Independent Review of the HELP Debt Reduction Program – Final report

Rachel Hunter AO PSM

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Contents

1 Covering letter

Dear Minister

In my role as Lead Reviewer, I provide the report of the independent Review of the Rural and Remote Higher Education Loan (HELP) Debt Reduction Program (the Program) for your consideration.

In broad terms, the Review's Terms of Reference required that I consult widely to assess the effectiveness of the Program in terms of its contribution to attracting and retaining teaching and certain doctors and nurse practitioners to rural and remote areas.

In doing so, I had the privilege of meeting a broad group of stakeholders, including the National Rural Health Commissioner and the Regional Education Commissioner. Both play key advisory roles in terms of access to health and education services in regional and remote communities. The consultation process included a survey of those who have applied for debt relief through the Program. I am deeply grateful to all those who shared their experiences and views.

There is broad support for the continuation of the Program, understanding that it complements incentive schemes offered by the States and Territories to attract and retain their health and teaching workforces. Feedback confirmed that the Program is a strong lever and motivator, particularly for early career professionals with most debt load. In doing so, it sits alongside other incentive schemes in addressing professional skills gaps in health and education in rural and remote areas, but it is not a fix all. For example, the particular challenges faced by community based and community-controlled organisations in attracting and retaining professional practitioners warrants further policy consideration.

One challenge for the Program is its visibility. There are opportunities for the Australian Government to work with other levels of government, such as the States and Territories, and stakeholders, notably universities and professional bodies, to increase the promotion of the Program within the suite of offerings and ensure potential applicants are aware of what it offers and how it works with other initiatives.

The administration of the Program has benefitted from investment in a digital technology capability, which will deliver improved processing efficiency, and should be the focus of continuous improvement. On the understanding that the Government has a commitment to fiscal sustainability, this will not require additional resources, rather a redirection of administrative funding through efficiencies achieved. Program administration could be further improved by reconsidering some eligibility requirements, such as 'live and work' which place significant administrative burden on applicants and staff.

The Terms of Reference include a question about expansion of the Program to other professional sectors which are in demand in rural and regional communities, with a focus on health, mental health, and education. While I have recommended that the Program not extend to other groups at this point, the need to consider incentives for allied health professionals, oral health practitioners, registered nurses and midwives was raised in numerous consultations.

I also met with representatives from the legal sector and from the veterinary sector at their request. Both groups raised the challenges of attracting and retaining professionals in remote and rural communities. Both are engaged in workforce data integration and analysis with their counterpart Australian Government departments, namely the Attorney-General's Department and the Department of Agriculture, Fisheries and Forestry, which will provide a future context for consideration of incentive programs.

My thanks go to all who supported me throughout the Review. Their professionalism and advice have been invaluable and deeply appreciated.

Rachel Hunter AO PSM

2 Background

This section provides background on the Program and Independent Review.

2.1 Overview of the HELP Debt Reduction Program

The **HELP Debt Reduction Program (the Program)** is an Australian Government initiative that aims to attract and retain key professionals in rural, remote and very remote Australia, to help address issues of access and equity of education and healthcare. While workforce supply and its distribution is a responsibility of State and Territory governments, the Australian Government has worked with jurisdictions on national workforce plans to address skills shortages for teachers, medical and nursing professionals. This Program complements that work.

This Program is a unique Commonwealth mechanism, as only the Australian Government has the authority to waive or reduce HELP debts under the *Higher Education Support Act 2003* (Cth) (HESA). It complements, rather than replaces, State and Territory incentive schemes by providing a national debt relief benefit that encourages qualified health and teaching professionals to live and work in areas of need.

The Program comprises two initiatives:

- The **Very Remote Teachers HELP Debt Reduction initiative (VRT initiative)** supports teachers working in very remote areas as defined by the ABS Remoteness Area (ASGS-RA) classification. This initiative, led by the Department of Education, commenced in 2019. It was established under Division 142 of HESA.

- The **Rural Doctors and Nurse Practitioners HELP Debt Reduction Program (Med-HELP initiative)**, supports medical practitioners and nurse practitioners (NPs) living and working in rural, remote and very remote areas as defined by the Modified Monash Model (MMM) classification. This initiative, jointly led by the Department of Education and Department of Health, Disability and Ageing, commenced in 2022. It was established under Division 144 of HESA.

Eligible participants may receive a waiver of indexation on their accumulated HELP debt and/or a reduction of their debt, in line with Program rules.

2.2 Purpose and scope of the Independent Review

Under Section 144-20 of HESA, an independent review of the Program must be undertaken in 2025 and 2028. In line with this, the Minister for Education, the Hon Jason Clare MP, initiated the **Independent Review of the HELP Debt Reduction Program (the Review)** in July 2025. The Review was led by Ms Rachel Hunter AO PSM, supported by the Department of Education and Nous Group (Nous).

The Terms of Reference for the Review were to examine:

a) the effectiveness of the Program in attracting and retaining eligible professionals

b) the level of uptake of the Program by eligible professionals

c) how the Program operates in relation to similar initiatives implemented by the Australian Government, state and territory governments, local governments, and industry

d) the appropriateness and consistency of eligibility requirements for the Program

e) how efficiently and effectively the Program is being delivered within current resources

f) future opportunities for the Program, including opportunities to meet future high skills needs within the education, health and mental health sectors in rural, remote and very remote Australia.

The full Terms of Reference are provided in Appendix A.

2.3 Approach to the Independent Review

The Review was conducted between July 2025 and October 2025. The findings and recommendations of the Review have been informed by desktop research, data analysis, and stakeholder engagement.

Desktop research

The Review was informed by a review of the legislation, guidelines and program documentation, including operating procedures and communication materials. This provided insight into the Program's intent, design and operation. A review of comparable programs in Australia and overseas was also undertaken, to better understand the incentives ecosystem within which the Program operates.

Data analysis

The Department of Education supplied Nous with high-level de-identified program data for analysis, including applicant locations, application outcomes and statuses, and debt reduction values. This provided insight into program uptake and operational efficiency. It is important to note that program data collection was limited to data collected through the application process. As such, broader data about applicant demographics, participant experiences and program outcomes (e.g. retention) could not be supplied.

Nous also analysed publicly available data, including from the Australian Bureau of Statistics (ABS), Australian Institute of Health and Welfare (AIHW), and Australian Institute of Teaching and School Leadership (AITSL), to contextualise the Program.

Stakeholder engagement

Section 144-20(1B) of HESA specifies that the review should consult with rural and remote communities and their health, mental health and education service providers and specifically, must consult the National Rural Health Commissioner and the Regional Education Commissioner.

Accordingly, interviews and focus groups were conducted with:

- Professor Jenny May AM, National Rural Health Commissioner

- The Hon Fiona Nash, Regional Education Commissioner

- Professor Mary O'Kane AC, Interim Chief Commissioner of the Australian Tertiary Education Commission

- Professor Barney Glover AO, Jobs and Skills Australia Commissioner

- Ms Anita Hobson-Powell, Chief Allied Health Officer

- Ms Natalie Bekis, Acting Commonwealth Chief Nursing and Midwifery Officer, Department of Health, Disability and Ageing

- Mr Robert Katter, Member of the Queensland Legislative Assembly

- Senior executives from the Department of Health, Disability and Ageing

- Representatives from the Program administration teams

- Representatives from health and education professional organisations

- Representatives from health and education peak bodies

- Representatives from health and education unions

- Representatives from schools in very remote areas

- Representatives from universities

- Representatives from State and Territory health and education agencies.

- Representatives from the National Indigenous Australians Agency (NIAA)

- Representatives from the National Aboriginal Community Controlled Health Organisation

- Representatives from Aboriginal Community Controlled Health Organisations (ACCHOs)

- Representatives from the Attorney-General's Department and community based legal services

- Representatives from the Australian Veterinary Association

The purpose of the interviews and focus groups was to explore stakeholders' views about program uptake and effectiveness, program delivery, participant experience and future skills needs within the education, health and mental health sectors in rural, remote and very remote Australia. The Review also consulted groups that represented the legal and veterinary sectors.

A survey of program participants was conducted to capture their experiences and perspectives about the Program. The survey was completed by 311 participants. Of these participants, 77 were prospective, 107 were current, and 127 were completed.[1] 223 had applied for the VRT initiative, whilst 88 had applied for the Med-HELP initiative.

2.4 About this Report

This Report presents the findings and recommendations of the Review, organised into six sections in Table 1. The full Terms of Reference are provided in Appendix A.

Table 1 | Report structure

Section	Focus	Relevant Terms of Reference
Section 4 – Program context	What need does the Program intend to address?	a) consider the effectiveness of the current HELP Debt Reduction Program to attract and retain: i) Medical practitioners and nurse practitioners in rural, remote and very remote locations, and ii) Teachers in very remote locations c) consider how the HELP Debt Reduction Program operates in relation to other offerings or schemes to benefit medical practitioners and nurse practitioners and teachers offered by: i) the Australian Government ii) State and Territory governments iii) Local governments iv) Industry or business or any other non-government organisations f) consider, and make recommendations to the Australian Government about future opportunities for the HELP Debt Reduction Program including: i) which sectors may be those with future high skill needs in rural, remote and very remote Australia based on Australian Government analyses with a focus on the health, mental health and education sectors;
Section 5 – Program type	Does the Program use appropriate levers to	a) consider the effectiveness of the current HELP Debt Reduction Program to attract and retain:

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[1] Prospective participants have applied for benefits but have not yet received an outcome. Current participants have received some benefits and will likely apply again for further benefits. Completed participants have received some benefits and will not apply again.

Section	Focus	Relevant Terms of Reference
	address this need?	i) Medical practitioners and nurse practitioners in rural, remote and very remote locations, and ii) Teachers in very remote locations b) consider the levels of take up of the HELP Debt Reduction Program by those who are: i) Medical practitioners and nurse practitioners or studying to be so ii) Teachers or studying to be so c) consider how the HELP Debt Reduction Program operates in relation to other offerings or schemes to benefit medical practitioners and nurse practitioners and teachers offered by: i) the Australian Government ii) State and Territory governments iii) Local governments iv) Industry or business or any other non-government organisations
Section 6 – Program design	How appropriate is the design of the Program?	d) consider the current eligibility requirements of the HELP Debt Reduction Program and how they are being applied and any adjustments that may be needed to ensure they are appropriate and consistent; f) consider, and make recommendations to the Australian Government about future opportunities for the HELP Debt Reduction Program including: ii) whether the current definitions of rural, remote and very remote used in the program are appropriate for settings that apply to some of these workforces, for example where teachers are required to work at different campuses of a school that are located in different classifications; iii) whether there are more effective ways that that funding for the program could be used to meet the objectives of the program; and g) report on any other relevant matters raised by stakeholders relating to the HELP Debt Reduction Program.
Section 7 – Program delivery	How effectively and efficiently has the Program been implemented?	e) consider the current operational delivery of the HELP Debt Reduction Program and how efficiently and effectively the program is being delivered within current resources; f) consider, and make recommendations to the Australian Government about future opportunities for the HELP Debt Reduction Program including: iv) how delivery of the program could be enhanced including timeframes for the assessment of applications and the use of secure digital technology platforms in receiving applications, and
Section 8 – Program uptake and effectiveness	What outcomes has the Program delivered?	a) consider the effectiveness of the current HELP Debt Reduction Program to attract and retain: i) Medical practitioners and nurse practitioners in rural, remote and very remote locations, and ii) Teachers in very remote locations b) consider the levels of take up of the HELP Debt Reduction Program by those who are: i) Medical practitioners and nurse practitioners or studying to be so ii) Teachers or studying to be so

Section	Focus	Relevant Terms of Reference
		e) consider the current operational delivery of the HELP Debt Reduction Program and how efficiently and effectively the program is being delivered within current resources;
Section 9 – Future opportunities	What opportunities exist to enhance the Program?	f) consider, and make recommendations to the Australian Government about future opportunities for the HELP Debt Reduction Program including: i) which sectors may be those with future high skill needs in rural, remote and very remote Australia based on Australian Government analyses with a focus on the health, mental health and education sectors; ii) whether the current definitions of rural, remote and very remote used in the program are appropriate for settings that apply to some of these workforces, for example where teachers are required to work at different campuses of a school that are located in different classifications; iii) whether there are more effective ways that that funding for the program could be used to meet the objectives of the program; and iv) how delivery of the program could be enhanced including timeframes for the assessment of applications and the use of secure digital technology platforms in receiving applications, and g) report on any other relevant matters raised by stakeholders relating to the HELP Debt Reduction Program.

3 Summary of findings and future opportunities

This section summarises the key findings of the review and outlines future opportunities to strengthen the design, delivery and effectiveness of the HELP Debt Reduction Program.

3.1 Findings

As part of this review, evidence was drawn from Program documentation, administrative data, participant surveys and stakeholder consultations to assess the design, delivery and effectiveness of the HELP Debt Reduction Program. The key findings are summarised below.

Program context

1. Rural and remote areas face persistent workforce shortages in health and education
2. A wide range of initiatives aim to address these persistent workforce shortages

Program type

3. HELP debt reduction can be effective for attraction, particularly for early career professionals
4. Other systemic constraints outside the Program will affect how effective HELP debt relief can be for retention

Program design

5. Initiatives under the Program share the same policy intent but provide different incentive arrangements for health and education professionals
6. There is a balance to be struck between determining eligibility and ensuring support is going to areas of workforce shortage
7. There are opportunities to consider alternatives to the Program's current use of geo-classifications
8. Positioning of the Program with other rural and remote workforce initiatives could be strengthened

Program delivery

9. The administration process for the Program comprises five key stages
10. The application process fulfills Program requirements with opportunities for further efficiency
11. The Program could include data for outcome measurement and continuous improvement

Program uptake and effectiveness

12. Stakeholders are supportive of the Program's intent
13. Uptake of the Program has been modest
14. The extent to which the Program itself has influenced attraction and retention is difficult to assess

3.2 Future opportunities

Building on these findings, the review identified nine recommended actions to strengthen the Program. These actions aim to improve uptake, streamline administration and strengthen the evidence base ahead of the next independent review in 2028.

1. Review and test proposed changes to eligibility settings
2. Refine how remoteness is defined to better reflect local realities
3. Simplify the process for annual indexation waivers

4. Better complement other rural and remote workforce initiatives where appropriate
5. Strengthen guidance and communication with applicants throughout the process
6. Strengthen targeted promotion and partnerships to reach the right audiences
7. Finalise and implement a benefits realisation plan for both initiatives
8. Improve baseline data collection to support ongoing improvement of the Program
9. Defer program expansion until the Program matures

4 Program context

This section describes the need that the Program intends to address.

(Refer to ToR (a)(i–ii), (c), (f)(i) as set out in Appendix A.)

4.1 Rural and remote areas face persistent workforce shortages in health and education

Workforce shortages in rural and remote Australia are an enduring challenge – with factors such as higher costs of living, limited infrastructure (e.g. housing, transportation), reduced access to amenities and services, and fewer professional opportunities – all of which impede attraction and retention. Shortages are particularly acute in the health and education sectors, which are primarily State and Territory responsibilities.

While the Commonwealth plays a key role in funding, policy direction, and national workforce programs, it does not directly operate hospitals, general practices or schools, or employ these workforces. This means the Commonwealth works in partnership with States and Territories to help address shared workforce challenges.

Significant primary care workforce shortages in rural and remote areas exacerbate existing health inequities

Australians living in rural and remote areas experience significantly poorer health outcomes than those living in metropolitan areas. Life expectancy is generally lower for people living in rural and remote areas, and the gap in life expectancy between First Nations and non-First Nations Australians is highest in remote areas.[2] As remoteness increases, so does the burden of disease – it is 1.4 times higher in remote and very remote areas than in metropolitan areas. The prevalence of people living with two or more long-term health conditions is highest in regional areas.[3] As shown in Figure 1, death rates due to conditions such as chronic obstructive pulmonary disease, coronary heart disease, diabetes, lung cancer and suicide are notably higher in remote and very remote areas.[4] Similarly, remote and very remote areas experience higher rates of preventable hospitalisations, 2-4 times the rate in metropolitan areas.[4]

Increasing remoteness is also linked to higher behavioural and biomedical risk factors.[5] Daily smoking and alcohol consumption above National Health and Medical Research Council (NHMRC) Guidelines are more common, while non-medical use of painkillers and opioids is slightly higher.[6,7] Biomedical risks, such as

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[2] Australian Bureau of Statistics (ABS), *Life expectancy, 2021 – 2023*, 8 November 2024 (accessed 1 October 2025). https://www.abs.gov.au/statistics/people/population/life-expectancy/latest-release; ABS, *Aboriginal and Torres Strait Islander life expectancy, 2020 – 2022*, 29 November 2023 (accessed 1 October 2025). https://www.abs.gov.au/statistics/people/aboriginal-and-torres-strait-islander-peoples/aboriginal-and-torres-strait-islander-life-expectancy/latest-release

[3] Public Health Information Development Unit, Torrens University Australia, *Long-term health conditions: variations in the number of conditions by socioeconomic disadvantage and remoteness,* June 2023 (accessed 1 October 2025). https://phidu.torrens.edu.au/pdf/2020-onwards/factsheets/Long-term_health_conditions-2021.pdf

[4] Australian Institute of Health and Welfare (AIHW), *Rural and remote health*, 30 April 2024 (accessed 1 October 2025). https://www.aihw.gov.au/reports/rural-remote-australians/rural-and-remote-health

[5] Behaviour risk factors are modifiable behaviours that influence health outcomes, such as smoking, alcohol consumption and drug use; Biomedical risk factors are bodily conditions that directly contribute to health risks, such as abdominal fat, obesity and high blood pressure; AIHW, *Risk factors*, *Overview* 13 June 2024 (accessed 1 October 2025). https://www.aihw.gov.au/reports-data/behaviours-risk-factors/risk-factors/overview

[6] AIHW, *National Drug Strategy Household Survey 2022-2023*, 27 May 2025 (accessed 1 October 2025). https://www.aihw.gov.au/reports/illicit-use-of-drugs/national-drug-strategy-household-survey/contents/about

[7] ABS, *National Aboriginal and Torres Strait Islander Health Survey, 2022-2023 financial year*, 26 November 2024 (accessed 1 October 2025). https://www.abs.gov.au/statistics/people/aboriginal-and-torres-strait-islander-peoples/national-aboriginal-and-torres-strait-islander-health-survey/latest-release; National Rural Health Alliance, *Rural Health in Australia Snapshot 2025*, 26 February 2025 (accessed 1 October 2025), https://www.ruralhealth.org.au/wp-content/uploads/2025/02/NRHA-Rural-Health-in-Australia-Snapshot-2025.pdf

obesity and high blood pressure, are more prevalent in remote areas.[8] Maternal and infant health is also affected, with higher smoking rates during pregnancy, more premature births and lower exclusive breastfeeding rates (except among First Nations infants).[9]

Figure 1 | Death rate by cause and ASGS remoteness for selected conditions, 2019-2023

Source: AIHW, *Mortality Over Regions and Time (MORT) books*, 9 April 2025 (accessed 1 October 2025).
https://www.aihw.gov.au/reports/life-expectancy-deaths/mort-books/contents/mort-books
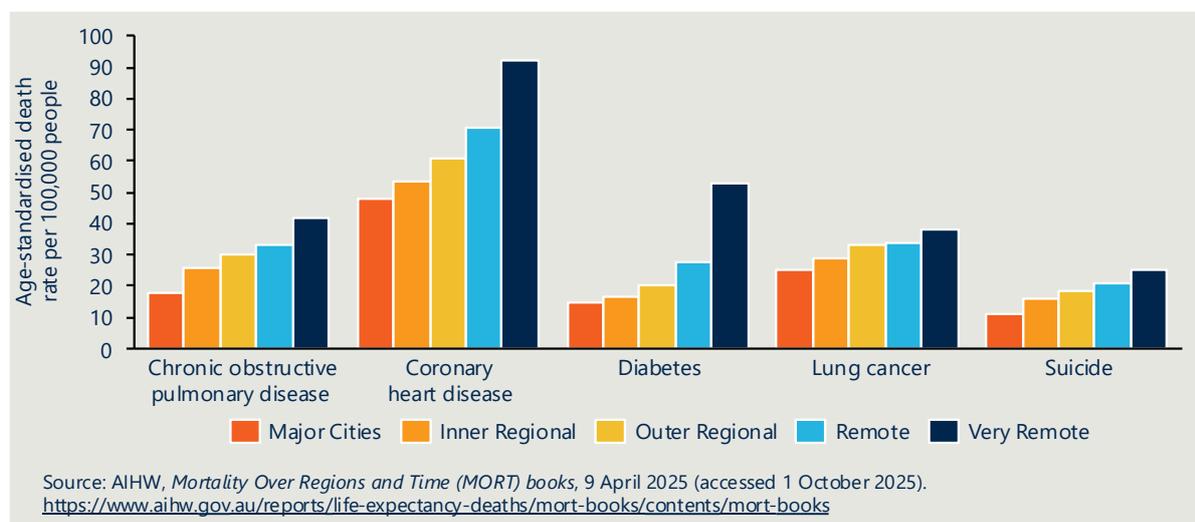
Primary care plays a critical role in addressing these disparities, by supporting health promotion and disease prevention, detecting and managing chronic conditions early, and reducing preventable hospitalisations. Ensuring access to culturally safe, community-based primary care is essential for improving health outcomes for First Nations people in rural and remote areas, who experience a disproportionate burden of disease.[10]

Rural and remote areas face significant challenges in accessing primary care, often needing to travel long distances or relocate to access them – with workforce shortages being a key contributor. As shown in Figure 2 the number of overall employed health professionals decreases with increasing remoteness, particularly GPs. Despite observed increases of NPs as rurality increases, the overall need for primary care services in rural and remote regions far exceeds the available workforce – particularly GPs, rural generalists and nurses who deliver frontline care.

Additionally, there are disproportionate shortfalls in workforce supply in small rural towns (MM5) likely due to differences in employment patterns between private and public/not for profit (NFP) sectors. These regions have fewer private sector healthcare workers compared to MM1-4 and fewer public sector workers compared to MM6-7. The private sector shortfall may stem from market failure, low socioeconomic status, and challenges for businesses in small towns, compounded by an older workforce. Unlike MM6–7, which compensated with more public/NFP workers, MM5 regions lack such mechanisms, resulting in disproportionate workforce gaps.[11]

This results in reduced access, with approximately 18,405 people in remote and very remote areas having no primary healthcare within an hour's drive.[12] Use of chronic disease management services, as well as participation in cancer screening programs,[4] are also lower in these areas. While telehealth has helped bridge

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[8] AIHW, *Overweight and obesity, Summary*, 17 June 2024 (accessed 1 October 2025). https://www.aihw.gov.au/reports/overweight-obesity/overweight-and-obesity/contents/summary; ABS, *National Health Survey, 2022*, 15 December 2023 (accessed 1 October 2025). https://www.abs.gov.au/statistics/health/health-conditions-and-risks/national-health-survey/latest-release

[9] AIHW, *Australia's mothers and babies, Data*, 31 July 2025 (accessed 1 October 2025). https://www.aihw.gov.au/reports/mothers-babies/australias-mothers-babies/data

[10] AIHW Indigenous Health Performance Framework, *Leading causes of disease burden and mortality*, 22 May 2025 (accessed 1 October 2025). https://www.indigenoushpf.gov.au/report-overview/overview/summary-report/4-tier-1-%E2%80%93-health-status-and-outcomes/leading-causes-of-disease-burden-and-mortality

[11] Cortie CH, Garne D, Parker-Newlyn L, Ivers RG, Mullan J, Mansfield KJ, Bonney A. The Australian health workforce: Disproportionate shortfalls in small rural towns. *Aust J Rural Health*. 2024 Jun;32(3):538-546. doi: 10.1111/ajr.13121. Epub 2024 Apr 10. PMID: 38597124.

[12] Royal Flying Doctor Service of Australia, *Best for the Bush Rural and Remote Health Baseline 2023*, 2024, flyingdoctor.org.au/download-document/best-bush-rural-and-remote-health-baseline-2023/

some of these gaps, its effectiveness depends on reliable digital infrastructure and on-site support. Research shows that telehealth is best used as a supplementary tool, not a replacement for face-to-face care, highlighting the ongoing need to strengthen the primary care workforce in rural and remote areas to improve equitable access[13]. These factors point to a critical need to strengthen the primary care workforce in rural and remote areas to improve access to essential health services and achieve better health outcomes.

Figure 2 also shows a spike in the number of specialists in MM6 areas. While the reasons for this are unclear from the data, it may reflect that some MM6 communities function as bases for visiting or fly-in-fly-out (FIFO) or drive-in-drive-out (DIDO) specialists. FIFO and DIDO models are increasingly used to address workforce shortages in remote Australia. These models can improve access to specialist care in the short term but may also raise questions about sustainability and the development of a stable local workforce.[14]

Figure 2 | Health Professionals by Remoteness: MM1 to MM7 FTE per 100,000 Population, 2023

Line chart showing that workforce supply decreases as remoteness increases for most professions, with specialists, general practitioners, nurse practitioners, registered nurses and core allied health all lowest in MM5, then lifting slightly in MM6 and MM7.

[13] Mathew S, Fitts MS, Liddle Z, Bourke L, Campbell N, Murakami-Gold L, Russell DJ, Humphreys JS, Mullholand E, Zhao Y, Jones MP, Boffa J, Ramjan M, Tangey A, Schultz R, Wakerman J., Telehealth in remote Australia: a supplementary tool or an alternative model of care replacing face-to-face consultations? *BMC Health Serv Res*. 2023 Apr 5;23(1):341. doi: 10.1186/s12913-023-09265-2. PMID: 37020234; PMCID: PMC10074370.

[14] Perkins, D., Fly in Fly out and Drive in Drive out: useful contribution or worrying trend? *Australian Journal of Rural Health*, 2012 Oct;20(5):239-40. doi: 10.1111/j.1440-1584.2012.01308.x. PMID: 22998195.

Source: Australian Government Department of Health, Disability and Ageing, *National Health Workforce Dataset*, 24 January 2025 (accessed 1 October 2025), https://hwd.health.gov.au/resources; Australian Government Department of Health, Disability and Ageing, *Allied Health Dashboard*, 22 October 2024 (accessed 1 October 2025), https://hwd.health.gov.au/alld-dashboards/index.html

Note: the General Practitioners (GP) figure refers to GPs that are providing primary care; the Specialists figure refers to total Specialist employment; the Nurse Practitioners (NP) figure refers to qualified NPs that work as and do not work as NPs; the Registered Nurses (RN) are RNs that work in nursing; the Core Allied Health (AH) figure refers to total AH employment.

Remote and very remote schools face critical teacher workforce shortages, contributing to poorer student outcomes

Australia is amid a teacher workforce shortage, which is heightened in remote and very remote areas.[15] Schools in these areas face challenges in recruiting teachers and experience high turnover rates.[16] This leads to issues such as teachers being required to teach outside their field more frequently (65% of teachers in remote and very remote areas teach outside their field, compared to 53% of teachers in major cities),[17] and

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[15] McPherson, A., & Lampert, J (2024). An analysis of Australian teacher workforce policy: Challenges and opportunities for teacher recruitment and retention. *Policy Futures in* Education. 23, 446 - 463.

[16] Knipe, S., & Bottrell, C. (2023). Staffing remote schools: Perennial failure. Journal of Global Education and Research, 7(2), 183-198. https://doi.org/10.5038/2577-509X.7.2.1197

[17] Australian Institute for Teaching and School Leadership (AITSL), *National Trends Teacher Workforce*, June 2025 (accessed 1 October 2025), https://www.aitsl.edu.au/research/australian-teacher-workforce-data/atwd-reports/national-trends-teacher-workforce-jun2025

experiencing higher levels of stress and burnout.[18] These issues in turn exacerbate attraction and retention challenges.

Teacher workforce shortages in remote and very remote areas are complicated by factors such as teachers' experience levels and career stages. In these areas, there is a greater proportion of early career teachers and teachers aged 29 years or younger, as shown in Figure 3. The typical challenges faced by new teachers are greater in remote and very remote schools, where teachers are often required to teach outside of their field and manage multi-stage classes, and have limited professional support.[19,] Some stakeholders suggested that these teachers tend to be underprepared for a remote education context – with cultural competency being a crucial gap. A key theme which emerged from consultation was the need not just for more teachers in remote and very remote schools, but for more experienced teachers who can offer culturally responsive practice, instructional leadership, and mentorship for their colleagues.

Figure 3 | Proportion of teachers who are aged 29 or below and early career by remoteness

	REMOTE OR VERY REMOTE	OUTER REGIONAL	INNER REGIONAL	MAJOR CITIES
TEACHERS AGED 29 YEARS OR YOUNGER (% of total teachers)	17%	12%	8%	12%
TEACHERS WITH 1-5 YEARS' EXPERIENCE (% of total teachers)	29%	21%	15%	20%

Source: Australian Institute for Teaching and School Leadership (AITSL), National Trends Teacher Workforce, June 2025 (accessed 1 October 2025), https://www.aitsl.edu.au/research/australian-teacher-workforce-data/atwd-reports/national-trends-teacher-workforce-jun2025

Teacher workforce challenges disrupt learning continuity and impact instructional quality, contributing to poorer educational outcomes for students in remote and very remote areas. In 2025, these students had consistently lower NAPLAN scores compared with the major city students across all learning domains and year levels. This geographical disparity was amplified for First Nations students, who face further systemic barriers that impact engagement and achievement. Figure 4 presents the different percentages of all Year 7 students and First Nations Year 7 students assessed as 'developing or above' in reading (by remoteness).[20] The inequity in outcomes underscores the urgent need to attract and increase retention of the teacher workforce in remote and very remote areas.

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[18] Carroll A, Forrest K, Sanders-O'Connor E, Flynn L, Bower JM, Fynes-Clinton S, York A, Ziaei M. Teacher stress and burnout in Australia: examining the role of intrapersonal and environmental factors. Soc Psychol Educ. 2022;25(2-3):441-469. doi: 10.1007/s11218-022-09686-7. Epub 2022 Feb 25. PMID: 35233183; PMCID: PMC8874312.

[19] Country Education Partnership, *Regional and Rural Early Career Teachers Survey*, September 2021 (accessed 1 October 2025), https://cep.org.au/wp-content/uploads/2021/10/Early-Career-Teacher-Survey-Report-Sept2021.pdf

[20] Australian Institute for Teaching and School Leadership (AITSL) 2025, National trends teacher workforce, June, viewed 1 October 2025, https://www.aitsl.edu.au/research/australian-teacher-workforce-data/atwd-reports/national-trends-teacher-workforce-jun2025
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Figure 4 | Percentages of all Year 7 students and First Nations Year 7 students assessed as 'developing or above' in reading by remoteness

ASSESSED AS 'DEVELOPING OR ABOVE' IN READING					
	REMOTE OR VERY REMOTE	OUTER REGIONAL	INNER REGIONAL	REMOTE	MAJOR CITIES
% OF ALL STUDENTS	**41.1%**	**70.4%**	**82.2%**	**86.7%**	**91.6%**
% OF FIRST NATIONS STUDENTS	**21.4%**	**41.2%**	**62.3%**	**71.6%**	**74.6%**

Source: Australian Institute for Teaching and School Leadership (AITSL), National Trends Teacher Workforce, June 2025 (accessed 1 October 2025), https://www.aitsl.edu.au/research/australian-teacher-workforce-data/atwd-reports/national-trends-teacher-workforce-jun2025
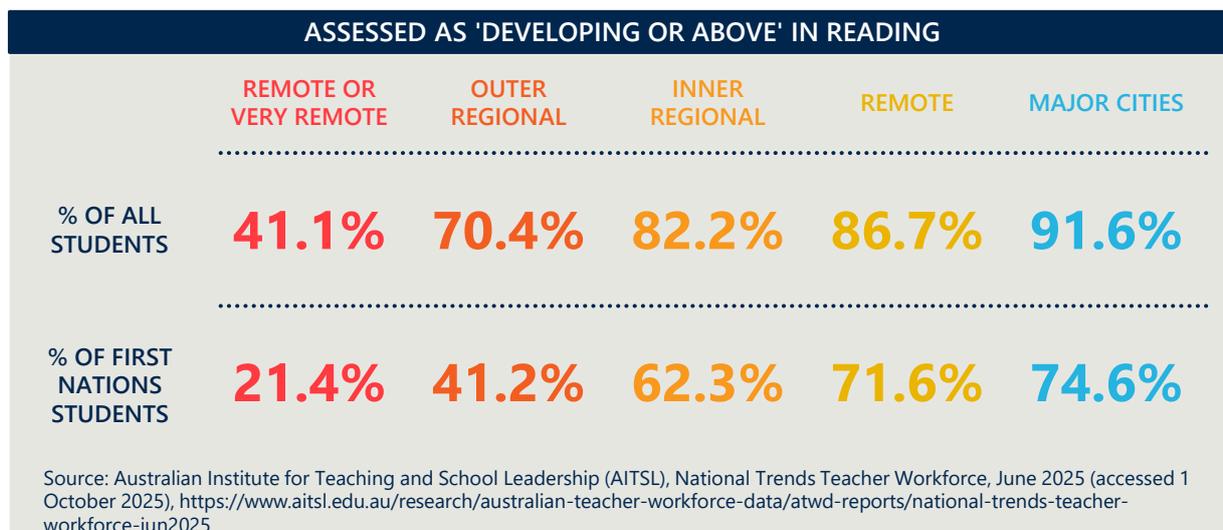
4.2 A wide range of initiatives aim to address these persistent workforce shortages

The Program operates within a complex ecosystem of initiatives designed to address persistent workforce shortages. While the Program provides targeted financial relief, it is only one component of a much broader suite of Commonwealth, state/territory, local government and industry supports. The Commonwealth's contribution sits alongside state and territory initiatives that offer their own financial, professional and location incentives, each addressing workforce challenges from different policy angles and within distinct areas of responsibility.

The following list, while not exhaustive is illustrative of the types of initiatives available to applicants (see Table 22 for the types of incentives offered nationally and internationally).

Commonwealth-level initiatives complement the Program by targeting both workforce attraction and retention. For example, the Workforce Incentive Program (WIP) provides direct payments to rural general practitioners and supports multidisciplinary teams in general practice (including nurse practitioners), with additional payments for advanced skills in remote areas (through the Rural Advanced Skills Stream).[21] The Bonded Medical Program (BMP) offers Commonwealth Supported Places to medical students in exchange for a return-of-service in regional and remote locations, while the Rural Health Multidisciplinary Training (RHMT) network funds rural clinical schools and training hubs to build local training pipelines and support professional development.[22]

As part of the National Teacher Workforce Action Plan, the federal government offers scholarships up to $40,000 to help attract high quality candidates from targeted backgrounds to the teaching profession, with top-up payments of $2,000 for those that take placements in remote areas. This is complemented by the Commonwealth Prac Payment, which from July 2025 will provide weekly financial support to teaching,

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[21] Australian Government Department of Health, Disability and Ageing, *Workforce Incentive Program*, 6 June 2025 (accessed 15 October 2025), https://www.health.gov.au/our-work/workforce-incentive-program

[22] Australian Government Department of Health, Disability and Ageing, *Bonded Medical Program*, 17 October 2025 (accessed 22 October 2025), https://www.health.gov.au/our-work/bonded-medical-program; Australian Government Department of Health, Disability and Ageing, *Rural Health Multidisciplinary Training program*, 6 June 2025 (accessed 15 October 2025), https://www.health.gov.au/our-work/rhmt

nursing, midwifery, and social work students during mandatory placements, further reducing financial barriers to rural practice.[23]

State and territory governments offer a diverse range of incentives tailored to local workforce needs. These typically include recruitment and retention bonuses, relocation assistance, subsidised or guaranteed housing, travel allowances, additional leave entitlements and professional development funding. For example, Victoria provides up to $50,000 in incentives for teachers in hard-to-staff schools, Queensland offers a suite of professional and financial incentives through the Recognition of Rural and Remote Service Scheme, and Tasmania provides $100,000 incentives for GPs (through HECS reimbursement) and $15,000 relocation payments for nurse practitioners.[24] States also invest in modular and refurbished teacher housing and provide targeted support for rural health professionals through grants and scholarships. One such scholarship is the *teach.Rural Scholarship* offered by New South Wales, which provides financial support, course contribution fees, an appointment allowance and a permanent position in a rural or remote NSW public school following successful completion of studies.[25]

Local governments, particularly smaller or more remote communities, and industry also play a role by offering direct supports such as subsidised housing, vehicles, relocation grants and even direct payments to attract and retain essential professionals. For example, Inverell Shire Council offered incentives of up to $90,000 to recruit a GP, while another council in the state's Riverina spent up to $300,000 a year for a local doctor.[26] Also, rural workforce agencies, such as Rural Health West, helps with relocation assistance for health professionals relocating to rural WA, as well as travel support for locums working in primary health.[27]

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[23] Australian Government Department of Education, *National Teacher Workforce Action Plan, Priority Area 1 – Improving teacher supply*, 10 January 2024 (accessed 15 October 2025), https://www.education.gov.au/national-teacher-workforce-action-plan/priority-area-1-improving-teacher-supply; Australian Government Department of Education, *Commonwealth Prac Payment*, 13 August 2025 (accessed 15 October 2025), https://www.education.gov.au/commonwealth-prac-payment-cpp

[24] State Government of Victoria, *Relocation incentives to teach in Regional Victoria*, 16 May 2025 (accessed 15 October 2025), https://www.vic.gov.au/Relocation-incentives-to-teach-in-Regional-Victoria; Queensland Government Department of Education, *Choose your teaching adventure*, 23 January 2023 (accessed 15 October 2025), https://teach.qld.gov.au/studyteaching/Documents/remote-teaching-booklet.pdf; Department of Premier and Cabinet, *Our Nation-Leading GP Guarantee*, (accessed 15 October 2025), https://www.premier.tas.gov.au/our-plan/building-an-even-better-health-system/our-nation-leading-gp-guarantee

[25] NSW Government Department of Education, *teach.Rural Scholarship*, (accessed 15 October 2025), https://education.nsw.gov.au/teach-nsw/get-paid-to-study/teach-rural-scholarship

[26] Peter Sanders and Kristy Reading, *Country councils paying tens of thousands of dollars a year to attract GPs*, *ABC News*, 6 August 2024 (accessed 15 October 2025), https://www.abc.net.au/news/2024-08-06/international-doctors-recruited-inverell-regional-nsw-incentives/104154058

[27] Rural Health West, *Financial Support for Health Professionals*, 2025 (accessed 15 October 2025), https://ruralhealthwest.com.au/financial-support/health-professionals/

Table 2 | Types of incentives offered in jurisdictions outside of the Program

Jurisdiction	Financial benefits	Relocation assistance	Travel allowances	Additional leave	Subsidised housing	Professional benefits
NSW	●	●	●	●	●	●
QLD	●	●	●	●	●	●
NT	●	●		●	●	●
VIC	●	●			●	●
WA	●	●		●	●	●
SA	●	●	●	●	●	●
TAS	●	●		●	●	●
Federal	●					●

5 Program type

This section examines whether the Program uses an appropriate lever to address the identified need.

(Refer ToR (a)(i–ii), (b)(i–ii), (c)(i–iv), as set out in Appendix A)

5.1 HELP debt reduction can be effective for attraction, particularly for early career professionals

Financial incentives have proven to be effective in attracting health workers and educators to rural and remote areas

A review of the literature revealed that financial incentives can be effective in attracting health workers to rural and remote areas. For example, a review of interventions for improving the attraction and retention of health workers in rural and remote areas found that bonus payments and higher salaries were amongst the most critical factors for medical students in taking up rural and remote positions.[28] Similarly, the literature shows that financial incentives can be effective in attracting teachers to rural and remote areas. One such study examined a teacher financial incentive (TFI) scheme aimed at attracting qualified teachers in hard-to-staff government schools. It found that, when combined with a relocation payment, the TFI scheme successfully influenced teachers to relocate to take up positions they would not otherwise have considered.[29] Further, a review aimed at identifying the most promising approaches to attract and retain teachers in hard-to-staff areas found that financial incentives were the only approach that seemed to work in attracting teachers to challenging schools, though not effective for retention.[30] These findings reinforce the rationale for the Program using financial incentives to attract medical practitioners, nurse practitioners and teachers to rural and remote areas.

HELP debt reduction is most valuable to early career professionals, with arguably less relevance for experienced professionals

While financial incentives can influence a wide range of professionals, HELP debt reduction appears to be most appealing to those at the beginning of their careers. This was confirmed by several stakeholders, who reflected that the Program offers the most benefit to early career professionals, given their larger debts and lower incomes. By contrast, the Program is arguably less relevant for mid and later-career professionals. As one stakeholder observed, the value proposition of the Program appeals to graduates, but "for experienced teachers, it is a bit harder... they have likely paid off their debt." While some mid-career and experienced professionals may still have residual HELP debt and can therefore benefit from the Program, the financial incentive tends to be smaller and less influential for this group.

Stakeholders recognised that, in rural and remote areas, there is a greater need for experienced professionals than early career professionals, however, they noted that attracting them can be more difficult. Many have already repaid most of their HELP debt, reducing the appeal of financial incentives, and are more likely to have families or caring responsibilities that make relocation challenging without adequate housing, childcare and community infrastructure to support them. Stakeholders suggested that programs using financial

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[28] E.B. Esu et al., Interventions for Improving Attraction and Retention of Health Workers in Rural and Underserved Areas: A Systematic Review of Systematic Reviews, *Journal of Public Health (Oxford)*, vol. 43, Suppl. 1, 2021, pp. i54–i66, doi: 10.1093/pubmed/fdaa235.

[29] Jill Blackmore, Linda Hobbs, and Julie Rowlands, 'Aspiring Teachers, Financial Incentives, and Principals' Recruitment Practices in Hard-to-Staff Schools', *Journal of Education Policy*, published online 27 March 2023, pp. 233–252, doi: 10.1080/02680939.2023.2193170.

[30] Beng Huat See, Rebecca Morris, Stephen Gorard, and Nada El Soufi, 'What Works in Attracting and Retaining Teachers in Challenging Schools and Areas?', *School Leadership & Management*, published online 30 June 2020, pp. 678–697.

incentives, like this Program, are best targeted towards early career professionals – provided they are supported by structured placements, professional development, and mentoring to increase the likelihood of longer-term retention.

The appeal of HELP debt reduction for graduates is likely to be greater for those experiencing cost-of-living pressures

There is the potential that HELP debt reduction has become even more appealing to early career professionals who may be experiencing cost-of-living pressures. The average HELP debt for people in their twenties has risen from approximately $13.496.80 in 2006 to over $31,726.50 in 2024.[31] At the same time, young people are increasingly impacted by financial pressures, with 37 per cent of 23-year-old Longitudinal Surveys of Australian Youth participants reporting financial stress and 19 per cent reporting going without meals due to money shortages in 2023.[32] In this context, HELP debt reduction has the potential to have influence over the career decision-making of graduates and provide them with significant assistance.

The recent 20 per cent reduction in HELP debts introduced by the Australian Government may influence the appeal of HELP debt reduction initiatives. While this reduces the overall financial burden for graduates, it may also lessen the relative value of additional HELP-related incentives.

The Program attracts early career professionals, but its eligibility settings could be better targeted to them

Although the Program is most appealing to early career professionals, its eligibility settings do not specifically target them. Under the Med-HELP initiative, medical practitioners are eligible from PGY3 (postgraduate year 3), by which time many have already settled on a practice location and pathway. Several stakeholders raised issues with the three-year delay, with one observing that "those early years are when practitioners are trying to get the right experience for fellowship pathways and may already have settled elsewhere," and that the Program is thus "influencing decisions too late." Stakeholders also stressed the benefit of earlier exposure to rural and remote practice, noting that exposure in PGY1 (postgraduate year 1) or PGY2 (postgraduate year 2) is far more influential in shaping long-term intentions. This is supported by research, with a study conducted by McGrail et al. concluding that the training period shortly following medical school plays a substantial role in shaping the subsequent distribution of the medical workforce."[33] Stakeholders felt adjusting the Program's eligibility timing to target medical practitioners earlier in their training – when the financial incentive is most beneficial and rural exposure is most influential – would enhance its impact.

In addition, it was noted by some stakeholders that, given the benefits of the Program is linked to the size of an individual's HELP debt it may not be the most appropriate lever for attracting nurse practitioners to rural and remote areas. These stakeholders reflected that nurse practitioners are typically well-established in their careers, with an average age of 40 to 50, who are more likely to have prepaid or paid down their HELP debt. Moreover, compared to general practitioners, nurse practitioners tend to incur smaller HELP debts and are less likely to see material benefit from an initiative like the Program. As a result, the Program may hold limited appeal for this cohort, which is reflected in a proportionally lower nurse practitioner uptake compared to medical practitioners (see Section 8.2). There is an opportunity to potentially reconsider the Program's target cohorts – to ensure it is targeted toward those who are most likely to benefit.

Many stakeholders proposed that the Program be extended to registered nurses (RNs), who represent a younger and more mobile workforce cohort. As one health organisation noted, "Extending it to RNs is very important. If you can get people fresh out of school who are keen to learn and provide a support structure around them, it's a big jump, so it should be extended out." Another stakeholder added, "RNs are a key

[31] Study and Training Support Loans - Dataset - Data.gov.au

[32] Longitudinal Surveys of Australian Youth, *Generation Z: life at 23*, 30 September 2024 (accessed 1 October 2025), https://lsay.edu.au/publications/search-for-lsay-publications/generation-z-life-at-23

[33] McGrail MR, Gurney T, Fox J, Martin P, Eley D, Nasir B, et al. Rural medical workforce pathways: exploring the importance of postgraduation rural training time. Hum Resour Health. 2023;21(1):31

cohort this can tap into. You can get a lot of grads in rural areas, but this could keep them there." RNs were seen as critical to sustaining a generalist nursing workforce in rural and remote areas, where staff are often required to perform a wide range of duties.

Some stakeholders also suggested extending eligibility to midwives, particularly in communities with higher infant mortality rates, to strengthen access to maternal healthcare. However, others cautioned careful consideration of any expansion to eligibility to avoid diluting the Program's focus and ensure appropriate support frameworks were in place.

5.2 Other systemic constraints outside of the Program will affect how effective HELP debt relief can be for retention

HELP debt reduction appears to be effective for attraction, but less so for retention, which is driven by practical, professional and social factors

While HELP debt reduction can attract professionals to rural and remote areas, it does not seem to materially influence whether they remain in their roles. This was a view shared by several stakeholders, noting that the Program "is a way to attract people, but it really doesn't align with other factors." Retention is primarily influenced by factors beyond financial gain, including the following:

Practical factors:

- Stakeholders emphasised that the appeal of financial incentives is greatly outweighed by practical needs such as availability of housing, childcare and transport, with one reflecting that "there is no housing in these areas... so the attractiveness of the Program has its own challenges." This is well-supported in the literature, with housing consistently being called out as a critical factor for retention.[34]

Professional factors:

- Health services and schools in rural and remote areas can often struggle to provide supervision, mentorship and development opportunities, due to staff shortages and workload challenges. Without these supports, professionals may take up placements but find it difficult to remain, regardless of the financial benefit. Education stakeholders noted that many teachers leave after their first service period because they cannot access the professional support available in major cities and larger regional centres. The importance of professional support is reinforced by research, with various studies highlighting poor self-efficacy, due to a lack of mentorship and other professional support, as a key barrier to retention in rural and remote areas.[35]

- Research indicates that inadequate preparation for rural and remote working can also impede retention. Eacott et al. highlighted "a lack of awareness of the challenges associated with working in regional, rural and remote schools" as an important barrier to attraction and retention, and stressed a need to "focus on

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[34] Halsey, J. *Independent Review into Regional, Rural and Remote Education: Final Report*, January 2018, https://www.education.gov.au/recurrent-funding-schools/resources/independent-review-regional-rural-and-remote-education-final-report; Humphreys, J., Wakerman, J., Pashen, D., & Buykx, P. (2009). Retention strategies & incentives for health workers in rural & remote areas: What works? Australian Primary Health Care Research Institute, ANU College of Medicine, Biology & Environment. https://openresearch-repository.anu.edu.au/server/api/core/bitstreams/39d9029e-e8de-4ec4-ace0-354b7d02333e/content; New South Wales Department of Education, *A review of rural and remote incentives in NSW public schools [PDF]*, 24 September 2021, https://education.nsw.gov.au/content/dam/main-education/about-us/strategies-and-reports/media/documents/Final_Societel_Copy_Edited_240921.pdf

[35] Jill Blackmore, Linda Hobbs, and Julie Rowlands, 'Aspiring Teachers, Financial Incentives, and Principals' Recruitment Practices in Hard-to-Staff Schools', *Journal of Education Policy*, published online 27 March 2023, pp. 233–252; Jennifer A. Ashiedu and Brenda D. Scott-Ladd, 'Understanding Teacher Attraction and Retention Drivers: Addressing Teacher Shortages', *Australian Journal of Teacher Education*, vol. 37, no. 11, 2012, https://doi.org/10.14221/ajte.2012v37n11.1; Eacott, S., Raffe, C., Niesche, R., Loughland, T., Durksen, T., Heffernan, A., & Gobby, B. (2020). *Recruiting and retaining high-impact educators in regional, rural and remote schools, Report 1: Barriers and challenges*. Report prepared for the Australian Government Department of Education.

preparedness... to reduce drop-out rates and initial culture-shock."[36] Preparing professionals for rural and remote working is not only critical for retention, but also for enhancing the experiences and outcomes of those they serve. This was echoed by stakeholders, with an education stakeholder emphasising that "we need preparation processes that allow for greater success for everyone."

- Stakeholders also noted that professional colleges and universities are taking steps to recognise rural and remote service delivery within professional recognition and career progression frameworks. These developments were seen as positive steps towards strengthening the perceived value of rural and remote practice and supporting long-term retention.

Social factors:

- Place-based factors are central to rural retention. Research shows that social connection, community participation and a sense of belonging strongly influence whether professionals remain in rural and remote areas. A rapid review highlighted that attachment to place, which can be fostered through community interaction, is critical to attracting, retaining and sustaining a rural health workforce.[37] Similarly, a study on rural teachers found that long-stayers tend to be integrated into their communities.[38] A scoping review by Cosgrave et al. (2019) found that familiarity with rural life and integration into the community were key determinants of retention,[39] yet these influences are often under-recognised in program design and policy.

- Early exposure and local recruitment are also critical for building a sustainable rural workforce. The literature also finds that attachment to place can be fostered by "a strong rural upbringing,"[40] which suggests that targeting those with rural and remote backgrounds is critical. Studies show that health and education professionals from rural backgrounds, or those who train and complete placements in rural or remote areas, are far more likely to stay. Russell et al. (2021) found that distributed training and preferential selection of rural students significantly improved retention outcomes,[41] while Skinner et al. (2022) confirmed that both rural origin and time spent training in rural areas predict where graduates choose to work.[42]

- First Nations health and education professionals play a vital role in improving outcomes in their communities. Strengthening local training pathways that enable First Nations people to train and work within or return to their own communities supports culturally safe care and long-term workforce stability. Programs that build local capability through partnerships with Aboriginal Community Controlled Health Organisations (ACCHOs) and regional training providers have shown promise in improving recruitment and retention outcomes, helping ensure rural and remote services are sustained by people who are connected to place.[43]

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[36] Eacott, S., Raffe, C., Niesche, R., Loughland, T., Durksen, T., Heffernan, A., & Gobby, B. (2020). *Recruiting and retaining high-impact educators in regional, rural and remote schools, Report 1: Barriers and challenges*. Report prepared for the Australian Government Department of Education.

[37] L. Beccaria, P. McIlveen, E. C. Fein, T. Kelly, R. McGregor, and R. Rezwanul, 'Importance of Attachment to Place in Growing a Sustainable Australian Rural Health Workforce: A Rapid Review', *Australian Journal of Rural Health*, first published 6 October 2021, doi: 10.1111/ajr.12799.

[38] Colin Boylan and David McSwan, 'Long-Staying Rural Teachers: Who Are They?', *Australian Journal of Education*, vol. 42, no. 1, 1998, https://doi.org/10.1177/000494419804200104.

[39] Cosgrave C, Malatzky C, Gillespie J. Social Determinants of Rural Health Workforce Retention: A Scoping Review. *Int J Environ Res Public Health*. 2019 Jan 24;16(3):314. doi: 10.3390/ijerph16030314. PMID: 30678350; PMCID: PMC6388117.

[40] L. Beccaria, P. McIlveen, E. C. Fein, T. Kelly, R. McGregor, and R. Rezwanul, 'Importance of Attachment to Place in Growing a Sustainable Australian Rural Health Workforce: A Rapid Review', *Australian Journal of Rural Health*, first published 6 October 2021, doi: 10.1111/ajr.12799.

[41] Russell, D., Mathew, S., Fitts, M. et al. Interventions for health workforce retention in rural and remote areas: a systematic review. *Hum Resour Health* 19, 103 (2021). https://doi.org/10.1186/s12960-021-00643-7

[42] Skinner TC, Semmens L, Versace V, Bish M, Skinner IK. Does undertaking rural placements add to place of origin as a predictor of where health graduates work? *Aust J Rural Health*. 2022 Aug;30(4):529-535. doi: 10.1111/ajr.12864. Epub 2022 Mar 24. PMID: 35324046; PMCID: PMC9545767.

[43] Panaretto, K., Wenitong, M., Button, S., & Ring, I. (2014). *Aboriginal community controlled health services: leading the way in primary care. Medical Journal of Australia*, 200(11), 649–652.

HELP debt reduction is not the only solution to rural and remote workforce shortages

HELP debt reduction alone will not address persistent workforce shortages in rural and remote areas and was not created to do so. It is a Program that uses one of the distinct levers available to the Commonwealth to incentivise more people participating in workforces that primarily benefit the States and Territories' service delivery.

Stakeholders stressed that, while the Program has value, its impact will remain modest unless it is embedded in a more systemic approach. Many of the barriers to retention, including housing, childcare and transport, preparation and professional support, and community integration, are State and Territory challenges and were not intended to be dealt with by the Program. One stakeholder stressed that "you can't just say, 'you have no more HECS debt.' There needs to be more support."

The impact of the HELP Debt Reduction Program will be maximised when complemented by other targeted supports. For example, the Remote Area Nursing Incentive Package provides professional development leave and allowances for Queensland nurses and midwives, while the Northern Territory offers a 100 per cent rental concession for teachers in remote areas. Better visibility and packaging across these initiatives would strengthen the overall policy effort to attract and retain professionals in rural and remote communities.

Stakeholders emphasised that workforce incentives must also be aligned with broader regional skills strategies. This means taking a place-based approach that considers the unique skills needs of local communities and how education and health services can build capacity and capability within regions. Regional universities and training providers, which can be more responsive to local workforce needs, play a key role in strengthening this link. Embedding the Program within a place-based workforce skills ecosystem would help ensure that financial incentives complement other measures to address local skills demand.

6 Program design

This section examines whether the Program's design, including its eligibility settings and geographic classifications, effectively supports rural and remote workforce needs and aligns with related workforce initiatives.

(Refer ToR (d), (f)(ii–iii), (g) as set out in Appendix A)

6.1 Initiatives under the Program share the same policy intent but provide different incentive arrangements for health and education professionals

The Program comprises two targeted initiatives, the VRT initiative and Med-HELP initiative, which aim to help address persistent workforce shortages in underserved regions, to improve access and equity to healthcare and education. These initiatives share the same policy intent and vary in scope and approach in response to the different contexts in which they are implemented. These differences are explored in the following sections. The key design features of each initiative are outlined in Table 33 below.

Table 3 | Key program design features

	VRT initiative[44]	Med-HELP initiative[45]
Eligible professions	Early childhood, primary and secondary teachers	Medical practitioners and nurse practitioners
Qualification requirements	A course of study in education, meaning a "course of study, completion of which would satisfy the minimum academic requirements for registration as a teacher by an authority of a State or Territory." This also includes an undergraduate qualification that is a direct pre-requisite to entry into an initial teacher education qualification.	**Medical practitioner:** Registration or accreditation as a health practitioner where the person has completed a course of study in medicine leading to their registration as a medical practitioner. **Nurse practitioner:** Registration or accreditation as a health practitioner, that is the nurse practitioner, where the person has completed all relevant postgraduate courses of study in nursing required to be endorsed as a nurse practitioner.
Service requirements	Work as a teacher in a 'face-to-face' manner at a centre-based daycare, preschool, primary school or secondary school to be at least eligible for an indexation waiver.	Provide general practice services for a minimum of 24 hours per week during that time to be at least eligible for an indexation waiver.
Geographic coverage	Very remote locations Uses the ABS Remoteness Area (ASGS-RA) classification to define eligible areas	Rural, remote and very remote locations. Uses the Modified Monash Model (MMM) classification to define eligible areas
Minimum service period	Four years of teaching within a six-year period	MM6-7: • Quarter of the length of degree/ program of study for a 50% HELP debt reduction. • Half the length of degree/program of study for a 100% reduction. MM3-5:

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[44] *HELP Debtor Guidelines (Teachers) 2023*, created under the authority of the *Higher Education Support Act 2003* and provides further details for **Division 142**

[45] *HELP Debtor Guidelines (Health Practitioners) 2023*, created under the authority of the *Higher Education Support Act 2003* and provides further details for **Division 144**

		• Half the length of degree/program of study for a 50% HELP debt reduction. • Full length of degree/program of study for a 100% HELP debt reduction
Debt forgiveness approach	When they complete the minimum service period, debt reduction to the value of the lesser of: • HELP debt incurred to achieve their initial teacher qualification (capped at 5 years of full time study), and • Outstanding HELP debt when they first met the program eligibility criteria. Waiver of indexation applies during eligible service. This operates retrospectively and can be applied for annually, or at the end of the service period.	HELP debt reduction to the value of the lesser of: • HELP debt incurred to achieve their qualification, and • Outstanding HELP debt when they first met the program eligibility criteria. 100% reduction when they complete the service period equivalent to: • Half the length of degree/program of study in MM6-7 location. • The full length of degree/program of study in MM3-5 location. 50% reduction when they complete the service period equivalent to: • Quarter of the length of degree/program of study in MM6-7 location. • Half the length of degree/program of study in MM3-5 location. Waiver of indexation applies during service as per VRT.

6.2 There is a balance to be struck between determining eligibility and ensuring support is going to areas of workforce shortage

Governments across Australia face competing demands for professional skills. In this context it is prudent to ensure that this Program supports the areas and professionals most affected by workforce shortages. This is achieved through eligibility settings that ensure Commonwealth funding is directed to those most in need and in settings where it can have the greatest impact.

Discussions with stakeholders and survey results from program participants confirmed support for the Program but also identified opportunities where changes to eligibility settings could perhaps better address workforce shortages and support improved service delivery in target areas. The potential benefits of these changes must be weighed against additional costs. Opportunities raised included:

• Explore whether the Program could be expanded to include other education and health professionals who make critical contributions in rural and remote settings, such as alternatively authorised teachers, hospital-based doctors (including those in emergency medicine or obstetrics), oral health practitioners and other medical practitioners working outside general practice.

• The fixed four-year requirement for VRT debt relief could be reviewed to provide greater flexibility, which may attract teachers who are interested in working in very remote schools but uncertain about committing to a full four-year term.

• The 'live and work' requirement for Med-HELP could be revisited to ensure it reflects the practical realities of rural service delivery, as some stakeholders view it as unnecessarily restrictive.

• The '24-hour' work threshold may unintentionally limit participation, particularly among practitioners working part-time or balancing family and community responsibilities. Reviewing this threshold could support greater inclusion and workforce diversity.

- The current requirement for participants to work in a general practice may not reflect the multi-setting nature of healthcare delivery in rural and remote areas. Recognising service across multiple clinical settings could better capture the realities of these roles.

- There is an opportunity to strengthen funding and policy support for nurse practitioners to live and work in rural, remote and very remote areas, where their skills are often in high demand and essential to local service delivery.

Each of these are explored in turn below.

Certain education and health professionals are not eligible for the Program, with differing stakeholder views on whether this should change

To be eligible for the VRT initiative, teachers need to have completed a course of study in education which satisfies the minimum academic requirements for registration as a teacher in their state or territory.[46] Given this, those with alternative authorisation to teach[47] are not eligible. This cohort represents only 5 per cent of teachers[48]. However, some stakeholders suggested they play a key role in addressing teacher workforce shortages in very remote areas, with one commenting that "a higher proportion of [alternatively authorised] teachers are in remote locations," and another noting "a growing cohort of Permission to Teach [teachers]" in very remote areas.

Some stakeholders felt that this cohort should be eligible for the VRT initiative, flagging that "the issue is that these teachers aren't being counted towards the Program, even though they are doing the same tough job in [...] remote schools." However, others raised concerns with expanding program eligibility to include teachers with alternative authorisation, noting they are compensated by remuneration during training, and there are challenges in providing sufficient supervision and support in very remote schools. The typical issues faced by early career teachers, described in Section 4.1, are further exacerbated for this cohort. Another concern raised was that expanding program eligibility in this way could encourage the use of alternatively authorised teachers to fill teaching vacancies in very remote schools, even though "you want fully qualified teachers to go to these challenging locations."

Similarly, in relation to the Med-HELP initiative, some stakeholders suggested that there is significant unmet need for allied health services in rural, remote and very remote areas, with one noting that "there are reports of vacancies persisting for years; for example, there has been a two-year vacancy for a speech pathologist in Wagga." It was also flagged that "families [in these locations] are waiting up to two years for paediatric allied health services, leading to frustration." These stakeholders proposed that, to help address this need, program eligibility could be expanded to include allied health professionals. A "targeted" approach was recommended – with a focus on speech pathology, podiatry, physiotherapy, occupational therapy, exercise physiology, and dietetics. However, other health stakeholders cautioned that the Program "can't be everything to everyone," and "[do] not dilute it with too many roles." It was stressed by these stakeholders that, "at the moment, we don't have the core workforce to save lives. [...] We need to think about what are our 'must-haves'."

Views on whether to expand the Program's eligibility settings to include alternatively authorised teachers and allied health professionals vary substantially across stakeholders. These differing perspectives underscore the need for any expansion to be considered carefully, to ensure it will have the desired benefits and not deliver unintended and undesirable consequences.

Requiring teachers to stay four years to be eligible for HELP debt relief may be too long

Currently, the VRT initiative provides HELP debt relief to teachers that complete the equivalent of four-years full-time teaching in a very remote school. In contrast, the Med-HELP initiative offers a more flexible model,

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[46] *Higher Education Support Act 2003* S142-5
[47] Permit to teach in the ACT, conditional accreditation in NSW, authority to teach in the NT, permission to teach in QLD and Victoria, special authority to teach in SA, and limited registration in WA.
[48] Australian Institute for Teaching and School Leadership (AITSL), National Trends Teacher Workforce, June 2025 (accessed 16 October 2025), https://www.aitsl.edu.au/research/australian-teacher-workforce-data/atwd-reports/national-trends-teacher-workforce-jun2025

providing a 50 per cent debt reduction after half the required service period. This staged approach has several advantages:

- It lowers the barrier to entry.

- Reduces the risk of participants leaving without any debt relief benefit.

- Better accommodates life changes such as family or health needs.

The VRT initiative is designed to attract individuals who may not have previously lived outside urban areas. As such, requiring a full four-year commitment before any debt relief is awarded may deter those who are unsure about adapting to life in a very remote community or face changes in their personal circumstances that necessitate moving away. For example, one participant served three and a half years in a very remote school but had to relocate closer to family for support during pregnancy. Despite their substantial service, they received no debt relief. A progressive model, like Med-HELP, would allow participants to receive partial relief even if they are unable to complete the full term. This recognises their contribution and mitigates the risk of receiving no benefit at all.

There are opportunities to reconsider the 'live and work' requirement

Under the Med-HELP initiative, medical practitioners and NPs must not only work, but also reside, in a rural, remote or very remote area.[49] Stakeholders held various perspectives on the intent behind this requirement, with some suggesting that it is rooted in concerns regarding "people doing a [fly-in-fly-out] model," whilst others felt that there are economic drivers: "[they] reside in the communities they work in so they can spend their incomes [there]." However, regardless of their perspective on its intent, stakeholders generally agreed that the 'live and work' requirement needs to be reviewed, asking, "if the Program is actually about getting services where they are needed, why do we care where they live?"

Housing was flagged as a barrier to professionals living in rural, remote and very remote areas. For example, one program participant sharing that "I have been rejected as while I work full-time in a [MM5 location], my main residence is [MM2] which reflects housing prices in our region and [...] family-specific factors." As such, the 'live and work' requirement is perceived by some stakeholders as unfair – with one noting that "you're punishing people for the postcode of their house, not where they deliver care." It was also flagged that the 'live and work' requirement has added to the administrative burden on both applicants and administrators. For these reasons, stakeholders felt there is a need to reconsider the requirement to reside in a rural, remote or very remote area, without increasing exposure to intermittent 'fly in-fly out' services.

The requirement to work in a General Practice should consider the multi-setting nature of rural and remote healthcare delivery

To be eligible for the Program, medical practitioners and NPs must provide General Practice services a minimum of 24 hours per week.[50] Stakeholders suggested that this does not align with the reality of healthcare provision in rural, remote and very remote areas. In these areas, medical practitioners and NPs tend to deliver services across multiple settings, including general practice clinics, emergency departments and hospital wards.[51] This is reflected in the formal recognition of rural generalist medicine as a field of speciality practice in September 2025 – with rural generalists providing "comprehensive general practice and emergency care as well as care in at least one other area of medicine [...] in hospital and community settings."[52] Stakeholders called for the Program to recognise that rural and remote medical practitioners and

[49] *HELP Debtor Guidelines (Health Practitioners) 2023* **S12-2(b)**, created under the authority of the *Higher Education Support Act 2003*, and provides further details for **S144-10(1)(b)** of the Act

[50] *HELP Debtor Guidelines (Health Practitioners) 2023* **S8**, created under the authority of the *Higher Education Support Act 2003*, and provides further details for **S144-1(1)(g)** of the Act

[51] Australian Medical Association, *AMA plan for improving access to rural general practice*, 14 September 2023 (accessed 16 October 2025), https://www.ama.com.au/improving-access-to-rural-general-practice

[52] Australian Health Practitioner Regulation Agency, *Rural generalist medicine approved as a new field of specialty practice,* 21 September 2025 (accessed 16 October 2025), https://www.ahpra.gov.au/News/2025-09-21-Rural-generalist-medicine.aspx

NPs work across settings, noting that the Program's eligibility settings "focus on primary care in a clinic, but that is not what rural medicine looks like."

The '24 hour' requirement may be creating barriers to participation

As noted, the Med-HELP initiative requires doctors to work in a General Practice a minimum of 24 hours per week.[53] Many stakeholders have raised issues with this requirement, with one noting that "the reality is that it's only supporting full-time workers, and a lot of doctors are not full-time." This sentiment is supported by the literature, with a 2023 report by the Rural Doctors Foundation finding that 26 per cent of rural medical practitioners worked part-time hours.[54] Similarly, a 2023 report by Rural Health West found that 37.9 per cent of GPs in rural WA worked part-time.[55] Stakeholders suggested that the Program should be more supportive of part-time work, with a health stakeholder noting that "you shouldn't lose eligibility just because you work flexibly."

Research indicates that female doctors are more likely than male doctors to work part-time, with the 2023 report by Rural Health West finding that, in rural WA, 63.3 per cent of part-time GPs were female.[56] This was raised by several stakeholders, who were concerned that the '24 hour' requirement disadvantages women. One stakeholder noted that it "unfairly affects younger females who are more likely to work part-time due to family commitments." A program participant felt that the requirement "discriminates against female doctors balancing work and family," and reflected on their own experience: "I have worked my entire career in [MM3] with the most recent 4 years in [MM7], but the previous 3 years [don't] count because of the minimum hour requirements." Stakeholders recommended reviewing the '24 hour' requirement to better support part-time medical practitioners and NPs, particularly women.

Current funding and policy settings could be strengthened to support NPs

NPs are a critical part of the solution to addressing demand for an experienced primary care workforce shortage in rural, remote and very remote areas, given their advanced training, broad scope of practice and capacity to practice independently.[57] With the ability to diagnose, prescribe and refer,[58] they are well-positioned to strengthen access to primary care in areas where GPs are in short supply. The inclusion of NPs in the Program recognises their potential to help address this critical service delivery gap. However, despite their capabilities, NPs face significant structural barriers to practicing in rural, remote and very remote areas. For example, NPs have fewer Medicare Benefit Schedule (MBS) item numbers and attract lower MBS rebates.[59] This impacts their financial viability, with one stakeholder sharing that "most practice managers would pick getting a new GP over an NP from a revenue perspective. There is a huge funding difference." Another noted that "the hardest thing for NPs in MM6-7 is to get in. They get locked out because the settings just are not [there] to take them on." While the Program rightly recognises the potential of NPs in addressing rural and remote primary care workforce shortages, the reality is that current funding and policy

[53] Australian Health Practitioner Regulation Agency, *Rural generalist medicine approved as a new field of specialty practice,* 21 September 2025 (accessed 16 October 2025), https://www.ahpra.gov.au/News/2025-09-21-Rural-generalist-medicine.aspx

[54] Rural Doctors Foundation, *The health of our rural practitioners – Research report [PDF]*, July 2024 (accessed 16 October 2025), https://ruraldoctorsfoundation.org.au/wp-content/uploads/2024/07/Rural-practitioner-health-report.pdf

[55] Rural Doctors Foundation, *The health of our rural practitioners – Research report [PDF]*, July 2024 (accessed 16 October 2025), https://ruraldoctorsfoundation.org.au/wp-content/uploads/2024/07/Rural-practitioner-health-report.pdf

[56] Rural Health West, *Rural General Practice in Western Australia: Annual Workforce Update November 2023*, July 2024, https://ruralhealthwest.com.au/wp-content/uploads/2024/09/Annual-Workforce-Update-November-30-2023_FINAL_WEB_13-09-2024.pdf

[57] Mills, J., Giles, F., & Hooker, L. With the training to diagnose, test, prescribe and discharge, nurse practitioners could help rescue rural health. *The Conversation*. 6 February 2023 (accessed 16 October 2025), https://theconversation.com/with-the-training-to-diagnose-test-prescribe-and-discharge-nurse-practitioners-could-help-rescue-rural-health-199287; Rossiter R., Prior K. & Phillips R. How nurse practitioners can help address rural health workforce shortages, *InSightPlus*, 18 September 2023 (accessed 16 October 2025)

[58] Nursing and Midwifery Board of Australia, *Fact sheet: Scope of practice and capabilities of nurses*, May 2024 (accessed 16 October 2025), https://www.nursingmidwiferyboard.gov.au/Codes-Guidelines-Statements/FAQ/Fact-sheet-scope-of-practice-and-capabilities-of-nurses.aspx

[59] Rossiter R, Phillips R, Blanchard D, van Wissen K, Robinson T. Exploring nurse practitioner practice in Australian rural primary health care settings: A scoping review. Aust J Rural Health. 2023; 31: 617–630. https://doi.org/10.1111/ajr.13010; Goddard, L. Restricting Medicare rebates for telehealth risks increasing health inequalities, *Eucalyptus*, 27 June 2024 (accessed 16 October 2025), https://www.eucalyptus.health/blog/restricting-medicare-rebates-for-telehealth-risks

settings are not sympathetic. This has likely contributed to very low program uptake amongst NPs, with only 15 applications received since commencement (see Section 8.2).

6.3 There are opportunities to consider alternatives to the Program's current use of geo-classifications

Using a purely geographical measure of remoteness may not reflect the lived experience of potential applicants

To be eligible for the VRT initiative, teachers must work in an area classified as very remote under ASGS-RA.[60] This divides Australia into five classes of remoteness, ranging from Major Cities to Very Remote Australia. To determine eligibility, the Med-HELP initiative utilises MMM,[61] which is consistent with the geo-classification methodology used by other health workforce initiatives (e.g. the Bonded Medical Program). Both ASGS-RA and MMM are based on road distance to population centres across Australia, and do not consider factors such as population size; population demographics; and access, availability and cost of services. For example, Terranora Public School, a primary school in a town with population of 2,926 in NSW, is classified as being in a Major City despite being 820 km from Sydney, due to its proximity to the Gold Coast in Queensland.[62] As a result, these geo-classifications do not necessarily reflect the reality of remoteness.

The sole reliance on geo-classifications to determine eligibility for the Program risks excluding communities experiencing significant disadvantage and unmet service need. This was recognised by stakeholders, with an education stakeholder noting that "programs that only look at remoteness boundaries risk missing places of need. Socioeconomic and cultural complexity matter, too." Another stakeholder flagged that "there is a huge difference between being remote and being underserved. The classification doesn't capture that." There is a particular risk for schools with multiple campuses that are classified differently despite experiencing the same challenges – one stakeholder highlighted the "unfairness of teachers in one location accessing [the Program] and not in another."

The remoteness status of localities in geo-classifications can change, impacting eligibility

Solely relying on geo-classifications to determine program eligibility risks volatility, given geo-classifications such as ASGS-RA and MMM were designed for purposes independent of education and health policy, and are updated over time, based on factors disconnected from policy intent. As such, a locality's classification could change, even if there is no change to its level of disadvantage nor service need. This was flagged as an issue by many stakeholders, who reflected that "we've had sites shift from MM5 to MM4 with the new MMM review, and people suddenly lose eligibility mid-service. It's hard to explain and harder to fix," and "a location can change classification between census updates, which can completely alter eligibility – even if nothing on the ground has changed."

Since its establishment in 2019, VRT initiative eligibility has changed slightly in response to ASGS-RA changes. A small number of providers have been affected, with five becoming eligible and one becoming ineligible, as shown in Figure 5. While ASGS-RA is relatively stable, a small number of localities change remoteness in each iteration of the geo-classification.

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[60] ABS, *Remoteness Areas, July 2021 – June 2026*, 21 March 2023 (accessed 16 October 2025), https://www.abs.gov.au/statistics/standards/australian-statistical-geography-standard-asgs-edition-3/jul2021-jun2026/remoteness-structure/remoteness-areas
[61] Australian Department of Health, Disability and Ageing, *Modified Monash Model*, 10 April 2025 (accessed 16 October 2025), https://www.health.gov.au/topics/rural-health-workforce/classifications/mmm
[62] Nous Group, *Final Report – Geographical classification in HELP funding initiatives*, 29 November 2023

Figure 5 | Changes in VRT school eligibility
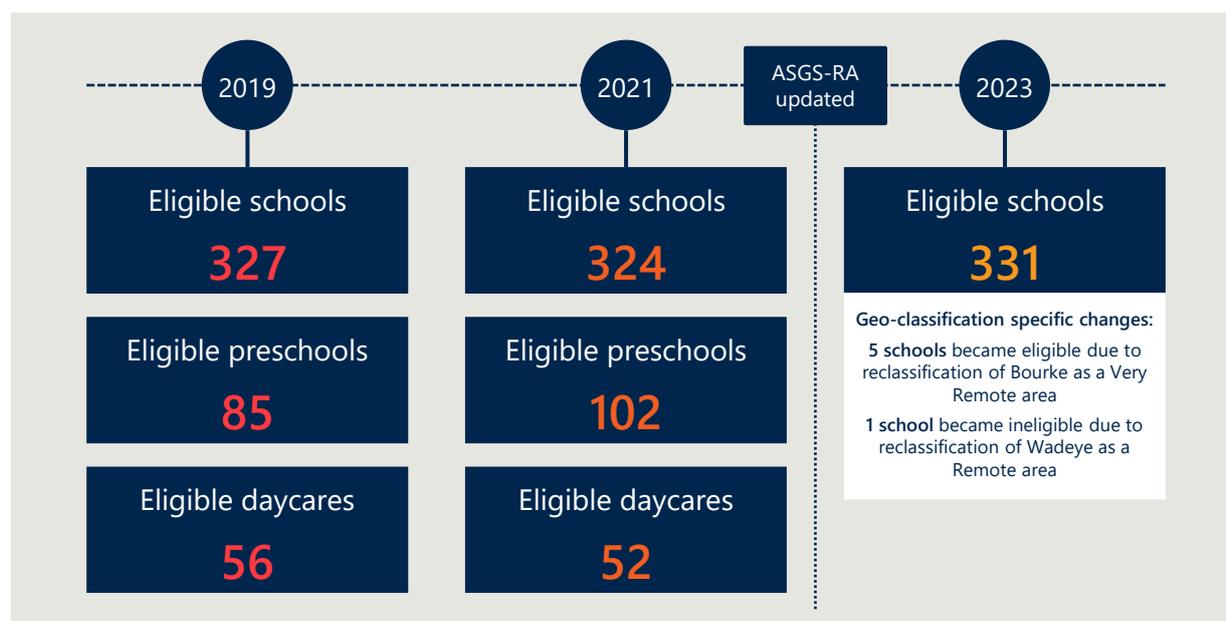
Similarly, MMM is updated in relation to census data, most recently in 2023. Between MMM 2019 and MMM 2023, 76 SA1s (0.1 per cent) became more remote and 1798 (3 per cent) became less remote. Table 44 sets out the changes in SA1 categorisation by classification.

Table 4 | Changes in SA1 classification from MMM 2019 to MMM 2023[63]

	Less remote	More remote	No change
1 – Metropolitan		32	42490
2 - Regional Centres	273	1	5427
3 - Large Rural Towns	64	1	4089
4 - Medium Rural Towns	72	26	2492
5 - Small Rural Towns	1203	7	4037
6 - Remote Communities	133	9	766
7 - Very Remote Communities	53		636

While this is an issue, it is important to recognise that the likelihood of reclassification is low, with changes to ASGS-RA and MMM impacting only a small proportion of localities. In the 2023 ASGS-RA update, only 0.4 per cent of all localities changed classification. Similarly, in the 2025 MMM update, only 3.2 per cent of all SA1s changed classification. This suggests that impacts on schools and clinics may be limited to a small number of

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[63] ABS, *Statistical Area Level 1*, July 2021 – June 2026, 20 July 2021 (accessed 16 October 2025), https://www.abs.gov.au/statistics/standards/australian-statistical-geography-standard-asgs-edition-3/jul2021-jun2026/main-structure-and-greater-capital-city-statistical-areas/statistical-area-level-1; Australian Government Department of Health, Disability and Ageing, *Modified Monash Model 2023*, 2 July 2025 (accessed 16 October 2025), https://www.data.gov.au/data/dataset/modified-monash-model-mmm-2023; Australian Government Department of Health, Disability and Ageing, *Modified Monash Model 2019*, 3 September 2024 (accessed 16 October 2025), https://www.data.gov.au/data/dataset/modified-monash-model-mmm-2019

marginal cases; however, it must be considered that these schools and clinics may support some of the nation's most disadvantaged communities.
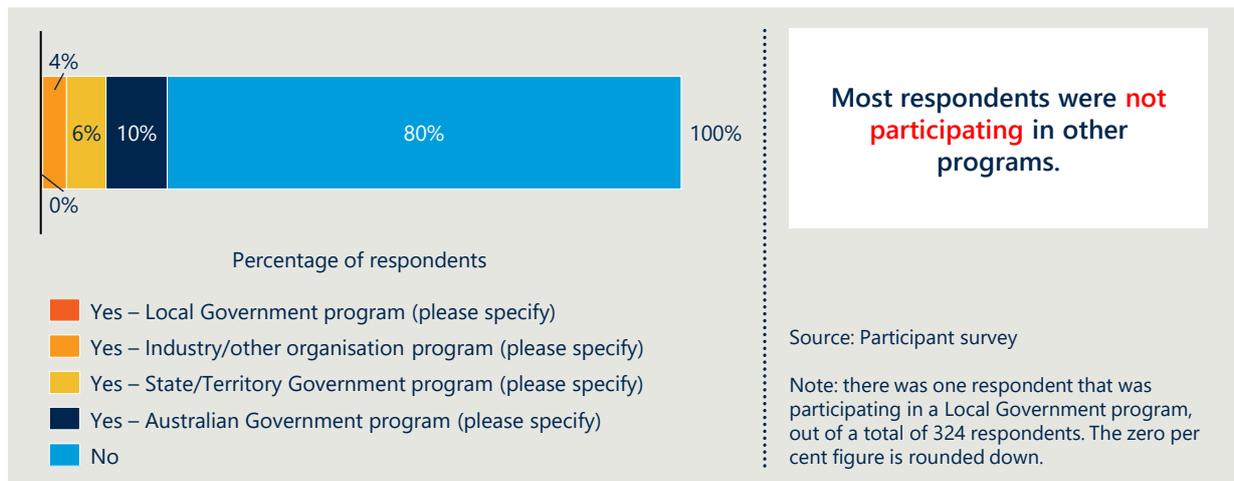
6.4 Positioning of the Program with other rural and remote workforce initiatives could be strengthened

Some program participants are engaged in other rural and remote workforce initiatives

Survey results in Figure 6 shows that 80 per cent program participants were not participating in other programs that support their work. The take-up of incentives is a product of what is on offer, knowledge and awareness of this offering, and whether it aligns with individual needs. Incentives offered by States and Territories may be deemed more attractive or relevant by eligible participants depending on their circumstances.

The remaining 20 per cent of respondents were participating in other programs and incentives. Some survey respondents involved in Med-HELP also accessed programs such as the Workforce Incentive Program (WIP), General Practice Rural Incentives Program (GPRIP), Bonded Medical Program and Medical Rural Bonded Scholarship. Respondents participating in the VRT initiative reported involvement in programs like Education Queensland's Attraction and Retention Incentive Scheme, remote teaching allowances, relocation and housing supports, and state-based initiatives such as the Queensland HECS Waiver, NSW Rural Doctors Network and WA Rural Doctors Association. While these overlaps can offer cumulative benefits, stakeholders noted that inconsistent eligibility criteria and reporting processes across programs cause confusion and can potentially dilute impact.

Figure 6 | Proportion of all respondents – Are you participating in any other programs that support your work in a rural, remote or very remote area?

Source: Participant survey

Note: there was one respondent that was participating in a Local Government program, out of a total of 324 respondents. The zero per cent figure is rounded down.

Legend:
- Yes – Local Government program (please specify)
- Yes – Industry/other organisation program (please specify)
- Yes – State/Territory Government program (please specify)
- Yes – Australian Government program (please specify)
- No

Chart values: 4%, 6%, 10%, 80%, 0%, 100%

Callout: Most respondents were **not participating** in other programs.

Rural and remote workforce initiatives offer distinct incentives which target a variety of needs

Med HELP and VRT share broad policy intent with a diverse range of other rural and remote workforce initiatives.

Stakeholders acknowledged that this diversity could make the policy landscape complex for participants to navigate, with some noting that overlapping eligibility and reporting requirements across programs such as the HELP debt reduction, Bonded Medical Program and Workforce Incentive Program (WIP) can create administrative burden and confusion. At the same time, others observed that these programs are intentionally differentiated, each responding to distinct workforce levers, professional cohorts and

jurisdictional responsibilities. For example, while states and territories manage a range of targeted incentives, only the Commonwealth can offer relief from a Commonwealth debt.

The opportunity therefore lies not in standardising programs, but in exploring opportunities for shared data, clearer communication and coordinated monitoring of outcomes to enhance visibility of complementary programs and better achieve the shared objective of improved rural and remote workforce supply and retention.

The distinct purposes of Commonwealth and State and Territory rural and remote workforce initiatives could be communicated in a more coordinated manner

As noted in Section 5.2, HELP debt reduction cannot, in isolation, resolve workforce shortages in rural, remote and very remote areas. Financial incentives are one lever among many that both the Commonwealth and the States and Territories use, and while they can attract professionals, they are not sufficient by themselves to ensure long-term retention. Stakeholders continually emphasised that housing availability, childcare access, community integration and family support are equally critical factors in encouraging professionals to stay.

A range of Commonwealth and State programs aim to provide broader support. For instance, the Workforce Incentive Program (WIP) sustains rural practices through professional and financial support, while state initiatives target attraction and retention. Other examples include Tasmania's Rural General Practice Settlement Incentive, which provides up to $100,000 over five years, and Queensland's Inaccessibility Allowance of up to $48,300 a year to offset higher living costs. For teachers, Western Australia's Remote Teaching Service package offers housing and relocation support, and New South Wales's Rural Teacher Incentive combines recruitment and retention payments.

Stakeholders advocated for a more unified, coordinated approach to communication about the Program and how it fits with others. One stakeholder remarked that it is "overwhelming to consider all the programs and options available". A more holistic and integrated approach to communication would allow these initiatives to work collectively to attract, support and retain professionals in rural and remote areas. However, aligning communication and incentive structures across Commonwealth and state governments also presents practical challenges, given differing program objectives, funding mechanisms and eligibility rules, even before considering the autonomy of States and Territories to create their own programs. Even so, greater coordination in messaging and joint promotion would strengthen overall awareness of available supports.

7 Program delivery

This section outlines how the Program is delivered and administered.

(Refer ToR (e), (f)(iv), as set out in Appendix A)

7.1 The administration process for the Program comprises five key stages

The Program is administered by the Department of Education, with delivery arrangements differing for each initiative. The Med-HELP initiative is jointly managed with the Department of Health, Disability and Ageing, whilst the VRT initiative is managed solely by the Department of Education. For both initiatives, the Australian Taxation Office (ATO) applies approved indexation waivers or debt reductions to participants' HELP loan accounts. These governance arrangements reflect HESA, and the distinct eligibility requirements for the health and education workforces. Successful program administration is reliant on close coordination between departments, and the alignment of processes, records and systems. There are five key stages in the program administration process, outlined in Table 55 below.

Table 5 | Overview of the program administration process

Stage	VRT initiative	Med-HELP initiative
1. Applications are received, logged and verified	Applications are submitted to the program mailbox and recorded in the case management system. Supporting documents are stored in secure shared folders for review and tracking.	Applications are submitted to the program mailbox and registered in the tracking system. Supporting documents are stored in secure shared folders for review and tracking.
2. Eligibility is assessed	The Department of Education reviews each application to confirm that it is a valid application and that qualifications, registration, employment location and service period meet eligibility requirements.	The Department of Health, Disability and Ageing reviews employment, residency and registration details and makes a recommendation. The Department of Education verifies HELP loan and HELP debt data against the requirements.
3. Decisions are endorsed and authorised	Assessments are checked for accuracy and endorsed through Department of Education governance processes and structures before final approval is recorded in the database.	Verified outcomes are compiled for review by the Department of Education and endorsed by the program delegate before being recorded as approved.
4. Applicants are notified of the outcome	Applicants are informed of the outcome in writing, including details of any approved indexation waivers or debt reductions, and next steps if further information is required.	Applicants are informed of the outcome in writing, including details of any approved indexation waivers or debt reductions, and next steps if further information is required.
5. Debt adjustments are made	Approved outcomes are consolidated and securely provided to the Australian Taxation Office to apply the relevant HELP debt adjustments.	Approved outcomes are consolidated and securely provided to the Australian Taxation Office to apply the relevant HELP debt adjustments.

7.2 The application process fulfills Program requirements with opportunities for further efficiency

A continued focus on improving the applicant experience can streamline access for applicants and processing by the Department

Applicants and administrators acknowledged that the Program's application process is detailed and rigorous. This reflects the strong governance and evidentiary requirements necessary to ensure eligibility and compliance under the HESA.

During the Program's early implementation, manual workflows and system limitations meant that assessing applications required considerable effort from both applicants and staff. Over time, these processes have continued to mature, supported by introduction of an ICT system and clearer applicant guidance.

Program administrators noted that eligibility verification, particularly for the Med-HELP initiative, can be resource-intensive. For example, verifying both residential and employment evidence within eligible locations ensures program integrity but can add to administrative complexity.

Some applicants reported uncertainty about eligibility criteria or the information needed to support their claims. Administrators similarly noted that work underway to improve communication and guidance will help to reduce rework and improve the experience for both applicants and administrators.

Overall, these findings point to an opportunity for ongoing refinement rather than fundamental change. As systems continue to evolve and digital functionality expands, the application process is becoming more efficient and is improving the experience for applicants while maintaining the Program's high integrity standards.

Legislative timeframes have proven challenging given administrative complexity

Under HESA there is a requirement for applicants to be notified of a decision within 60 days of receipt of their application.[64] HESA allows the extension of this decision-making timeframe to up to six months.[65] Processing times vary depending on how complete and accurate the information provided is at submission. The 60-day period does not commence until the point at which the submission is complete.

Improvements continue to be made to improve the application and assessment process to ensure it is efficient and effective

The efficient and effective delivery of the Program is related to the complexity of the policy: if a policy is relatively simple, then the application process also tends to be; if a policy has some complexity, then the application process also tends to reflect that. Stakeholders noted that the effectiveness and efficiency of the delivery of the Program was impacted by the complexity of its policy, especially a policy that has a requirement for 'time served' which means benefits are not necessarily quick to be realised.

The introduction of the new applicant portal IT system has already and will continue to simplify the application process, whereby applicants will submit their application through an online portal, which integrates with the Department's customer relationship management system, using myID.

Stronger program promotion should help drive uptake and awareness

Program visibility was a key theme which emerged out of consultation, with stakeholders consistently reporting that many eligible professionals were unaware of the Program. For example, one health stakeholder noted that "very few of our members had heard of the Program until we mentioned it," whilst an education stakeholder shared that "teachers are not talking about it because they don't know that it exists." Similarly, a
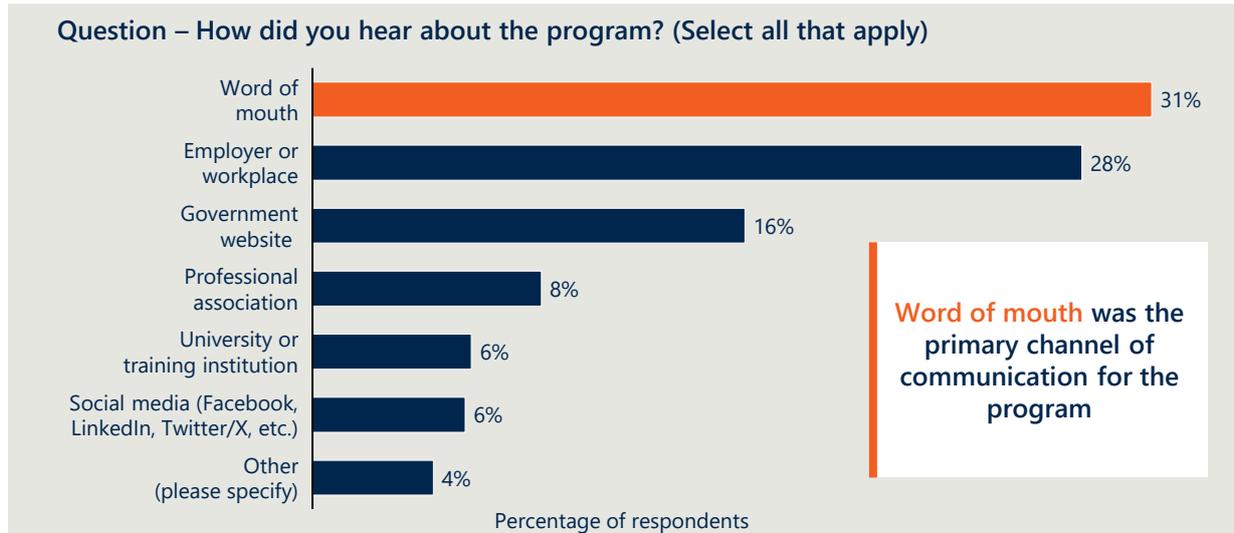
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[64] *Higher Education Support Act 2003*; **S144-5(3), (4), (6) and (7)** in relation to indexation, and **S144-10(4), (5), (7) and (8)** in relation to accumulated debt reduction.
[65] *Higher Education Support Act 2003*; **S142-10(3A) – Teachers, S144-5(4) – Health practitioners**.

program participant noted that they "only found out about it after three years remote," and while this participant can include those three years in a very remote school towards their eligibility, it does speak to the opportunity to increase awareness of the Program and the opportunities to potentially attract more participants.

Stakeholders reflected that the Program is mostly promoted through informal channels. Survey results confirmed this, with word-of-mouth being the most frequently cited channel for program promotion. Stakeholders identified the need for a more structured, proactive approach to promoting the Program, which would help improve awareness and uptake.

Figure 7 | Approaches to promotion

Question – How did you hear about the program? (Select all that apply)

Channel	Percentage
Word of mouth	31%
Employer or workplace	28%
Government website	16%
Professional association	8%
University or training institution	6%
Social media (Facebook, LinkedIn, Twitter/X, etc.)	6%
Other (please specify)	4%

Percentage of respondents

Word of mouth was the primary channel of communication for the program

A communications strategy has been developed to target state and territory agencies along with a broad range of stakeholders — eligible professionals, universities and training institutions, peak bodies and professional organisations — and uses multiple communication channels, including email campaigns, newsletters and social media. There is a potential opportunity to also target employers, such as professional practices and schools, as they are an important channel through which applicants hear about the Program (see Figure 7).

7.3 The Program could include data for outcome measurement and continuous improvement

More program data could be collected and used to inform program impact

Program data collection is appropriately limited to the required information for applications, including school or practice locations, qualifications, and outstanding HELP debt amounts. More detailed demographic data (e.g. gender, cultural or linguistic background, and First Nations status) are not currently collected.

The performance of the Program is measured based on activity and output; there is opportunity for this to now focus on outcome and impact. Currently, the Program has one Key Performance Indicator (KPI) – the proportion of applications that are assessed within 60 days of receipt, which is a requirement under HESA. While it is a useful measure of operational efficiency, it does not assess effectiveness.

Without KPIs focused on effectiveness, it is challenging to determine the extent to which the Program is achieving its intended objective of attracting and retaining key professionals in rural, remote and very remote areas.

The Department of Education is developing a benefits realisation plan, in the context of the new IT project, that provides a foundation for measuring outcomes in the short, medium and long-term.[66] This will include KPIs that are activity and output-focused (e.g. application volumes), as well as KPIs that are outcome-focused (e.g. preventable hospitalisation rates or access to general practice services). In addition to developing this plan, the Department could look to leverage existing datasets, such as the Tertiary Collection of Student Information, to link educational pathways with workforce outcomes, including where graduates work, how long they remain in rural and remote areas, and which population cohorts participate in the initiatives. Together, these actions will help establish a coherent, data-driven foundation for assessing program impact.

With the launch of a new system, there is also an opportunity for the Department of Education to also consider putting in place a formal mechanism to capture feedback from participants or other stakeholders on the Program. An understanding of how the Program is experienced by participants and perceived by stakeholders, will enable the Program to assess and continuously improve its performance.

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[66] Internal departmental documentation.

8 Program uptake and effectiveness

This section assesses how effectively the Program is achieving its intended outcomes.

(Refer ToR (a)(i–ii), (b)(i–ii), (e), as set out in Appendix A)

8.1 Stakeholders are broadly supportive of the Program's intent

Stakeholders were largely supportive of the Program's intent, viewing it as a necessary measure to attract and retain key professionals in rural, remote and very remote areas, with one stakeholder observing that "any initiative that helps attract and retain or home-grow the workforce is a positive measure," whilst another shared that "when people first hear about the Program, they think it is an obvious and much-needed policy." Stakeholders consistently expressed that the Program is worthwhile and should continue being delivered, noting that "this is a great opportunity to support access and equity." This notion was reflected in the survey results, with 68% per cent of participants indicating they are extremely likely or somewhat likely to recommend the Program to others (see Figure 8). Taken together, this suggests stakeholders see a clear, continuing role for the Program in strengthening the rural and remote workforce.

Figure 8 | All cohorts – How likely, or unlikely, are you to recommend the Program?
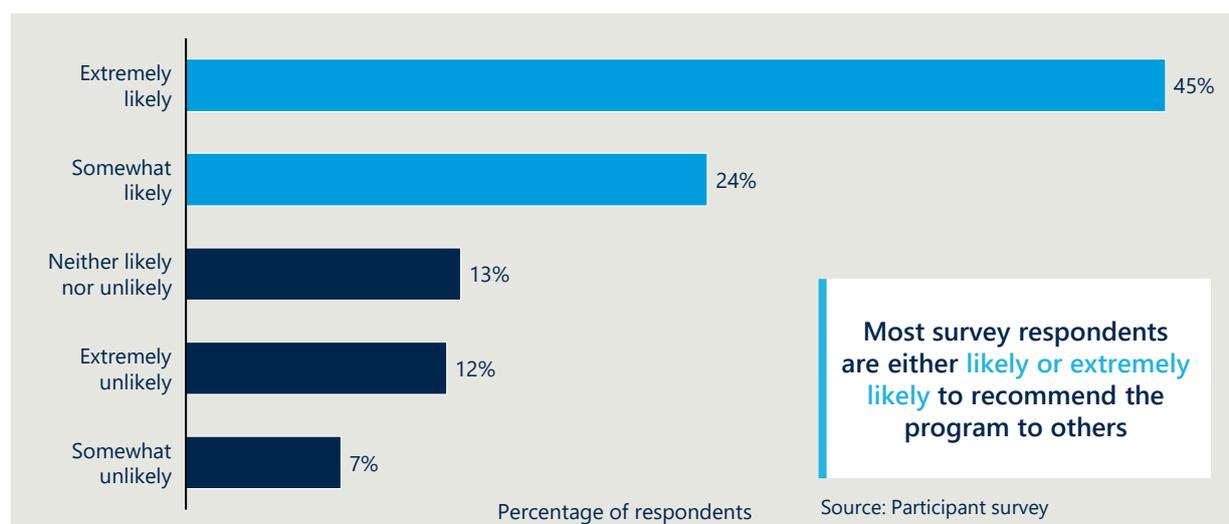
Program administrators from the Department of Health, Disability and Ageing noted that support for the Program is not universal across all professions. They emphasised the need for stronger metrics to assess effectiveness over time. These views reinforced the importance of improvements to monitoring and evaluation.

8.2 Uptake of the Program has been modest

Program participation has been modest.

- For the **VRT initiative,** 335 teachers applied for a debt reduction in 2023. By 2025, the Program had received 126 applications. The reason for this decline is unclear, but it may reflect a combination of factors, including levels of awareness of the Program among key stakeholders such as state and territory governments and universities, as well as the availability of other, better-promoted initiatives offering financial or career incentives for teachers in rural and remote areas.

- For the **Med-HELP initiative,** 400 applications have been received since commencement.

Uptake has been particularly low amongst nurse practitioners, with 16 applications received since commencement, representing 0.5 per cent of all nurse practitioners (approximately 3,000 across Australia), compared to 0.93 per cent of all primary care general practitioners (40,375 across Australia).[67] However, it is important to note the Med-HELP initiative has only been operating for three years. Practitioners seeking full HELP debt relief typically need to live and work in an eligible regional or remote area for four to six years before applying. Given the limited, short-term value of indexation waivers, practitioners may choose not to apply annually for them and instead wait until they can apply for the full HELP debt relief. As such, there could be many potential participants who have not yet reached the point of applying for the Med-HELP initiative.

Figure 9 | Estimated and actual debt reduction applications for the VRT Program

Source: Internal departmental documentation
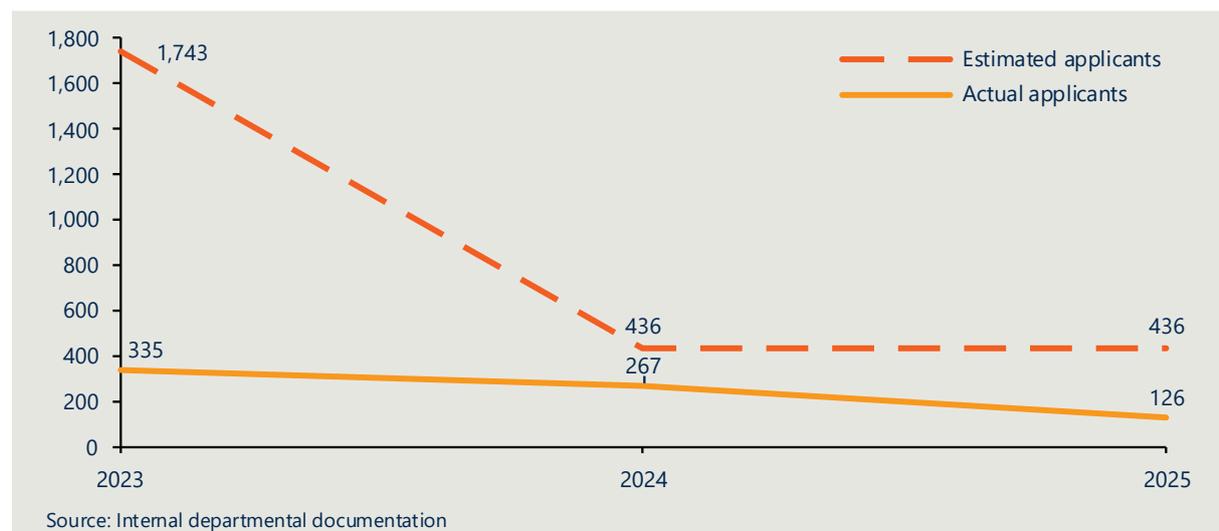
Table 6 | Actual applications for the Med-HELP Program[68]

Application year	Medical practitioner applications	Nurse practitioner applications	Total
2023	12	0	12
2024	243	10	253
2025	129	6	135
Total	384	16	400

Program participation varies nationally

Geographically, applications for the VRT initiative are concentrated in the Northern Territory, Queensland and Western Australia, reflecting their higher population in very remote areas. As shown in Figure 10, the VRT initiative has wide geographic coverage, reaching most of very remote Australia. However, demand is thinly spread – 60 per cent of postcodes had three or fewer applicants and 50 per cent had only one. A small number of applications had postcodes outside of very remote areas, potentially due to applicants incorrectly providing an address they lived at prior to relocating or after completing the Program.

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[67] RACGP - Current workforce characteristics
[68] Internal departmental documentation.

Figure 10 | VRT applications by postcode[69]
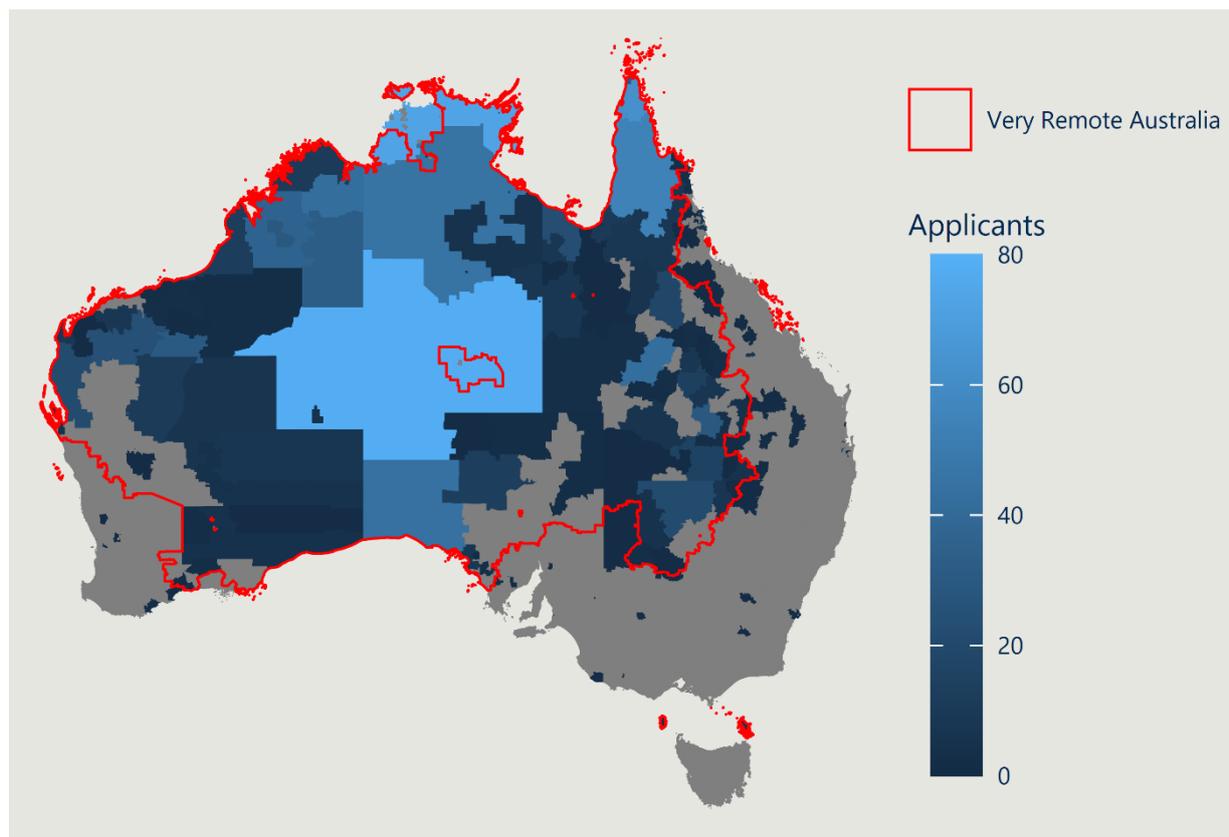
As shown in Figure 11, participation in the Med-HELP initiative is distributed unevenly, with demand being concentrated in more accessible regional centres, rather than in more remote areas. Over half of applicants are in New South Wales and Victoria (see

Table 7), which have less extensive remote and very remote areas than other states and territories. Around 70 per cent of participants are working in MM3-5 locations, whilst only 20 per cent work in MM6-7 locations, where primary care workforce shortages are most acute. 10 per cent provided a postcode outside the eligible areas, but this may be explained by applicants incorrectly providing an address they lived at prior to relocating or after completing the Program.

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[69] ABS, *Digital boundary files, July 2021 – June 2026*, 20 July 2021 (accessed 10 October 2025), https://www.abs.gov.au/statistics/standards/australian-statistical-geography-standard-asgs-edition-3/jul2021-jun2026/access-and-downloads/digital-boundary-files

Figure 11 | MED applications by postcode[69]
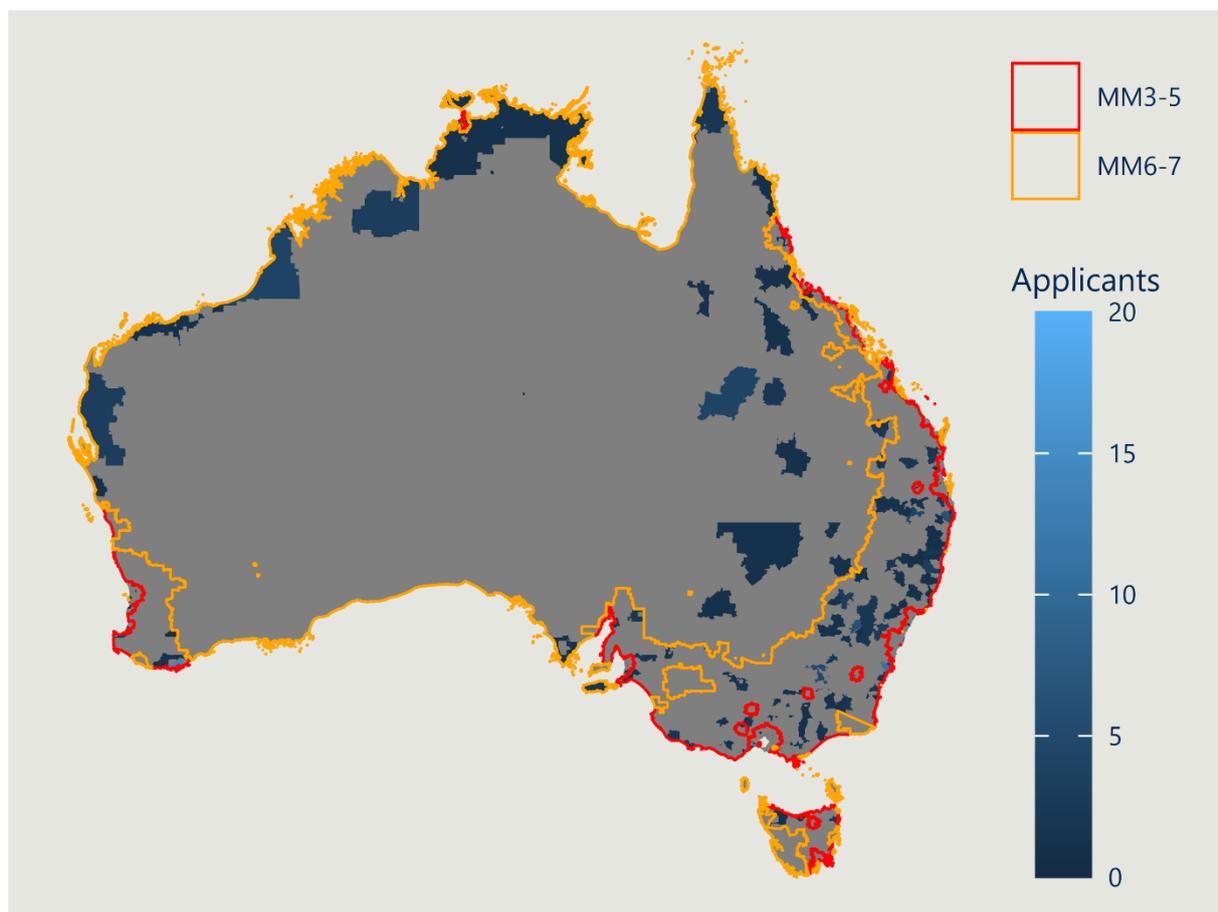
Table 7 | Med-HELP initiative applications by jurisdiction[70]

Jurisdiction	Applications	Proportion
NSW	140	35 per cent
NT	24	6 per cent
QLD	53	13 per cent
SA	42	11 per cent
Tasmania & ACT	8	2 per cent
VIC	83	21 per cent
WA	50	13 per cent
Total	400	

Note: Proportions may not add due to rounding.
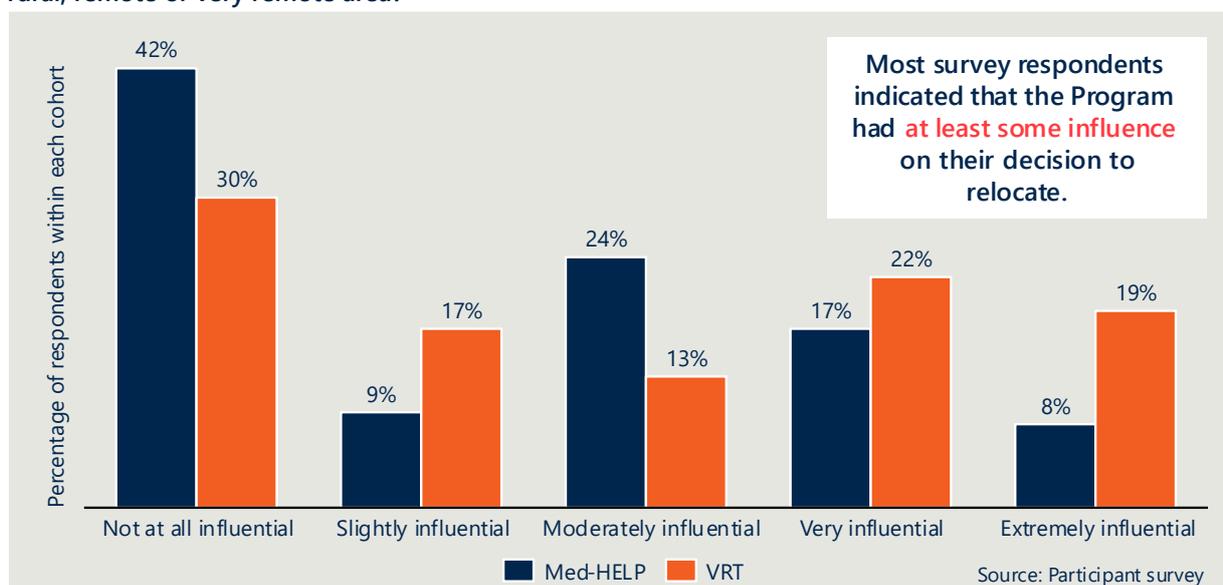
[70] Internal departmental documentation.

8.3 The extent to which the Program itself has influenced attraction and retention is difficult to assess

The Program had an influence on most participant's decision to relocate

There are many factors which will contribute to a decision by a professional to relocate to a rural or remote location to live, work and stay. Importantly, the Program has offered an incentive for people to make these decisions.

Many survey respondents described the Program as a "positive motivator," with most indicating it had an influence to some degree on them relocating to a rural, remote or very remote area. This reflects its value as a strong complement to State and Territory efforts.

Figure 12 | All respondents - How influential, if at all, is/was the Program to your intention to relocate to a rural, remote or very remote area?

Most survey respondents indicated that the Program had **at least some influence** on their decision to relocate.

Med-HELP: Not at all influential 42%, Slightly influential 9%, Moderately influential 24%, Very influential 17%, Extremely influential 8%

VRT: Not at all influential 30%, Slightly influential 17%, Moderately influential 13%, Very influential 22%, Extremely influential 19%

Source: Participant survey

A range of other factors were also identified that influence program participants' decisions to relocate (see Figure 13), noting there is variation between VRT initiative participants and Med-HELP initiative participants. While VRT initiative participants are most likely to be driven by a desire for a new experience, community or cultural engagement, and lifestyle preferences, those in the Med-HELP initiative are most likely to be driven by lifestyle preferences, family reasons, career progression and job availability. Taken together with the findings above, it appears that the Program's attractiveness may be greater for those who are already motivated to relocate by broader personal or professional reasons. While the Program is seen as a positive motivator, existing data makes it difficult to determine its definitive impact on the decision to live and work regionally or remotely.

Figure 13 | Completed and current respondents – Beyond the Program, what other factors influenced your decision to relocate? (Select all that apply)

Lifestyle preferences — Med-HELP 25%, VRT 15%
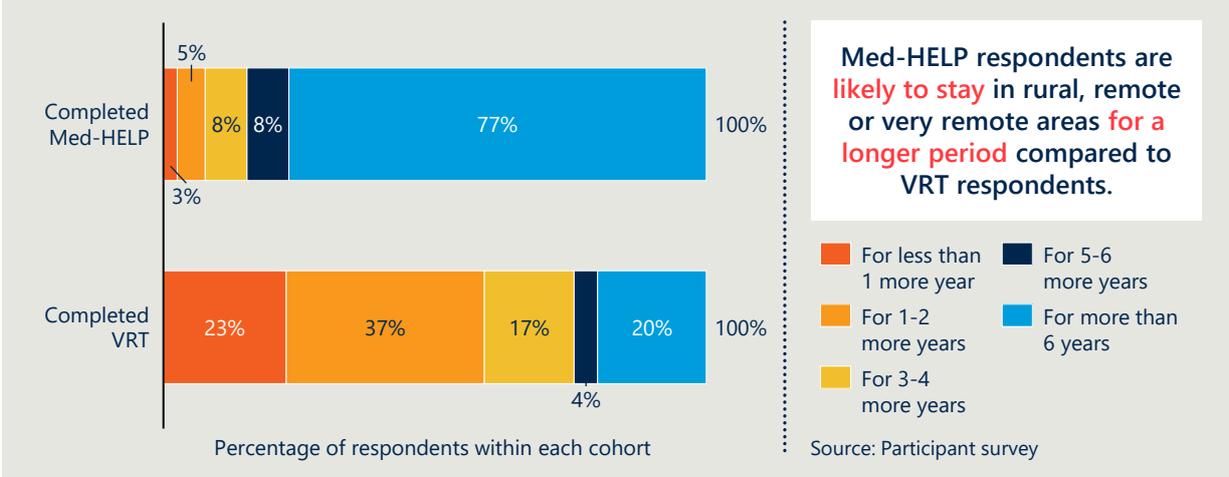Desire for a new experience — Med-HELP 11%, VRT 22%
Job availability — Med-HELP 13%, VRT 15%
Community or cultural engagement — Med-HELP 10%, VRT 16%
Professional development opportunities — Med-HELP 11%, VRT 11%
Career advancement opportunities — Med-HELP 7%, VRT 13%
Family reasons — Med-HELP 14%, VRT 4%
Other (please specify) — Med-HELP 8%, VRT 3%

Outside the program, Med-HELP respondents were most influenced by lifestyle preferences. VRT participants were more likely to cite a desire for a new experience

Med-HELP VRT

Percentage of respondents within each cohort

Source: Participant survey

Many participants remain in rural, remote and very remote areas post-program

Survey results showed that some program participants continue to live and work in rural, remote and very remote areas after completing the Program, particularly those who participated in the Med-HELP initiative. Figure 14 shows that 80 per cent of Med-HELP initiative participants choose to stay in rural, remote or very remote areas post-program. However, this is more split amongst VRT initiative participants, with 50 per cent of teachers leaving very remote areas after completing the Program. Survey responses to the question: "How much longer do you intend to work in a rural, remote or very remote areas?" were similarly mixed. While 77 per cent of Med-HELP initiative participants expected to remain for more than six years, 60 per cent of VRT initiative participants planned to stay for two or less years (see Figure 15).

Figure 14 | Completed respondents – Are you still working in a rural, remote or very remote area?

Completed VRT — No 50%, Yes 50% — 100%
Completed Med-HELP — No 20%, Yes 80% — 100%

Significantly more Med-HELP respondents are still working in a rural, remote or very remote area compared to VRT respondents

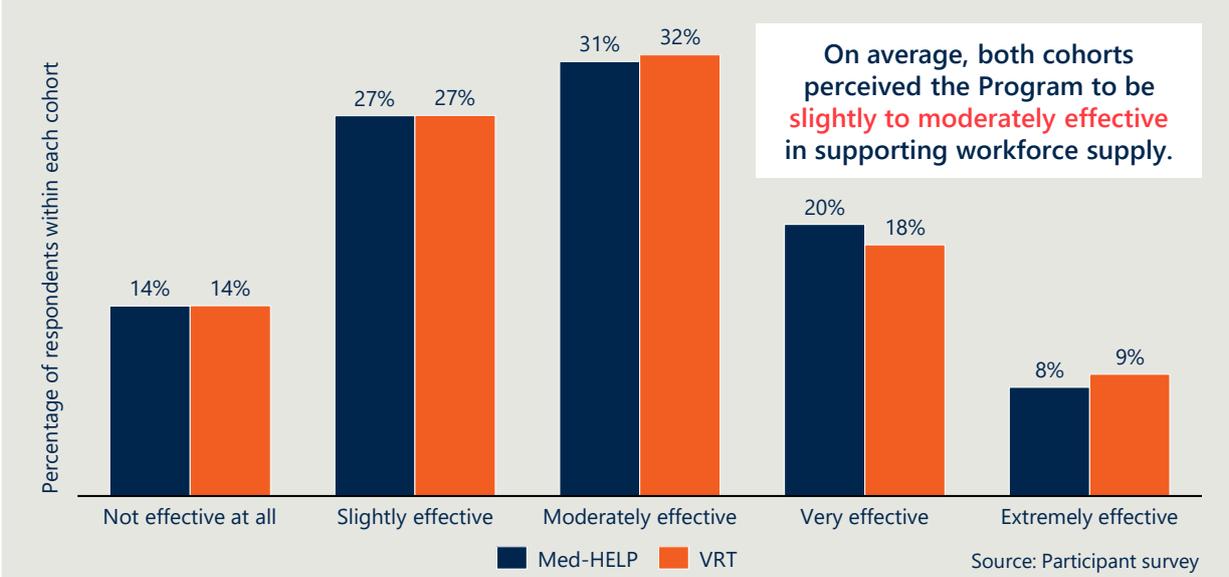No Yes

Percentage of respondents within each cohort

Source: Participant survey

Figure 15 | All respondents – How much longer do you intend to work in a rural, remote or very remote area?

Med-HELP respondents are likely to stay in rural, remote or very remote areas for a longer period compared to VRT respondents.

Completed Med-HELP: 5%, 3%, 8%, 8%, 77% — 100%
Completed VRT: 23%, 37%, 17%, 4%, 20% — 100%

Percentage of respondents within each cohort

Legend:
- For less than 1 more year
- For 1-2 more years
- For 3-4 more years
- For 5-6 more years
- For more than 6 years

Source: Participant survey

The difference across initiatives could be reflective of their varied geographic focus – the Med-HELP initiative offering more flexibility by targeting rural, remote and very remote areas, whereas the VRT initiative is limited to very remote areas. This may also reflect differences between the professions, with medical practitioners tending to have more stable and longer-term career pathways supported by structured training and qualification frameworks, whereas teachers are typically more mobile across schools and regions.[71]

Stakeholders generally saw value in the Program and noted that it was not the only solution, with one stakeholder noting that "a debt reduction scheme has value but cannot be a standalone solution." Program participants appreciated the financial support but suggested that the Program needs to be supported by other measures and initiatives to be effective. One participant noted that "I think more investment in helping people integrate into the community is key. A financial benefit is just one part of it." This underscores the earlier observations about the value of complementary incentives offered by the Commonwealth and the States and Territories.

Figure 16 | All respondents – How effective, if at all, do you feel the Program is in supporting workforce supply to rural, remote or very remote areas?

Percentage of respondents within each cohort

	Med-HELP	VRT
Not effective at all	14%	14%
Slightly effective	27%	27%
Moderately effective	31%	32%
Very effective	20%	18%
Extremely effective	8%	9%

On average, both cohorts perceived the Program to be slightly to moderately effective in supporting workforce supply.

Source: Participant survey

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[71] Russell, D., Mathew, S., Fitts, M., et al. (2021). *Interventions for health workforce retention in rural and remote areas: a systematic review. Human Resources for Health.* https://doi.org/10.1186/s12960-021-00630-1.

9 Future opportunities

This section outlines recommended actions to strengthen the Program's design, delivery and overall impact.

(ToR (f)(i–iv), (g), as set out in Appendix A)

The review found that the Program responds to a genuine need to attract and retain professionals in rural, remote and very remote areas, and that stakeholders strongly support its intent. It has had a modest uptake (to date) and there are opportunities to ensure its specific purpose amongst a suite of supporting initiatives offered by the States and Territories is clearly understood.

This section presents nine recommendations for the Program that directly address the Minister's Terms of Reference for the Review (see Appendix A), ensuring that findings and future directions are clearly aligned with the scope and intent of the Review.

Table 8 | Summary of recommendations

Recommendation	Relevant Terms of Reference
1. Review and test proposed changes to eligibility settings	(a)(i), (a)(ii), (d), (e), (f)(iii)
2. Refine how remoteness is defined to better reflect local realities	(a)(i), (a)(ii), (d), (f)(ii)
3. Simplify the process for annual indexation waivers	(e), (f)(iv)
4. Strengthen alignment with other rural and remote workforce initiatives	(a)(i), (a)(ii), (c)(i–iv), (f)(iii)
5. Strengthen communication with applicants throughout the process	(e), (f)(iv)
6. Strengthen targeted promotion and partnerships to reach the right audiences	(a)(i), (a)(ii), (b)(i), (b)(ii), (c), (e)
7. Finalise and implement a benefits realisation plan for both initiatives	(a)(i), (a)(ii), (e), (f)(iii)
8. Improve baseline data collection to support ongoing improvement of the Program	(a)(i), (a)(ii), (b)(i), (b)(ii), (e), (f)(iii)
9. Defer program expansion until the Program matures	(f)(i), (f)(iii), (g)

1. Review and test proposed changes to eligibility settings

Consideration should be given to several adjustments to the current eligibility settings, including:

- Assessing whether targeting medical practitioners from PGY1 rather than PGY3 would better encourage early-career participation in rural and remote practice.

- Considering removal or modification of the 'live and work' requirement to reflect the realities of rural work patterns, commuting arrangements and housing availability.

- Whether the current focus on general practice excludes other relevant clinical roles that contribute to rural service delivery, such as emergency medicine, obstetrics, anaesthetics, psychiatry or other hospital-based specialities.

- Whether the 24-hour minimum work requirement disproportionately excludes part-time or flexible practitioners, particularly women and carers.

- Consider introducing a staged debt relief model for the VRT initiative, allowing participants to access partial HELP debt reduction after completing two years of service in a very remote school, with full relief after four years.

2. Refine how remoteness is defined to better reflect local realities

Consideration should be given to refining geo-classification systems by applying additional data overlays to address the limitations of using a purely geographical measure of remoteness. For the VRT initiative, this could include at minimum an overlay of population density (like the MMM approach) to better capture the distribution of workforce need and service access. Additional overlays could include:

- Service availability and access, to reflect actual community need rather than distance alone.

- Population demographics and cost of living, to account for social and economic factors influencing workforce attraction and retention.

- Consider the preservation of eligibility for participants impacted by changes to geo-classifications.

Refining the geo-classification system to better reflect local realities would also support greater flexibility and stability in how remoteness is applied. Once a school or community is classified as one type of location (e.g., very remote), it should remain eligible even if future boundary updates shift the classification. This would ensure consistency of intent and avoid anomalies between programs.

3. Simplify the process for annual indexation waivers

The Department could review the current approach to annual indexation waivers to reduce reapplication while maintaining compliance with legislative timing requirements. Although indexation is generally applied before a waiver is processed by the ATO, participants could instead have their waiver processed at the end of their service period, once they have met the required timeframe. Where circumstances change, a mid-point application can be submitted to update details or leave the Program. This approach would meet legislative requirements, ensure integrity, and reduce unnecessary administrative burden for both participants and the Department.

This refinement would retain an annual process where it adds value but remove it where it imposes unnecessary burden on participants and administrators. As outlined, a more proportionate approach would improve user experience, reduce administrative effort, and preserve the Program's capacity to focus on higher-risk or changeable cases.

4. Better complement other rural and remote workforce initiatives where appropriate

The Department should consider how the Program complements other State, Territory and Commonwealth initiatives that aim to attract and retain professionals in rural and remote areas. This includes clearer articulation of how the Program supports other strategies such as the Stronger Rural Health Strategy, the National Strategic Framework for Rural and Remote Health, National Teacher Workforce Action Plan and equivalent plans in States and Territories. The particular challenges faced by the community-controlled sector warrants consideration. The Regional Education Commissioner and the National Rural Health Commissioner hold valuable expertise and data relevant to understanding future workforce needs and shortages across education and health. Their continued engagement will be highly valuable in ensuring the Program aligns with broader national workforce priorities and responds effectively to regional and community realities

5. Strengthen guidance and communication with applicants throughout the process

The Department should continue building on recent improvements to communication practices and ensure the resourcing necessary for the new ICT system to be fully implemented and enhanced as planned.

The new ICT system includes functionality for automated communication and real-time status tracking through the applicant portal. Ensuring these features are fully implemented and actively used will allow applicants to receive confirmations on submission, alerts when further information is required, and reminders for annual confirmations. This will improve transparency, reduce processing delays and align with the ICT project's intent to centralise communication and streamline assessment.

Embedding clear and proactive communication across every stage of the applicant journey, from initial enquiry through to outcome, would improve the applicant's experience. Updated guidance materials could include detailed examples of eligible roles, locations and work patterns, as well as common reasons for ineligibility. Progress updates at key points in the application process could also improve transparency and applicant confidence.

6. Strengthen targeted promotion and partnerships to reach the right audiences

There is the opportunity to improved promotion of the Program to reach those most likely to be eligible and benefit. This could include a structured communications plan and partnering with trusted intermediaries such as State and Territory governments, universities, professional colleges, community-controlled organisations, rural workforce agencies and unions. These partners are well placed to share information through existing networks, training pathways and recruitment processes, ensuring potential applicants are aware of the Program early in their career.

A partnership-based approach would build program visibility, improve understanding of eligibility and processes, and reinforce alignment across related initiatives.

7. Finalise and implement a benefits realisation plan for both initiatives

Developing a joint benefits realisation plan covering both Med-HELP and VRT would provide a consistent framework for measuring and demonstrating the outcomes of the whole HELP Debt Reduction Program. Building on the existing Med-HELP plan, the framework could be expanded to capture teacher-specific indicators and adapted to reflect the distinct settings of the education sector. This would enable a single set of metrics and reporting arrangements across both initiatives, simplifying performance monitoring and supporting a clearer line of sight to the Program's overall objectives.

The joint plan could draw on existing program logics and monitoring materials to ensure continuity in data collection and avoid duplication. It would capture short-term indicators such as awareness, application volumes and processing timeliness, alongside medium- and long-term measures such as workforce retention and community outcomes. A unified benefits realisation plan would provide a clearer evidence base for future evaluation, support transparent reporting to stakeholders, and present a comprehensive picture of the Program's contribution to rural and remote workforce outcomes.

8. Improve baseline data collection to support ongoing improvement of the Program

A more structured approach to data collection would strengthen the Program's ability to measure outcomes and inform continuous improvement. Establishing a clear schedule for baseline data collection and using existing administrative datasets would create a consistent evidence base across both Med-HELP and VRT. This foundation would also support future evaluations and provide ongoing feedback to refine design and delivery settings.

Opportunities for regular and linked data collection could include:

- Embedding baseline measures from a joint benefits realisation plan, such as application volumes, processing timeliness and workforce participation rates, to ensure consistent year-on-year tracking.

- Undertaking a periodic participant survey to capture satisfaction, awareness and perceived barriers, supplementing administrative data with qualitative insights.

- Linking existing datasets such as the Tertiary Collection of Student Information (TCSI) with workforce data to track educational pathways, employment locations and duration of rural service.

- Using workforce and service data from the Australian Institute of Health and Welfare, Medicare, and state education departments to assess distribution, retention and access outcomes.

These processes will help with the improvement of the Program, particularly when combined with regular reporting cadences.

9. Defer program expansion until the Program matures

Expansion of the Program to additional professional groups, such as registered nurses, midwives, oral health staff, allied health professionals (such as speech pathologists and occupational therapists), and alternatively authorised teachers, should be deferred until the current initiatives are more mature and evidence of their effectiveness is available. These groups have been identified by stakeholders and research as critical to addressing workforce shortages in rural and remote communities. However, expanding too early risks embedding existing design and administrative challenges before they are resolved.

While the Terms of Reference for this Review are confined to questions of expanded eligibility to the health workforce, there have been other professional groups which have sought eligibility consideration for remote workforce incentives in legal and veterinary practice (noting the Occupation Standard Classification for Australia (OSCA) code as of 2024 includes Veterinarians and Veterinary Technologists as Health professionals).

Both professions face similar remote workforce attraction and retention challenges as experienced by health and education. There is important work underway in their counterpart Commonwealth Departments to better quantify the dimensions of regional and remote workforce shortages within these professional groups. This work will be vital to informing any policy decisions about eligibility for a like program.

Appendix A Terms of Reference

RURAL AND REMOTE HIGHER EDUCATION LOAN PROGRAM (HELP) DEBT REDUCTION

REVIEW TERMS OF REFERENCE

I, Jason Clare, Minister for Education, initiate an independent review of the operation of the special measures for location-preferred HELP debtors, in accordance with section 144-20 of the *Higher Education Support Act 2003.*

The review will:

a) consider the effectiveness of the current HELP Debt Reduction Program to attract and retain:
   i) Medical practitioners and nurse practitioners in rural, remote and very remote locations, and
   ii) Teachers in very remote locations
b) consider the levels of take up of the HELP Debt Reduction Program by those who are:
   i) Medical practitioners and nurse practitioners or studying to be so
   ii) Teachers or studying to be so
c) consider how the HELP Debt Reduction Program operates in relation to other offerings or schemes to benefit medical practitioners and nurse practitioners and teachers offered by:
   i) the Australian Government
   ii) State and Territory governments
   iii) Local governments
   iv) Industry or business or any other non-government organisations
d) consider the current eligibility requirements of the HELP Debt Reduction Program and how they are being applied and any adjustments that may be needed to ensure they are appropriate and consistent;
e) consider the current operational delivery of the HELP Debt Reduction Program and how efficiently and effectively the program is being delivered within current resources;
f) consider, and make recommendations to the Australian Government about future opportunities for the HELP Debt Reduction Program including:
   i) which sectors may be those with future high skill needs in rural, remote and very remote Australia based on Australian Government analyses with a focus on the health, mental health and education sectors;
   ii) whether the current definitions of rural, remote and very remote used in the program are appropriate for settings that apply to some of these workforces, for example where teachers are required to work at different campuses of a school that are located in different classifications;
   iii) whether there are more effective ways that that funding for the program could be used to meet the objectives of the program; and
   iv) how delivery of the program could be enhanced including timeframes for the assessment of applications and the use of secure digital technology platforms in receiving applications, and
g) report on any other relevant matters raised by stakeholders relating to the HELP Debt Reduction Program.

The review will include consultation with:

a) rural, remote and very remote health, mental health and education service providers;
b) the National Rural Health Commissioner;
c) the Regional Education Commissioner;
d) professional organisations;

e) national peak bodies;
f) unions; and
g) the Australian Tertiary Education Commission, Jobs and Skills Australia, and other Australian Government departments and agencies.

2) The review is to be conducted within three months of commencement and a report of the review is to be provided to me by no later than mid-November 2025.

Jason Clare

Minister for Education

[Authority: Section 144-20 of the *Higher Education Support Act 2003*]