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Australia's Remote Vocational Training Scheme: training and supporting general practitioners in rural, remote and First Nations communities

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The Remote Vocational Training Scheme (RVTS) is an independent rural general practice workforce and training program fully funded by the Department of Health and Aged Care since 2000. It is operationally delivered by the Remote Vocational Training Scheme Ltd (a national training provider). This perspective article describes the RVTS and its development over time to lay the foundations for this supplement on *Growing and sustaining doctors in rural, remote and First Nations communities*, which shows the outcomes of the RVTS program.

The RVTS supports the delivery of vocational general practice and rural generalist training for the Royal Australian College of General Practitioners (RACGP) and/or the Australian College of Rural and Remote Medicine (ACRRM). In doing so, the RVTS regularly liaises with both general practice colleges to manage accreditation, training requirements, and examinations among other issues. However, the RVTS has a nuanced focus compared with other rural general practice vocational training pathways (Box 1).

First, the RVTS specifically aims to support vocational training in more remote locations classified as Modified Monash Model (MMM) 4–7 and rural Aboriginal Medical Services (AMS) (MMM2–7) through a Remote and an AMS Stream respectively.[1] Second, although the ACRRM and the RACGP apply remote supervision selectively when they hope to expand the training in rural locations with limited supervisors,[2,5] the RVTS fully uses remote supervision (ie, online and intermittent face-to-face) because of its context of supporting more isolated and remote doctors.[3] Many RVTS registrars are in areas with major general practice workforce shortages and a high clinical workload, which function as barriers to sourcing local supervision.[6,7]

Third, the RVTS only enrols doctors who are already working in eligible rural and remote general practices or AMS as prevocational doctors with minimum level 3 or 4 supervision under the Australian Medical Council (ie, deemed able to work independently with remote supervision).[3] This differs from wider rural general practice training models where doctors commonly move to a rural training practice to commence training, relative to the eligibility and accreditation requirements of various rural general practice training pathways.

Fourth, the RVTS has a specific requirement for the participating doctors to continue to work in the same practice (in the eligible location from where they applied for the RVTS) while completing the RVTS' three-to-four years of practice-based general practice training.[3] If the doctors choose to move locations, they typically need to withdraw and re-apply in subsequent rounds (note the RVTS has two intakes per year since 2022). This focus on continuity of work/retention in the same practice is unique among general practice training models, the latter usually involving registrars moving between practices and/or hospitals for diversity of experience.[2,4] The retention-focused training of the RVTS plays an important role in stemming the higher workforce turnover in locations where the RVTS operates.[8,9] Primary care workforce turnover in remote locations affects patients and costs through lower value care, increased hospitalisations, and the direct and indirect costs of replacing staff.[9-11] Halving remote workforce turnover and reducing the use of short term staff is projected to save $32 million annually in the Northern Territory alone.[11]

Finally, the RVTS period of three-to-four-years of practice-based training is longer than that provided through other general practice training models, which involve a year of hospital training and up to two years of practice-based training.[2,4] Further details about the RVTS program are described in the Supporting Information.[3]

Characteristics of the RVTS cohort

Box 2 presents data from the RVTS administrative dataset, showing the program has grown over time related to an incremental growth in funding. The RVTS commenced in 2000 as a pilot program with 11 doctors targeting MMM4–7 areas, increasing to an annual cohort of 22 Remote Stream places in 2013. The AMS Stream commenced in 2013 and included ten additional places per year mostly in AMSs in MMM2–7 areas. The total annual quota has been relatively stable at around 32 doctors since 2014, other than a once-only surge in 2022 due to commencing an additional mid-year intake process (to spread the operational workload across the year). In some years the AMS cohort did not reach ten places, mainly due to fewer applicants, and the Department of Health and Aged Care agreed for increased selection of Remote Stream candidates in such years. Occasionally, annual cohorts have been more than 32 when the Department of Health and Aged Care has agreed to additional enrolments as a suitable use of underspent funding.

Box 3 identifies that the RVTS reaches rural areas of all states and territories with reasonable parity to MMM4–7 and First Nations populations. The bulk of the Remote Stream participants has been based in the eastern states, where there are higher proportional MMM4–7 populations. However, the RVTS has the potential to weight its distribution to the states and territories with greater land sizes and sparsity of regional centres, such as the Northern Territory, Western Australia and South Australia.

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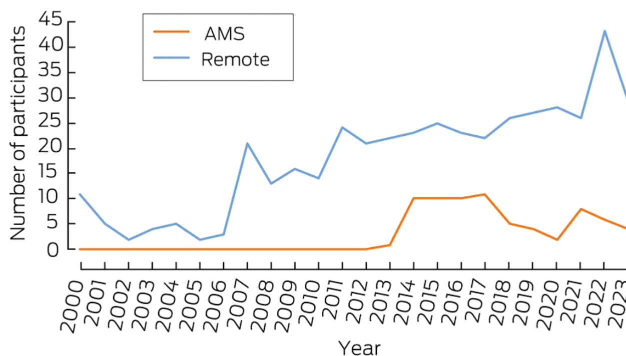
1 Key differences between the Remote Vocational Training Scheme (RVTS) and other rural general practice training[1-4]

RVTS	Other rural general practice training models
More remote locations MMM4–7 and AMS MMM2–7	Any rural location MMM2–7, with ACRRM having a focus of 12 months minimum in MMM4–7, not specific to AMS
Non-vocationally registered doctors already employed in eligible practice before commencing and who have no less than level 3 or 4 supervision	Most registrars move into the rural practice that meets requisite supervision requirements for the general practice pathway they are on
Mostly uses a remote supervision and support model, as practices generally have limited capacity	Mostly face-to-face supervision, with remote supervision models used selectively
Continuity of service/retention — stay in same practice as the one when the doctor enrolled in the RVTS, while progressing towards fellowship	Registrars typically move around
Registrars complete the first year of general practice training (hospital component) as a part of their overall general practice role. RVTS provides 3–4 years of practice-based training	Registrars complete a year of hospital-based training and then around two years of practice-based training
12 months' advanced skills training can be done at any point in a hospital or the same community setting	12 months' advanced skills training can be done at any point in any hospital or community setting.
Fellowship of ACRRM and/or RACGP, including the general practice or rural generalist fellowship	Registrars pursue ACRRM or RACGP fellowship including rural generalist fellowship

AMS = Aboriginal Medical Services; ACRRM = Australian College of Rural and Remote Medicine; MMM = Modified Monash Model; RACGP = Royal Australian College of General Practitioners. ◆

2 The Remote Vocational Training Scheme participants over time (n = 506)



AMS = Aboriginal Medical Services. The AMS Stream commenced in 2013. A mid-year intake commenced in 2022 which brought enrolments for 2023 forward. The data source is the program's deidentified administrative dataset. ◆

Box 4 shows that AMS Stream participants are mostly concentrated in MMM2–4 locations; in contrast, half of the Remote Stream participants are in MMM5 areas, with 82.7% in MMM5–7 locations and only 32.2% in coastal areas, showing the RVTS mostly supports inland communities.

Box 5 identifies that the number or participants matured to 506 by 2023; most are in the Remote Stream (86%), with both streams predominantly enrolling international medical graduates (IMGs). In the early cohorts, similar numbers of IMGs and Australian medical graduates were enrolled, but since 2013 the RVTS program has enrolled over 80% IMGs — a group that is relied upon for providing medical services in rural, remote and First Nations communities.[12,13] Australian policy requires

3 Distribution of Remote and Aboriginal Medical Service (AMS) Stream Remote Vocational Training Scheme (RVTS) participants by state[1]

State or territory	Remote Stream: RVTS locations, n (%)	Proportion of population (MMM4–7)	AMS Stream: RVTS locations, n (%)	Proportion of First Nations population*	Overall land size ('000 km^2)	Number of regional centres ≥ 50 000†
New South Wales	182 (41.9%)	32%	15 (21%)	34%	801	8
Queensland	119 (27.4%)	22%	27 (38%)	29%	1730	9
Victoria	38 (8.8%)	21%	18 (25%)	8%	227	5
Western Australia	41 (9.4%)	10%	4 (6%)	11%	2527	1
Northern Territory	27 (6.2%)	3%	4 (6%)	8%	1348	0
Tasmania	15 (3,5%)	3%	1 (1%)	4%	68	1
South Australia	12 (2.8%)	9%	2 (3%)	5%	984	0

MMM = Modified Monash Model. * First Nations population does not add to 100% because the Australian Capital Territory is not included, it has no eligible RVTS sites. † Regional centres were counted as ≥ 50 000 population excludes capital cities of states and territories. One Remote Stream candidate was in Papua New Guinea. The data source is the program's deidentified administrative dataset. ◆

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4 Distribution of Remote Vocational Training Scheme (RVTS) participants by Remote and Aboriginal Medical Service (AMS) Streams[1]

Rurality	Remote (*n* = 434)	AMS (*n* = 71)
MMM1	1 (0.2%)	8 (11.3%)
MMM2	5 (1.2%)	16 (22.5%)
MMM3	3 (0.7%)	16 (22.5%)
MMM4	66 (15.2%)	15 (21.1%)
MMM5	218 (50.2%)	7 (9.9%)
MMM6	68 (15.7%)	4 (5.6%)
MMM7	73 (16.8%)	5 (7.0%)
Coastal (within 50 km of coast)	140 (32.2%)	42 (59.2%)

MMM = Modified Monash Model. AMS Stream placements were temporarily eligible in MMM1. Initially, MMM1 was eligible within the AMS Stream, MMM2–7 only from 2019. A small number of MMM1–3 locations were deemed eligible in the Remote Stream through special consideration. The data source is the program's deidentified administrative dataset. ◆

IMGs to work for up to ten years in distribution priority areas, which include rural and AMS services, to access Medicare provider numbers.[14] As a group, IMGs have nuanced professional support and career development needs; they can be less satisfied under mandated rural work arrangements and more likely to turnover in rural practice.[15-19]

Box 5 also shows that IMGs and Australian medical graduates enter the RVTS with an average of five to six years of Australian clinical experience and a total average overall clinical experience of 14 years. The characteristics of the RVTS cohort, previous clinical experience and the challenges of general practice in rural, remote and First Nations communities means that a nuanced training and professional support model is needed. The supervision and support model needs to accommodate busy doctors who have access to limited staff, equipment, diagnostic tools and referral options and working in communities with distinct geographical, professional and social characteristics; involving caring for people on low incomes, with culturally safe medical services.[7,20-22] Box 6 provides a high level overview of the RVTS' supervision and support model, which is explained more by O'Sullivan and colleagues[23] in this supplement.[3]

Drawing evidence from the RVTS

Although the RVTS has been operating since 2000 and its basic characteristics have been noted, its overall outcomes and the reasons why it might be effective have not been holistically described in the recent peer reviewed literature.[24,25] This supplement aims to address this gap and summarise the results of an independent mixed methods evaluation of the RVTS which was led by the University of Queensland in 2023–2024. This supplement describes the results in four articles. These results have direct relevance for shaping the evidence base around solutions for a well distributed and sustainable general practice workforce for rural, remote and First Nations communities in Australia. Box 7 shows how the articles in this supplement help to inform current major national rural workforce strategies in Australia.[26]

In this supplement, McGrail and colleagues[27] provide evidence of the continuity of service and longer term retention outcomes of the RVTS, drawing on 23 years'

5 Characteristics of the commencing participants 2000–2023

Characteristic	Result (IMGs*)	Result (AMGs)
Total number of commencing participants	373	133
Training stream (*n*, %)		
Remote	319/435 (73.3%)	116/435 (26.7%)
AMS	54/71 (76.1%)	17/71 (23.9%)
Sex, male (*n*, %)	247 (66.6%)	81 (60.9%)
Age, years (median, IQR)	40 (35–45)	36 (32–43)
Australian work experience, years (median, IQR)	5 (3–8)	6 (4–11)
Overall clinical experience, years (median, IQR)	14 (10–19.5)	6 (4–11)
IMGs (*n*, %)		
Entry 2000–2012	75/141 (53.2%)	na
Entry 2013–2020	205/249 (82.3%)	na
Entry 2021–2023	93/116 (80.2%)	na
IMG region of origin: Asia, Middle East or Africa (*n*, %)	313 (84.1%)	na

AMG = Australian Medical Graduate; AMS = Aboriginal Medical Services; IMG = international medical graduate; IQR = interquartile range. * Moratoriums require IMGs to work in Distribution Priority Areas for ten years to access Medicare provider numbers[14] and regardless, all doctors on the Remote Vocational Training Scheme, including AMGs, are required to stay in the eligible community where they applied, to access the program.[3] The data source is the program's deidentified administrative dataset. First Nations doctors were not identified in the dataset. In the IMG cohort, two were missing data about sex which changed the IMG denominator to 371 for the sex calculation. ◆

6 The Remote Vocational Training Scheme (RVTS) supervision and support model[3]

- The RVTS program uses a model of remote supervision mostly with one continuous supervisor employed in another practice (and different community).
- Supervisors are mostly experienced rural general practitioners/rural generalists, familiar with both the RVTS program (many past participants and international medical graduates) and knowledgeable of the participant's location.
- Structured online webinars and workshops are delivered outside of work hours.
- Other activities include regular in-practice teaching and workplace-based assessment by experienced supervisors and medical educators as well as asynchronous online learning resources.
- Support is enhanced through the provision of tools, methods, and training to facilitate and enhance productive, safe, and high quality services by confident, comfortable doctors despite being a more isolated cohort.

More information is described in the Supporting Information and by O'Sullivan et al[23] in this supplement. ◆

7 Alignment of the Remote Vocational Training Scheme (RVTS) to selected major rural medical workforce strategies in Australia

Major strategies	RVTS program evidence helps inform	Additional information (references)
National Medical Workforce Strategy[26]	How to promote distribution of sustainable general practice workforce for rural, remote and First Nations communities	23,27–29
Independent review of regulatory settings[30]	How to effectively support rural international medical graduate doctors when they are working under regulatory conditions	23
Single employer model[31]	The benefits of training continuously as a general practitioner in the same rural practice	29
Closing the Gap[32]	How to expand continuity of rural general practice services in Aboriginal medical services and rural areas where there is a high proportion of First Nations peoples	23,27,28
Australian General Practice Training Program[33]	Mature remote supervision and support model for doctors in general practice vocational training, working in areas of high need that have limited supervisors and professional and personal supports	23
Strengthening Medicare Taskforce Report[34]	Access to sustainable, equitable, continuity of care across the primary health care system	23,27–29
Digital Health Blueprint and Action Plan[35]	A sustainable learning health system for rural and remote and First Nations community settings using digital innovation	23,29
Independent Scope of Practice Review[36]	How to unleash rural and remote general practice workforce capacity through sustainable support and retention of doctors within multidisciplinary teams; remaining in the same community enables doctors contributing to up-skilling other staff and service quality improvements	23,27,29

registrar data linked with the Australian Health Practitioner Regulation Agency information about current practice location.

Following this, O'Sullivan and colleagues[23] provide the first full description of the RVTS' supervision and support model and how and why it is effective for addressing personal and professional support of this unique cohort. This article uses a realist evaluation that draws on theory and empirical data from interviews. It teases out what enables the RVTS doctors to feel professionally and non-professionally supported when continuously working and training in challenging settings.

O'Sullivan and colleagues[28] draw on focus groups and thematic analysis aiming to summarise the results of an emerging new strategy that the RVTS has been using since 2018 called the Targeted Recruitment Strategy. This strategy involves the RVTS working with communities and rural workforce stakeholders to decide priority locations and bundle tailored recruitment initiatives with the RVTS' retention and training support. The aim is to attract more prevocational doctors to high need areas where they can access general practice vocational training and support through the RVTS.

Through interviews, O'Sullivan and colleagues[29] explore stakeholder perspectives of the benefits of the RVTS, as an example of a place-based retention-focused general practice training program. This value is important to differentiate from more supply-focused training models, such as the Australian General Practice Training Program (AGPT),[33] which typically involve moving between hospital and various practices (Box 1). Further, it can usefully inform concepts such as the single-employer model because it explores perceived benefits of registrars maintaining continuity of employer.[31] Any data presented in the articles of this supplement are provided with ethics approval (The University of Queensland Human Research Ethics Committee; Ref. 2023/HE001926; 24 October 2023).

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In summary, the RVTS is a nuanced general practice training program that remotely supports and trains doctors already working in a challenging context, while aiming to promote the continuity of service to high needs communities. This supplement draws on insights from administrative data, interviews, focus groups, and theory, to provide unique evidence which can inform major national policies.

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Supporting Information

Additional Supporting Information is included with the online version of this article.

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