Recruitment and retention of new doctors in remote and Aboriginal medical services through the Remote Vocational Training Scheme's Targeted Recruitment Strategy: a focus group study

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The known: Bundling and integrating tailored strategies is recommended to attract new doctors in rural communities, but there is limited research on how to do this and the resulting outcomes.

The new: This research describes the results of the Remote Vocational Training Scheme's Targeted Recruitment Strategy that, since 2018, has involved collaboration with stakeholders to attract new doctors in remote and Aboriginal medical services where they can access Remote Vocational Training Scheme training and support to qualify as general practitioners.

The implications: The strategy builds access to general practice services in high need areas. Areas for ongoing optimisation include ensuring that bundles of initiatives are more clearly defined and carefully implemented, and that agency roles and responsibilities are defined.

Abstract

Objective: To explore the results of a targeted recruitment strategy designed to attract and retain new doctors in remote and Aboriginal medical services where they can access Remote Vocational Training Scheme (RVTS) training and support to qualify as general practitioners.

Study design: Two 2-hour purposeful online focus groups on the RVTS' Targeted Recruitment Strategy.

Setting and participants: Five participants and nine stakeholders with knowledge and experience of the strategy. Data were transcribed and deductively and inductively coded for themes including insights from separate project reference and stakeholder advisory groups.

Main outcomes measures: Perspectives of the strategy.

Results: The overarching theme was that the strategy is useful for attracting and retaining new general practitioners in areas of high need and is potentially scalable. Since 2018, 20 new doctors were recruited via the Targeted Recruitment Strategy and six of them completed the RVTS program. The strategy could better differentiate target locations because increasing communities are experiencing major general practice workforce shortages. The package of employment and training could also be more clearly defined for participants, nationally marketed and collaboratively implemented. Further, more site accreditation and ongoing risk and quality review is needed, along with intense early supports for participants who are new to both the community and general practice work.

Conclusion: The Targeted Recruitment Strategy is still maturing but the early results suggest it is a unique and proactive model for attracting and improving access to general practitioners in places with high needs. It could be strengthened through formal agreements between communities and agencies, ensuring coordinated implementation, clarifying roles and responsibilities, and developing clear pathways for risk and quality management.

Building the rural general practice workforce relies on collaboration to attract and retain doctors using bundled or integrated strategies.[1-4] Major global frameworks recommend coordinated place-based planning involving a range of stakeholders.[5,6] Among them, communities contribute important insights for place-based solutions.[7-9] Local governance is also relevant for integrated rural workforce strategies.[3,7,10-12] However, despite the importance of this issue, there is little published evidence on implementing collaborative approaches to attract and retain new general practitioners in high need communities.

In this article, we describe a five-year pilot of the collaborative Targeted Recruitment Strategy that has been led by the Remote Vocational Training Scheme (RVTS) since 2018. The strategy involves liaising with communities and stakeholders to bundle initiatives to attract new prevocational doctors who are eligible for the RVTS program to locations with high medical workforce need.[13] Once recruited, participants immediately join one of two existing RVTS streams — the Aboriginal Medical Service (AMS) Stream, supporting rural Aboriginal medical services (Modified Monash Model [MMM] categories MMM2–7), or the Remote Stream, supporting doctors in rural and remote locations (categories MMM4–7), as described elsewhere in this supplement.[13,14] This allows the newly recruited doctors to receive the same RVTS support and general practice training as other RVTS participants, with excellent satisfaction and retention outcomes.[15,16] The RVTS program is unique as a longstanding, comprehensive retention model for general practitioners in Aboriginal medical services and remote settings, compared with shorter term, siloed interventions.[15,17]

The Targeted Recruitment Strategy evolved because many Aboriginal medical services and remote communities are in dire need of doctors and have significant trouble recruiting. Until doctors have an offer of employment, they are not eligible for the RVTS program.[13] Furthermore, many doctors are reluctant to work in locations with limited access to general practice vocational training. The strategy operates as a stage before the RVTS selection process, involving the RVTS team working with the local community and stakeholders to prioritise locations and develop a recruitment and retention strategy for the place, including the offer of vocational training through the RVTS (Box 1). We aimed to explore the early results of the Targeted Recruitment Strategy and identify potential areas for optimisation.

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1 Components of the Targeted Recruitment Strategy

The strategy aims to bundle tailored initiatives to increase recruitment of new prevocational doctors in eligible locations where they can receive the regular Remote Vocational Training Scheme (RVTS) general practice training and support. It intends to operate before the RVTS intake process to address recruitment and retention, and its four key components are outlined below.

- **Suitable locations identified:** Before the RVTS selection process, the RVTS collaborates with communities, health departments, rural workforce agencies, Aboriginal community-controlled health organisations, and relevant general practice employers in each state and territory, to identify and prioritise eligible locations across Australia that have high workforce needs and relevant resources for supporting a doctor for three to four years while they are on the RVTS and progressing towards a general practice fellowship. Sites with strong community engagement and demonstrated experience in training registrars are preferred. The process differs slightly at each location, as it is led by different stakeholders, employers and communities.
- **Engagement and marketing:** Once sites are prioritised, all stakeholders independently market them at the jurisdictional level, promoting the recruitment and retention supports (including the RVTS training and support) as an integrated package.
- **Participant selection and support:** Workforce agencies, communities and employers support prevocational doctors to undertake a site visit and, if successfully employed, enable orientation of doctors and their families. Some also provide rural relocation packages and assistance with housing and transport (note that attractive employment packages are locally governed through negotiation between doctor and employer, with additional salary support offered where sites are eligible according to policy exemptions). The bundled initiatives vary — the exact nature of each bundled initiative depends on the resources of the stakeholders, employers and communities.
- **Recruitment and retention:** Once an offer of employment has been received, doctors are eligible to apply for the regular RVTS program (receiving the same support as other RVTS registrars). There are up to five positions available per year for the Targeted Recruitment Strategy (2018–2023) using unfilled places within the RVTS' annual training allocation of 22 Remote Stream and ten Aboriginal Medical Service Stream positions as outlined elsewhere in this supplement.[13] The RVTS remotely delivers training, supervision and support, tailored to personal and professional needs, to promote resilience and facilitate progress of general practice training as described elsewhere in this supplement.[15] Agencies independently liaise to oversee the implementation of recruitment and retention elements under their governance, and these vary depending on the resources of the stakeholders, employers and communities.

Methods

This study was conducted between September 2023 and March 2024. Data were collected from two 2-hour online focus groups, and supplemented with limited administrative data about enrolled doctors. Focus groups are useful for gathering detailed insights from different stakeholders.[18] This research used a constructivist approach drawing on the perspectives of participants and agencies.[19] Purposeful sampling sourced participants with experience of the Targeted Recruitment Strategy (including different jurisdictions, agencies, doctors and communities), as informed by a ten-person project reference group (inclusive of the RVTS executive and the research team).

For the first focus group, nine doctor participants of the strategy were invited; for the second, ten stakeholders and community representatives were invited. Invitations were emailed and included information about the study. The reason for conducting two focus groups was to promote deeper discussion for triangulation and to ensure that participating doctors could safely contribute, without providers or funders present.

The focus group questions (Supporting Information) explored key components of the strategy (Box 1), which were based on the RVTS program documentation[20] and discussion by the project reference group. The questions were deliberately broad, asking about the results of each of the components of the strategy, and any potential areas for optimisation. The final questions were piloted and refined through the project reference group. A wider stakeholder advisory group, consisting of 12 executive-level rural workforce leaders with expertise in rural general practice workforce and training provided wider system insights for the overarching project and for interpreting the data.

Procedure

Participants provided written informed consent before attending the focus groups. Focus group questions were circulated to participants in advance and displayed during the sessions to stimulate engagement and reflection. One trained rural health researcher facilitated each focus group, encouraging active participation and prompting participants to draw deeper reflections. The researcher wrote reflective notes at the conclusion of each group. The groups were recorded, verbatim transcripts were anonymised, and participants were assigned an identification code. In recognition of their time, participants received a $100 payment.

To describe the recruitment and retention outcomes, deidentified data about participating doctors were extracted from the RVTS administrative system.

Data analysis

Thematic analysis was conducted over a four-month period, applying constructivist theory drawing on the perspectives of participants.[19] The researcher who conducted the focus groups firstly sorted the data through deductive analysis guided by the strategy's components (Box 1).[21] Inductive coding was then done, informed by wider theory within the literature about collaborative and bundled workforce strategies,[2,4,10,12,22] seeking to understand broader themes.[21] Additions and alterations to the coding framework were made as each transcript was read. Another researcher who had read the transcripts then double coded, demonstrating reasonable concurrence with the themes and adding extra codes where these applied. The "big tent" criteria and the reporting guidelines for qualitative research were used to guide reflectivity, credibility and coherence.[23,24] Thick description and triangulation were supported through use of the researcher's reflective notes and regular meetings of the project reference group and stakeholder advisory group; this further aided reflexivity as to contextual interpretations and helped to test and refine any subjective bias of the researchers.[21,23] The notes were used to guide re-examination of the data with further deductive and inductive coding continuing until final coherent themes were agreed.[23]

The administrative data about participants were analysed using simple counts and compared with published evidence on the RVTS cohort, which is described elsewhere in this supplement.[13] The project had ethics approval from the University of Queensland Human Research Ethics Committee (reference 2023/HE001926, 24 October 2023).

Results

Overall, 14 participants joined one of two focus groups: five in the session for doctor participants, and nine in the session for stakeholders (Box 2). An overarching theme was that the Targeted Recruitment Strategy is useful and scalable. Community representatives and stakeholders along with the doctor participants agreed that the strategy is a unique approach

2 Focus group participants

Group	Participants
1	Five doctors who participated in the pilot: two who participated in the Aboriginal Medical Service Stream, two who participated in the Remote Stream, and one who was engaged in the strategy as a past registrar and current employer. Two of these participants were women and three were men.
2	Nine stakeholders from across Australia who were responsible for Targeted Recruitment Strategy implementation for their community or organisation: senior community representatives leading local recruitment and retention efforts, director-level members of workforce agencies, employers, and representatives of state health departments and other aligned agencies. Four of these participants were women and five were men.

for overcoming general practitioner shortages and turnover in high need communities. This theme and four other deductive themes (aligned with the components described in Box 1) and the inductive findings are summarised below.

Suitable locations

This theme covered the justification of locations, networking of sites, costs, community involvement, and quality and risk management. Stakeholders collaboratively applied place-based data, local insights and partnership perspectives to prioritise suitable locations. However, they noted that further justification of the target locations may be required in the face of increasing workforce shortages: "it is about setting the right expectations as there are a lot of communities with the need" (FG24). Developing nationally networked sites, maintained over longer periods was considered a potential option for stakeholders and employers to reduce the direct and indirect costs of recruitment on small sites: "your average [general practice] clinic … going to the extremes … to get candidates" (FG12). Stakeholders noted that suitable locations need community involvement: "Communities are incredibly important … when our registrar arrived … he needed a lot of support" (FG21). Further, participants felt the sites should target practices engaged in teaching and learning: "they are focusing on the workforce gap" (FG13). Participants also noted that more site risk assessment could ensure that sites were set up to adequately support doctors: "how well are the practices screened? It didn't happen …" (FG13).

Marketing and engagement

This theme covered access to clear information for consumer transparency and the use of auditing processes. Even though marketing strategies were considered by stakeholders to be nuanced and costly, many participating doctors simply: "stumbled across [the strategy] through pure luck" (FG12). Participants wanted more quality information about the bundle and allowances before signing up: "what you can do, and what is not possible … some things we didn't find out until we started" (FG11). Having the information published in one place was considered optimal to: "compare and contrast" options (FG12). Without clear information and auditing as to whether the bundled initiatives were implemented as planned, participants also considered it was difficult to negotiate issues around employment and conditions: "the transparency isn't there so I can't defend myself" (FG13).

Suitable participant selection and support

This theme included realistic expectations, supported learning and personal support. Some participating doctors relayed having unrealistic expectations of the opportunity: "I was pretty optimistic … I didn't necessarily appreciate what I was signing up for" (FG12). Stakeholders also noted the realities of working in the targeted locations were not always understood by participants: "to get an x-ray you need a day and a half to get it done" (FG22). Most participants experienced dual pressures of being new to the targeted locations and new to general practice: "it was pretty much 'do general practice' … I learnt a lot of it on the fly and I adapted over time" (FG13). Many had a challenging time with this transition: "an intense focus … without a [general practice] background" (FG12). The RVTS provided valuable supervision and support according to the participants; however, other supports they expected as part of relocating were not always available from their perspective: "I had to stay in a hotel with a small baby and my wife … for 3 months" (FG15).

Recruitment and retention

This theme encompassed recruitment and retention, employment challenges and withdrawals. Between July 2018 and July 2023, the Targeted Recruitment Strategy recruited 20 doctors (Box 3). At the time of this research, six of the 20 had completed the RVTS program and three had achieved Registrar of the Year awards from general practice colleges, as a mark of their peer-recognised achievements as trainee doctors in rural and remote communities. Recruiting 20 doctors was the total allocation available because places were allocated from those unfilled in the regular twice yearly RVTS rounds.

Comparing the selection of participants for the Targeted Recruitment Strategy with that of the wider RVTS program as described elsewhere in this supplement, a higher proportion were Australian medical graduates (10/20, 50%) compared with the wider RVTS cohorts in the AMS Stream and Remote Stream (17/71 [24%] and 116/435 [27%] respectively).[13] They were also younger when enrolling (median age, 34 years) compared with the wider RVTS cohort (median age, 39 years), and more likely to be employed in Aboriginal medical services (7/20, 35%) compared with the wider RVTS cohort (71/506, 14%).[13] The main detractor to doctor satisfaction and a constant factor prompting consideration of leaving was local employment issues: "the employment side of things, it hasn't been great … I have had a lot of issues … I have had a lot of billing pressure around how much money I am earning to cover my position" (FG13). The

3 Targeted Recruitment Strategy doctors employed by stream, July 2018 to July 2023*

Stream†	Active (still enrolled in RVTS)	Completed (finished RVTS)	Withdrawn from RVTS	Total
Aboriginal Medical Service Stream	5‡	1	2	8
Remote Stream	3	5	4	12
Total	8	6	6	20

RVTS = Remote Vocational Training Scheme. * Data were sourced from the program's de-identified administrative dataset. † The Aboriginal Medical Service Stream is in rural Aboriginal medical services (Modified Monash Model [MMM] categories MMM2–7) and the Remote Stream is in locations categorised as rural or remote (MMM4–7).[14] ‡ Two of five active at the time of this research had completed fellowship assessment and were due to become general practitioner fellows in 2024. ◆

proportion of participants who withdrew was 30% (6/20), which was higher than that for the wider RVTS cohort in the Remote Stream (67/348, 19%), although these approximated withdrawal rates related to the wider enrolments in the AMS Stream (21/57, 37%) (the wider enrolment figures excluding those still active) (as described elsewhere in this supplement);[16] and three of six trainees who withdrew re-enrolled in the RVTS in another location.

Useful and scalable

The overarching theme linking all the others involved the benefit and potential expansion of the Targeted Recruitment Strategy. The strategy was considered a useful lever to attract and retain doctors in areas with high medical workforce shortages: "We faced having one doctor and the practice was going to close and the only way to find one was through [this strategy]" (FG21). Participants noted: "I am surprised that RVTS is one of the only institutions doing this because it makes entire sense to me for others to do it" (FG12). However, stakeholders considered it would be challenging to scale up the strategy because it was so hard to attract enough candidates within the competitive market for general practitioners, including different general practice training pathways: "Is the scope of candidates out there, because if we add more sites … we are not attracting people to the sites?" (FG24). One consideration was to better differentiate the communities which are targeted and clarify and market the bundled supports better: "more support around the marketing so that it stands out" (FG27). Participants noted that maturing the design and quality and risk management of the strategy was also important before scaling up.

Discussion

We have described a case study of a collaborative strategy seeking to implement bundled or integrated recruitment and retention packages to attract and retain doctors in rural and remote communities with high needs. There are few other demonstration models of national agencies collaborating to design and implement bundled recruitment and retention strategies over a five-year term; and few examples of implemented strategies to build the general practice workforce in this context. Our research findings suggest that the Targeted Recruitment Strategy has areas for further development and needs more time to mature. Other researchers have noted that time and collaborative arrangements are important for strategies to achieve a longer term collective impact on complex health system issues.[25,26]

The strategy was led by the RVTS, which has a holistic and mature retention model tailored for general practice vocational trainees in remote and Aboriginal medical service settings.[13] This program achieves strong satisfaction and retention of general practitioners in more remote areas, which are most prone to workforce turnover as shown elsewhere in this supplement.[15,16,27] In countries or disciplines without similar national workforce retention programs, it might take longer to aggregate bundled initiatives for the retention aspect. However, the RVTS model, as fully described in this supplement, is an exemplar that could be adapted and applied elsewhere.[13,15,16] It could equally be applied to disciplines beyond medicine.

The bundled or integrated strategy, at the time of this research, had already achieved the recruitment, and three to four years of continuous service, of up to six doctors training to become general practitioners or rural generalists. Three who commenced have won awards, despite working in challenging remote MMM5–7 communities.[14] However, retention of the Targeted Recruitment Strategy cohort in high need areas is challenging. Several individuals withdrew and reapplied through the standard RVTS program in a different location. Notable challenges reflected by participants were the quality and risk issues at the sites, including employment and conditions focused on filling service gaps rather than promoting learning, which candidates felt needed better screening and oversight. In a guide for addressing rural workforce challenges, it has been noted that a "whole of person" rural retention encompasses an awareness of workplace, organisational, role, career, community and place factors.[3] Building on this, our research identified that retaining and up-skilling registrars in areas with high medical workforce shortages is strongly affected by supportive employment along with opportunities to progress in the general practice curriculum. When compared with the wider RVTS cohort, a higher proportion of Targeted Recruitment Strategy candidates were Australian medical graduates new to both the community and general practice, and a higher proportion were working in Aboriginal medical services. More intense supports — such as increased face-to-face early engagement from supervisors and mentors, and full insights into the bundled package — could assist this group when navigating complex local issues related to employment and practising as a doctor-in-training in relatively isolated conditions.

Our findings also suggest that, given the growing number of communities with extreme workforce needs, along with the complexity of general practice training pathways, the Targeted Recruitment Strategy may require more differentiation of its market. This could involve developing a typology of relevant communities where this strategy is likely to be the most feasible and sufficient. This could be guided by criteria — inclusive of engaged communities, with baseline resources in place and the capacity to foster quality learning and employment conditions — that would be challenging to address through other general practice training pathways. Feedback also suggested that creating a list of nationally networked sites and differentiating the Targeted Recruitment Strategy through nuanced marketing could build momentum for recruitment. This could help address the challenge of attracting doctors from a limited pool of candidates who are interested in relocating to work and train as a general practitioner in a challenging remote setting.

The Targeted Recruitment Strategy could also be strengthened if the bundled employment supports, such as housing, were uniformly funded and implemented well across all participating locations. Communities play a critical role in identifying and responding to the needs of recruited doctors and their families. However, they also need tailored investment from external agencies and governments and may need to advocate for policies and programs which suit their needs. Other research has highlighted that place-based collaborative initiatives are strengthened when they are aligned with and inform governmental policies.[28,29]

In areas of extreme workforce shortages, strategic investments have the potential to fail because of rapidly changing local conditions. Effective implementation of the Targeted Recruitment Strategy may require more ongoing management of quality and risk issues around the bundled supports. There are opportunities to reflect on whether a committee consisting of local stakeholders and agencies could oversee the coordinated roles and responsibilities related to implementing the bundled strategy and the required troubleshooting. This could involve

regular cross-agency meetings and a memorandum of understanding centred on place-based governance.[7,10] Officially recognising roles and responsibilities within collaborative leadership models has been suggested to support the engagement of public, private and civic actors involved in innovative place-based solutions.[10,30]

This was an exploratory study that included the perspectives of a limited number of participants, as the Targeted Recruitment Strategy is still quite new. However, it provides a national example of a bundled recruitment and retention strategy. The range of stakeholders consulted shared diverse perspectives, but many were limited to commenting on individual places or their own role in the Targeted Recruitment Strategy, and they were only consulted briefly. Further longitudinal research benchmarking the performance of the collaboration, context and outcomes is warranted for deeper perspectives to emerge.

In conclusion, the Targeted Recruitment Strategy is a proactive collaborative approach for bundling tailored recruitment and retention initiatives to improve access to the continuity of general practice workforce in rural and remote areas of high workforce shortage. The strategy achieved the engagement and contribution of multiple workforce agencies and communities for the recruitment and retention of general practitioners in areas of high workforce need. Our research identified that the Targeted Recruitment Strategy could be more differentiated and targeted, with the bundle of initiatives for each location more clearly defined and carefully implemented. It also suggested that defining clear agency roles and responsibilities, along with shared risk management and quality processes, is important before the strategy is expanded.

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Data sharing: The de-identified data we analysed are not publicly available, but we will seek to provide data through requests to the corresponding author which will be considered on a case-by-case basis. ■

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Supporting Information

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