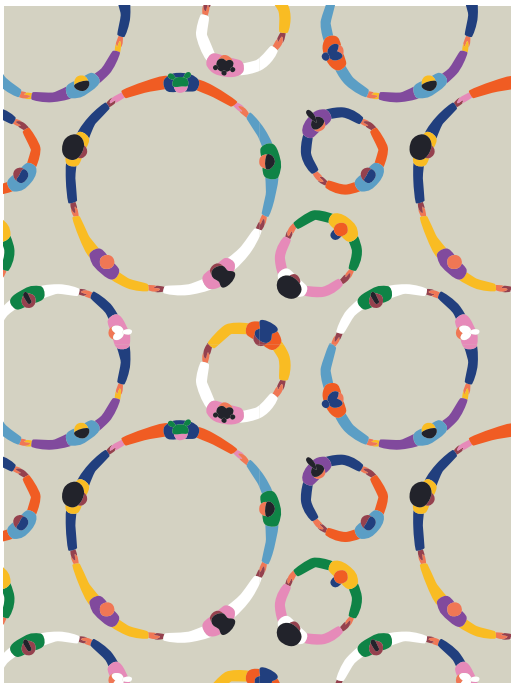


Building a sustainable rural workforce:
A continuity-based hybrid approach for rural and remote general practice

Jill Benson, Karin Jodlowski-Tan, Megan Yannakouros

Background
Persistent general practitioner (GP) maldistribution, declining full-time equivalent (FTE) supply in remote areas and difficulty retaining doctors place rural and remote services under pressure. Reliance on locums can preserve access but weaken continuity, while rigid employment models might be misaligned with GP preferences for flexibility and sustainable careers.

Objective
To outline a continuity-based hybrid workforce approach combining regular onsite practise with funded offsite clinical care and team support.

Discussion
The approach brings established elements of visiting care, telehealth and remote team support into a more structured longitudinal arrangement. A named GP or small GP team would return regularly to the same community and remain clinically connected between visits through telehealth, results review, case discussion, education and escalation support. Success depends on culturally safe partnerships, a skilled onsite team, digital infrastructure, clinical governance and remuneration for non-face-to-face work. It should complement, not replace, resident workforce development and be evaluated for continuity, access, safety, GP wellbeing and cost.

RURAL AND REMOTE GENERAL PRACTICE IS UNDER SEVERE PRESSURE. The challenge is not simply doctor numbers but the interaction of supply, distribution, retention, training capacity and workforce sustainability. National data show poorer access outside metropolitan Australia.[1,2] The Royal Australian College of General Practitioners' (RACGP) national general practice workforce *Insights report 2025* provides a general practitioner (GP)-specific picture: Modified Monash (MM)6 has the lowest GP full-time equivalent (FTE) rate per 100,000 population, 40% below the national rate; MM2–7 communities are more than three times as reliant on GPs in training as MM1 communities (16% vs 5%); and more than four in 10 GPs are aged 55 years or older.[3] The RACGP national workforce strategy 2025–30 projects that GP FTE per 100,000 population could fall by 43% in remote areas by 2040.[4] These pressures affect communities with greater morbidity, geographic barriers and reduced access to other health services.[4,5]

Responses must include a stronger domestic training pipeline, rural-origin pathways, continued support for international medical graduates (IMGs), appropriate remuneration and better distribution (Box 1).[4,6] Workforce documents also call for flexible or hybrid work and digitally enabled care,[7,8] but these require service models that protect continuity and GP wellbeing. More than half of Australia's GP FTE workforce is overseas trained.[3] Pipeline strategies take years to mature, and distribution does not guarantee retention. The RACGP strategy notes that financial incentives have consistently supported short-term retention internationally, while longer-term retention remains difficult.[4] In Semester 2, 2025, 241 of 387 incentivised training-site placements in high-workforce-need catchments were filled.[3] Incentives can support distribution, but a training placement is not, by itself, a sustainable service model.

Supervision is another constraint. In the 2023 General Practice Supervision Australia survey, more than 20% of supervisors intended to retire within 5 years, while 63% reported disengagement and 73% exhaustion.[9] RACGP data show that 24% of training sites have only one accredited supervisor,

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Box 1. Design principles for a continuity-based hybrid rural general practitioner approach

Community governance and cultural safety: Co-design the model with the community and local service; in Aboriginal and Torres Strait Islander Community Controlled Primary Health Services, governance remains community controlled.

Continuity: Use a named GP or small stable GP team returning to the same community on a predictable schedule.

Defined onsite and offsite care: Fund face-to-face blocks, telehealth, results and recalls, correspondence review, case conferencing, education, supervision and quality improvement as agreed locally.

Capable onsite team and infrastructure: Build on existing remote team-based practice, including RANs, NPs and Aboriginal and Torres Strait Islander Health Practitioners where relevant; ensure shared records, reliable connectivity and fit-for-purpose equipment.

Clinical governance: Define scopes and responsibilities; align emergency, consultation and transfer pathways with local/jurisdictional frameworks (eg CARPA or PCCM); document backup and outage contingencies.

GP and supervisor wellbeing: Protect off-duty time, workload limits, leave, peer support, professional development and backup; avoid an 'always on' model.

Evaluation: Measure continuity, access, cultural safety, hospital transfers, patient and community experience, team stability, GP and supervisor wellbeing, retention and cost.

CARPA, Central Australian Rural Practitioners Association; GP, general practitioner; NPs, nurse practitioners; PCCM, Primary Clinical Care Manual; RANs, remote area nurses.

while more than 60% of accredited supervisors were not actively training a registrar in Semester 2, 2025.[3] This points to distribution and participation, not simply supervisor numbers. Remote supervision can be feasible with clear governance, relationships and escalation arrangements.[10] Any hybrid approach should use this learning without adding unbounded work to rural GPs.

Locum work must also be understood in this context. It can offer flexibility, higher remuneration and control over work–life balance, but recurrent turnover can reduce continuity, local knowledge and team cohesion.[11] The RACGP strategy identifies growing interest in portfolio careers, influenced by work–life balance, flexibility and career longevity, and argues that planning should respect doctors' career aspirations.[4] Professional diversification can support GP wellbeing when it meets doctors' needs.[12] These preferences point to a workforce design question: how can rural communities obtain continuity and accountability while GPs obtain sustainable workloads, family connection, professional support and genuine time away from work?

During the COVID-19 pandemic, some remote Aboriginal and Torres Strait Islander Community Controlled Primary Health Services provided one possible answer. When borders closed, some services maintained care through established GPs working offsite with onsite nurses, Aboriginal and Torres Strait Islander Health Workers/Practitioners and other staff, using telehealth, results review and team communication.[13,14] This was not simply telehealth: it depended on existing relationships, local capability, reliable systems and culturally safe care, and was not possible where funding, staffing or infrastructure were inadequate.[13] It nevertheless showed that continuity of GP responsibility and continuous physical presence are not always the same thing.

Aim

To outline a continuity-based hybrid workforce approach for rural and remote general practice that structures established elements of visiting and remote care to improve access and continuity while supporting GP wellbeing and workforce sustainability.

Discussion

The proposed approach differs from episodic fly-in fly-out (FIFO) locum care. A systematic review of visiting primary care services found that value depends on regularity, continuity of provider, relationships with communities, coordination with resident staff and familiarity with local context.[14,15] Similar lessons have been reported from visiting dental services in an Aboriginal and Torres Strait Islander Community Controlled Primary Health Service.[16] The central principle is therefore not FIFO itself, but continuity: the same GP, or small stable GP team, returns to the same community and remains part of the clinical team between visits.

This is not intended as a new model of care. Rural and remote services already use team-based arrangements in which remote-area nurses, nurse practitioners and Aboriginal and Torres Strait Islander Health Workers/Practitioners work within authorised scopes, supported by medical consultation and escalation. The Central Australian Rural Practitioners Association (CARPA) Standard Treatment Manual and Queensland Primary Clinical Care Manual (PCCM) provide established guidance for assessment, treatment, emergency care, consultation and transfer.[17,18] The contribution proposed here is organisational: a stable, funded GP relationship layered across existing local systems, so responsibility and team connection persist between visits.

Under a fractional appointment, the GP would undertake planned onsite blocks and defined offsite responsibilities. These could include telehealth consultations, review of results, recalls and correspondence, case conferencing with the onsite team, participation in continuous quality improvement, and education or supervision where appropriate. The frequency of face-to-face visits should be determined with the community and service according to clinical need, geography, onsite capability and patient preferences rather than by a universal minimum.

Funding is crucial. The approach cannot depend on goodwill or invisible labour. An illustrative contract might be 0.3–0.5 FTE, adjusted to community need, with remuneration covering onsite clinical work,

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travel, offsite clinical review, team communication, education and administrative responsibilities. Travel and accommodation, leave, indemnity, professional development and backup arrangements should be explicit. Employment, industrial, credentialing and Medicare arrangements vary across jurisdictions, so no single contractual structure will suit every service. The RACGP strategy supports consideration of salaried and single-employer models, portability of employment benefits, targeted distribution incentives and innovative supervision approaches.[4] These mechanisms could provide a policy architecture for locally tailored hybrid appointments.

GP wellbeing must be a design requirement, not an incidental benefit. Hybrid work might allow doctors with rural experience to maintain meaningful longitudinal relationships without permanently relocating their families. It might also appeal to later-career GPs, doctors with caring responsibilities and GPs seeking portfolio careers.[4,12,19] However, remote availability can easily become an 'always on' expectation. Contracts therefore need protected off-duty periods, clear escalation pathways, safe workload limits, peer support and reliable clinical backup. A model that improves patient continuity by eroding GP wellbeing will not be sustainable.

The onsite team is equally important. Hybrid care requires skilled local clinicians; suitable diagnostic equipment and connectivity; shared records; agreed scopes and responsibilities; and clear emergency, consultation, transfer and escalation arrangements. These should align with local and jurisdictional governance and, where applicable, frameworks such as CARPA and the Queensland PCCM.[17,18] Contingency plans are needed for internet failure, community disruption, acute deterioration or GP unavailability. In Aboriginal and Torres Strait Islander Community Controlled Primary Health Services, governance must remain community controlled and reflect local priorities and cultural safety.[20] The remote GP should strengthen, not displace, the resident workforce.

Training remains relevant but is not the paper's focus. Hybrid appointments might broaden the pool of experienced GPs able to contribute to supervision where appropriate, but supervision must be funded and governed.[3,10] The approach should complement, not substitute for, rural training, resident workforce development and permanent recruitment.

A continuity-based hybrid approach will not suit every community or jurisdiction. It requires a stable onsite team, dependable infrastructure, clearly defined clinical governance and sufficient face-to-face care. Its value is most plausible where repeated contact can build community attachment and trust while giving the GP a sustainable connection to place. It should be trialled only where these prerequisites are present and evaluated against patient access, continuity, cultural safety, emergency transfers, team stability, GP and supervisor wellbeing, retention and cost. Evaluation should also ask whether the approach strengthens local capability and relationships over time.

Conclusion

Rural workforce sustainability requires more than recruiting doctors to vacancies. It requires ways of organising care that reconcile continuity for communities with sustainable careers for GPs. A continuity-based hybrid approach could convert some of the flexibility currently associated with locum and portfolio work into longitudinal responsibility to a community. Properly funded, locally governed and carefully evaluated, it could become one component of a broader rural workforce strategy – not a replacement for resident GPs or established team-based remote practice, but a practical bridge between the workforce Australia has and the workforce rural communities need.

Key points

- Rural GP shortages are compounded by maldistribution, retention difficulties, supervision capacity and declining clinical FTE.
- Workforce models must support GP wellbeing and sustainable career choices as well as patient access and continuity.
- A continuity-based hybrid approach combines predictable onsite blocks with funded, structured offsite clinical responsibility.
- Success requires community-led governance, a capable onsite team, reliable digital infrastructure, clinical backup and remuneration for all work.
- The model should complement resident workforce development and rural training, and be evaluated for access, continuity, cultural safety, wellbeing, retention and cost.

Authors

Jill Benson AM MBBS DCH, MPH PhD, FRACGP (Hon), FACRRM, FARGP, AFRACMA, National Lead Medical Educator, Remote Supervision, The Royal Australian College of General Practitioners, Adelaide, SA; Clinical Associate Professor, Discipline of General Practice, Adelaide University, Adelaide, SA; Clinical Associate Professor, College of Medicine and Public Health, Flinders University, Adelaide, SA; Clinical Associate Professor, School of Medicine and Psychology, Australian National University, Canberra, ACT

Karin Jodlowski-Tan FRACGP-RG, FACRRM, BSc (Hons), MBBS (Hons), FAMAC, GAICD, National Clinical Head of Rural Pathways, The Royal Australian College of General Practitioners, Melbourne, Vic; Chief Medical Officer, Wurli-Wurlinjang Health Service, Katherine, NT

Megan Yannakouros BSc, BNurs, MD, FRACGP, Acting Director of Medical Services, Gove District Hospital, Nhulunbuy, NT

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Correspondence to:

jill.benson@adelaide.edu.au

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correspondence **ajgp@racgp.org.au**

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