NATIONAL RURAL HEALTH ALLIANCE INC

Position Paper

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Bonded Medical Scholarships and University Places

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This Position Paper represents the agreed views of the National Rural Health Alliance but not the full or particular views of all 23 Member Bodies.

BONDED MEDICAL SCHOLARSHIPS AND UNIVERSITY PLACES

Introduction

There is a global shortage of health professionals, including doctors, nurses and allied health professionals. Australia is relatively well-off and has a good overall health system but there is, nevertheless, a recognised shortage of health professionals in the nation. The shortages are worst in rural and remote areas and some outer-metropolitan suburbs.

The shortage and maldistribution of general practitioners is particularly prominent in people's understanding of this issue. Governments over the years have made a number of efforts to rectify this, recognising that in Australia (as elsewhere) GPs play a central role in providing primary health care. Workforce shortages result in poor access for patients, unmet health need, overworked doctors and expensive strategies for governments.[1] Because the shortages contribute to a lack of primary care and illness prevention, they also result in higher public and personal costs as patients move unnecessarily or more quickly to acute and tertiary care.

It is accepted that the reduction of this maldistribution of GPs is a key health workforce issue for Australia. A number of programs are in place to try to meet the challenge, building on various determinants of doctors' decisions and attitudes: personal factors like family ties; where they were raised and trained; the scope of practice to which they aspire; and remuneration and the sustainability of their practice.

A number of government programs intervene in what might be seen as free market approaches to the training of GPs and their choice of training and practice locations. Universities have been asked to achieve targets for the proportion of their medical student intake that comes from rural areas. Many GPs who choose to work in rural and remote areas have access to differential remuneration loadings in programs such as the Practice Incentive Program, and some of them are eligible for retention payments. Governments and registration bodies collaborate to expedite the placement of overseas trained doctors and temporary resident doctors in areas of need.

Despite all such efforts to redress the shortage, altered expectations about the pattern of work, and other personal preferences related to family, social and professional goals have resulted in the persistence of this adverse situation. Currently the situation is seriously worsened by costs and uncertainties related to indemnity insurance.

It is therefore important that a suite of integrated policy approaches remains in place to improve the recruitment and retention of rural GPs in Australia and to help assure people in rural areas of access to a GP. Despite some evaluation activities there is not yet strong empirical evidence of the greater effectiveness of any particular policy approach. Nationally co-ordinated, adequately funded, long-term research and evaluation programs on workforce recruitment and retention must continue.[2]

This Position Paper describes some of the Alliance's views on two quite different forms of bonding currently being applied to medical education. They are the established rural bonded scholarships and the proposed bonding of students to future rural or urban areas of workforce need in return for additional places in Australia's Medical Schools.

Market Intervention

Services in rural areas are still declining on a number of fronts, such as in essential services like banking, transport and retailing. Market forces have failed to bring about an equitable distribution of medical practitioners as well, so that governments have intervened in a number of ways. The Commonwealth's interventions have included incentive schemes and support services, active recruitment of temporary resident doctors, outreach programs, support for technology, rural training programs and differential support for rural students. State, Territory and local governments have also contributed to efforts to attract GPs to rural areas, with packaged incentives such as housing, a surgery, salary under-writing and spouse support, and co-operation with other agencies on efforts related to Overseas Trained Doctors.

Market intervention is also revealed in some of the activities of the Australian Medical Schools. They have modified their undergraduate selection processes to encourage rural and remote student applications and admissions. They have developed rural curricula that are reinforced with a program of rural clinical placements. The establishment of Regional Clinical Schools and University Departments of Rural Health has offered supportive infrastructure for rural medical training.[3]

One particular form of government intervention in market processes is the provision of scholarships for medical training. Several examples exist and some are bonded, some are not. The most extensive are those provided by the Commonwealth Government, while some of the longest-standing are those provided by State Governments and bodies such as the Country Women's Association.

In the context of recruiting to the rural and remote health workforce, many of the scholarships in existence are targeted at students who come from rural or remote areas. This is based on some evidence that, all other things being equal, an important determinant of willingness to practise in rural areas is that an individual was raised and went to primary school there. There is evidence now that another factor predisposing an individual to settle and practise in the country is rurality of the spouse.

Bonded scholarships are those which provide incentives (normally financial) in return for a commitment to serve for a particular time in a particular area. Many people in Australia are familiar with the concept because of the existence of large numbers of such scholarships in the 60s and 70s for teaching. There were also bonded scholarships offered by organisations such as State Railways and, to this day, they are still available from a range of private and public sector organisations. Indigenous Graduate Assistants are put through University by organisations such as Land Councils and expected to serve the sponsoring body when they graduate. Such bonded scholarships have generally had a positive reputation, being sought after and providing supported access to vocational education and some early career certainty.

The Australian Government announced the Medical Rural Bonded Scholarship scheme in 2000.

In mid 2003, another 'workforce-based' scheme was announced in which an additional 234 HECS-funded medical places in Australian universities are being offered to students willing to be 'bonded' to areas of medical workforce shortage.

Current Commonwealth Medical Undergraduate Initiatives

The Australian Government's medical scholarships and bonding initiatives fall into three categories: scholarship programs without bonds, bonded scholarship programs and bonded university places.

Scholarship programs without bonds

The first of the contemporary Australian Government undergraduate health scholarship schemes announced was the John Flynn Scholarship Scheme. This is an experiential program that places selected medical students under the mentorship of rural general practitioners for two weeks for four consecutive years. The aim is to expose the students to rural health practice in order to encourage them to consider rural practice after graduation. This scheme is not bonded.

The Rural Australia Medical Undergraduate Scholarship Scheme (RAMUS) was the second of these scholarship initiatives. RAMUS offers $10,000 a year to selected applicants in recognition of the higher costs that rural and remote people face in studying medicine at metropolitan medical schools. There are a total of 500 RAMUS scholarships available. This scholarship is not bonded.

Bonded scholarship programs

The third in this suite of scholarships is the Medical Rural Bonded Scholarship Scheme. Announced in 2000 as part of the Regional Health Strategy and operational from 2001, the scheme offers bonded scholarships to 100 undergraduate medical students annually. Scholars receive $20,000 a year indexed and, following graduation and postgraduate training, are bonded to take up rural practice for 6 years. At the time of writing there is a cohort of 300 Medical Rural Bonded Scholars studying in Australian universities. Each cohort of 100 will graduate at varying times because their courses run for 4, 5 or 6 years.

The package also contained the HECS (Higher Education Contribution Scheme) Reimbursement Scheme. This Scheme wipes off 20% of a student's HECS debt for each year they spend in a designated rural area.

Bonded university places

The fifth initiative, announced in the 2003 Federal Budget, makes available 234 additional fully-funded undergraduate medical places (a 16% increase in HECS places), with the students accepting them to be bonded to work in areas of workforce shortage. There is no income support for students in these places.

The draft Deed of Agreement for these places is available from the Department of Health and Ageing.[1]

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[1] http://www.health.gov.au/workforce/ Note: Guidelines for the Bonded Medical Placement scheme were released at the end of October 2003. Some of those connected with the Medical Schools expressed concerns about apparent restrictions on the ways in which people with these places could usefully serve as doctors. The contract apparently would not allow for doctors to continue to work in the public health system, despite public hospitals seeking a greater number of career medical officers or 'hospitalists'. Such doctors choose not to complete a fellowship but continue to practise medicine in a public hospital in a variety of roles, including administration.

Also, a doctor who chose to take on a role in politics rather than obtain a fellowship would also break his/her contract. Such opinions suggest that section 3.1 of the proposed guidelines needs re-working. Not all graduates

In the case of graduates from these additional places who become GPs (cf specialists) these areas of need will be any that are not in an Inner Metropolitan Area[2] and that have a ratio of GPs to population less than the national average at the time. They will therefore be in outer-metropolitan, regional, rural or remote areas.

For the purpose of medical specialties, a District of Workforce Shortage is all of RRMA 2-7 plus RRMA 1 places in which the specialist:population ratio is less than the national average for that specialty, or any other area deemed appropriate by the Minister. Professional service of GPs and specialists may be undertaken in an Aboriginal Medical Service or After-Hours-Only Medical Service anywhere in Australia.

As there are no financial or support incentives associated with these places, they are in effect bonded university places rather than bonded scholarships. Those who accept a place under this scheme will be required to start work in a "District of Workforce Shortage" within 12 months of obtaining a Fellowship. They will be required to work in a District of Workforce Shortage in Australia for 6 years, for a minimum of 20 hours a week for not less than 9 months a year. These extra places "will be integrated with existing medical school places in such a way that total bonded medical school places (available under this measure and the existing Medical Rural Bonded Scholarship Scheme) are appropriately distributed across universities. Periods of up to three years of postgraduate training undertaken by doctors in rural areas will count towards meeting the bonding requirement" (from the Government's MedicarePlus package information).

Students with these bonded places will be liable for HECS fees and other course expenses in the normal way. They cannot "render a Professional Service outside a District of Workforce Shortage" while they are completing their "Work Period".

If the contract is breeched the recipient must repay the real (indexed) "aggregate of the amounts paid by the Commonwealth to the University" for the medical course.

Discussion

It is now widely accepted that the notion of 'sustainable general practice', particularly for non-metropolitan areas, be considered in a flexible and integrated way. The days are long gone when rural and, especially, remote areas are provided with effective medical services by a handful of committed individuals who give a lifetime of service in such areas. Sustainable

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enter and complete clinical postgraduate training - or even want to. Some of them work in industry, research and hospitals. The guidelines ask all of those in the scheme to practise relatively isolated, responsible clinical medicine. They do not allow for the graduate who finds a useful future in a pharmaceutical company or in the public service.

Also there seems to be no allowance made for graduates who are unable to gain entry into a Fellowship training program, particularly one of their choice or who, having got into such a program, fail to pass the qualifying exams and are then excluded from the program. The FRACGP is no longer a default option as the College of GPs has its own selection criteria. Doctors working outside the jurisdiction of Fellowship training (Other Medical Practitioners or OMPs) are not mentioned in the guidelines, yet this is where most non-trainees exist. It is understand that there are around 5000 OMPs in Australia, many working in rural areas. The guidelines need to take this category into consideration rather than assuming completion of Fellowship - unless the Government decides to guarantee every graduate a place in Fellowship training.

[2] This is the class in the ASGC Remoteness classification system with an ARIA index value of 0.0-0.2; see http://www.abs.gov.au/websitedbs/D3110122.NSF/0/f9c96fb635cce780ca256d420005dc02?OpenDocument

practice in rural areas these days is more likely to involve a shorter period of practice from a range of individuals, many of whom will also spend part of their professional life in cities. The contemporary structure of sustainable rural general practice also needs to accommodate the needs of an increased proportion of female GPs, new attitudes to work-life balance, the opportunities provided by information and communication technology, and the desirability of having a complete primary health care team practising collaboratively within a geographic area.

Programs for the recruitment of GPs need to accommodate these new realities.

The bonded scholarships

There is obviously much public support for efforts to source more GPs for practice in country areas. The community's general approach to bonded scholarships is therefore that if they can succeed without adversely affecting either the student doctors concerned or the communities they serve, then they should be supported. Anecdotally, some rural people feel that the students are well enough looked after and they wonder why they are not getting more doctors.

Nevertheless some of the Alliance's Member Bodies are strongly opposed to bonding of any sort, believing it to be coercive and discriminatory. Some in the Country Women's Association argue that bonding is "a retrograde step - a band-aid solution to a long-term problem". The main concerns with bonding as an approach come from medical undergraduates themselves, doctors who understand their predicament, and consumers who fear that they may have to put up with an unwilling conscript fulfilling a bond and so, potentially, a second-class service.

There is also strong opposition to the bonding of any Indigenous health students, including medical students, on the grounds that they are already committed to their local country and community.

Where the bonded scholarships are concerned, the Alliance believes that the critical issues are the conditions and requirements placed on the students who elect to take them up. If the conditions are fair and reasonable, and information on them is openly available, the bonding contract should be acceptable. In these circumstances students will be able to make the informed life choices that will impact on them for many years into the future.

With bonding an established part of efforts to recruit and retain medical practitioners for rural and remote areas, the focus of attention needs to be directed to the conditions that are imposed on students. These conditions must be fair, fully and openly described up-front, and not varied over the (lengthy) period for which the bonding will apply to individual students.

A case can be made for the period of bonding to be no longer than the length of the course and some of the Alliance's correspondents believe that one year's service for every two years funding would be fair.

Although bonded scholars complete the same course as other medical students, it is possible that the commitment they have made may impact on the quality of their undergraduate experience. For instance, the bonded scholars with $20,000 (indexed) a year are likely not to face the same imperative to obtain casual or part-time work as some others. This may make

them better students, but there may be a countervailing loss of workplace and social experiences.

The current medical undergraduate bonding system is being compared by some to the historical bonding arrangements for professionals such as teachers. The efficacy of the new bonded scholarship program has not been tested because recipients have not yet graduated. What is clear is that the bonded medical scholars will be assured of a provider number, but only to work in a prescribed geographical area – RRMA 4-7 if they are in general practice, or 3-7 of they have a specialty. The majority of them are likely to be in private practice in which they may have control over the development of a business. In sum, therefore, the bonded medical scholars are likely to be faced with greater professional and commercial risks, as well as opportunities, than people who (like teachers "in the old days") were bonded to guaranteed positions in the public service.

The precise legal situation with respect to bonding is also unclear. There has been some unfounded speculation that bonding of GPs may be unconstitutional.

In summary, the Alliance provides conditional support for the bonded scholarships as fair contracts based on full disclosure by both parties, with a genuine benefit being provided by one, in return for services made available by the other. Students and the public are likely to support them if - and only if - the terms and conditions are fair, openly explained and do not result in any lessening of quality or safety in the services provided. In this matter, as with so much else, the devil is in the detail.

The bonded university places

The Alliance overall is not supportive of the bonding associated with the extra 234 places in university Medical Schools.

Certainly these extra places will provide opportunities for people to study medicine who would otherwise not be able to do so. They will be bonded to 'districts of workforce shortage' for six years following completion of vocational education. For the universities, these additional places pose difficulties associated with extra numbers of students without extra infrastructure and other facilities. Worst of all, the proposal seems to have been implemented with indecent haste and without proper consultation with students, the universities or professional bodies.

A very broad definition of 'district of workforce shortage' is currently proposed. There is the possibility that such a definition could be changed, potentially in response to 'base political motive'. This is another argument in favour of development of robust and commonly-agreed definitions of health needs and of service accessibility, which might include measures of staff turnover. Ideally areas of need should be forecast so that schemes with designated areas of activity can be part of useful workforce planning.

There are also ethical questions relating to this policy. As Professor Nick Saunders summarises, in essence they mean:

- large numbers of commencing students - one in five - in every Australian medical school will now be bonded in one way or another;
- in return for a place in medical school - but no financial incentive - eighteen year olds will be asked to make major decisions about their lives ten to fifteen years hence;

- as there are no incentives to take up a bonded place apart from the place itself, these students will be admitted in a second phase, once all unencumbered places are filled. It is likely that the 'second phase' will become 'second tier' or 'second class', however worthy the students; and
- if the proposed Nelson Higher Education reforms are passed by the Federal Parliament, domestic fee-paying places will also be available in Australian medical schools from 2005. The mechanics of University admissions processes will require these fee-paying places to be offered once unencumbered HECS places are filled, so that fee-paying places and bonded places will be on offer at the same time. This introduces a number of ethical issues around equity and access with regard to places in Australian medical schools.[4]

In comparison with full-fee places, the bonded places will seem like a cheap alternative. However it is very hard to justify bonding without some immediate material incentive being provided. One of the Alliance's correspondents has described it as "indentured servitude – horrible". The incentive could be financial (eg they could receive $20,000 a year or be made automatically eligible for the HECS Reimbursement Scheme) or in-kind (eg support with career pathways and planning, which the Regional Clinical Schools and Regional Training Providers could undertake). Carrots are better than sticks.

It has been suggested that some of those who take a place among the additional 234 will do so because they are very highly motivated to get into medicine by any means, but with the intention of buying their way out of their commitment rather than serving an area of workforce need. On the other hand if the debts for students increase to be "of house mortgage proportions" – as for some in North America – students may well be forced to agree that they "would rather pay back time than money".

There is some possibility that the students who take up the 234 special places may regard themselves, or may be regarded, as the poor cousins of other medical undergraduates. They do not have the financial benefits of the Medical Rural Bonded Scholars or the practice options of the other unassisted students. RAMUS students have both some financial incentive and unconstrained options. There will also be up to ten per cent who are full-fee-paying students. It might be useful for universities to manage these different groups differentially, eg by providing special positive support as needed. However confidentiality issues and the feasibility of such a task will probably mean that this is not possible. For example at the University of Queensland the MBBS Program is likely to have an intake over 300, making special treatment of particular groups an administrative challenge requiring real commitment.

Currently there is concern within the student body and medical practitioner representative groups about whether the current system provides adequate peer support and mentor support services for students. These networks will need additional support in order to cater for the 234 new undergraduate places (16% extra) and the demands they will make on the system as they progress through it.

General

The Alliance is concerned to protect and evaluate the incentives to rural general practice, and to see them extended to other rural health professions. The relative lack of similar schemes for allied health, nursing, and other health team practitioners could mean that doctors end up working in areas of need without the support of heath care team members from other disciplines – or indeed refusing to do this. In practice, it will be difficult for doctors to

provide effective and comprehensive care in such circumstances. "Doctors cannot work in a vacuum; they cannot do it all alone."

Support is required for all rural scholars, whether bonded or not. Queensland has a long history of State-bonded scholarships but the Alliance has been informed they are becoming less popular due to a perceived lack of support and poor access to vocational training and appropriate career paths. This emphasises the importance of the work currently being done by the Rural Clinical Schools, the professional Colleges, General Practice Education and Training Ltd., and Regional Training Providers to adjust their activity and support medical training. The rural student clubs and Rural Workforce Agencies are other key players in the provision of such support.

Overall, people feel anxiety and uncertainty about a system that locks young people into a commitment for periods of ten to sixteen years down the track. One of the consequences of this is that there needs to be careful consideration of the arrangements in place for students to opt out of the system should they need to: the penalties and other conditions that will apply. The amount re-payable will apparently be about one quarter of the new full-fee equivalent. Non-financial penalties could also be considered, eg repayment of service in other tightly-defined areas of need in addition to Aboriginal Medical Services (eg selected public hospitals or an alcohol and drug service).

The attitudes of other stakeholders to bonded scholarships vary. The Australian Government and Opposition and some State Governments support the initiative with the Opposition keen to extend these bonded scholarships to nurses and the placement of nurses in rural general practice.

If bonding helps locate additional new practitioners for needy areas, the idea is viable. Overall, rural communities are likely to support any initiative that provides them with more doctors, particularly if they are confident that they are appropriately trained, motivated and supported.

Suggested alternatives to bonding include an increase in the number of unbonded HECS places for medicine, increasing the numbers of RAMUS and John Flynn scholarships, increasing funding for Rural Clinical Schools, that bonding be mixed with other initiatives such as the extension of coverage of the HECS reimbursement initiative to newly graduated rural practitioners, and the ongoing development of incentives to encourage doctors to enter rural practice. One particular proposal is for the additional university places to be delivered through the Rural Clinical Schools. This would enhance the universities' moves to produce the right generalist medical competencies for rural and remote areas, including through further curriculum changes within the Clinical Schools.

The public should be encouraged to think of bonded scholars as those willing to accept slightly reduced 'future options' in return for slightly greater 'future certainty'. They may therefore become a group of doctors characterised by a different average approach to risk, but not by any differences in terms of the quality and safety of their service. Experience in Queensland suggests that the rural bonded doctors offer a superior service, mainly due to their increased amount of procedural work and the training required for rural general practice.

No suggestion of second-rate service should be allowed to develop - in reality or in the public's mind - from application of the principle of bonding. Rural people will naturally express apprehension if rural programs come to be seen in negative terms.

It will not be possible to evaluate fully the effectiveness of these two bonding schemes until fifteen or even twenty years have passed. It will therefore be important to maintain ongoing evaluation of them.

Recommendations

1. The Alliance accepts bonded scholarships as one of a suite of policies to increase recruitment and retention of GPs for country areas as long as there is reward (financial and/or other) and understanding for the students, and the conditions imposed upon them are fair, open and fixed. This will require continual appraisal of the terms and conditions that apply from time to time, with due attention being given to the views of students themselves.

2. The Alliance does not support the 'bonding' of additional places in Medical Schools that are provided without an associated incentive to either the students or the universities involved.

3. Any program designed to increase the exposure of medical students to rural areas must allow for the impact of greater numbers of rural and remote placements on communities, mentors, teachers in the field, and students themselves.[5]

4. There must be continued longitudinal studies to evaluate the impact of bonded scholarships, in particular on the students at medical schools, the schools themselves, their mentors and, most significantly, on the supply of GPs to rural and remote areas. Long-term decisions on the two approaches will be determined on the evidence from such research.

5. Ideally, university authorities should continue their efforts to monitor the various groups of medical undergraduates in order to see that no particular cohort is disadvantaged or marginalised.

6. The Alliance recommends that all medical undergraduate scholarships be brought into line and standardised as much as possible in terms of the benefits offered to the scholars. This would equalise the opportunities and make it easier for universities and training providers to administer the programs and minimise the risks of different cohorts of students developing.

7. The Alliance will encourage the public, the press and students to regard bonded scholarships as a positive approach to an important health workforce issue, helping to ensure that there will be a positive cycle associated with bonded scholarships.

References

1. Australian Medical Workforce Advisory Committee and Australian Institute of Health and Welfare (1998), *Medical Workforce Supply and Demand in Australia: A Discussion Paper,* AMWAC Report 1998.8, AIHW Cat. No HWL 12, Sydney; October 1998.

2. McDonald J (2003), "*Recruiting and retaining rural general practitioners: a mismatch between the research evidence and current initiatives?"* in papers to the 7th National Rural Health Conference, Hobart, March 2003. www.ruralhealth.org.au

3. Evidence from Japan and Norway supports the value of a decentralised medical school approach with training opportunities in rural and community-based settings. Canadian research also shows that the combination of a rural background and a decentralised training program encourages individuals into rural practice. See for instance Dunbabin JS and Levitt L (2003), "*Rural origin and rural medical exposure: their impact on the rural and remote medical workforce in Australia*", Rural and Remote Health 3 (online), 2003: 212. http://rrh.deakin.edu.au

4. Nick Saunders, *"Future Challenges in Postgraduate Vocational Education in Medicine"*, National General Practice Education Convention, 15 August 2003, Melbourne.

5. The Alliance is developing a separate Position Paper on an integrated rural placement system for all health disciplines.

APPENDIX 1

GP:Population ratios in Australia and some of the characteristics of rural practice

Rural General Practice

- 123 GPs per 100 000 population in capital cities
- 108 GPs per 100 000 population in outer metropolitan areas
- 111 GPs per 100 000 population in large rural centres
- 94 GPs per 100 000 population in small rural centres
- 77 GPs per 100 000 population in other rural areas
- 66 GPs per 100 000 population in remote centres and other remote areas

While the reasons for patient presentation are generally similar between metropolitan and rural areas, the characteristics of rural practice differ in a number of ways:

- there is more procedural work undertaken
- the rural general practitioners are associated with their local hospitals
- the average hours worked per week by rural practitioners is higher
- the proportion of general practitioners on call, and the number of hours on call, id much higher
- there is a lower proportion of female general practitioners in rural areas
- there is a higher proportion of general practices in rural areas, and
- the turnover of general practitioners is higher in rural areas.

Source: Department of Education and Training - Higher Education Funding Amendment Bill (No 1) 2000.