NRHSN Position Paper

Student Perspectives on the HELP-Debt Reduction Scheme

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national rural health student network

Introduction

The National Rural Health Student Network (NRHSN) represents the future of rural health, bringing together medicine, nursing, and allied health students from across Australia. Being Australia's only National multidisciplinary student health network, we bring together over 7000 current members, and 37 000 alumni from 29 rural health clubs nation-wide. The NRHSN is an initiative of the Australian Government Department of Health, Disability and Ageing and administered as a consortium by the Rural Workforce Agencies (RWAs).

The NRHSN is built upon several aims, which help guide our activities and initiatives throughout each year. These aims include;

1. Instill culturally safe practices regarding First Nations peoples within the future regional, rural and remote health workforce.
2. Promote health careers to students who are interested in practicing in regional, rural, and remote settings.
3. Advocate for the future regional, rural, and remote health workforce at State and Federal levels, including policy and project implementation.
4. Support and promote stakeholders who are working to improve the working conditions for rural clinicians, and access to healthcare for regional, rural and remote communities.

As the peak national body representing rural health students across Australia, the NRHSN represents a substantial proportion of the future rural and remote medical and nurse practitioner workforce. A significant number of our members come from rural and remote backgrounds or intend to practise in these settings following graduation. Consequently, policies that influence training pathways, financial burden, and incentives for rural service such as the Higher Education Loan Program (HELP) Debt Reduction Scheme, have the potential to directly affect the career decisions and workforce participation of our membership.

The HELP Debt Reduction Scheme ('the Scheme' from hereafter) was launched by the Australian Federal Government in 2022 and is a workforce incentive designed to attract and retain doctors and nurse practitioners in rural and remote areas by reducing their study debt in exchange for eligible rural service[1]. Under the Scheme, clinicians can receive partial reductions of their accumulated HELP debt for each year they work in approved locations, directly linking workforce distribution with financial relief. This is particularly important for students who graduate with substantial HELP debts as it can influence career choices, training pathways, and willingness to work in rural or remote settings. By lowering the long-term financial burden, the Scheme aims to make rural practice more accessible and appealing, supporting equity of access to healthcare for underserved communities. Individuals must meet a set of eligibility requirements before being able to access the Scheme and can only apply retrospectively once the required period of eligible service has been completed. The level of HELP debt reduction is determined by the rurality of the clinician's work location, as classified by the Modified Monash Model[2]. Given the Scheme's intent to address rural workforce

shortages and improve equity of access to healthcare, the NRHSN has a strong interest in understanding;

- How well it is known amongst students and recent graduates
- How it is perceived by students and recent graduates
- Whether it meaningfully influences these individual's intentions to work rurally

In 2022, the NRHSN undertook a qualitative study to explore early ideas, concerns, and perspectives of its student body following the Scheme's launch. In 2024, the NRHSN commenced a single-site cohort pilot study examining awareness of, and attitudes toward, the Scheme among rural health students. Building on these earlier findings, the NRHSN conducted a national survey in 2025 to assess current knowledge, understanding, and perceptions of the Scheme among students and junior health professionals across Australia.

Methods

The NRHSN conducted a cross-sectional survey study using a questionnaire originally developed by Laura Dunlop, 2024 Medical Officer for the NRHSN. The survey comprised 13 structured and semi-structured questions, with additional opportunities for respondents to provide free-text comments. The estimated completion time was 2–10 minutes. The survey was distributed to all 29 Rural Health Clubs nationwide and targeted medical, nursing, and nurse practitioner students. Data collection occurred between August and October 2025. Responses were collected via SurveyMonkey and subsequently exported to Microsoft Excel for analysis. Descriptive analysis was undertaken, with key themes and emerging trends identified from both quantitative responses and qualitative free-text data.

Results

Demographics

The survey received 119 responses, of which 92% were medical students or junior doctors (PGY1-2) and 5% were Master of Nurse Practitioner or Bachelor of Nursing students. These students represented 22 universities across Australia (Figure 1). Of the respondents, 56% reported growing up in a Modified Monash (MM) 2 or above region, and 86% expect to be working in the healthcare workforce within the next two years.

Figure 1. Visual representation of the Universities attended by student respondents in the survey. 1) Bond University, 2) Charles Sturt University, 3) Curtin University, 4) Deakin University, 5) Federation University, 6) Flinders University, 7) Griffith University, 8) Macquarie University, 9) Monash University, 10) The University of Adelaide, 11) The University of Melbourne, 12) The University of Notre Dame Broome, 13) The University of Notre Dame Fremantle, 14) The University of Notre Dame Sydney, 15) The University of New England, 16) The University of Queensland, 17) The University of South Australia, 18) The University of Sydney, 19) The University of Western Australia, 20) The University of Wollongong, 21) University of New South Wales, 22) University of Tasmania.

Student Perspectives on the HELP-Debt Reduction Scheme

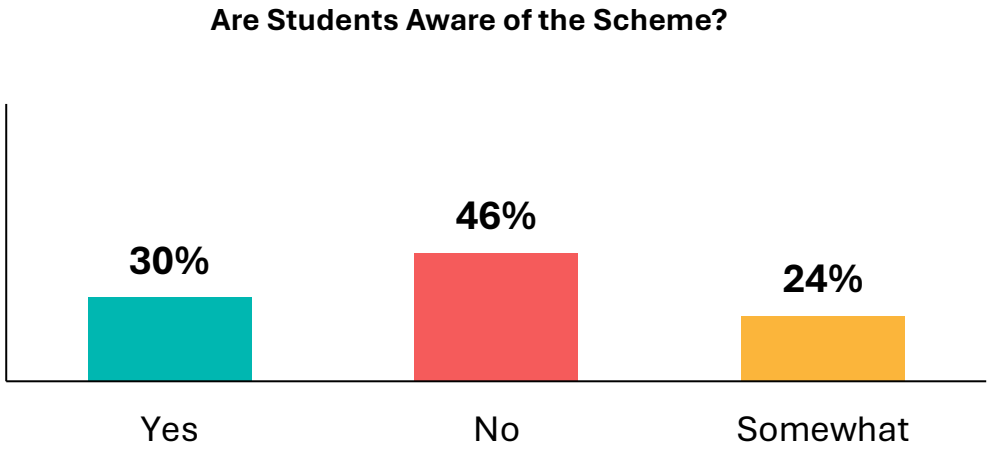

Figure 2. Percentage of student responses to the question 'Are you aware of the HELP-Debt Reduction Scheme?'. 46% of respondents were not aware of the Scheme before the survey, 30% were aware and 24% were somewhat familiar with the Scheme.

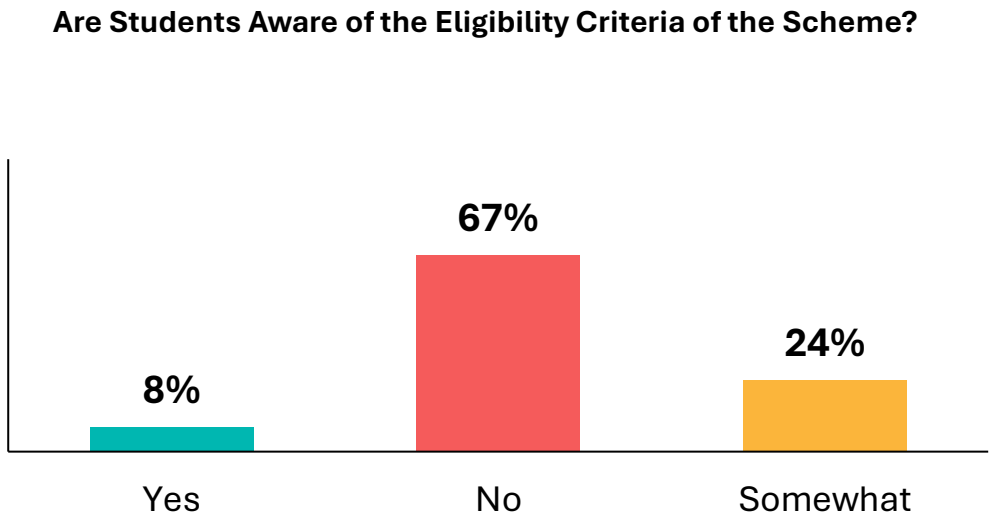

Figure 3. Percentage of student responses to the question 'Are you aware of the eligibility requirements of the HELP-Debt Reduction Scheme?'. 67% of respondents were not aware of the eligibility requirements of the Scheme, 8% were aware and 24% were somewhat aware of the eligibility requirements.

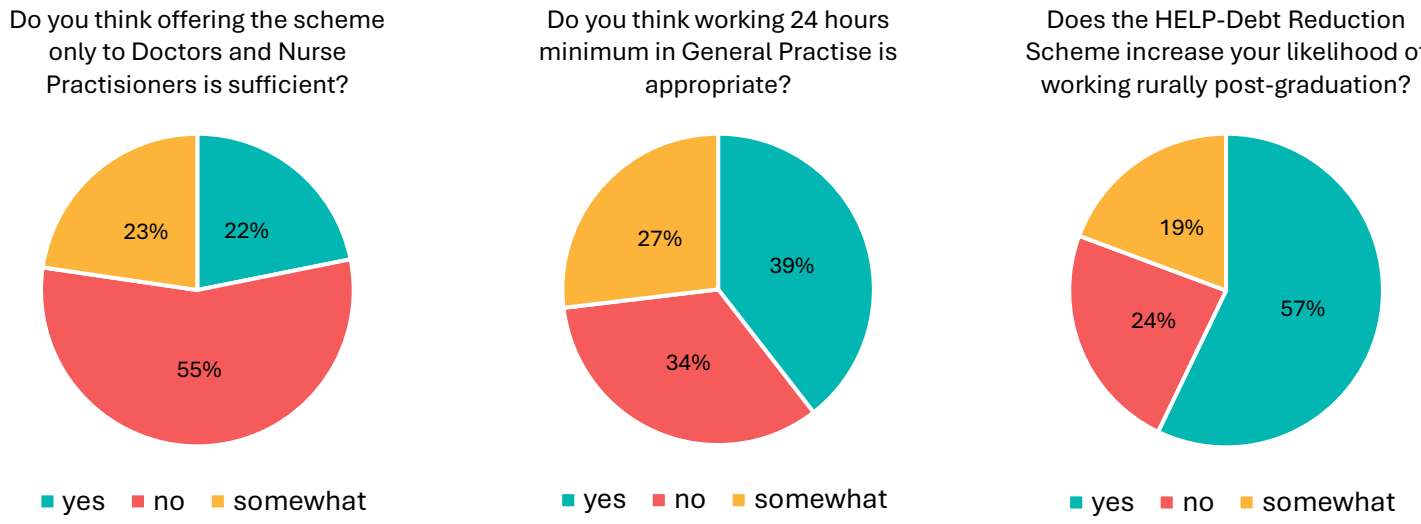

Figure 4. Student responses to eligibility of the scheme. When asked if offering the Scheme to Doctors and Nurse Practitioners is sufficient 55% responded no, 22% responded yes and 23% responded somewhat. When asked if working 24 hours per week in General Practise (GP) is appropriate, 34% responded no, 39% responded yes and 27% somewhat. When asked if the Scheme would increase the likelihood of the students working rurally after they graduate and 57% said yes, 24% said no and 19% said somewhat.

Advantages

Survey respondents highlighted several perceived advantages of the Scheme. The most frequently mentioned benefit was its potential to encourage more graduates and junior doctors to work rurally, with many noting that the financial incentive may help shift decision-making, particularly for those who are undecided or burdened by significant HELP debt. Respondents felt the Scheme could reduce financial stress, improve cost-of-living pressures, and offer meaningful debt relief, especially for students with large debts from multiple degrees (undergraduate and postgraduate study) and those from lower socioeconomic backgrounds.

Many participants believed the Scheme would help increase rural workforce numbers, at least in the short to medium term, improving service availability and access to primary care in underserved regions. Others noted that early exposure to rural practice may encourage graduates to stay longer or return later in their careers, helping build familiarity and confidence in rural work. Some respondents also described personal advantages, such as being financially rewarded for pursuing GP or primary care roles they already intend to take up or being able to consider rural employment that would have otherwise been unaffordable.

Disadvantages

Survey respondents identified several recurring concerns about the Scheme. The most prominent theme was that the Scheme's eligibility criteria are too narrow, being limited to doctors who work 24 hours minimum in General Practice, and excluding rural hospital doctors such as rural generalists, as well as specialists, allied health professionals, nurses, part-time workers and early-career doctors below post-graduate year (PGY) 4. Many participants also felt the Scheme would encourage only short-term rural relocation, with doctors likely to move rurally just long enough to reduce their debt before returning to metropolitan areas, thereby failing to improve long-term retention.

Several respondents believed the financial incentive was insufficient or poorly timed, noting that debt reduction occurs too late in training to influence decision-making and may not outweigh stronger metropolitan earning or training opportunities by this stage of one's career. Another common theme was poor awareness and confusion about the Scheme, with many respondents stating they had never heard of it or did not understand the criteria.

Issues of fairness and equity were also raised, particularly for part-time parents, disadvantaged students, and international graduates. Several comments suggested that the Scheme is misaligned with real training pathways, potentially pushing junior doctors into GP too early and failing to recognise rural hospital experience. Some respondents also felt the Scheme does not address the underlying causes of rural workforce shortages, such as lack of resources, multidisciplinary teams, community support, and sustainable working conditions, with some expressing concern that it may be open to misuse and further perpetuate the high workforce turnover rurally.

Discussion

Key Themes:

1. Limited knowledge of the Scheme among Students and recent graduates
2. Eligibility requirements are too narrow
3. The Scheme is a bonus for many already deciding to practise rurally
4. May contribute to high workforce turnover
5. Access to scheme occurs too late in training

The eligibility criteria and application process for the HELP Debt Reduction Scheme were commonly perceived as complex and difficult to navigate, highlighting the need for clearer guidance, improved communication, and broader promotion of the Scheme. Greater awareness and a more transparent, streamlined eligibility framework may enhance engagement among eligible students and clinicians. Consideration should also be given to broadening eligibility to include other in-demand professions currently excluded, such as hospital-based doctors, certain rural specialists, and allied health professionals, as to address the continuing shortages of healthcare workers in rural locations. Additionally with the recent formal recognition of Rural Generalism as a specialty field, there should be great consideration of inclusion of this field into the eligibility criteria due to the expected future growth of the specialty field.

While the requirement for a minimum of 24 hours of GP work is understandable in the context of ongoing rural GP shortages, this criterion may result in the failure to capture clinicians seeking to work part-time as GPs along-side other vital roles such as in hospital settings and as university educators or work reduced hours due to personal circumstances such as maternity leave. Many of these clinicians are positively contributing to the community across multiple facets, supporting acute care, primary health and teaching the next generation of clinicians. Many clinicians who take time off for maternity leave, are likely setting up roots in these rural locations, and hence are able to provide long term service to these rural areas. Hence, the minimum hours threshold may unintentionally exclude part-time GP's and should be reconsidered to better reflect contemporary workforce patterns and support inclusive participation.

More than half of respondents reported that the Scheme would make them more likely to practise in a rural or remote setting. However, the Scheme was commonly viewed as an additional incentive rather than a factor that would fundamentally alter career trajectories. Many respondents already had strong rural connections, including growing up in rural areas, having family based rurally, participation in the Bonded Medical Program, or a pre-existing interest in rural health. As the respondent cohort largely comprised students already engaged with rural health pathways, these findings should be interpreted with caution. Further research would be valuable to explore the impact of the Scheme among metropolitan-based students, to determine whether it alone is a sufficiently strong incentive to encourage consideration of a rural career.

The Scheme is intended to strengthen the rural health workforce, and survey findings indicate that many students agree it has the potential to increase the number of clinicians practising in rural and remote areas. However, it is important to note that the

minimum period of rural service required to fully repay a typical four-year postgraduate medical degree may be as little as two years when undertaken in MM6–7 locations. As a result, while the Scheme may support short-term workforce supply, it is potentially failing to contribute to long-term retention in rural and remote settings. There is also a risk that the Scheme may inadvertently reinforce existing patterns of high staff turnover, with clinicians completing the minimum service required to reduce their debt before transitioning out of rural practice.

Additionally, evidence suggests that early exposure to rural and remote practice during medical training and the early postgraduate years is associated with increased likelihood of long-term retention in these settings[3]. However, as the Scheme can only be accessed from PGY3 onwards, it does not align well with this evidence base supporting early-career rural exposure. By PGY3, many clinicians have already committed to specialty training pathways and may have formed firm intentions regarding whether they plan to practise rurally. Consequently, consideration should be given to enabling earlier access to the Scheme, which may better support early-career rural exposure, influence career decision-making at a formative stage, and ultimately improve long-term retention of clinicians in rural and remote areas.

Overall, the feedback suggests that while the Scheme is well-intentioned and valued by students, its current design may limit its ability to meaningfully strengthen the rural health workforce without further refinement.

Limitations

This study has several limitations that should be considered when interpreting the findings. The sample size was small, representing 0.6% of the Australian medical student population, which limits the generalisability of the results. Additionally, nurse practitioner and nursing students were significantly underrepresented, restricting the extent to which conclusions can be drawn for these professional groups. As the NRHSN predominantly comprises students with a pre-existing interest in rural health, the findings may not be reflective of the broader medical student population, and levels of awareness or interest in the Scheme may differ among students without a rural health focus. The NRHSN wishes to acknowledge that some executive members, including the lead author, are Australian medicine students who may be directly influenced and affected by the Scheme.

Future Directions

Future directions include engagement with relevant government stakeholders to discuss the survey findings and their implications for the future of the HELP Debt Reduction Scheme, including evidence-informed policy refinement to better align the Scheme with the needs and expectations of students and junior health professionals. Additionally, inclusion of larger, more representative national studies and longitudinal research that assess the awareness of, and engagement with the Scheme could be beneficial to continuing to refine the scheme for the benefit of the future rural health work force.

References

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3. National Rural Health Alliance. Rural Health Education and Training Factsheet. March 2024. Accessed 15 Dec 2025. https://www.ruralhealth.org.au/wp-content/uploads/2024/05/nrha-rural-health-education-training-factsheet-apr-24.pdf