

Policy Document

Bonded Medical Schemes (2025)

Executive Summary

Australians in rural and remote areas continue to face poorer health outcomes and reduced access to healthcare compared with metropolitan populations. The Bonded Medical Places (BMP) Scheme, introduced to address these inequities, has demonstrated consistently low completion rates of the Return of Service Obligation (RoSO) and limited evidence of effectiveness in retaining doctors rurally. The Australian Medical Students' Association (AMSA) recognises an urgent need for reform.

AMSA calls for the continuation of the Community Affairs Senate Inquiry into the BMP, with independent evaluation of its outcomes, harms, and cost-effectiveness. This inquiry should include assessment of participant motivations, reasons for withdrawal, and the financial and wellbeing impacts of the scheme. If evidence confirms the BMP Scheme does not meet its objectives, AMSA advocates for its cessation and reallocation of resources toward proven rural workforce strategies, including recruiting rural-origin students, funding longitudinal rural clinical placements, and dismantling barriers to training and career progression in rural settings.

AMSA recognises that the current BMP Scheme potentially inequitably impacts specific groups, particularly marginalised groups such as carers, future parents and those planning a family, LGBTQIASB+ practitioners, Aboriginal and Torres Strait Islander doctors, culturally and linguistically diverse practitioners, and doctors with disabilities. AMSA urges that these groups be central to all policy discussions and reforms surrounding the BMP Scheme. Additional key stakeholders under this policy include the Australian Government, the Australian Medical Council, the Australian Medical Association, medical schools, specialty colleges, student-run medical associations and societies.

If the BMP Scheme is continued, AMSA advocates for contractual fairness and transparency as key priorities. AMSA recommends that participants that sign the contract for a position in the BMP Scheme as minors be able to reaffirm their contract as they turn 18, and that students who withdraw from medicine before the completion of their course only be liable to the HECS debt equivalent of their course. Finally, if changes to the BMP are made or the BMP is removed, participants must be able to withdraw or transition to the new scheme. Clearer communication of obligations, transparent allocation of places, and consistent national support frameworks are also critical to ensure informed consent and equitable treatment.



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To reduce attrition and improve BMP Scheme outcomes, support for students during training must be expanded. AMSA advocates for the availability of BMP-specific career advisors through all medical schools, structured peer networks, regional training hubs, and student organisations and access to legal and financial counselling prior to program entry. Rural Workforce Agencies, Regional Hubs, and student organisations should collaborate to provide accessible support, guidance, and peer support.

Finally, if the BMP is proven to be ineffective, AMSA calls for a shift away from mandatory bonded schemes toward voluntary, evidence-based alternatives. Programs such as Rural Clinical Schools, extended rural placements, rural high school engagement, and targeted scholarships like the Rural Australia Medical Undergraduate Scholarship (RAMUS) have demonstrated stronger outcomes in rural recruitment and retention.



Policy Points

AMSA calls upon:

1. The Australian Commonwealth Government to:

- a. Continue the Community Affairs Senate Inquiry or other appropriate evaluation strategy to formally assess the Bonded Medical Program's (BMP) efficacy in addressing the rural workforce shortage, by using an independent review (such as the Australian Institute of Health and Welfare, the Productivity Commission, or an academic research consortium with no program delivery role) to evaluate:
 - i. The number of students and graduates have completed their return of service obligation (RoSO), intend to complete their RoSO, or have withdrawn from their RoSO;
 - ii. How many BMP graduates who have completed their RoSO continued to and are currently practising rurally, as well as their motivations to do so;
 - iii. The reasons graduates have withdrawn from the BMP;
 - iv. The potential harms associated with the BMP, including its financial implications for students;
 - v. What students' initial motivations were before undertaking the BMP, and if their plans changed, what changed their plans to complete their RoSO during medical school and afterwards; and
 - vi. Effects on students and doctors from First Nations, culturally and linguistically diverse, LGBTQIASB+, women and those with disabilities or with carer responsibilities;
- b. Pass a bill to amend Part VD of the Health Insurance Act 1973 to:
 - i. Remove the Medicare ban – as a consequence of withdrawal or upon breaching a condition – for ex-Medical Rural Bonded Scholarship (MRBS) Scheme bonded participants;
 - ii. Extend the 'grace period' for students to withdraw from their course of study in medicine, without consequence, from the HECS Census date in their second year of study, up to the award of the degree; and
 - iii. Make provision for the responsible minister to make additional rules to support the administration of the Program that better support participants' personal circumstances and the objectives of the Program;
- c. Amend the Part VD of Health Insurance Act 1973 for provision of continuous evidence-based reviews into the Bonded Medical Program, considering 1a.ii to 1.a.vi;
- d. Ensure information regarding RoSO provided to prospective student participants or legacy scheme participants is accurate and up to date;
- e. Remove the BMP if the Senate Inquiry shows that the BMP has not been successful in achieving its goal of providing more doctors in

- areas of workforce shortage, particularly in regional, rural and remote Australia;
- f. If the BMP is removed, reallocate funding involved in maintaining the administrative infrastructure required to track compliance and administer penalties towards evidence-based initiatives which have been proven to increase the rural workforce retention, such as:
 - i. recruiting students from rural backgrounds;
 - ii. funding extended longitudinal rural clinical placements; and
 - iii. removing barriers to training and career progression in a rural setting;
 - g. If the BMP cannot be removed, allocate funding to non-BMP evidence-based initiatives which have been proven to increase the rural medical workforce retention (above d.i, d.ii, and d.iii);
 - h. If the BMP is amended, implement a graduated Return of Service Obligation (RoSO) based on the Modified Monash Model, with shorter obligations for more remote areas compared to regional centres, to direct the workforce towards areas of greatest need;
 - i. If the BMP is removed or amended, make sure that people who previously signed onto the program can withdraw or transition immediately to the new program and participants from previous schemes are provided with timely and accurate updates regarding any changes to their existing contract;
 - j. Provide support to other stakeholders, including but not limited to medical schools, Rural Clinical Schools, Regional Hubs, Rural Workforce Agencies and the National Rural Health Student Network (NRHSN), to implement support strategies which increase participant retention, ensuring that these stakeholders are involved in any decisions regarding the BMP, and continually work to connect students with these stakeholders;
 - k. Reduce the financial penalty for students that withdraw from the BMP Scheme during their medical degree to the Higher Education Contribution Scheme (HECS) equivalent which would be applicable upon their agreement not to re-enrol in a medical course for a minimum period of time, barring withdrawal for any reasons under the special consideration component of the contract;
 - l. Ensure that groups marginalised by the health system, including but not limited to primary-care givers or future primary care givers, LGBTQIASB+ people and culturally and linguistically diverse people, Aboriginal and Torres Strait Islander doctors, and doctors with disabilities are not negatively impacted by any changes to the BMP, and ensure these groups are continuously involved in all relevant discussions;
 - m. Allow more flexibility for the completion of RoSO on either side of fellowship in relation to speciality training, particularly for specialities which are challenging to practise rurally;

- n. Offer financial and logistical support to graduates who are working rurally to complete their RoSO, ensuring that this support is consistent across state and territory health departments, regional hospital and health services, and for graduates completing locum work;
- o. Improve transparency as to how how BMP places are allocated, to all students, including undergraduate, provisional and postgraduate-entry students at the earliest possible time;
- p. Fund support services for students undertaking the BMP;
- q. Streamline and clarify the criteria and process for applying for special consideration when graduates cannot complete their RoSO due to unforeseen or extreme circumstances; and
- r. Clarify messaging about administrative requirements for BMP participants, and reduce administrative penalty.

2. The Australian Medical Council (AMC) and Australian Medical Association (AMA) to:

- a. Provide support and career planning advice to BMP graduates in conjunction with the stakeholders listed in 1.e., to make it more achievable for them to complete their RoSO; and
- b. Advocate for a formal assessment of the efficacy of the BMP.

3. Medical Specialty Colleges to:

- a. Provide graduates with flexibility needed to complete their RoSO throughout specialty training and following fellowship; and
- b. Expand opportunities for specialist training in rural and regional areas, and support rurally based career paths.

4. Rural Workforce Agencies and Regional Hubs to:

- a. Facilitate a BMP Student Network in every state and territory, and connect these Student Networks to medical schools within their respective states and territories;
- b. Provide up-to-date information regarding the predicted workforce gaps to students and graduates; and
- c. Increase organisational awareness of the BMP, including but not limited to the designation of staff with specific knowledge who are able to provide case-assistance to students and graduates;

5. Australian Medical Schools to:

- a. Suggest that prospective BMP students seek legal advice and career-planning advice, and provide students with referrals subsidised or ideally free to legal aid and career planning advice;
- b. Provide a transparent explanation of how BMP places are allocated, to all students, including undergraduate, provisional and postgraduate entry students at the earliest possible time, including prior to enrolments for provisional entry programs;

- c. Provide transparency about what happens if students accept a BMP place, and if they can transfer to a CSP place in further rounds, and if this is not the case, assure this can happen;
- d. Connect students with their respective state and territory Rural Workforce Agencies and Regional Hubs; and
- e. Employ an adequately trained and resourced career advisor and establish structured peer support networks, to provide guidance to BMP students in relation to how to complete their RoSO.

6. Australian Medical Student Association (AMSA), other student organisations, and other groups to:

- a. Formally collect data and assess medical student perspectives of the BMP, including:
 - i. an anonymous survey of why students elected for a BMP Scheme place;
 - ii. how many BMP students intend to fulfil their RoSO after graduation; and
- b. Advocate for the improvement and reform of, or the cessation of the BMP in line with the results of a formal assessment of the BMP Scheme's efficacy.

7. The National Rural Health Student Network (NRHSN) to:

- a. Create a national student network for BMP students, with the goals of:
 - i. Connecting students;
 - ii. Providing opportunities for peer support;
 - iii. Providing students with information about the BMP; and
 - iv. Connecting students with support services including but not limited to Rural Health Workforce Agencies and Regional Hubs;

8. Medical student societies and student-lead rural health clubs to:

- a. Provide students with information about the BMP, and connect them with support services such as Rural Workforce Agencies and career advisors within their School of Medicine; and
- b. Collect data on student perspectives on the BMP during medical school and relay this information to relevant bodies including AMSA.

Background

INTRODUCTION TO THE BMP

Rationale for the Bonded Medical Program.

Australians in rural and remote areas face poorer health outcomes and reduced access to healthcare compared to those in metropolitan regions. They have lower life expectancy, higher mortality and hospitalisation rates, and a 1.4 times greater disease burden, particularly those from chronic conditions like asthma and diabetes. Despite a greater need for healthcare, access remains limited.

These areas also suffer from a shortage of specialists and allied health professionals. Major cities have over five times more specialists per person than very remote areas, and twice as many as outer regional areas.

The Bonded Medical Program (BMP) in its Current Iteration.

The Bonded Medical Program (BMP) is an Australian Government initiative designed to address doctor shortages in regional, rural, and remote areas. In exchange for a Commonwealth Supported Place (CSP) in a medical degree, participants commit to working for 3 years in designated areas (MMM 2–7, DPA, or DWS) within 18 years of graduation. This is known as the Return of Service Obligation (RoSO).

The current BMP began in 2020 under reforms from the 2019 Health Insurance Amendment Act (1), offering more flexibility and a shorter RoSO than its legacy versions (MRBS and Bonded Medical Places). Legacy participants can opt into the new scheme as well.

It is part of the Stronger Rural Health Strategy (SRHS), a 10-year strategy plan with multiple versions, the latest of which is from 2018. The strategy aims to deliver 3,000 more doctors and 3,000 more nurses to workforce shortage areas by 2028. It focuses on three themes: teaching, through rural student pathways like the Murray-Darling and Regional Medical Pathways; training, via programs like the Junior Doctor Training Program and Medicare billing changes to facilitate general practise billing; and recruitment and retention, through initiatives such as the Bonded Medical Program (BMP) to boost the rural medical workforce and support postgraduate training in MM2–7 regions.

The 3-year commitment can be completed full-time (35+ hours/week), part-time (20+ hours/week), or on a daily basis (up to 20 hours/week). RoSO must be served in a Distribution Priority Area (DPA), District of Workforce Shortage (DWS), or a MMM 2–7 region. At least 18 months must be completed after fellowship. If fellowship isn't achieved within 12 years of graduation, any remaining RoSO must be completed in the following 6 years. A 6-month RoSO discount applies if the first two intern years are completed in MMM 4–7 areas (2). If individual circumstances change, enrolled participants may apply for an extension if they or a family member develop a medical condition preventing RoSO completion (3).

While the BMP recognises service return in MMM2-7, this treats all eligible areas equally. Evidence shows doctors are disproportionately distributed in larger regional centres (MMM2-3), while remote and very remote areas (MMM5-7) continue to experience acute workforce shortages. Other Commonwealth programs, such as the 2023 HELP debt reduction scheme, already scale incentives by MMM, rewarding doctors for serving in more remote zones (4). Integrating a staged RoSO into the BMP may assist with aligning service obligations with demonstrated need. Australian Universities are required to allocate approximately 28.5 per cent of all commencing Commonwealth places for medical courses to BMP students (5).

Controversies and Complications in the Implementation of the New Bonded Medical Program.

Early implementation of the BMP faced issues with legacy scheme participants opting in from legacy schemes. Due to Department of Health errors in 2020, many were incorrectly bonded or remained under old RoSO obligations (6). Misleading guidance on RoSO timeframes regarding timeframes allowed for completion of RoSO under the new BMP (3), affecting over 2,000 participants (6) and leading to a program pause in June 2020 (3). To avoid this happening again, if the BMP is removed or amended, the Australian government should make sure that people who previously signed onto the program will be provided with accurate and up to date information regarding the changes to their contract, ensure that all participants will be given the opportunity to withdraw or transition immediately to the new program, and that administrative arrangements be made to minimise the chance for administrative error.

Given repeated administrative errors, limited public reporting, and the cessation of the 2022 Senate Inquiry, effective evaluation of the BMP could be best achieved with independence from both government and program administrators. Past national workforce reviews (such as the Review of Australian Government Health Workforce Programs in 2013) demonstrate the feasibility of appointing independent statutory or academic bodies to undertake such assessments (7).

Publicly Available Data on the BMP.

There is minimal publicly available data that identify the number or milestone status of participants in the latest BMP. Data available under the Freedom of Information Act is only as current as 2017 and was released in 2021. Between 2001 and 2018, of 9,971 bonded participants, only 4.94% began their Return of Service Obligation (RoSO), and just 0.61% completed it. More participants withdrew (0.57%) or abandoned the program (0.33%) than completed their service (8). At face value, the effectiveness of bonded programs are doubtful; but further information is required.

POSSIBLE CHANGES TO THE BMP AND SUPPORT BEFORE, DURING, AND AFTER TRAINING

Limited Equity Considerations for Marginalised Groups.

Both the current BMP and its legacy schemes are potentially inequitable across cohorts from marginalised backgrounds and steps should be taken to address this for the following groups:

- **People with families or plans to start families who require childcare support (particularly birth-giving parents)** often reach consultant level in their early 30s, coinciding with family planning. The need for metropolitan-based family support can conflict with RoSO requirements.
- **Culturally and linguistically diverse practitioners** report racism and social exclusion in some regional communities, creating barriers to retention.
- **Aboriginal and Torres Strait Islander doctors** may face cultural dislocation when required to leave Country, undermining wellbeing and connection to community.
- **Doctors with disabilities** encounter reduced availability of disability support services in rural regions, limiting feasible placement options.
- **LGBTQIASB+ practitioners** may struggle to establish connectedness with other members of the LGBTQIASB+ community when living rurally and face lack of anonymity which can lead to discrimination and minority stress.

Limited Information Provided to Potential Participants Before Acceptance.

Many students accept bonded places with little understanding of the long-term legal and financial implications, often signing contracts as minors. Penalties for withdrawal can exceed \$140,000 with a 15 percent interest rate, and many join the program out of desperation to get into medicine rather than a genuine intent to complete rural service (9). BMP attrition is around 94%, far higher than voluntary programs like the past John Flynn Placement Program (9, 10).

To improve outcomes, students should receive early, transparent information and access to legal, independent financial advice, and be linked to Rural Workforce Agencies and the National Rural Health Student Network (NRHSN) before signing contracts.

During Medical Training:

Career advice and support:

Support for BMP students during medical school is fragmented and poorly coordinated. Many are unaware of their obligations until late in their studies and lack connection to support services such as Rural Clinical Schools or Rural Workforce Agencies. Poor communication has led to increased stress and disengagement, as noted in a 2022 Senate Community Affairs report (18).

Embedding BMP-specific career advisors and peer support networks in medical schools could improve program navigation. Evidence also shows students with extended rural training, especially those from rural backgrounds, are significantly more likely to practise rurally. Integrating BMP obligations into existing rural training pathways is therefore more effective than managing the program separately.

Rural-origin students with Rural Clinical School experience are up to 4.8 times more likely to enter rural practice compared to metropolitan-origin students without rural placements, and metropolitan students with rural placements were still 1.9 times more likely than those without to remain in rural practice (12). This highlights the importance of integrating BMP obligations into existing rural training pathways, rather than managing the program in isolation.

Reconfirming contracts signed as minors:

As many students consent to the BMP as minors, when students reach the age of 18, a participant's agreement to the BMP should be explicitly re-affirmed and participants should be able to withdraw themselves from the program after obligations and breach of contract consequences have been covered.

Changes for students who withdraw during their medical degree:

Many students accept bonded places without fully understanding the demands of medicine, only realizing it's not the right fit in later clinical years—often after the penalty-free withdrawal period (after first year). These students may leave medicine but still face significant financial penalties without the option to complete their RoSO, which can have life-altering consequences.

As such, withdrawal penalties during medical school be reduced to the HECS equivalent, provided students agree not to re-enrol in medicine for a set period, except in cases covered by special consideration.

After Graduation.

Financial and logistical assistance for graduate doctors varies between states and health services. Uniform national frameworks are required to ensure consistent postgraduate support. Streamlined rural training pathways are particularly important and have been a strong predictor of long-term rural practice in the past (12, 13). There is also evidence that general practitioners with recent rural-based training tend to continue serving rural populations (14). Expanding rural training pathways across specialties and investing in supported rural training opportunities across training stages could help address workforce shortages. In addition, clearer information on BMP requirements should be communicated to participants, as although the introduction of the Bonded Return of Service System (BRoSS) has improved contract transparency, rollout errors and unclear obligations continue to cause confusion (6).

Barriers to completing RoSO.

Even where students sign BMP contracts with the intention to complete their RoSO, changing life circumstances can make fulfilment difficult due to factors like the availability of specialty training, family and carer responsibilities, and spousal employment. Half the RoSO must be completed after fellowship, which is often when relocating to a rural area is the hardest due to early family formation. Additionally, some specialties cannot be practised rurally due to lack of resources or support staff. Many junior doctors report additional barriers when seeking training

opportunities outside of metropolitan areas, including poor recognition of rural training experience in specialty college selection criteria and reduced networking and research opportunities (15).

COMMUNICATION AND TRANSPARENCY WITH THE BMP

In spite of several revisions since their inception, the BMP and its legacy schemes have faced ongoing issues with poor communication and transparency around obligations, outcomes, and recruitment, especially due to many revisions leaving participants unclear on their obligations. Confusion and administrative delays led to the program's temporary suspension in June 2020, prompting the AMA to call for urgent updates to affected participants (16). Subsequent policy amendments in 2021 highlight the continued struggle to improve clarity and communication within the scheme.

Even with these changes, fundamental communication and transparency gaps still exist in relation to the purpose of, support during, and obligations as a participant of the BMP Scheme and RoSO. Support networks like Rural Workforce Agencies exist across Australia to support and provide a wealth of information, placements, contacts and grants to BMP students, but these are largely underutilised by both aspiring and current BMP participants.

Aside from the limited literature available on the Australian Government website, information regarding the longitudinal obligations and impacts of the BMP on future careers is not included in general discourse surrounding the program and draws into question whether participants are truly providing informed consent.

Additionally, literature review conducted by the National Health Rural Students Network (NHRSN) in 2016, found that across 7 systematic reviews, none provided sufficient evidence to assess the effectiveness of bonded medical programs (17). This was largely due to insufficient data regarding completion rates of RoSO's, longitudinal retention of doctors in rural areas and an overall lack of formal public reviews of the program by the AMA or Australian government beyond completion and withdrawal rates. Moreover, recruitment strategies for the BMP remain heavily obscured and appear to differ from university to university. It is unclear whether these places are allocated in a randomised selection or based on performance in the application process.

ALTERNATIVES TO THE BMP

To date, there has been limited direct evaluation of the Bonded Medical Places (BMP) scheme. The most recent assessment of the BMP, conducted in 2017, suggested that the BMP has not been effective in achieving its objectives of recruiting or engaging future rural health practitioners (18) and few assessments have been done since.

Consequently, there is insufficient evidence to determine whether the BMP should be continued, modified or ceased; a rigorous study of the BMP and its outcomes is

essential to inform such decisions. In the meantime, consideration of evidence-based alternatives such as extended rural placements, regional training hubs, and targeted recruitment could be beneficial to support the rural medical workforce.

AMSA's stance on a variety of alternative initiatives is further developed in the Rural Health in the Medical Curriculum (2025), Rural Clinical Schools (2021) and Rural Training Pathways for Junior Doctors (2024) Policies, however, solutions to the rural doctor shortage should include:

1. Selecting students from rural backgrounds to become health professionals: rural background has repeatedly proven to be one of the strongest predictors of doctors working rurally and remotely longer term
2. Rural and remote exposure during medical school and subsequent training; which have been proven to be particularly effective in Australia and globally (12) [51]
3. Integrating rural medicine, including general medicine, outreach health promotion, clinical reasoning and skills in low-resource settings, into the medical school curriculum;
4. Removing barriers for further professional qualifications within the rural setting; and (19, 20, 21) [47, 48, 49]
5. Programs and initiatives to engage rural high school students to start them on a pathway to medicine (pipeline programs with practical experience being the most effective). (21, 22, 23, 24) [37, 59, 49, 63]

Targeted Rural Recruitment and Scholarships.

Rural background and training exposure strongly predict long-term rural practice (12, 13). The Rural Australia Medical Undergraduate Scholarship (RAMUS), which provided \$10,000 annually and rural mentorship to rural-background students, supported over 2,200 students from 2000. By 2019, at least 744 had entered rural practice, far exceeding the 32 BMP participants who had completed RoSO by 2017. With 35% of RAMUS graduates returning to rural practice (vs. <10% of metro-origin students) (13), the program offers a more effective alternative to the BMP with stronger evidence for a higher return on investment.

Incentives for Retention.

Direct financial incentives, like the 2023 HELP debt reduction initiative, offer a voluntary alternative to compulsory bonding. Eligible doctors and nurse practitioners in MM 3–7 areas can have up to 100% of their HELP debt erased—potentially saving up to \$70,000 (25). Unlike the BMP, which ends after service completion, this reward-for-service model (26) ties financial benefits to the length of rural practice, providing a stronger incentive for long-term retention

MORE RESEARCH INTO THE BMP PROGRAM

Although the BMP has existed in various forms for over two decades, its current effectiveness in addressing rural workforce shortages has not been effectively

audited in the last 5 years, and previous reviews have been critical of the program's effectiveness. The 2013 Health Workforce Programs Review found no clear evidence that bonded schemes improve long-term rural workforce retention (7). A Community Affairs Senate Inquiry into the BMP began and produced an interim report in 2022. However, the inquiry was ceased when Parliament was dissolved on April 10. Although it was recommended that the next Parliament complete the report, the committee has not resumed its inquiry.

Given the low completion rate of the RoSO (8, 27), it is not clear that the BMP meaningfully contributes to recruitment and retention of clinicians in rural and remote areas. In fact, the Australian Medical Association (AMA), the Medical Deans Australia and New Zealand and ACRRM have called for an urgent review and evaluation of the BMP to assess whether it is meeting its objectives (7, 8, 28, 29). Without robust data from recent research, the BMP risks continuing as a costly intervention without demonstrable benefits to rural health equity.

Evidence gaps include:

- The proportion of BMP graduates who remain in rural practice after fulfilling their RoSO;
- The motivations and barriers influencing BMP participants' decisions to withdraw or complete service;
- Initial motivations of participants entering the BMP- intentions to "pay out" of the scheme and plans on integrating return of service into future careers
- The long-term workforce impact compared to alternative initiatives such as Rural Clinical Schools, longitudinal integrated clerkships, or rural-origin recruitment strategies (12, 13); and
- The ethical and financial implications of participation, particularly among minors and students from disadvantaged or marginalised groups (3).

For More Information

Appendix 1: Rural Workforce Agencies by state/territory

ACT	N/A
NSW	New South Wales Rural Doctors Network
NT	Northern Territory Primary Health Network (NT PHN)
QLD	Health Workforce Queensland
SA	Rural Doctors Workforce Agency (RDWA)
Tas	HR Plus
VIC	Rural Workforce Agency Victoria
WA	Rural Health West
National	Rural Health Workforce Australia (RHWA)

Please refer to **The Health Workforce Locator** to identify which health workforce classifications and incentives apply in various parts of Australia.

Australian Government Department of Health and Aged Care. Health Workforce Locator [Internet]. Australian Government Department of Health and Aged Care. 2025. Available from:

<https://www.health.gov.au/resources/apps-and-tools/health-workforce-locator/app>

Please refer to rural workforce agencies including the **Rural Workforce Agencies Network (RWA Network)**, and the **Rural Doctor's Association of Australia (RDAA)**:

<https://rwanetwork.com.au/>

<https://www.rdaa.com.au/>

APPENDIX 2: REPAYMENT OF COMMONWEALTH CONTRIBUTION AMOUNT FOR WITHDRAWAL FROM THE BMP

Upon breach of BMP conditions or withdrawal from the program, the amount a former participant pays is based on the following formula: (4)

$$\frac{\text{incomplete RoSO (months)}}{\text{total RoSO (months)}} \times \text{total repayment amount (\$)}$$

Total repayment amount is defined as “the Commonwealth contribution amount for a place in medicine for each year of study completed, and for any parts of a year commenced, but not completed.” (5, section 17) Interest on overdue repayment amounts is calculated on the basis of the unpaid principal amount after the invoice

due date, at 15% per annum, on a daily basis and is not compounded. (5, section 18)
In 2023, the Commonwealth contribution amount for medical courses was \$28,196 (AA3). The Commonwealth contribution amount for each year changes according to that year's indexation and is always increasing (42, section 198-5, section 198-10). Note that the Commonwealth contribution amount is separate from the maximum student contribution amount, which was \$11,800 for medical courses in 2023, payable upfront or via HECS-HELP. (43, see funding cluster 4)

For example, the total repayment for a person after completing a five year bonded medical course and who fulfils none of their RoSO is at least \$140,980, given they commence their course in 2023. If a person, in a similar situation, completes half of their RoSO (18 months), their repayment is halved to at least \$70,490. If a bonded student drops out after their fourth year of medical school, with no chance to complete their RoSO, they would be subject to at least \$112,784 in repayments. These figures do not take into account indexation and are assumed at 2023 Commonwealth contribution rates.

If a medical student withdraws prior to the census date of their second year of study they will not be required to make any repayments. However, they will still be required to pay student contribution amount for the first year of enrollment. (1)

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