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Findings: Overall, the findings suggest that the NCMS has a positive effect on annual hours worked on the farm, with a 4-5% decrease in the likelihood of not working and a 5% increase in the likelihood of off-farm labor force participation. When stratified by individual characteristics, the effects on labor supply are similar for males and females, while statistically significantly different for older, those older than 35 years of age, and poorer, those households with per capita income below the median level in China, individuals.

Interpretation: Studies concerning the effects of public health insurance on labor supply in developing countries remain limited. The findings of this study provide important insights into how public health insurance programs, like the NMCS, may affect patterns of labor supply among rural residents, and can help policymakers improve health policies aimed to reduce the number of uninsured farmers while maintaining high levels of labor supply and productivity as well as health status among the most vulnerable of populations.

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A Qualitative Approach to Evaluating the Global Barriers of International Emergency Medicine Development

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Background: The ACEP International Ambassador Program was developed as a venue for international experts to provide current status and progress of Emergency Medicine (EM) in their assigned countries. An annual one-day conference was created to convene ambassadors and allow for collaboration to reach the common interest of advancing emergency care. Our objective was to analyze the major perceived barriers for the evolution our specialty.

Methods: Open-ended interviews conducted during the program's annual conference were collated from 2013-2015. Ambassadors (N=75) were divided into focus groups. Interviews were centered on themes: barriers by stage of EM development; local, regional, and international needs for EM development; and barriers and needs of International EM education. Data collection obtained by real-time scribes and grouped into key findings. An inductive approach was used to identify barriers for the evolution of EM abroad.

Findings: Ambassadors represented 83 countries (almost 50% of the world's nations). The definition of EM is very country specific. Identifying local stakeholders that could advocate for EM can be difficult. Even though the motivations of local governments are difficult to recognize at times, the involvement of Ministers of Health, public officials, and local leaders are an essential part in advancing the specialty. Furthermore, international organizations could provide quality control for the development of EM through a process of merit. A heterogeneous curriculum and lack of knowledge of EM as a specialty has been a major challenge for residency programs. Centralizing educational resources can reduce duplication of efforts and would benefit educational processes for EM residency programs and health personnel.

Interpretation: International Emergency Medicine remains underdeveloped. No clear definition of EM as a specialty exists. The scope of practice of EM abroad is still not widely recognized, which further increases the difficulty of its evolution. The indispensable expansion of EM will be exponential with the support of regional leaders to form a unique identity of the specialty. Leaders play a vital role in standardization and communication, while serving as catalysts in resolving shared concerns. It is important to attempt to professionalize IEM education. With the support from ACEP and IFEM, initial steps to professionalize IEM education would include course maps with milestones and guide for a core curriculum.

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State of Emergency Medicine Residencies in Colombia

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Background: Emergency medicine is in different stages of development around the world. Colombia has made significant strides in the development of emergency medicine in the last two decades and recognized it as a medical specialty in 2005. The country now has seven emergency medicine residency programs, three in the capital city of Bogota, two in Medellin, one in Manizalez, and one in Cali. The seven residency programs are in different stages of maturity, with the oldest founded 20 years ago and two founded in the last two years. The goal of this study was to characterize this seven residency programs.

Methods: Semi-structured interviews were conducted with faculty and residents from all the existing programs in 2013 and 2016. Topics included program characteristics and curricula.

Findings: Colombian emergency medicine residency programs last three years, except for one that is four years. Programs accept 3-10 applicants every year. Only one program has free tuition and the rest charge a fee to the resident. The number of emergency medicine faculty ranges from 2-15. Emergency medicine rotation requirements range from 11% to 33% of total clinical time. One program does not have a pediatric rotation. The other programs require one to two months of pediatrics or pediatric emergency medicine. Critical care requirements range from 4 to 7 months. Other common rotations include anesthesia, general surgery, internal medicine, obstetrics, gynecology, orthopedics, ophthalmology, radiology, toxicology, psychiatry, neurology, cardiology, pulmonology, and trauma. All programs offer 4-6 hours of protected didactic time each week. Some programs require ACLS, PALS and ATLS, with some programs providing these trainings in house or subsidizing the cost. A majority of programs require one research project for graduation. Resident evaluations consist of written tests and oral exams several times per year. Point-of-care ultrasound training is provided in four of the seven programs.