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Till Bärnighausen and David E. Bloom

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Designing financial-incentive programmes for return of medical service in underserved areas: seven management functions

Till Bärnighausen¹ and David E. Bloom²

¹ Africa Centre for Health and Population Studies, University of KwaZulu-Natal

² Harvard School of Public Health, Harvard University

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Corresponding author:

Prof. David E. Bloom, PhD
Department of Global Health and Population
Harvard School of Public Health
665 Huntington Avenue
Boston, Massachusetts 02115, USA
E-mail: dbloom@hsph.harvard.edu

Abstract

In many countries worldwide health worker shortages are one of the main constraints in achieving population health goals. Financial-incentive programmes for return of service, whereby participants receive payments in return for a commitment to practice for a period of time in a medically underserved area, can alleviate local and regional health worker shortages through a number of mechanisms. First, they can redirect the flow of those health workers who would have been educated without financial incentives from well-served to underserved areas. Second, they can add health workers to the pool of workers who would have been educated without financial incentives and place them in underserved areas. Third, financial-incentive programmes may improve the retention in underserved areas of those health workers who participate in a programme, but who would have worked in an underserved area without any financial incentives. Fourth, the programmes may increase the retention of all health workers in underserved areas by reducing the strength of some of the reasons why health workers leave such areas, including social isolation, lack of contact with colleagues, lack of support from medical specialists, and heavy workload.

We draw on studies of financial-incentive programmes and other initiatives with similar objectives to discuss seven management functions that are essential for the long-term success of financial-incentive programmes: financing (programmes may benefit from innovative donor financing schemes, such as endowment funds, international financing facilities, or compensation payments), promotion (programmes should utilize tested communication channels in order to reach secondary school graduates and health

workers), selection (programmes may use selection criteria to ensure programme success and to achieve supplementary policy goals), placement (programmes may use matching of participants to areas to ensure programme success), support (programmes should prepare participants for the time in an underserved area, stay in close contact with participants throughout the different phases of enrolment, and help participants by assigning them mentors, establishing peer support systems, or financing education courses relevant to work in underserved areas), enforcement (programmes may utilize community-based monitoring or outsource enforcement to existing institutions), and evaluation (in order to broaden the evidence on the effectiveness of financial incentives in increasing the health workforce in underserved areas, programmes in developing countries should evaluate their performance).

In comparison to other interventions to increase the supply of health workers to medically underserved areas, financial-incentive programmes have advantages – unlike initiatives using non-financial incentives, they establish legally enforceable commitments to work in underserved areas and, unlike compulsory service policies, they will not be opposed by health workers – as well as disadvantages – unlike initiatives using non-financial incentives, they may not improve the working and living conditions in underserved areas (which are important determinants of health workers' long-term retention) and, unlike compulsory service policies, they cannot guarantee that they will supply health workers to underserved areas who would not have worked in such areas without financial incentives. Financial incentives, non-financial incentives, and compulsory service are not mutually exclusive and may positively affect each other.

Review

Background

In many countries, one of the main constraints in achieving population health goals is the lack of health workers. The 2004 Joint Learning Initiative (JLI) for 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], and 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].

Interventions to alleviate health worker shortages in medically underserved areas¹ include selective recruitment of those individuals into health care education who are (given observable characteristics) most likely to remain in such areas, training specifically for practice in underserved areas, improvements in working or living conditions, compulsion or incentives to serve in specific areas (compare [3]). The topic of the present article is financial incentives for return of medical service in underserved areas: A health worker

¹ A medically underserved area is an area where the number of health workers falls below a target. There are many different methods to determine health worker targets, including methods based on need (i.e., the number of health workers necessary to achieve certain population health goals), demand (i.e., the number of health workers sufficient to supply the health services demanded by patients), or supply (i.e., the number of health workers sufficient to staff existing health care facilities). Commonly, a mix of need, demand and supply criteria is used in the definition of underserved area – see below for examples of definitions that have been used by financial-incentive programs. In this article, we use the term “medically underserved area” to denote any area that has been identified as a placement site for health workers enrolled in financial-incentive programs, independent of the particular definition used.

enters into a contract to practice for a number of years in an underserved area in exchange for a financial pay-off.

Table 1 shows the characteristics of five different types of financial-incentive programmes that have been described in the literature [4-6]: service-requiring scholarships (“conditional scholarships”) (e.g., [7-9]), educational loans with service requirement (e.g., [10]), service-option educational loans (e.g., [11]), loan repayment programmes (e.g., [12]), and direct financial incentives (e.g., [13]). These programme types differ according to the time a (future) health worker commits to participation (before, during, or after completion of health care education), the time when participants receive monetary payments (during or after completion of health care education), spending restrictions on the received payments (for educational purposes only or for any purpose), and the type of obligation (service and/or financial repayment).²

All five types of financial-incentive programmes can potentially serve to increase the numbers of health workers in underserved areas through four mechanisms. First, they may increase the supply of those health workers who would have been educated without financial incentive in underserved areas by decreasing the supply in well-served areas.

For instance they may decrease the net emigration flows of nurses and physicians from the developing world to developed countries [14-16]. This first mechanism can take hold

² All service-option educational loan programmes offer a choice between service and repayment of the financial incentive. The other four types of programmes commonly offer a “buy-out” option. Service-requiring scholarships with a buy-out option are similar to service-option education loans. However, while programme managers of service-option loans would normally consider repayment and service equally desirable outcomes, managers of service-requiring scholarships would normally prefer service over buy-out. This difference manifests itself in the fact that given equal financial incentives, a buy-out is commonly more expensive than the financial repayment of an educational loan.

if there are health workers who normally would not work in underserved areas, but who are willing to do so in return for a financial incentive. Second, they may add health workers to the pool of workers who would have been educated without financial incentives and place them in underserved areas. This second mechanism can take hold if there are qualified candidates who normally would not have the means to finance a health care education, but who can afford to do so, if they receive financial incentives, and if a country's health care education system can absorb additional students. Third, financial-incentive programmes may improve the retention in underserved areas of those health workers who participate in a programme, but who would have worked in an underserved area without any financial incentives (for instance, because the contractual obligation of the programmes is longer than the average time health workers would have remained in an underserved area without financial incentive). Fourth, programmes may increase the retention of all health workers in underserved areas by improving the supply of health workers to underserved areas and thus reducing the strength of some of the reasons why health workers leave such areas, e.g., social isolation [17], lack of contact with colleagues [18], lack of support from medical specialists [19], or heavy workload [17, 18, 20]).

We have previously shown that a specific type of financial-incentive programme, scholarships in return for a commitment to deliver antiretroviral treatment in SSA, is highly cost-beneficial under a wide range of assumptions [21]. In a recent systematic review, we identified 42 studies evaluating financial incentive programmes for return of service [22]. With the exception of one study from rural South Africa [7], all of the reviewed studies evaluate programmes in developed countries (33 studies took place in

the US, five in Japan, two in Canada, and one New Zealand). While financial-incentive programmes in other countries have not been evaluated in published studies, they have nevertheless been used, for instance in Swaziland [23], Ghana [24], and Mexico [25]. Table A1 in the appendix shows an overview of studies of financial-incentive programme *results* (i.e., descriptions of outcomes among programme participants without comparison to outcomes among non-participants), programme *effects* (i.e., analysis of programme effectiveness at the individual-level through comparison of outcomes among participants and non-participants), and programme *impacts* (i.e., analysis of programme effectiveness at the population level, such as changes in physicians density or population mortality) [22]. The table describes the type of study, the type of outcome observed in the study, and the main study findings. Overall, the existing evidence suggests that financial-incentive programmes can be effective in increasing the supply of health workers³ to underserved areas. Programmes recruit substantial proportions of participants to underserved areas (the random-effects estimate of the pooled recruitment proportion across the studies in our review was 71% (95% confidence interval 60-80%)) [22]. In addition, a number of studies have found that programme participants are more likely than health workers who do not participate in a financial-incentive programme to remain in underserved areas in the long run [27-30].

³ The majority of published studies on financial-incentive programs examine programs for doctors [22]. However, a number of articles investigate programs that enrol other health professionals in addition to doctors, such as nurses, pharmacists, or dentists [7, 11, 26]. As these programs demonstrate, many aspects of the operations of a financial-incentive program are not specific to one type of health worker. In most instances in this article, we thus use the general term “health workers” rather than the name of any specific category of health worker.

Financial-incentive programmes may be an attractive intervention to increase the supply of health workers to medically underserved areas for a number of reasons. First, they can subsidize the education of poor students, thus potentially increasing equity of access to higher education. Second, unlike many of the other strategies to attract health workers to underserved areas (such as selective recruitment and training or improvements in working and living conditions [3]), they establish legally enforceable commitments to work in underserved areas and should thus more reliably increase the size of the health workforce in underserved areas. Third, unlike compulsory service policies, they will not be opposed by health workers.

However, financial-incentive programmes are not easy to implement [11, 24, 31, 32]. In this article, we discuss seven management functions that are essential for the long-term success of financial-incentive programmes (Figure 1). First, programmes need a sustainable source of financing to pay for the financial incentives and programme administration (financing). Next, programmes need to promote their offers in order to attract candidates for participation (promotion), select participants out of the pool of candidates (selection), and place the selected participants in medically underserved areas (placement). Finally, programmes should support the participants during all phases of enrolment (support), enforce the service obligations (enforcement), and evaluate whether programme objectives are achieved (evaluation).

In the following, we describe insights from published studies regarding how these seven management functions can be performed. We draw not only on studies of financial-

incentive programmes, but also on initiatives whose objectives or functions partially overlap with those of financial-incentive programmes. For instance, educational-loan programmes share with financial-incentive programmes the objective to recruit participants to receive financial support for education and the management functions of financing, promotion, selection, support, enforcement, and evaluation; and compulsory service policies share with financial-incentive programmes the objective to increase the supply of qualified workers to certain communities and the management functions of placement, support, enforcement, and evaluation.

The seven management functions

First function: financing

Four of the five types of financial-incentive programmes shown in Table 1 necessarily require ongoing external financing, while one type (educational loans with service requirement) could theoretically finance itself in the long term if the total amount of money repaid in a period of time equalled at least the total amount required to finance the new incentives given out over the same period of time plus the programme's administration costs. Such a steady state of revolving refinance, however, will take a long time to achieve because student loans will only start to be repaid after many years of initial investment [33]. Moreover, both in developed and in developing countries existing student loan programmes usually require financial injections even in the long term, because losses due to unemployment, default, illness, or refusal to repay are usually not priced into the repayment amounts. If they were, such programmes would not be an attractive option for education finance for many eligible students and would increase the

rate of repayment refusal among those students who do take out an educational loan [34]. While substantial long-term finance is thus required for the incentive programmes, in many developing countries public finance for such programmes may not be available because governments commonly receive only limited tax revenues, face borrowing constraints, or may not be able to increase the proportion of public finance allocated to spending on education for political reasons [35].

An alternative is to finance the incentive programmes through aid from donors. However, traditional donor financing may not be well-suited for this purpose, which may explain why large international donors have not yet supported financial-incentive programmes. For one, donors tend to finance projects for periods that may not be sufficiently long to create sustainable programmes and they may be reluctant to provide “running cost” support for training health workers [35]. The latter problem is highlighted by recent discussions about whether large disease-specific aid agencies, e.g., PEPFAR, the Global Fund to Fight AIDS, Tuberculosis and Malaria, and the GAVI Alliance, should invest in human resources for health in developing countries [1, 36-38]. In addition, countries which cannot achieve an intended increase in the rate of health worker education through financial-incentive programmes because of limited education capacity may need substantial start-up financing to build educational institutions and to educate health care teachers.⁴ The relatively constant flows of traditional donor financing may not allow substantial initial investment with lower rates of continuing finance.

⁴ In particular situations, countries may be able to increase education rates of health workers through financial-incentive programs without large start-up investment in additional health care education capacity. For instance, some countries in sub-Saharan Africa, such as Botswana, Lesotho, and Swaziland, fund their citizens’ health care education in other countries, if the prospective health workers commit to service in

Recent innovation in donor funding may address both shortcomings. On the one hand, donor-financed endowment funds [42] can provide steady long-term money flows well-suited to fund scholarships, loans and salary support. On the other hand, organizations such as the International Finance Facility for Immunisation (IFFIm) [43] can leverage development aid by issuing bonds on international capital markets against long-term commitments of annual payments from donor nations in order to "frontload" aid, allowing immediate large-scale investments (such as in education infrastructure) [44].

Another financing option would be compensation payments from countries receiving health workers to those countries losing them. It has been argued that developed countries that recruit health workers from African countries with severe health worker shortages have an ethical obligation to compensate the governments of these countries for the loss [45]. While there may be a number of practical problems in implementing compensation payments – for instance, the 2005 *Report of the Global Commission on International Migration* [46] points out that migrating professionals commonly work in more than one country, in which case it is unclear which country is responsible for the payments – financial-incentive programmes seem an especially fitting purpose on which

their home countries after graduation. This strategy, however, may only be feasible for countries with relatively small population sizes and good relationships with countries that have unused health care education capacity. Moreover, the strategy carries the danger that health care workers educated abroad will not return to their country of origin [39]. Financial-incentive programs could also be used to motivate health workers from relatively well-served countries to practice in relatively underserved countries [40]. In this case, underserved countries would benefit from education capacity in well-served countries. Such use of financial incentive programs could make important contributions to health care in many regions of the world [41]. For countries as a whole, however, such incentivized migration is unlikely to be a sufficient or sustainable solution.

to spend such payments because they would contribute to decreasing similar losses in the future.

Second function: promotion

The pool of potential candidates to apply for participation in a financial-incentive programme depends on the start of the programme relative to the stage of health care education (Table 1). In the case of service-requiring scholarships, educational loans with service requirement and service-option loans, potential candidates will be the secondary school graduates who are qualified to pursue a health care education [35]. In the case of loan repayments and direct financial incentives, it will be fully qualified health care professionals who are eligible for participation. The ratio of potential to de-facto applicants will depend on the knowledge of the programme among eligible people as well as the attractiveness of the programme conditions. There is little published evidence about how secondary school students attain knowledge of tertiary education, including financing options [47-50]. However, a range of communication channels have been successfully used to increase students' knowledge of behaviours to reduce health risks [51]. They include classroom or group sessions led by teachers [52, 53] or peers [54, 55], or printed material [56]. As post-graduate students and health care professionals commonly use the internet [57-61] and e-mail [62-64] to access and exchange medical information, financial-incentive programmes for fully qualified health workers may be successfully promoted through advertisements on websites or through e-mail campaigns.

Third function: selection

Selection of programme participants among all candidates who apply for a place in a financial-incentive programme can contribute to achieving the main objective of the programme, i.e., to increase the supply health workers to medically underserved areas, as well as supplementary policy goals. One strategy to maximize the effectiveness of the programme in increasing the supply of health workers to underserved areas is to select candidates based on characteristics that have been observed to be associated with a low probability of defaulting on the service obligation and a high probability of remaining in an underserved area after completion of the obligation. There is evidence from both developing countries [65-67] and developed countries [65, 68-72] that health care students from rural background are more likely to choose rural practice than their peers from urban areas. For instance, a 2003 study from South Africa found that ten years after graduating from medical school doctors of rural origin were 3.5 times more likely than doctors of urban origin to practice in rural areas [67]. In settings where the selected students would have attained a health care degree even if they had not received the financial incentive, it is difficult to judge whether selective recruitment does indeed maximize programme effectiveness [27]. The selected students might have taken up practice and remained in medically underserved areas, even if they had not received a financial incentive for return of service. However, in many developing countries, large proportions of students with characteristics associated with a high propensity to practice in medically underserved areas (such as poor rural students) will be unable to finance a health care education without financial support. In these countries, a selective recruitment strategy is likely to improve the effectiveness of financial-incentive

programmes in increasing the supply of health workers to underserved areas (compare [3]).

Policy makers can also use selection into a financial-incentive programme to achieve supplementary health care education goals. Financial equity in access to tertiary education could be improved if eligibility for the financial incentives were based on a means test [73]. Merit could be rewarded if eligibility were based on secondary school performance. The proportion of health care students from traditionally underrepresented population groups (e.g., women or underrepresented ethnicities) could be increased if these groups received a proportion of the incentives higher than their proportion in the eligible population.

Fourth function: placement

Placement of programme participants in particular underserved areas is likely to be an important determinant of programme success. Policy makers first need to decide on a definition or a process to decide which areas to designate as “medically underserved”. Some programmes in developed countries have used simple definitions of “medically underserved areas” (e.g., rural communities with populations of 5,000 or less [74] or towns or villages with populations of 2,500 or less [10]); while others have designated areas as underserved through committee consensus informed by a range of criteria (e.g., health worker-to-population ratios, demographic characteristics of the population, and population health [75, 76]). Once areas have been designated as “medically underserved”, individual programme participants need to be matched to specific

underserved areas. In order to maximize the social value of financial-incentive programmes, policy makers could consider placing participants preferentially in those underserved areas where unmet health care need is greatest, because the impact of a placement on population health in these areas is likely to be most significant. Without such a preferential placement policy, it is possible that the neediest population will benefit least from financial-incentive programmes. For instance, one study of the National Health Service Corps (NHSC), a national financial-incentive programme that has operated in the United States since 1972 [77], found that the poorer an underserved area and the worse its population health, the less likely it was to receive a physician who is obligated to work in an underserved area [78].

However, such a policy would strongly restrict participants' choice of placement area. As a result, participants may be less likely to be satisfied with their work and personal life during the obligated service, decreasing the chances of long-term retention in the placement 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 best-suited site among those offered" [32]. A study from South Africa found that physicians were dissatisfied with their compulsory community service placements *inter alia* because, they were forced to serve in a particular location and because their social lives were disrupted [79] – two problems that should be less likely to occur if programme participants were given the choice to serve in one of many underserved areas. A number of studies in the US have found that programme participants were significantly *less* likely to remain in the

same underserved area over time than health workers who worked in underserved areas but had not participated in any financial-incentive programme [12, 27, 32, 80]. However, several other studies in the US have found that participants in financial-incentive programmes are *more* likely to continue to practice in *some* underserved area [27, 32] or to provide care to an underserved population [28, 30, 32] than health workers who had chosen – without financial incentive – to start practicing in an underserved area at the same time that programme participants started serving their obligations. These findings can be explained as follows. Participants in financial-incentive programmes are more likely to practice in underserved areas in the long run than non-participants, including those health workers who initially choose to work in underserved areas without financial incentive. However, placement does not lead to optimal matches between participants and areas. In order to improve their satisfaction with their practice location, participants thus relocate from the placement area to another underserved area after having completed their service obligations.

Financial-incentive programmes aiming to attain high retention of obligated health workers in the placement area should attempt to accommodate health workers' wishes to practice in particular underserved areas as far as possible. Optimal placement could be achieved, for instance, by a matching process such as the one used for specialist training places in the US , whereby candidates and training institutions rank each other in order of declining preference and a computer algorithm implements explicit rules to identify the best assignment of candidates to institutions [81].

Fifth function: support

It is likely that the satisfaction of health workers with their participation in financial-incentive programmes will be important in determining whether they start and complete their service obligations and whether they remain in an underserved area in the long run [80]. Evidence from the US shows that participants' work and life satisfaction can vary substantially by programme type [12, 80]. Such differences across programmes can be due to a number of reasons. Different types of health workers may choose to participate in different programmes, and programmes may differ in how far they take participants' wishes into account in selecting placement areas (see above). However, programmes may also be able to influence participants' satisfaction before and during their time of service by offering support. For instance, the NHSC has developed "tools to prepare providers for underserved areas", which include learning modules on "personal and professional development", "cross cultural issues in primary care", "leading group discussions", and health care issues important in working with "disenfranchised populations" (such adolescent pregnancy, HIV/AIDS, child abuse, domestic violence, substance abuse) [82]. In addition, the NHSC has established a "recruitment, training and support center" which maintains contact with underserved areas, offers "guidance and support to NHSC scholars during the relocation process", and monitors participants during their service [83].

The Friends of Mosvold Scholarship Scheme (FOMSS), which provides scholarships to health care students from the rural Umkhanyakude district of South Africa in return for a commitment to work in the district after graduation [84], assigns each participant a

mentor. The mentor supports the participant during her studies: “Regular visits to the campuses supplemented by telephone calls by the main mentor made the students feel that he was there for them and that he cared. Struggling students were encouraged to analyse their situation using questions such as ‘What do you think is the problem?’ and ‘What have you done to find a solution?’. Wherever practicable, solutions were found quickly and included interventions such as the student (and sometimes the mentor) contacting a lecturer or head of department, finding better accommodation, or providing a computer for FOMSS students where university resources were inadequate, etc. [7]”.

As described for FOMSS, ongoing contact with participants enables managers of financial-incentive programmes to detect difficulties that health workers are facing and to intervene rapidly. In addition to assigning participants to mentors, programmes can ensure that they remain in close contact with participants through regular meetings with individual health workers, discussions with groups of participants, telephone hotlines [83], or frequent surveys of participant satisfaction [19, 85, 86]. Programmes can offer support by initiating peer group meetings [79], establishing peer-support systems, such as Balint groups [87], paying for education courses that teach skills relevant to health care in underserved areas [88], or funding equipment that participants need in their clinical work.

Sixth function: enforcement

Programme participants can default on their obligation in several different ways. In programmes without repayment or buy-out option, they can, firstly, refuse placement and service after having received the financial incentive and, secondly, comply with

placement but fail to perform the specific duties they are obliged to perform in the placement area. An example of the latter type of default is a physician who fails to fulfil her obligation to work in a public-sector hospital in the placement area and instead sees patients in private practice. While the first type of default is comparatively easy to detect (for instance, through spot checks or calls to local hospital administrators), the second type can be difficult to detect (for instance, if the health services administration in the placement area is weak). In programmes with a buy-out option, participants default if they neither fulfil their service obligation nor repay the financial incentive.

In order to ensure that participants fulfil their obligations, programmes must have a monitoring strategy in place to identify defaulters, as well as a strategy to deal with detected defaulters. Such strategies will depend on legal, institutional, and technological factors specific to a country. Experiences from educational-loan programmes in Africa suggest that rather than building up an infrastructure to monitor default on service or financial obligations themselves, financial-incentive programmes should outsource this function to existing institutions that already have the structures and experience to deal with contractual default, such as the tax system, the social security system, or banks [73].

An alternative to using such large existing systems to monitor participants is community-based monitoring approaches [89], including monitoring through local leaders, citizen report cards (“participatory surveys that provide quantitative feedback on user perceptions on the quality, adequacy and efficiency of public services”, i.e., the services of health workers participating in financial-incentive programmes [90]), or community

score cards (“qualitative monitoring tools that are used for local level monitoring and performance evaluation of services” [90]). Community-based monitoring may be preferable for relatively small local financial-incentive programmes.

Monitoring and punishment are reactive approaches to reduce default. Preventive strategies to decrease default rates include regulation, such as withholding diplomas or licenses from scholarship recipients until they have completed their service [35], requiring completion of the obligated service for specialist training [66], or restricting the visa eligibility of obligated health workers before completion of their service [15].

Seventh function: evaluation

A large number of descriptive case studies and cohort studies have evaluated financial-incentive programmes (Table A1) [22]. However, with one exception from South Africa [7], all of the published evaluations have taken place in developed countries. In order to improve the scope of the existing evidence, financial-incentive programmes in developing countries should collect quantitative and qualitative data on their experiences and outcomes and publish them.

While the evidence on the effects of financial-incentive programmes on recruitment and long-term retention in underserved areas is extensive, it has a number of limitations. For one, the evidence may not be generalizable to many of the countries that suffer from the most severe shortages of health workers in rural and remote areas, in particular sub-Saharan African countries. The majority of published evaluations of financial-incentive

programmes have taken place in the US (Table 1A). Only one article has examined a financial-incentive programme in a developing country (South Africa). The US health care education system, however, is unusual in comparison to many other countries in that students pay high tuition for their education. Within the US, it has been found that medical students' propensity to enrol in a financial-incentive programme increases with their debt burden [32]. Thus, it would seem plausible that in countries where health care education is subsidized to such an extent that students have to pay very little tuition, financial-incentive programmes could be substantially less attractive than in the US. However, in a number of countries with very low tuition for health care education, students nevertheless incur substantial expenses, for instance, for housing, meals, medical textbooks and equipment [91], requiring them to seek funding support, for instance, through a financial-incentive programme. Future studies should evaluate outcomes of financial-incentive programmes in developing countries, such as Swaziland [23], Ghana [24], and Mexico [25].

Another fundamental difference between the US and many of the developing countries that currently face severe health worker shortages is that the income differential between underserved and well-served areas is larger in the latter than in the former. Pathman and colleagues find that US physicians fulfilling a service commitment in underserved areas did not earn significantly less than physicians without such an obligation [32]. In contrast, in many developing countries health workers in private practice earn substantially more than their colleagues in the public sector, and opportunities for full- or part-time work in private practice may only exist in well-served urban areas and not in rural and remote areas where financial-incentive programmes offer positions. Insofar as

financial incentives simply compensate for income differentials between underserved and well-served areas, they are unlikely to be attractive. Salary mark-ups specifically for participants in financial-incentive programmes, on the other hand, may not be feasible because they would imply that participants earn more than non-participants working in underserved areas, which may be difficult to justify. Thus, in some developing countries, financial incentive programmes similar to the ones offered in the USA and other developed countries may not be successful, unless the incomes of all health workers in underserved areas are increased. An example of such a universal change in salary structures is the “rural allowance” in South Africa, which was added in 2004 to the salaries of public-sector health workers in rural areas [92]. In some countries, work in underserved areas would be financially more attractive if health workers were allowed to rotate between the public sector in underserved areas and the private sector in well-served areas.

Another limitation of the evidence is that it is exclusively based on observational studies, which do not allow to firmly establish causality in the relationship between programme participation and work in underserved areas. On the one hand, financial-incentive programme may place health workers in underserved areas who would never have worked in such areas. Further, financial-incentive programmes may expose participants who would have worked in underserved areas without any financial incentive to experiences, which they would not have had, had they not enrolled, and which increase their propensity to work in underserved areas in the long run. On the other hand, health workers choose to participate in financial-incentive programmes and it is difficult to rule

out the possibility that those workers who choose to participate would have practiced in underserved areas for exactly the same length of time (or even longer) without any financial incentive. In order to strengthen the evidence on the effects of financial-incentive programmes, researchers should conduct controlled experiments, wherever funders and policy makers are willing to support such studies.

Comparison of financial-incentive programmes to other interventions to increase the supply of health workers in underserved areas

Financial-incentive programmes are only one type of intervention to increase the supply of health workers in underserved areas. Two other types are compulsory service and non-financial incentives. In the following, we will briefly describe these two types of alternative interventions and then contrast them to financial-incentive programmes.

Compulsory service vs. financial-incentive programmes

Compulsory service policies require health workers (e.g., all doctors or all nurses) who are educated in a country to work for a period of time in an underserved area in that country. Such programmes have been established in many countries worldwide.

Beginning in the 1920s, the Soviet Union required all medical, dental, and nursing graduates to serve for three years in rural areas [93]. In 1936, Mexico started requiring six months of rural service as a condition for medical students to graduate from medical school. The six-month requirement was later extended to one year [94]. Other countries in Latin America followed with similar programmes, including Cuba (in 1960) [95], the Dominican Republic (in the 1960s) [96, 97], Ecuador (in 1970) [94], and Bolivia (in 1979) [94]. In Africa, Nigeria established a National Youth Service Corps in 1973,

which requires all graduates of tertiary education institutions, including health workers, to serve for one year in underserved areas [98]. Since 1998, all South African medical graduates have had to perform a one-year “compulsory community service” [79]. Compulsory service policies also exist in South Asia (e.g., in several states of India [99, 100]), the Middle East (e.g., Iraq [101]), and Europe (e.g., Greece [102]).

While compulsory service is used widely, the evidence on its performance is scarce. The 2007 US Council on Graduate Medical Education Report *New Paradigms for Physician Training for Improving Access to Health Care* comes to the conclusion that “[t]he impact of these [compulsory service] programmes had been difficult to assess, and there is a dearth of rigorous studies of their effectiveness and viability. It is clear from existing information that it is possible to create and sustain such programmes over a period of decades, although not necessarily with enthusiastic support of those required to serve” [95]. The evidence that does exist is mainly on the satisfaction of health workers with their compulsory service. An evaluation of the South African compulsory community service finds that 64% of the doctors felt that “they had developed professionally” during the service, but that their development had taken place mostly “in the area of gaining confidence and insight in themselves as practitioners, as opposed to formal learning of clinical skills from supervisors” [79]. Similarly, a study in Ecuador reports that 94% of health workers found “their [compulsory] year of rural service rewarding both personally and professionally” [94]. Many of the participants “commented on how much they learned about doctor-patient relations” and “[s]ome said they matured emotionally, learned the meaning of responsibility, and acquired greater self-confidence” [94].

Because very few empirical studies have been published on compulsory service, a comparison of the programmes to financial-incentive programmes has to be based on theoretical considerations. Table 2 outlines differences in the characteristics and possible effects between the two types of interventions. The main difference is of course that compulsory service policies force all health workers (in a particular category) to serve, while financial-incentive programmes enrol only those health workers who choose to participate. Thus, compulsory service policies (if they can be enforced) ensure that a substantial proportion of workers who – given the choice – would never have practiced in underserved areas do so for some period of time and that, at least in the short-term, such requirements will be effective in increasing the supply of health workers to underserved areas. In contrast, financial-incentive programmes cannot ensure that they will be effective in recruiting health workers to underserved areas who would not have chosen to do so without financial incentive.

Compulsion, however, implies a “loss of autonomy” and can create an “aversion”, which may lead to a number of negative consequences [95]. For one, the introduction of compulsory service may be difficult politically. For instance, in 2008, a strike of medical students and doctors forced the government of Kerala, India, to reduce the planned compulsory rural service for doctors from three years to one year [103, 104]. Further, it is possible that health workers who are forced to work in an underserved area for some period of time are less likely to voluntarily work in such an area and more likely to emigrate to another country in the long run.

Moreover, compulsory service may decrease the attractiveness of a health care education because it limits graduates' choices of where to work. As such, compulsory service could lead to fewer applicants to health care education institutions, which could reduce the total number of health workers educated per time (if the number of education places exceeds the number of qualified applicants) [35], or decrease the average quality of health care students (if education institutions lower entry requirements in order to fill their education places) [95]. In contrast, financial-incentive programmes could increase the total number of educated health workers and increase the proportion of students from poor backgrounds, if the financial incentives enable students who would otherwise not have been able to do so to pay for a health care education, and if a country's education system can absorb the additional students.

Non-financial incentives vs. financial incentives

Health workers are not only motivated by financial compensation, but also by other factors, such as altruism, the satisfaction of successfully applying their skills in caring for their patients, and recognition from their peers. For instance, a study in Benin and Kenya found in semi-structured interviews that nurses and doctors more commonly referred to "healing patients", "vocation", "professional satisfaction", and "recognition by supervisors" than to "remuneration", when asked what currently encourages them to do their work well [105]. A study in rural Vietnam found that "the main motivating factors for health workers were appreciation by managers, colleagues and the community, a stable job and income and training", while "them main discouraging factors were related

to low salaries and difficult working conditions” [106]. As such, non-financial factors should be expected to influence the supply of health workers in underserved areas. A WHO study found that while health workers in the public sector in Cameroon, Ghana, South Africa, Uganda, and Zimbabwe most commonly considered “salaries” as one of the “key issues ... that will motivate them to remain in the country” (between 68% and 85% of the respondents in the five countries), they also considered non-financial factors to be important in their migration decisions, for instance, the “working environment” (between 36% and 81%) and “opportunities for education and training” (between 29% and 67%) [107].

In addition to such work-related factors, living conditions are likely to be important in determining health workers’ decisions to move to and remain in underserved areas. In Ecuador, health workers fulfilling their compulsory service ranked transportation “highest as an adaptation problem, followed by, in descending order, communication, housing, food, and access to potable water and electrical power” [94]. In the US, physicians working in the Navajo Area Indian Health Services referred to “the poor local school system” and “marginal housing facilities” as reasons why they might leave their positions [108]. Rural doctors in Limpopo, a poor rural province of South Africa, provided a range of themes in response to the question about which interventions they thought would retain South African doctors in rural hospital service in the province, including financial incentives (“increasing salaries and rural allowances”), improvements in working conditions (such as “ensuring career progression”, “providing continuing medical education”, “improving the physical hospital infrastructure and rural referral

systems”, “ensuring the availability of essential medical equipment and medicines”, and “strengthening rural hospital management”), and improvements in living conditions (such as “improving rural hospital accommodation”, “providing recreational facilities”, and “assisting rural doctors’ families”) [19].

Work-related factors that affect health workers’ location choices can potentially be influenced through investment in health care facilities, medical equipment and workplace safety [35], as well as through a range of management interventions [109, 110], such as training of supervisors [35], “quality improvement teams”, “team building”, “participatory problem assessments and problem-solving processes”, and “development of career development plans” [105]. Living conditions can be improved through investment in infrastructure in underserved areas, such as roads, electricity, telecommunication, water, sanitation and housing. However, only a few countries (such as Thailand [111] and Zambia [112]) have implemented interventions to improve health workers’ working or living conditions in underserved areas, and evidence on their effectiveness in increasing the supply of health workers in those areas is largely lacking [3, 113].

In thinking about alternative interventions to increase the supply of health workers in underserved areas, governments and donors should bear in mind that such interventions are usually not mutually exclusive. For instance, in South Africa the national compulsory community service [79] operates alongside national [92] and local [7] financial-incentive programmes. Non-financial incentives improving health workers’ satisfaction with their

professional and personal lives could be important in improving long-term retention of health workers in areas to which they were originally attracted by a financial incentive [22]. Zambia established a “Health Workers Retention Scheme” to improve the supply of doctors to “rural and underserved parts of Zambia”. The scheme provides a financial incentive (a “rural hardship allowance”) and several non-financial incentives, including guaranteed eligibility for post-graduate training after three years of service and investment to improve housing for health workers in underserved areas [112].

Policy makers should further consider that on the continuum from incentive to compulsion there are intermediate forms of interventions, which may be the best choices in particular situations. For instance, in some countries practice in underserved area is not compulsory but necessary or desirable for acceptance into specialist training programmes [114]. Incentives, on the other hand, can come in the form of cash payments to the health worker, earmarked allowances for housing or schooling, fringe benefits (such as old-age pension or health insurance), and improvements in living and working conditions in underserved areas [35].

Conclusion

Financial-incentive programmes for return of medical service in underserved areas have been used in both developed and developing countries. Seven management functions are essential for the long-term success of such programmes: financing (programmes may benefit from innovative donor financing schemes, such endowment funds, international financing facilities, or compensation payments), promotion (programmes should utilize

tested communication channels in order to reach secondary school graduates and health workers), selection (programmes may use selection criteria to ensure programme success and to achieve supplementary policy goals), placement (programmes may use matching of participants to areas to ensure programme success), support (programmes should prepare participants for their time in an underserved area, stay in close contact with participants throughout the different phases of enrolment, and help participants by assigning them mentors, establishing peer support systems, or financing education courses relevant to their work in underserved areas), enforcement (programmes may utilize community-based monitoring or outsource enforcement to existing institutions), and evaluation (in order to improve the evidence on the effectiveness of financial incentives in increasing the health workforce in underserved areas, programmes in developing countries should evaluate their performance).

Financial-incentive programmes have a number of advantages and disadvantages in comparison to other interventions to increase the supply of health workers to medically underserved areas. Unlike non-financial incentives, they establish legally enforceable commitments to work in underserved areas; however, they may not improve the working or living conditions in underserved areas, which are important determinants of health workers' long-term retention in those areas. Unlike compulsory service policies, they will not be opposed by health workers; however, they cannot guarantee that they supply health workers to underserved areas who would not have worked in such areas without financial incentives. Financial incentives, non-financial incentives, and compulsory

service are not mutually exclusive and may positively affect the performance of each other.

Competing interests

We have no competing interests.

Authors' contributions

Till Bärnighausen and David E. Bloom jointly conceived the study and contributed equally to the analyses and the drafting and revising of the manuscript. Both authors have approved the final version of the manuscript.

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Tables and figures

Table 1: Types of financial-incentive for return of service programmes

Type of programme	Time of commitment	Time of money receipt	Spending restrictions	Type of obligation
Service-requiring scholarships (“conditional scholarships”)	Before the start of health care education or early in the course of health care education	During health care education	Money can only be used for health care education	Service*
Educational loans with service requirement	Before the start of health care education or early in the course of health care education	During health care education	Money can only be used for health care education	Service and financial repayment*
Service-option educational loans	Before the start of health care education or early in the course of health care education	During health care education	Money can only be used for health care education	Service or financial repayment
Loan repayment programmes	After completion of health care education	After completion of health care education, during committed service	Money can only be used to pay back educational debt	Service*
Direct financial incentives	After completion of health care education	After completion of health care education, during committed service	Money can be used for any purpose	Service*

*Programme may have a buy-out option.

Table 2: Comparison of financial-incentive programmes to compulsory service

	Financial-incentive programmes	Compulsory service
Enrolment	Self-selected	Universal
Compulsion	No	Yes
Length of service	Commonly >3 years	Commonly 1-3 years
Effect on equity of access to tertiary education	Improvement possible	None
Effect on total number of health workers	Increase possible	Decrease possible
Effect on composition of health worker population	Increase in proportion of health workers from poor backgrounds possible	Increase in proportion of lower-quality health workers possible

Figure 1: Management functions of financial-incentive programmes



	Financing	Promotion	Selection	Placement	Support	Enforcement	Evaluation
Definition	<ul style="list-style-type: none"> • Source of financing to pay for financial incentives and programme administration 	<ul style="list-style-type: none"> • Promotion of programmes to attract candidates for participation 	<ul style="list-style-type: none"> • Selection of participants out of the pool of candidates 	<ul style="list-style-type: none"> • Placement of participants in medically underserved areas 	<ul style="list-style-type: none"> • Ongoing contact with participants and support during all stages of enrolment 	<ul style="list-style-type: none"> • Monitoring and enforcement of contract fulfilment 	<ul style="list-style-type: none"> • Evaluation of programme performance
Literature source	<ul style="list-style-type: none"> • Donor-financed endowment funds 	<ul style="list-style-type: none"> • Health risk reduction programmes 	<ul style="list-style-type: none"> • Selective recruitment for health care education 	<ul style="list-style-type: none"> • Compulsory service 	<ul style="list-style-type: none"> • Financial-incentive programmes in developed countries 	<ul style="list-style-type: none"> • Educational loans 	<ul style="list-style-type: none"> • Financial-incentive programmes in developed countries

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Appendix

Table A1: Overview of evidence on financial-incentive programmes for return of medical service

Study	Programme	Country	Type of study	Type of outcome	Conclusions
Fitz et al. 1977 [74]	Commonwealth Fund Medical Under-graduate Scholarship Program	USA	Description of programme outcomes	<i>Programme results</i> Recruitment Retention	54% of all participants fulfilled their service obligation and 4% repaid the financial incentive. 51% of all participants practiced in small communities for most of their working lives.
Mason 1971 [11]	State scholarship and educational loan programmes	USA	Description of programme outcomes	<i>Programme results</i> Recruitment Retention	60% of participants fulfilled their obligation to practice in an underserved area, 37% repaid the financial incentive. Across programmes, between 50% and 90% of participants remained in rural communities after having fulfilled their obligation.
Bradbury 1963 [10]	Carolina Rural Loan Program	USA	Description of programme outcomes	<i>Program results</i> Recruitment Retention Participant satisfaction	75% of participants fulfilled their obligation to practice in an underserved area. 71% of participants in the financial-incentive programme were satisfied with their overall experience.
Navin and Nichols 1977 [31]	Arizona Medical Student Exchange Program	USA	Description of programme outcomes Time series	<i>Programme results</i> Recruitment Retention <i>Programme impact</i> Health system	59% of participants fulfilled their obligation to practice in an underserved area, while 37% of participants repaid the financial incentive 85% of participants who fulfilled their obligation remained in Arizona. The programme did not succeed in increasing the medical student population density in Arizona.

Study	Programme	Country	Type of study	Type of outcome	Conclusions
Bass and Copeman 1975 [75]	Ontario Under-served Area Program	USA	Description of programme outcomes Time series	<i>Programme results</i> Recruitment Retention <i>Programme impact</i> Health system	53% of participants fulfilled their obligation to practice in an underserved area, while 47% repaid the financial incentive. 74% of participants who fulfilled their obligation remained at the original placement location. The programme was effective in increasing the number of physicians practicing in small communities in northern Ontario.
Anderson and Rosenberg 1990 [13]	Ontario Under-served Area Program	USA	Before-after comparison	<i>Programme impact</i> Health system	Increase in supply of physicians to underserved areas cannot be attributed to the programme.
Inoue et al. 1997 [115]	Jichi Medical University	Japan	Description of programme outcomes	<i>Programme results</i> Recruitment Retention	96% of all participants fulfilled their obligation to practice in an underserved area, while 4% repaid the financial incentive. 67% of participants remained in the prefecture of original placement after having fulfilled their obligation.
Inoue et al. 2007 [116]	Jichi Medical University	Japan	Description of programme outcomes	<i>Programme result</i> Recruitment <i>Programme effect</i> Provision of care	98% of participants fulfilled their obligation to practice in an underserved area. Participants were more likely than non-participants to practice in a rural area.
Matsumoto et al. 2008a [9]	Jichi Medical University	Japan	Retrospective cohort study	<i>Programme effect</i> Provision of care	After having fulfilled their obligation to practice in an underserved area, participants were about four times more likely to work in rural areas than non-participants.
Matsumoto et al. 2008b [117]	Jichi Medical University	Japan	Retrospective cohort study	<i>Programme results</i> Retention	21% of participants of rural background, and only 12% of participants of urban background, remained in a rural area after having fulfilled their service obligation.
Matsumoto et al. 2008c [118]	Jichi Medical University	Japan	Description of programme outcomes	<i>Programme results</i> Recruitment Retention	95% of participants fulfilled their obligation to practice in an underserved area. Of all participants who had fulfilled their obligation at least 6 years ago 70% remained in the prefecture of original placement.

Study	Programme	Country	Type of study	Type of outcome	Conclusions
Woolf et al. 1981 [78]	National Health Service Corps	USA	Comparison of characteristics of underserved areas with and without programme participants Discriminant analysis	<i>Programme impact</i> Health system	Underserved communities that had less resources and higher need for health care were less likely to receive programme participants than underserved communities that were better-off.
Stamps and Kuriger 1983 [119]	National Health Service Corps	USA	Descriptive study	<i>Programme result</i> Retention	56% of the participants who were currently fulfilling their obligation intended to practice in a rural area after fulfilling their obligation.
Stone et al. 1991 [120] and Brown et al. 1990 [121]	National Health Service Corps	USA	Descriptive study	<i>Programme results</i> Retention Participant satisfaction Family satisfaction	67% of participants who were currently fulfilling their practice obligation intended to remain in their placement site after fulfilling the obligation. Reasons for intending to leave the placement site included dissatisfaction with the community, the salary, and the workload, as well as unmet needs of family members.
Pathman et al. 1992 [122]	National Health Service Corps	USA	Retrospective cohort study	<i>Programme effect</i> Retention	Participants were about twice as likely to leave their practice of original placement and about 50% more likely to leave rural practice than non-participants.
Pathman et al. 1994a [123]	National Health Service Corps	USA	Retrospective cohort study	<i>Programme effects</i> Retention	Participants were about half as likely to remain in a non-metropolitan area and about three times less likely to remain in the same practice than non-participants.
Pathman et al. 1994b [80]	National Health Service Corps	USA	Retrospective cohort study	<i>Programme result</i> Participant satisfaction <i>Programme effects</i> Retention Participant satisfaction	Five years after starting work at a practice site, participants were less than half as likely as non-participants to have remained at the site. Participants were less satisfied with their work and personal lives in the underserved area than non-participants.

Study	Programme	Country	Type of study	Type of outcome	Conclusions
Pathman and Konrad 1996 [124]	National Health Service Corps	USA	Retrospective cohort study	<i>Programme results</i> Retention Participant satisfaction Family satisfaction	Minority and non-minority participants did not differ in their retention in the practice of original placement after having fulfilled their service obligation. Minority physicians reported lower satisfaction with their work and personal lives in the underserved area (for themselves and their families) than non-minority physicians.
Rosenblatt et al. 1996 [125]	National Health Service Corps	USA	Description of programme outcomes	<i>Programme results</i> Retention Participant satisfaction	Six years after having fulfilled their practice obligation 25% of participants continued to practice in the county of original placement, while 27% had left the original placement site to practice in another rural county. 33% of participants rated their experience in the programme as “positive”.
Cullen et al. 1997 [126]	National Health Service Corps	USA	Description of programme outcomes	<i>Programme result</i> Retention	8-10 years after having graduated from medical school, 20% of the participants remained in the county of their original placement, while 40% remained in a rural county. 11-13 years after graduation these proportions had fallen to 17% and 36%, respectively. 14-16 years after graduation they had fallen to 13% and 35%.
Xu et al. 1997a [127]	National Health Service Corps	USA	Retrospective cohort study	<i>Programme effect</i> Provision of care	Participants were significantly more likely to practice in an underserved area ten years after graduating from medical school than non-participants.
Xu et al. 1997b [128]	National Health Service Corps	USA	Retrospective cohort study	<i>Programme effect</i> Provision of care	30% of participants’ patients, but only 19% of non-participants’ patients, were either considered poor or had Medicaid as their primary insurance.
Singer et al. 1998 [129]	National Health Service Corps	USA	Retrospective cohort study	<i>Programme effect</i> Retention	After five years of work in a community health centre, 36% of participants, but only 17% of non-participants, still worked in the same centre.
Rabinowitz et al. 2000 [30]	National Health Service Corps	USA	Retrospective cohort study	<i>Programme effect</i> Provision of care	“Participation in the NHSC is the only experiential factor related to caring for the underserved”.

Study	Programme	Country	Type of study	Type of outcome	Conclusions
Mofidi et al. 2002 [26]	National Health Service Corps	USA	Description of programme outcomes	<i>Programme result</i> Retention	47% of participants continued to provide care to the underserved after their obligated service.
Brooks et al. 2003 [130]	National Health Service Corps	USA	Retrospective cohort study	<i>Programme effect</i> Provision of care	13% of rural primary care physicians, but only 3% of suburban and 3% of urban primary care physicians, had participated in the programme.
Porterfield et al. 2003 [131]	National Health Service Corps	USA	Descriptive study	<i>Programme result</i> Retention	7 to 17 years after starting to fulfil their practice obligation, 53% of the participants still worked in an underserved area.
Probst et al. 2003 [28]	National Health Service Corps	USA	Retrospective cohort study	<i>Programme effect</i> Provision of care	28% of the patients discharged by programme alumni were Medicaid patients, while only 19% of the patients discharged by non-alumni were Medicaid patients.
Holmes 2004 [27]	National Health Service Corps	USA	Retrospective cohort study	<i>Programme effects</i> Provision of care Retention	Participants were less likely to remain in their first practice location than non-participants. Participants were more likely to serve in any underserved area than non-participants.
Pathman et al. 2005 [132]	National Health Service Corps	USA	Pre-post comparison	<i>Programme impact</i> Health	The programme may have contributed to improvements in age-adjusted mortality rates in underserved communities, in particular in communities that received programme participants for more than 11 years.
Holmes 2005 [133]	National Health Service Corps	USA	Retrospective cohort study	<i>Programme impact</i> Health system	The programme contributed 10-11% to the existing US physician workforce in underserved areas.
Pathman et al. 2006 [134]	National Health Service Corps	USA	Retrospective cohort study	<i>Programme impact</i> Health system	Presence of a programme participant increased the supply of non-participating physicians in underserved areas on average by 6%.
Rittenhouse et al. 2008 [135]	National Health Service Corps	USA	Retrospective cohort study	<i>Programme effect</i> Provision of care	Participants were significantly more likely to work in a community health centre than non-participating physicians.
Weiss et al. 1980 [136]	Scholarship for Indian students in health sciences	USA	Description of programme outcomes	<i>Programme result</i> Recruitment	In a programme in which participants are not obligated to serve in an underserved area, 74% of participants decided to work in an underserved area.

Study	Programme	Country	Type of study	Type of outcome	Conclusions
Holmes and Miller 1985 [29]	Oklahoma Rural Medical Education Scholarship Loan	USA	Description of programme outcomes	<i>Programme result</i> Recruitment	68% of participants fulfilled their practice obligation, while 32% repaid the financial incentive.
Lapolla et al. 2004 [137]	Oklahoma Rural Medical Education Scholarship Loan	USA	Description of programme outcomes	<i>Programme results</i> Recruitment Retention	75% of participants fulfilled their obligation to practice in an underserved area, while 25 repaid the financial incentive. 53% participants remained in the placement community after having fulfilled their obligation.
Pathman et al. 2000 [32]	National Health Service Corps Indian Health Service Corps State scholarships State loan repayment programmes Practice and hospital-sponsored financial incentives	USA	Retrospective cohort study	<i>Programme effect:</i> Provision of care	In comparison to non-participants, participants in financial-incentive programmes were about five times more likely to practice in rural areas and 85% more likely to care for underserved populations.
Dunbabin et al. 2006 [8]	New South Wales Department of Health Rural Resident Medical Officer Program	Australia	Description of programme outcomes	<i>Programme results:</i> Recruitment Retention	About 87% of participants fulfilled their obligation to practice in a rural area. Retention in rural communities after completion of the obligation was substantial.

Study	Programme	Country	Type of study	Type of outcome	Conclusions
Jackson et al. 2003 [4]	West Virginia Community Scholarship Program West Virginia Health Sciences Scholarship Program West Virginia Recruitment and Retention Community Program West Virginia State Loan Repayment Program	USA	Retrospective cohort study	<i>Programme results:</i> Recruitment Participant satisfaction <i>Programme effects:</i> Retention Participant satisfaction	78% of participants fulfilled their obligation to practice in an underserved area. Retention in the first practice site was not significantly different between programme participants and non-participants. 98% of programme participants, but only 85% of non-participants, “agreed that clinical worker was personally rewarding”.
Pathman et al. 2004 [12]	State scholarship programmes State loan programmes with service option State loan repayment programmes State direct financial-incentive programmes for medical residents State direct financial-incentive programmes for fully trained health professionals	USA	Description of programme outcomes Retrospective cohort study	<i>Programme results:</i> Participant satisfaction Family satisfaction <i>Programme effect:</i> Retention	Participants in programmes that enrolled physicians after graduation from medical school were more likely to fulfill their service obligation than participants in programmes that enrolled participants during medical school. Participants were about 25% less likely to remain at their site of first practice than non-participants. The majority of participants in a financial-incentive programmes were satisfied with their experience; their spouses were significantly less satisfied.

Study	Programme	Country	Type of study	Type of outcome	Conclusions
Ross 2007 [7]	Friends of Mosvold Scholarship Scheme	South Africa	Description of programme outcomes	<i>Programme result:</i> Recruitment	All participants fulfilled their obligation to practice in the underserved area.