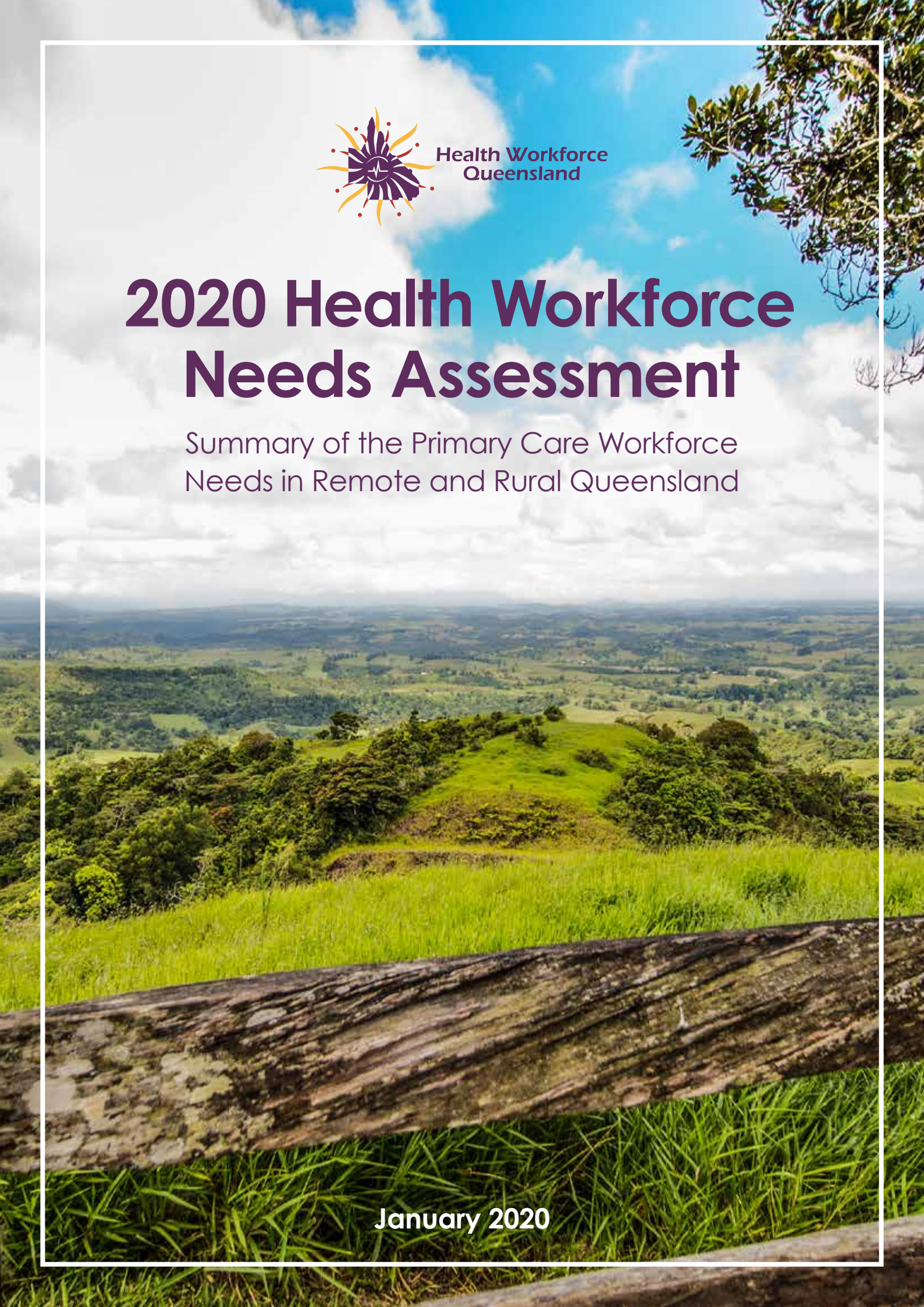
Health Workforce Queensland

2020 Health Workforce Needs Assessment

Summary of the Primary Care Workforce Needs in Remote and Rural Queensland



January 2020

Our Vision

To ensure optimal health workforce to enhance the health of Queensland communities.

Our Mission

Creating sustainable health workforce solutions that meet the needs of remote, rural and regional and Aboriginal and Torres Strait Islander communities.

Our Values

Integrity

We behave in an ethical and professional manner at all times showing respect and empathy.

Commitment

We enhance health services in rural and remote Queensland communities.

Equity

We provide equal access to services based on prioritised need.

Acknowledgements

Health Workforce Queensland is funded by the Australian Government Department of Health.

Health Workforce Queensland acknowledges the traditional custodians of the land and sea where we live and work, and pay our respects to Elders past, present and future.

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Executive Summary

This report summarises the findings from the 2020 Health Workforce Needs Assessment (HWNA) for remote and rural Queensland undertaken by Health Workforce Queensland. The HWNA methodology consisted of a desktop audit, stakeholder engagement activities, an online survey, and a quantitative methodology to prioritise SA2 locations and identify key health workforce issues.

The online survey saw a 43 percent increase in the number of participants for the 2020 HWNA with 825 health professionals and managers completing the survey and sharing their perceptions of workforce and service gaps in their communities of practise. There was also a greater representation of nurses and allied health professionals with this combined group making up 38 percent of participants. Workforce gap means were found to be consistently higher than 2019 across all 18 workforce disciplines with psychology, social work, and speech pathology workforce once again having the highest mean gap ratings.

For service areas, mental health, and alcohol and other drugs were once again amongst the highest gap ratings, along with the new addition to the 2020 survey of community-based rehabilitation services. Service gap rating means were also higher than 2019 results across all services areas. Survey participants suggested better access to general practitioners and mental health services as 'single change' actions to improve health workforce in their communities.

This year the supply of GPs was found to be a growing concern across the state with many reports from practices of increasing difficulties recruiting and retaining a stable medical workforce within general practices. Factors contributing to this may include the fall in the number of junior doctors applying for GP training over recent years, and policy changes that have made recruitment, particularly for international doctors, more complex and more restrictive in some regions.

The health workforce overall continues to experience maldistribution with rural and remote areas more likely to experience workforce shortages. More policy enablers are needed to increase the appeal and viability of rural general practice and primary care and to attract experienced, capable and culturally responsive health professionals.

Developing the current and emerging workforce has its challenges including limited opportunities for graduates in rural and remote areas, few rural clinical placement opportunities in primary care, lack of capacity for clinical supervision and mentoring, and limited opportunities for professional and career development. This is particularly the case for the nursing and allied health professions. Place based learning opportunities would enhance opportunities for a locally grown workforce.

Greater flexibility in service and workforce models for rural and remote is also required, particularly around shared funding models, staff levels and skill mix, and maximisation of multidisciplinary teams.

The report also identifies strategies that Health Workforce Queensland, in collaboration with others, can progress and work closer towards our mission of ***creating sustainable workforce solutions that meet the needs of remote, rural and regional and Aboriginal and Torres Strait Islander communities.***

Introduction

Health Workforce Queensland undertakes an annual primary care workforce needs assessment for remote and rural areas of Queensland classified as Modified Monash Model (MMM) 2-7 (2015). This report summarises the findings from the 2020 HWNA and builds on the baseline understanding of the workforce needs established in the first two HWNAs.

The purpose of the HWNA is to identify priority locations with regards to health workforce, inform and prioritise the utilisation of Health Workforce Queensland resources, and inform outcomes to the Department of Health for program planning and policy development.

The HWNA also contributes to the development and implementation of an evidence-based Activity Work Plan (AWP) and assists in addressing priorities relating to localised health workforce needs and service gaps. As part of the process, the jurisdictional Health Workforce Stakeholder Group (HWSG) provides strategic advice and expertise to inform planning, analysis, and strategy development as well as provide validation of findings. Furthermore, the HWNA aims to identify workforce issues under the priority areas of:

1. **Access –** Improving access and continuity of access to essential primary health care;
2. **Quality –** Building health workforce capability; and
3. **Sustainability –** Growing the sustainability of the health workforce.

Methodology

The methodology was largely consistent with previous HWNAs and comprised four main components:

1. **Desktop Audit:** Collection and review of key sector reports released throughout 2018/19.
2. **Online Survey:** An online survey targeting general practitioners (GPs), practice managers, primary health care nurses, allied health professionals, and both Aboriginal and Torres Strait Islander Health Workers and Health Practitioners. Survey items gauged participants' beliefs about workforce and primary care service gaps in their community(s) of practise.
3. **Stakeholder Engagement:** Information was sourced from consultations with key stakeholders, communities, and health professionals throughout 2019. The jurisdictional Health Workforce Stakeholder Group (HWSG) also provided input at the annual HWSG meeting.
4. **Quantitative Methodology** – Data at an SA2 level was used to prioritise locations based on:
   - GP full time equivalent to estimated resident population ratio (2016)
   - Modified Monash Model (MMM) classification of remoteness
   - Index of Relative Socio-economic Advantage and Disadvantage (IRSAD)
   - Vulnerable population aged < 5 or > 65 years
   - Aboriginal and Torres Strait Islander status

Higher SA2 ratios indicate regions with possible greater workforce need.

Remote and Rural Health Workforce Overview

Photo: *Budd Photography*

> The demand for access to quality primary care and a skilled health workforce has never been greater. Health care and social assistance is the sector with the fastest projected industry employment growth in Queensland to 2022, with an advancement of almost 20 percent[1]. This growth can be attributed to aged care and disability reforms and an escalating burden of chronic disease. Currently, primary care services are not adequately organised to support integrated, comprehensive care for the 20 percent of Australians who have these complex and chronic conditions.
>
> Teamwork involving GPs, pharmacists, nurses and allied health professionals, is central to better-integrated care for these groups. Swerissen and Duckett (2018) highlight there are barriers to this including; fragmented and variable funding arrangements, insufficient access to data to properly plan the distribution of services and the split governance and accountability between various levels of government and separate agencies, making overall system management complicated[2].

These barriers are magnified in remote, rural and regional Queensland where thin markets, recurrent catastrophic climate events and ambiguous policy arrangements all contribute to a fragile and sometimes failing health service and workforce environment. In terms of health workforce, particularly in remote Queensland, this fragility is revealed through maldistribution, long term vacancies, high reliance on visiting and outreach, high turnover and an overrepresentation of a young, graduate workforce lacking the clinical leadership and mentorship they need to stay and succeed in an isolated environment. The four rural PHN health needs assessment reports all reflect difficulties in recruiting and retaining a skilled, culturally proficient workforce, particularly within the mental health and alcohol and other drugs sectors.

Photo: *Budd Photography*

There is also increasing difficulty in recruiting and retaining a stable medical workforce within general practice.

An endorsed (state and federal) overarching vision is needed for primary care that is proactive, preventative, co-ordinated and integrated. Creating genuine private/public partnerships by adequately resourcing joint workforce and service planning activities at the local level should be a priority within the vision. Local planning must include Hospital and Hospital Services, PHNs, Rural Workforce Agencies and community representatives, and workforce and service plans must be endorsed by all parties with funds pooled and distributed accordingly.

The Regional Australia Institute (2019) has also called for a new approach to regional policy in Australia by asking Governments to offer flexible, place-based approaches in the way that policies are delivered to ensure better results across diverse regional and remote areas of the country.

"Regions need different approaches, especially where policies are designed to work in areas with large populations, while effective delivery is difficult to achieve where populations are small and dispersed."

They advocate for local knowledge and expertise in planning and locally-led solutions with regards to employment and in the delivery of health care. Importantly, they also promote the importance of "soft" infrastructure to support liveability including quality child-care, employment opportunities for spouses, and education for children, all key factors in retaining highly skilled staff within regions[3].

For many, a career in remote and rural health can be exciting and offer a unique, challenging and rewarding experience. Great need paired with limited resources generates innovation, and there are many exemplars of unique service and workforce models in rural Queensland. Models that empower and provide an environment of supported learning and growth, and that allow health professionals to undertake meaningful work with clear career pathways, recognition and rewards.

There is also fertile ground to employ "grow your own" strategies to develop a local workforce designed to fit community need both clinically and culturally, with the health workforce pipeline commencing at high school through traineeships, working through industry pathways and progressing into tertiary education. Working in remote and rural Queensland needs to be promoted to our future workforce for its career and lifestyle opportunities to ensure a health workforce that will survive and thrive.

General Practice Workforce

> Policymakers in Australia are aware of the increasing supply of Australian trained doctors yet despite these increases, maldistribution continues. In response, they have engaged policies to encourage a fairer distribution of workforce across remote and rural areas to support sustainability and reduce the reliance on International medical graduates (IMGs).

However, while the proportion of IMGs in remote and rural Queensland has gradually reduced since the peak between 2005-2009, IMGs continue to play a substantial and necessary role in remote and rural Queensland, with IMGs making up 48 percent of all general practitioners in MMM 2-7 Queensland in 2018[4]. Other recent policy changes including the move from Districts of Workforce Shortage to Distribution Priority Areas in 2019, as well as 3GA program changes (RLRP to MDRAP) have made access to the IMG workforce more complex and more restrictive. For the many communities unable to attract Australian trained practitioners, these changes have further reduced access to a much-needed medical workforce.

"Retaining Australian trained GPs is very difficult and increasingly so."

Making general practice (and rural general practice) an attractive career choice for Australian medical graduates is vital. There has been a 20 percent fall in the number of junior doctors applying nationally for all GP training between 2015 and 2019, dropping from 2,460 to just 2,015[5]. The RACGP attributes this decline to a number of factors including the disparity between the average commencing GP registrar's income to that of a hospital-based registrar (around $30,000 per annum), as well as the lack of access to paid parental leave. Additionally, longer term accrual of leave including sick leave, carer's leave, annual leave and long service leave does not occur when a GP registrar changes employers to complete training rotations[6]. With many rural practices currently relying on a GP registrar workforce to meet demand, the decline is being felt on the ground and is threatening service access and practice viability.

"The government's Medicare rebate freeze and other cuts is deterring Australian medical graduates from a career in general practice and is resulting in reduced enrolments in the AGPT training programs."

In an effort to increase the appeal and viability of rural general practice, there are draft reforms proposed by the National Rural Generalist Taskforce whereby GPs and rural generalists who are endorsed with an advanced skill would be able to claim certain Medicare items usually reserved for specialists which are substantially higher than the equivalent GP item. The Taskforce also called for the creation of a tiered rural loading on the Medicare rebate for all clinical services, increasing with remoteness[7]. There is potential for these higher payments to attract more doctors with the right skills for rural communities, should these recommendations be advanced.

"GPs leave and are unable to be replaced. GP's also want to retire, but feel they can't as there is no one to replace them."

This year's HWNA survey results show perceived workforce gap ratings for general practitioners have incrementally increased from 2018-2020 (38.66 in 2018 to 58.46 in 2020). Strategies to address these gaps are required and need to be coordinated and integrated across the medical workforce pipeline to attract future workforce and support the current workforce.

Nursing and Midwifery Workforce

> While nurses and midwives are the best distributed health workforce in comparison to other professions, there are still not enough, with the Health Workforce 2025[8] report projecting a significant shortfall in nurses due to an ageing workforce by 2025.

"Difficulty recruiting and retaining. Still rely on agency staff."

Feedback from Health Workforce Queensland's HWSG meeting in October 2019 highlighted current issues including:

- Chronic vacancies in nursing within rural and remote Queensland
- Lack of graduate opportunity within practice nursing
- Lack of clinical placements within primary health care nursing and rural and remote settings
- Perceived low status of practice nursing
- Lower remuneration compared to hospital positions
- Lack of a model for clinical supervision for nursing

"Queensland Health finds it easier to recruit but privately it is difficult to get good nurses."

Rural areas not only require a large number of nurses but also nurses who have the requisite skill sets to meet the needs of their communities. However, the nursing profession continues to suffer poor retention rates, particularly in very remote areas. The 2018 APNA workforce survey with over 2000 respondents nationally reports that one in four nurses believe they are underutilised within their workplaces. Fifty percent of respondents reported requesting more complex activities and only half were permitted to do so. Forty-four percent of nurses also reported feeling isolated or lacking necessary support to best perform their roles[9]. Key to the retention of the nursing and midwifery workforce are workplace environments which enable nurses and midwives to work to their full scope of practice facilitated by safe staffing levels and skills mix appropriate for meeting care needs.

With workforce redesign and a greater unregulated/delegated health workforce in hospitals and in general practice, workplace factors such as training and supervision requirements, skill mix and role creep have to be considered carefully.

Innovative workforce models to increase access to services are essential. Nurse Practitioners are highly experienced and educated through a Masters degree to function autonomously and collaboratively in an expanded clinical role. They generate immediate, sustainable capacity in health care delivery and there are many exemplars of successful, high quality service models in remote regions to support further expansion to assist with addressing workforce shortages in Queensland.

Aboriginal and Torres Strait Islander Health Workforce

> With only two of the seven Closing the Gap targets on track to be met, and neither of these in the health arena, a different approach is required with Aboriginal and Torres Strait Islander peoples. This includes increased engagement with Elders and Community leaders to ensure increased understanding of needs as well as greater shared responsibility across different levels of government[10].

"Improved recently with us touching base with local traditional land owners and I also see a new service in the XXX [Town] community."

Currently there are a relatively low proportion of Aboriginal and Torres Strait Islander peoples engaged in the health workforce.

Low educational attainment and few opportunities for Aboriginal and Torres Strait Islander peoples to participate in the health workforce in remote communities across Australia is a known barrier. Ideally into the future there will be more Aboriginal and Torres Strait Islander people at the forefront of health clinics, a greater representation of Aboriginal and Torres Strait Islander doctors, nurses and health workers in private practices and a larger number of Indigenous drug and alcohol workers to support their communities.

Queensland Health has made strides by appointing a Chief Aboriginal and Torres Strait Islander Health Officer in 2019, a first for the state. The new Aboriginal and Torres Strait Islander Health Division will deliver policies and programs to work to close the health gap for First Nation Queenslanders including focused development of the Aboriginal and Torres Strait Islander workforce.

Cultural competence and culturally appropriate services were also identified as problems in every PHN needs assessment report. Aboriginal and Torres Strait Islander Health Workers and Health Practitioners play an important role in reducing anxiety and improving the quality and cultural safety of care for Aboriginal and Torres Strait Islander clients. The lack of support for their professional development and career progression as well the need for a clearly defined scope of practice, within the primary care setting, are all key issues that still need addressing. Targeted strategies are needed to develop the current and future Aboriginal and Torres Strait Islander health workforce. Some of these strategies could include:

- Support for youth to commence vocational training in health-related studies, close to home.
- Vocational coaching and support to identify career goals with access to culturally appropriate career pathway information.
- Targeted mentoring of Aboriginal and Torres Strait Islander students to assist with completion rates for studies.
- Supportive workplaces that embed cultural orientation and recognition of cultural practices.
- Succession planning and leadership training to ensure a pipeline of strong Aboriginal and Torres Strait Islander leaders into the future.

"Very sad that there are not a lot of culturally appropriate service providers to support Aboriginal and Torres Strait Islanders to remain home in community."

Allied Health Workforce

> Allied health workforce data is very limited when considering the number of practitioners by profession and location of employment by remoteness, particularly for non-AHPRA registered professions. However, it is generally agreed that the number of allied health practitioners in remote and very remote areas is far below population needs.

Recruitment and retention of the allied health workforce in remote, rural and even regional areas appears to be a common challenge experienced across all professions with psychology, social work, speech pathology and occupational therapy rating highest in our workforce gap analysis for Queensland this year. With no locally based service providers available in many communities, this often results in patients traveling longer distances to get assistance or even deferring treatment because of time and extra costs.

"As a small rural community, we do not attract the allied health services of a big city or regional centre. Many of our customers cannot access the transport needed to reach these services, so they miss out."

Feedback from Health Workforce Queensland's HWSG meeting in October 2019 highlighted current issues including:

- Allied health undergraduate training does not align with population health needs – i.e. lack of allied health in aged care and disability.
- Over representation of early career workforce that don't stay.
- Need for mentoring for new allied health graduates.
- Lack of Leadership and clinical governance (and training opportunities for both).
- Lack of senior consultants in rural and remote areas.
- Lack of opportunities for health professionals to share, observe and learn from each other.
- Lack of funding models and guidelines to support allied health organisations who do provide diverse workforce.

Swerissen and Duckett 2018 claim the scope and role of allied health in primary health is not yet well defined or governed[2], and within thin markets in rural settings, the viability of private practice is perilous. Contemporary allied health includes a broad range of professionals and technicians, assistants and support workers and these are often not understood or utilised effectively within health services or the community.

There is also a greater emphasis on client-centred care with funding now following the client. This is evident in programs such as the National Disability Insurance Scheme and My Aged Care and has significantly increased demand for quality allied health services close to home, often a challenge in remote and rural centres. There is a need to review models of care in rural primary health care to improve efficiencies and achieve co-ordinated care to meet this demand.

"NDIS is proving problematic for both allied health practitioners and clients/families in my community."

Innovative workforce strategies are also needed. Strategies that enable flexibility, ongoing professional development, supervision and mentoring, and clear career progression such as the allied health rural generalist pathway. More research to assess the impact of recruitment and retention interventions on the rural and remote allied health workforce is also necessary to effectively attract and retain current and future workforce.

"Being in a rural area, we also only have visiting Allied Health and Specialists who change like a revolving door, so continuity of care is ALWAYS LOST. Where is the patient care?"

References

1. State of Queensland (Jobs Queensland). Anticipating Future Skills: Jobs growth and alternative futures for Queensland to 2022.
2. Hal Swerissen, Stephen Duckett, and Greg Moran (2018). Mapping primary care in Australia. Grattan Institute.
3. Our Regions Rising – Policy Hack Summary 2019. A call for a new approach to regional policy in Australia. Regional Australia Institute. May, 2019.
4. Health Workforce Queensland (2019). Minimum Data Set Summary Report 2018. A snapshot of the general practitioner workforce landscape in Queensland as at 30 November, 2018.
5. Australian Doctor. 'Ominous': 20% drop in GP training applicants. 22nd July 2019. Available at: https://www.ausdoc.com.au/news/ominous-20-drop-gp-training-applicants
6. The Royal Australian College of General Practitioners. Pre-budget submission 2020–21. East Melbourne, Vic: RACGP, 2019.
7. Australian Government. National Rural Health Commissioner. National Rural Generalist Taskforce Advice to the National Rural Health Commissioner on the Development of the National Rural Generalist Pathway, December 2018.
8. Health Workforce Australia 2012: Health Workforce 2025 – Doctors, Nurses and Midwives – Volume 1.
9. APNA/Health Professionals Bank Workforce Survey. (2018). For primary care nurses.
10. Commonwealth of Australia, Department of the Prime Minister and Cabinet, Closing the Gap Report 2019.

Workforce Data

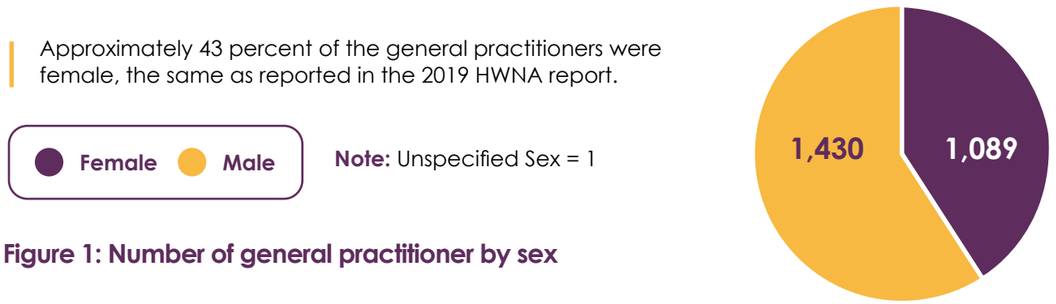
Photo: *Budd Photography*

State-wide Workforce Snapshot of General Practitioners in MMM 2-7

Health Workforce Queensland maintains a database of medical practitioners working in a general practice context (private practice, small hospitals, RFDS and ACCHO) in remote, rural and regional Queensland.

For this HWNA report, a snapshot of the workforce was taken on 30 November 2019. In line with reporting requirements to the Department, only doctors working in MMM 2-7 locations were investigated. At the census date there were 2,520 medical practitioners listed on the Health Workforce Queensland database as working in MMM 2-7 locations in Queensland, more than 200 greater than reported in the 2019 HWNA.} The average age was 49.7 years. The number of general practitioners by sex are presented in Figure 1.

Approximately 43 percent of the general practitioners were female, the same as reported in the 2019 HWNA report.



Note: Unspecified Sex = 1

Figure 1: Number of general practitioner by sex

Table 1: General practitioner sex by PHN

The number and percentage of female and male general practitioners for each of the four rural PHNs are presented in Table 1 (does not include practitioners from Brisbane North, Brisbane South and Gold Coast PHNs). Northern Queensland PHN had 338 more general practitioners than any of the other rural PHNs and had the highest percentage of female practitioners (47 percent). In contrast, the Western Queensland PHN had approximately 900 fewer general practitioners and only 36 percent were female.

PHN	Female *n*	%	Male *n*	%	Total *n*
Central Queensland, Wide Bay, Sunshine Coast	276	40.9	398	59.1	674
Darling Downs and West Moreton	232	41.7	325	58.3	557
Northern Queensland	472	46.6	540	53.4	1,012*
Western Queensland	40	36.4	70	63.6	110

Note: *One general practitioner of unspecified sex.

Country of Basic Medical Qualification

General practitioners were grouped according to whether they received their basic medical qualification from an Australian university or from an overseas university. Overall, there were 1,340 Australian trained practitioners (53.2 percent), and 1,180 overseas trained practitioners (46.8 percent). The percentage results for each of the rural PHNs are presented in Figure 2.

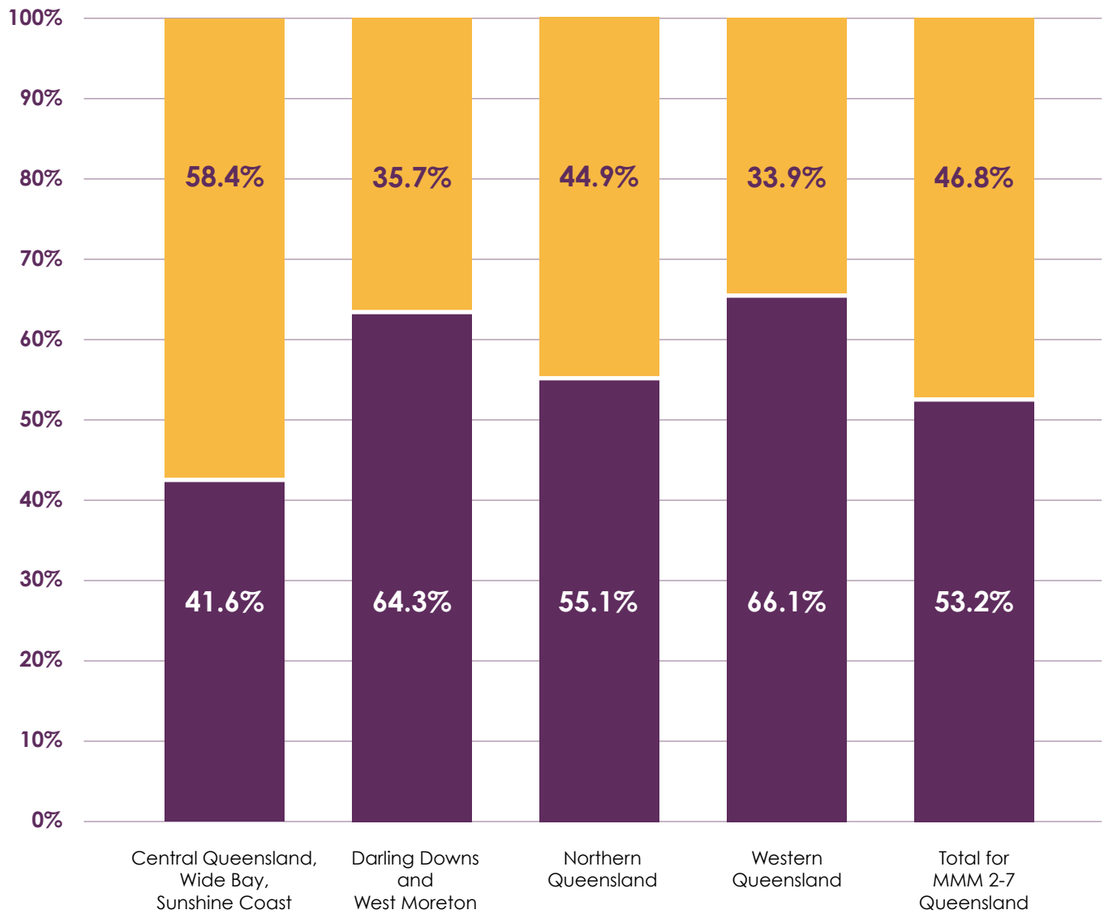


Figure 2: Percentage of general practitioner by country of basic medical qualification and PHN

Compared to the overall MMM 2-7 percentage of Australian trained practitioners (53 percent), the Central Queensland, Wide Bay, Sunshine Coast PHN was the only one to have a lower percentage of Australian trained practitioners (42 percent). In contrast, almost 25 percent more of the general practitioner workforce in the Western Queensland PHN was Australian trained.

Number of Medical Workforce by PHN: AHPRA Workforce Survey 2018

Queensland Health have provided an analysis to Health Workforce Queensland of the number of medical practitioners working in MMM 2-7 Queensland that self-described their main role as either 'General Practice' or 'Hospital non-specialist' from the 2018 Annual Workforce Survey completed during annual registration renewal through AHPRA. This is a national self-report survey completed during yearly registration. It is important to note that this would not include some medical practitioners that work in hospitals but have qualifications as specialists in general practice (through RACGP and/or ACRRM) or have qualified as Queensland Health Rural Generalists. The total number of medical practitioners likely to be undertaking general practice roles was 2,435.

The number of medical practitioners for each PHN is provided in Table 2 with the Health Workforce Queensland database numbers for comparison (see Table 1).

Table 2: AHPRA 2018 workforce survey general practitioners/hospital non-specialists by PHN

PHN	*AHPRA N*	*HWQ N*
Central Queensland, Wide Bay, Sunshine Coast	685	674
Darling Downs and West Moreton	417	557
Northern Queensland	1,132	1,013
Western Queensland	124	110
Total MMM 2-7 Queensland*	**2,435**	**2,520**

Note: Data provided by Queensland Health; *The Total MMM 2-7 Queensland numbers are based on all practitioners in MMM 2-7 QLD, including those in the Brisbane North, Brisbane South and Gold Coast PHN regions.

The total number identified in MMM 2-7 Queensland through the AHPRA workforce survey was within 100 of the number identified earlier in the Health Workforce Queensland database. For two of the PHN regions the agreement in practitioner numbers between AHPRA and the Health Workforce Queensland database was within 30 (Western Queensland PHN and Central Queensland, Wide Bay, Sunshine Coast PHN), while the other two PHN totals were within 150.

Practice Nurse Workforce

Health Workforce Queensland Database

The number of nurses and midwives working in MMM 2-7 general practice settings and captured in the Health Workforce Queensland database was 1,480, an increase of 190 compared to the last report. The number of these according to level of registration and diabetes education specialty are presented in Figure 3.

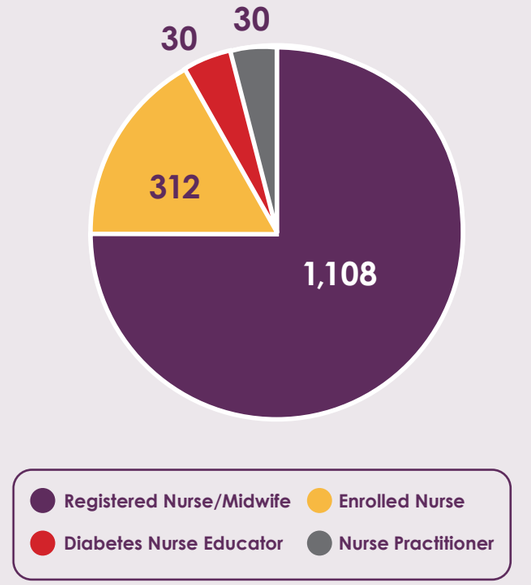


Figure 3: Number of general practice nurses by level of registration and specialty

Seventy-five percent were RNs and the majority of the remainder were ENs. There was a 50 percent increase in the number of Nurse Practitioners this year compared to 2019, although this was building on a small base.

Along with the nurses based in general practice, we are also provided with headcounts from Queensland Health of nurses working at smaller communities in primary care centres. The number of these according to level of registration and diabetes education specialty are presented in Figure 4.

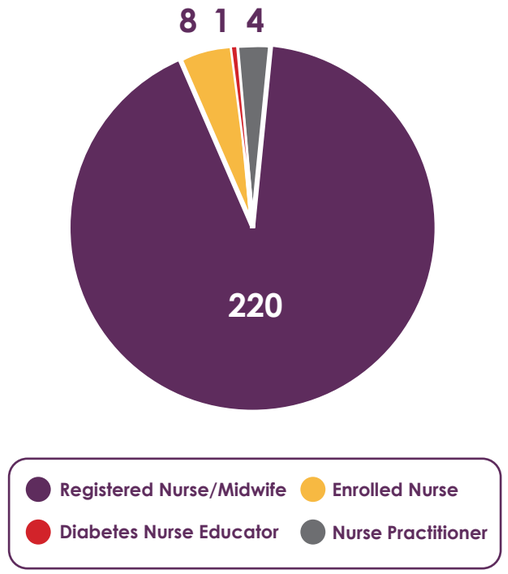
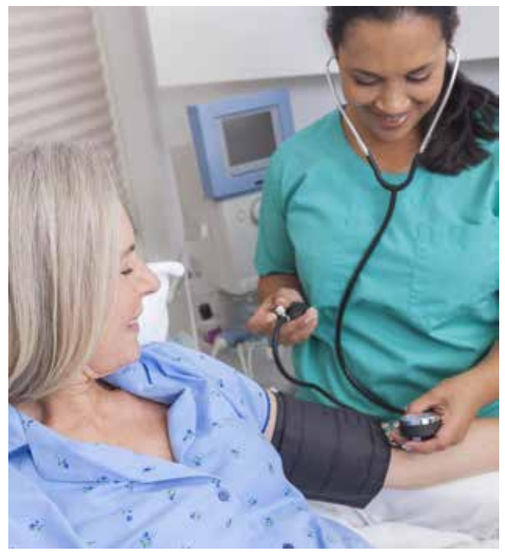


Figure 4: Number of primary health care centre nurses by level of registration and specialty

Ninety-four percent of the nursing workforce in remote and rural primary health care centres were registered nurses and midwives. There was only one diabetes nurse educator, and there was one extra nurse practitioner compared to last year. The total nursing workforce in primary health care centres was approximately 50 more than reported last year.



AHPRA Workforce Survey Data

Below is the number of nurses working in MMM 2-7 Queensland by rural PHN that self-described their main role as 'Practice Nurse' from the 2018 Annual Workforce Survey completed during annual registration renewal through AHPRA. This is a national self-report survey and includes both RN and EN qualified nurses. It is believed the response rate was around 97 percent of nurses across Australia. Results for the four mainly remote and rural PHNs in Queensland are available in Table 3, for both registered and enrolled nurses along with the percent of these that described their primary work as private. For comparison, the number of total practice nurses presented last year, from the 2017 workforce survey, are also included.

Table 3: Number of Practice Nurses by PHN in MMM 2-7 and percent in private employment from 2018 AHPRA Workforce Survey

PHN	Registered Nurse/Midwife *n*	Enrolled Nurse *n*	AHPRA Total *n*	Percent Private	2017 Total *n*
Central Queensland, Wide Bay, Sunshine Coast	513	166	679	90.6%	689
Darling Downs and West Moreton	292	104	396	90.9%	392
Northern Queensland	414	133	547	86.3%	550
Western Queensland	47	12	59	59.3%	64
Total	**1,266**	**415**	**1,681**	**88.0%**	**1,695**

Note: Data provided by Queensland Health

The number of registered nurses and midwives, and the number of enrolled nurses roughly aligned with PHN populations. Central Queensland, Wide Bay, Sunshine Coast PHN had the highest population and also had the most nurses in each category. The percentage of Enrolled nurses in the composition of all nurses ranged from 20 percent in Western Queensland, to 26 percent in Darling Downs and West Moreton.

While three of the PHNs had more than 85 percent of their nursing workforce describe their main employment as private practice, this was less than 60 percent in the Western Queensland PHN region. Compared to the numbers reported last year (from the 2017 Workforce Survey) there was little change.

Photo: *Budd Photography*

Aboriginal and Torres Strait Islander Health Workers and Health Practitioners

Health Workforce Queensland Database

There were 201 Aboriginal and Torres Strait Islander Health Workers and 22 Aboriginal and Torres Strait Islander Health Practitioners in the Health Workforce Queensland database. Figure 5 presents these according to MMM location.

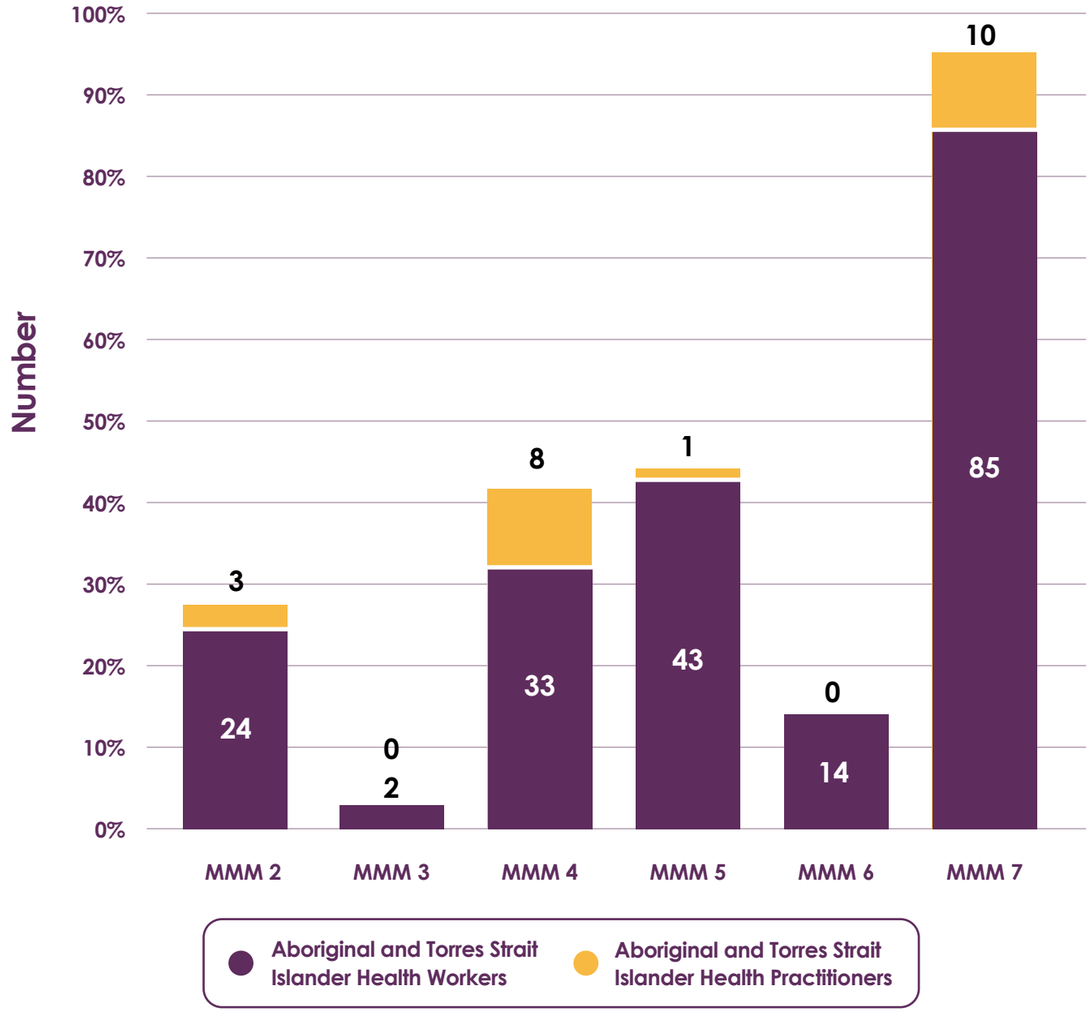


Figure 5: Aboriginal and Torres Strait Islander Health Workers/Practitioners by MMM

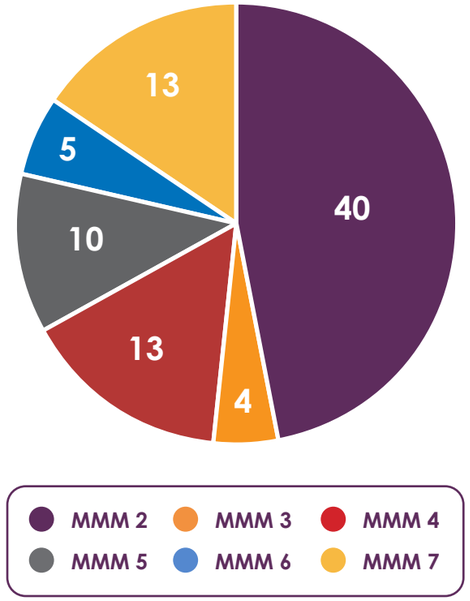
More health workers and health practitioners were working in MMM 7 locations than any other MMM categories. For Aboriginal and Torres Strait Islander health workers there were more than twice as many in MMM 7 than any of the other classifications. Compared to last year, there were approximately 50 more Aboriginal and Torres Strait Island Health Workers in the database.

Aboriginal and Torres Strait Islander Health Workers and Health Practitioners Continued

AHPRA Workforce Survey Data

The results from the 2018 AHPRA workforce survey, provided by Queensland Health, indicate that there were 85 Aboriginal and Torres Strait Islander Health Practitioners working in MMM 2-7 Queensland. Results according to MMM category are provided in Figure 6.

Figure 6: AHPRA 2018 workforce survey count of Aboriginal and Torres Strait Islander Health Practitioners by MMM



Almost half (47 percent) of the Aboriginal and Torres Strait Islander Health Practitioners were in MMM 2 locations. MMM 7 and MMM 4 each had approximately 13 percent of the Health Practitioner workforce. The remote areas covered by MMM 6 had approximately 6 percent of the workforce. Almost 84 percent of the Aboriginal and Torres Strait Islander Health Practitioner workforce were female.

Note: Data provided by Queensland Health

Allied Health

AHPRA Workforce Survey Data

The allied health workforce data outlined in the following section has been provided by Queensland Health based on the self-report responses to the 2018 AHPRA Workforce Survey that practitioners complete while renewing their registration. Because only some allied health professions are registered on the AHPRA database, the professions examined were:

- Psychology
- Podiatry
- Optometry
- Dentistry
- Physiotherapy
- Occupational Therapy
- Pharmacy
- Radiology

The numbers of practitioners in each of the allied health professions were calculated for all MMM 2-7 locations for each of the mainly rural PHNs. For the Central Queensland, Wide Bay, Sunshine Coast PHN, and the Darling Downs and West Moreton PHN, the number of practitioners in the PHN but working in MMM 1 location were also included.

This includes practitioners working in and around Ipswich (Darling Downs and West Moreton PHN) and on the Sunshine Coast in major towns such as Caloundra and Maroochydore (Central Queensland, Wide Bay, Sunshine Coast PHN). Results are presented in Table 4.

Table 4: MMM 2-7 Allied health practitioner by PHN and percent mainly in private employment

Allied Health Professions	MMM 2-7 *N*	Percent Private	MMM 1 *N*
Psychologists	**1,134***	**61 %***	**3,757**
Central QLD, Wide Bay, Sunshine Coast	296	68 %	352
Darling Downs and West Moreton	237	56 %	161
Northern Queensland	531	60 %	-
Western Queensland	22	57 %	-
Physiotherapists	**1,272***	**62 %***	**4,199**
Central QLD, Wide Bay, Sunshine Coast	341	66 %	466
Darling Downs and West Moreton	216	63 %	137
Northern Queensland	623	58 %	-
Western Queensland	49	48 %	-
Podiatrists	**214***	**83 %***	**618**
Central QLD, Wide Bay, Sunshine Coast	70	88 %	60
Darling Downs and West Moreton	43	88 %	31
Northern Queensland	75	78 %	-
Western Queensland	15	57 %	-
Occupational Therapists	**1,123***	**49 %***	**2,586**
Central QLD, Wide Bay, Sunshine Coast	271	51 %	309
Darling Downs and West Moreton	191	51 %	114
Northern Queensland	601	46 %	-
Western Queensland	42	49 %	-
Optometrists	**279***	**96 %***	**781**
Central QLD, Wide Bay, Sunshine Coast	88	100 %	80
Darling Downs and West Moreton	68	100 %	44
Northern Queensland	111	95 %	-
Western Queensland	7	100 %	-
Pharmacists	**1,408***	**66 %***	**3,654**
Central QLD, Wide Bay, Sunshine Coast	397	67 %	303
Darling Downs and West Moreton	289	69 %	191
Northern Queensland	609	63 %	-
Western Queensland	53	58 %	-
Dentists	**1,220***	**74 %***	**3,065**
Central QLD, Wide Bay, Sunshine Coast	382	73 %	350
Darling Downs and West Moreton	235	79 %	161
Northern Queensland	529	73 %	-
Western Queensland	32	47 %	-
Radiographers	**622***	**49 %***	**1,773**
Central QLD, Wide Bay, Sunshine Coast	201	59 %	215
Darling Downs and West Moreton	99	49 %	86
Northern Queensland	296	42 %	-
Western Queensland	19	53 %	-

Note: Data provided by Queensland Health. *MMM 2-7 total numbers and percent private for each discipline include the Brisbane North, Brisbane South and Gold Coast PHN regions.

The number of practitioners for each of the disciplines in MMM 2-7 ranged from 1,408 for pharmacists, to 214 for podiatrists. Generally, the Western Queensland PHN had a considerably smaller percentage of private practitioners than the other PHNs in the disciplines of dentistry (47 percent private), physiotherapy (48 percent private) and podiatry (49 percent private).

Central Queensland, Wide Bay, Sunshine Coast PHN had more practitioners in MMM1 locations than MMM 2-7 locations for psychology, physiotherapy and occupational therapy.

In the Darling Downs and West Moreton region, there were more practitioners for every discipline outside the MMM 1 areas.

Survey Results

Quantitative Findings

An online survey was conducted targeted at GPs, practice managers, primary health care nurses, Aboriginal and Torres Strait Islander Health Workers and Health Practitioners as well as allied health professionals working in MMM 2-7 locations. Survey items were developed to gauge health practitioner and health service manager beliefs about workforce and primary care service gaps in their community(s) of practise.

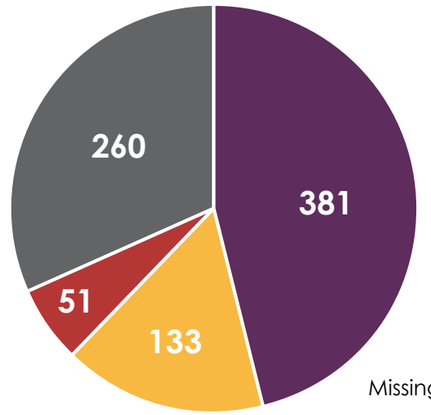
The survey items were phrased as statements (e.g. 'There is a serious gap in the physiotherapy workforce in my community') and participants were asked to rate their level of agreement.

Ratings were from '0 = Strongly disagree', to '100 = Strongly agree'. Higher scores therefore reflected greater agreement that there was a serious workforce gap.

There were statements for 18 workforce disciplines (e.g. general practice, pharmacy) and 13 primary care services that aligned with identified priorities for the PHNs (e.g. alcohol and other drug services; mental health services). There was a sample size of 825, a considerable increase from 577 last year. The number of participants by their main role (e.g. nurses, allied health professionals) are provided in Figure 7.

General practitioners accounted for 46 percent of survey responses, while allied health professionals/others represented 32 percent, practice managers 16 percent and nurses had the smallest representation of the total participants. The roles of participants for each of the rural PHNs are available in Figure 8.

Figure 7: Number of survey participants by main role



Missing = 1

Figure 8: Number of participants by main role for rural PHNs

Survey participant numbers ranged from 125 for Western Queensland, to 269 in Northern Queensland. For three of the PHNs, the Central Queensland, Wide Bay, Sunshine Coast PHN, the Darling Downs and West Moreton PHN and the Northern Queensland PHN, general practitioners represented between 49 and 51 percent of participants. In contrast, general practitioners only accounted for 28 percent of the participants in the Western Queensland PHN region.

Workforce Gap Ratings

Workforce gap rating means for remote, rural and regional QLD are provided below in Figure 9 (Workforce gap ratings).

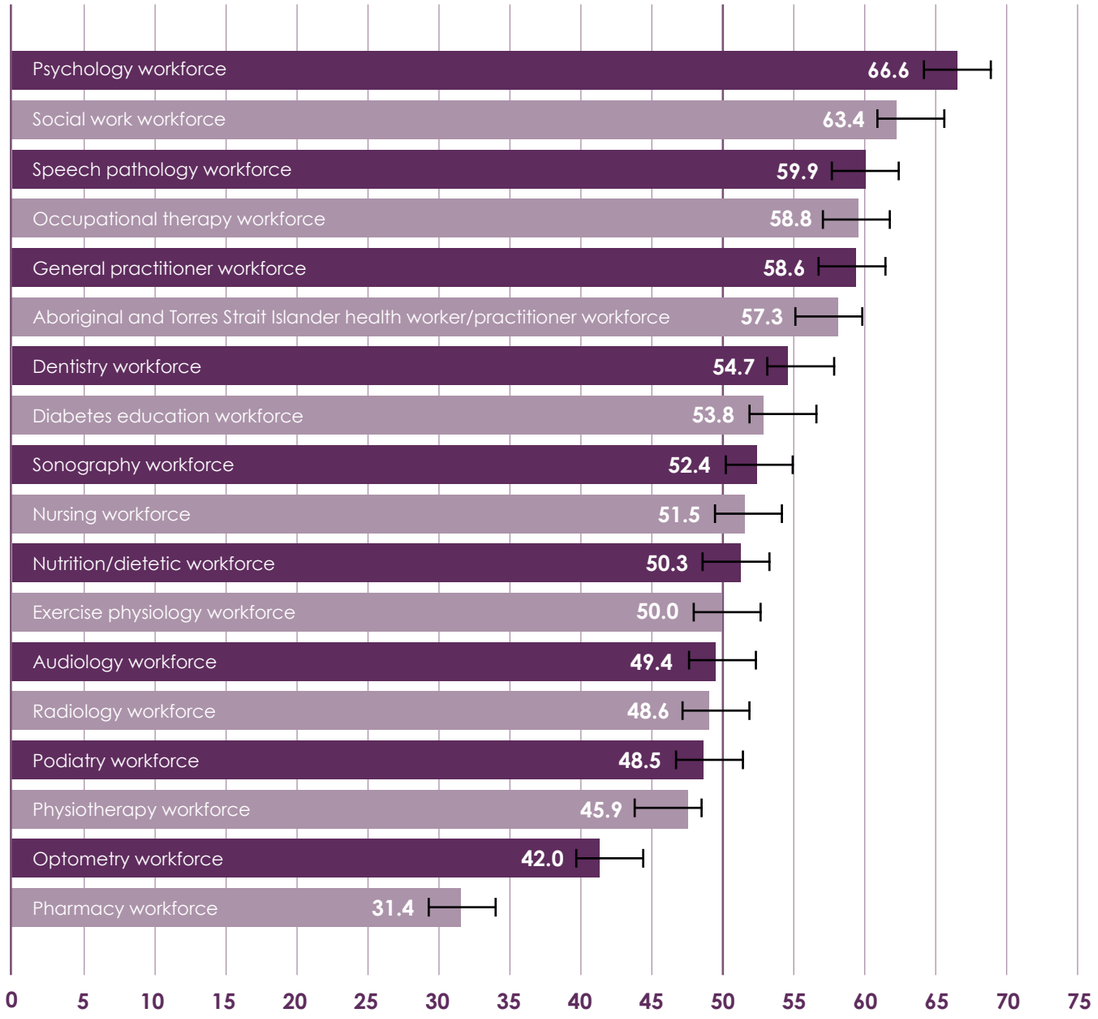


Figure 9: Workforce gap rating means

The highest workforce gap rating means were for psychology, social work, speech pathology, occupational therapy and general practitioner workforce, the first three with means of 60 or higher. However, unlike previous HWNA reports where few workforce gap means were higher than 50, there were 12 workforce disciplines with means greater than 50. Table 5 provides the workforce gap means across 2018 to 2020.

Table 5: Workforce gap rating means for 2018, 2019 and 2020

Type of workforce	2020 M	2019 M	2018 M
Psychology workforce	66.63	59.09	46.75
Social work workforce	63.35	56.12	50.27
Speech pathology workforce	59.88	51.33	45.58
Occupational therapy workforce	58.78	50.48	48.40
General practitioner workforce	58.58	50.75	38.66
Aboriginal and Torres Strait Islander health worker/practitioner workforce	57.27	48.09	38.69
Dentistry workforce	54.66	47.92	46.80
Diabetes education workforce	53.76	43.63	40.43
Sonography workforce	52.42	44.55	--*
Nursing workforce	51.55	44.57	39.02
Nutrition/dietetic workforce	50.30	42.96	41.34
Exercise physiology workforce	50.05	42.22	37.18
Audiology workforce	49.44	40.73	33.44
Radiology workforce	48.63	39.98	35.32
Podiatry workforce	48.51	40.76	34.45
Physiotherapy workforce	45.86	36.72	32.29
Optometry workforce	42.05	36.26	30.08
Pharmacy workforce	31.38	25.23	22.11

Note: *Rating question not contained in survey

The results indicate that there has been a gradual increase in the discipline workforce gap rating means across all disciplines from 2018. The extent to which this reflects increasing impacts of workforce shortages or is related to the composition of the sample is difficult to appraise. The most notable differences in the sample composition since 2018 is the increased number of survey participants and a reduction in the proportion of general practitioners in the total sample, although not in the total number of general practitioners.

Workforce Gap Comments

A thematic analysis was undertaken of comments provided in response to the workforce gap rating questions. The two most often mentioned workforce gaps were around **mental health** and **general practice.**

For mental health, the majority of responses were simply the words: mental health; psychology, or; psychologists. From the longer responses, three key themes and are shown below:

Mental Health

- No or limited mental health services available
- Long waiting time for mental health services
- The cost of mental health services

For general practice, the key themes were:

General Practice

- GP shortage and recruitment difficulties
- GP workload increasing in response to the lack of mental health professionals
- Cost for patients as bulk billing reduced
- Inadequate GP referral to allied health professionals

One comment provided further details about how all of the issues above were manifesting in their community:

"There is a shortage of GPs in XXX [Town] that is impacting on mental health clients being able to undertake timely review referrals. For example, one surgery has been using locums for 18 months which has impacted on continuity of mental health care. Another GP is not planning to get a locum when he is overseas for a month. Another surgery has been unable to recruit behind the two GPs that have recently relocated. Together, this is placing more stress on the local hospital which also has difficulty recruiting health professionals."

Across all comments for workforce gaps, the most common threads were related to limited accessibility and availability of affordable health workforce across most allied health disciplines, particularly so in smaller communities where the added cost of travel to larger centres further reduced access. Limited access to reliable public primary health services was also seen as impacting access for lower SES clients who could not afford private services even if they were available.

Service Gap Ratings

Service gap rating means for remote, rural and regional QLD are provided below in Figure 10.

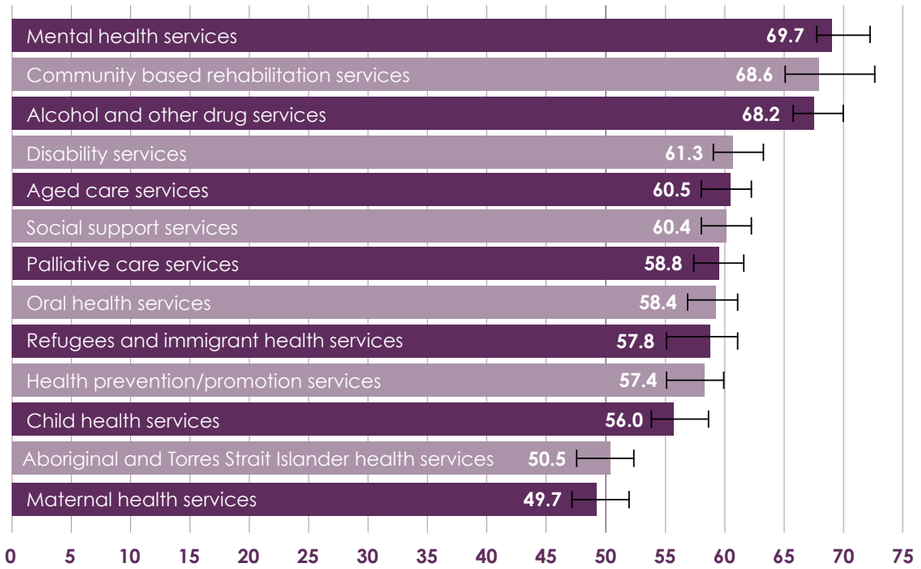


Figure 10: Service gap rating means

The highest service gap rating means were for mental health services, community-based rehabilitation services (added this year), alcohol and other drug services, disability services, aged care services and social support services, all with means of 60 or higher. This was unlike previous HWNA reports where few workforce gap means were higher than 60. Table 6 provides the workforce gap means across 2018 to 2020.

Table 6: Service gap rating means for 2018, 2019 and 2020

Type of workforce	2020 M	2019 M	2018 M
Mental health services	69.72	65.25	57.83
Community-based rehabilitation services	68.56	--*	--*
Alcohol and other drug services	68.20	60.14	58.38
Disability services	61.33	55.23	53.44
Aged care services	60.51	51.53	46.25
Social support services	60.45	54.97	--*
Palliative care services	58.80	52.55	48.37
Oral health services	58.37	54.44	--*
Refugee and immigrant health services	57.82	50.36	48.82
Health prevention/promotion services	57.38	50.84	46.09
Child health services	56.04	47.52	43.63
Aboriginal and Torres Strait Islander health services	50.47	43.13	--*
Maternal health services	49.68	40.43	33.01

Note: *Rating question not contained in survey

The results indicate that there has been a gradual increase in the primary care service gap rating means across all services with records from 2018. While there is not any definitive data to indicate that this reflects worsening service gaps in remote and rural Queensland, the increase in participant numbers for the current survey, particularly increases in the number of nurses and allied health practitioners, suggest that there are considerable concerns amongst primary care staff and practice managers in remote and rural Queensland.

Service Gaps Comments

A thematic analysis was undertaken of comments provided in response to the service gap rating questions. The two most often mentioned workforce gaps were around mental health and aged care. Further analyse was then undertaken to identify sub-themes under each. These are displayed below:

Mental Health Services

- High Demand, limited services
- Lack of services after hours
- Lack of workforce (i.e. Psychologists, Psychiatists, Social Workers, Counsellors, Mental Health Workers)
- Cost of services/lack of bulk-billing
- Lack of prevention, promotion and early intervention

Aged Care Services

- Access issues - long wait lists, lack of places/beds in aged care facilities
- Poor quality of care
- Workforce issues - shortages (i.e. GPs, Nurses), quality, poor work conditions, low remuneration, lack of career interest in aged care
- Poor management of chronic disease

Other Service Gaps Identified

- Alcohol and Other Drugs
- Palliative Care
- Child Health
- Aboriginal and Torres Strait Islander Health

Single Change to Primary Care Workforce

As part of the survey, participants were also asked to indicate the one workforce initiative/ change they believed would be most helpful to their community. The question asked:

If you could make a single change to the primary care workforce in your community, what would it be?

There were 481 responses received to this question. Responses were thematically analysed and results are shown below.

The two most common suggested changes were to improve **Access to General Practitioners** and improve **Access to Mental Health Services**. These two top themes were analysed further to identify sub-themes under each. Sub-themes are outlined below:

"Because of the chronic staffing issue, current staff always burn out and then have to leave..."

"Our GP clinics cannot attract a GP to town to replace those that have retired or moved away."

"We have a mental health team who are focused on acute or chronic mental health conditions. We don't have people to help with situational crisis etc which is frequent in XXX [Town] due to social factors."

"There is a serious gap in Mental Health care as people accessing care through the NDIS are being prioritised over people who are not eligible for NDIS funding. This is causing long wait times for those most at risk of mental health problems as there is a lack of services available."

Other identified themes among suggestions were:

- Improve access to Allied Health professionals.
- Improve communication, collaboration, co-ordination among workforce and service providers.
- Improve overall workforce quality through education, training and upskilling.
- Greater focus on health prevention and promotion.
- Strategies to attract and retain workforce in rural and remote more generally.

"In many remote communities the gap is in having a team that works together and is more connected to community. There may be a lot of ad hoc services that come and go and are much needed but sit there doing nothing because they do not have the connections to understand the needs or get the referrals."

Quantitative Methodology Findings - Priority SA2s

Below are the top ranked SA2s by PHN region based on the quantitative methodology described on page two of this report. The methodology incorporates; GP FTE to population ratio, MMM classification of remoteness, SEIFA (IRSAD), vulnerable population aged < 5 or > 65 years, and Aboriginal and Torres Strait Islander status.

Priority SA2s indicate areas of possible current and/or ongoing workforce need.

Northern Queensland PHN

Torres Strait Islands
Aurukun
Herberton
Palm Island
Croydon - Etheridge
Tablelands
Collinsville
Kowanyama - Pormpuraaw
Northern Peninsula
Cape York

Western Queensland PHN

Carpentaria
Far South West
Far Central West
Mount Isa Region
Charleville

Darling Downs and West Moreton PHN

Kingaroy Region - North
Tara
Nanango
Inglewood - Waggamba
Crows Nest - Rosalie
Jondaryan
Lockyer Valley - East
Esk
Millmerran
Warwick

Central Queensland, Wide Bay, Sunshine Coast PHN

Kilkivan
Maryborough Region - South
Agnes Water - Miriam Vale
Mount Morgan
Gin Gin
Cooloola
Central Highlands - East
Gayndah - Mundubbera
Bundaberg Region - South
Monto – Eidsvold

It should be noted that this list is not a comprehensive reflection of the need in these PHN regions. The findings of the quantitative methodology are a starting point.

Further qualification of need in these regions are discovered through ongoing communication and collaboration at the local level.

Key Issues and Strategies

Photo: *Budd Photography*

Access

Improving access and continuity of access to essential primary health care

Key Issues

- Shortages of GP, nursing, allied health, and Aboriginal and Torres Strait Islander health worker/practitioner workforce in remote and rural Queensland.
- Inequitable distribution of health workforce.
- Lack of or inadequate infrastructure (ICT, physical).
- Lack of affordable and appropriate transport to access services.
- Cost of travel for health professionals for rural outreach/hub and spoke arrangements.
- Limited/Lack of services available after hours.
- Cost of services.
- Culturally inappropriate services.
- Service awareness/service understanding.

Strategies

- Employ targeted recruitment support and retention packages. to priority communities, including locums.
- Continue to build evidence through collation of workforce data.
- Assist health professionals with relocation grants and incentives.
- Support clinical and leadership development.
- Promote the increased use of ICT including Telehealth.
- Streamline processes for patients to access transport subsidies.
- Develop innovative workforce models to support community need and increase workforce capacity.
- Encourage workplace cultural training of health professionals to support cultural safety.
- Encourage interprofessional collaboration and communication.
- Advocate for further policies and activities to attract health professionals to remote and rural areas including an overarching vision for primary care.

Desired Outcomes

- Increased supply of primary care workforce to priority areas.
- Improved availability of appropriate infrastructure to support health service requirements.
- Increased availability of affordable and appropriate transport to access health services.
- Increase in technology and financial supports for health professionals.
- Greater access to affordable and appropriate primary care within communities.
- An endorsed overarching vision for primary care (state and federal).

Quality

Building workforce capacity

Key Issues

- Skill mix of workforce not aligned to local needs.
- Care is episodic rather than comprehensive, continuous and person-centred.
- Workforce not equipped to deliver culturally appropriate health care.
- Low representation of Aboriginal and Torres Strait Islander people delivering health care.
- Difficulty accessing quality professional development and clinical upskilling.
- High representation of early career graduates in allied health.
- Challenges to training and developing a local workforce.
- Lack of mentoring and leadership opportunities.
- Barriers to expanding or utilising full scope of practise.

Strategies

- Support for youth to commence vocational training in health-related studies, close to home.
- Facilitate and coordinate continuing professional development.
- Provision of scholarships and bursaries to support upskilling aligned to community need.
- Organisational support for staff to undertake leadership training.
- Encourage activities that support role development and enhancing scope of practice.
- Support commissioning of providers that embed cultural orientation and training in their organisations.
- Support succession planning to ensure a continuous pipeline of strong clinical leaders.
- Increase workforce capacity through workforce redesign to deliver quality multidisciplinary care.
- Targeted recruiting of Indigenous health professionals to support cultural safety.

Desired Outcomes

- A capable workforce that is responsive to local needs.
- Increased availability of quality primary health care services.
- Increased availability of quality training, close to home.
- Work environments that enable staff to work to the top of their scope providing workforce satisfaction and quality care.
- Increased capability of the health workforce to deliver culturally appropriate health care.

Sustainability

Growing the sustainability of the health workforce

Key Issues

- Ongoing challenges for remote and rural communities attracting and recruiting health workforce.
- High turnover of health professionals in rural and remote.
- Limited pipeline of locally trained workforce.
- Decline in interest in rural health, general practice and primary care as career choices.
- Inefficient and fragmented care due to high visiting/outreach models.
- Vulnerable and non-viable workforce models i.e:
  - > Challenges to the viability of private health services in remote and rural areas including cost of living, distances to travel, income of clients, access to workforce and economies of scale.
  - > Current fee for service general practice models in remote and rural areas does not support sustainability.
  - > Current models don't support 'Easy Entrance, Gracious Exit' of workforce creating financial, administrative and work/life balance burdens.
- Lack of workforce retention due to: Lack of access to continuing professional development (CPD), professional isolation, burnout due to lack of relief, poor housing and accommodation, high cost of living, spouse/family and lifestyle considerations.

Strategies

- Offer rural immersion opportunities to attract students into rural health careers.
- Support rural high school visits to create interest in a rural health career.
- Work with universities to support more student placements in remote and rural Queensland.
- Support navigator and liaison roles to promote better system integration, coordination and collaboration.
- Investigate blended funding models (particularly for allied health) to support financial viability of service provision.
- Promote public/private employment models for skills retention and increased viability.
- Work within priority communities to assess and develop innovative workforce models that expand scope of practice and considers emerging health workforce roles.
- Family support opportunities.

Desired Outcomes

- Greater numbers of future workforce taking up careers in rural health.
- Greater numbers of the medical workforce choosing general practice.
- Higher rates of health workforce retention in remote, rural, and regional areas.
- Health service delivery is optimised through improved system integration, coordination and collaboration.
- Workforce models are developed to meet local need and support viability and sustainability of services.
- Developing the future workforce to address maldistribution and local need.

"Access - there may be some practitioners under various disciplines...but access is very difficult due to small numbers, especially if a patient does not have private medical insurance coverage.

Cost - there may be 'gap fees' between what Medicare cover and the practitioner's charges, which makes it very difficult for people on no or low income (pensioners) to access needed services.

Altogether, patients in rural and regional locations experience major inconvenience and cost challenges in accessing essential services."

Photo: *Budd Photography*

Supporting Remote and Rural Towns

Case Study - St George

Health Workforce Queensland works with the rural PHNs and their communities to assist with supporting access, quality and sustainability of the local health workforce.

This case study highlights some of the activities and supports Health Workforce Queensland have provided to the remote town of St George in South West Queensland. Situated on the banks of the Balonne River with a population of 3,100 residents, St George has approximately 600 Aboriginal and Torres Strait Islander people living in the community.

It has a number of health services including the St George Medical Centre, Goondir Health Services an Aboriginal Community Controlled Health Service (ACCHS), as well as the St George Hospital. The St George Medical Centre was growing and had been on the search for an additional GP for some time. In 2019, Health Workforce Queensland was successful in attracting Dr Jeet Patel, a vocationally registered doctor to St George Medical Centre.

"In December 2018, I visited St George to complete a short locum…I thoroughly enjoyed this experience and decided to make the move. Plus, I think I preferred rugby to AFL!"

Health Workforce Queensland provided free of charge recruitment services to St George Medical Centre and financially assisted Jeet with his relocation and orientation to the town.

"I have always been up for a challenge… I felt that there was a real need for a doctor in St George and that I could really make a difference to the health care provision here."

Other primary care health workforce in St George have also accessed the scholarship program, administered on behalf of the Australian Government Department of Health, with nine scholarships approved in total during 2019 to doctors, physiotherapist, dietitian, occupational therapist and clinical psychologist.

Health Workforce Queensland are also working collaboratively with St George Medical Centre, Western Queensland PHN and CheckUP to source a locum to enable the medical centre to provide an outreach clinic to the nearby town of Thallon to ensure local access to general practice services after a closure of the service in 2019.

Health Workforce Queensland have also worked with the Remote Vocational Training Scheme (RVTS) and Goondir is now is an approved placement site for an RVTS candidate. This is a very attractive recruitment tool as it allows doctors to access supported training while they continue to provide general medical services within their local community.

In 2020, Health Workforce Queensland will also visit St George with the GROW Rural South West Program. GROW Rural is a rural immersion experience for a cohort of undergraduate medical, nursing and allied health students who will visit the town every year for three years to get to know its residents and to understand the attractions of working in the region.

Supporting remote communities like St George by undertaking activities that contribute to improving access, quality and sustainability of the health workforce underpins our vision to ensure optimal health workforce to enhance the health of Queensland communities.

St George, QLD to Brisbane, QLD

Stakeholder List and Acknowledgements

Photo: *Budd Photography*

Stakeholder List

Below is a list of stakeholders we have engaged with throughout the year through face to face meetings, forums and teleconferences to discuss key workforce issues in Queensland locally and statewide.

- Australian Primary Health Care Nurses Association
- Australian College of Rural and Remote Medicine
- Central Queensland Rural Health
- Central Queensland, Wide Bay, Sunshine Coast Primary Health Network
- Centre for Rural and Remote Health, Mount Isa, James Cook University
- CheckUp
- College of Medicine and Dentistry, James Cook University
- CRANAplus
- Central Highlands Healthcare
- Darling Downs Hospital and Health Service
- Darling Downs and West Moreton Primary Health Network
- Department of Health, Queensland
- Faculty of Medicine, The University of Queensland
- General Practice Training Queensland
- Gidgee Healing
- Goondir Aboriginal and Torres Strait Islanders Corporations for Health Services (Goondir Health Services)
- Indigenous Allied Health Australia
- JCU GP Training
- Northern Queensland Primary Health Network
- North West Remote Health
- Queensland Aboriginal and Islander Health Council
- Remote Vocational Training Scheme
- Royal Flying Doctors Service, Queensland
- Rural Doctors Association of Queensland
- Services for Australian Rural and Remote Allied Health
- Statewide Rural and Remote Clinical Network, Department of Health, Queensland
- The Royal Australian College of General Practitioners
- Western Queensland Primary Health Network

Acknowledgements

Health Workforce Queensland would like to thank the above organisations along with the many general practices liaised with across remote and rural Queensland for contributing to this report. Health Workforce Queensland would also like to acknowledge and thank the hundreds of remote and rural health professionals and practice managers who took the time to have their say via the online survey.

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