Policy Document

Bonded Medical Schemes Policy

Background

The Australian Medical Students’ Association (AMSA) is the peak representative body for medical students in Australia.

The people of rural and remote Australia face significantly poorer outcomes in all aspects of health than their metropolitan counterparts [1]. The Commonwealth government has developed programs and initiatives in to improve access to health services and shortage of doctors working in these areas [2].

There has been a significant amount of literature on the ontology of rural doctors [3-6] in order to inform targeted strategies of increasing the proportion of student and young doctors who take up rural careers. The highest predictors of a medical student developing into rural doctor are:

a) Rural origin [3-5]
b) Positive rural experiences late in training [4,5,7]
c) A partner from a rural area [6]

Furthermore, recent research by Zadoroznyj and Martin has called to capitalise on “ruralmindedness” over bonding strategies and the specialisation pathways in rural work to address concerns about fulfilling career aspirations [8].

Since the 1990s, the Australian Commonwealth Government has developed initiatives to address educational disadvantage and under-representation of rural students in medicine [9-11] such as Rural Australia Medical Undergraduate Scholarships (RAMUS) (2000) and Rural Undergraduate Support and Coordination (RUSC) Program (1994) (now combined with the RCS). Student exposure to rural medicine has increased through the Rural Clinical Schools (RCS) (1992), General Practice Rural Incentives Program (GRIP) (1992), University Departments of Rural Health (UDRH) (1996) and John Flynn Placement Programme (JFPP) (1997). These initiatives acknowledge and implement the above evidence to cultivate rural doctors for the long-term.

Bonded Medical Schemes were established in 2001 for the intention of addressing the shortage of doctors in rural areas. The Medical Rural Bonded Scholarship (MRBS) was a $26,310 per annum scholarship (indexed to 2015) in exchange for 6 consecutive years in a rural area along with hefty penalties for breach of contract, such as not completing a recipient’s training within 16 years*[5].

Following the MRBS, the Bonded Medical Places (BMP) were released in 2004. The BMP differed from the MRBS as students were now required to complete their return of service in a district of workforce shortage rather than a rural area. BMP make up 25% of medical school places. These provide no financial assistance but still come with a return of service contract. The MRBS and BMP did not target rural background students nor provided positive rural experiences to students.

In fact it had been found that the Bonded Medical Places Scheme perpetuates stigma around rural and outer metropolitan practice, undermining the attractiveness of working in these areas [12-14]. The failure of these programs has been acknowledged by the Australian Government through the most recent Australian senate estimates. The report states that there are low levels of completion of the MRBS (7.7%) and BMP (0.58%) [15]. The penalties for
contract breach in the MRBS are severe with no pay out option however 95 students have still withdrawn. BMP students are able to buy out of their contract and the proportion of BMP students who are completing the return of service to those who withdraw the ratio is 1:8 which also demonstrates low levels of completion and a high withdrawal rate from the program[15].

International examples suggest such schemes are ineffective. One OECD (The Organisation for Economic Co-operation and Development) paper noted that many students enrolled in such schemes ultimately elect to buy their way out of the scheme or, if they do complete their return of service, leave areas of need upon completion [16]. A systematic review of largely North American programs suggested bonded programs are considerably less effective than voluntary recruitment in long-term retention of rural doctors [17]. According to a study by the World Health Organization in 2010, no other government requires a Return of Service Obligation of up to 6 years through their respective compulsory service programs [18].

Despite significant evidence against Bonded Medical Schemes and scant evidence to the contrary[20], the 2015 Budget created more Bonded Medical Places [19]. The return of service was reduced from the length of one’s medical degree to 1 year. The MRBS was terminated and the scholarship funds were rolled into a pool of “Health Workforce Scholarships” with 9 other scholarship programs, including RAMUS [19]. Now all of these scholarships are accompanied by a 1-year bond [19]. Of note is that these changes do not apply to students currently under the BMP or MRBS Schemes. Consequently, those BMP students who commenced prior to 2016 will have a longer return of service than new entries who commence in 2016 and onwards.

Financial incentives for rural practice, such as the HECS Reimbursement Scheme (HRS), are in competition with specialist career choices where a higher income will also pay student debt off quicker [17]. While there has been an underspend in the HRS in the past due to low participation rates, a significant amount of reimbursement will make it a more competitive option to take up. The provision of Continued Professional Development (CPD) is a strong factor of rural doctors retention [21]. Furthermore, if student debt is to increase so will the attractiveness and utilisation of financial incentive-based programs [17].

Position Statement

AMSA believes that bonded medical schemes will not effectively address long term rural health workforce shortages.

Policy

AMSA believes that:

1. Rural and remote Australia require an adequate supply of doctors to deliver and maintain equitable health services.
2. In Australia, there is scant evidence that students of Bonded Medical Schemes
   a) Take on rural practice when they otherwise would not;
   b) Consistently complete return of service;
   c) Continue to work in rural areas after their return of service;
   d) Have created a positive change to the health outcomes of rural and remote people.
3. There is evidence that these schemes may be counterproductive to efforts to attract people to rural medicine.
4. Other more effective and proven means of attracting doctors to areas of workforce need should be prioritised ahead of the bonded medical places scheme.
   a) Positive rural experiences [7,21,22]
   b) Placements at Rural Clinical Schools [7]
   c) Financial incentive [15, 23]
5. Financial support during medical school under the aforementioned bonded schemes should not be dependent on compulsory return of service, which has the potential to exploit students who are financially disadvantaged.
6. Evidenced-based initiatives such as RAMUS which allows financially disadvantaged rural-background students to access medical education, and the JFPP which delivers positive rural medical experiences, should be maintained in their current form.

AMSA calls for:
1. Bonded Medical Schemes to be removed from Medical education and training.
2. An adequate number and distribution of training positions in rural areas.
3. Specialty training positions to be developed and expanded in rural areas to retain junior doctors.
4. Incentive-based payments, such as relieving significant portions of Higher Education Contribution Scheme debt and Continuing Professional Development subsidies to promoting rural health careers.
   a. Such payments should be scaled so that regions of increased remoteness attract greater remuneration than comparatively less remote regions.
5. All Australian graduates to have the opportunity to complete a period of time in a rural area to gain an adequate understanding of the unique health needs of the rural Australia.
6. The Australian Government to offer any future changes to bonded schemes to those who are already contractually obliged to complete their return of service.
7. That all monies raised by BMP payout sums, to be guaranteed to be reinvested into positive initiatives for the rural health workforce.

*Note: medical course: 4-6 years, internship: 1 year, residency 1-2 years, specialist training 3-5 years which, even if the student passes everything in the first encounter, can equal up to 14 years. Even with the best intentions, students who don’t pass on first attempt will face a breach of contract.

References


Policy Details

Name: Bonded Medical Schemes Policy

Category: A – Medical School Programs and Admissions

History: Adopted Council 2 2015