

Questions on Notice
Rural Health Workforce Australia
Albury Hearing
5 June 2012

Please see below, Rural Health Workforce Australia's responses to Senate Questions

1. National Rural Health Students' Network "National Priorities Paper: Extended Version 2011 – 2012. This paper provides information around the expansion of HECS program to nursing and allied health.

2. Information around process for working with ML's regarding Locum issue

The Department of Health and Ageing have determined that a number of the Medical Locals will not be ready to deliver Rural GP locum service from 1 July 2012. As a result, Rural Health Workforce has been re-contracted to deliver Locum Services from 1 July 2012 through to January 2013. Our delivery of the services will continue on the model we have been using since 2009. In the next 6 months we will be working with the Australian Medical Local Alliance to develop a process that up-skills Medical Locals with the knowledge required to deliver locum services from January 2013 in a Nationally consistent way. Currently a communique is being developed to inform GP's, Locums and Medical Locals of process for accessing locums services until end 2012.

3. Evidence and information regarding incentives that changes behaviour and choices:

To our knowledge, evaluations on behaviour change in Australia relating to incentives to go rural has not been undertaken. Some work on intentions to go rural has been undertaken with student populations and publications on this topic can be found at the following websites:

Medical Schools Outcomes Database is tracking students intentions to go rural

<http://www.medicaldeans.org.au/medical-schools-outcomes-database>

Australia's Health Workforce Online also has gathered data around Medical students intentions to go rural after graduating, but again it is not linked to the incentives:

<http://www.ahwo.gov.au/publications.asp>

An International review on Financial incentives for return of service in underserved areas: a systematic review is published in BMC. This review does not capture incentive programs in Australia, however there may be some transferable learning's (attached)

The Medical Education and Training Branch, DoHA would likely have evidence on the Bonded Medical Scheme and Medical Rural Bonded Scholarship Scheme and it would be worth investigating this with them.

Attachments

1. NRHSN Position Priorities Paper 2011 – 12
2. NRHSN Position Statement on BMP and MRBS 2010
3. Baringhausen and Bloom. Financial incentives for return of service in underserved areas: a systematic review. 2009, *BMC Health Services Research*

Research article

Open Access

Financial incentives for return of service in underserved areas: a systematic review

Till Bärnighausen*^{†1,2} and David E Bloom^{†2}

Address: ¹Africa Centre for Health and Population Studies, University of KwaZulu-Natal, 3935 Mtubatuba, South Africa and ²Department of Global Health and Population, Harvard School of Public Health, Harvard University, 665 Huntington Avenue, Boston, USA

Email: Till Bärnighausen* - tbaernig@hsph.harvard.edu; David E Bloom - dbloom@hsph.harvard.edu

* Corresponding author †Equal contributors

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Abstract

Background: In many geographic regions, both in developing and in developed countries, the number of health workers is insufficient to achieve population health goals. Financial incentives for return of service are intended to alleviate health worker shortages: A (future) health worker enters into a contract to work for a number of years in an underserved area in exchange for a financial pay-off.

Methods: We carried out systematic literature searches of PubMed, the Excerpta Medica database, the Cumulative Index to Nursing and Allied Health Literature, and the National Health Services Economic Evaluation Database for studies evaluating outcomes of financial-incentive programs published up to February 2009. To identify articles for review, we combined three search themes (health workers or students, underserved areas, and financial incentives). In the initial search, we identified 10,495 unique articles, 10,302 of which were excluded based on their titles or abstracts. We conducted full-text reviews of the remaining 193 articles and of 26 additional articles identified in reference lists or by colleagues. Forty-three articles were included in the final review. We extracted from these articles information on the financial-incentive programs (name, location, period of operation, objectives, target groups, definition of underserved area, financial incentives and obligation) and information on the individual studies (authors, publication dates, types of study outcomes, study design, sample criteria and sample size, data sources, outcome measures and study findings, conclusions, and methodological limitations). We reviewed program results (descriptions of recruitment, retention, and participant satisfaction), program effects (effectiveness in influencing health workers to provide care, to remain, and to be satisfied with work and personal life in underserved areas), and program impacts (effectiveness in influencing health systems and health outcomes).

Results: Of the 43 reviewed studies 34 investigated financial-incentive programs in the US. The remaining studies evaluated programs in Japan (five studies), Canada (two), New Zealand (one) and South Africa (one). The programs started between 1930 and 1998. We identified five different types of programs (service-requiring scholarships, educational loans with service requirements, service-option educational loans, loan repayment programs, and direct financial incentives). Financial incentives to serve for one year in an underserved area ranged from year-2000 United States dollars 1,358 to 28,470. All reviewed studies were observational. The random-effects estimate of the pooled proportion of all eligible program participants who had either fulfilled their

obligation or were fulfilling it at the time of the study was 71% (95% confidence interval 60–80%). Seven studies compared retention in the *same* (underserved) area between program participants and non-participants. Six studies found that participants were less likely than non-participants to remain in the same area (five studies reported the difference to be statistically significant, while one study did not report a significance level); one study did not find a significant difference in retention in the same area. Thirteen studies compared provision of care or retention in *any* underserved area between participants and non-participants. Eleven studies found that participants were more likely to (continue to) practice in any underserved area (nine studies reported the difference to be statistically significant, while two studies did not provide the results of a significance test); two studies found that program participants were significantly less likely than non-participants to remain in any underserved area. Seven studies investigated the satisfaction of participants with their work and personal lives in underserved areas.

Conclusion: Financial-incentive programs for return of service are one of the few health policy interventions intended to improve the distribution of human resources for health on which substantial evidence exists. However, the majority of studies are from the US, and only one study reports findings from a developing country, limiting generalizability. The existing studies show that financial-incentive programs have placed substantial numbers of health workers in underserved areas and that program participants are more likely than non-participants to work in underserved areas in the long run, even though they are less likely to remain at the site of original placement. As none of the existing studies can fully rule out that the observed differences between participants and non-participants are due to selection effects, the evidence to date does not allow the inference that the programs have caused increases in the supply of health workers to underserved areas.

Background

In many geographic regions, both in developing and in developed countries, the number of health workers is insufficient to achieve population health goals. The 2004 Joint Learning Initiative (JLI) report *Human Resources for Health* estimated that "Sub-Saharan countries must nearly triple their current numbers of workers by adding the equivalent of one million workers through retention, recruitment, and training if they are to come close to approaching the MDGs [Millennium Development Goals] for health" [1]; the 2006 *World Health Report* concluded that "[t]he severity of the health workforce crisis in some of the world's poorest countries is illustrated by WHO estimates that 57 of them (36 of which are in Africa) have a deficit of 2.4 million doctors, nurses and midwives" [2]. In many developed countries, there are areas (commonly rural or poor communities) that are considered to be underserved with health workers (for instance, because the number of workers is insufficient to provide primary health care to all residents in an area) [3-5].¹

Interventions intended to alleviate health worker shortages include selective recruitment and training for practice in underserved areas, improvements in working or living conditions, compulsory service, or incentives [6]. In this article, we systematically review the evidence on one specific set of interventions: financial incentives for return of service. These interventions work as follows. A health worker in training or a fully trained health worker enters

into a contract to work for a number of years in an underserved area in exchange for a financial pay-off. Financial incentives can increase the numbers of health workers in underserved areas by a number of mechanisms. First, they can redirect the flow of those health workers who would have been educated without any financial incentive from well-served to underserved areas, for instance by decreasing the net emigration flow of nurses and physicians from developing to developed countries [7-9] or by increasing the net flow of physicians from urban tertiary care to rural primary care in developed countries [10,11]. This first mechanism can take hold if there are (future) health workers who normally would not work in an underserved area, but who are willing to do so in return for a financial incentive. Second, financial-incentive programs can add health workers to the pool of workers who would have been educated in the absence of such programs and place them in underserved areas. The second mechanism can take hold if, on the one hand, there are qualified candidates who would not have the means to finance a health care education without a financial incentive and, on the other hand, a country's health care education system can absorb additional students. Third, financial-incentive programs can decrease the outflow of health workers from underserved areas, if they prolong the retention times in underserved areas of those workers who participate in a financial-incentive program, but who would have worked in an underserved area even if they had not received a financial incentive. Improved retention in this group of health workers can be a direct result of the contractual

obligation to remain for a certain number of years in an underserved area or can be caused by a program's additional efforts to increase retention (e.g., by increasing health workers' satisfaction with their work environment and career progression, or by increasing the satisfaction of health workers' families with their integration into the community) [12]. Fourth, the programs can decrease the outflow of participating and non-participating health workers from underserved areas by increasing the number of health workers in those areas through any of the three mechanisms described above. Such positive feedback may occur because increasing the number of health workers can diminish reasons for non-retention in rural and remote areas, such as high workload [13-15], lack of contact with colleagues [14], lack of support from medical specialists [16], or social isolation [15].

We have recently shown that a specific type of financial-incentive program, scholarships in return for a commitment to deliver antiretroviral treatment in Sub-Saharan Africa, is highly cost-beneficial under a wide range of assumptions [17]. In the following, we will first systematically review studies on financial incentives for return of service. Then, we will critically summarize the findings from existing studies and draw implications for policy and future research. One previous study has systematically

reviewed the evidence on financial-incentive programs for return of service. Sempowski (2004) reviewed 10 studies of financial-incentive programs published between January 1966 and July 2002 [18]. The author concluded that "ROS [return-of-service] programs to rural and underserved areas have achieved their primary goal of short-term recruitment but have had less success with long-term retention" [18]. Prima facie, an update of this systematic review is useful because more than six years have passed since the end of the period of publication of articles considered therein. In addition to the update of evidence, our review differs from the previous one in two aspects. First, the previous review was restricted to studies of physicians, while we consider studies of all types of health workers. Second, the previous review focused on program results (i.e., descriptions of outcomes among program participants without comparison to outcomes in non-participants) [18], while our review includes program results, program effects (i.e., analysis of program effectiveness at the individual-level through comparison of outcomes among participants and non-participants), and program impacts (i.e., analysis of program effectiveness at the population level, such as changes in physicians density or population mortality) (Table 1).

Table 1: Study outcomes

Program results (Program outcomes among participants)	Program effects (Program effectiveness at the individual level)	Program impacts (Program effectiveness at the population level)
<i>Recruitment</i> What proportion of program participants fulfill their obligation to work in an underserved area? (14)	<i>Provision of care</i> Does program participation affect a health worker's likelihood of providing care in an underserved area? (11)	<i>Health system</i> Does the program affect health systems outcomes (e.g., physician density)? (6)
<i>Retention</i> What proportion of program participants continue to work in an underserved area after having fulfilled their obligation? (17)	<i>Retention</i> Does program participation affect a health worker's likelihood of continuing to provide care in an underserved area after a certain period of time? (7)	<i>Health</i> Does the program affect health outcomes (e.g., mortality)? (1)
<i>Participant satisfaction</i> What proportion of program participants are satisfied with - work in the underserved area - life in the underserved area - other aspects of the financial-incentive program? (7)	<i>Participant satisfaction</i> Does program participation affect a health worker's satisfaction with - work in the underserved area - life in the underserved areas? (2)	
<i>Family satisfaction</i> What proportion of relatives of program participants are satisfied with - work in the underserved area - life in the underserved area - other aspects of the financial-incentive program? (3)		

The term underserved area in the table encompasses both underserved geographical areas and underserved populations. The number of studies investigating the specific outcomes is shown in parentheses. The numbers in parentheses add up to 68. Twenty-five studies contribute 1 outcome each to this sum, while nine studies contribute 2 outcomes each, seven studies contribute 3 outcomes each, and one study contributes 4 outcomes. Two published articles report the same outcomes from the same study [41,42]; these outcomes are counted only once in the table

Methods

Data sources and search strategies

We carried out a systematic literature search in four electronic databases: PubMed [19] in order to cover articles on financial-incentive programs published in the medical literature; the Excerpta Medica database (EMBASE) [20] in order to cover articles in medical journals that are not included in PubMed, in particular European journals [21]; the Cumulative Index to Nursing and Allied Health Literature (CINAHL) [22] in order to cover articles published in the literature on nursing and allied health professions; and National Health Services Economic Evaluation Database (NHS EED) [23] in order to cover health economics studies. We used the Cochrane Library to search in NHS EED [23]. Because MEDLINE records were included in the search, we excluded MEDLINE records in both the EMBASE and the CINAHL search. No search option to exclude MEDLINE records was available in NHS EED. In order to detect any early financial-incentive program, we searched the literature from the earliest date at which records were available in each of the four databases given our search strategies. We searched all four databases on 31 January 2009 and included all relevant articles available in the databases up to the search date. In addition, we searched the reference lists of all publications included in the final review as well as of all articles that were excluded from the review because they were review articles, editorials, or commentaries. Finally, we asked colleagues with a research interest in human resources for health to identify articles on financial incentives for return of service.

To identify articles for review, we combined three search themes using the Boolean operator "and": health workers or students, underserved areas, and financial incentives. We combined several search terms with the Boolean operator "or" in order to operationalize the search themes. We drew the search terms from the controlled vocabularies used for subject indexing in PubMed (i.e., Medical Subject Headings (MeSH) [24]), EMBASE (i.e., Emtree [25]), and CINAHL (i.e., CINAHL Subject Headings [26]). We used all search terms from the controlled vocabularies in their "exploded" versions. That is, in addition to the selected terms, all narrower terms that are categorized below it in the vocabulary hierarchies were included in the searches. While MeSH are available in NHS EED when searched through the Cochrane Library, we entered the search terms in all searchable, subject-specific fields (title, keyword, and abstract), because such a search strategy has been found to be superior to MeSH-based strategies in NHS EED [27]. The four search algorithms are shown in the Appendix.

Selection criteria

Articles were considered for inclusion in the systematic review if they reported data from a quantitative study of

results, effects, or impacts of at least one financial-incentive program for return of service. We considered articles published in any language. We excluded studies that evaluate programs that attempt to increase the number of health workers in underserved areas primarily through non-financial means [28-32]. For instance, studies evaluating the Physician Shortage Area Program (PSAP) of Jefferson Medical College were excluded because the program aims to increase the number of rural family physicians primarily through selective admission of candidates to medical school and through intensive exposure of the program participants to rural family practice, while offering only "a small amount of additional financial aid [...] almost entirely in the form of repayable loans", which "represents only a small portion of each student's entire tuition and expenses" (Rabinowitz et al. 2005).

Reviews, commentaries, editorials, news and policy briefs were excluded. Studies of financial incentives for return of service within the military (e.g., [33]) were excluded because experiences with return-of-service programs in the military are likely to be very different from civilian experiences, as the military can exert more control over its members than most civilian institutions over citizens. Studies of financial incentives for research positions (e.g., [34]) were excluded because health workers who conduct medical research are commonly motivated by very different factors than health workers in patient care [35], and this article's objective is to examine the evidence on financial incentives for return of patient care in underserved areas. We further excluded studies of financial incentives to enroll in a specific residency program [36], unless they were explicitly linked to work in underserved areas, and studies investigating the attractiveness of hypothetical financial-incentive programs [37].

After exclusion of 131 duplicate records, our searches identified a total of 10,495 articles, 10,302 of which were excluded based on their titles or abstracts. We conducted full-text reviews of the remaining 193 articles and of 26 additional articles identified in reference lists or by colleagues. Forty-three articles were included in the final review. While we did not apply any language restrictions in our search, all reviewed titles and abstracts were available in English (some as translations of original-language versions) and all articles included in the final review were published in English.

Statistical analysis

We used DerSimonian and Laird meta-analysis [38] to compute both fixed- and random-effects estimates of the pooled recruitment proportion (and its 95% confidence interval (CI)). We defined the recruitment proportion as the proportion of all eligible program participants who had either fulfilled their service obligation or were fulfill-

ing it at the time of the study. Participants were eligible if they had completed the required minimum medical training and were available to fulfill their obligation. Participants could be unavailable for a number of reasons, including disease, imprisonment, or temporary deferral of service. For the meta-analysis, both the recruitment proportion of a program and the total number of eligible program participants needed to be known. We thus could only include those studies in the meta-analysis that reported sufficient information to calculate these two measures. To determine the pooled recruitment proportion, the variances of the raw proportions were stabilized using the Freeman-Tukey double arcsine transformation [39]. After meta-analysis of the transformed variable, we retransformed the pooled mean and its 95% CI back to proportions. Heterogeneity of the recruitment proportion across studies was diagnosed with the Q test [40]. When significant heterogeneity was present, we selected the random-effects estimates.

Results

Table 1 describes the outcomes that were investigated by the 43 studies included in the review and the number of studies investigating each outcome (in parentheses). Twenty-five studies investigated 1 outcome; nine studies investigated 2 outcomes; seven studies investigated 3 outcomes; and one study investigated 4 outcomes. Two published articles report the same outcomes from the same study [41,42]; these study outcomes are counted only once in Table 1.

Additional file 1 shows descriptions of each of the programs that were evaluated in at least one of the included studies. When information on some program characteristics was not available in the reviewed study itself, we extracted the information from other sources (shown in the column "Other sources" in the table). All monetary values in the column "Financial incentive and obligation" are shown both as they are provided in the reviewed study and – for ease of comparison – in year-2000 United States dollars (USD). We used the purchasing power parity index from the World Bank Development Indicators [43] in order to translate the values of a non-US currency into US dollars and the consumer price index from the US Department of Labor Bureau of Labor Statistics [44] to adjust for differences in the real value of one USD over time.

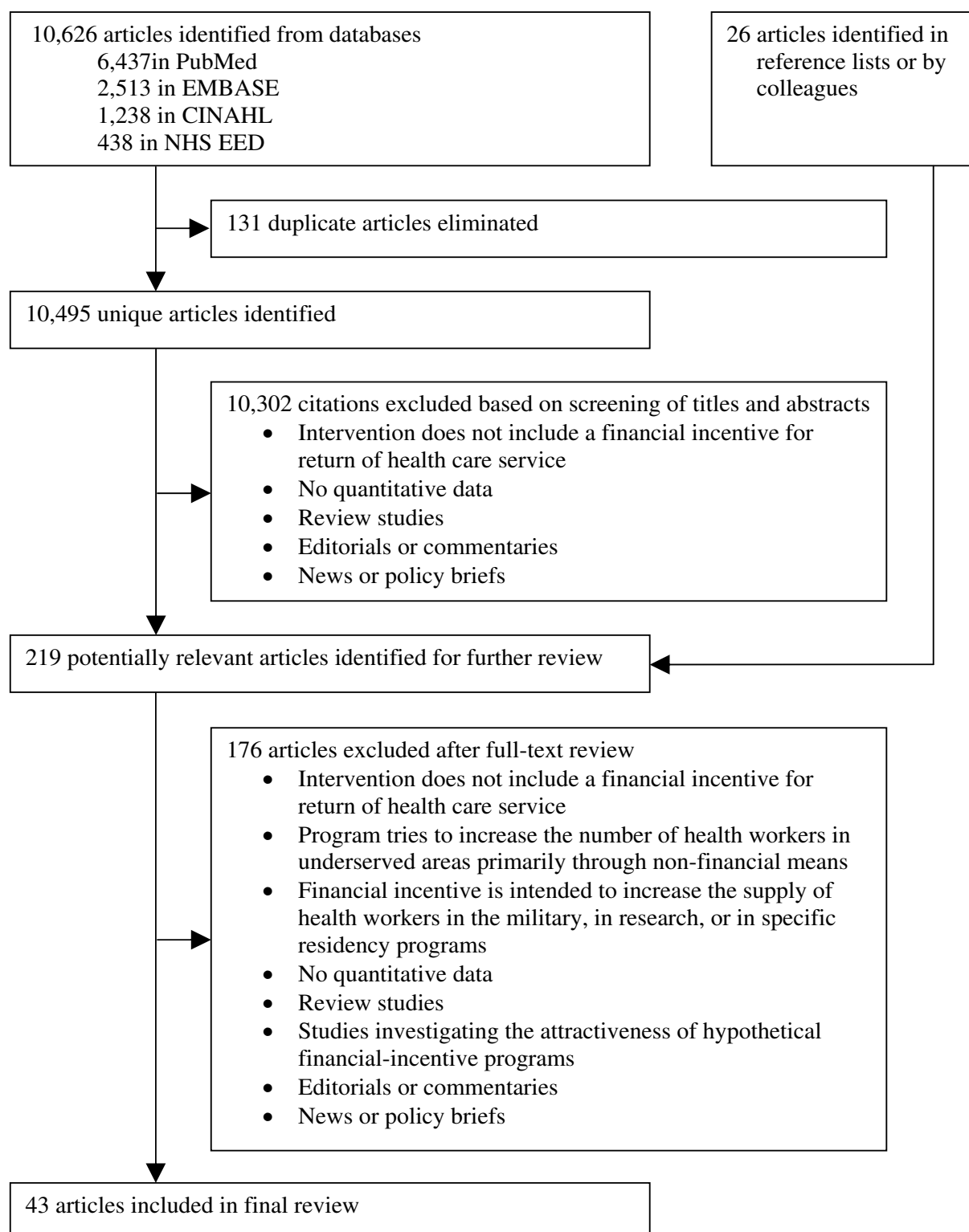
The programs evaluated in the studies included in this review started between 1930 and 1998. With the exception of five programs that accepted a range of health professionals (the North Carolina Rural Loan Program, the National Health Service Corps (NHSC), the West Virginia Recruitment and Retention Community Project, the West Virginia State Loan Repayment Program in the US, and the Friends of Mosvold Program in South Africa), the

financial incentives of the evaluated programs were targeted only at future or current physicians (Additional file 1).

With the exception of three programs that cover, respectively, "tuition, entrance and equipment fees and living expenses" [45], "tuition, fees" and "a living stipend" [46], and "funds for university tuition, books, residence fees and food" [47], the precise monetary values of the financial incentives of all programs included in this review were available in published articles or on web pages. The financial incentives per year of service ranged from year-2000 USD 1,358 to 28,470. One study compared the average award amount across five types of programs – service-requiring scholarship programs, service-option educational loans, loan repayment programs, direct financial-incentive programs, and resident support (in the form of service-requiring scholarships, loan repayment, or direct financial incentives). The study did not find significant differences in the size of the financial incentives [48] (Additional file 1).

We identified 43 studies that met all our inclusion and exclusion criteria. The previous systematic review of financial-incentive programs for return of service by Sempowski [18] identified only 10 articles, three of which were not included in our review. Two articles were not included because they evaluated a program that "tried to increase the number of health workers in underserved areas primarily through non-financial means" [49,50] (Figure 1); one study was not included because it did not report "data from a quantitative study of results, effects, or impacts of financial incentives for return of service" [51] (see "Selection criteria" above). Of the 36 articles covered in our study but not included in the review by Sempowski, 17 were published after the end of the review period of the previous study (i.e., after 2002) [11,48,52-66]. The remaining articles were not included because the previous study used different inclusion and exclusion criteria. In particular, our review considers programmatic outcomes and health worker types that were not covered in the previous study (see "Introduction" above).

Of the 43 reviewed studies, 34 investigated financial-incentive programs in the US, 24 of which evaluated the NHSC; 8 evaluated programs in specific US states or communities; 1 evaluated both the NHSC and state-based programs; and 1 evaluated the national Commonwealth Fund Medical Undergraduate Scholarship Program. Five studies investigated the Jichi Medical University (JMU) program in Japan, two assessed the Ontario Under-served Area Program (UAP) in Canada, and one study each evaluated the New South Wales Department of Health Rural Resident Medical Officer Program (Cadetship Program) in New Zealand and the Friends of Mosvold Schol-

**Figure 1**

Flowchart of the systematic review. EMBASE = Excerpta Medica database, CINAHL = Cumulative Index to Nursing and Allied Health Literature, NHS EED = National Health Services Economic Evaluation Database.

arship Scheme (FOMSS) in South Africa.² Additional file 2 describes the study outcomes, study designs, sample criteria, sample sizes, data sources, outcome measures, effect sizes, conclusions, and methodological limitations of all studies included in the review. Sample sizes across the thirty-seven studies in which individuals were the unit of observation ranged from 24 to 493,142. Eighteen studies had sample sizes greater than 1,000, and four had sample sizes greater than 50,000.

Types of financial-incentive programs for return of service

In our review, we identified five different types of financial-incentive programs for return of service, viz.: service-requiring scholarships (or "conditional scholarships") (e.g., [57,66]), educational loans with service requirements (e.g., [67]), service-option educational loans (e.g., [68]), loan repayment programs (e.g., [48]), and direct financial incentives (e.g., [69]) (Additional file 1). These program types differ according to the following criteria: time of commitment and time of money receipt, spending restrictions, and type of commitment. First, in the case of service-requiring scholarships, educational loans with service requirements, and service-option loans, students commit to participation in a program before or early in the course of their health care education and receive money during the education. In the case of loan repayment programs and direct financial incentives, health workers commit to participation after completion of their health care education. Direct financial incentives are commonly paid at the beginning of service in an underserved area while loan repayments are commonly made after each period of service in an underserved area (e.g., every three or six months). Second, while direct financial incentives can be used for any purpose, the money from any of the other four programs must be spent on health care education either during the education (in the case of service-requiring scholarships, educational loans with service requirements, and service-option educational loans) or after the education to repay educational debt (in the case of loan repayment programs). Finally, people who participate in service-requiring scholarships, loan repayment, or direct financial-incentive programs commit to work in an underserved area, while those receiving educational loans with service requirements commit to service and financial repayment. Individuals who receive service-option educational loans commit to either service or financial repayment. While all service option educational loans offer a choice between service and repayment of the financial incentive, some of the programs belonging to the other four types offer a buy-out option. The difference between service-option loans and service-requiring scholarships with a buy-out option is that the managers of the former will normally consider repayment and service equally desirable outcomes, whereas the managers of the latter will prefer service over buy-out. Given equal financial

incentives a buy-out is thus commonly more expensive than the financial repayment of a service-option educational loan [70]. Note that many loan repayment programs do not require a buy-out option because the programs pay participants after each period they have served in an underserved area.

Program result: recruitment

The recruitment proportion varied between 33% and 100% across programs (see Additional file 2). Fourteen studies reported for 25 different financial-incentive programs both the recruitment proportion and the total number of participants who had ever been eligible to serve their obligation (or values from which these two variables could be calculated) [45,56-58,66,68,71-73].³ The random-effects pooled recruitment proportion across these 25 programs was 71% (95% CI 60–80%, heterogeneity $p < 0.001$).

Program participants who were available for practice, but did not fulfill their commitment to work in an underserved area, either defaulted on their obligation or bought out of it. Of the 25 programs included in the meta-analysis, only four did not offer a buy-out option [57,66,67,72]. Some programs allowed participants to repay half [74] or all [71,75] of the principal without interest in lieu of service repayment. Other programs set the buy-out price at the principal plus interest (the "prevailing rate of interest", or a fixed rate of interest varying between 2% and 10% [68]), while yet other programs charged a buyout price of the principal plus a penalty ("principal plus penalty up to 100%", or "triple the loan amount plus interest" [56]). The random-effects pooled recruitment proportion across those programs that did not offer a buy-out option (84%, 95% CI 73–92%, heterogeneity $p < 0.001$) was not significantly different (overall test of heterogeneity between subgroups, $p = 0.652$) from the pooled recruitment proportion across those programs that did allow buy-out (67%, 95% CI 55–79%, heterogeneity $p < 0.001$).

Program result: retention

The proportion of program participants who remained in underserved areas after completing their obligation ranged from 12% to 90% across the eighteen articles that reported retention results [41,42,45,56,57,61-63,67,68,71,74-80]. The reported proportions, however, could not be meaningfully compared to each other, because the definition of retention, the length of time during which participants were enrolled in a study (enrolment period), and the length of time between the end of the enrolment period and the time when retention results were observed (lag time) varied widely across studies. The studies measured retention in any underserved area in a country [45,57,61,63,75,77-80], in any underserved area

in a specific state [68,74], in any area in a specific state [45,56,61,62], in the underserved area of original program placement [41,42,56,67,71,77,78], or in a particular practice entered during a specific period of time [76]. Three articles reported the retention *intentions* of program participants who were fulfilling their obligations at the time rather than actual retention [41,42,79]. All of the other 15 articles described outcomes of retrospective cohort studies. One of the fifteen studies did not report an enrolment period or lag time [68]. Enrolment periods in the remaining 14 studies were four [76,77], five [71], nine [78], ten [57], fifteen [75], eighteen [63,80], nineteen [67], twenty [62], twenty-three [74], twenty-four [45], twenty-five [56], and twenty-six [61] years. There was no lag between enrolment and observation in five studies [45,56,67,71,74]; lag times in the other studies were 1 [58,63,76,80], 6 [57], 8 [78], 11 [77], and 29 [75] years; two studies assessed retention results after three different

lag times (3, 7 and 9 years [61] and 9, 13, and 15 years [62]).

Program effects: provision of care and retention

In all 17 studies of program effects, program participation was defined as having received a financial incentive and serving or having served the obligation; i.e., people who received a financial incentive but could not be recruited to serve in an underserved area were excluded from the cohorts of program participants. Figure 2 shows four categories of effect studies by outcome and sample. Three categories of studies investigated retention (in the same area, in the same underserved area, or in any underserved area), and one category investigated provision of care in any underserved area. Three studies report two different program effect outcomes [53,81,82].

		Outcome: retention or provision of care in	
		Same area	Any underserved area
Sample	All physicians	<i>Retention in the same area:</i> Holmes 2004 [53] Pathman et al. 2004 [48]	<i>Provision of care in any underserved area:</i> Brooks et al. 2003 [11] Holmes 2004 [53] Inoue et al. 2007 [59] Matsumoto et al. 2008 [60] Pathman et al. 2000 [85] Probst et al. 2003 [52] Rabinowitz et. al. 2000 [84] Rabinowitz et al. 2001 [88] Rittenhouse et al. 2008 [65] Xu et al. 1997 [86] Xu et al. 1997 [87]
	Physicians who initially worked in an underserved	<i>Retention in the same underserved area:</i> Jackson et al. 2003 [58] Pathman et al. 1992 [81] Pathman et al. 1994 [12] Pathman et al. 1994 [82] Singer et al. 1998 [83]	<i>Retention in any underserved area:</i> Pathman et al. 1992 [81] Pathman et al. 1994 [12]

Figure 2
Studies of program effect on retention and provision of care.

Five of the seven studies that compared retention in the *same* (underserved) area between program participants and non-participants found that participants were significantly less likely to remain in the area [12,48,53,81,82], while one study did not report a significance level but found a substantially higher retention in non-NHSC physicians than in NHSC physicians [83], and another study did not find a significant difference in retention between the two groups [58]. In contrast, 11 of the 13 studies that compared differences between participants and non-participants in provision of care or retention in *any* underserved area found that participants were more likely to (continue to) practice in such an area [11,52,53,59,60,65,84-88]. These differences were shown to be statistically significant in nine of the eleven studies [11,52,53,65,84-88]. Two studies did not provide the results of significance tests [59,60]. Two of the thirteen studies reported the converse finding: program participants were significantly less likely than non-participants to remain in any underserved area [81,82].

The studies of program effects reported hazard ratios [48,81], odds ratios [12,52,65,84,87,88], relative risks (or two proportions) [11,58-60,82,83,85], or beta-coefficients [53,86] as measures comparing retention or care provision among program participants and non-participants. Except for the two studies that reported hazard ratios, which took into account the duration of retention of each individual in the sample [48,81], and one study that used the proportion of underserved patients as its dependent variable [86], these studies used a binary concept of retention or care provision measured at different time intervals after an initial observation (at least 1 year [58], 1-28 years [65], 3 years and 1 month and 5 years and 1 month [12], or 5 years [83]) or after graduation from medical school (0-16 [59], 0-26 [60], 6-21 [88], 7-9 [53], 7 and 11 [85], 9-10 [84,87], 10-11 [86], 10-20 [82] or up to 29 [52] years, or an unknown time interval [11]).

Program results and effects: participant satisfaction and family satisfaction

Seven studies investigated the satisfaction of participants with aspects of their enrolment in financial-incentive programs [12,41,48,58,67,76,77], viz. satisfaction with the overall experience in the program [48,58,67,77], satisfaction with work [12,41,48,58,76] or personal life [12,41,76] in the underserved areas, or satisfaction with aspects of program administration [58,67]. Three studies examined the satisfaction of members of participants' families with their lives in the underserved area [41,48,76]. Four of the seven studies investigated satisfaction outcomes in the NHSC [12,41,76,77]; the three other studies examined satisfaction outcomes in US state programs [48,58,67].

While the studies on participant and family satisfaction were too few to draw any strong generalized inferences, a contrast emerged between the NHSC and the US state programs. Three studies measured overall satisfaction with financial-incentive programs in US states by asking participants whether they would enroll again in the same program [48,58,67]. They found a high counterfactual willingness to enroll again: 71% of interviewed participants in the North Carolina Rural Loan Program answered "yes" to the re-enrolment question [67]; 73% of interviewed participants in four programs in West Virginia answered either "definitely yes" or "probably yes" to the re-enrolment question [58]; and 90% of interviewed participants in US state programs indicated that they would "definitely" or "likely" enroll again [48]. In contrast, a study analyzing 183 unstructured written accounts of time in the NHSC found that only 20% of participants rated their experience as "positive", while 80% rated it either "negative", "mixed or ambivalent", or "neutral" [77].

A similar difference emerged in the comparison of NHSC and US state-based programs across specific aspects of participants' work and personal-life satisfaction (Additional file 2) For instance, in a study of state-based programs, Pathman and colleagues found that more than 80% of program participants were "satisfied with practice", more than 90% found their "work rewarding", and more than 70% felt "a sense of belonging to the community," while a comparison group of non-obligated physicians scored significantly lower on all three dimensions of satisfaction [12]. In contrast, in a study of the NHSC, Pathman and colleagues found that participants rated their satisfaction level between "dissatisfied" and "neutral" for 7 of 15 "work issues" and "personal-life" issues and participants' satisfaction level exceeded "satisfied" for only one issue ("caring for needy patients"). A control group of non-participants reported significantly higher satisfaction than the participants for 9 of 15 issues (for which a comparison was made) and significantly lower for only one issue [48].

Program impacts: health system and health

Six articles examined whether financial-incentive programs have led to changes in the number or density (i.e., number per population) of certain types of health workers [55,64,69,71,74,89]. One of the six studies described the medical student density in Arizona over time and concluded that a scholarship aiming to increase student density was not effective [74]. Two studies compared changes over time – in physician numbers (from 1966 to 1972 [71]) and in physician densities (from 1956 to 1986 [69]) – in northern Ontario to changes in the same measures in Ontario as a whole. The first study concluded that an observed increase in the absolute number of physicians in northern Ontario was likely caused by the program

(because the speed of increase rose substantially after introduction of the program in northern Ontario, while there was no change in the speed of increase in Ontario overall) [71]. The second study concluded that an increase in physician density in northern Ontario was not due to the program but due to the overall increase of physicians in the province (because a measure of inequality between physician density in northern Ontario and Ontario as a whole did not improve) [69]. It is possible that an initial effect of the program in the first three years after its introduction (from 1969 to 1972) – as reported in the first study [71] – ceased to exist in the longer run (until 1986) – as reported in the second study [69]. A fourth study used data from the American Medical Association Masterfile to model the practice location choices of US physicians in sequential multinomial logit regression. The parameter estimates of NHSC participation from the regression equation were then used to predict the supply of physicians in underserved areas, assuming the NHSC had not existed. Through comparison of this counterfactual to the status quo, the study concluded that elimination of the NHSC would lead to a 10–11% decrease in the supply of physicians in underserved areas [64].

Two further studies of health system impacts of financial-incentive programs used communities as units of observation. One of the studies investigated whether underserved areas that succeeded in attracting obligated physicians were different from communities that failed to do so. It found that communities that were economically worse-off and had worse population health were less likely to receive an obligated physician than underserved communities that were economically better-off and had better population health [89]. The second study investigated whether the presence of an obligated physician in a community changed the supply of non-obligated physicians in that community and found that, when controlling for a range of demographic, economic, and health systems factors, communities staffed by NHSC clinicians experienced a larger increase in non-NHSC primary care physicians per population than communities without NHSC clinicians [55]. Only one study analyzed the effect of a financial-incentive program on a health outcome [54]. The study compared age-adjusted all-cause mortality rates in two periods, 15 years apart, in underserved communities with different levels of staffing by obligated physicians. It found no clear relationship between the level of staffing and mortality.

Causal inferences

Causal inferences from studies reporting program results are necessarily weak, because these studies merely describe outcomes in individuals enrolled in financial-incentive programs and do not allow any comparison to individuals who did not receive financial incentives.

While analyses of program effects are based on comparisons of cohorts of program participants and non-participants, causal inferences from comparisons of outcomes in different cohorts can be invalid, if there are no controls for differences between participants and non-participants.

Of the 17 studies of program effects, 11 controlled for additional variables in the comparison of retention and provision of care between people who did and did not participate in a financial-incentive program [12,48,52,53,65,81,84-88]. Eight of these studies controlled for sex of the health worker [48,52,53,65,84,86-88], five controlled for ethnicity [52,53,84,86,87], four for medical specialty [12,48,52,81], three for age [48,53,87], three for growing up in an underserved area [84,86,87], two for "strong interest" prior to medical school to practice as a doctor in an underserved area [84,87], two for childhood family income [84,87], two for characteristics of the underserved area where the health worker practices [12,52], one for marital status [48], one for the type of medical school a participant had attended (private vs. public, receiving vs. not receiving Title VII-funding [65]⁴), one for debt, experience in an underserved area during medical school, and experience in an underserved area during residency [87], one for "importance of small community living" [81], one for commitment to long-term practice in underserved areas before starting work in such an area [12], and one for expected peak income, freshman-year plans for family practice, rural preceptorship, participation in PSAP, and location of family practice clerkship [88]. Another study did not describe the particular control variables used, but reported that its effect measures remained significant "while controlling for selected characteristics of physicians" [85].

While a number of studies controlled for differences in observed characteristics between participants and non-participants, only one study of program effects attempted to control for unobserved heterogeneity in program participation. The study used a bivariate probit selection model to control for the potential bias due to selective participation [53]. In order to identify the program effect, the study used four medical school characteristics, viz. the "historical proportion of graduates specializing in primary care", the "quality of the school", a "tuition index", and a "public school indicator", assuming that these variables affected selection into financial-incentive programs but did not affect provision of care or retention in underserved areas other than through their effect on program participation. One study of program impact (by the same author) used the same medical school characteristics as identifying variables in a joint model of program participation and practice location decisions [64].

Four of the six other studies of program impacts observed changes over time in the availability of a financial-incentive program and an outcome (number or density of health workers [69,71,74] or mortality [69]), but did not control for changes over time of any other variable. Thus, in these studies it could not be ruled out that an observed relationship (or the apparent lack of a relationship) between program participation and outcome was due to a confounding variable. In addition, three of the six studies [69,71,89] may have suffered from ecological bias [90] because they observed variables at a level of aggregation that was higher than the level at which inferences were made. For instance, Anderson and Rosenberg (1990) [69] observed changes in physicians density in *counties* in order to evaluate the impact of the Ontario Underserved Area Program in attracting physicians to underserved *communities* within those counties. Thus, the observed average change in physician density in any a county could have been caused by an infinite number of combinations of effect sizes in the different underserved and sufficiently serviced communities in the county.

Discussion

Of the 43 studies included in the review, 34 evaluated financial-incentive programs located in the US. The remainder examined programs in other developed countries (Japan, Canada, New Zealand), with but one exception that described a program in South Africa. The US financial-incentive programs have placed substantial numbers of health workers in underserved areas. For instance, between 1972 and 2009, the NHSC – the largest financial-incentive program in the US – placed approximately 30,000 primary care clinicians in underserved areas [46]. At the same time, the US programs have met only a small proportion of national unmet health care need. In 2008, 4,600 clinicians were serving in the NHSC, but according to NHSC estimates 27,000 additional primary care professionals were required to provide care to the 50 million people who still lacked access to primary health care in the United States [91].

While most of the evaluated programs were located in the US, the US market for health care education is unusual in comparison to many other countries in that students pay high tuition for their education. Countries where students of health care do not usually incur large debt, such as many Western European countries, may not be as successful as the US in recruiting students and health professionals into programs that provide scholarships or repayment of educational loans in return for service in underserved areas. In many developing countries, by contrast, education for a health profession can be quite costly because of tuition and school fees as well as costs of housing and living. Some of the experiences from the US may thus be more applicable to health care education markets in

developing countries than to other developed countries. On the other hand, (future) health workers in the US have many options for funding their education, while funding opportunities for education may be few in some developing countries. Thus, the generalizability of US findings to other countries where students have substantial financing need for health care education may be limited because the selection into financial-incentive programs for underserved service may depend on the availability of funding alternatives. Numerous other differences, such as in the capacity to enforce and monitor obligated service (compare [92]), may limit the generalizability of the studies included in this review to other settings. One study from South Africa suggests that scholarship programs for health care education can be a successful instrument to recruit health workers for practice in rural Africa [66]. Future studies should evaluate outcomes of financial-incentive programs from other developing countries where such programs have been offered in the past or are currently offered, such as Swaziland [93], Ghana [94], and Mexico [95].

Notwithstanding the above caveats about generalizability, it is useful to summarize some of the key findings from our review. First, most of the financial-incentive programs experienced substantial losses to recruitment before the start of the service obligation. Across the 25 programs included in the meta-analysis in our review, on average about 3 in 10 participants did not fulfill their commitment to work in an underserved area. However, there was wide variation in loss to recruitment. As reported previously by Pathman and colleagues [48] and Jackson and colleagues [58], state programs in the US that committed students to service (service-requiring scholarships and educational loans with service requirements) had significantly lower recruitment proportions than state programs that committed health workers after their training (direct financial incentives and loan repayment programs). This finding is not surprising, because preferences change over time. For instance, students who found careers in primary care appealing at entry into medical school may develop a strong interest in highly specialized health care during their training, which depends on technology that is usually not available in underserved areas.

Furthermore, we find that the recruitment proportion did not differ significantly between programs that offered a buy-out option and those that did not. While this result suggests that participants who have decided not to serve their obligation will do so independent of the conditions of the program they are enrolled in, it is important to note that the proportion of participants who would have taken up work in underserved areas had they not enrolled in a specific financial-incentive program is unknown. Thus, it

is impossible to infer from such comparison the relative recruitment effectiveness of different types of programs.

Second, participants in financial-incentive programs were significantly more likely to leave their sites of first practice after completion of their obligation than non-obligated health workers in comparable sites of first practice after service of similar length of time. There may be several reasons for this finding. For one, some of those health workers who – without financial incentive – find practice in any underserved area less attractive than practice in sites that are not underserved decide to enroll in financial-incentive programs and to complete their obligations. These health workers are likely to leave the underserved area after having served the obligated term. On the other hand, even those obligated health workers who find practice in underserved areas to be the most attractive career path in general may be more likely to leave their sites of initial practice than their non-obligated colleagues in the same underserved areas. Obligated health workers have less choice over the particular underserved area in which they first practice than their non-obligated peers and are thus less likely to be satisfied with their work and personal life in the underserved area. For instance, one study of the NHSC concludes that NHSC enrollees "placed in rural sites in the late 1980s experienced a site-matching process that they felt offered few acceptable sites" and "offered little opportunity to locate the bestsuited site among those offered" [12]. Financial-incentive programs aiming to achieve high retention of health workers in the sites where they fulfill their obligated service should attempt to accommodate health workers' wishes to practice in a particular underserved area to the greatest extent possible.

Third, while participants in financial-incentive programs were less likely than non-participants to remain in the particular underserved area of first practice, the reviewed studies suggest that participants were more likely to practice in some underserved area or to work with an underserved population than their peers who did not participate in a financial-incentive program. This summary finding from our systematic review is in contrast to the conclusion of the one previous review of financial incentives for return of service, which concluded that incentive programs "have achieved their primary goal of short-term recruitment but have had less success with long-term retention" [18].

Many of the analyses of retention in studies in this review compared the behavior of participants in financial-incentive programs to that of non-participants, controlling for a few observed health worker characteristics, such as sex, age, ethnicity, or marital status. However, since participants self-selected into programs, it is difficult to identify whether any difference in behavior between participants

and non-participants was due to unobserved characteristics distinguishing participants from non-participants or due to program effects. It is possible that those health workers with the strongest preferences to serve underserved populations chose to participate in financial-incentive programs and that these unobserved preferences fully explain the different work and retention patterns in participants and non-participants, i.e., participants would have worked for exactly the same lengths of time in underserved areas without the incentives they received.

An ideal strategy to identify causal effects of financial-incentive programs is randomized controlled trials. However, since program participation is an individual choice, it will be impossible to randomize individuals into program participation and control arms. While it would theoretically be possible to randomize cohorts of medical students (e.g., by year of graduation or by medical school) to financial-incentive offers of different sizes, such a randomization strategy may not be politically or administratively feasible. An alternative strategy to identify causal effects involves the use of statistical models that control for selection into financial-incentive programs on unobserved individual characteristics. Two studies in this review (one of program effect [53] and one of program impact [64]) implemented selection models of program participation. The two studies used medical school characteristics (e.g., the "historical proportion" of graduates pursuing careers in primary care) to identify program effect. However, the type of medical school that students choose is likely to be related not only to the decision to enroll in financial-incentive programs, but also – independent of program participation – to the decision to work in underserved areas. For instance, students with strong preferences to work in underserved areas may be more likely than their peers with weaker preferences for such care to select medical schools with a high "historical proportion" of graduates pursuing careers in primary care, because such schools are likely to focus on medical education relevant for underserved practice. This selection may determine work location decisions, independent of any effect the medical school characteristic may have on participation in financial-incentive programs. Thus the characteristic may not be a valid variable to identify program effects. Despite the difficulty in finding variables to identify program effects in selection models, future studies using already-existing data should emphasize control of biases due to selection effects. In the absence of a valid method to control for selection into program participation on unobserved variables, studies of retention and provision of care should attempt to control for variables capturing health workers' preferences to work in underserved areas before financial-incentive programs could have influenced those preferences. Studies in this review controlled for intention to work in an underserved area

prior to the decision to enroll in a financial-incentive program [84,87], for the intention to practice in an underserved area for a time period that is longer than the service obligation in a financial-incentive program prior to such practice [12], or for variables that are likely to be closely related to the preference to work in an underserved area in the absence of financial incentives, such as having grown up in an underserved area [84,87] or a predilection for living in small communities [81]. Two of these four studies found that physicians participating in the NHSC were significantly *less* likely than non-NHSC physicians to remain in the *same* underserved area where they initially took up work [12,81], while the other two found that NHSC participants are significantly *more* likely to provide care in *an* underserved area than non-NHSC physicians [84,87]. These four studies suggest more strongly than the other studies in this review that the finding that program participants are more likely than non-participants to work in underserved areas in the long run (even though they are less likely to remain at their site of original placement) is indeed causal. Nonetheless, they cannot rule out that the observed effects are due to selection on unobserved variables.

Fourth, financial-incentive programs varied substantially in the level of participant satisfaction. Participants in some programs were more satisfied than non-participants with their work and personal life in underserved areas, while the converse was true for participants in other programs. Health workers' satisfaction with work and personal life in underserved areas is important for several reasons. For one, health worker satisfaction influences retention, as has been shown in several studies [96-98], including in studies of financial-incentive programs for return of service [12,41,63]. Moreover, health worker satisfaction is associated with patient satisfaction [99] and quality of care [100,101]. Health workers are also likely to share their experiences with colleagues and may thus influence the supply of health workers to underserved areas as well as participation in financial-incentive programs. The reviewed studies offer some insight into the mechanism through which individual programs affect participant satisfaction. This evidence, based on case reports and participants' accounts, suggests that programs that achieved high participant satisfaction successfully interacted with participants during different stages of program enrolment, viz. participant selection, the matching of underserved areas to the preferences of individual participants, preparation of the participants and their families before the start of the obligated service, as well as career guidance, mentoring, monitoring of problems, and ongoing support during the service [12,48,58,66,70,77]. Detailed case studies of relatively successful and unsuccessful programs could further improve our understanding of management skills, organizational processes, and

program features that increase participant satisfaction and retention in underserved areas.

Fifth, there is no clear evidence that financial-incentive programs had any significant impact on the supply of health workers to underserved areas. The results of three studies suggest that certain programs led to an increase in health worker numbers or densities, while two other studies did not find such program impacts. This discrepancy could be due to actual differences in impact between programs or over time; or they could be caused by methodological limitations of the studies. The impact of financial-incentive programs on health worker numbers and densities is not only a function of program scale and program effect on participating individuals, but depends also on the effect of the programs on non-participating health workers. It is plausible that participating health workers will deter non-participants from practice in underserved communities because the former will compete with the latter for patients and practice personnel. Conversely, it also seems plausible that the inflow of program participants into underserved communities attracts non-participating health workers to the same communities because the former decrease the overall work load per health worker (which may be perceived as too high) and increase opportunities for referral and exchange among colleagues. A study by Pathman and colleagues is significant insofar as it suggests "that the NHSC contributed positively to the non-NHSC primary care physician workforce in the rural underserved counties where its clinicians worked during the 1980s and 1990s" [55]. In the above discussion of summary findings from our review, we caution that the existing evidence regarding program results, effects, and impacts does not allow (strong) causal inferences. It is further important to keep in mind that the summaries are across five countries, five types of programs, programs of different geographic reach ranging from community to country, seven types of health workers, and study publication dates ranging from 1963 to 2008. Program recruitment, retention, and satisfaction outcomes differed widely, even within some of the strata defined by program location, type, geographical reach, health worker type, and time period. Health planners can use our review to gain an overview of the existing evidence. In designing future programs, however, they need to carefully consider the applicability of findings from the studies in the review to the market for health care education in their country, the specific health worker group they intend to target with a program, and the type of underserved areas they aim to supply with program participants.

Conclusion

Financial-incentive programs for return of service are one of the few health policy interventions to improve the distribution of human resources for health on which sub-

stantial evidence exists. However, the majority of studies to date are from the US and only one study reports findings from a developing country. The existing studies show that financial-incentive programs placed substantial numbers of health workers in underserved areas and that program participants were more likely than non-participants to work in underserved areas in the long run, even though they were less likely to remain at their site of original placement. As none of the existing studies can fully rule out that the observed differences between participants and non-participants are due to selection effects, the evidence to date does not allow the inference that the programs have caused increases in the supply of health workers to underserved areas. In order to improve the scope of evidence on financial-incentive programs for return of service in underserved areas, future studies should evaluate programs from a more diverse set of countries, in particular in the developing world. In these studies, researchers should attempt to control selection biases as rigorously as possible, using selection models in observational studies and randomized controlled trials where funders and policy makers are willing to support such experiments.

Competing interests

The authors declare that they have no competing interests.

Authors' contributions

TB and DB jointly formulated the study design, obtained and analyzed the data, interpreted the findings, and wrote the article. Both authors read and approved the final manuscript.

Appendix

Endnotes

¹In this article, unless otherwise specified, we use the term underserved area for underserved communities, regions, or populations within countries, as well as for countries where by some standards even the best-served geographic regions are underserved. The precise definition of underserved area differs across the financial-incentive programs evaluated in the studies reviewed in this article. The different definitions are reported in Additional file 1.

²One study evaluated jointly the NHSC and US state programs (Additional file 1). It is included in the count of both studies evaluating the NHSC and studies evaluating US state programs.

³Three studies reported recruitment proportions in the same program using highly overlapping samples of participants [45,59,62]. Of the three studies, we only included the one with the largest sample size in the meta-analysis [45].

⁴In the US, "Title VII grants are intended to strengthen the primary care educational infrastructure at medical schools and residency programs and to encourage physicians in training to pursue careers working with underserved populations" [65].

Search algorithms

PubMed search

("Health Manpower" [MeSH Term] OR "Health Personnel" [MeSH Term] OR "Students" [MeSH Term] OR "Internship and Residency" [MeSH Term] OR "Education, Medical" [MeSH Term])

AND

("Medically Underserved Area" [MeSH Term] OR "Professional Practice Location" [MeSH Term] OR "Rural Health" [MeSH Term] OR "Rural Health Services" [MeSH Term] OR "Primary Health Care" [MeSH Term] OR "Family Practice" [MeSH Term] OR "Career Choice" [MeSH Term])

AND

("Financial Support" [MeSH Term] OR "Training Support" [MeSH Term] OR "Physician Incentive Plans" [MeSH Term] OR "Health Planning" [MeSH Term])

EMBASE search

('health care manpower'/exp OR 'health care personnel'/exp OR 'student'/exp OR 'medical education'/exp)

AND

('rural health care'/exp OR 'professional practice'/exp OR 'primary health care'/exp OR 'general practice'/exp)

AND

('student assistance program'/exp OR 'finance'/exp OR 'health care personnel management'/exp OR 'health care planning'/exp)

AND

[embase]/lim NOT [31-01-2009]/sd AND [<1950-2009]/py

CINAHL search

((MH "Health Manpower+") or (MH "Nursing Manpower+") or (MH "Health Personnel+") or (MH "Students+") or (MH "Internship and Residency") or (MH "Education+"))

and

((MH "Medically Underserved Area") or (MH "Rural Health") or (MH "Rural Health Services") or (MH "Primary Health Care") or (MH "Family Practice") or (MH "Career Planning and Development"))

and

((MH "Financial Support+") or (MH "Employee Incentive Programs") or (MH "Health and Welfare Planning+"))

NHS EED search

((Health Manpower) OR (Health Personnel) OR (Students) OR (Internship and Residency) OR (Medical Education))

AND

((Medically Underserved Area) OR (Professional Practice Location) OR (Rural Health) OR (Rural Health Services) OR (Primary Health Care) OR (Family Practice))

AND

((Career Choice) OR (Financial Support) OR (Training Support) OR (Physician Incentive Plans) OR (Health Planning)) in NHS Economic Evaluation Database

Additional material

Additional file 1

Evaluated financial-incentive programs.

Click here for file

[<http://www.biomedcentral.com/content/supplementary/1472-6963-9-86-S1.pdf>]

Additional file 2

Reviewed studies.

Click here for file

[<http://www.biomedcentral.com/content/supplementary/1472-6963-9-86-S2.pdf>]

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- National Health Service Economic Evaluation Database (NHS EED) [http://mrw.interscience.wiley.com/cochrane/cochrane_cleed_articles_fs.html]
- Medical Subject Headings [<http://www.nlm.nih.gov/mesh/>]
- EMTREE [http://www.elsevier.com/wps/find/bibliographicdata/sedescription.cws_home/707574/description#description]
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Bonded Medical Places and Medical Rural Bonded Scholarships POSITION STATEMENT

BACKGROUND

The Bonded Medical Places (BMP) and Medical Rural Bonded Scholarship (MRBS) Schemes were introduced in 2004 and 2001, respectively, by the Australian Government with the intention to provide more doctors for districts of workforce shortage and rural and remote communities.

Through the BMP Scheme, the Australian Government provides over 600 additional Commonwealth Supported Places each year at Australian medical schools. When accepting a BMP place, students must agree to work in a District of Workforce Shortage of their choice for a period equal to the length of their medical degree. Up to half of the return of service obligation may be undertaken during prevocational and vocational training. This commitment is formalised by the student signing a legal Deed of Agreement with the Australian Government at the time of enrolment. There is no financial incentive attached to accepting a BMP place.

Through the MRBS Scheme, the Australian Government provides 100 additional Commonwealth Supported Places each year at Australian medical schools. These scholarships provide participants with over \$24,000 per annum for the duration of the student's medical course. In return, MRBS students must agree to work in a rural or remote community of their choice for 6 continuous years. For MRBS students, the return of service obligation does not begin until they have obtained college fellowship. This commitment is formalised by the student signing a legal Deed of Agreement with the Australian Government at the time of enrolment.

In 2010, the Australian Government introduced a new initiative called "Scaling" whereby BMP and MRBS students have the opportunity to reduce their return of service obligations. Participants who choose a more remote location to work have the opportunity to gain credits enabling them to complete their return of service obligations over a shorter timeframe.

Currently the application and selection process for BMP and MRBS places are determined by individual Australian medical schools following the submission of an application by the student to study medicine.

Both BMP and MRBS students are eligible to join the Bonded Support Program administered by the Australian College of Rural and Remote Medicine on behalf of the Department of Health and Ageing. This program was introduced in 2007.

POSITION

The NRHSN recognises the need for strategies including the role of bonded programs to ensure a future health workforce in the areas they are needed most. The Network believes that in order to be effective and attract students who are going to be committed to working in these areas in the long term, these programs must be fair and reasonable in what they expect participants to agree to. Furthermore, these programs must ensure that participants are given reasonable financial and non-financial support which acknowledges the valuable commitment that students are making when they accept a bonded position.

The current situation where there is a discrepancy between the length of the degree and fixed return of service obligations for MRBS participants is unfair.

Currently, medical students signing up to the MRBS scheme who are undertaking a four or five year medical degree have the same return of service obligation as those who are undertaking a six year medical degree. This translates to some medical students receiving up to two years more support, both financially and through the other benefits provided through the bonded support program, with the same 6 year return of service obligation post-attainment of their college fellowship. This is clearly unfair for MRBS participants undertaking a four or five year medical degree.

RECOMMENDATION 1: That the MRBS return of service obligation be equalised with degree length to create an equitable system where all MRBS students receive the same entitlements and return of service obligations.

The BMP scheme in its current format where it does not provide any financial incentive other than HECS Reimbursement for return of service in eligible country locations is unreasonable.

Apart from eligibility to have their HECS debt reduced through the HECS Reimbursement Scheme during their return of service if undertaken in an eligible country location, currently BMP students do not receive any other financial incentives. In signing up to the BMP scheme, participants are make a significant commitment to work in a district of workforce shortage which will no doubt influence their professional career and have financial implications including but not limited to costs of relocation later on. The NRHSN believes that in line with other bonded programs, the BMP scheme must recognise this commitment by providing reasonable financial support to all BMP participants.

RECOMMENDATION 2: That the BMP scheme in its current format is not expanded to include allied health or nursing students.

RECOMMENDATION 3: There should be more material promotion to increase awareness of the HECS Reimbursement Scheme among BMP students.

RECOMMENDATION 4: Financial support should be introduced into the BMP Scheme that rewards and is accessible to all participants such as providing BMP participants

with a relocation grant on completion of their medical degree to assist them to meet the costs of moving to a district of workforce shortage.

More must be done to ensure that students at the time of joining the BMP and MRBS Schemes are well informed of the possible responsibilities and implications of accepting a place.

Accepting a BMP or MRBS place is a significant long-term commitment which will have implications on a participant's personal life and professional career path several years later. It is critical that adequate information about the contract as well as their rights and obligations are provided to students before they choose to accept a BMP or MRBS place.

Currently most students are not becoming aware of the BMP and MRBS schemes until very close to when they are making the decision to accept a medical school place. In this current situation, there is a high risk that many students impulsively accept a bonded place because of their overwhelming desire to study medicine, only to regret that decision and have a negative perception of the program later on. This is clearly counterproductive as it discourages other students who may be open to the idea of accepting a BMP or MRBS place from considering the schemes in a more positive way. In so doing, it also reduces the ability of BMP and MRBS schemes to attract and reward medical students who are genuinely interested in contributing to districts of workforce shortage and rural Australia.

RECOMMENDATION 5: Increase communication to potential medical students and their families about the BMP or MRBS schemes so they can understand the benefits and associated return-of-service obligations well before the application process for a medical school place. Suggestions include:

- Working with universities and faculties that hold open days for year 12 and undergraduate students considering applying for entry into medicine to increase material promotion;
- Informing all medical school applicants about the BMP and MRBS schemes when they are registering for the UMAT or GAMSAT and submitting their medical school preferences;
- Inviting all medical school applicants to attend a BMP/MRBS workshop or information session in their state or Territory before they are required to submit their preference for a Commonwealth Supported Place, BMP or MRBS place;
- Provide students with links to past and current BMP and MRBS students for advice and support.

RECOMMENDATION 6: Provide all BMP and MRBS applicants with a voucher or financial reimbursement for any costs associated with obtaining legal and career advice prior to signing up to the schemes.

The selection process for students entering the BMP and MRBS schemes should be standardised across all the universities.

Currently, the process of selecting students for the BMP and MRBS programs is inconsistent across the different Australian medical schools. There should be a similar selection process at all universities – preferably one where students need to demonstrate why they are interested in accepting the place.

RECOMMENDATION 7: Review the current BMP and MRBS student selection process across the different Australian medical schools with a plan to develop and implement of a national standardised process that is fair and transparent.

The capacity of the Bonded Support Program must be increased in line with the increased numbers of participants in the BMP and MRBS Schemes.

Through the first hand experiences of our members, we know that positive associations and exposure to rural health play a major role in shaping students' impressions regarding future rural careers. Students who have positive experiences remember these most and these can provide the student with a strong motivation to pursue a rural career.

The NRHSN recently welcomed the introduction of the Bonded Support Program administered by the Australian College of Rural and Remote Medicine on behalf of the Department of Health and Ageing. The networking, mentoring, support and opportunities to attend conferences which the program seeks to provide cannot be underestimated in terms of their influence on students' professional interests and career choices.

With now increased numbers of students participating in the Bonded Support Scheme since it was first introduced, the Government must commit to increasing funding for the Bonded Support Program to ensure that the program can continue to provide all BMP and MRBS participants with opportunities to gain positive exposures to areas they will come across when they begin their return of service obligations. This is especially important given that a considerable proportion of students accepting BMP and MRBS places may have limited opportunities to experience regional and rural Australia during the course of their medical studies.

RECOMMENDATION 8: Increase funding for the Bonded Support Program in line with the increased numbers of participants in the BMP and MRBS Schemes.

RECOMMENDATION 9: Increase the range of the support available to students participating in the BMP and MRBS schemes. Suggestions include:

- Inviting BMP and MRBS students to participate in an annual “rural week” of activities specifically designed for BMP and MRBS students in their first year;
- Facilitate opportunities for BMP and MRBS students to develop mentor relationships with doctors working in districts of workforce shortage and/or rural Australia;
- Link BMP and MRBS students to rural health clubs and the NRHSN which will in turn provide opportunities for networking, support and education surrounding rural health issues and exposure to positive rural health experiences;

- Increase opportunities for BMP and MRBS students to connect with each other face-to-face at relevant conferences, especially ones with a student focus;
- Offer BMP and MRBS students free membership of their state/territory rural doctor's network or agency or other relevant rural health organisation such as the Rural Doctors' Association of Australia (RDAA) or Australian College of Rural and Remote Medicine (ACRRM).

The next few years will be an important opportunity to review the BMP and MRBS Schemes.

With the few first cohorts of BMP and MRBS Scheme participants commencing their return of service obligations, the NRHSN sees the next few years as a timely and important opportunity for Government and stakeholders to review the BMP and MRBS Schemes for their effectiveness in delivering a sustainable health workforce for Australian in the areas they are needed most.

The NRHSN believes that it is important to review the impact of the BMP and MRBS Schemes in their ability to address workforce shortages in the long-term compared to other means of encouraging rural recruitment and retention such as the HECS Reimbursement Scheme.

RECOMMENDATION 10: That the BMP and MRBS schemes are reviewed in terms of their effectiveness in delivering a long-term sustainable rural health workforce.

The NRHSN believes the implementation of these recommendations are vitally important so that students positively identify with the program, and that the program is seen as fair and an attractive stepping stone in the pathway towards a regional or rural career.

National Rural Health Students' Network**National Priorities Paper: Extended Version
2011-2012**

This paper is also available online at www.nrhsn.org.au
(Go to Publications then Position Statements)



the future of rural health

2012 Student Executive**James Roth and Simon Reid**

Co-chairs

Ben Crough

Secretary

Ph 03-9860-4700 (c/-Rural Health Workforce Australia)
exec@nrhsn.org.au

National Rural Health Students' Network
Level 5 10 Queens Road Melbourne Vic 3004
Telephone 03 9860 4700 Facsimile 03 9820 8383
Email info@nrhsn.org.au www.nrhsn.org.au

The National Rural Health Students' Network

The National Rural Health Students' Network (NRHSN) is the peak body providing a voice for health students who are passionate about improving the health workforce and health outcomes for rural and remote Australians. With over 9,000 student members from 29 Rural Health Clubs at universities across the country, the Network is the only national multi-disciplinary student network of its kind. Members include students from medical, nursing and a vast array of allied health courses.

The Network offers students access to information, multi-disciplinary networking and professional development opportunities to support their interest in rural health whilst we promote rural health issues and careers. Funded by the Australian Government Department of Health and Ageing, the NRHSN Program is managed by Rural Health Workforce Australia.

Executive Summary

The NRHSN welcomes continued commitment from all sides of politics and levels of government to reform the health system so that it delivers better health for Australian rural and remote communities. As the future workforce for rural health, we believe that it is important that health initiatives at both national and local levels consider the particular needs of rural and remote communities. NRHSN provides direct feedback from students across the disciplines, with insights into how this generation of up and coming health professionals want to train and work.

The NRHSN is pleased to support the National Rural Health Alliance (NRHA) vision for equivalent health and wellbeing in regional, rural and remote Australia by the year 2020. Network members additionally support efforts to close the gap in health inequity between Indigenous and non-Indigenous Australians within a generation. To support achievement of the above, the NRHSN would like to see policymakers and stakeholders take action now in the following national priority areas:

1. Rural and remote training pathways
2. Aboriginal and Torres Strait Islander Health
3. Mental health training for all health students
4. Ensuring Medicare Locals deliver for the rural and remote health sector
5. Regional development and health infrastructure

This National Priorities Paper outlines these key issues from the NRHSN student perspective. In so doing, it also offers thirty-two key recommendations to inform the rural, remote and Indigenous health reform agenda including the new National Rural and Remote Health Plan. This Paper has been developed in consultation with members of the 29 NRHSN Rural Health Clubs. The NRHSN also has a number of other policy documents on specific issues, which can be accessed by contacting the Executive (details on front cover) or visiting the website: www.nrhsn.org.au

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PRIORITY 1: RURAL & REMOTE TRAINING PATHWAYS

The Australian Government's Rural Health Workforce Audit¹, published in April 2008, demonstrated the gross undersupply of medical practitioners, specialist nurses and allied health professionals in rural and remote areas compared to metropolitan Australia. This section will outline what the Network believes could be done to ensure its 9000 health students and more move into rural and remote areas.

1) ENSURE A MINIMUM OF 33% OF HEALTH STUDENTS ARE FROM A RURAL BACKGROUND

There is substantial evidence to support the fact that students coming from rural backgrounds are more likely to return to rural areas after they graduate^{2,3,4}. The Australian Government needs to promote policy based around this knowledge and address the differences in rural entry schemes across the country. Rural entry schemes which fail to include high school students who have attended urban boarding schools discriminate against a substantial proportion of potential rural health graduates.

The NRHSN supports current Rural Clinical Training and Support (RCTS) Program guidelines which require Universities to maintain an intake of at least 25% rural origin students for the Commonwealth Supported Places in their medical schools. The NRHSN would welcome the extension of the RCTS Program at a University level to support active recruitment of a greater number of rural students into all health degrees.

- 1.1.1 *Recommendation: 33% of health students should be of rural backgrounds as students from rural backgrounds are likely to return to rural areas.*
- 1.1.2 *Recommendation: For current rural entry schemes to be expanded to include all health disciplines*
- 1.1.3 *Recommendation: For rural entry schemes to more fairly assess students' rurality by considering the student's place of residence or where they spent a vast period of their life and not just their secondary school*
- 1.1.4 *Recommendation: For the RCTS Program to be extended to include all health disciplines*

2) IMPROVE PLACEMENT & GRADUATE SUPPORT

Positive rural experiences, such as placements, are integral to recruitment of health practitioners to rural practice and are among the leading factors in determining eventual rural practice for

¹ Australian Government Department of Health and Ageing (2008), *Report on the Audit of Health Workforce in Rural and Regional Australia*, April 2008. Commonwealth of Australia, Canberra

² Australian Medical Workforce Advisory Committee (2002). *Career decision making by doctors in their postgraduate years: A literature review*. AMWAC report 2002.1, Sydney

³ World Health Organisation (2010), *Increasing access to health workers in remote and rural areas through improved retention: Global policy recommendations*. Geneva: World Health Organisation

⁴ Rabinowitz, J. Diamond, Markham F & Paynter N (2001), *Critical Factors for Designing Programs to Increase the Supply and Retention of Rural Primary Care Physicians*, JAMA Vol. 286, No. 9. pp. 1041-1048

students^{5,6}. The less time students have to spend in the city for their training, the greater the likelihood they will be recruited to rural and remote practice.

Nursing and Allied Health students continue to lack access to quality and well-supported rural placement opportunities both as part of their degree and also extra-curricular opportunities. It is inequitable that these students are also more likely to have to organise their own placements and receive less financial support to pay for the costs of accommodation and travel.

1.2.1 *Recommendation: For additional rural placement programs to be established (or the guidelines for the current ones expanded) for nursing and allied health students to ensure that students across all health disciplines have equal access to placements in rural and remote communities.*

1.2.2 *Recommendation: For rural placements to be well supported; we need access to supervisors, transport, and financial assistance.*

3) ENSURE WORK FOR GRADUATES

There are currently a record number of medical students graduating from medical schools across the country and a short-term undersupply of graduate nursing positions. There are also low numbers of allied health professionals working in rural or remote Australia with the majority working in private practice in metropolitan areas⁷, which limits the number of graduate level positions outside of metropolitan centres.

The NRHSN recognises that quality clinical teaching and training in public hospitals and general practice underpins medical education in Australia. Core rotations of medicine, surgery and emergency medicine must be maintained as part of the intern year with a minimum duration of 8-weeks each⁸.

1.3.1 *For internship training options to be diversified to offer placements in general practice, Aboriginal Community Controlled Health Organisations and smaller public and private rural hospitals to provide opportunities to experience greater variety of medical practice and alleviate pressure on current teaching hospitals. In this process, it is essential that quality educational support and supervision is maintained for interns who choose to undertake these rotations so that these places meet the 'National Training and Assessment Guidelines for Junior Medical Doctors PGY 1 and 2'⁹ and 'Standards for the Supervision of Prevocational Doctors in General Practice'¹⁰.*

1.3.2 *Recommendation: For the undersupply of nursing graduate nursing positions to be addressed by:*

⁵ Australian Medical Workforce Advisory Committee (1998), *Influences On Participation In The Australian Medical Workforce*, AMWAC Report 1998.4, Sydney, p9

⁶ Eley D and Baker P (2006), *Does recruitment lead to retention? – Rural Clinical School training experiences and subsequent intern choices*, Rural and Remote Health 6:511

⁷ Australian Government Department of Health and Ageing (2008), *Report on the Audit of Health Workforce in Rural and Regional Australia*, April 2008. Commonwealth of Australia, Canberra

⁸ Australian Medical Association (2011), *Prevocational Medical Education and Training – 2011*, Australian Medical Association, Canberra.

⁹ Australian Government Department of Health and Ageing (2003), *National Training and Assessment Guidelines for Junior Medical Doctors PGY 1& 2*. Commonwealth of Australia, Canberra

¹⁰ The Royal Australian College of General Practitioners (2007). *Standards for the Supervision of Prevocational Doctors in General Practice*, South Melbourne, The Royal Australian College of General Practitioners.

- a. *Attracting more graduate nurses to rural areas with positive rural incentives such as expansion of the HECS reimbursement scheme for nurses working in an undersupplied area for a specific term.*
- b. *Incorporating and promoting an optional rotation at a rural area into graduate positions to allow nurses to experience greater variety in their training and enable extra graduates to be accommodated into graduate programs.*

4) INCREASE FOCUS ON RURAL SPECIALIST TRAINING PATHWAYS

Vast amounts of money, energy and resources have been invested in increasing the number of medical schools and medical students across the country as well as being invested into initiatives (eg. rural-focused medical schools, Rural Clinical Schools, University Departments of Rural Health, HECS-Reimbursement Schemes, John Flynn Placement Program and Rural Health Clubs) aiming to increase positive perception of rural careers among medical students such that more are seriously contemplating taking up rural posts when they graduate.

This means more medical students are graduating with an interest in working in a rural or remote area. However, more internship, junior doctor training or specialist training positions have not been made available in these areas. This gap in the training pipeline must be rectified to prevent a significant waste of money and a continued loss of potential rural doctors back to metropolitan areas.

- 1.4.1 *Recommendation: For regional and rural training facilities to be developed that support graduates wanting to specialise and work in rural or remote areas, particularly in specialties that are most beneficial for rural and remote areas. At the same time, continuing to ensure quality and the maintenance of the characteristics that make training and practicing in rural areas unique and appealing*

PRIORITY 2: ABORIGINAL AND TORRES STRAIT ISLANDER WORKFORCE

The policy of the NRHSN states that all Australians have a right to accessible, appropriate and high quality health care¹¹. This is not necessarily the case with regards to Indigenous Australians and eliminating the disparities between Aboriginal and Torres Strait Islander peoples and the general population should be a key national priority¹². The comprehensive training of health students from all disciplines must provide opportunities that will facilitate the development of clinically and culturally competent professionals, who are confident in all aspects of Aboriginal and Torres Strait Islander health.

Addressing health inequalities between Indigenous and non-Indigenous Australians is a generational issue¹³. It requires a change in the culture of learning for the next generation of health professionals, to foster health professionals who are critical thinkers and informed with regards to the social, historical, environmental, political and cultural determinants of Aboriginal and Torres Strait Islander health¹⁴. This vision should be a core objective to all individuals involved with 'closing the gap' and is a crucial element to Aboriginal and Torres Strait Islander health reform.

There needs to be significant investment of time and effort into the development of the future health workforce¹⁵. However, a health workforce that truly addresses the needs of Aboriginal and Torres Strait Islander peoples will provide significant benefits and opportunities for Indigenous and non-Indigenous patients, students and health professionals.

This section will focus on the changes needed to drive the development of the Indigenous regional, rural and remote health workforce.

1) RECRUITMENT, RETENTION AND GRADUATION OF ABORIGINAL AND TORRES STRAIT ISLANDER STUDENTS

Whilst an increasing number of institutions provide opportunities for Aboriginal and Torres Strait Islander peoples studying health programs, the number of Indigenous students in these courses is still minimal compared to non-Indigenous Australians¹⁶. There needs to be an increased focus on attracting Aboriginal and Torres Strait Islander students to reach parity across all health disciplines. For example, there needs to be 928 doctors, 4056 nurses and 946 allied health professionals of Indigenous heritage trained over the next 10 years to reach non-Indigenous levels¹⁷.

2.1.1 Recommendation: For there to be an increased focus on attracting Aboriginal and Torres Strait Islander students into health courses so that the representation of Aboriginal and Torres Strait Islander students across health disciplines reaches parity with the representation of Aboriginal and Torres Strait Islanders in the Australian population.

¹¹ NRHSN Indigenous Health Policy (2010), Melbourne VIC

¹² Minniecon D, Kong K (2005) *Healthy Futures: Defining best practice in the recruitment and retention of Indigenous medical students*, Canberra ACT, Australian Indigenous Doctors Association.

¹³ Calma T (2010) *2010 Chalmers Oration – What's needed to close the gap?* Rural and Remote Health 10, 1586

¹⁴ Carson B, Dunbar T, Chenhall R & Bailie R (2007) *Social determinants of Indigenous Health*, Sydney NSW, Menzies School of Health Research.

¹⁵ Calma T (2005) *Social Justice Report*, Aboriginal and Torres Strait Islander Social Justice Commission, Sydney NSW.

¹⁶ Drysdale M, Faulkner S & Chesters J (2006) *Footprints forwards: Better strategies for the recruitment, retention and support of Indigenous medical students*, Moe VIC, Monash University of Rural Health.

¹⁷ National Close the Gap Campaign 2011

2.1.2 *Recommendation: For there to be continued support for programs that promote early engagement with health careers in both primary and secondary education such as through high school visits and mentoring.*

2.1.3 *Recommendation: For national guidelines for flexible entry schemes to medical and health courses to be developed and implemented.*

2) TRAINING AND EDUCATION

The paucity and inconsistency of curriculum and training opportunities in Aboriginal and Torres Strait Islander health, along with lack of community and clinical placements in this area are major barriers precluding the motivation of health students to work in Indigenous health settings. Vertical integration of curriculum and professional development of health students in Aboriginal and Torres Strait Islander health needs to be considered¹⁸.

2.2.1 *Recommendation: For an integrated Indigenous health curriculum (as per the Committee of Deans of Australian Medical Schools (CDAMS) Indigenous Health Curriculum Framework) to be facilitated by all health education providers, applying these principles across all health disciplines.*

2.2.2 *Recommendation: For there to be increased clinical placement opportunities in Aboriginal and Torres Strait Islander health across primary, secondary and tertiary health services in regional, rural and remote contexts that are beneficial, educational and safe for the community and the student.*

2.2.3 *Recommendation: For universities and graduate training providers to engage with professional peak bodies to ensure vertical integration of Indigenous health content throughout health professional training pathways.*

3) LEADERSHIP, INFRASTRUCTURE AND COMMUNITY RELATIONSHIPS

Commitment to Indigenous health must be implemented at an institutional level. Lack of institutional and faculty commitment to Indigenous health, along with limited Aboriginal and Torres Strait Islander academic and administrative positions within institutions has been noted as a major contributor to the lack of motivation of health students to work in Indigenous settings¹⁹. In addition, strong networks and relationships between institutions and local Aboriginal medical services and other key community organisations are needed²⁰ in order to improve the future health workforce. These will provide opportunities for teaching resources, clinical placements and student support.

2.3.1 *Recommendation: Promote institutional commitment to Aboriginal and Torres Strait Islander health and social priorities (eg. Reconciliation Action Plan)*

2.3.2 *Recommendation: Training bodies should ensure a clear commitment to addressing issues pertaining to recruitment and education.*

¹⁸ Personal Interview, Associate Professor Ngiare Brown, June 4th 2011

¹⁹ Minniecon D, Kong K (2005) *Healthy Futures: Defining best practice in the recruitment and retention of Indigenous medical students*, Canberra ACT, Australian Indigenous Doctors Association.

²⁰ Eckemann A, Dowd T, Chong E, Nixon L, Gray R, Johnson S (2010) *Binan Goonj: Bridging cultures in Aboriginal health*, Sydney NSW, Elsevier Australia.

- 2.3.3 *Recommendation: Whilst some universities provide comprehensive support for Indigenous academic positions, universities and other health training organisations should ensure the appointment and support of qualified, competent and motivated Aboriginal and Torres Strait Islander academic positions who are supported by Indigenous community to address the recruitment of Indigenous students, Indigenous curriculum and teaching. Training institutions should ensure core resourcing for these academic positions.*
- 2.3.4 *Recommendation: For there to be a co-ordinated and equitable approach to financial support for Aboriginal and Torres Strait Islander students across all health disciplines.*
- 2.3.5 *Recommendation: Universities and other health training organisations should prioritise the development and maintenance of relationships with the local Indigenous communities, including Aboriginal medical services and other relevant Indigenous health organisations. This will provide students with the opportunity to experience Indigenous health settings with confidence and institutional support via these partnerships.*

PRIORITY 3: MENTAL HEALTH TRAINING FOR ALL HEALTH STUDENTS

The NRHSN believes that in developing a competent and sustainable future rural health workforce, it is important to not only harness health students' desire to work in the bush, but ensure that these students are equipped with the appropriate knowledge and skills to succeed when they get there. Mental health for health students is one key area which the NRHSN sees as requiring immediate attention.

The NRHSN identifies that mental health is a significant issue for developing the future rural health workforce. The NRHSN, in partnership with Beyond Blue, recently produced the 'When The Cowpat Hits the Windmill' mental health guide by students for students. Further, Mental Health nights, Mental Health First Aid and Applied Suicide Intervention Skills Training have become more regular and popular features of Rural Health Club events. This section will outline what the NRHSN believes should be done to help make mental health for health students a national priority.

1) BETTER UNDERSTAND MENTAL HEALTH ISSUES AFFECTING ALL HEALTH STUDENTS

In addition to demands associated with balancing study with relevant family, work, social, and financial commitments, our experience indicates that students in health degrees can be at particular risk of mental health issues²¹. The significant number of contact hours, volume of learning materials and clinical placement requirements attached to many health courses challenge the life management skills of students undertaking them and place these young Australians at increased risk of reduced mental health and wellbeing⁹. Feelings of isolation that may accompany rural placements involving a move away from family, friends and other regular support structures may add further stress⁹. In addition, certain personality traits common among health students have been found to place them at increased risk of mental health problems²².

Rural origin students may also be at increased risk as they must often additionally cope with the pressures associated with relocation in order to attend tertiary studies⁹.

While there is emerging evidence supporting the prevalence of depression and anxiety among medical students and junior doctors²³, there is a considerable lack of understanding of the extent of mental health challenges experienced by students and professionals of the other health disciplines.

3.1.1 Recommendation: There is little research on the mental health challenges experienced by health students during tertiary study; research is required in this area.

2) PRIORITISE MENTAL HEALTH FIRST AID TRAINING FOR ALL HEALTH STUDENTS

Promotion and training in mental health is integral to the development of resilient, healthy and confident practitioners, and it must start at the university level. Students equipped with practical knowledge and basic skills to manage their own mental health and that of those around them will be valuable assets to the future health workforce and will be more likely to take roles as mental health champions and advocates in their communities. Greater confidence in handling mental health issues

²¹ Frazer S, Johnson S (2011) *Investing in the future – promoting mental wellbeing for students, by students: Proceedings of the 11th National Rural Health Conference*, Perth, Australia, March 2011, accessed 30/6/2011, http://nrha.org.au/11nrhc/papers/11th%20NRHC%20Frazer_Stephanie_B1.pdf

²² Henning K, Ey S, Shaw D (1998) *Perfectionism, the imposter phenomenon and psychological adjustment in medical, dental, nursing and pharmacy students*. Medical Education 32: 456-464

²³ Elliot L, Tan J, Norris S (2010) *The mental health of doctors: A systematic literature review*. Beyond Blue

is especially significant for students who will later work in rural and remote Australia, as these areas have higher rates of mental illness and may have scarcer access to mental health services.

The Network sees an urgent need for mental health training to be made more widespread and accessible to health students, as it may help reduce the stigma of mental illness and encourage future health professionals to actively pursue greater mental health literacy.

Mental Health First Aid is a nationally recognised course, which has been shown to effectively increase mental health literacy through improving participant understanding of common mental health problems and confidence to recognise and respond to various mental health scenarios. Investment in Mental Health First Aid and similar training for health students will support greater levels of mental wellbeing among health students not only during their training but also in their future careers so they are less likely to experience professional burnout.

3.2.1 Recommendation: Ensure all health students undertake mental health training during their degree to stimulate resilience to combat the challenges of being a health care professional.

PRIORITY 4: ENSURING MEDICARE LOCALS DELIVER FOR THE RURAL AND REMOTE HEALTH SECTOR

Medicare Locals have been assigned responsibility to support a greater integration and coordination of primary care across organisations and health disciplines. The Network is particularly hopeful of what these new entities could deliver in terms of better health outcomes for the rural and remote health sector, if implemented effectively and with appropriate scope to help fill service and workforce gaps.

In order to drive real reform in primary care particularly for rural Australia, the NRHSN would like to see Medicare Locals not only integrate primary care services, but have an active role in addressing broader rural primary health care needs. This we believe should include supporting the provision of appropriate health-related infrastructure in the regions as well as developing greater capacity within regional, rural and remote Australia to train and retain a sustainable health workforce.

In this section, the NRHSN will outline ways in which we feel extension of the Medicare Local role could help address the broader primary health care challenges including the need to develop and support a future health workforce for regional, rural and remote Australia.

1) ENSURE SCOPE TO ADDRESS LOCAL HEALTH INFRASTRUCTURE NEEDS

Adequate and appropriate health infrastructure is important to improve service delivery and to attract and retain a future health workforce. This is especially important in rural and remote areas.

Today's health students seek locations where they will be well supported to train and work in multidisciplinary teams, and in multi-professional practice. The Network would like to see opportunities pursued to ensure more rural communities are equipped with health facilities that will offer attractive and supportive training environments to the next generation of health professionals. The NRHSN identifies Medicare Locals as one such opportunity.

4.1.1 Recommendation: For Medicare Locals covering rural and remote areas to be given scope and appropriate funding to help identify local health infrastructure needs in terms of training the future health workforce and delivering improved health services in rural and remote communities.

2) ENSURE SCOPE TO ENHANCE RURAL AND REMOTE TRAINING OPPORTUNITIES

The NRHSN believes that more needs to be done to enhance the continuity of the pipeline for today's health students to pursue training and careers in the bush. Health student training is a key role of health services and the NRHSN believes that Medicare Locals should be encouraged to take on an extended role to encourage local and regional partnerships to enhance their regions' ability to support seamless pathways for training the next generation of health professionals.

The NRHSN would like to see Medicare Locals involved in encouraging partnerships and collaborations between health services, tertiary referral centres and training providers with regard to the provision of health workforce training. We believe this type of extended role will prove valuable in opening up the greater options and flexibility that will assist in the attraction and retention of rural health workers.

4.2.1 Recommendation: For Medicare Locals to support increased collaboration between specialty colleges, graduate program coordinators and rural communities regarding

infrastructure requirements so that more rural areas can better position themselves to take postgraduate medical trainees in specialties where a rural training program is already in place or being developed.

3) SUPPORT ALTERNATIVE EMPLOYMENT ARRANGEMENTS

To attract health graduates, rural health systems, particularly private practices, will need to provide employment arrangements where new graduates do not need to deal with the host of issues associated with the business side of medicine.

New health graduates today do not receive training in skills such as administration, management, staffing and other aspects of running a small business, and many are reluctant to make significant financial investments into a practice especially early in their career. Recent literature strongly suggests that new medical graduates wish to work either as an employee or in a practice model whereby business administration and management is undertaken by another person or entity²⁴. This trend is likely to be similar across the other health disciplines.

The NRHSN therefore believes that in their integrative and co-ordinating role, Medicare Locals should also be encouraged to identify and implement alternative work arrangements that will be attractive to the future health workforce.

4.3.1 *Recommendation: For Medicare Locals to be involved in identifying alternative employment arrangements such as health service managers and empowering local governments, community health centres and communities to take a greater role managing rural health practices.*

²⁴ Joyce et al (2007), "Riding the wave: current and emerging trends in graduates from Australian university medical schools", MJA Vol. 186, No. 6, pp 309-312

PRIORITY 5: REGIONAL DEVELOPMENT AND HEALTH INFRASTRUCTURE

The NRHSN identifies that an intersectoral approach is fundamental to closing the life expectancy gap between urban and rural Australia, and believes that regional development to help tackle the social determinants of health and the provision of relevant health infrastructure in regional, rural and remote communities must be key national priorities.

Regional development addresses social determinants that impact on the health and wellbeing of people in the bush. Economically healthy regions are more attractive destinations for a future health workforce to live and work. Given there are more health students studying across Australian universities than ever before, it is essential that regional, rural and remote communities are well equipped to support the training of a significant proportion of these soon-to-be health professionals such that these locations become better placed to attract a sustainable health workforce into the future. The call for Government to invest in such infrastructure is further strengthened by the significant opportunities it would present for rural origin students to train closer to home.

The NRHSN applauds the Governments commitment of more than \$46 million in funding over the 2008-2012 period to the National Rural and Remote Health Infrastructure Program (NRRHIP), aimed at improving access to health services, resources and facilities in rural and remote areas. The Network, however, believes that there is great potential for further infrastructure development to be targeted to improve the health status of rural and remote communities.

This section will outline key considerations with regard to regional development and health infrastructure which the Network sees as imperative to delivering better health outcomes for rural and remote Australia.

1) ENHANCE RURAL COMMUNITY INFRASTRUCTURE

Enhancement of community infrastructure in regional, rural and remote communities is vital to addressing the gross discrepancies in health outcomes observed with increasing remoteness. Not only will improvements to rural access to running water, appropriate sanitation and fresh foods support positive health outcomes, but communities with affordable well-maintained housing, quality schools, safe roads and sufficiently upgraded public transport will be better served to attract and retain future health professionals who want to work in locations which have adequate and quality infrastructure and services to meet their lifestyle and family needs. Where practical, the NRHSN also encourages development of infrastructure such as cycle-ways and footpaths for rural communities where not already present, to promote healthy lifestyles.

5.1.1 *Recommendation: For the Australian Government to implement an extension to the NRRHIP to ensure the establishment or maintenance of essential infrastructure in rural and remote communities that directly address the social determinants of health and strengthen the viability of rural communities into the future.*

2) IMPROVE RURAL ACCESS TO TECHNOLOGY

Reliable high speed broadband to homes and businesses represents critical infrastructure which must be made equitably accessible and affordable for people living in rural and remote Australian communities. Further to the economic growth, efficiency and social gains to rural and remote communities, such emerging technology has great potential to improve health outcomes for the people living there. From opening up greater opportunity for flexible and innovative models of health care, to supporting clinical decision making, to increasing the access of health professionals to

ongoing professional education and their peers, it is clear that reliable high speed broadband technology represents a major enabler for improving health in rural and remote communities.

Improved access clearly has a role in encouraging more health students to choose to work in these areas in the future. With technology playing such an integral role in the provision of education to health professionals in training, it is essential that rural and remote communities hosting students can provide equitable, affordable and reliable internet services comparable to those available in the city, so those based in these areas are not disadvantaged.

5.2.1 Recommendation: For Government to review the nature, quality and affordability of information technology and connectivity available in rural communities, and to support the relevant technology and its potential to improve the health outcomes of rural and remote residents. This includes methods for clinical decision making and continued professional development.

3) SUPPORT RURAL HEALTHCARE SETTINGS TO DEVELOP APPROPRIATE CAPACITY TO TRAIN STUDENTS IN TWO TIERS

Capacity needs to be built to enable regional and rural centres to accommodate different length and tiered placements during health student training. The NRHSN recommends that all health degrees include a rural health curriculum which provides rural/remote exposure in two tiers. Firstly, an early (first or second year) rural placement to facilitate the breakdown of stigmas associated with rural practice. Secondly, a longer term rural placement which affords interested students the opportunity to become integral members in a rural community. It is essential that rural health services have an understanding of the type of placements it wishes to support when designing clinical training infrastructure.

Infrastructure to support longer rural student placements should build on successful models such as University Departments of Rural Health (UDRH) and Rural Clinical Schools (RCS). Given many UDRH and RCS placements are becoming oversubscribed and some regions lack a connection with a UDRH, the NRHSN sees opportunity for expansion of the UDRH and RCS programs.

5.3.1 Recommendation: Increase the number of short and long health student placements available through both the establishment of new sites and the extension of existing sites within the UDRH and RCS programs. Increases must be accompanied by a proportional increase in funding to enable the program to service more students and more sites.

4) ENSURE PROVISION OF ADEQUATE ACCOMMODATION AND EDUCATIONAL RESOURCES AT RURAL TRAINING SITES

It is essential that health services in rural and remote communities which currently or are looking to accommodate health students during their training are equipped with the necessary infrastructure to ensure students have access to a quality, well-supported educational experience. Students training in such areas will need access tutorials, lectures and other learning opportunities just like their city counterparts. In ensuring that more of these young professionals in training are attracted to these areas in the future, it is vital that the infrastructure is there to support them so they do not feel educationally-disadvantaged on their placements.

5.4.1 Recommendation: For rural and remote health settings to be supported to provide secure computing facilities with fast, reliable broadband internet access, and quality IT and videoconferencing facilities to interact with tertiary education institutions.

- 5.4.2 *Recommendation: For accommodation to be provided for all health students undertaking rural placements free of charge or at a minimal/subsidised cost. Ensure accommodation is close to the hospital or practice location.*

5) INTER-PROFESSIONAL EDUCATION AND CO-PLACEMENTS

There is significant interest in interprofessional education as a method for training and preparing current health students for future practice, as well as creating a broader support network for health students during their placement in rural areas. Programs overseas and pilot programs in Australia demonstrate that interprofessional education can successfully educate students^{25,26}. It is important that any new development of health infrastructure in rural communities considers this trend and how the local accommodation, educational infrastructure, teaching spaces, and resources can be designed and shared in such a way to promote interaction and interdisciplinary collegiality among students across the medical, nursing and allied health disciplines that are placed in the same community in the same period, further, increase potential for cost-savings across the board. Interprofessional education should be encouraged across institutions including universities, TAFE and other organisations which train health workers.

- 5.5.1 *Recommendation: Create a national inter-professional learning (IPL) policy to drive institutional change within educational institutions for IPL to become a larger part of the training of health professionals.*

- 5.5.2 *Recommendation: Promote greater collaboration between health services and institutions involved in placing medical, nursing and allied health students and graduates to improve student access to infrastructure supporting interdisciplinary learning. This should be encouraged when applying for rural health infrastructure grants.*

²⁵ Shannon CK et al (2005), "Evaluation of a required statewide interdisciplinary rural health education program: student attitudes, career intents and perceived quality", Rural and Remote Health 5:405

²⁶ McNair R et al (2005), "Australian evidence for interprofessional education contributing to effective teamwork preparation and interest in rural practice", Journal of Interprofessional Care 19(6)