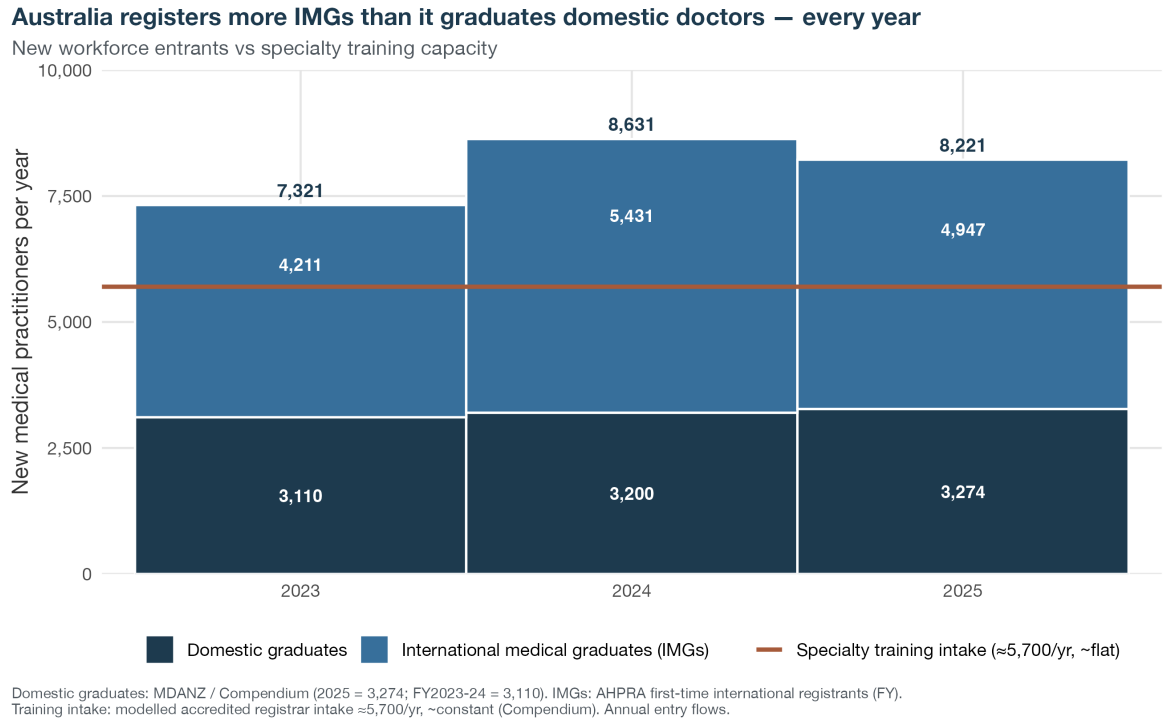

Figure 1: New medical workforce entrants (domestic graduates and IMGs) versus annual specialty training intake, 2023–2025. Sources: MDANZ; AHPRA first-time international registrants (FY); Compendium (5,10,14).

Critically, this recruitment is concentrated at the training gate that domestic graduates cannot get through. The Compendium projects that, between 2025 and 2048, IMGs will account for 28% of growth in prevocational doctors, 50% of growth in career medical officers and **64% of growth in registrar numbers** (5, p.4). The National Medical Workforce Strategy records the mechanism that permits this: IMGs who complete Australian Medical

Council requirements are treated as "equivalent to Australian graduates" at entry to training, so that in periods of oversupply internationally qualified doctors "compete with domestic graduates for prevocational and vocational training positions" (9). It is this equivalence, at the point of competitive selection, that NSWMSC's prioritisation framework addresses.

Independent regulator data confirms the same pattern at entry to the profession. The Medical Board of Australia registrant records show that, among doctors holding provisional registration (the supervised stage every new doctor must complete), the internationally trained share rose from 37% in 2023 to 43% in 2026, while the number of Australian- and New Zealand-trained provisional registrants held flat at about 4,000. Almost all of this increase came through the Competent Authority Pathway, whose provisional registrations grew by roughly a third. Over the same period, "limited" registration for supervised practice more than doubled, from about 2,400 to almost 6,000, a direct measure of the expanding supervised and service-registrar workforce. This 43% international share, taken from the regulator's own records, independently corroborates the international-graduate share used in NSWMSC's modelling (4,15).

This reliance runs against Australia's own strategy. The National Medical Workforce Strategy names heavy IMG dependence as a strategic risk, supports working toward an agreed definition of national self-sufficiency, and stresses the importance of intervening early because supply is slow to adjust (9). The AMA concurs that policy should improve "self-sufficiency" and calls for an independent workforce-planning agency (6). NSWMSC goes further than these positions: while it shares their commitment to self-sufficiency, ethical recruitment and IMG support, it holds that a duty to the domestic students the public has funded requires active prioritisation at selection, not merely improved planning.

WHAT "BALANCE" CONCEALS

The Compendium's reassuring headline rests on how demand is defined. The model defines demand as current observed service utilisation and states that it "preserves current patterns of over- and under-utilisation" and does not capture unmet need from people who cannot access care (5, p.13; 16). In effect, "enough doctors" is defined as enough to sustain today's level of unmet need. Genuine clinical need, in rural, regional and outer-metropolitan communities and in undersupplied specialties, is therefore understated. The same report records a near four-fold metropolitan-to-rural gap in doctor supply and concedes that "it cannot be assumed that workforce growth alone will solve the problem" (5, p.26). A specialist undersupply already exists, projected to deepen from 2,250 FTE in 2025 to 12,812 FTE by 2048 (5, p.22). On the model's own met-demand definition that figure is a floor, not an estimate of true need and it represents a present and growing shortage of the very specialists that junior doctors are trying to become.

MODELLING THE EFFECT OF PRIORITISATION

To quantify the choice before government, NSWMSC modelled the training pipeline using the Compendium's own figures (4). The model tracks the queue of prevocational doctors waiting for accredited training year by year and separately projects the specialist workforce against demand. It is illustrative rather than predictive, and every input is drawn from sources that are available publicly.

Under the current "do nothing" path, the competition ratio for training rises from approximately 2.8:1 today to 6.7:1 by 2048, and the typical postgraduate year at entry climbs from around PGY4 to nearly PGY8 (4). Under our domestic-graduate prioritisation scenario, the picture changes sharply. Because accredited registrar places (about 5,733 each year) already exceed the number of domestic graduates (about 3,800 and rising), prioritising domestic graduates clears the waiting queue within a few years: the competition ratio for the priority group falls from 2.8:1 to about 1:1, and the postgraduate year at entry falls to the minimum eligible year (Figure 2, top panels). Prioritisation is therefore sufficient, on its own, to relieve much of the training bottleneck for domestically trained doctors.

Prioritisation has the effect of redistributing who has access to training. Figure 2 (lower panel) tracks who fills accredited training places over time: through the late 2020s the places clear the existing domestic backlog; from 2031, international graduates who complete five years of Australian service re-enter the priority pool and take a growing share, around a quarter of places; and newly arrived international graduates retain a residual share, directed to genuine area-of-need. The resulting allocation, roughly 93% of places to the priority group, is directionally consistent with the United Kingdom's first-cycle outcome of 98% (1,17).

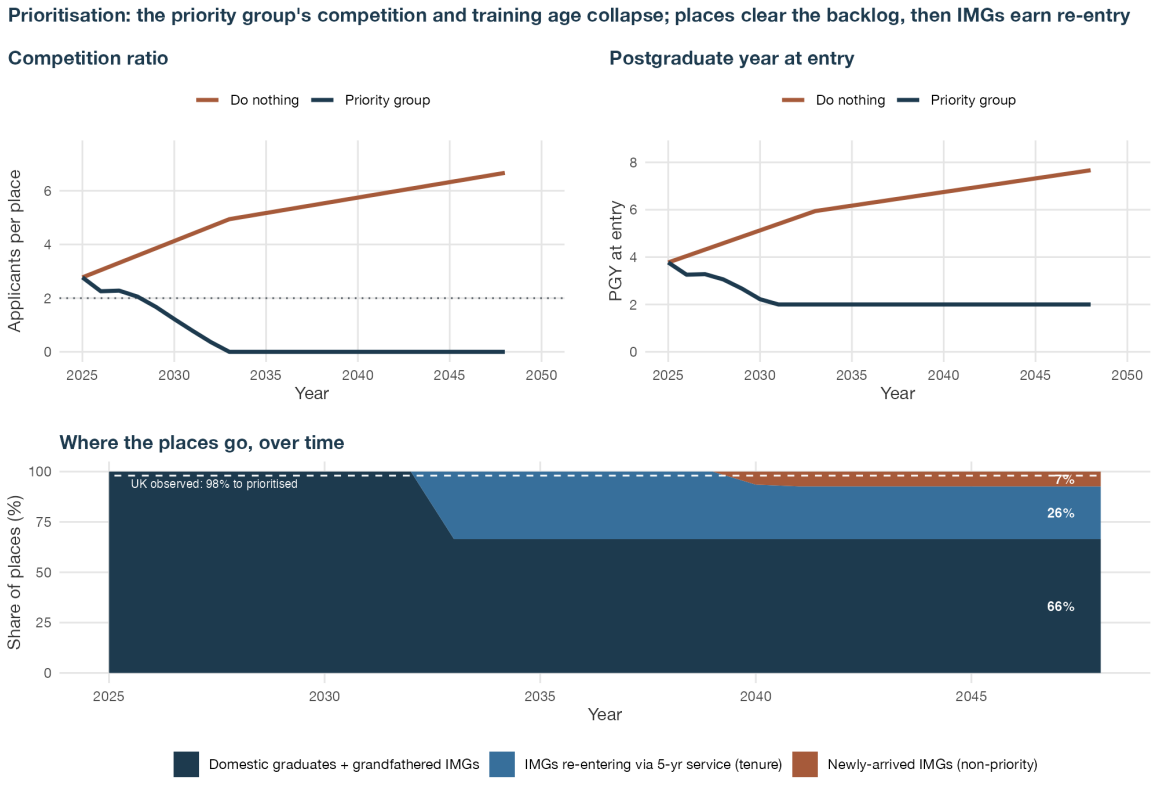

Figure 2: The effect of domestic-graduate prioritisation. Top: the priority group's competition ratio falls to about 1:1, and its postgraduate year at entry falls to the minimum eligible year, against the do-nothing paths (which rise to 6.7:1 and nearly PGY8). Bottom: share of accredited training places over time, by group (domestic and grandfathered; IMGs re-entering after five years' service; newly arrived IMGs), benchmarked to the United Kingdom's first-cycle 98% prioritised outcome (1,4,17).

However, prioritisation does not close the projected shortfall of specialists on its own. The Compendium projects a specialist undersupply that deepens from about 2,250 FTE in 2025 to 12,812 FTE by 2048 (5, p.22), and prioritisation alone does not close it. Doing so requires expanding accredited training capacity. Modelling the pipeline (registrar training of about six years, at observed completion rates), NSWMSC finds that a sustained increase of

roughly 1,150 accredited registrar places per year, about 20% above current intake and phased in from 2027, closes the projected shortfall by 2048 (Figure 3) (4). Both figures are conservative: demand is defined as currently met demand, and the pipeline does not net out specialist attrition over the horizon, so the shortfall and the required expansion should each be read as "at least" (4). Because extra trainees become fellows only after the training lag, expansion must begin by the early 2030s at the latest to take effect in time.

One implication matters for candour and for sequencing. Domestic graduates (about 3,800 each year) cannot by themselves fill even the current number of training places, let alone an expanded number; the balance must continue to be met by international graduates directed to areas of genuine need, or by a later and carefully calibrated increase in domestic student places once training capacity has caught up. The two levers are therefore complementary, and neither alone is sufficient to address the whole picture: prioritisation is the immediate lever that relieves the bottleneck for domestic graduates, while phased place expansion is the durable solution that closes the specialist shortage.

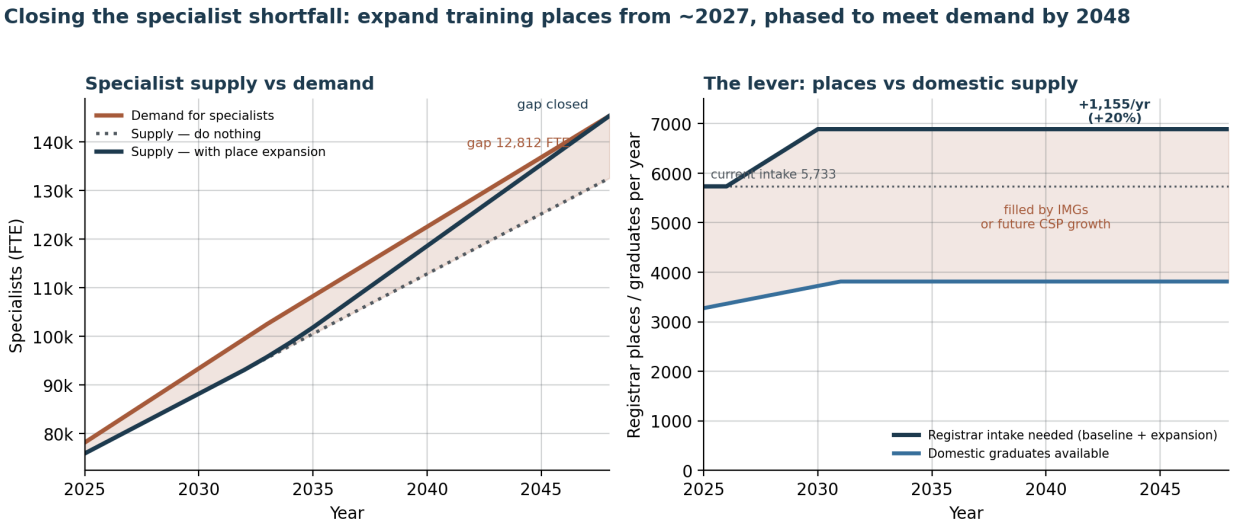

Figure 3: Specialist supply versus demand, 2025–2048. A sustained increase of about 1,150 accredited registrar places per year, phased in from 2027, closes the projected 12,812 FTE specialist shortfall by 2048; the right panel shows total training places needed against domestic graduate supply (4,5).

The model also reveals an important nuance, drawn from Medical Deans registration data (10). IMG penetration runs **inverse to competitiveness**: the hardest-to-enter specialties have the fewest IMGs (ophthalmology 22% IMG, against a competition ratio above 20:1; surgery 26%), while the most IMG-reliant are the less-competitive, service-heavy specialties (emergency medicine 46%, psychiatry 43%, general practice 42%) (10). This independently corroborates the AMA's finding that IMGs comprise 43% of general practitioners and 53% of the rural workforce (6,18). It also disciplines the argument: prioritisation delivers the largest ratio reductions where competition is already lower, and the smallest where the bottleneck is most acute, which is precisely why it must be paired with place expansion, and why overseas recruitment is best directed to the area-of-need specialties where IMGs already concentrate (Figure 4).

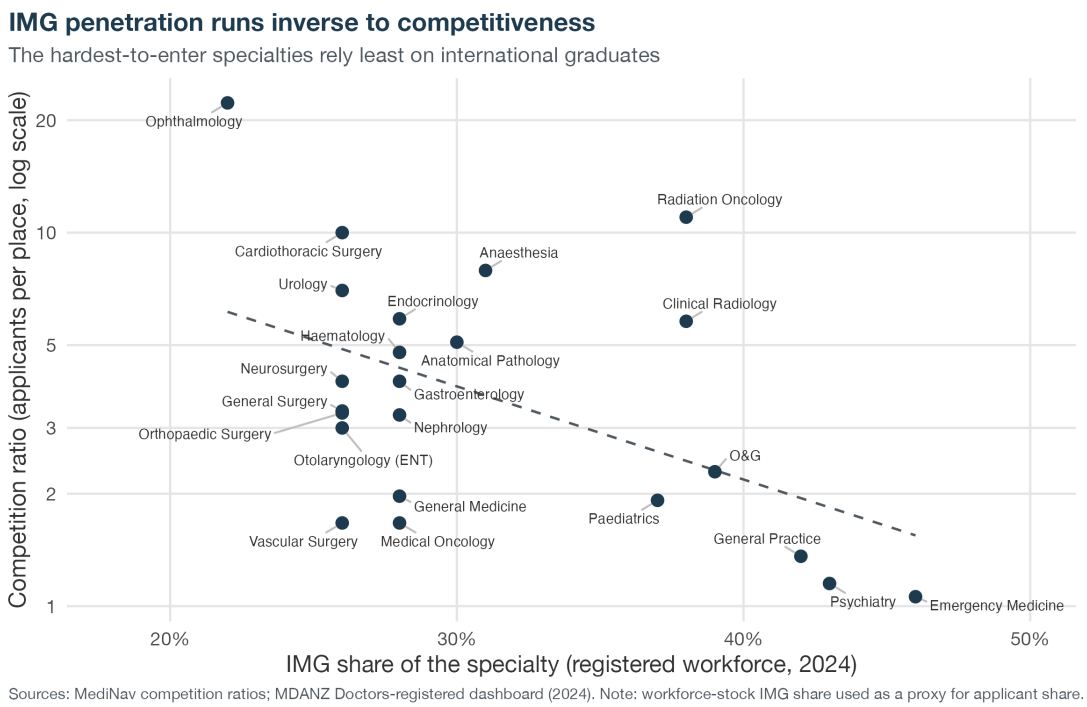

Figure 4: IMG share of the registered workforce versus competition ratio, by specialty (2024). The hardest-to-enter specialties rely least on IMGs (10).

Table 1: Modelled outcomes, 2048 (NSWMSC Workforce Model v0.7)

Measure (2048)	Do nothing / Status-quo	Prioritise + expand
Competition ratio (applicants per place)	6.7 : 1	~1 : 1 (queue clears)
PGY-at-intake	~7.7	minimum eligible year (specialty-specific)
Specialist shortfall, 2048	12,812 FTE undersupply	closed (+~1,150 places/yr from 2027)

Source: NSWMSC Workforce Model v0.7 (4), built on Compendium figures (5) and MDANZ/AHPRA data (10,14). Priority-group ratio and PGY from the transient-queue model; specialist shortfall and place expansion from the supply–demand model.

CLEARING THE EXISTING BACKLOG

The competition ratio describes the steady pressure at the training gate; it does not by itself show how quickly prioritisation would relieve the queue of doctors already waiting. NSWMSC therefore modelled the prevocational pool as a transient queue, beginning from the approximately 15,900 doctors waiting in 2025 (4). Under a do-nothing path the queue more than doubles, reaching the Compendium's own projection of 38,222 FTE by 2048. Under prioritisation, with every IMG already in the system grandfathered so that only domestic graduates enter the priority pool, the backlog falls below a 2:1 competition level by 2029 and drains toward zero by the late 2030s, holding at or below 2:1 for the remainder of the projection (Figure 5).

The same model tests a fairer, tenure-based design in which international graduates who complete five years of Australian service re-enter the priority pool from 2031. Because the existing backlog clears first, the system does not re-tighten: it remains at or below 2:1 through to 2048 across the plausible range of re-entry rates, up to roughly half of all arriving IMGs. The order of operations is the decisive result: clear the queue the public has already

paid to create, and then allow overseas-trained doctors to earn priority through Australian service.

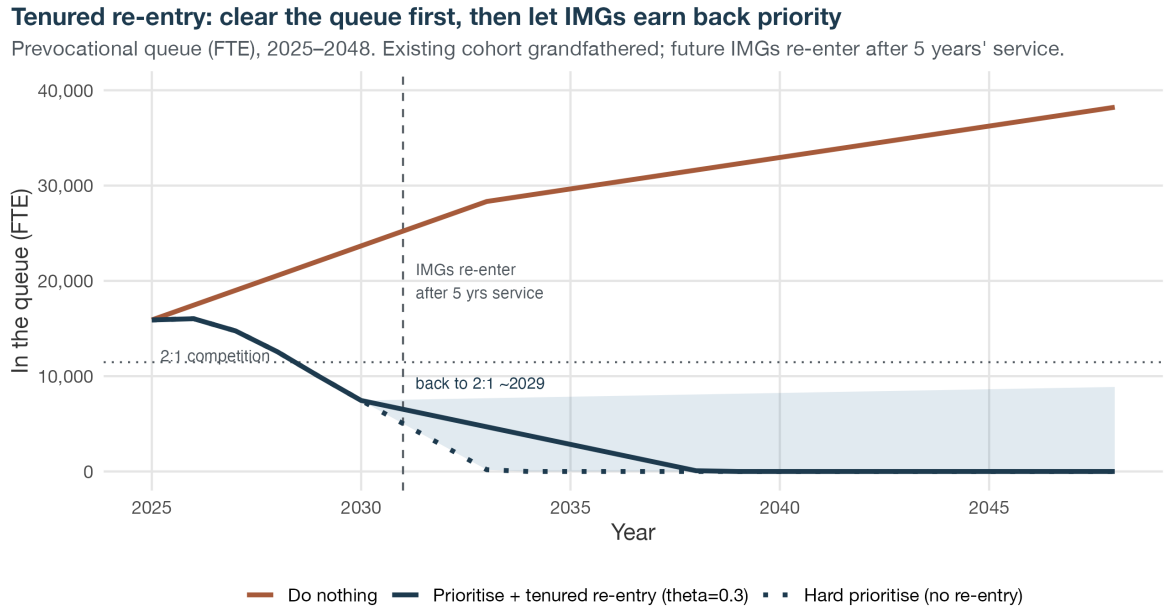

Figure 5: Prevocational training queue (FTE), 2025–2048: do nothing versus domestic-graduate prioritisation with tenured IMG re-entry. The existing cohort is grandfathered; future IMGs re-enter the priority pool after five years' service (from 2031). Because the backlog clears first, the system holds at or below a 2:1 competition level for re-entry rates up to approximately 0.49 (4). Prioritisation is modelled as reclaiming all but an area-of-need residual (≤ 500 places per year) of the approximately 3,450 annual training-gate slots that new international entry currently absorbs; the result is robust for residuals up to roughly 650 per year (see the accompanying methodology note, Appendix A.5).

THE UNITED KINGDOM PRECEDENT

Australia's position closely mirrors the United Kingdom before its reform: rising domestic graduate output, a sharp increase in overseas applicants able to compete on equal footing, and home-trained doctors unable to progress. The United Kingdom responded with the Medical Training (Prioritisation) Act 2026, which prioritises UK graduates and doctors with substantial NHS experience for training places, with grandfathering for IMGs already in the system (1). The Act contains no five-year service period; the tenure-based re-entry design modelled in this paper is NSWMSC's own proposal, for which the Act supplies the precedent of prioritisation and grandfathering only. NSWMSC notes for transparency that this reform is recent. Even so, NHS England's first-cycle data show a clear effect: the competition ratio for prioritised candidates fell from 4:1 to 2:1; 98% of posts were filled by prioritised doctors, up from 72%; and non-prioritised acceptances fell from 27.95% to 1.75% in a single cycle, with remaining posts filled in the specialties and locations that prioritised candidates did not take, directing overseas recruitment toward genuine areas of need (17).

RISKS AND COUNTER-ARGUMENTS

Equity and discrimination.

A prioritisation framework must operate on the basis of **training origin and Australian service**, not nationality or ethnicity, and should preserve open application for all

candidates, as the United Kingdom model does (1). IMGs already serving in Australia, including Australian citizens who trained overseas are protected through grandfathering. NSWMSC is upfront about one consequence of an origin-of-training basis: an Australian citizen who chooses to train overseas in future would enter behind the priority group until they accrue Australian service, exactly as an overseas-trained national would. This outcome is to be expected and in many ways this is how most Australian jurisdictions evaluate this group for the purposes of internship allocations. Legislative drafting should nonetheless be informed by specific advice on discrimination law, procedural fairness and Australia's trans-Tasman obligations, including the treatment of New Zealand-trained doctors under the Trans-Tasman Mutual Recognition Act 1997 (Cth) (19).

Prioritisation by training origin is, moreover, the international norm rather than an aberration. Canada operates separate residency-match streams that reserve most first-round places for its own (and United States) graduates (20); the United States and Ireland strongly preference their own graduates and residents (13); and in 2026 the United Kingdom joined them (1). Australia's own 2013 National Medical Intern Summit observed that "all comparable nations with the exception of the United Kingdom prioritise entry to training programs for graduates who are also citizens of the country" (13). With the United Kingdom's reform, Australia is now the outlier. The principle is also already embedded domestically at the first postgraduate gate: under the July 2006 COAG agreement the states and territories agreed "to guarantee to provide high-quality clinical placements and intern training for Commonwealth-funded medical … students" (7), and every jurisdiction prioritises domestically trained graduates for internship accordingly. The principle also has three decades of statutory precedent: since 1996, section 19AB of the Health Insurance Act 1973 has restricted overseas-trained doctors' access to Medicare billing for ten years except in districts of workforce shortage — an origin-of-training distinction, directed to service need, that has survived sustained legal and parliamentary scrutiny (21). Extending the same origin-based principle to the next gate is an incremental and well-precedented step.

IMGs are essential and valued.

NSWMSC affirms the substantial contribution of IMGs, particularly in rural and under-serviced communities (6). Prioritisation does not reduce the role of IMGs in areas of genuine need; it redirects recruitment to these communities.

Rural and area-of-need supply.

It is sometimes argued that prioritising domestic graduates would worsen rural and area-of-need supply, which currently relies on overseas-trained doctors. The evidence on graduate intentions points the other way. In the Medical Schools Outcomes Database, domestically-trained students express markedly stronger intentions than international students at Australian schools to work in rural and remote communities (15.8% versus 3.6%), in general practice and rural generalism (16.8% versus 7.1%), and to include Indigenous health in their careers (48.1% versus 24.5%) (22). The cohort of domestic graduates the public has funded is therefore more willing to serve areas of need. Prioritising them in combination with ensuring good rural training opportunities will help ease rural supply shortages, not threaten it

This complements, rather than displaces, the role of overseas-trained doctors. It mirrors the long-standing principle of section 19AB of the Health Insurance Act 1973, under which overseas-trained doctors supplement service need in districts of workforce shortage rather than substitute for domestic doctors elsewhere (21). Prioritisation applies the same logic at the training gate: domestic graduates are directed toward the regional and generalist careers they are willing to take up, while overseas recruitment is directed to the genuine, ongoing areas of need where it is most valuable.

Prioritisation alone will not fix the bottleneck.

This is correct and forms a core part of our demands, though the two reforms do work in different ways. Prioritisation clears the bottleneck at the training gate for domestic graduates, because accredited places already exceed domestic graduate numbers; it does not, by itself, close the projected specialist shortfall of at least 12,812 FTE by 2048. That requires a commensurate, phased expansion of accredited training places, paired with a pause on further medical-school expansion until capacity matches and restored independent workforce planning (2,4,5). Prioritisation can be implemented immediately, while place-expansion is the long-term solution.

The human cost of the status quo.

Beyond the fiscal cost, the present arrangement wastes developed clinical capability. Doctors capable of progressing are held for years in unaccredited service roles, reapplying annually for the same positions and unable to develop across the domains of practice the Australian Medical Council sets for a competent specialist. This is a loss of capability the public has already paid to create, and a steady erosion of the morale and retention of the very domestic workforce the system most needs.

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Policy Details

Name: Training the Doctors We Have Already Paid For — Domestic-Graduate Prioritisation in Specialty Training.

Category: Medical Workforce and Training.

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