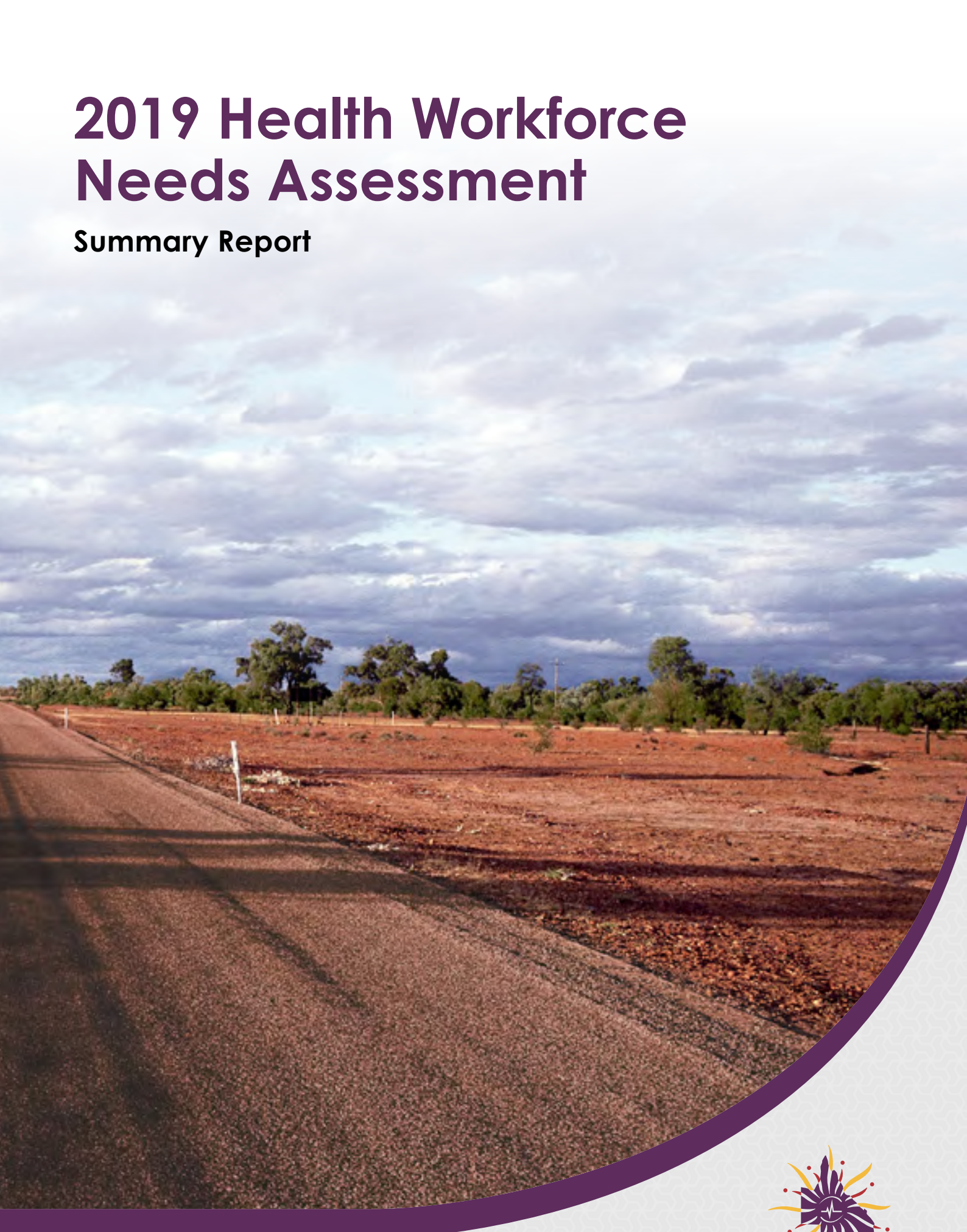
2019 Health Workforce Needs Assessment

Summary Report



Health Workforce Queensland

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.

The front cover image is of Cunnamulla, QLD. Image courtesy of Tourism and Events Queensland

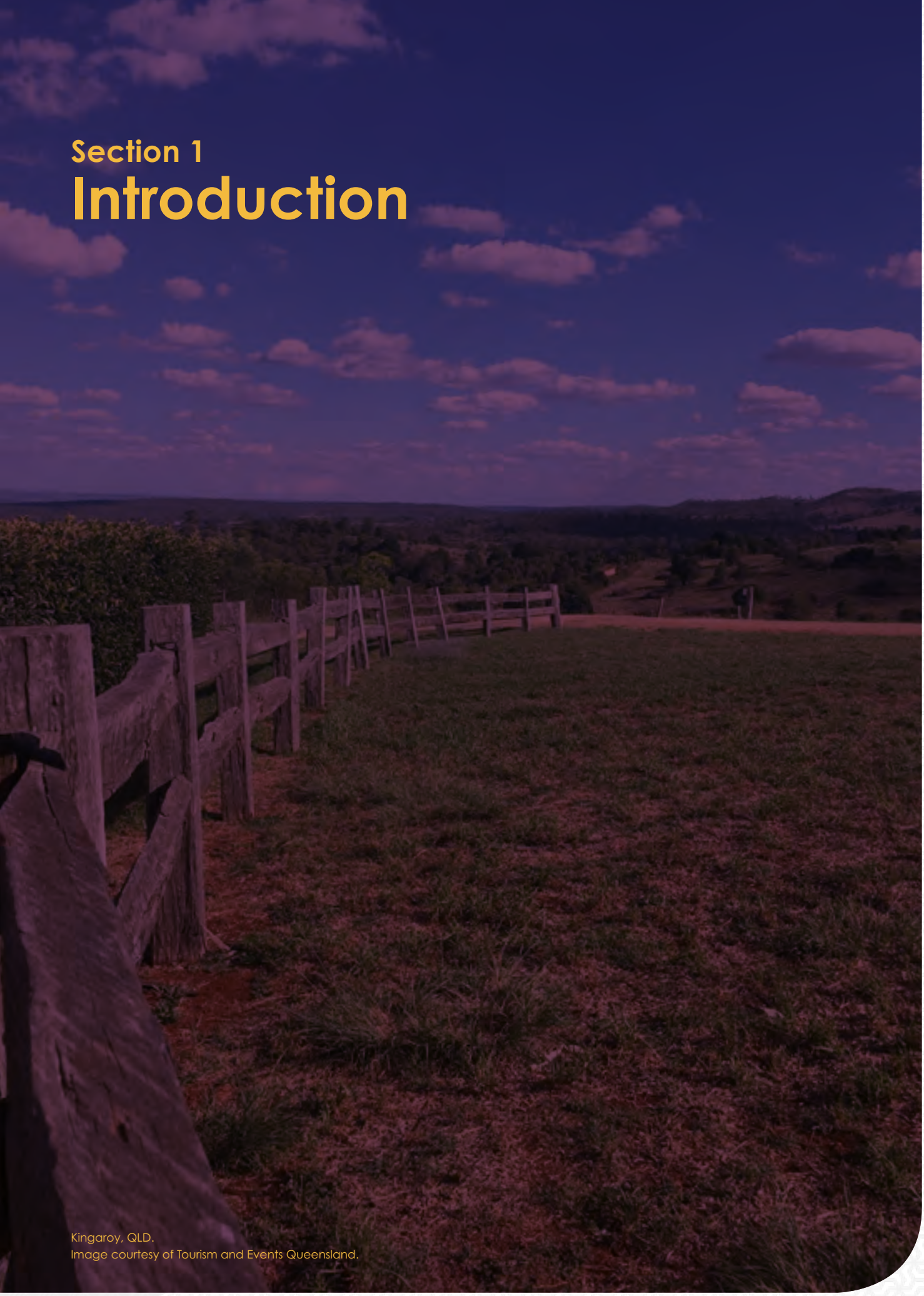
Table of Contents

Our Strategic Plan

Our Focus	Our Goals
Identify health workforce needs of remote and rural communities that need it most	Increase evidence base of health workforce needs of remote and rural communities
	Develop and maintain strong and meaningful collaborations with key stakeholders to identify priority locations, professions and skills
Increase access to primary healthcare workforce for remote and rural communities that need it the most	Deliver evidence-based and locally responsive health workforce solutions
	Increase the supply of highly skilled, culturally competent health workforce when and where they are needed
	Increase the supply of highly skilled, culturally competent health workforce to support Aboriginal and Torres Strait Islander communities
The Agency foster high quality service delivery	Develop our people
	Develop our culture
	Improve our capability and systems

Section 1

Introduction



Kingaroy, QLD.
Image courtesy of Tourism and Events Queensland.

Introduction and Purpose

As part of our funding agreement with the Australian Government Department of Health, (referred to as 'the Department'), Health Workforce Queensland undertakes an annual state-wide 'all of health' primary care workforce needs assessment for remote and rural Queensland, leveraging off the comprehensive population health and service needs assessments undertaken at regional levels through the Primary Health Networks (PHNs) and others.

With a focus on the primary health care landscape, the Health Workforce Needs Assessment (HWNA) identifies high priority locations, professions and workforce requirements to develop and support evidence-based and effective models of service delivery in remote and rural Queensland.

The purpose of the HWNA is three-fold:

1. Identify priority Statistical Areas Level 2 (SA2) locations across Queensland with regards to health workforce;
2. Inform and prioritise the utilisation of Health Workforce Queensland resources; and
3. Inform outcomes to the Department for program planning and policy development.

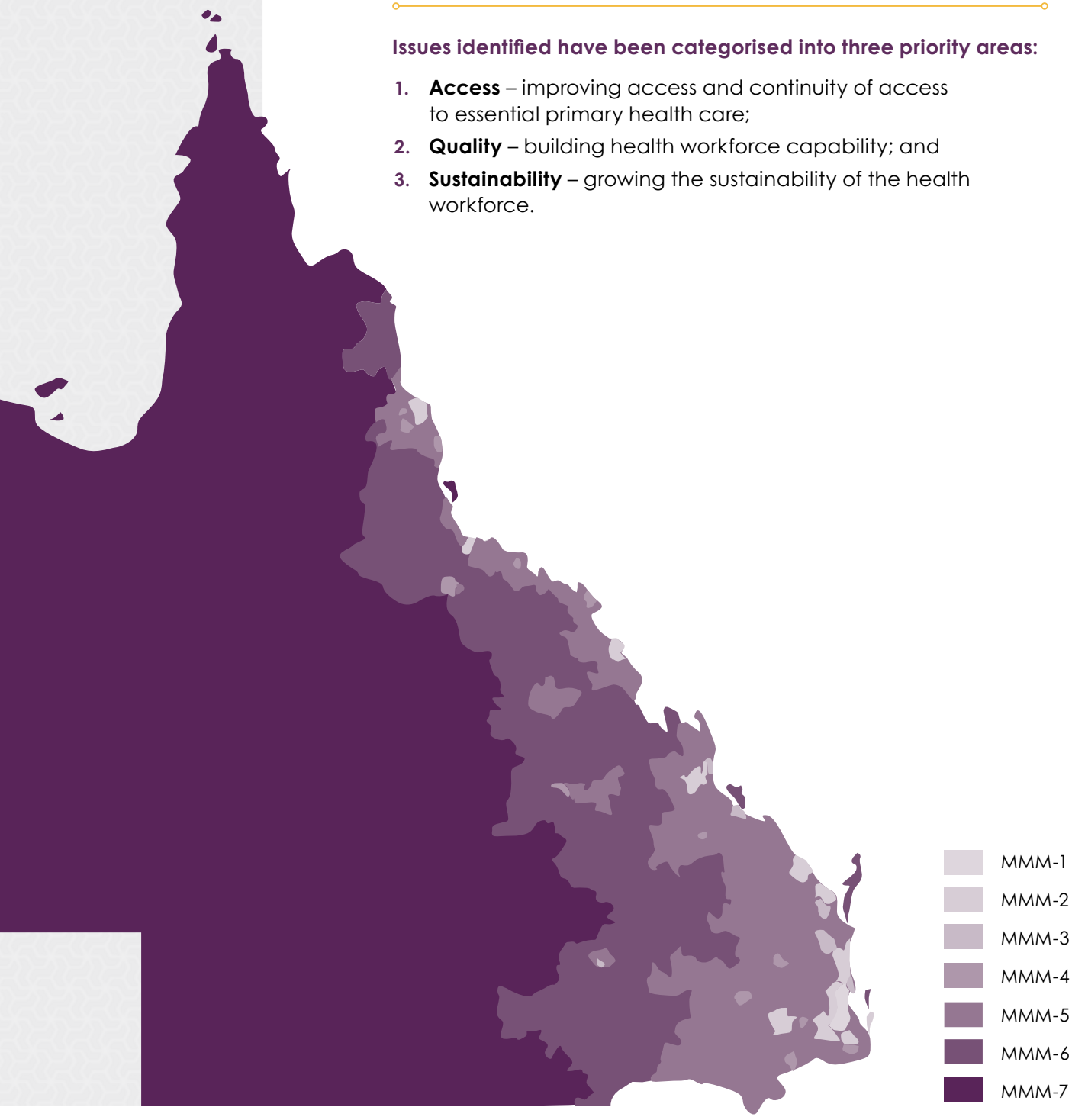
The HWNA also contributes to the development and implementation of an evidence-based Activity Work Plan (AWP), to address national and specific priorities relating to localised health workforce needs and service gaps. Information used to inform the HWNA was sourced from available data sources and from consultations with communities, health professionals and stakeholders. As a key part of the process, a formal jurisdictional Health Workforce Stakeholder Group (HWSG) was created to provide strategic advice and expertise to inform planning, analysis and strategy development.

Scope

This is the second annual HWNA and builds on our baseline understanding of the primary health care workforce needs of populations and communities in Modified Monash Model (MMM) areas 2-7 in Queensland. It integrates demographic, population health and workforce data alongside structured consultations and considers populations with special needs and those at risk of poorer health outcomes.

Issues identified have been categorised into three priority areas:

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.



Eligible Professions

The list of professions eligible for support in the AWP, as agreed upon by the HWSG were:

- Aboriginal and Torres Strait Islander Health Worker and Health Practitioner
- Allied Health Assistant
- Alcohol and Other Drugs Worker
- Audiology
- Dental Hygiene
- Dentistry
- Diabetes Education
- Dietetics
- Exercise Physiology
- Family Support Worker
- Health Promotion
- Medical Imaging (Radiography, Sonography)
- Medical Receptionist
- Medicine
- Nursing and Midwifery
- Nutrition
- Occupational Therapy
- Optometry
- Paramedicine
- Pharmacy
- Physician Assistant
- Physiotherapy
- Podiatry
- Practice Manager
- Psychology
- Social Work
- Speech Pathology

Health professionals involved in education, supervision and mentoring in priority locations were also included.

Guiding Principles

The identification of "hot spot" locations forms part of the reporting requirements for the HWNA. After deliberations within the HWSG in 2018, it was agreed that rather than endorsing a list of "hot spot" locations, the HWSG preferred a longer list of priority SA2s (less exclusionary) and proposed that Health Workforce Queensland develop a set of principles to guide the prioritisation of SA2s to be assisted (not only based on numeric ranking) and further principles to direct actions (if any) that could potentially be undertaken in these regions. An extended list of priority SA2s by PHN region, as determined by the methodology, has been updated in 2019 and is provided in Appendix A. There was also a recognition that there can be emerging critical workforce situations at any given time, outside of the listed SA2s. These will also be measured against the set of principles to determine if they should be prioritised and if so, what course of activities should be taken by Health Workforce Queensland.

Principles to underpin prioritising locations

The principles are:

- A list of priority locations (SA2s) by PHN region are identified through an evidence-based methodology incorporating key measures of remoteness, socioeconomic disadvantage, GP workforce, Indigenous status and age, will be a guide in the first instance;
- Discussion with key stakeholders verifies that a locality has a critical workforce need. Determination of workforce need will consider not only the quantity of workforce, but also dimensions of health service accessibility, cultural appropriateness and alignment with community need; and
- Aboriginal and Torres Strait Islander communities with critical workforce need are the highest priority.

Principles to guide Health Workforce Queensland's activities in prioritised locations

Once a location is identified, an assessment will be made as to whether any Health Workforce Queensland activities will be undertaken based on the following principles.

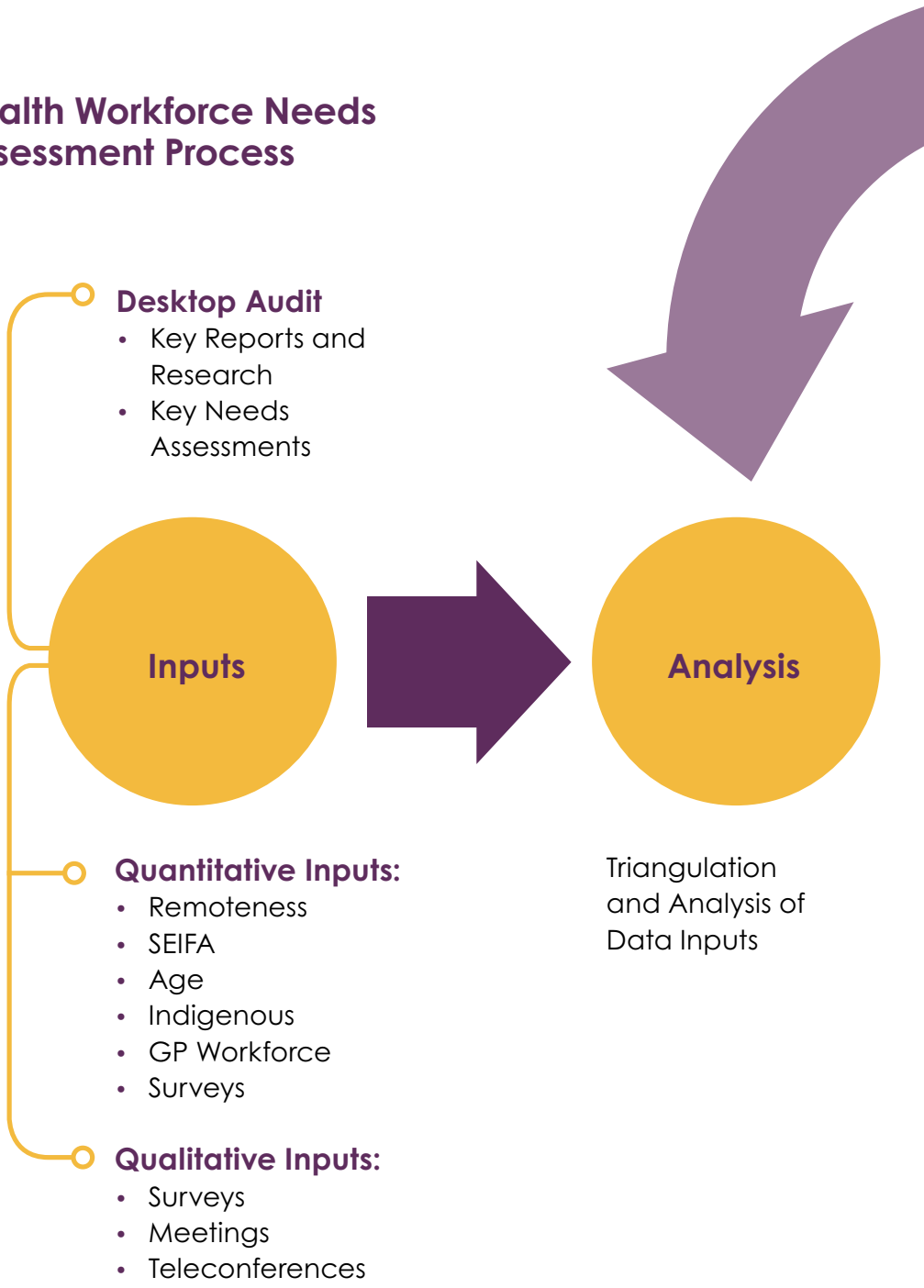
- Collaboration with key stakeholders validates that there is potential for Health Workforce Queensland to play a role in addressing identified workforce issues;
- Mechanisms already in place to address workforce issues are considered in the first instance;
- Workforce solution elements identified to be the role of Health Workforce Queensland align with its funding parameters and available resources;
- The impact of workforce gaps in each locality are considered and prioritised accordingly;
- Potential workforce solutions are developed in collaboration with key stakeholders within the locality;
- The workforce needs of Aboriginal and Torres Strait Islander Community Controlled Health Services are an embedded priority;
- Potential workforce solutions are viable, sustainable and in alignment with community need; and
- Workforce solutions requiring Health Workforce Queensland's involvement over the long term are given equal consideration to those where workforce needs can be addressed in the short term.

Section 2

Methodology

Baralaba, QLD.
Image courtesy of Roslyn Budd Photography

Health Workforce Needs Assessment Process



The HWNA Process was comprised of several phases (Figure 1) including:

1. Desktop audit;
2. Determine and stratify the relative health workforce risk of Queensland communities by SA2 using a methodology combining quantitative and qualitative data;
3. Triangulation and analysis of data;
4. Validation of findings through the HWSG; and
5. HWNA final report.

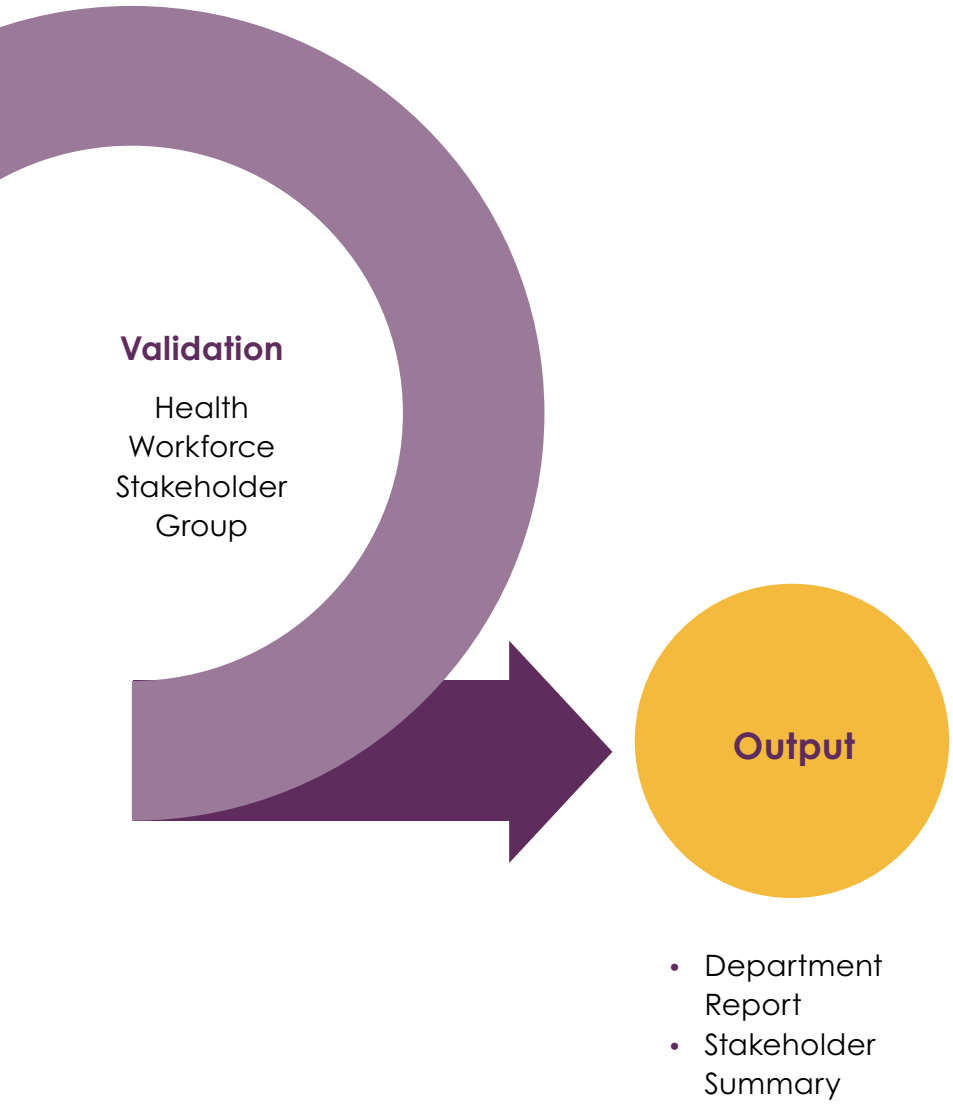


Figure 1. Health Workforce Needs Assessment Process.

Desktop Audit

A desktop audit was undertaken through a search of grey literature, journal publications and website searches such as published reports, frameworks, needs assessments, projects and policy documents. All PHNs within the HWSG provided Health Workforce Queensland with their latest needs assessment reports. Literature was reviewed with specific attention to the three key themes: Quality, Access, and Sustainability. Data was entered into a thematic spreadsheet to be drawn upon in the analysis phase.

Quantitative Methodology

A quantitative methodology was developed across Australia with other state and jurisdiction Rural Workforce Agencies so that there was a nationally consistent approach. This methodology has remained unchanged in this 2019 report. Data from a number of sources were stratified to SA2 in MMM 2-7 Queensland. These included:

a. Population level data obtained from the Australian Bureau of Statistics
b. Index of Relative Socio-economic Advantage and Disadvantage (IRSAD)
c. Estimated resident population (2016)
d. Population aged < 5 or > 65 years
e. Aboriginal and Torres Strait Islander status

The Australian Government Department of Health – DoctorConnect website was accessed to determine the MMM geographic coding(s) for each community in the state; and General Practitioner (GP) Full Time Equivalent (FTE) data was extracted from Health Workforce Queensland's own database.

Firstly, SA2s were categorised according to their health need by remoteness (MMM 2-7) and IRSAD and filtered into Extreme, High, Medium and Low risk quadrants (Figure 2).

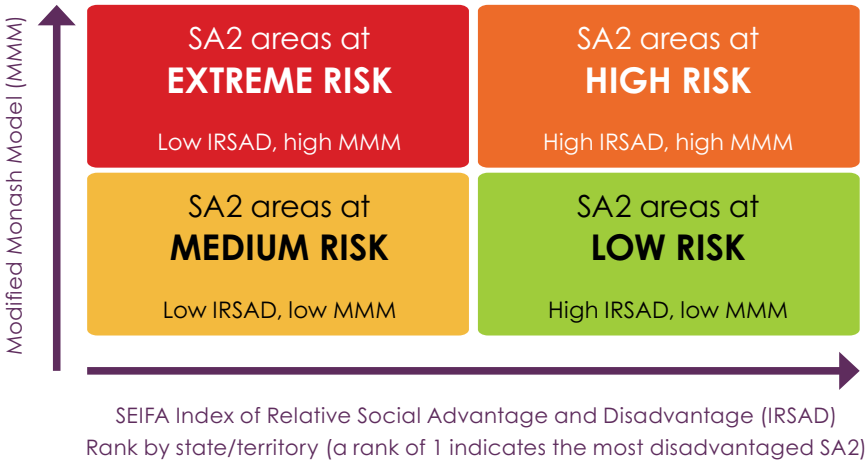


Figure 2. Categorisation of SA2 areas in quadrants based on remoteness and socio-economic disadvantage.

The next step involved applying GP FTE numbers to the estimated resident population (2016) by SA2 to provide a ratio for each SA2. This ratio was used for ranking purposes. Separate GP FTE ratios were then developed for two vulnerable population characteristics (aged < 5 or > 65 years and people who identified as Aboriginal and/or Torres Strait Islander). These ratios were used for ranking purposes.

Finally, all SA2s that fell in the extreme quadrant were ranked based on MMM, SEIFA (IRSAD), GP FTE to population ratio, GP FTE to vulnerable

population by age (aged < 5 or > 65 years) ratio, and GP FTE to Indigenous population ratio. An overall rank for SA2s was then calculated based on the sum of all five rankings. SA2s ranked most highly for each PHN were treated as an indicator of possible ongoing workforce need (see Appendix 1 for prioritised lists by PHN).

Limitations of SA2 Prioritisation Approach

There are some important limitations of the methodology that are acknowledged by Health Workforce Queensland. This approach does not take into account other factors such as visiting workforce, prevalence of disease, or service demand. In addition, only GP workforce data was used in the quantitative methodology and does not include workforce data relating to other health professions. Workforce numbers were based on Health Workforce Queensland's own database only and may not reflect the full extent of GP workforce within each region. Furthermore, some SA2s had no available GP workforce data that eliminated them from the ranking process. Further investigation and stakeholder engagement were needed to identify current workforce needs or issues within priority SA2s within each PHN.

Online Survey

An online survey was conducted targeting 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 gauged health practitioner and health service manager beliefs about workforce and primary care service gaps in their community(s)of practise. There were some additions and revisions to the workforce and service gap rating items this year. The main two sections of the survey affected were the disciplines defined in the workforce gap section and the services defined in the service gap section. Changes are listed below:

1. Workforce Gap Ratings Revisions
    a. The Aboriginal and Torres Strait Islander Health Worker discipline was expanded to include both 'health workers' and 'health practitioners'
    b. Sonography was added.
2. Service Gap Ratings Revisions
    a. Services for Aboriginal and Torres Strait Islander people, Oral health services and Social support services were added
    b. Palliative Care was moved from workforce gaps to service gaps

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. For the 2019 report there were statements for eighteen workforce disciplines (e.g. general practice, pharmacy) and twelve primary care services that aligned with identified priorities for the PHNs (e.g. alcohol and other drug services; mental health services).

Additionally, open questions were added asking practitioners/ managers to: indicate the most concerning health issue and suggest the type of health professional(s) required; and to indicate whether upskilling of the current workforce may alleviate some primary care issues. As part of the online survey, participants were given the opportunity to provide qualitative comments regarding the health workforce and primary care service gaps in their community(s) of practise. These were summarised and major themes were drawn out to contribute to the development of key priorities and issues.

Stakeholder Engagement

Consultations and stakeholder engagement meetings were undertaken with regional groups, PHNs, Aboriginal Community Controlled Heath Services and Hospital and Health Services (HHSs) to determine their perceptions of workforce needs in their regions and identified priority locations. Feedback from these meetings were entered into a thematic spreadsheet alongside the reports to draw out key issues and themes. The list of stakeholders can be found in Appendix 3.

Triangulation and Analysis of Data

Analysis of data was undertaken including triangulation of quantitative data and surveys results, feedback from consultations and the desktop audit to inform the findings in this assessment. A state-wide summary of needs, key issues and evidence, based on these findings was developed under the three priority areas of Access, Quality and Sustainability.

Strategies were developed in collaboration with the HWSG to address the identified needs and issues. It should be noted that not all strategies identified and discussed can be carried out by Health Workforce Queensland, but these have been included to reflect the feedback from the HWSG.

Strategies undertaken by Health Workforce Queensland will be enacted in collaboration with various key stakeholders including:

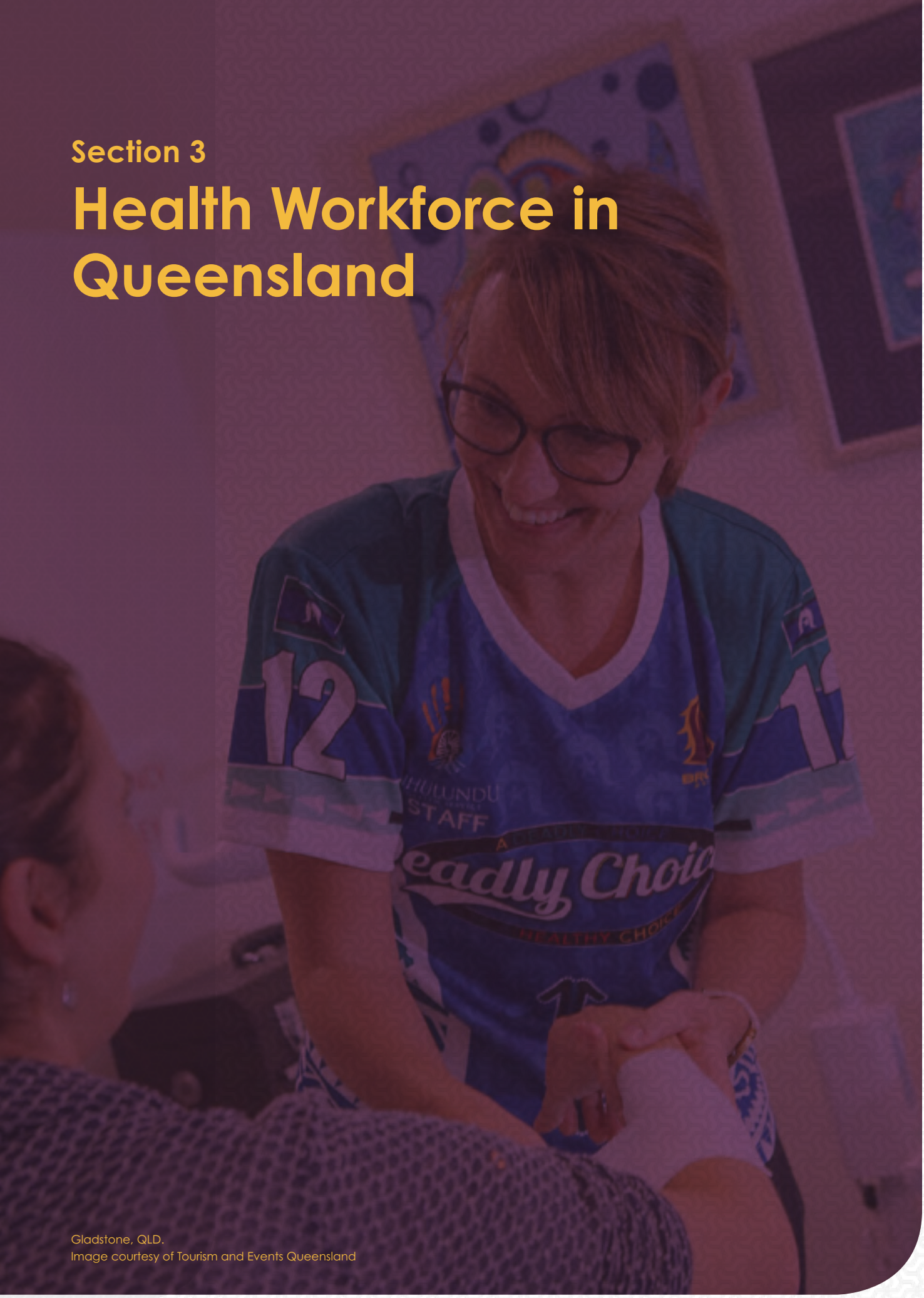
- Primary Health Care Service Providers
- Outreach Service Providers
- Aboriginal Community Controlled Health Services
- PHNs
- Hospital and Health Services
- Universities
- Colleges
- Registered Training Organisations

Validation of Findings

The HWSG provide an external validation mechanism to ensure that the HWNA is a fair and accurate representation of the current workforce challenges and opportunities for remote, rural and regional Queensland. The 2019 HWNA builds on and updates the 2018 Report's baseline of priorities and will underpin the development of Health Workforce Queensland's Activity Work Plan for 2019-20.

Section 3

Health Workforce in Queensland



Gladstone, QLD.
Image courtesy of Tourism and Events Queensland

> With vast distances between communities and services, small local populations with diverse health needs, and a comparatively small health workforce, there are still significant workforce shortages in many remote and rural locations in Queensland.

The Royal Flying Doctor Service (RFDS) Looking Ahead Report[1] notes that the health workforce is projected to increase in line with population growth and improve slightly per 100,000 people. However, workforce distribution is still projected to be an issue impacting remote and rural communities unless further policy interventions are successfully implemented.

As far back as 2008, the National Rural Health Alliance distinguished the demand for health professionals from the demand for health care. Workforce planning needs to focus on the latter and should adopt a creative and flexible approach to how such health care may best be provided. If the focus is only on workforce and not on addressing other health system factors, we will continue to struggle with poorer health outcomes in remote and rural communities.

The 2005 Productivity Commission report, Australia's Health Workforce[2], recognised that simply expanding the health workforce would not adequately address the increasing pressures within the Australian healthcare system. The report noted the importance of improving the efficiency and effectiveness of health workforce arrangements. These included implementing a broader scope of practice for health disciplines and recognised a need for 'realignment of existing health workforce roles, or the creation of new roles, to make optimal use of skills and ensure best health outcomes.'

Health care and social assistance is the fastest growing sector in Queensland with 27.2% employment growth over the last five years[3]. Many of these reflect the increasing number of university graduates in medicine, nursing/midwifery and allied health. However, with this need to meet spiraling demands in the health, aged care and disability sectors, the Vocational Education and Training (VET) sector will increasingly play a vital role in developing a much needed locally grown health workforce and should be considered in health workforce planning in the regions.

The PHN needs assessment reports cite many workforce challenges, including high staff turnover, difficulties recruiting local, qualified staff, long wait times for appointments and high costs of accessing services outside of the public health system.

[1] Gardiner, F. W., Gale, L., Ransom, A., Laverty, M. (2018). Looking Ahead: Responding to the health needs of country Australians in 2028/ the centenary year of the RFDS. Canberra, Australia, The Royal Flying Doctor Service

[2] Productivity Commission 2005, Australia's Health Workforce, Research Report, Canberra

[3] Australian Bureau of Statistics, 2018, 'Labour Force, Australia, Detailed - Electronic Delivery' July 2018, Cat. no 6291.0.55.001.

This year, feedback from the HWNA survey and other needs assessments shows a marked increase in the reporting of GP workforce shortages and a continuing high need for mental health and alcohol and other drug (AOD) workforce. The following section aims to outline some of the profession specific challenges facing our remote and rural primary health care workforce and the organisations that support them, as reported through current literature, relevant reports as well as stakeholder feedback from the HWNA survey.

General Practitioners

Current and Emerging Workforce Issues

> The ratio of GPs to population in Australia has been improving overall due to the significant increase in Australian trained graduates over the last decade or more. However, there are still significant gaps in many remote and rural areas of Queensland.

In part, this can be attributed to lifestyle factors relating to long working hours, heavy on-call demands, locum unavailability, lack of part-time opportunities, professional isolation, lack of opportunities for partners and children and additional costs to access training. However, higher-level policy changes may also be having an impact.

The shortage of GPs in remote and rural areas is a problem that poses serious challenges to equitable healthcare delivery and, with recent visa changes, it may be worsening in some areas. The employer-sponsored 457 visa program was abolished in March 2018 and was replaced with a new visa program known as the Temporary Skill Shortage (TSS) visa. Under the TSS, short-term visas are issued for two years, while medium-term visas are issued for up to four years. However, the short-term stream of the visa does not provide a pathway to permanent residency and this may be seen as less appealing for overseas medical practitioners to pursue. The flow on effects with the reduction of this vital medical workforce pipeline is already apparent in many areas of Queensland, in particular Far North Queensland and Western Queensland.

The Australian Government have invested in programs such as the Rural Health Multidisciplinary Training (RHMT) Program which supports Rural Clinical Schools (RCSs), Multidisciplinary University Departments of Rural Health (UDRHs) and Regional Training Hubs with the intent of delivering rural clinical training experiences to health students to encourage them

to remain in these communities when they complete their training. However, evaluation of the effectiveness of these initiatives to eventually grow the rural workforce will not be known for several years, too long for the current shortfall to be addressed.

Attracting Australian trained graduates continues to be a challenge. Despite scholarships, bursaries, relocation assistance and incentive payments, more mechanisms are needed to entice this cohort. JCU GP Training have had difficulty filling their allocation of the more restrictive rural bonded pathway placements in 2018 which in turn may lead to reduced availability of a GP Registrar workforce in rural Queensland.

The Rural Generalist (RG) Program has been successful within Queensland Health as a workforce solution, but this has not always translated to more positions being filled in private general practice. Additionally, there is a need for a bridging program to assist doctors to transition from urban to rural practice if they are unsuccessful in accessing general practice training programs. The new More Doctors for Rural Australia Program (MDRAP) pathway which, as of January 2019, will replace the Rural Locum Relief Program (RLRP) attempts to address this. Unfortunately, restricting access to this program to District of Workforce Shortage (DWS) areas and the reduction in Medicare rebates for participants could make it a reluctant choice for many eligible Australian graduates as well as employers.

Policy changes with the intent of improving the quality of the GP workforce through the Stronger Rural Health Strategy also sees new fee arrangements for doctors who are non-vocationally recognised. Non-vocationally recognised medical practitioners providing services in a regional, rural or remote area (MMM 2-7) are now paid at a rate that is 80 percent of the benefit for the equivalent vocationally recognised (VR) GP.

> “Existing non-VRed doctors who are participating on one of the Other Medical Practitioner (OMPs) programs will have until July 2023 to achieve their Fellowship or lose their right to access 100% of the benefit. This adds significant pressure to an already time poor workforce and adversely impacts small remote and rural practices and their sustainability.

There are numerous other reasons the private general practice workforce is compromised:

- The viability of rural general practice remains highly challenging due to the current fee-for-service payment model not being suited to managing complex and chronic conditions or having the flexibility required for workforce redesign opportunities;

- Attracting quality medical graduates to general practice (and rural general practice) with some perceiving it to be less attractive than the Queensland Health RG pathway and other specialist pathways;
- Lack of supervisors in some remote and rural locations to sustain training practices for students and registrars as well as meeting the substantial supervision requirements required for non-VRed overseas trained doctors;
- The declining motivations of the future medical workforce to run their own businesses and participate in onerous on call arrangements; and
- DWS restrictions impacting some regional centres who also lay claim to significant workforce shortages

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 2018. In line with reporting requirements to the Department, only doctors working in MMM 2-7 locations were investigated. On the 30 November 2018, there were 2,284 medical practitioners working in MMM 2-7 locations in Queensland. The MMM breakdown by sex are provided in Table 1 along with mean age.

Table 1. Medical Practitioner by MMM location, age and sex

	N	Female *n* (%)	Male *n* (%)
Total Medical Practitioners	**2,284**	**988 (43%)**	**1,296 (57%)**
MMM 2	1,245	566 (45%)	679 (55%)
MMM 3	181	74 (41%)	107 (59%)
MMM 4	393	171 (44%)	222 (56%)
MMM 5	334	133 (40%)	201 (60%)
MMM 6	61	24 (39%)	37 (61%)
MMM 7	70	20 (29%)	50 (71%)
Age*	***M***	***SD***	
Age in Years	50.11yrs	10.83	

*Missing = 930 (Age is self-reported)

The mean age was just over 50 years and almost 45 percent were female with considerable proportional variety according to MMM category. For example, female medical practitioners constituted 45 percent of the MMM 2 workforce but only 29 percent of the MMM 7 workforce. It is of note that the true mean age of the whole population of rural Queensland medical practitioners is likely to be younger than stated because of the self-report nature of this measure. With so many new medical graduates entering rural practice each year it is difficult to obtain details around date of birth for these younger practitioners during their initial placements.

How many were Australian trained and how many vocationally registered?

Table 2 provides the breakdown of Australian and overseas trained doctors, as well as the number vocationally registered with either RACGP or ACRRM, and those in training for vocational registration.

Table 2. Country of basic medical training and vocational registration status

	N	*%*
Country of Basic Medical Training*		
Australia	1,192	52%
Overseas	1,092	48%
VR Status		
Vocationally registered	1,163	51%
Registrar (in training)	626	27%
Non-VR	495	22%

*Missing = 1

> There were slightly more doctors that received their basic medical training in Australia than from other countries. Just over 50 percent were Fellows of ACRRM or RACGP with another 27 percent in training for Fellowship.

How many hours do GPs work and what type of work?

Health Workforce Queensland has several different methods of collecting work hours of practitioners. We ask for the number of hours associated with each role during our annual surveys (medical practitioner and practice manager surveys) and a six-monthly telephone ring around of practices and smaller hospitals in Queensland. This means that when a practitioner has more than one role, the hours for each role only represent a proportion of the total. Additionally, in the medical practitioner survey we ask medical practitioners to self-report the total hours spent on GP related activities during an average week, and then ask for estimates in several areas. These areas include the hours of routine GP work, hours of routine hospital work and hours spent teaching and supervising medical students and Registrars. Hours worked in total and according to the primary practice role are listed in Table 3.

Table 3. Mean hours worked in total and in primary role by sex and MMM

	Total hours		Primary role hours	
	M	*N*	*M*	*N*
QLD Total	**43.80**	**1,097**	**34.44**	**1,675**
Female	38.11	435	31.57	723
Male	47.72	662	36.61	952
MMM Category				
MMM 2	42.33	584	34.09	879
MMM 3	44.23	100	34.77	139
MMM 4	44.98	189	34.98	300
MMM 5	46.97	165	34.20	264
MMM 6	47.68	31	37.70	43
MMM 7	46.35	28	34.78	50

GPs in remote, rural and regional Queensland worked on average around 44 hours per week on general practice related activities. However, they tended to work almost 10 hours less than this in their primary role (not including secondary roles, teaching/supervision, public health research etc). Females tended to work less than males with this difference being almost 10 hours for the total hours worked per week, but only around five hours less in their primary role. Doctors working in MMM 5-7 locations tended to work up to five hours more in total hours than doctors in more regional and rural locations. However, the differences in hours for just the primary role did not have large differences except for MMM 6 practitioners, who tended to work about three hours more per week than doctors in all other locations.

There were a sample of 1,075 doctors that completed sufficient detail in the Health Workforce Queensland annual Medical Practitioner survey over the past three years to calculate the breakdown of type of work hours into routine general practice hours, routine hospital hours, and teaching and supervision hours per week. Results are presented for Queensland, by sex and MMM category in Table 4.

Table 4. Mean hours worked in routine general practice, hospital and teaching by sex and MMM

	GP Hours		Hospital Hours		Teaching Hours	
	M	*N*	*M*	*N*	*M*	*N*
QLD Total	**35.26**	**1,075**	**4.47**	**1,075**	**2.24**	**1,075**
Female	31.57	424	3.00	424	2.67	424
Male	37.66	651	5.43	651	1.96	651
MMM Category						
MMM 2	36.83	570	1.57	570	1.75	570
MMM 3	37.94	98	2.76	98	1.72	98
MMM 4	31.09	186	9.53	186	3.15	186
MMM 5	34.88	163	7.26	163	2.75	163
MMM 6	32.71	31	10.00	31	4.00	31
MMM 7	26.11	27	14.00	27	3.17	27

Medical practitioners in Queensland, on average, worked most hours in routine general practice (35 hours), with almost four and a half hours of routine hospital work and just over two hours per week teaching or supervising medical students and registrars. In all categories except teaching, male practitioners reported more hours than female practitioners. Practitioners working in MMM 2 and 3 tended to spend more hours each week in routine general practice work and less hours in a hospital or undertaking teaching and supervision than their more remote colleagues. In contrast, doctors from MMM 4-7 reported more than twice, and up to eight times, the number of routine hospital hours than reported by MMM 2 practitioners.

Interestingly, when means were calculated for just those respondents with some hospital or teaching hours, the state averages rose to *M* = 15.07 hours (Hospital) and *M* = 4.98 hours (Teaching/Supervision) respectively. That is, of the practitioners reporting hospital hours each week the average was 15 hours, and those that were teaching or supervising averaged around 5 hours per week.

Additional medical practitioner workforce data from Queensland Health and RFDS

In a collaborative arrangement with both Queensland Health and RFDS Queensland Section, de-identified headcount numbers have been provided to Health Workforce Queensland to help overcome some of the potential data blind spots in relation to general practice services in Queensland. For instance, in many more remote facilities operated by Queensland Health we already know that there is continual rotation of medical practitioners making it impossible to pin a name against a position. The same applies to the clinics operated by the RFDS in Queensland, especially those that may operate on one day a week or less often, using a Fly-in, Fly-Out (FIFO) model to deliver services.

Both Queensland Health and the RFDS Queensland Section supply headcounts for each service. The Queensland Health headcount encompasses the number of doctors outside of metropolitan and regional hubs (with larger hospitals), listed against the service at which their payroll is processed. This is particularly important for the smaller community health centres and primary care centres which are not serviced with fulltime medical services. Similarly, RFDS Queensland Section has supplied a list of each regular clinic, the number of doctors who attend, and the number of days per year a doctor is present on site. This data is cross-checked against the existing Health Workforce Queensland database and headcount numbers added to each site.

The headcount of doctors does not necessarily refer to the number of individual doctors because some will spend one day per week or per fortnight at more than one location, and privacy considerations do not permit sharing of identified practitioner information. However, for remote locations it does enable us to include the presence of a GP against each site that may not have been captured in the Health Workforce Queensland database of registered medical practitioners.

The total number of medical practitioners working in MMM 2-7 locations based on the headcount data provided by Queensland Health and RFDS Queensland Section was 322. These were headcount numbers from 116 locations of Queensland Health HHS services and RFDS Queensland Section clinic sites. This data was used alongside Health Workforce Queensland's workforce data to determine priority communities.

Nursing

Current and Emerging Workforce Issues

Although the numbers and distribution of nurses in rural and remote areas in Queensland is often greater than many other health professions, data from the Australian Health Practitioner Regulation Agency (AHPRA) Workforce labour force surveys for Nursing from 2013-2016 still indicates a general reduction in the nurse to population ratio with increasing distance from metropolitan areas as measured using the MMM classifications, particularly for practice nurses classified as Registered Nurses (RNs) and Enrolled Nurses (ENs). Findings also suggest an ageing practice nurse workforce that will result in increasing industry workforce loss due to retirement over the next 5-10 years.

Primary health care nursing refers to nursing that takes place as a first point of care within a range of primary health care settings including general practice. Practice nurses are a key part of a primary health care team and evidence shows that practice nurses working to the full breadth of their scope can potentially facilitate better outcomes for patients, enhance productivity, increase service capacity, and add value for money for health services.

Funding of practice nurses can be supported through the Medicare Benefits Schedule, the Practice Nurse Incentive Program, grants, and patient co-payments. However, overall there is a lack of definitive funding and support for nursing services in general practice. The complexities of the current financing structure can constrain practice nurses, including the ability to initiate and lead care that would usually fall within a nurse's scope of practice. It can however lead to innovation and novel models of care including nurse practitioners and nurse-led clinics that improve health outcomes, increase patient satisfaction, and improve access to healthcare in certain remote and rural areas.

The Australian Primary Health Care Nurses Association (APNA) 2016/17 workforce surveys identified that almost one third of nurses surveyed felt that they could do more in their roles and were not using their knowledge or skills to full extent. And, despite speaking to their employers, less than half were able to negotiate extended roles or carry out more complex tasks. Common barriers to expanded scopes of practise include financial resourcing challenges, lack of support by the broader practice team, State and Territory legislation and health service policies, and perceptions and attitudes of other health professionals or employers about the role of primary health care nurses.

In attracting and retaining practice nurses, there is currently a lack of clearly defined training pathways into primary health care nursing. And, until recently, no framework for skills development and career progression; although APNA has recently developed a Career and Education Framework and Toolkit for nurses in primary health care in line with international models. Transition to primary practice remains difficult with limited student placements and positions for new graduates. Funded remote clinical placements and employment opportunities with adequate support and resources are needed along with investment in structured programs that prepare health managers and leaders for remote practise.

The cost of holding training events and lack of demand in rural locations means training may only be possible in large regional centres or capital cities which means extra travel cost, time away and backfilling difficulties.

Other barriers to careers in practice nursing include low remuneration with a significant lack of parity with Queensland Health award rates as well as status and value (stigma around ending up in primary care, i.e. you only go to primary practise when you are approaching retirement). This is supported by findings from the APNA survey where they found that half of the practice nurses surveyed did not have a formal appraisal of their work in the last two years, and almost one third of respondents had never been offered a pay increase.

State-wide Workforce Snapshot of Practice Nurses in MMM 2-7

Over the last 18 months, Health Workforce Queensland has been working to increase our headcount of nurses working in general practice. Our annual survey for Practice Managers asks for the number of nurses working at the practice and we capture this information on our six-monthly ring around. The headcount includes the number of:

- Registered nurses
- Enrolled nurses
- Nurse Practitioners
- Diabetes nurse educators.

While the data is not quite complete, it will provide a benchmark for comparison over coming years. To encompass as much of general practice as possible, the data presented below will be for all private and public general practices, Aboriginal Medical Services and the RFDS.

Table 5 presents the number of nurses working in each of these categories by MMM category, along with the number of unique practice sites at which these primary care services were delivered.

Table 5. Headcount of nurses working in general practice by MMM and nurse category

Type	Nurse *N*	Sites *N*	Ratio - Nurse/ Sites
Registered Nurse	**951**	**423**	**2.25**
MMM 2	510	206	2.48
MMM 3	67	28	2.39
MMM 4	113	54	2.09
MMM 5	178	86	2.07
MMM 6	46	25	1.84
MMM 7	37	24	1.54
Enrolled Nurse	**290**	**210**	**1.38**
MMM 2	149	94	1.59
MMM 3	23	15	1.53
MMM 4	57	33	1.73
MMM 5	51	48	1.06
MMM 6	6	13	0.46
MMM 7	4	7	0.57
Nurse Practitioner	**20**	**74**	**0.27**
MMM 2	12	29	0.41
MMM 3	0	1	0.00
MMM 4	2	7	0.29
MMM 5	6	22	0.27
MMM 6	0	8	0.00
MMM 7	0	7	0.00
Diabetes Nurse Educator	**27**	**81**	**0.33**
MMM 2	11	29	0.38
MMM 3	1	2	0.50
MMM 4	1	6	0.17
MMM 5	12	27	0.44
MMM 6	2	10	0.20
MMM 7	0	7	0.00
Total Nurse Headcount			**1,288**

There were 951 Registered Nurses, 290 Enrolled Nurses, 20 Nurse Practitioners and 27 Diabetes Nurse Educators working in general practice, Aboriginal Medical Services and the RFDS that were counted in the Health Workforce Queensland database. More nurses in each category were working in MMM 2 locations than more remote locations with the exception of Diabetes Nurse Educators, where there were more nurse educators in MMM 5 locations. The ratio of RN to location tended to decrease with increasing remoteness, from 2.48 in MMM 2, to 1.54 in MMM 7. A generally similar pattern was found with the EN to location ratio except for the highest ratio being found in MMM 4. The low number of Nurse Practitioners and Diabetes Nurse Educators makes interpretation of trends difficult. However, it is of note that there were no Nurse practitioners recorded in MMM 3, MMM 6 and MMM 7, and there were no Diabetes Nurse Educators noted in MMM 7.

Additional primary care nurses do work in the public health system in many remote and rural communities through the network of 'Primary Health Care Centres' and clinics. For instance, Napranum (Malakoola) Primary Health Care Centre and Jundah Primary Health Care Centre. Nurses at these centres are employed by Queensland Health but focus on primary care in communities that may not support private general practice, predominantly in MMM 6 and 7 locations. Some of these centres are led by nurses rather than doctors, who may appear only occasionally at the centres or not at all. De-identified payroll data is provided to Health Workforce Queensland every six months by Queensland Health, and the number of nurses working in primary health care centres is provided in Table 6 by nurse category.

Table 6. Headcount of state employed nurses working in Primary Health Care Centres

Type	*N*
Registered Nurse	164
Enrolled Nurse	13
Nurse Practitioner	3
Diabetes Nurse Educator	1
Total	**181**

Note: Data provided by Queensland Health

The number of nurses working in the state public health system in a primary care role was 181, the majority of whom were RNs. When these were added to the private general practice nursing workforce (see, Table 5), it indicated a total primary care nursing workforce of 1,469. However, it is likely that this count of practice nurses is under the actual number of nurses working in remote, rural and regional Queensland.

Queensland Health have also provided an analysis to Health Workforce Queensland of the number of nurses working in Queensland by PHN that self-described their main role as 'Practice Nurse' from the 2017 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 7, along with the percent of these that described their primary work as private, and the total population of each PHN from the 2016 Census have been provided for context.

Table 7. Practice Nurse frequency by PHN and percent in private employment from 2017 AHPRA Workforce Survey

PHN	*N*	Percent Private	Population 2016
Central Queensland, Wide Bay, Sunshine Coast	689	89 %	841,119
Darling Downs and West Moreton	392	88 %	558,803
Northern Queensland	550	86 %	692,832
Western Queensland	64	55 %	63,719
Total	**1,695**		**2,156,473**

Note: Data provided by Queensland Health

The total practice nurse count was 200 more than calculated based on the general practice and primary health care clinic nursing workforce (Tables 5 and 6, combined Total N = 1,469). One possible explanation for the shortfall could be that Health Workforce Queensland does not include practices that are considered to be specialised in one area of general practice only. For instance, services operated by general practitioners that offer single services such as skin cancer clinics and sexual health clinics, as well as armed services clinics not available to the general public. Nursing staff in these specialised services are likely to describe their role as a 'practice nurse' in a specialised environment and be included as that in the AHPRA survey data.

> Interestingly, while 89 percent of the practice nurse workforce in the Central Queensland, Wide Bay, Sunshine Coast PHN identified as working mainly in a private organisation, this reduced to just 55 percent in the Western Queensland PHN region.

Aboriginal and Torres Strait Islander Health Workers and Health Practitioners

Current and Emerging Workforce Issues

Aboriginal and Torres Strait Islander Health Workers and Health Practitioners have a critical contribution to health care in Australia in both specialised service delivery and in mainstream primary care. Their roles may include enhancing the amount and quality of clinical services provided to Aboriginal and Torres Strait Islander peoples, facilitating communication with Aboriginal and Torres Strait Islander people and communities, communication with care providers, and practice administration and management.

Through cultural brokerage, 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. Qualified Aboriginal and Torres Strait Islander Health Workers and Health Practitioners are eligible to claim Medicare Benefit Items for particular services including adult health checks and follow-up chronic disease management plans. They can assist general practitioners to better understand and respond to client concerns and help clients to better understand their illness and treatment.

In 2012, the new profession of Aboriginal and Torres Strait Islander Health Practitioner was registered under the Health Practitioner Regulation National Law Act 2009. They are registered by AHPRA and as of 1 March 2018 there were 650 registered Aboriginal and/or Torres Strait Islander Health Practitioners in Australia. In Queensland, Aboriginal and Torres Strait Islander Health Practitioners are almost exclusively employed by Queensland Health and there is a pilot program running in the Torres & Cape Hospital and Health Service to outline a formal Scope of Practice (SOP) for the practitioners.

Aboriginal and Torres Strait Islander Health Practitioners have an extended scope of practice to Aboriginal and Torres Strait Islander Health Workers, and on the 9 November 2018, there was an approved amendment to the Queensland Health (Drugs and Poisons) Regulation 1996 whereby Aboriginal and Torres Strait Islander Health Practitioners are able to obtain, possess, administer and supply specified schedule 2, 3, 4 or 8 substances in isolated practice areas in HHS's and ACCHO on the oral or written instruction of a dentist, doctor or nurse practitioner.

This workforce is becoming increasingly qualified, with Aboriginal and Torres Strait Islander Health Workers attaining higher level primary healthcare and other health qualifications. Evidence shows that they are engaging in the VET sector in increasing numbers, however, qualification completion rates remain low and employment outcomes are not noticeably improving.

Key to increasing the translation of training into employment is determining how retention and completion in VET can be improved, in conjunction with identifying how VET can enhance the employability of Aboriginal and Torres Strait Islander Health Workers living in remote communities.

> Queensland Health have committed to increase the number of Aboriginal and Torres Strait Islander people working within their organisation with a state-wide participation target of three per cent by 2022, but more also needs to be done in the primary health care sector.

Despite being an important component of primary health care, there is a general undervaluing and underutilisation of these roles, particularly by some non-indigenous service providers. There is a need to continue to recognise and promote understanding of the contribution that Aboriginal and Torres Strait Islander Health Workers and Health Practitioners make in improving health.

Understanding the importance of attracting and supporting students through their training with flexible training options and mentoring is vital and then, once qualified, retaining staff through structured career pathways and the provision of culturally safe and responsive work environments in both mainstream and specialised services. The inclusion of strong, quality Aboriginal and Torres Strait Islander leadership and ongoing succession planning at the senior manager and executive levels is essential for this to occur.

State-wide Workforce Snapshot of Aboriginal and Torres Strait Islander Health Workers and Health Practitioners in MMM 2-7

Health Workforce Queensland has not traditionally maintained a database of Aboriginal and Torres Strait Island Health Workers and Health Practitioners. However, because of the substantially poorer health outcomes for Aboriginal and Torres Strait Islander persons compared to the non-indigenous population, particularly in remote and rural Queensland, efforts have been made to include counts for this workforce in the primary health care setting. Although we do not expect that all of the workforce will be covered, the numbers presented will be used as a benchmark for future years.

The headcount of Aboriginal and Torres Strait Islander Health Workers and Health Practitioners from the Health Workforce Queensland database are provided in Table 8 according to MMM category along with the number of unique practice sites at which these primary care services were delivered.

Table 8. Aboriginal and Torres Strait Islander Health Workers and Health Practitioners by MMM category

Type	*N*	Sites *N*	Ratio Professional /Sites
Health Workers	**153**	**119**	**1.29**
MMM 2	3	20	0.15
MMM 3	2	2	1.00
MMM 4	24	16	1.50
MMM 5	38	31	1.23
MMM 6	18	21	0.86
MMM 7	51	33	1.55
Health Practitioners	**9**	**66**	**0.14**
MMM 2	3	20	0.15
MMM 3	0	1	0.00
MMM 4	0	5	0.00
MMM 5	1	20	0.05
MMM 6	0	9	0.00
MMM 7	5	11	0.45
Total Health Worker/Practitioner	**162**		

There were 153 Aboriginal and Torres Strait Islander Health Workers in remote and rural Queensland, captured in the Health Workforce Queensland database, more of them working in MMM 7 locations than any other MMM categories. While MMM 2 and 3 had the majority of general practitioners and nurses, there were only five Aboriginal and Torres Strait Islander Health Workers in these locations. The ratio of health workers to sites varied from 0.15, in MMM 2, to 1.55 in MMM 7. Only nine Aboriginal and Torres Strait Islander Health Practitioners were captured in the databases of Health Workforce Queensland, the majority of these working in MMM 7 locations.

> A large component of the Aboriginal and Torres Strait Islander Health Worker and Health Practitioner headcount in Queensland, are situated within Queensland Health. De-identified payroll data from Queensland Health (September 2018) were used as a measure of those employed publicly.

Table 9. State employed Aboriginal and Torres Strait Islander Health Worker/Practitioner frequency by PHN

PHN	Health Worker *N*	Health Practitioner *N*
Central Queensland, Wide Bay, Sunshine Coast	51	13
Darling Downs and West Moreton	40	3
Northern Queensland	270	75
Western Queensland	33	8
Total	**394**	**99**

Note: Data provided by Queensland Health

Of the 394 Aboriginal and Torres Strait Islander Health Workers identified, approximately 69 percent identified as working in the Northern Queensland PHN region. There was a similar percentage of Aboriginal and Torres Strait Islander Health Practitioners working in the Northern Queensland PHN region. There were 99 identified Aboriginal and Torres Strait Islander Health Practitioners and this aligns with 2017 AHPRA data that reports 100 practitioners in Queensland. This also reflects that the practitioner workforce is almost exclusively employed in the public sector at this time.

This is a baseline dataset and considerably more effort is required to capture health workers and health practitioners at their current workplace(s) to further assist in describing the health workforce distribution and for use in future workforce planning.

Allied Health

Current and Emerging Workforce Issues

Allied health professionals are becoming increasingly important as part of multidisciplinary healthcare teams and are playing a larger role within the aged care and disability sectors to address health priorities such as Mental Health, Alcohol and Other Drugs, sectors which have a shortage of specialised workforce overall. However, for many reasons, there is a low availability of the allied health workforce in remote and rural Queensland. Experienced allied health professionals are less readily accessed with a high representation of new graduates requiring high levels of mentoring, supervision and peer support.

Allied health care delivery in Queensland has been reported as being episodic, fragmented and poorly coordinated, with lack of continuity of care, as identified in the 2018 HWNA and in the more recent PHN needs assessments. This is particularly so for the prevention,

management and treatment of chronic disease within priority population groups such as those in remote communities, people of low social and economic status, and Aboriginal and Torres Strait Islander peoples.

Lack of access to bulk billing for many allied health services can result in people in remote and rural areas being more likely to delay or forego treatment due to cost. There is also poor community awareness of the various allied health professions and how they contribute to healthcare. Communities want and need increased education around acute and primary healthcare, as well as what appropriate services are available to them locally.

The RFDS Looking Ahead Report cites lack of access to professional and clinical support, lack of orientation to the type of environment in which they are working, demanding caseloads, excessive travel requirements, difficulty in accessing locums or backfill when on leave, difficulty in accessing continuing education and postgraduate education, and lack of access to appropriate equipment and accommodation as challenges to practising in remote and rural regions.

Allied health professionals are frequently employed as sole private practitioners and in part-time roles. Current funding models are a disincentive when considering remote and rural practice and solutions are needed to address viability and sustainability of practice. One incentive could include extending existing allied health MBS items to be delivered via telehealth as well as expanding access with new MBS items for a broader range of allied health professionals to support multidisciplinary care. Examples could include physiotherapy spinal telehealth assessments and speech pathology swallowing assessment.

Currently, public and private providers usually work independently of one another so flexible workforce employment models within regions where services are developed around the needs of individuals, families and communities is required. Greater consultation with allied health professions to develop and deliver comprehensive and multidisciplinary models of health care for remote and rural areas is needed.

Employment of allied health professionals in general practice may become more attractive with the introduction of the new Workforce Incentive Program (WIP) as of July 2019, to replace both the General Practice Rural Incentive Program (GPRIP) and the Practice Nurse Incentive Program (PNIP). General practices will be able to access incentive payments of up to $125,000 a year to employ allied health professionals including non-dispensing pharmacists. A rural loading will also be applied to practices located in MMM 3–7.

Telehealth technology also has the potential to significantly increase access to some allied health services and choice of workforce for consumers in remote and rural regions. The allied health sector will need support to engage with digital health technology, along with improved funding allocation and increased flexibility of funding models including Medicare funded telehealth sessions.

There is a need to develop recognised and sustainable vocational training pathways for allied health professionals which include structured supervision, support and professional development to assist early career professionals to optimise their scope of practice and support them to remain in rural areas. The Allied Health Rural Generalist Pathway is currently being trialled as a way of expanding the scope of services that individual health professionals can provide, to help improve equality of access in areas of low workforce availability and contribute to increased workforce retention rates.

Allied health assistants are another role which can enhance workforce capacity through supporting the delivery of allied health services under supervision. However, the full impacts of these new roles on other professionals in healthcare teams as a result of changes to scope of practise is yet to be seen.

Executive and clinical allied health leadership will be important to drive change, to support workforce development and career progression, create changes to clinical practice, as well as to improve education, training and research.

Finally, access to comprehensive and reliable allied health workforce data continues to remain an issue. Funding is needed to support high quality data collection, management, and research to better inform service and workforce planning within regions.

State-wide Workforce Snapshot of AHPRA Registered Allied Health in MMM 2-7

Headcount data for some of the allied health workforce has been collected by Health Workforce Queensland only for the past year, and mainly for allied health practitioners attached to general practices and smaller Queensland Health hospital and primary care settings. As such, it is not expected to be an accurate reflection of the current allied health workforce in remote and rural Queensland.

Therefore, the allied health workforce data outlined in this section has been provided by Queensland Health based on the self-report responses to the 2017 Health Workforce Survey that practitioners complete while renewing their registration with AHPRA. Because only some allied health professions are registered on the AHPRA database the professions examined were:

- Psychology
- Physiotherapy
- Podiatry
- Occupational therapy
- Optometry
- Pharmacy
- Dentistry

The numbers of practitioners in each of the allied professions for each of the rural PHNs are presented in Table 10.

Table 10. Allied health practitioner by MMM and percent mainly in private employment

Allied Health Professions	*N*	Percent Private
Psychologist (state-wide)	**6,360***	**48 %***
Central QLD, Wide Bay, Sunshine Coast	804	50 %
Darling Downs and West Moreton	533	44 %
Northern Queensland	687	45 %
Western Queensland	50	48 %
Physiotherapist (state-wide)	**6,000***	**56 %***
Central QLD, Wide Bay, Sunshine Coast	868	61 %
Darling Downs and West Moreton	354	55 %
Northern Queensland	631	50 %
Western Queensland	62	35 %
Podiatrist (state-wide)	**860***	**80 %***
Central QLD, Wide Bay, Sunshine Coast	132	83 %
Darling Downs and West Moreton	79	81 %
Northern Queensland	78	76 %
Western Queensland	19	53 %
Occupational Therapist (state-wide)	**4,060***	**38 %***
Central QLD, Wide Bay, Sunshine Coast	650	37 %
Darling Downs and West Moreton	319	39 %
Northern Queensland	653	37 %
Western Queensland	50	28 %
Optometrist (state-wide)	**1,098***	**87 %***
Central QLD, Wide Bay, Sunshine Coast	169	93 %
Darling Downs and West Moreton	111	86 %
Northern Queensland	108	90 %
Western Queensland	5	100 %
Pharmacist (state-wide)	**6,253***	**51 %***
Central QLD, Wide Bay, Sunshine Coast	839	55 %
Darling Downs and West Moreton	545	59 %
Northern Queensland	728	54 %
Western Queensland	67	46 %
Dentist (state-wide)	**3,480***	**78 %***
Central QLD, Wide Bay, Sunshine Coast	530	77 %
Darling Downs and West Moreton	300	78 %
Northern Queensland	442	70 %
Western Queensland	29	55 %

Note: Data provided by Queensland Health

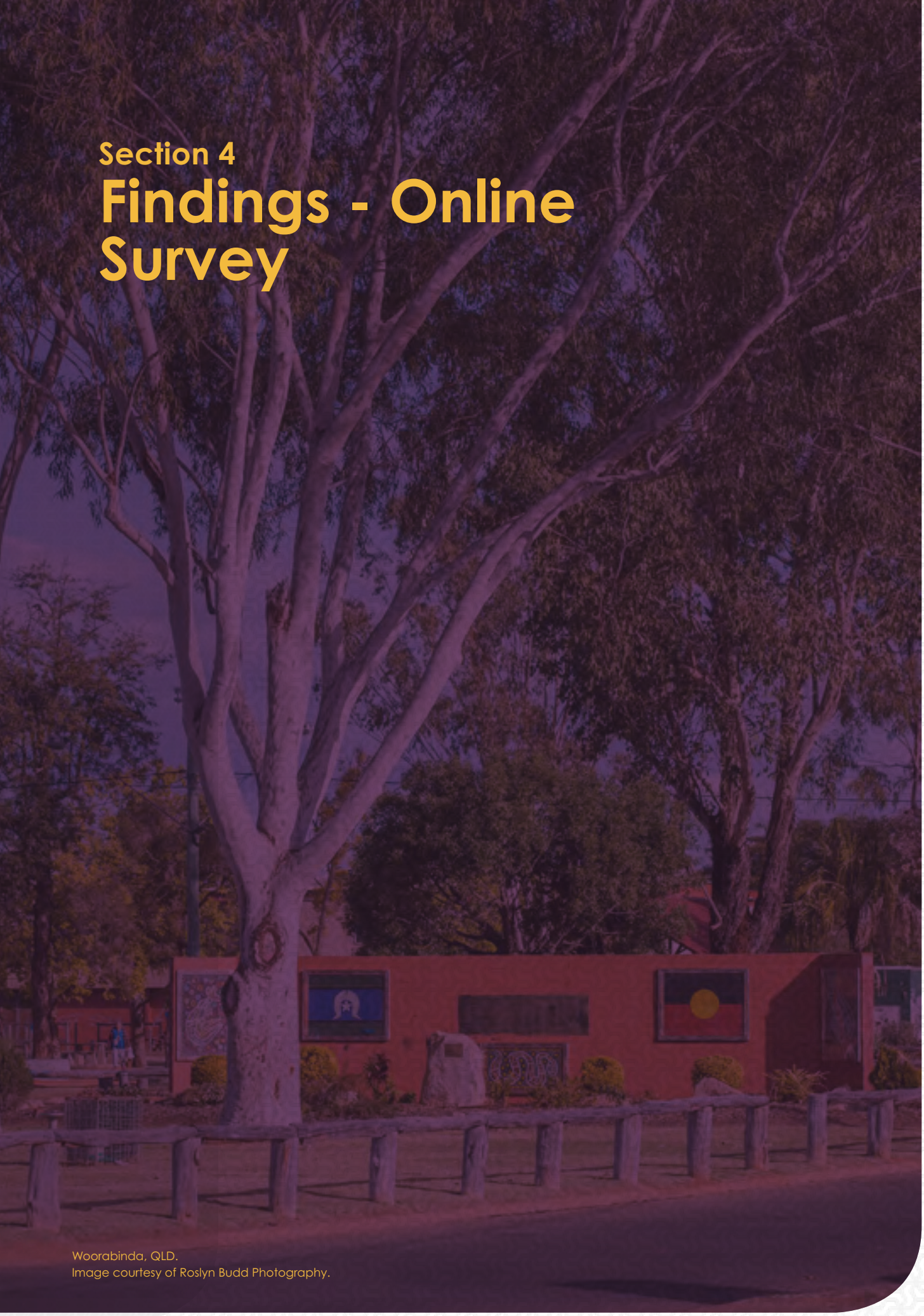
*State-wide numbers and percent private for each discipline are based on practitioners in all of Queensland, including the Brisbane North, Brisbane South and Gold Coast PHN regions.

The number of practitioners for each of the disciplines in the four rural PHNs ranged from 2,179 for Pharmacy, to 393 for Optometry. For each of the disciplines, except Occupational Therapy, there were more practitioners in the Central Queensland, Wide Bay, Sunshine Coast PHN than any of the other PHNs. There were three more Occupational Therapists in the Northern Queensland PHN than in the Central Queensland, Wide Bay, Sunshine Coast PHN. The result of most note was the small number of optometrists recorded in the Western Queensland PHN region (n = 5), a vast geographic area covered by a small resident population of optometrists. One hundred percent of these optometrists listed their main employment as being in the private system. Taken together, it suggests that there may be a hidden public workforce of optometrists that reside elsewhere but rotate into the Western Queensland PHN region on a rostered basis.

> Western Queensland PHN also had the lowest percent of private dental practitioners, more than 20 percent less than both Central Queensland, Wide Bay, Sunshine Coast PHN and Darling Downs and West Moreton PHN.

Section 4

Findings - Online Survey



Woorabinda, QLD.
Image courtesy of Roslyn Budd Photography.

State-wide Workforce Gap Ratings

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 12 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 577 (Nurse and allied health professionals and managers = 151; Practice Managers = 133; Medical Practitioners = 293). Workforce gap rating means for remote, rural and regional Queensland are provided below in Figure 3.

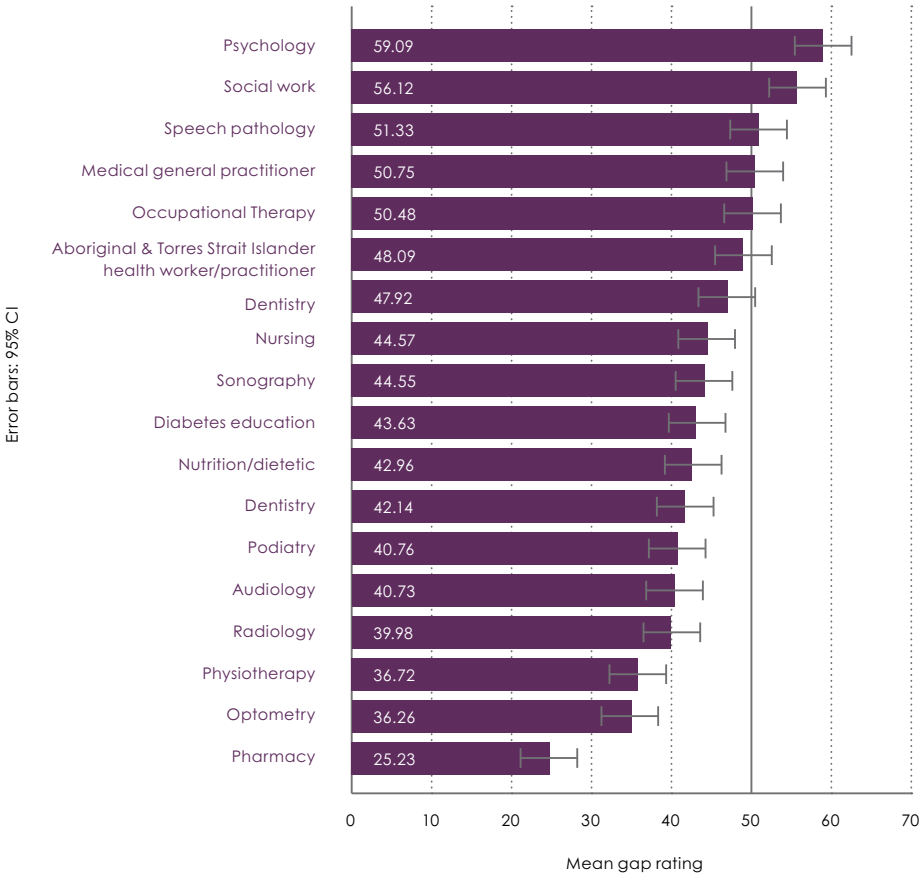


Figure 3. Mean primary care workforce gap ratings for remote, rural and regional Queensland

The highest workforce gap rating means across remote, rural and regional Queensland were for psychology workforce, social work workforce, speech pathology workforce, general practitioner workforce and occupational therapy workforce. All of these means were higher than 50. Compared to results from the 2018 HWNA, all means were higher. This probably reflects the increased responses from nurses and allied health practitioners and may indicate changes in workforce in the last 12 months. In particular, the general practitioners workforce gap rating mean increased almost 12 points from last year.

Workforce Gap Rating by PHN

GP Workforce

The gap rating mean for the general practitioner workforce was, *M* = 50.8 (Last year, *M* = 38.66). Results for each of the four mainly rural PHNs were:

Table 11. GP Workforce Gap Rating by PHN

	2019 *M*	2018 *M*
Darling Downs and West Moreton PHN	37.42	37.27
Central Queensland, Wide Bay and Sunshine Coast PHN	49.12	38.22
Northern Queensland PHN	56.37	38.46
Western Queensland PHN	64.72	56.42

Nursing Workforce

The gap rating mean for the nursing workforce was, *M* = 44.57 (Last year, *M* = 39.02). Results for each of the four mainly rural PHNs were:

Table 12. Nursing Workforce Gap Rating by PHN

	2019 *M*	2018 *M*
Darling Downs and West Moreton PHN	38.09	36.29
Central Queensland, Wide Bay and Sunshine Coast PHN	41.07	34.09
Northern Queensland PHN	48.23	42.99
Western Queensland PHN	53.42	43.58

Aboriginal and Torres Strait Islander Health Worker/Practitioner Workforce

The gap rating mean for the Aboriginal and Torres Strait Islander Health Worker/Practitioner workforce was, *M* = 48.09 (Last year, *M* = 38.69). Results for each of the four mainly rural PHNs were:

Table 13: Aboriginal and Torres Strait islander Health Worker/Practitioner Workforce Gap Rating by PHN

	2019 *M*	2018 *M*
Darling Downs and West Moreton PHN	38.49	34.40
Central Queensland, Wide Bay and Sunshine Coast PHN	44.52	40.03
Northern Queensland PHN	52.77	41.75
Western Queensland PHN	55.79	39.17

Psychology Workforce

The gap rating mean for Psychology workforce was, *M* = 59.09 (Last year, *M* = 46.75). Results for each of the four mainly rural PHNs were:

Table 14: Psychology Workforce Gap Rating by PHN

	2019 *M*	2018 *M*
Darling Downs and West Moreton PHN	55.52	46.84
Central Queensland, Wide Bay and Sunshine Coast PHN	54.07	44.71
Northern Queensland PHN	58.53	43.47
Western Queensland PHN	75.08	67.03

Social Work Workforce

The gap rating mean for the Social Work workforce was, *M* = 56.12 (Last year, *M* = 50.27). Results for each of the four mainly rural PHNs were:

Table 15: Social Work Workforce Gap Rating by PHN

	2019 *M*	2018 *M*
Darling Downs and West Moreton PHN	53.41	45.91
Central Queensland, Wide Bay and Sunshine Coast PHN	52.13	52.14
Northern Queensland PHN	56.73	51.11
Western Queensland PHN	62.61	50.79

Speech Pathology Workforce

The gap rating mean for the Speech Pathology workforce was, *M* = 51.33 (Last year, *M* = 45.58). Results for each of the four mainly rural PHNs were:

Table 16: Speech Pathology Workforce Gap Rating by PHN

	2019 *M*	2018 *M*
Darling Downs and West Moreton PHN	48.25	41.06
Central Queensland, Wide Bay and Sunshine Coast PHN	45.00	44.51
Northern Queensland PHN	54.70	48.66
Western Queensland PHN	54.82	45.14

Qualitative Findings

Participants were asked to outline any important insights or issues relating to the primary care workforce gap ratings. Comments were analysed and a summary of the most common responses state-wide from a total of 151 respondents is provided below:

Psychologists were the most commonly reported workforce shortage overall, with more than one quarter of comments about psychologists being specifically about needing child psychologists.

General Practitioners were the second most frequently reported area of workforce shortage.

Other than psychologists, the allied health professions reported to be most in need were radiologists and sonographers, social workers, speech pathologists, occupational therapists, and diabetes educators.

The cost of accessing health professionals/services with a need for more bulk-billing was a common theme throughout. This was particularly so for allied health generally, and more specifically, psychology.

Difficulty recruiting and retaining workforce in remote and rural areas was another theme among responses with high turnover rates and a general lack of permanent GPs. Many remote areas were also said to rely heavily on infrequent visiting services, and distance to travel was a major barrier to accessing services.

Other workforce and/or service areas of need were a general lack of health professionals specialising in mental health, various allied health, specialists, and dentists.

There were multiple comments suggesting various social determinants were negatively impacting on physical and mental health in many remote and disadvantaged communities leading to higher service utilisation and workforce demand. Greater investment in community development along with increased services and workforce around health promotion and prevention is needed. Participants also expressed the need for a workforce better equipped to deal with chronic disease.

State-wide Service Gap Ratings

Quantitative Findings

Service gap rating means for remote, rural and regional Queensland are provided below in Figure 4 (Primary care service gap ratings).

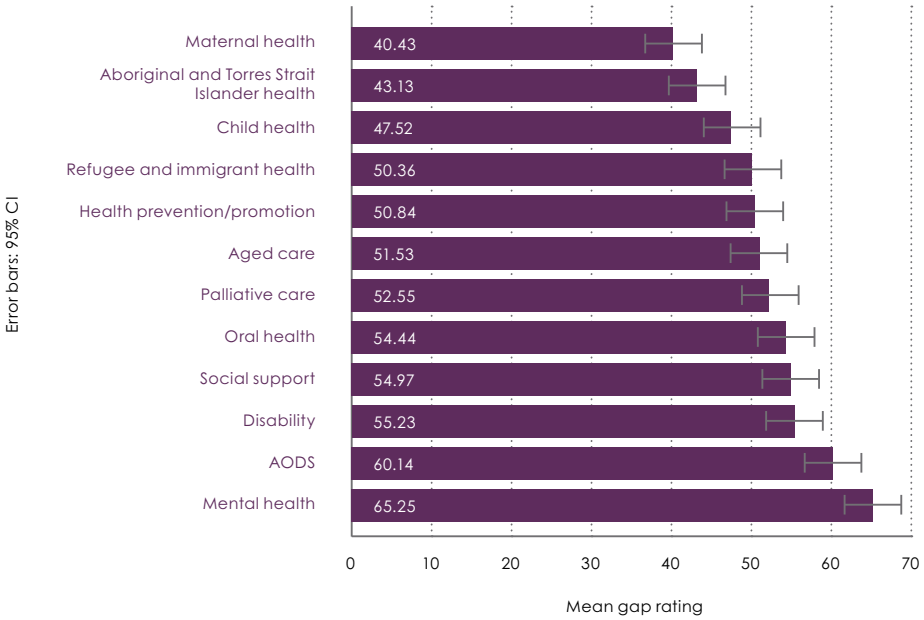


Figure 4. Mean primary care service gap ratings for remote, rural and regional Queensland

All but three of the primary care service gap ratings were higher than 50, with mental health (M = 65) and AODs (M = 60) being the highest. Both of these were higher than any of the 'workforce gap' ratings in Figure 3. Social support and oral health were two new service categories added to the survey this year and rated 4th and 5th highest respectively.

Results for the five highest service gap ratings are provided below by PHN.

Service Gap Ratings by PHN

Mental Health Services

The gap rating mean for Mental health services was, *M* = 65.25 (Last year, *M* = 57.83). Results for each of the four mainly rural PHNs were:

Table 17: Mental Health Services Gap Rating by PHN

	2019 *M*	2018 *M*
Darling Downs and West Moreton PHN	61.59	56.82
Central Queensland, Wide Bay and Sunshine Coast PHN	62.29	56.84
Northern Queensland PHN	65.56	57.53
Western Queensland PHN	72.26	59.93

Alcohol and Other Drug (AOD) Services

The gap rating mean for AOD services was, *M* = 60.14 (Last year, *M* = 58.38). Results for each of the four mainly rural PHNs were:

Table 18: Alcohol and Other Drug Services Gap Rating by PHN

	2019 M	2018 M
Darling Downs and West Moreton PHN	56.45	55.26
Central Queensland, Wide Bay and Sunshine Coast PHN	62.63	60.11
Northern Queensland PHN	58.02	58.62
Western Queensland PHN	63.06	57.50

Disability Services

The gap rating mean for Disability services was, *M* = 55.23 (Last year, *M* = 53.44). Results for each of the four mainly rural PHNs were:

Table 19: Disability Services Gap Rating by PHN

	2019 M	2018 M
Darling Downs and West Moreton PHN	48.43	47.99
Central Queensland, Wide Bay and Sunshine Coast PHN	52.76	54.88
Northern Queensland PHN	56.81	54.77
Western Queensland PHN	66.27	59.07

Social Support Services

The gap rating mean for Social Support services was, *M* = 54.97 (Not included last year). Results for each of the four mainly rural PHNs were:

Table 20: Social Support Services Gap Rating by PHN

	2019 M	2018 M
Darling Downs and West Moreton PHN	49.75	N/A
Central Queensland, Wide Bay and Sunshine Coast PHN	54.74	N/A
Northern Queensland PHN	55.75	N/A
Western Queensland PHN	59.36	N/A

Oral Health Services

The gap rating mean for Oral Health services was, *M* = 54.44 (Not included last year). Results for each of the four mainly rural PHNs were:

Table 21: Oral Health Services Gap Rating by PHN

	2019 *M*	2018 *M*
Darling Downs and West Moreton PHN	52.50	N/A
Central Queensland, Wide Bay and Sunshine Coast PHN	54.86	N/A
Northern Queensland PHN	52.46	N/A
Western Queensland PHN	58.98	N/A

Qualitative Findings

Participants were asked to outline any important insights or issues relating to the primary care service gap ratings. Comments were analysed and a summary of the most common responses state-wide from a total of 115 respondents is provided below:

Mental Health - more comments were received relating to mental health services than for any other service area. Most issues related to a general lack of services in the community, particularly for the less acutely unwell, as well as poor service co-ordination and lack of referral pathways. Other issues were around access to services such as stigma, poor mental health literacy levels and a lack of service awareness in the community.

Palliative Care Services - palliative care was the second most discussed service area. Issues included: Lack of funding for services; lack of or poor-quality of services generally; lack of services available in the home and GP home visits; cost of services; and lack of specialist GPs and social workers working in palliative care. Poor management within the sector and unsafe and unsupportive work environments was also discussed.

Aged Care Services - issues relating to aged care services was frequently reported. These included: Lack of services generally; poor service co-ordination; lack of workforce in aged care such as social worker and nurses; cost of care; and poor management within sector.

Dental Services - A general lack of access to dental services was another key theme among comments. This was particularly a problem in Aboriginal communities. High cost of services and wait time were also mentioned.

Other comments overall suggested a lack of social workers and social support services in community, particularly for youth and elderly, and high cost of services generally, although Psychology, Dentistry, and Palliative care were reported to be most costly.

Open Ended Workforce Questions

As part of the HWNA survey, participants were asked: What is the most concerning health issue(s) in your community(s) and what type of health professional(s) is needed most to assist with this? Responses were received from 338 participants and these were analysed and grouped into key health issues. The main health issues identified were:

1. Mental Health (n = 91)
2. Alcohol and Other Drugs (n = 50)
3. Dental (n = 30)
4. General practice (n = 29)
5. Chronic disease (n = 27)
6. Obesity (n = 27)
7. Diabetes (n = 26)
8. Aged care (n = 20)

Participants were then asked to indicate the type of health professional needed most to assist with this problem(s). The main professionals listed for issues around mental health and AODs were:

1. Psychologists (n = 63)
2. Psychiatrists (n = 33)
3. Social Workers (n = 32)
4. Counsellors (n = 17)
5. AODs services and workers (n = 18)
6. Mental health workers (n = 15)

These findings align with the workforce and service gap ratings and comments with mental health and AODs once again being perceived as the highest health issue within remote, rural and regional communities.

Dental was the next highest priority with 18 participants indicating a need for dentists and two mentioned either a dental hygienist or a dental therapist.

Doctors were mentioned by 41 participants. These included general practitioners as well as those with a special interest in areas such as mental health, addiction and rural generalism.

Under chronic disease, 40 participants mentioned specialist medical staff encompassing areas from endocrinology to palliative care. Nurses were also mentioned by 28 participants, 17 participants indicated occupational therapists were required.

For the combined areas of obesity and diabetes, there were a number of allied health professionals mentioned. There were 27 mentions of either dietitians or nutritionists, diabetes educators were mentioned by 16 participants, as were exercise physiologists (n = 14) and podiatrists (n = 8).

Many of the workforce already mentioned also work across aged care, particularly nursing and allied health. However, there were five specific mentions of geriatricians and palliative care staff.

Section 5

Findings - Access

Rockhampton, QLD.
Image courtesy of Tourism and Events Queensland.

To inform the findings in this report, an analysis of data was undertaken including triangulation of quantitative data and surveys results, feedback from consultations and the desktop audit. A state-wide summary of needs, key issues and evidence, based on these findings has been developed under the three priority areas of Access, Quality and Sustainability. This section provides a summary of key issues related to Access.

Access to Local Health Workforce

Key Issue

Shortage of GP, nursing, allied health and Aboriginal and Torres Strait Islander health worker/practitioner workforce in remote, rural and regional Queensland

Evidence	Strategy
SA2s from the Extreme and High quadrants found to have the lowest number of GPs relative to population size were: Gympie Region (24,138 or 1 GP FTE per 24,138 people), Kilkivan (18,765), Tablelands (11,648.9), Miles – Wandoan (4,660.6), and Maryborough Region – South (4,299.5). Access to primary health care nursing, allied health and Aboriginal and Torres Strait Islander health worker workforce decreases by remoteness as evidenced by Queensland Health and Workforce Survey data. The highest workforce gap rating means across remote, rural and regional Queensland in the current HWNA survey were for psychology workforce, social work workforce, speech pathology workforce, general practitioner workforce and occupational therapy workforce. Workforce gap ratings have increased across the board in 2019 compared to 2018 data. In particular, General practice with a 12-point rise.	• Prioritised communities receive recruitment support including the provision of locums in areas of need. • In collaboration with others, develop methods to monitor the stability of the health workforce and agree upon "next steps" to tackle critical workforce situations. • Provide workforce and service planning support to priority communities. • Employ targeted recruitment and retention packages to priority communities. • Continue to build evidence through collation of workforce data from internal and external sources.

Desired Outcome

Increased supply of primary care workforce to priority areas in remote, rural and regional Queensland

Maldistribution of GP Workforce

Key Issue

Inequitable distribution of health workforce in rural areas

Evidence	Strategy
There remains GP vacancies. Although there are overseas trained doctors willing to accept these positions, they often do not have general registration or vocational registration and cannot be placed in these towns due to their supervision requirements. Primary care workforce gaps are higher in PHNs with more remote areas across most professions – psychology, social work etc. Attracting Australian trained graduates to remote and rural positions remains a great challenge.	• Develop mechanisms to attract Australian trained doctors and other health professionals to remote and rural areas. • Assist with relocation grants and incentives. • Support models that allow 'easy entrance, gracious exit' conditions for doctors. • Support clinical and leadership development within general practice to build clinical leadership in rural and remote.

Desired Outcome

Increased supply of primary care workforce to priority areas in remote, rural and regional Queensland

"We have been trying to recruit a GP for six months with not one applicant. It is impossible to get doctors and we have no DWS to help out. Furthermore, we lost our Rural Incentive Payment a few years ago which is another disincentive to working in Far North Queensland."

Lack of Appropriate Infrastructure

Key Issue

ICT infrastructure – Telehealth and internet access

Evidence	Strategy
Underutilisation of Telehealth is cited state-wide and is required to increase access to specialists as well as GPs and some allied health. Feedback on unreliable internet access is also regularly cited as a major impediment.	• Promote the increased use of ICT including Telehealth and interprofessional teams to increase productivity and reduce professional isolations. • Advocate for telehealth Medicare Items numbers to expand to more allied health and nursing services

Key Issue

Physical infrastructure – staff accommodation, clinical space

Evidence	Strategy
Spaces to host registrars and students are needed to support a training environment. Affordable and appropriate accommodation for permanent and visiting health professionals. Safe and updated clinical spaces to support procedural work. Private and culturally safe consultation spaces are required.	• Support general practices to apply for relevant infrastructure grants to increase capacity. • Collaborate to identify opportunities to utilise/develop existing infrastructure for primary health care i.e. University space, unused government buildings and local councils.

Desired Outcome

Improved availability of appropriate ICT and physical infrastructure to support health service requirements

> “Where we can provide the services, we cannot always get rooms to operate out of in rural towns, especially where demand is high.”

Remoteness/Distance to Travel

Key Issue

Lack of affordable and appropriate transport to access services

Evidence	Strategy
A long-term concern cited in all PHN needs assessments and from stakeholder feedback in the HWNA survey. Lack of public transport to attend local appointments, particularly for the elderly and disabled. Increasing centralisation of health services in major centres leading to longer journeys that often disrupt home and work life significantly increasing costs in accessing health services.	• Streamline processes for patients to access transport subsidies. • Encourage place-based solutions (working with councils and others) to local transportation issues. • Explore viability of mobile primary health care service delivery models to enhance access. • Encourage coordination of services to maximise efficiency and capacity to access services locally.

Key Issue

Cost of travel for health professionals for rural outreach/hub and spoke arrangements

Evidence	Strategy
Noted in PHN needs assessment reports and from health professional feedback. Cost of travel both in time and dollars makes many services unviable in remote regions without considerable support.	• Promote the increased use of Information, Communication and Technology (ICT) where possible as an adjunct to face to face appointments. • Support rural loading of provider rebates to cover extra costs incurred. • Explore locally grown delegated workforce models to reduce number of visits by visiting health professionals i.e. allied health assistants.

Desired Outcome

Increased availability of affordable and appropriate transport to access health services

Increased technology and financial support for health professionals in remote regions

Barriers to Accessing Health Care

Key Issue

After Hours Services

Evidence	Strategy
Cited as an issue in all PHN needs assessments, accessing after hours services is a challenge, especially amongst many communities in the remote and rural areas because of inadequate GP and allied health workforce.	• Promote workforce models that support after hours service provision. • Support initiatives to service after hours high needs services i.e palliative care, mental health and AODS.

Key Issue

Cost of services

Evidence	Strategy
Cost was repeatedly mentioned as an important limitation on accessing primary health care services, in particular lack of bulk billing for GP and allied health services.	• Promote workforce models that provide affordable access to medical and allied health services.

Key Issue

Culturally appropriate health services

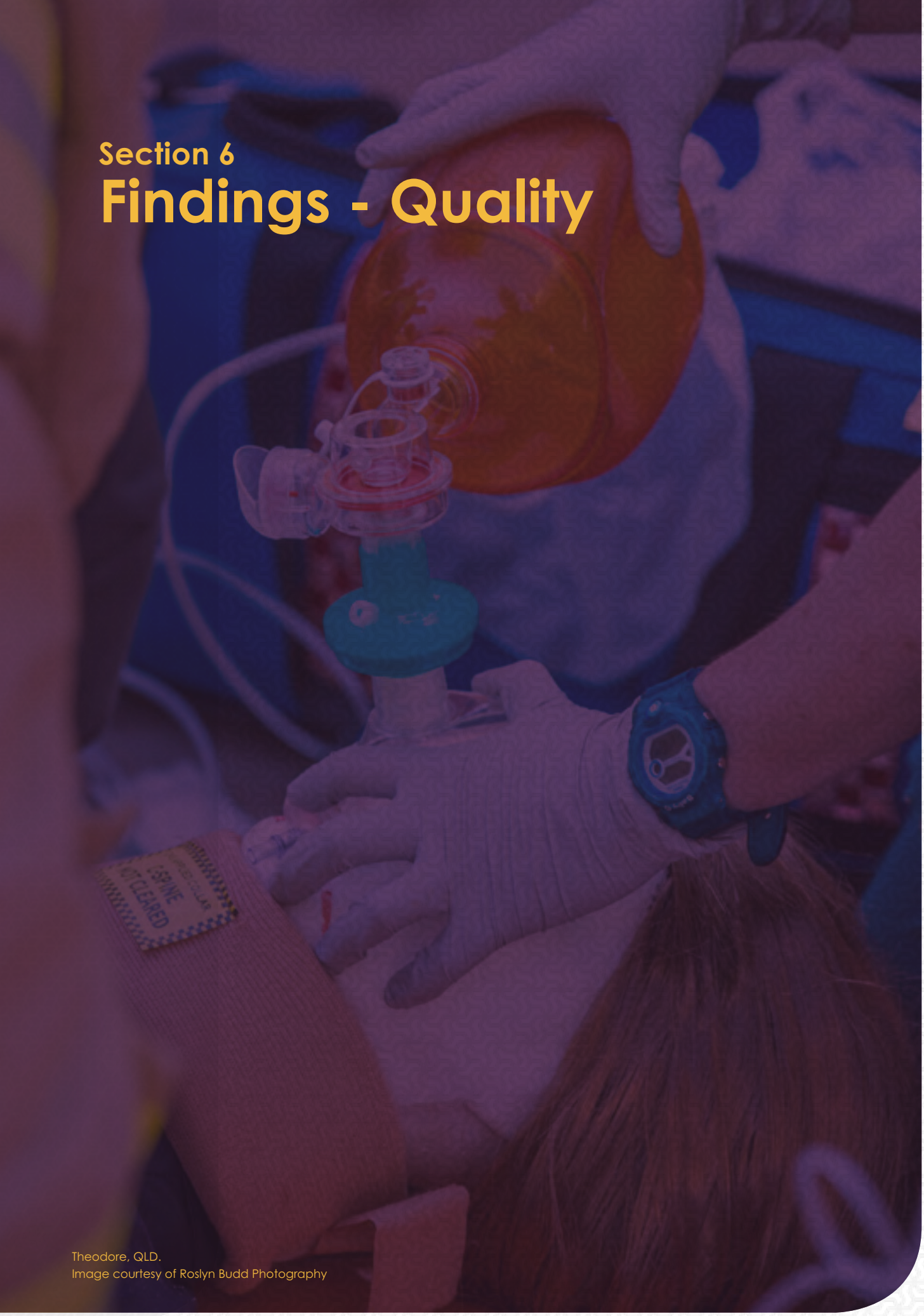
Evidence	Strategy
The lack of access to, culturally appropriate health services was cited in all PHN reports. Access to refugee and immigrant health services was also recognised as a gap.	• Encourage workplace cultural training of health professionals and other staff to support cultural safety. • Promote GP and nursing placements to remote areas with culturally appropriate orientation. • Collaborate with Aboriginal and Torres Strait Islander Organisations to ensure appropriate training is provided.

Key Issue	
Service awareness/service understanding	
Evidence	**Strategy**
Communities lack of knowledge of what services are available within their area (including after hours). Lack of awareness of what practitioners can do. Lack of knowledge about referral pathways within the region. Health professionals lack of knowledge of other service providers in their region.	• Promote activities to expand health literacy within communities to encourage appropriate service access. • Build awareness of existing services such as the National Health Service Directory and My Community Diary to better link customers with available health services. • Encourage collaboration and communication of service providers and health professionals to raise awareness of services within their region.
Desired Outcome	
Greater access to affordable and appropriate primary care within communities in remote and rural Queensland	

“I regularly see people decline referrals for specialist care outside their local area because they are unable to travel away due to financial hardship and time constraints due to huge rural workloads and family commitments.”

Section 6

Findings - Quality



Theodore, QLD.
Image courtesy of Roslyn Budd Photography

To inform the findings in this report, an analysis of data was undertaken including triangulation of quantitative data and survey results, feedback from consultations and the desktop audit. A state-wide summary of needs, key issues and evidence, based on these findings has been developed under the three priority areas of Access, Quality and Sustainability. This section provides a summary of key issues related to Quality.

Adequately Skilled Workforce

Key Issue	
Building a capable workforce that is responsive to local needs	
Evidence	**Strategy**
Need for increased access to quality continuing professional development for all health workforce. Survey participants were asked to indicate what staff would be most suited to up-skilling. There were responses from 165 participants and the main practitioners mentioned were Nurses (n = 57), Doctors (n = 42), Social workers (n = 14), Aboriginal and Torres Strait Islander Health Workers/ Practitioners (n = 13), Allied health – generic (n = 7) and Dietitian (n = 6) Strategies needed to develop the health workforce locally including supporting youth to commence vocational training in health-related studies. Need for mentoring and leadership training. The increasing number of Aboriginal and Torres Strait Islander people working in health-related areas should be supported to achieve career goals, including through positive mentoring and leadership training. Reports from NATSIHA and PHNs have indicated that some Aboriginal Community Controlled Health Organisations may particularly benefit from increasing mentoring and leadership training for their staff. Need to expand existing scopes of practise and creation of new roles in all professions.	• Provide grants to support health professionals to become vocationally qualified and up-skilled. • Facilitate and coordinate professional development to ensure a knowledgeable, confident and competent workforce. • Provide organisational support to improve supervision and mentoring and providing education and training for supervisors and mentors. • Provide organisational support for staff to undertake leadership training. • Offer support for role development and enhancing scope of practice. • Encourage collaboration between organisations with respect to career pathways and professional development. • Build clinical leadership and mentoring through training support.
Desired Outcome	
A capable workforce that is responsive to local needs	

Access to Quality Primary Care Health Services

Key Issue

Care available is episodic rather than comprehensive, continuous and person-centred

Evidence	Strategy
Poor availability of primary health care services may be represented by the percentage of presentations in emergency departments classified as triage category 4 and 5 (low acuity). Based on Queensland Health emergency presentation data from November 2018, all hospitals in MMM locations 4-7 were well above the average for Queensland (43.8%). There was also a strong, significant positive correlation between the percentage of triage category 4 and 5 presentations and increasing remoteness. PHNs report consumer confidence in quality of care is eroded by lack of consistency in staff (specifically GPs). Sustainable general practice services are particularly challenging in remote Queensland and support in these regions should be prioritised.	• Promote the development of workforce models that provide GP led, person-centred care with multidisciplinary support services. • Develop strategies to retain quality workforce to ensure continuity of care. • Support the many existing general practice models – both traditional and subsidised, non-Indigenous and Indigenous. • Support strategies to extend workforce capacity to improve access to quality comprehensive primary care services particularly in remote communities including use of nurse practitioners, Rural and Isolated Practice Registered Nurses (RIPRN) and Aboriginal and Torres Strait Islander Health Workers and Practitioners.

Desired Outcome

Increased availability of quality primary health care services

> “Long waiting lists for service. High turnover of staff - especially medical staff. Very low levels of specialist medical staff.”

Culturally Appropriate Care

Key Issue	
Capability to deliver culturally appropriate health care	
Evidence	**Strategy**
All PHN needs assessments report a need for a health workforce that is able to deliver culturally appropriate care.	• Support commissioning of providers that embed cultural orientation and training in their organisations. • Provision of services in non-traditional settings that support the individual's cultural background. • Targeted recruiting of Indigenous health professionals to promote culturally safe service delivery. • Ensure cultural orientation for health professionals recruited to remote and rural communities. • Location specific orientation for health professionals doing outreach to discrete communities. • Develop capacity for local cultural mentors.
Desired Outcome	
Increased capability of the health workforce to deliver culturally appropriate health care	

"It is vital that our health workers are well trained in current practices to ensure people accessing services locally do not receive a lesser quality service than they would if the travelled to metropolitan areas."

Section 7

Findings - Sustainability

Emerald, QLD.
Image courtesy of James Laws Photography.

To inform the findings in this report, an analysis of data was undertaken including triangulation of quantitative data and surveys results, feedback from consultations and the desktop audit. A state-wide summary of needs, key issues and evidence, based on these findings has been developed under the three priority areas of Access, Quality and Sustainability. This section provides a summary of key issues related to Sustainability.

Growing the Health Workforce Pipeline

Key Issue	
Developing the future workforce with a view to address maldistribution and local need	
Evidence	**Strategy**
Workforce data reflects an ageing nursing workforce There is a low availability of the allied health workforce in more remote and rural areas of Queensland. Experienced allied health professionals are less readily accessed with a high representation of inexperienced graduates requiring high levels of mentoring, supervision and peer support. Other evidence reported includes low representation of Aboriginal and Torres Strait Islander people in the workforce and limited opportunities to train locally.	• Promote rural health career opportunities for medical, nursing, allied health and Aboriginal and Torres Strait Islander primary care providers. • Career management support to future workforce. • Offer rural immersion opportunities to attract students into rural health careers such as the John Flynn Placement Program, GO Rural and GROW Rural. • Support rural high school visits to create interest in a rural health career. • Support RVTS and Regional Training Organisations to enhance GP vocational training of doctors in rural areas of need. • Invest in initiatives that increase recruitment of allied health and nursing graduates. • Work with universities to support more student placements in remote and rural Queensland.
Desired Outcome	
Greater numbers of people taking up careers in rural health	

Service Provider Collaboration

Key Issue	
Inefficient and fragmented care	
Evidence	**Strategy**
Lack of clear pathways for care. Better system integration, coordination and collaboration is needed. PHNs report lack of integration of other primary care and specialist services with general practice, resulting in poorly coordinated and often duplicated care. Design of new services within regions not aligning with current services.	• Support navigator and liaison roles to promote better system integration, coordination and collaboration. • Encourage communication and collaboration in the design and delivery of primary care services between providers. • Encourage professional, interprofessional and interagency meetings at the local level.
Desired Outcome	
Health service delivery is optimised through improved system integration, coordination and collaboration	

“Mental health continues to be a gap service within the community. Referral pathways are often difficult to navigate and promotion of mental health services could improve further.”

Achieving Sustainable Workforce Models

Key Issue	
Vulnerable and non-viable workforce models	
Evidence	**Strategy**
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. Look for more "Easy Entrance, Gracious Exit" models with financial, administrative and work/life balance burdens being lessened.	• Work within priority communities to assess and develop innovative workforce models that expand scope of practice and considers emerging health workforce roles (i.e. rural generalist roles, allied health assistants). • Promote public/private employment models for skills retention and increased viability. • Investigate blended funding models (particularly for allied health) to support financial viability of service provision. • Build clinical leadership, support, and mentoring. • Develop models that support multidisciplinary teams rather than sole professionals.
Desired Outcome	
Workforce models are developed to meet local need and support viability and sustainability of services	

"Struggling to find a vocationally registered GP to buy into our practice when one of our doctors retires. Not DWS and Australian trained GPs are not interested in living and working outside of the metropolitan areas."

Attracting Health Workforce

Key Issue
Attracting future workforce to health careers and rural health **Attracting current workforce to general practice and rural health**

Evidence	Strategy
All PHN needs assessment reports and the HWNA reflect that remote and rural communities continue to experience problems attracting and recruiting health workforce.	• Undertake rural immersion programs such as GROW Rural and John Flynn Placement Program. • Rural high school visits promoting careers in health. • Work with organisations to develop attractive incentives as 'add ons' to entice workforce to hard to recruit areas. • Provide reimbursement for relocation costs and support for temporary accommodation. • Flexible models of employment – private/public joint appointments to enhance scope and variety.

Desired Outcome
Increased numbers of future workforce choose health careers and rural health **Greater numbers of the current medical workforce choose rural general practice**

"Students and trainees need to be offered a high-quality training, education and supervision experience to attract them."

Retaining Health Workforce

Key Issue
High turnover of health professionals in rural and remote

Evidence	Strategy
Robust evidence identifies many factors contributing to lack of retention including: • Lack of access to continuing professional development (CPD). • Professional isolation. • Burnout due to lack of relief. • Poor accommodation and high cost of living. • Spouse/family considerations. PHNs report lack of consistency in staff particularly seen as an issue in Indigenous communities, where forming relationships and building trust are of great importance.	• Grants to health professionals working in remote and rural locations. • Comprehensive and tailored case management to support health professionals. • Family support opportunities. • Locums for CPD or personal leave to priority areas. • Consideration of retention bonuses to increase retention of allied health and nursing professionals

Desired Outcome
Higher rates of health workforce retention in remote, rural, and regional Queensland through provision of grants and other supports

"We often get service providers, but they don't stay long. Some service providers are only in the area for a period of months."

Section 8

Appendices

Moura, QLD.
Image courtesy of Roslyn Budd Photography.

Appendix 1:
Priority SA2s by PHN

Appendix 1.1: Western Queensland PHN Priority SA2s

SA2 Name	Main Townships Within SA2
Carpentaria	Burketown Carpentaria Mornington Island Normanton Karumba
Far South West	Cunnamulla Thargomindah Quilpie
Far Central West	Birdsville Bedourie Boulia Windorah Jundah Winton
Mount Isa Region* *does not include Mount Isa	Camooweal Cloncurry Dajarra
Charleville	Charleville Morven Murweh Augathella

Changes from Last Year

- Balonne moved out of the extreme quadrant into high quadrant

Note: The reason some SA2s have moved quadrants is due to SEIFA, MMM, and the SA2 Geographic areas being updated.

Appendix 1.2: Darling Downs and West Moreton PHN Priority SA2s

SA2 Name	Main Townships Within SA2
Tara	Glenmorgan Meandarra Moonie Tara
Millmerran	Cecil Plains Millmerran
Kingaroy Region - North	Cherbourg Murgon Proston Wondai
Nanango	Benarkin Blackbutt Nanango
Jondaryan	Jondaryan Oakey
Crows Nest - Rosalie	Crows Nest Yarraman
Inglewood - Waggamba	Inglewood Texas
Esk	Esk Toogoolawah
Lockyer Valley – East	Hatton Vale Laidley Plainland
Stanthorpe	Stanthorpe

Changes from Last Year

- Southern Downs – West is no longer in the extreme quadrant
- Warwick is still in extreme quadrant but is out ranked by other SA2s
- Esk is now in the extreme quadrant as it has less GPs this year

Note: The reason some SA2s have moved quadrants is due to SEIFA, MMM, and the SA2 Geographic areas being updated.

High Quadrant SA2 of note

- Miles – Wandoan - high GP FTE to population ratio

Appendix 1.3: Central Queensland, Wide Bay, Sunshine Coast PHN Priority SA2s

SA2 Name	Townships within SA2
Kilkivan	Goomeri Kilkivan
Maryborough Region – South	Brooweena Mungar Tiaro
Agnes Water – Miriam Vale	Agnes Water Miriam Vale Seventeen Seventy
Central Highlands – East	Blackwater Woorabinda
Mount Morgan	Mount Morgan
Cooloola	Cooloola Rainbow Beach Tin Can Bay
Gin Gin	Gin Gin
Emu Park	Emu Park Kinka
Bundaberg Region - South	Childers
Gayndah – Mundubbera	Biggenden Gayndah Mundubbera

Changes from Last Year

- Burrum-Fraser and Gympie Region are out of extreme quadrant
- Emu Park and Bundaberg Region – South now come into the top rankings

Note: The reason some SA2s have moved quadrants is due to SEIFA, MMM, and the SA2 Geographic areas being updated.

High Quadrant SA2s of note

- Gympie Region – high GP FTE to population ratio
- Central Highlands – West – high GP FTE to population ratio

Appendix 1.4: Northern Queensland PHN Priority SA2s

SA2 Name	Main Townships Within SA2
Aurukun	Aurukun Wallaby Island
Torres Strait Islands	Badu Island Boigu Island Mabuiag Island Saibai Island
Northern Peninsula	Bamaga New Mapoon Injinoo
Herberton	Herberton Mount Garnett Ravenshoe
Collinsville	Collinsville Mount Coolon
Tablelands	Almaden Dimbulah Mount Malloy
Palm Island	Palm Island
Kowanyama - Pormpuraaw	Kowanyama Pormpuraaw
Cape York	Coen Hope Vale Laura Mapoon
Croydon - Etheridge	Croydon Georgetown

Changes from Last Year

- Burdekin and Babinda are now out of the extreme quadrant
- Mareeba has a much higher number of GPs this year and drops out of top rankings
- Palm Island, Tablelands and Croydon – Etheridge have come up into the list

Note: The reason some SA2s have moved quadrants is due to SEIFA, MMM, and the SA2 Geographic areas being updated.

High Quadrant SA2s of note

- Pioneer Valley - high GP FTE to population ratio
- Clermont - high GP FTE to population ratio
- Broadsound – Nebo - high GP FTE to population ratio
- Burdekin - high GP FTE to population ratio

Appendix 2:
Mean Workforce and Service Gap Ratings by PHN

Appendix 2.1: Northern Queensland PHN by Combined or Single SA2

	Townsville and surrounds	Cairns and surrounds	Mackay and surrounds	Cape York and Indigenous communities	Whitsundays and surrounds to Ayr	Inland communities	Ingham, Ingham Region, Tully	Innisfail	Atherton, Malanda – Yungaburra, Mareeba, Tablelands
General Practice	42.9	53.1	50.7	**67.5**	54.5	**61.6**	**63.3**	**85.8**	**68.8**
Aboriginal and Torres Strait Islander Health Worker/Practitioner	42.7	50.7	52.3	**62.5**	49.6	56.7	**61.8**	**62.8**	**66.6**
Audiology	27.2	34.6	30.9	**66.7**	39.3	**66.9**	**60.1**	37.8	53.3
Dentistry	32.5	54.4	31.5	**64.4**	39.5	35.1	**66.2**	**63.0**	**61.9**
Diabetes Education	35.7	46.8	51.6	57.8	41.5	57.1	56.9	51.0	54.7
Exercise Physiology	25.9	43.5	36.3	**77.6**	41.7	**60.9**	**62.9**	**71.0**	46.9
Nursing	34.7	44.5	49.8	55.7	42.1	**66.7**	41.7	**72.0**	54.7
Nutrition/Dietetics	37.3	46.5	35.2	52.5	**66.0**	**68.9**	**61.9**	51.8	50.5
Occupational Therapy	39.4	46.2	55.8	57.7	58.2	**62.7**	56.5	57.0	57.1
Optometry	21.6	32.4	23.2	58.1	33.7	52.5	39.5	31.0	41.6
Pharmacy	19.4	24.0	31.5	54.3	20.0	31.6	30.7	36.0	29.4
Physiotherapy	23.4	36.1	25.3	**60.8**	33.9	50.1	41.3	**62.8**	42.9
Podiatry	27.5	35.0	29.6	**65.6**	55.7	**72.7**	52.7	37.3	52.3
Psychology	48.8	39.1	58.6	**77.8**	**64.8**	**80.5**	**76.3**	**62.0**	**64.7**
Radiology	18.6	28.8	28.0	**65.1**	28.6	**76.8**	56.8	**63.5**	56.4
Sonography	26.7	30.7	37.9	**62.4**	31.7	**81.9**	**64.1**	**73.8**	**66.0**
Speech Pathology	41.4	47.2	**61.9**	50.7	56.0	**71.7**	**64.3**	46.8	**72.9**
Social Work	50.8	51.0	57.5	**72.3**	54.4	59.9	**75.9**	**75.0**	**61.2**
Aboriginal and Torres Strait Islander health Services	49.4	39.8	43.7	**65.4**	39.3	**60.7**	**62.8**	**60.8**	58.3
Aged Care Services	57.4	49.4	55.3	**76.7**	42.1	**70.8**	56.5	54.6	59.1
AOD Services	**63.1**	50.4	56.9	**65.1**	52.1	**66.5**	**63.2**	**74.7**	**61.2**
Child Health Services	54.9	38.1	52.9	57.7	39.2	56.8	58.9	**67.5**	58.5
Disability Services	52.9	45.8	**61.4**	**77.5**	46.9	**64.8**	**66.2**	**75.2**	**60.3**
Health Promotion Services	50.0	55.5	55.9	**73.1**	43.7	**67.8**	**62.9**	**79.0**	**65.4**
Maternal Health Services	34.8	32.9	33.1	49.1	40.3	58.8	48.5	**60.7**	43.7
Mental Health Services	**63.5**	53.4	**73.0**	**70.5**	**65.5**	**70.7**	**76.5**	**66.4**	**71.1**
Oral Health Services	45.9	56.4	36.4	**60.9**	44.8	38.1	**61.5**	**81.3**	**65.9**
Palliative Care Services	44.6	43.3	57.5	**69.6**	46.2	**78.4**	**62.5**	**76.2**	**62.9**
Refugee and Immigrant Health Services	**62.0**	50.0	54.5	**64.5**	31.3	57.7	55.4	**63.5**	51.3
Social Support Services	**60.1**	47.4	54.6	**73.6**	40.6	59.9	55.8	**77.6**	**63.7**

Workforce Gap Ratings

Service Gap Ratings

Note: Mean ratings ≥ 60.0 are in bold to highlight the highest gap ratings. For each combined SA2 area, the highest workforce or service gap rating is highlighted in red.

Appendix 2.2: Darling Downs and West Moreton PHN by Combined or Single SA2

	Toowoomba and surrounds	Kingaroy and surrounds	Dalby and surrounds	Warwick to Stanthorpe	Goondiwindi and surrounds	Gatton to Boonah	Lowood and Esk	Chinchilla, Millmerran, Tara, Taroom
General Practitioner	28.9	51.3	45.8	31.7	23.0	39.6	40.0	**72.2**
Aboriginal and Torres Strait Islander Health Worker/Practitioner	27.9	43.3	39.0	38.0	29.9	52.9	52.6	**70.3**
Audiology	21.4	32.1	42.6	24.7	32.4	43.4	**71.5**	**74.7**
Dentistry	39.0	48.3	52.4	29.1	27.6	52.5	58.2	**92.2**
Diabetes Education	26.0	43.2	44.1	41.8	16.7	35.8	49.5	50.5
Exercise Physiology	28.6	34.4	36.9	36.1	32.7	38.6	**63.8**	**78.3**
Nursing	35.3	28.3	38.0	43.0	25.3	44.7	42.4	**71.5**
Nutrition/Dietetics	27.2	31.2	31.9	35.8	35.4	34.8	41.3	**65.3**
Occupational Therapy	35.6	48.8	31.7	55.6	48.5	**64.1**	**68.3**	55.8
Optometry	24.4	36.0	30.2	40.8	33.3	39.2	**72.4**	**60.5**
Pharmacy	18.4	16.7	23.3	34.6	18.2	26.0	25.3	29.0
Physiotherapy	25.9	46.6	24.4	29.6	44.3	44.8	46.8	43.8
Podiatry	28.5	45.9	27.4	28.4	30.1	37.5	34.2	54.8
Psychology	45.5	**76.9**	54.9	55.4	56.1	43.1	**64.3**	**84.0**
Radiology	18.6	50.4	36.7	36.1	53.3	**60.7**	**86.2**	**73.5**
Sonography	23.3	**61.4**	39.7	33.4	49.5	57.3	**92.5**	**70.8**
Speech Pathology	36.1	51.2	30.2	51.4	52.1	58.5	**81.0**	56.5
Social Work	41.8	50.3	41.8	59.9	**67.2**	52.4	**64.5**	**77.0**
Aboriginal and Torres Strait Islander Health Services	26.8	35.1	32.9	37.3	33.4	44.9	54.3	58.5
Aged Care Services	37.0	49.1	26.5	49.1	15.3	42.6	**68.2**	57.2
AOD Services	47.4	59.8	45.4	55.1	50.4	**67.9**	**62.4**	**81.4**
Child Health Services	37.8	55.5	36.7	45.4	31.0	45.9	**60.3**	50.8
Disability Services	41.6	45.8	52.5	53.0	41.3	49.3	54.8	54.2
Health Promotion Services	35.2	58.4	41.9	**63.6**	27.6	46.5	**61.0**	49.0
Maternal Health Services	21.6	39.7	33.6	40.6	22.2	48.6	**61.1**	**62.0**
Mental Health Services	52.9	**80.9**	54.6	**61.6**	51.3	**65.3**	**71.4**	**65.3**
Oral Health Services	47.6	**63.6**	45.9	51.6	31.3	48.6	**65.0**	**94.8**
Palliative Care Services	38.9	**60.1**	37.3	56.3	38.4	45.7	**64.0**	54.3
Refugee and Immigrant Health Services	38.1	33.4	56.2	59.8	37.0	50.9	56.0	25.0
Social Support Services	44.9	50.5	37.4	**65.2**	33.6	44.8	51.8	57.3

Workforce Gap Ratings

Service Gap Ratings

Note: Mean ratings ≥ 60.0 are in bold to highlight the highest gap ratings. For each combined SA2 area, the highest workforce or service gap rating is highlighted in red.

Appendix 2.3: Western Queensland PHN by Combined or Single SA2

	Balonne, Charleville, Far South West	Balonne, Charleville, Far South West	Barcaldine – Blackall, Far Central West, Longreach	Mount Isa	Roma, Roma Region	Carpentaria, Mount Isa Region, Northern Highlands
General Practitioner	65.3	65.3	33.0	69.0	64.4	82.7
Aboriginal and Torres Strait Islander Health Worker/ Practitioner	46.6	46.6	54.4	**60.5**	40.3	**72.2**
Audiology	**69.3**	**69.3**	55.3	55.9	54.1	**69.4**
Dentistry	**63.7**	**63.7**	57.7	54.0	48.8	55.6
Diabetes Education	57.8	57.8	37.4	56.0	21.8	57.9
Exercise Physiology	54.7	54.7	23.0	44.9	48.1	53.3
Nursing	**61.4**	**61.4**	58.3	51.5	46.9	**67.2**
Nutrition/Dietetics	45.0	45.0	39.6	40.7	26.7	**70.3**
Occupational Therapy	47.5	47.5	51.1	50.5	27.4	**73.0**
Optometry	**68.4**	**68.4**	51.0	46.1	44.8	**67.2**
Pharmacy	39.0	39.0	39.1	29.8	32.3	50.7
Physiotherapy	**62.6**	**62.6**	49.2	56.1	24.8	57.3
Podiatry	46.3	46.3	**62.1**	52.9	32.7	**80.3**
Psychology	**64.7**	**64.7**	**67.1**	**72.9**	**66.7**	**94.7**
Radiology	**60.7**	**60.7**	20.3	51.1	15.5	**73.3**
Sonography	**73.6**	**73.6**	36.8	55.9	45.6	**77.6**
Speech Pathology	44.6	44.6	44.3	**64.9**	40.6	59.2
Social Work	49.2	49.2	57.3	**66.5**	**48.2**	**73.7**
Aboriginal and Torres Strait Islander Health Services	37.9	37.9	49.4	47.7	23.6	58.4
Aged Care Services	**68.0**	**68.0**	50.3	**73.3**	37.9	58.6
AOD Services	**80.9**	**80.9**	51.3	59.1	**64.8**	**76.4**
Child Health Services	39.8	39.8	33.0	51.6	37.5	40.9
Disability Services	**75.8**	**75.8**	50.2	**72.1**	53.9	**75.1**
Health Promotion Services	49.6	49.6	**76.9**	57.7	39.1	57.6
Maternal Health Services	33.9	33.9	41.9	48.2	16.0	54.7
Mental Health Services	**70.4**	**70.4**	**77.0**	**72.0**	**67.4**	**82.1**
Oral Health Services	**69.3**	**69.3**	**66.7**	58.8	31.6	**68.1**
Palliative Care Services	51.2	51.2	35.9	**67.6**	52.4	**70.3**
Refugee and Immigrant Health Services	51.6	51.6	40.0	56.3	**64.1**	59.3
Social Support Services	59.4	59.4	57.7	58.3	52.7	**71.2**

Workforce Gap Ratings

Service Gap Ratings

Note: Mean ratings ≥ 60.0 are in bold to highlight the highest gap ratings. For each combined SA2 area, the highest workforce or service gap rating is highlighted in red.

Appendix 2.4: Central Queensland, Wide Bay and Sunshine Coast PHN by Combined or Single SA2

	Bundaberg and surrounds	Gladstone and surrounds	Gympie and surrounds	Maryborough, Hervey Bay and surrounds	Rockhampton and surrounds	Emerald and surrounds	Sunshine Coast hinterland	Inland communities
General Practitioner	**67.5**	**67.0**	**73.3**	40.2	50.3	30.5	28.9	40.0
Aboriginal and Torres Strait Islander health Worker/Practitioner	40.1	41.2	50.0	53.2	51.6	50.5	37.5	40.8
Audiology	22.8	40.5	38.7	23.6	39.3	47.7	28.7	43.0
Dentistry	28.4	45.9	47.5	40.9	**60.5**	36.4	31.9	**71.1**
Diabetes Education	29.5	45.8	46.0	46.5	49.1	42.4	29.1	47.4
Exercise Physiology	23.7	52.8	29.0	35.1	37.2	**63.0**	33.7	37.7
Nursing	35.9	46.7	46.8	36.1	50.9	47.3	32.6	29.9
Nutrition/Dietetics	41.7	42.7	30.5	35.7	38.9	48.9	38.4	39.1
Occupational Therapy	36.3	54.3	43.9	48.0	51.0	56.7	45.6	48.9
Optometry	17.3	33.3	17.4	30.2	31.1	30.7	27.1	58.4
Pharmacy	14.9	23.1	12.3	29.8	28.0	24.7	9.5	30.8
Physiotherapy	17.4	29.7	32.7	25.8	34.1	49.3	16.3	53.2
Podiatry	20.4	36.3	34.3	28.5	42.8	50.6	24.8	**64.3**
Psychology	52.6	**76.4**	28.5	42.9	50.8	**87.6**	28.8	**60.9**
Radiology	32.1	39.8	25.0	24.7	38.8	32.6	26.1	58.9
Sonography	34.7	46.1	33.7	31.0	41.4	34.3	26.8	**68.0**
Speech Pathology	35.0	43.2	58.8	40.0	59.1	49.6	29.9	50.2
Social Work	28.6	59.9	**68.7**	46.5	47.0	58.9	55.1	57.0
Aboriginal and Torres Strait Islander Health Services	38.9	33.4	42.1	36.7	34.6	50.8	40.7	43.0
Aged Care Services	47.0	**65.3**	50.8	34.4	59.1	47.8	43.8	50.8
AOD Services	50.6	**72.4**	**72.2**	50.3	58.7	**62.8**	**77.5**	56.1
Child Health Services	33.9	49.6	52.6	39.9	45.7	59.8	44.4	59.7
Disability Services	34.1	55.3	48.3	44.5	58.5	**70.2**	**60.6**	48.6
Health Promotion Services	40.3	43.9	**67.5**	35.1	40.5	51.5	38.8	39.6
Maternal Health Services	36.5	55.4	36.8	31.3	45.5	42.0	46.7	52.3
Mental Health Services	59.9	**82.0**	**63.5**	52.1	57.7	**65.2**	58.9	52.3
Oral Health Services	42.6	**64.1**	**61.0**	37.7	**69.9**	46.7	44.1	**65.7**
Palliative Care Services	42.9	**61.1**	36.3	52.4	52.8	**63.8**	48.6	52.5
Refugee and Immigrant Health Services	33.5	48.6	47.4	45.6	46.5	48.0	59.0	**63.0**
Social Support Services	39.0	**66.1**	**65.3**	40.6	51.6	**61.3**	55.5	59.1

Workforce Gap Ratings

Service Gap Ratings

Note: Mean ratings ≥ 60.0 are in bold to highlight the highest gap ratings. For each combined SA2 area, the highest workforce or service gap rating is highlighted in red.

Appendix 3:
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 & Remote Health, 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
- Health and Community Services Workforce Council
- Indigenous Allied Health Australia
- JCU GP Training Program
- Northern Queensland Primary Health Network
- North Coast Aboriginal Corporation for Community 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

Health Workforce Queensland would like to thank staff from these organisations for the time taken to contribute to this report.

Health Workforce Queensland

07 3105 7800
07 3105 7801
admin@healthworkforce.com.au

GPO Box 2523
Brisbane QLD Australia 4001

Level 13, 288 Edward Street
Brisbane QLD Australia 4000

healthworkforce.com.au