Health Workforce Queensland

Health Workforce Needs Assessment Summary Report

Central Queensland, Wide Bay, Sunshine Coast Region

July 2022

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Our Vision

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

Our Purpose

Creating sustainable health workforce solutions that meet the needs of remote, rural, regional and Aboriginal and Torres Strait Islander communities by providing access to highly skilled health professionals when and where they need them, now and into the future.

Our Values

Our Values are Integrity, Commitment and Equity.

Integrity

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

Commitment

We enhance health services in rural and remote Queensland communities.

Equity

We provide equal access to services based on prioritised need.

Acknowledgements

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

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

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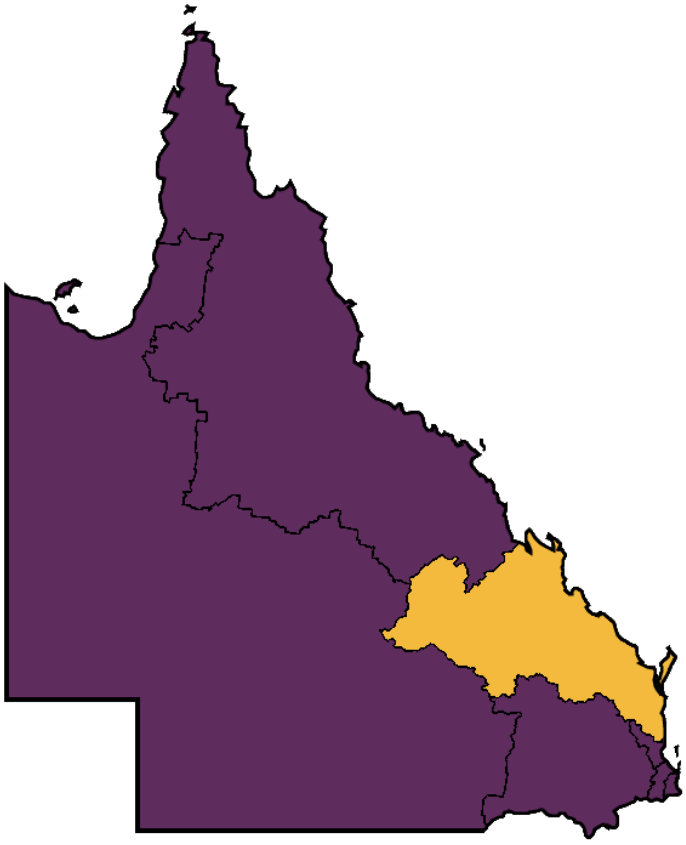
Introduction

The **Health Workforce Needs Assessment (HWNA)**, undertaken annually by Health Workforce Queensland, includes an online survey targeting general practitioners (GPs), practice managers, primary health care nurses/midwives, Aboriginal and Torres Strait Islander Health Workers/Practitioners and allied health practitioners (AHPs) working in **Modified Monash (MM) 2-7 locations in Queensland**. Survey items were developed to gauge health practitioner and health service manager perceptions about workforce gaps, primary care service gaps, and to identify primary health concerns in their community(s) of practice. GP workforce data for the **Central Queensland, Wide Bay, Sunshine Coast (CQWBSC) region** is provided in this report and is sourced from Health Workforce Queensland's **2021 Minimum Data Set (MDS)**. Quantitative and qualitative results from this survey applicable to the CQWBSC region are included in the following report.

This report for the CQWBSC region supplements the state-wide **2022 HWNA Summary Report** which is available on the Health Workforce Queensland website. The 2022 HWNA Summary Report details the HWNA methodology and provides an overview of state-wide workforce issues, numbers, and initiatives undertaken in Queensland during the previous 12 months.



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GP Workforce Snapshot

Health Workforce Queensland maintains a database of medical practitioners working in a general practice context (private practice, small hospitals, Royal Flying Doctor Service [RFDS] and Aboriginal Community Controlled Health Service [ACCHS]) in remote, rural, and regional **Modified Monash (MM)** 2-7 areas of Queensland.

A snapshot of medical practitioners working in a general practice context was taken on the **30th of November 2021** for Health Workforce Queensland's 2021 MDS. As of the census date there were 712 medical practitioners working their primary role in the CQWBSC region. For those where date-of-birth data was available, the average age of these practitioners was 50.61 years, marginally older than the MM 2-7 Queensland average of 49.95.

The number of GPs by sex are presented in ***Figure 1***.

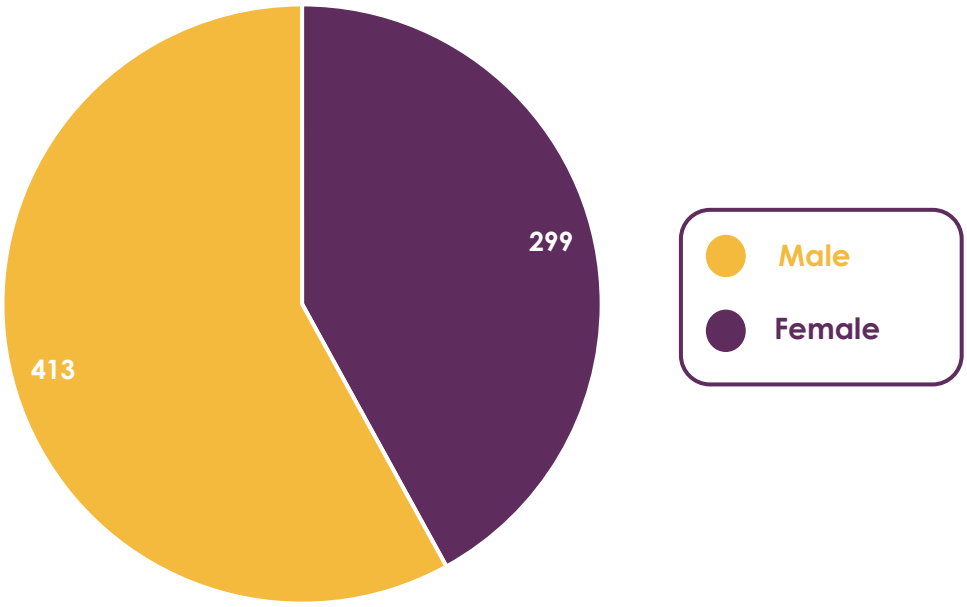

Figure 1: GPs in the CQWBSC region by sex.

Approximately 42 percent of the GPs in the CQWBSC region were female, slightly lower than the Queensland MM2-7 average of 45 percent.

Country of basic medical qualification

GPs were grouped according to whether they received their basic medical qualification from an Australian university or from an overseas university. In the CQWBSC region, there were 277 Australian-trained practitioners (38.8%) and 436 overseas trained practitioners (61.2%). The percentage result for the CQWBSC region and MM 2-7 Queensland are presented in ***Figure 2***.

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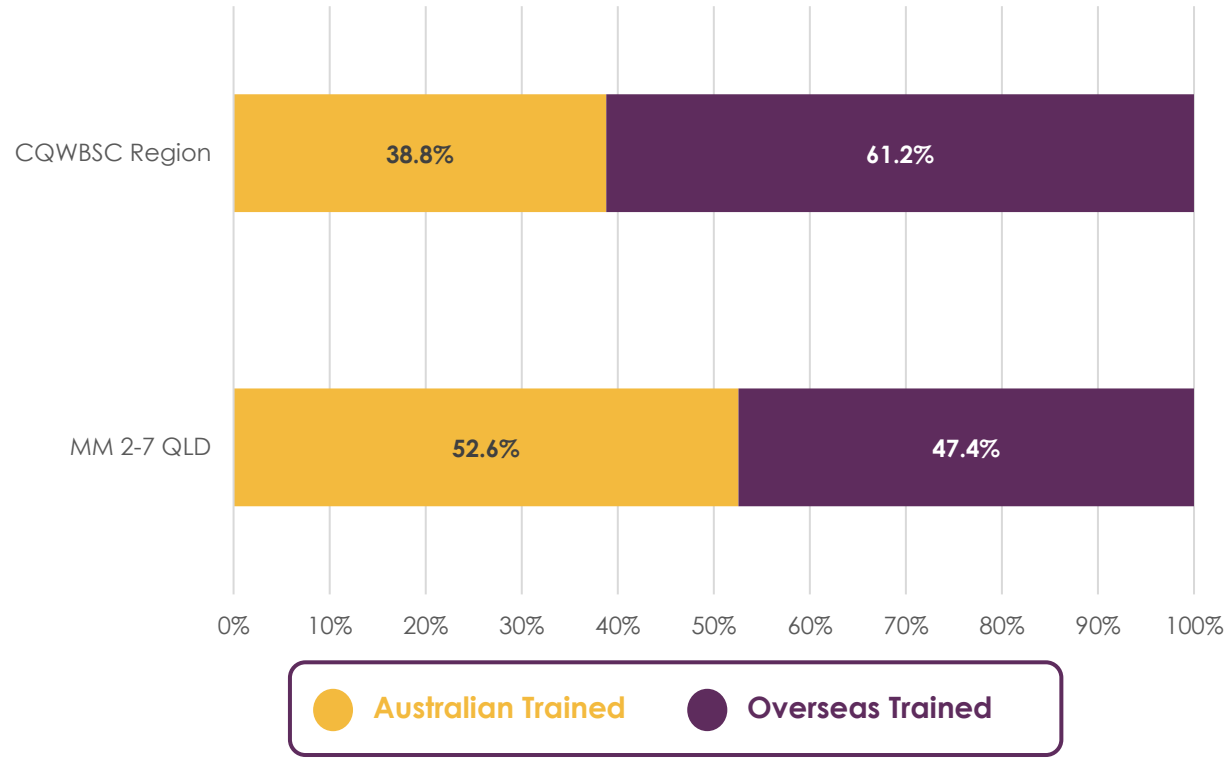

Figure 2: Percentage of GPs by country of basic medical qualification in the CQWBSC region and overall MM 2-7 Queensland.

The CQWBSC region had a substantially smaller proportion (38.8%) of Australian-trained practitioners when compared to the MM 2-7 Queensland average (52.6%).

HWNA Survey Participants

Surveys were distributed to GPs, health service practice managers, primary health care nurses/midwives, Aboriginal and Torres Strait Islander health workers/practitioners and AHPs. The total number of participants in the CQWBSC region was 236, which consisted of 136 GPs, 48 practice managers, 41 AHPs/others and 11 nurses/midwives. The distribution of survey participants by employment type and **Hospital and Health Service (HHS)** area is provided in ***Table 1***.

Table 1: CQWBSC region survey participants by employment type

Type	Central Queensland HHS *n (%)*	Wide Bay HHS *n (%)*	Sunshine Coast HHS *n (%)*	Total *N (%)*
General Practitioners	50 (51%)	57 (61%)	29 (63%)	136 (58%)
Practice managers	20 (21%)	12 (17%)	16 (26%)	48 (20%)
Nurses / Midwives	2 (26%)	7 (14%)	2 (7%)	11 (5%)
AHPs/others	25 (2%)	13 (8%)	3 (4%)	41 (17%)
Total	**97**	**89**	**50**	**236**

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Workforce and Service Gaps

The 2022 HWNA survey contained 30 statements about a serious primary care workforce or service gap existing in their community(s) of practice and required participants to rate their level of agreement from **'0 = Strongly disagree' to '100 = Strongly agree'**. There were 17 statements framed in terms of serious workforce gaps and 13 statements about serious primary care service gaps. Higher scores therefore indicate stronger levels of agreement with the statement and a stronger perception of the existence of a serious workforce gap or service gap in the community.

Mean workforce gap ratings are provided in ***Table 2*** and primary care service gap ratings in ***Table 3***. These are presented for the overall CQWBSC region as well as for each of the HHS areas, with gap rating means ranked from 1-17.

Means in 'bold' are values of 60 or higher, indicative of a potential serious gap in that region.

Table 2: Mean workforce gap ratings for the CQWBSC region and each HHS area.

Type of workforce	CQWBSC region Total *M* (Rank)	Central Queensland HHS *M* (Rank)	Wide Bay HHS *M* (Rank)	Sunshine Coast HHS *M* (*Rank*)
Psychology	**80.39 (1)**	**81.61 (1)**	**84.01 (1)**	**70.62 (1)**
Occupational Therapy	**74.33 (2)**	**79.61 (2)**	**77.80 (2)**	57.84 (5)
Social Work	**74.32 (3)**	**77.40 (3)**	**76.73 (5)**	**63.81 (3)**
Speech Pathology	**74.02 (4)**	**75.97 (5)**	**77.31 (3)**	**64.83 (2)**
General Practice	**73.14 (5)**	**76.91 (4)**	**76.87 (4)**	59.73 (4)
Nursing/Midwifery	**65.52 (6)**	**68.21 (6)**	**68.48 (6)**	55.55 (6)
ATSI Health	**60.57 (7)**	**63.73 (8)**	**61.49 (7)**	52.82 (7)
Diabetes Education	59.03 (8)	**64.82 (7)**	58.37 (9)	49.77 (8)
Nutrition/Dietetic	57.36 (9)	**61.22 (9)**	59.78 (8)	47.36 (9)
Exercise Physiology	54.23 (10)	59.03 (11)	57.07 (11)	39.32 (15)
Radiography/Sonography	54.16 (11)	59.58 (10)	56.34 (12)	41.06 (13)
Podiatry	53.57 (12)	58.39 (12)	55.68 (13)	39.55 (14)
Dentistry	52.99 (13)	52.76 (14)	58.19 (10)	44.00 (11)
Physiotherapy	51.78 (14)	54.57 (13)	53.54 (14)	43.56 (12)
Audiology	45.66 (15)	48.81 (15)	45.45 (15)	40.30 (14)
Optometry	43.85 (16)	42.54 (16)	43.92 (16)	46.28 (10)
Pharmacy	31.81 (17)	39.19 (17)	28.60 (17)	24.46 (17)

In the CQWBSC region there were seven workforce gap rating means of 60 or more. The highest were for psychology, occupational therapy, and social work workforces.

The **Central Queensland HHS** had nine workforce gap ratings of 60 or more and the three highest rated were same as the CQWBSC region overall: psychology, occupational therapy, and social work workforces.

For the **Wide Bay HHS** there were seven means higher than 60, with psychology, occupational therapy, and speech pathology workforces having the highest means.

In contrast, the **Sunshine Coast HHS** had only three means of 60 or more, with the highest ratings for psychology, speech pathology, and social work workforces.

Mean service gap ratings are provided in ***Table 3***.

Table 3: Mean service gap ratings for CQWBSC region and each HHS area

Type of service	CQWBSC region *Total* *M (Rank)*	Central Queensland HHS *M (Rank)*	Wide Bay HHS *M (Rank)*	Sunshine Coast HHS *M (Rank)*
Mental health	**83.39 (1)**	**84.16 (1)**	**84.89 (1)**	**79.03 (1)**
Community-based rehabilitation	**78.49 (2)**	**81.84 (2)**	**81.47 (2)**	**66.31 (3)**
Alcohol & other drugs	**77.58 (3)**	**78.29 (3)**	**76.75 (3)**	**77.85 (2)**
Aged care	**70.82 (4)**	**71.55 (5)**	**76.53 (4)**	58.61 (9)
Social support	**69.08 (5)**	**71.45 (7)**	**71.65 (7)**	59.86 (7)
Child health	**68.47 (6)**	**68.94 (9)**	**70.60 (8)**	**64.03 (4)**
Palliative care	**66.96 (7)**	**71.48 (6)**	**72.68 (5)**	49.00 (13)
Oral health	**66.54 (8)**	**65.24 (12)**	**72.00 (6)**	59.45 (8)
Refugee & immigrant health	**66.17 (9)**	**71.98 (4)**	**63.43 (9)**	**61.09 (6)**
Disability	**65.15 (10)**	**68.54 (10)**	**63.22 (10)**	**62.36 (5)**
Health prevention/promotion	**63.76 (11)**	**69.95 (8)**	**61.51 (12)**	56.91 (10)
ATSI health	**60.91 (12)**	**66.27 (11)**	**61.59 (11)**	51.59 (12)
Maternal health	59.82 (13)	**62.11 (13)**	**60.98 (13)**	52.26 (11)

There were 12 service gap means of 60 or more in the CQWBSC region, with the highest being mental health, community-based rehabilitation, and alcohol and other drug services.

The **Central Queensland HHS** had all 13 service means over 60 and the highest were the same as for the CQWBSC region overall**:** mental health, community-based rehabilitation, and alcohol and other drug services.

Similarly, the **Wide Bay HHS** also had all 13 service gap means above 60 and the highest of which were for mental health, community-based rehabilitation, and alcohol and other drug services.

In contrast, the **Sunshine Coast HHS** had only six means of 60 or more. The highest of these were for mental health, alcohol and other drug services, and community-based rehabilitation.

Comments about workforce and service gaps were thematically analysed. There were 61 comments received concerning workforce gaps. The main workforce gap themes were centred around AHP issues, mental health and psychology, GP shortages, and difficulties to attract, recruit and retain health professionals. The main workforce gap themes and issues are presented in ***Figure 3.***

Workforce and Service Gaps Qualitative Analysis

Workforce Gap Themes

Allied Health Practitioner issues (*n* = 21)
Workforce shortages; long wait lists; cost of services; increased workload

Mental Health and Psychology (*n* = 15)
High demand; workforce shortages; long wait lists; insufficient funding; cost of services

General Practitioner shortages (*n* = 12)
High workload; long wait lists; DPA issues; lack of locum relief; transient workforce

Attraction and retention of staff (*n* = 10)
Limited housing; transient and young workforce; isolation; inadequate incentives

Figure 3: Workforce Gap Themes for the CQWBSC region

There were 29 comments received for the primary care service gap comments. The main themes were around the general lack of local capacity and services and the need for allied health and mental health services:

Service Gap Issues

Lack of local primary care services (*n* = 14)
Reduced access; lack of facilities and health professionals; restricted scope of practice; lack of resources

Allied Health services lacking (*n* = 8)
Lack of services; aged care, dental, rehabilitation, social work, Aboriginal and Torres Strait Islander health, child/maternal health

Mental Health services lacking (*n* = 8)
High demand; lack of bulk billing services; insufficient access

Figure 4: Service Gap Themes for the CQWBSC region

Sustainability in Focus

This year our **'Issue in Focus'** was practice sustainability. Private practice for most health professions in rural and remote communities is currently only marginally financially viable. The HWNA survey included several questions to gauge the perceptions of practitioners and managers about issues that impact the sustainability and viability of their primary health care practices. Survey participants were provided a list of 15 factors (e.g., pay disparities, staff retention, place-based education) and were asked to respond to each factor along a 100-point scale from **'0 = Not at all Important'** to **'100 = Extremely Important'**.

These factors and their mean importance ratings for the CQWBSC region are presented in ***Table 4***.

Table 4: Mean Sustainability Importance Ratings for CQWBSC region and each HHS area

Sustainability Item	MM 2-7 QLD M (Rank)	CQWBSC region Total *M (Rank)*	Central Queensland HHS *M (Rank)*	Wide Bay HHS *M (Rank)*	Sunshine Coast HHS *M (Rank)*
Medicare/funding reform to better support remote and rural practitioners	**88.33 (1)**	**89.83 (1)**	**89.72 (1)**	**89.29 (1)**	**91.18 (1)**
Strategies to encourage remote and rural careers	**86.48 (2)**	**87.83 (2)**	**88.32 (2)**	**88.72 (2)**	**85.05 (3)**
Strategies to improve retention of staff (e.g., ongoing individual support)	**85.84 (3)**	**85.19 (3)**	**84.78 (4)**	**85.53 (3)**	**85.33 (2)**
Targeted infrastructure funding for remote/rural services	**83.26 (4)**	**84.97 (4)**	**87.78 (3)**	**83.53 (4)**	**82.50 (5)**
Better access to place-based education and training	**80.90 (6)**	**82.21 (5)**	**82.61 (7)**	**81.10 (8)**	**83.70 (4)**
Support for supervision	**80.42 (10)**	**81.56 (6)**	**82.96 (6)**	**81.82 (6)**	78.06 (11)
Information management systems that support continuity of care across public/private services	**81.18 (5)**	**81.42 (7)**	**82.50 (8)**	**80.82 (9)**	**80.52 (8)**
Targeted infrastructure funding for staff housing/accommodation	**80.61 (7)**	**81.17 (8)**	**82.46 (9)**	79.70 (12)	**81.71 (6)**
Increased support for family members	78.92 (12)	**80.29 (9)**	**81.08 (10)**	79.79 (11)	79.70 (9)
Addressing pay disparities between public and private services	**80.51 (8)**	**80.14 (10)**	**80.13 (11)**	**83.24 (5)**	73.10 (15)
Local cooperation for shared workforce models	**80.34 (11)**	**80.02 (11)**	78.11 (13)	**81.32 (7)**	**81.38 (7)**
Improved access to Continuing Professional Development (CPD) for remote/rural practitioners	**80.49 (9)**	79.25 (12)	**84.60 (5)**	76.10 (15)	74.82 (14)
Practice management support	78.21 (14)	79.14 (13)	77.72 (14)	**80.60 (10)**	78.74 (10)
Development of 'Rural Generalist' models across the health care sector to work across primary and secondary care	78.40 (13)	78.87 (14)	**80.09 (12)**	79.35 (14)	75.13 (13)
Improved telehealth and/or other technology to support community access.	77.81 (15)	76.75 (15)	73.59 (15)	79.45 (13)	77.51 (12)

Means in 'bold' are values of 80 or higher, indicative of the magnitude of their perceived importance on practice sustainability/viability.

Sustainability in Focus

Overall, in the CQWBSC region all importance rating means were higher than 76, indicating that there was a general agreement amongst survey participants that all of these factors were important to the sustainability and viability of their remote and rural practices.

There were 11 importance rating means higher than 80. Similar to MM 2-7 QLD overall, the highest means were for Medicare funding reform, followed by strategies to encourage rural careers and strategies to improve retention of staff. The CQWBSC region sustainability importance ratings were relatively consistent to the findings of overall MM 2-7 QLD. It is worthwhile to note that support for supervision ranked as the 6th most important factor in the CQWBSC region, whilst it only ranked 10th in MM 2-7 QLD.

Results were summarised by HHS area:

- The **Central Queensland HHS** had 12 importance rating means higher than 80. Similar to the CQWBSC region overall, the highest three ratings were for Medicare funding reform, strategies to encourage rural careers, and targeted infrastructure funding for remote/rural services. The **Central Queensland HHS** had the highest rating for improved access to CPD for remote/rural practitioners in the CQWBSC region.
- In the **Wide Bay HHS,** there were 10 importance rating means higher than 80. The three highest ratings were the same as for the CQWBSC region overall: Medicare funding reform, followed by strategies to encourage rural careers and strategies to improve retention of staff. At 81 points the **Wide Bay HHS** had the highest mean importance rating for practice management support in the CQWBSC region.
- In contrast, the **Sunshine Coast HHS** only had eight importance rating means higher than 80. However, similar to the CQWBSC region overall, the three highest means were for Medicare funding reform, strategies to improve retention of staff and strategies to encourage rural careers. At 83 points (ranked 4th) the **Sunshine Coast HHS** had the highest mean importance rating for place-based education and training in the CQWBSC region.

Sustainability Qualitative Analysis

Participants were asked to comment about the following:

1. What would improve the sustainability of your service? (*N* = 164)
2. What needs to change to ensure primary care services in your community are sustainable into the future? (*N* = 163)

Close examination of comments indicated that there were large areas of overlap of responses to both questions and, therefore, responses were combined in a single thematic analysis. The following main themes were identified.

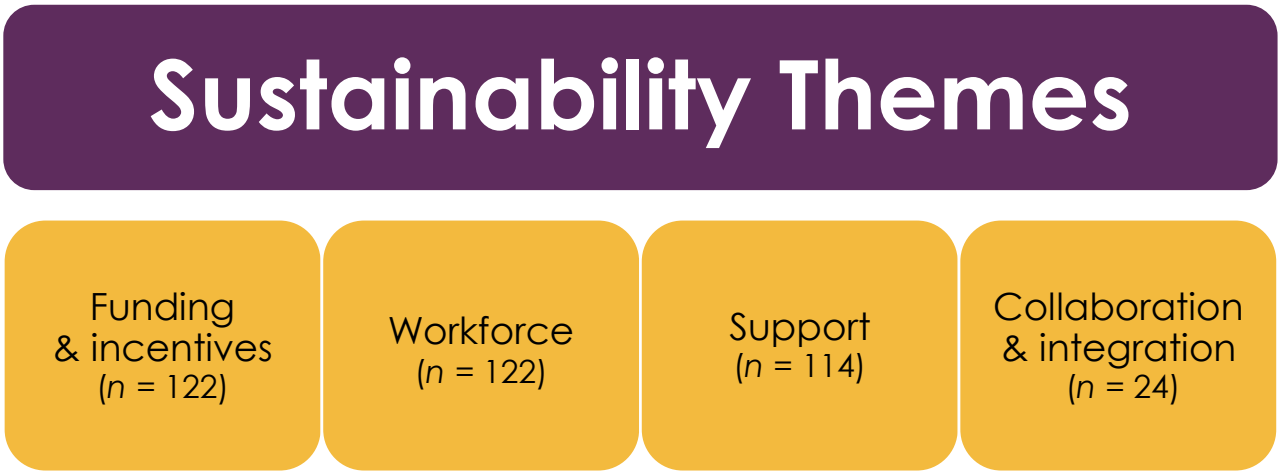


Figure 5: Sustainability Themes for the CQWBSC region

Theme 1: Funding and incentives

Many participant comments simply stated **increased or adequate funding** and knowledge of its existence would improve their situation. Others specifically requested **amendments to the current Medicare system** and referred to the current rates as unsustainable. For example,

> *"Medicare rates for allied health are completely unsustainable for OTs. I often do 1.5hrs of work for each Medicare client (once I do a proper assessment, intervention, and proper letter to GP) and get paid around $56 for that occasion of service (of which around $58 goes to paying my admin officer for that time). Basically, we lose money on those services, but do it out of love and care for our local community. Clients in this community on average have a lower-than-average income and have difficulty affording co-payments (plus GPs give the clients [the] impression that it's a "free" appointment). I can only stay afloat by doing NDIS and medicolegal clients. My wage is half what I use to earn in the public sector in a metro area. To make it sustainable, funding for community OT (including access to public services, which I am often functionally replacing with these Medicare referrals) should be equal to metro areas."*

A few requested for **recurrent grants to alleviate short-term funding issues** impacting continuity of service provision/staffing and as a way to support local businesses attract future employees to remain for the long-term. Incentives were also mentioned by several participants, mostly in terms of **increasing remuneration** but also through **increased access to locally available services** while living and working in remote and rural communities.

Some comments suggested a review of funding for community health programs to be aimed separately at **health promotion and chronic disease management**. Others invited for allocated funding to be managed by local providers to ensure long-term viability of community-based rural programs. Such as,

> *"Funding should be allocated by a local organiser or coordinator, someone that knows the local agencies, not a public servant at a desk in Brisbane who reads a well-written submission and thinks that that is the same thing as an organisation who can provide a service."*

Further, increased funding and access to **professional development activities** were frequently mentioned with a request for a wider range of educational activities to meet the needs of rural populations.

Theme 2: Workforce

Many participant responses mentioned the need for either **more staff or more GPs**, but there were also specific mentions of mental health needs and AHPs more generally. To attract workforce, the need for **investment into the future workforce** was highlighted through offered scholarships and funded trainee positions. Amendments to the **DPA process** was suggested by some to alleviate recruitment difficulties faced by rural communities. Encouraging **recruitment and retention** of the health workforce in primary care was emphasised and from another perspective on practitioner retention one participant stated,

> *"Practitioner retention. Invest in current students in the community and offer scholarships to attend [university] then return of service obligation to work back within the community."*

The importance of having **consistent workforce and services** to maintain continuity of care was acknowledged to ensure sustainability of primary care services in rural communities. For example,

> *"Being able to retain our registrars once they have gained their FRACGP. Currently they need to leave as we are only classified as RMA 2. This has a detrimental effect on our patients as they have a turnover every 12 months of their GP."*

A focus of some participants further addressed workforce shortages as a contributor to **increased workload and possible burnout**. Others mentioned the need for specialists, nurses and improved facilities at public health services in the region.

"We need our hospital getting extra help with staff doctors and nurses. We need mental health looked at and better services that are accessible to patients now not in 6 months. We need more doctors to provide health care so that the current GPs are not exhausted and over worked every day."

Others suggested **more staff and/or locum support** would enable existing staff to take time off for CPD or vacations. Additionally, a few comments suggested **broadening current scope of practice** for certain disciplines/programs tailored to rural communities they serve and was seen as a way to improve access to services, continuity of care as well as decrease workload.

Theme 3: Support

Under the theme of 'support', there were four main subthemes: **CPD and training; general support; IT and telehealth; and infrastructure**. Participant comments around the 'CPD and training' sub-theme focused on the provision of locally based education/training, as one participant highlighted,

"Training in the regional areas to give young doctors an insight to the practice. GP training to be encouraged at [university] and not seen as a last option, but a genuine specialty in itself."

Others emphasised the need for education surrounding the importance of **inter-disciplinary approaches** to client health and wellbeing as well as the provision of more health promotion and education opportunities aimed at **improving health literacy** in rural communities.

There were a variety of comments for the 'general support' sub-theme. Some of the comments included mental health support, support for AHPs staffing and training pathways as well as supervision/mentoring support. Several comments expressed the need to further **promote rural practice** and associated career benefits in addition to the lifestyle and social variety.

"Pay is a big thing. But also its marketed about the career benefits, but there is probably more about social benefits. My year in [MM 4 location] *has been exceptional socially and I've never had so many wonderful experiences jam-packed into such a short time."*

Comments on the 'IT and telehealth' sub-theme included mentions of improved online referral systems, improved access to practitioner portals, better connectivity, and **improved telehealth support**.

As for infrastructure, several comments were around improved resources, **accommodation** for staff and **transport** options. A few comments emphasised the need for growth of services in rural towns to incentivise practitioners and their families to remain rural. One such comment was,

"People like to work and live in places which provide enough lifestyle choices not just where they make money. Having enough services, like health, entertainment, and education, requires enough population to make those service survive financially otherwise they won't. Large cities attract people because they have all the services that people want."

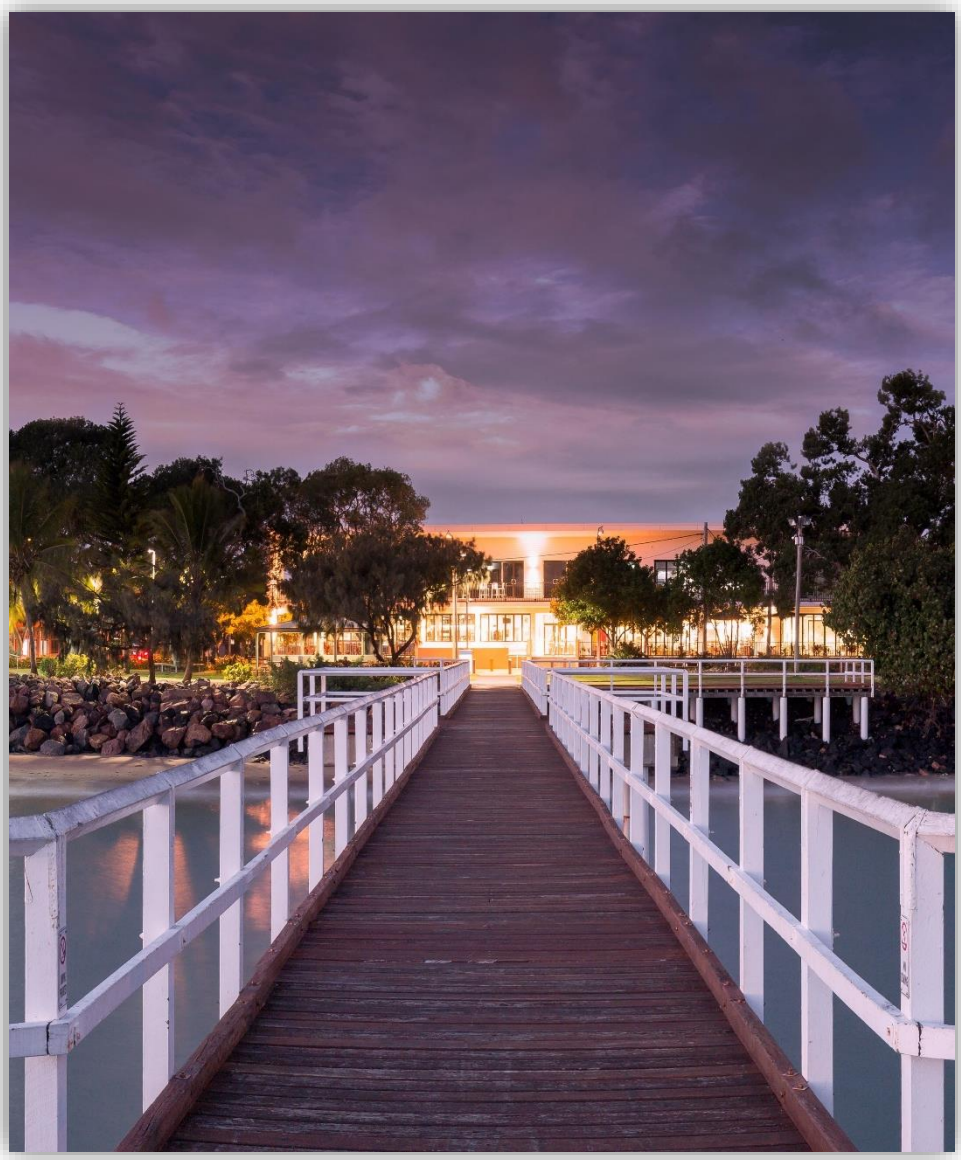
Other comments were directed at support required to **improve existing health facilities and infrastructure** through physical upgrades and expansions to meet the needs of the current community and into the future.

Theme 4: Collaboration and Integration

Collaboration and integration comments highlighted the importance to sustainability of services in smaller communities. A few participants addressed the need for collaboration across and between services. For example,

> *"Support from hospital and specialist care services would also be beneficial so that GPs aren't the only source of care for patients locally."*

Some highlighted the benefits of an **increased collaborative** approach in terms of **referral pathways** while others envisioned increased collaboration to improve **professional networking** and benefit community-based intervention programs.



Quantitative Methodology Findings: CQWBSC region

Below are the top ranked SA2s for the CQWBSC region by need based on the quantitative methodology in use by Health Workforce Queensland. This methodology incorporates; **GP FTE to population ratio, MM classification of remoteness, SEIFA (IRSAD), vulnerable population aged under 5 or over 65 years, and Aboriginal and Torres Strait Islander status**. Priority SA2s indicate areas of possible current and/or ongoing workforce need. ***Figure 6*** outlines the priority SA2s for the CQWBSC region and highlights the main towns or communities located within each priority area.

Further information about the methodology can be found in the state-wide HWNA available on the HWQ website.

Central Queensland, Wide Bay, Sunshine Coast Region: Statistical Area 2 (SA2) Ranked by Need

1. Kilkivan	Goomeri | Kilkivan
2. Maryborough Region (S)	Brooweena | Mungar | Tiaro
3. Mount Morgan	Mount Morgan
4. Agnes Water- Miriam Vale	Agnes Water | Miriam Vale Seventeen Seventy
5. Gympie Region	Amamoor | Curra | Goomborian Imbil | Kandanga
6. Cooloola	Cooloola | Rainbow Beach | Tin Can Bay
7. Gin Gin	Gin Gin
8. Gayndah- Mundubbera	Biggenden | Gayndah | Mundubbera
9. Central Highlands	Blackwater | Woorabinda
10. Monto - Eidsvold	Eidsvold | Monto | Mulgildie Mount Perry

Figure 6: CQWBSC Region: Statistical Area Level 2 (SA2) ranked by need

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