Bonded Medical Program– Discussion paper.

Amendments to the Health Insurance (Bonded Medical Program) Rule 2020

Introduction

The Australian Government intends to amend Part VD of the *Health Insurance Act 1973* to enhance the Bonded Medical Program (Program) through a bill introduced into Parliament on 4 September 2025.

The proposed amendments include:

1. extension of the 'grace period' for Bonded 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
2. removal of the Medicare ban – as a consequence of withdrawal or upon breaching a condition – for ex-Medical Rural Bonded Scholarship (MRBS) Scheme participants that have opted in to the Program
3. 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.

Should Parliament pass these amendments, consequential amendments to the Health Insurance (Bonded Medical Program) Rule 2020 (Rule) will be required to implement amendment 3 above. The consultation process on these consequential Rule amendments will also explore potential additional changes to the Rule intended to improve the effectiveness of the Program.

While Program effectiveness must be the primary consideration regarding any suggested additional amendments to the Rule, changes that streamline Program administration and/or enhance participant experience will also be considered.

This Discussion Paper seeks to elicit stakeholder ideas for amending the Rule in the pursuit of these outcomes.

Program Objective

The Bonded Medical Program was designed to address the doctor shortage in regional, rural and remote Australia[1].

The Program is part of a suite of measures that facilitates the appropriate distribution of medical workforce across Australia.

Background

The statutory Bonded Medical Program supports approximately 900 new medical students to become doctors each year. The Program provides a Commonwealth Supported Place (CSP) in a medical course at an Australian university. Universities must ensure that 28.5% of the total CSPs in Medicine are allocated to the Program each year.

In return for the CSP provided as a benefit to students, bonded participants commit to work in an eligible regional, rural and remote area or area of workforce shortage (outer metropolitan Distribution Priority Areas for GPs or outer metropolitan Districts of Workforce Shortage for non-GP specialists) for 3 years after they complete their medical course. This is called a 'return of service obligation' (RoSO).

[1] *Health Insurance Amendment (Bonded Medical Programs Reform) Bill 2019* Explanatory Memoranda

Bonded participants are bound by Part VD of the *Health Insurance Act 1973* (the Act) and must abide by the *Health Insurance (Bonded Medical Program) Rule 2020*. This includes the requirement to complete their RoSO within an 18-year period. Failure to do so results in financial penalties. Participants are required to complete at least half of their RoSO after either attaining fellowship or after 12 years since completing their course in medicine.

The Program commenced in 2020 and was designed to replace 2 legacy schemes, the Medical Rural Bonded Scholarship (MRBS) Scheme (2001 to 2015) and the Bonded Medical Places Scheme (2004 to 2019). The Bonded Medical Programs have approximately 13,500 active participants (6000 legacy / 7500 program). Legacy scheme participants can voluntarily 'opt-in' to the Program at any time. Doing so may offer participants a significant reduction in RoSO (from up to 6 years down to 3 years) and more flexible program conditions. Program participants use an online web portal to self-manage their RoSO.

Rule Amendments

1. **Consequential amendments**

   We are seeking your feedback on the best way to make the necessary consequential amendments to the Rule should the amendments to the Act be passed by Parliament.

   The consequential amendments are to ensure that all work completed in good faith, consistent with Program objectives, can be counted towards the RoSO. These will address:

   - Inconsistencies between the administration of the legacy schemes and Program that may result in participants who have opted into the Program not being able to claim credit for eligible work completed in eligible locations. Reducing these inconsistencies will more equitably manage RoSO between legacy scheme and Program participants and increase the appeal of opting into the Program.
   - Work undertaken by a participant in good faith after being erroneously advised by the department that the work would be eligible. Such work cannot currently be counted towards the RoSO.

2. **Potential Rule changes and rationale**

   The points below summarise potential changes to the Rule for discussion. We would also welcome other ideas for Rule amendments that would enhance the effectiveness of the Program.

   Removal of the fellowship requirement – potential benefits:

   - enables doctors to complete their RoSO immediately after becoming a medical practitioner.
   - enables doctors to complete RoSO before attaining a specialisation which cannot be practiced outside a metropolitan area.
   - aligns with evidence that early exposure to rural practice increases the likelihood of retention.

   Simplified MM2-7 location eligibility – potential benefits:

   - aligns with the intent of the Program to address the doctor shortage in regional, rural and remote Australia.
   - consistent with the Working Better for Medicare Review, which recommended that DPA and DWS are removed from the Program as they have different objectives.
   - simplifies location eligibility and improves clarity for participants navigating RoSO planning.

Enable former BMP Scheme 2016-2019 participants to complete their RoSO on a pro rata part time basis (they currently can only complete their RoSO on a full time basis) – potential benefits:

- Increases the likelihood of participants completing their RoSO.
- better manages competing personal and professional demands.

Options for reducing administrative burden on participants:

- *Telehealth from an eligible location (only)* would reduce the administrative burden on participants who are currently required to provide evidence of both doctor and patient location eligibility for each service provided.
- *Simplified reporting requirements* reducing Notifiable Events and RoSO Plan requirements to minimise the administrative burden on participants.

3. **Your suggestions**

   We want to obtain your feedback on potential Rule changes to improve the effectiveness of the Program, its administrative efficiency and/or the participant experience.

Next steps

- Consultation responses will be received via a web-based survey and stakeholder meetings.
- A summary report will be published on Consultation Hub.
- Your feedback will inform final reform design and implementation planning.
- Changes that align with the Program objective and improve Program effectiveness will be submitted to the Minister for Health for consideration in late 2025.