

Policy Document

Bonded Medical Schemes policy

Abstract

Australian government funded bonded medical schemes such as the Bonded Medical Places (BMP) and the Medical Bonded Rural Scholarship (MBRS) are not effective at creating a rural medical workforce. Historically, both schemes have low completion and high buy-out rates. While the MBRS has been ceased, the continuation of BMP places in the 2015 government budget represents a misallocation of Australian resources. In contrast, evidence based programs supporting rural background students and providing rural training experiences were discontinued in the same budget. AMSA calls for the discontinuation of all bonded places, and for budgetary savings to be reallocated to support rural training pathways and support for rural medical students.

Background

The problem: rural health inequality of access to health services

The people of rural and remote Australia face significantly poorer outcomes in all aspects of health than their metropolitan counterparts [1]. Of particular concern is access to medical practitioners, with a medical workforce maldistribution significantly contributing to poorer outcomes. Without even factoring access to specialist services, this maldistribution reduces the ability of rural Australians to access general practitioners for day to day care and preventative health measures. The disparity is seen in life expectancy and morbidity rates for chronic conditions. To improve access, the Commonwealth government has developed programs and initiatives to improve access to health services and doctors [2]. Bonded programs form part of this policy. Students on these programs are required to complete a rural return of service after graduation or obtaining fellowship from an Australian specialist medical college.

Current Australian government policy and initiatives

MRBS and BMPs were founded in 2001 and 2004 respectively, with the program being re-invented in the 2015 budget. Whilst the MRBS was ceased, the Australian government continues to fund BMPs [3]. The BMP program requires students to complete a rural return of service of one year within five years of obtaining Fellowship of an Australian medical college at the latest[4]. These places comprise 25% of all medical school places. Prior to this, holders of a BMP were required to complete a return of service of the length of their medical degree. Consequently, those BMP students who commenced prior to 2016 will have a longer return of service than those who follow them. In addition, as of the 2015-16 budget, there is no additional support in place for bonded students.

Effectiveness of current initiatives

Since their foundation, neither program has been successful in recruiting or engaging future rural health practitioners. A 2013 Australian government review found that there were low levels of completion of both the MRBS and BMP scheme. As of 2013, only one participant had completed their BMP return of service period, after the program had been

running for a decade. Only 50 participants had commenced their MRBS return of service [5]. It is worth noting that while the BMP contract has an opt out option that incurs a financial penalty, the MRBS does not. This allows BMP contract holders to be released from their contract before completion. The penalties for contract breach in the MRBS are severe: recipients are not able to access Medicare provider numbers for 12 years, effectively becoming unable to practice most types of medicine. Despite this, the MRBS program still has low completion rates noted above [5]. Stakeholder views have also noted in the past that there is some stigma associated with holding a BMP or MRBS place. Participants may be seen as lacking sufficient merit to gain a place in medical school without the additional bonded spots [5,6]. This undermines the effectiveness of the program.

The evidence: what works?

The need for rural doctors has generated a significant amount of literature on the factors contributing to a medical student taking up rural practice. The highest predictors of a medical student developing into a rural doctor are:

- a. Rural origin [8 - 11, 13, 14];
- b. Positive rural experiences late in training [9,10,12]; or
- c. A partner from a rural area [11]

Currently, the government has several successful schemes addressing these predictors. One such example is rural origin quotas for medical schools. The recent announcement in the 2017 budget to increase the target for rural background medical students from 25% to 30% to more appropriately align with the proportion of Australians living outside of metropolitan regions was a welcomed improvement. Furthermore, Rural Clinical Schools (RCS) and University Departments of Rural Health (UDRH) under the Rural Health Multidisciplinary Training (RHMT) program are designed to provide students with positive, high quality rural training experiences.

Exact estimates vary, however it has been consistently demonstrated that students from a rural background are more likely to return to rural practice [8 - 11, 13, 14]. These students face structural and financial barriers to attending medical school [15]. Previous government schemes to address this disadvantage have been discontinued or rolled into one year bonded scholarships, the new HWS.

Position Statement

Rural and remote Australia require an adequate supply of doctors to deliver and maintain equitable health services. In Australia, there is scant evidence that students of Bonded Medical Schemes complete a rural return of service or continue to work in these areas after their return of service period. AMSA believes that bonded medical schemes will not effectively address long term rural health workforce shortages. In addition, financial support during medical school should not be dependent on a compulsory return of service, which has the potential to exploit students who are financially disadvantaged. Instead of rural bonded schemes, the Australian government should commit to evidence based initiatives that generate long term commitment to rural health practice.

Policy

AMSA calls upon:

1. The Australian Government for:
 - a. Bonded Medical Schemes to be removed from medical education and training. Funding currently allocated to Bonded Medical Places should be reallocated to Commonwealth Supported Places;
 - b. The reduction of the return of service for all bonded scheme participants to one year;
 - c. The reinstatement of the bonded support program [throughout medical school and return of service];
 - d. Changes made to the terms of rural bonding contracts to be implemented retrospectively to include pre-existing MRBS and BMP contracts;
 - e. All monies raised by BMP payout sums to be guaranteed to be reinvested into effective rural health workforce initiatives.

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Policy Details

Name: Bonded Medical Schemes policy
Category: A - Medical School Programs and Admissions
History: Adopted, Council 2 2015
Reviewed, Council 2 2017
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