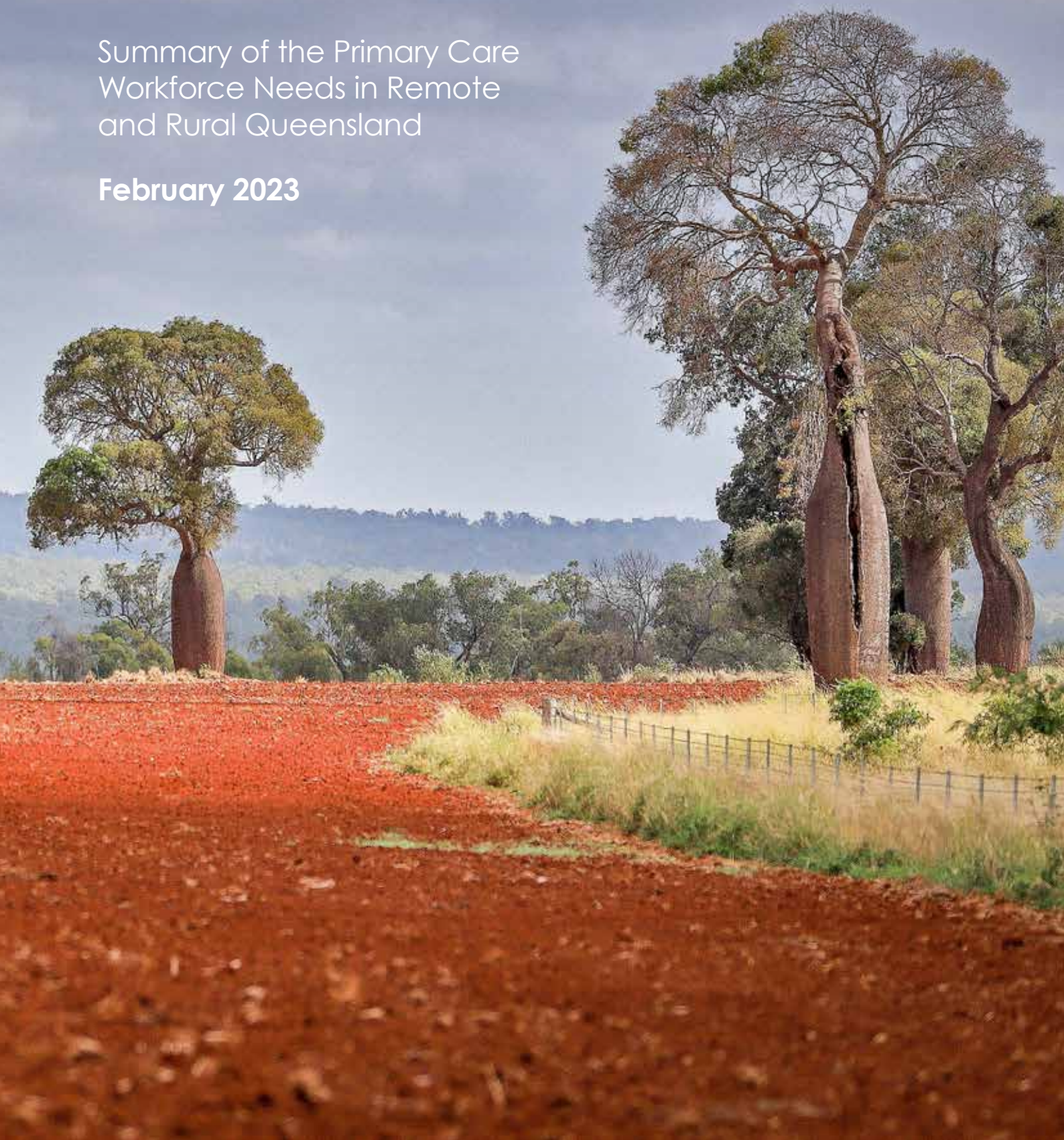
Health Workforce Queensland

Health Workforce Needs Assessment

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

February 2023



Foreword

The AHPRA Annual Report 2021/22 reports over 833,000 registered health practitioners in Australia.

This number represents an annual growth of almost four percent, with 97.4 percent of these registered practitioners holding some form of practicing registration. While this number is not inclusive of the total health workforce (due to some health disciplines not registering practitioners through AHPRA), the continued growth in absolute numbers of health practitioners should, on face value, mean that supply is adequate enough to meet demand.

The reality, however, tells a different story. Hospitals, general practices and other health services are facing unparalleled challenges with regards to attracting and retaining health workforce. Rural general practice has been likened to the canary in the coalmine with an unprecedented number of general practices closing their doors in 2022, further exacerbating stress on nearby practices, some of which have been reporting a four to six week wait for routine appointments.

The need for reform and collaborative solutions at the federal, state and local levels is vital, with almost 50 percent of general practitioners (GPs) indicating that it is financially unsustainable for them to continue practicing.[1] The Federal Government has convened a 'Strengthening Medicare Taskforce' chaired by the Federal Health Minister Mark Butler to advise on how to spend $250 million a year to fix the foundation of the health system, but more needs to be done. A number of states have joined forces to demand urgent reforms to Medicare at the first National Cabinet meeting of 2023, insisting an overhaul of the healthcare system is the 'most urgent challenge facing the country'.

The Grattan Institute Report, **A new Medicare – Strengthening general practice (2022)** speaks to the need for a new Medicare, with three big changes. Firstly, general practice needs to become a 'team sport', inviting more clinicians, such as nurses, pharmacists, physiotherapists and other allied health workers to be employed under the leadership of a GP, particularly in communities with the biggest gaps in care. The second change talks to reform in the way general practice is funded, with a shift to support team care and enable GPs to spend more time on complex cases and finally, the request for a clear vision about where general practice is heading, with support and accountability from government.

A genuine investment in primary care is needed, as it is irrefutable that well-resourced primary care makes for a more efficient and sustainable health system with better health outcomes for communities. Regarding efficiency, the Royal Australian College of General Practitioners (RACGP) notes that GPs provide more than twice the number of episodes of care a year than hospitals, for one-sixth of the expenditure. For primary care sustainability, carrot, not stick strategies and incentives are needed to attract and retain the future workforce to remote and rural communities. Considerations such as geographically limiting provider numbers and mandatory remote or rural service do not achieve the outcomes we need for the future workforce. Selecting rural origin students and those who do immersion programs, clinical placements and internships in non-metro areas are evidence-based strategies that grow the rural health workforce.

Training pathways and infrastructure that support end to end training in rural and regional centres for all professions are key enablers, and First Nations representation and leadership in all training and health settings is essential.

While the Federal government has a key role to play in maximising the efficiency and effectiveness of the health system and supporting the health workforce, local accountability and leadership is also required. Authentic joint place-based planning and a commitment to put funds where they are needed to meet community need is the place to begin. Adoption of innovation for sustainability, including multidisciplinary and virtual models of care across both the public and private settings, particularly in small communities is essential. Poor organisational culture, including inept management practices, need to be exposed and addressed. Health practitioners need to be incentivised and supported for the periods of time they are willing to give in difficult recruitment locations. Adequate remuneration with generous leave entitlements, comprehensive orientation and decision support, provision of access to upskilling and skill maintenance, a culturally responsive workplace and quality housing are key enablers of retention.

There are skilled and passionate health practitioners in remote and rural Queensland who love the richness of the work that they do, and they continue to dig deep to find solutions to their challenging circumstances, but burnout is growing. The call for system reform has never been louder and it is needed to ensure we do not lose any more workforce in the communities that need it most.

[1] *The Navigators, RACGP. (2022). General Practice Health of the Nation 2022.*

Executive Summary

Health Workforce Queensland undertakes an annual primary care Health Workforce Needs Assessment (HWNA) for remote, rural and regional areas of Queensland.

The 2023 report provides an update of current and emerging issues generally and by profession, as well as identifying primary care workforce and service gaps. The report also highlights priority areas by Primary Health Network (PHN) region, based on a quantitative methodology described on page seven.

Primary care workforce and service gaps have continued to increase over the past five years. The highest workforce gap rating means this year were for the psychology, GP, social work, and speech pathology workforces. Interestingly, the most notable workforce gap increase observed over the last year was for the nursing and midwifery workforce which appeared in the top five workforce gaps for the first time.

This year's highest service gap rating means were for mental health, community-based rehabilitation, alcohol and other drug services, aged care and social support services. The most significant increases observed over the last year were for maternal health services, as well as aged care and oral health services.

GP workforce shortages are at crisis levels. Medicare funding reform, the expansion of our First Nations workforce, strategies to encourage remote and rural careers, and strategies to improve retention of staff are all key factors highlighted throughout the document.

Staff retention in primary care remains a challenge for the allied health, nursing and midwifery workforces with pay disparities between private and public settings, and aged care and NDIS services drawing from the same shallow pool of workforce in smaller communities.

This year's *Issue in Focus* examines workforce turnover from two perspectives. Firstly, through a quantitative analysis of GPs to provide data about length of stay, and secondly, through a survey investigating practitioner and manager perceptions of why health staff left practices in remote and rural Queensland in the previous year. Findings show almost half of the GPs in Modified Monash (MM) 2-7 had been employed at their current practice for less than three years, suggesting considerable turnover. Furthermore, 46 percent of these GPs had been at their current employment for less than a year. Survey results indicate individual factors such as heavy workload/burnout, work/life balance, career progression, mental health and wellbeing, and inadequate remuneration were key factors in departures. Workplace factors included workplace culture, community and lifestyle, remuneration and cost of services, and again, workload and burnout.

The findings in this report represent a snapshot. Further qualification and validation of the health workforce need in remote and rural Queensland are discovered through ongoing communication and collaboration with key stakeholders at the state and local level.

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

Integrity

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

Commitment

We enhance health services in remote and rural 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 and Aged Care.

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.

Front Cover Photo

The front cover photo was taken of Bottle Trees by Sandie Read on Durong Road in the North Burnett Region of Mundubbera, Queensland.

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Introduction

Health Workforce Queensland undertakes an annual primary care HWNA for remote and rural areas of Queensland classified as Modified Monash (MM) 2-7 (2019).

This report summarises the findings from the 2023 HWNA and builds upon the baseline understanding of workforce needs established in previous HWNA reports.

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

The HWNA also contributes to the evidence base for the development and implementation of Health Workforce Queensland's Activity Work Plan (AWP) and assists in addressing priorities related to localised health workforce needs and service gaps.

As part of the process, the jurisdictional Health Workforce Stakeholder Group (HWSG) provides strategic advice and expertise to inform planning, analyses, and strategy development as well as provide validation of findings. The HWNA aims to identify workforce issues and develop collaborative strategies to address these issues under the priority areas of:

Access – Improving access and continuity of access to essential primary health care.

Quality – Building health workforce capability.

Sustainability – Growing the sustainability of the health workforce.

Methodology

The HWNA methodology is largely consistent with previous reports and comprised four main components:

Desktop Audit: Collection and review of key sector reports, reviews and policy documents released throughout 2022.

Online Survey: Online surveys targeting GPs, practice managers, primary health care nurses, midwives, allied health professionals (AHPs), and Aboriginal and Torres Strait Islander Health Workers/Practitioners. Survey items gauged participants' beliefs about workforce and primary care service gaps in their community(s) of practice. The surveys were open between October 2022, and February 2023.

Stakeholder Engagement: Information was sourced from consultations with key stakeholders, communities, and health professionals throughout 2022. The jurisdictional HWSG also provided input at the 2022 annual meeting.

Quantitative Methodology – Data was used to prioritise need at SA2 level locations based on:

- GP full time equivalent (FTE) to estimated resident population ratio (ABS 2021)
- MM classification of remoteness (2019)
- Index of Relative Socio-economic Advantage and Disadvantage (IRSAD) (2019)
- Vulnerable population aged < 5 and > 65 years (ABS 2021)
- Aboriginal and Torres Strait Islander status (ABS 2021)

Higher SA2 ratios indicate regions with possible greater workforce need. While SA2 mapping of GP FTE ratio alone cannot produce a complete picture of workforce need, the other four components of data have been accessed to gain the most accurate picture possible of the potential workforce need.

Allied Health Workforce Summary

As the largest clinical workforce in primary care, allied health professionals continue to play a vital role in the prevention, management and treatment of chronic disease and the subsequent reduction in preventable hospital admissions. Despite making up 20 percent of Australia's population, Queensland is reported to have only 16 percent of the allied health workforce.[2]

To understand workforce gaps and shortages, it is vital to have clear visibility of the allied health workforce. The lack of a single, consistent, integrated dataset for allied health workforce incorporating both registered and self-regulated professions[3] remains a limiting factor in workforce planning. A call has been made for the development of a National Allied Health Data Strategy[4] and a National Allied Health Workforce Minimum Dataset.[2,3]

Required to support this is:

- A comprehensive list of all allied health professionals through the development of a national register;
- The introduction of a nationally consistent allied health survey to inform the development of a national allied health workforce dataset; and
- A national repository to store, manage and analyse allied health workforce data.[2]

This year's HWNA findings show that the allied health disciplines of psychology, social work, and speech pathology remain in the top five highest primary health care workforce gaps. Retention remains a challenge with the allied health workforce reporting a range of individual and organisational factors contributing to staff departures from their service and/or community within the past 12 months. Remoteness and distance between services, insufficient collaboration and the cost associated with accessing and/or the inability to access professional development due to workload were cited as the main reasons for staff departures. At an organisational level, workplace culture, community and lifestyle, and remuneration ranked the highest.

Allied health professionals continue to work across multiple sectors, supported by a range of complex funding streams. Following the recent **Royal Commission into Aged Care Quality and Safety** and the Queensland Parliamentary Committee **Inquiry into the provision of primary, allied, health and private healthcare, aged care and NDIS care services and its impact on the Queensland public health system**, glaring problems in the aged and care sectors have come to the forefront. Despite strong evidence supporting the benefits of various allied health interventions for older populations,[5,6] access to allied health services is limited across aged care, with services provided by a temporary workforce with attrition rates as high as 25 – 26 percent.[7] Compounding this is the projected requirement for an additional 80,000 aged care workers by 2030, with allied health making up a significant portion.[4]

Similar trends are noted in the disability sector with attrition rates of 17 – 25 percent reported in the NDIS workforce between 2015 – 2018. Such attrition rates make it difficult to comprehend how the expected need of a 40 percent increase in allied health professionals for this workforce by 2024 can be met.[8]

In terms of maximising the current workforce, the use of allied health assistants (AHA) is one strategy identified as supporting the timely delivery of allied health services and enabling allied health professionals the capacity to work to their full scope of practice.[9]

With the ability to perform both clinical and non-clinical tasks, the effective use of suitably qualified and appropriately supervised AHAs can reduce demand on the allied health professional workforce, as well as improve access and continuity of service for patients.[8,9] Whilst there is a clear pathway, defined framework, and funding for AHAs in the public health system[8], funding and system reform is required to better support the adoption and use of AHAs in primary care, including the disability and aged care sectors.

The launching of leadership programs by Services for Australian Remote and rural Allied Health (SARRAH) (in partnership with the Australian Rural Leadership Foundation) and Indigenous Allied Health Australia (IAHA) are valuable development opportunities for AHPs in the primary care setting and will support their roles as managers and supervisors.

Another program by SARRAH, Building the Remote and rural Allied Health Assistant Workforce (BRAHAW), is designed to assist remote and rural allied health organisations to build their AHA workforce and provide models of service delivery to enhance practice reach and promote viability.

A **Grattan Institute paper** highlights the value of team care and the important contributions AHPs provide to patient care, particularly for patients with chronic disease. International evidence shows that AHPs are able to effectively take on roles within general practice, working within their own domains of expertise such as mental health and addiction support services.

In addition, they can contribute more broadly to health promotion, prevention, and chronic disease care, however, current funding and regulations prevent this in Australia.

In a small step towards effective system collaboration, Queensland Pharmacists became eligible to access Queensland Health's Health Provider Portal, enabling them to access comprehensive information from their patient's Queensland Health records, with this timely access assisting with enhanced clinical decision making.[10]

In another collaborative endeavour, a **National PHN Allied Health in Primary Care Engagement Framework** was developed, outlining opportunities for PHNs to support the allied health sector, including through workforce planning and development and the optimisation of, and commissioning for effective use of the current workforce.

Several initiatives focused on the training and development of the current allied health workforce are also underway including:

- Incorporation of Exercise Physiology into the Queensland Allied Health Rural Generalist Pathway
- The formation of the new Allied Health Rural Generalist Accreditation Council in December 2022, who will accredit programs in rural generalist practice for allied health[11]
- The launch of a new Master of Rural Health Practice in 2023 by James Cook University (JCU).[12]

Allied Health Profession Priorities – Insights from the HWSG

In September 2022, the Health Workforce Stakeholder Group for Queensland met and were invited to contribute to a 'pitch' to key policy makers about what was needed most for their professions in 2023.

Contemporary health care is team-based care. Allied health should be considered critical workforce in this model. Three key areas that need to be addressed include:

1. The paucity of allied health data impacts effective workforce planning. Commitment to the same level of investment in the collection, analysis and reporting of pipeline and workforce data at a national level for allied health as other professions is urgently required.
2. Support for allied health training pathways including teaching incentive payments to support private practice similar to those in general practice, and recognition within commissioning models of the resourcing required to develop the workforce pipeline (supervision and early career).
3. GPs are not the only small businesses in rural communities. Allied health are also small businesses and need the same practice incentives and supports to ensure practice viability, including the ability to attract workforce. For example, HELP debt reduction.

2 Parliament Health and Environment Committee. (2022). *Inquiry into the provision of primary, allied and private health care, aged care and NDIS care services and its impact on the Queensland public health system*. https://documents.parliament.qld.gov.au/tableoffice/tabledpapers/2022/5722T506-DEA6.pdf

3 Australian Government. Department of Health. (2022). *Allied health workforce data gap analysis: Issues Paper*. https://www.health.gov.au/sites/default/files/documents/2022/08/allied-health-workforce-data-gap-analysis-issues-paper_0.pdf

4 Australian Government. National Rural Health Commissioner. (2020). *Report for the Minister for Regional Health, Regional Communications and Local Government on the Improvement of Access, Quality and Distribution of Allied Health Services in Regional, Remote and rural Australia*. https://www.health.gov.au/sites/default/files/documents/2021/04/final-report-improvement-of-access-quality-and-distribution-of-allied-health-services-in-regional-rural-and-remote-australia.pdf

5 Commonwealth of Australia. (2021). *Royal Commission into Aged Care Quality and Safety. Final Report: Care, Dignity and Respect, Volume 1, Summary and recommendations*. https://agedcare.royalcommission.gov.au/sites/default/files/2021-03/final-report-volume-1_0.pdf

6 Allied Health Professions Australia. (2022). *Proposed Allied Health Aged Care Solutions for Jobs Summit*. https://ahpa.com.au/wp-content/uploads/2022/08/AHPA-Proposed-Allied-Health-Aged-Care-Solutions-for-Jobs-Summit-300822.pdf

7 Australian Government. Department of Health. (2021). *2020 Aged Care Workforce Census Report*. https://www.health.gov.au/sites/default/files/documents/2021/10/2020-aged-care-workforce-census.pdf

8 Australian Government. Department of Social Services. (2021). *NDIS National Workforce Plan: 2021-2025. Building a responsive and capable workforce that supports NDIS participants to meet their needs and achieve their goals*. https://www.dss.gov.au/sites/default/files/documents/06_2021/ndis-national-workforce-plan-2021-2025.pdf

9 Queensland Health. (2022). *Allied Health Assistant Framework*. https://www.health.qld.gov.au/__data/assets/pdf_file/0017/147500/AHAFramework.pdf

10 Queensland Health. (2022). *Health Practitioners resources: Training and support resources*. https://www.health.qld.gov.au/clinical-practice/database-tools/health-provider-portal/gps-resources/support

11 Services for Australian Remote and rural Allied Health. (2022). *Allied Health Rural Generalist Accreditation Council*. https://sarrah.org.au/our-work/ahrgpathway/n-s-g/allied-health-rural-generalist-accreditation-council

12 James Cook University. (2022). *Master of Rural Generalist Practice*. https://www.jcu.edu.au/courses/master-of-rural-generalist-practice

First Nations Health Workforce Summary

First Nations people are consistently under-represented in our health workforce. Health Workforce Survey data indicates that nationally, Aboriginal and/or Torres Strait Islander peoples' participation in the regulated health professions was 1.2 percent, well short of the 3.2 percent Aboriginal and Torres Strait Islander representation in the general population.

The publication of the **National Aboriginal and Torres Strait Islander Health Workforce Strategic Framework and Implementation Plan 2021–2031**, in March last year, signals a renewed focus on the building of Australia's First Nations health workforce. The plan was further supported by the Australian government in the October 2022-2023 federal budget through a commitment of $314.5 million to expand Aboriginal Community Controlled Health Services (ACCHS) and strengthen the First Nations health workforce.

In Queensland, the establishment of partnerships to co-design an Aboriginal and Torres Strait Islander health workforce plan, as outlined in Strategic Initiative 2.1 of the national plan, has commenced. Support for First Nations workforce growth across clinical and non-clinical roles has also been strengthened this year with 14 out of 16 Hospital and Health Services (HHS) publishing their Health Equity Strategies in accordance with *Health Legislation Amendment Act 2020*.

Table 1 below presents the number of AHPRA registered health professionals who identified as being of Aboriginal and Torres Strait Islander origin in the 2019 and 2020 National Health Workforce survey. Data from the 2021 survey was not available at the time of writing this report.

Table 1: 2019 and 2020 Aboriginal and Torres Strait Islander AHPRA registered health professionals in MM 2-7 Queensland

Registered Health Profession	2019	2020
Aboriginal and Torres Strait Islander Health Worker/Practitioner	91	**114**
Paramedic	51	**59**
Practice Nurse	42	**44**
General Practitioner	19	**19**
Psychologist	27	**25**
Physiotherapist	20	**20**
Dental Practitioner	15	**13**
Midwife	10	**9**
Occupational Therapist	12	**20**
Pharmacist	8	**7**
Medical Radiation Practitioner	6	**9**
Chiropractor	5	**6**
Optometrist	0	*
Podiatrist	*	*
Total	***306***	***345***

Number suppressed because less than 4.* **Note: *Data provided by Queensland Health.*

AHPRA highlights in their **Annual Report** that increasing participation in the registered health workforce is a goal of their Aboriginal and Torres Strait Islander Health and Cultural Safety Strategy. Seven identified positions have been created within AHPRA in areas of Registration, Research and Evaluation, Statutory Appointments, and the Health Strategy Unit to support this.

In education and training, the Grow Your Own Workforce Seed Funding pilot program commenced in the Western Queensland and Northern Queensland regions. The program is designed to build the capacity of the health workforce in remote, rural and regional areas by supporting place-based education to employment initiatives. Funded by CheckUP, the program aims to strengthen First Nations health workforces and reduce local disparities in education and employment. Depending on the success of the pilots, the program will be expanded to other regions of Queensland in the future.

Also of note is the commencement of the Indigenous Allied Health Association (IAHA) leadership program in March 2022. Recognising the importance of Aboriginal and Torres Strait Islander leadership in driving transformational change, IAHA hosted 65 participants from across 20 allied health disciplines in their inaugural leadership program. Expressions of interest for the IAHA 2023 leadership program opened in late 2022.

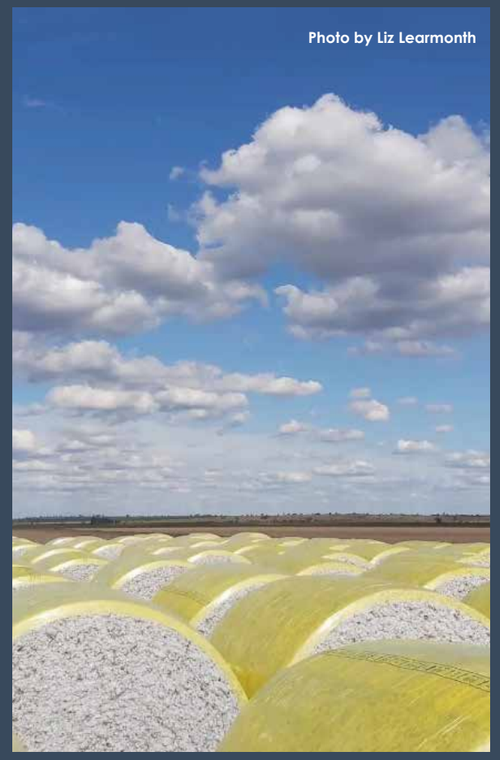


Photo by Liz Learmonth

First Nations Health Workforce Priorities – Insights from the HWSG

In September 2022, the Health Workforce Stakeholder Group for Queensland met and were invited to contribute to a 'pitch' to key policy makers about what was most needed for their professions in 2023.

- First Nations health workforce cannot be tackled in isolation. There needs to be a focus on appropriate place-based workforce planning to identify community needs and how organisations can work together to address this need at a national, state and local level.
- With the implementation of the Making Tracks Health Equity Framework and health reforms, measures are to be reported back to parliament, yet we are again not on track. If government wants to meet its obligations there needs to be system change, with authority given back to where the biggest impact will be made with the community on the ground. Get people at the centre of health care.
- There is a need for a coordinated approach across portfolios such as housing, justice, child safety and Indigenous affairs, with funds pooled as appropriate. Health equity is one thing, but it is needed across other government departments.

General Practitioner Workforce Summary

This year the crisis in general practice and its workforce expanded from mainly remote and rural settings to also include metropolitan areas. In October 2022, RACGP hosted the General Practice Crisis Summit in Canberra to discuss solutions to the critical challenges impacting patient access to affordable, quality care from a financially viable general practice sector.

The discussions were centred around the key topics of funding and fragmentation, GP workforce and GP data, which resulted in the publication of the ***General Practice Crisis Summit White Paper.***

The crisis summit recommendations were supported by the publication of the Grattan Institute report titled ***A new Medicare – Strengthening general practice*** and the Australian Medical Students Association (AMSA) Roundtable report on ***Medical Student Interest in General Practice – Reversing the Trend.*** The AMSA report found there was a need to increase funding and support for primary care to enable better teaching opportunities; improve the quality and quantity of general practice placements and teaching; move away from hospital-centric teaching in medical school curriculum and develop placements geared towards generalism and general practice-based teaching; and improve perception of general practice as a career through increasing incentives and addressing stigma.

GP workforce maldistribution continues, impacting remote and rural communities across Queensland. Following significant pressure from various groups, a review of the exceptional circumstances for District Priority Areas (DPAs) policy was completed in late 2021, resulting in the expansion of DPA eligibility from MM 4-7 to MM 2-7. An additional 323 general practices in Queensland have received DPA classification allowing them access to additional workforce support programs and employ overseas trained medical practitioners. While this change has been welcomed by practices in regional and outer metropolitan areas, anecdotal reports suggest the change has resulted in a drain of doctors away from the more remote MM 4-7 localities.

The government also announced changes to the skilled migration cap in 2022. The number of visas offered across all skill categories was increased by more than 20 per cent, from 160,000 to 195,000 places. This may see more overseas trained doctors in remote and rural areas, contributing to boosting supply in areas with fewer GPs.

Rural training pathway registrar numbers in northern Queensland have fallen again for 2023 with James Cook University General Practice Training (JCUGP) reporting both Australian College of Remote and rural Medicine (ACCRM) and RACGP filled places dropping to 61 percent of allocation (down from 80 percent in 2022) and 62 percent of allocation (down from 95 percent in 2022) respectively. The general pathway is slightly oversubscribed at 103 percent. In contrast, in southern Queensland, General Practice Training Queensland (GPTQ) reports the 2023 ACRRM pathway is oversubscribed at 158 percent of allocated places and the RACGP rural pathway is at 95 percent of allocation.

The transition to a nationally consistent College-led GP training model will be complete by 1 February 2023, and training responsibilities will be handed to the Colleges. It is hoped that this will instil more stability and clarity of the GP training pathway for future registrars.

In consideration of the widely publicised perception of the decline in medical students preferencing general practice, a deep dive was taken into the Medical Deans dataset to investigate medical graduate preferences compared with specialty registration achieved. There is around a 10-year lag from completion of basic medical education to attainment of specialty registration. Drawn from the Medical Deans Australia and New Zealand's Data Dashboard (Graduates' Locations & Specialties [Linked Data][13]), data in Table 2 shows medical graduates between 2008 and 2012 who indicated a preference for general practice accounted for between 10.3 percent and 13.1 percent of the cohort. However, the percentage of graduates who then went on to achieve a specialisation in general practice by 2020 was considerably higher, varying from between almost seven percent higher for the 2008 cohort and 12.9 percent for the 2010 cohort. This was not the case with other specialities such as physicians. It should be noted that the number of graduates that had not achieved any form of fellowship by 2020 was quite high, ranging between 24 percent for the 2008 cohort up to 59 percent for the 2012 cohort. Overall, however, these results may reflect positively for general practice in that many more graduates tend to specialise in general practice than indicate an initial graduation preference.

13 Medical Deans Australia and New Zealand. (2022). *Data Dashboard: Graduates' Locations & Specialties (Linked Data)*. Retrieved January 5, 2022, from https://app.powerbi.com/view?r=eyJrIjoiMzEyNjRmYjAtOGFlMS00MWQzLWI0Y2UtYmViMTgyOTM4NDQ3IiwidCI6IjIyY2Y4YjAxLWJhZTQtNDQ2ZC1hZWNhLTdkYTljMDFiZDBmOSJ9&pageName=ReportSection5e5459dc898591506e79

Table 2: Preferred and Actual Specialties of 2008-2012 Graduate Cohorts

Discipline	Preferred and Actual Specialties	Graduation Year				
		2008	2009	2010	2011	2012
General Practice	Preferred	10.3%	12.1%	11.0%	11.0%	13.1%
	Actual in 2020	17.1%	24.7%	23.9%	23.2%	23.2%
Adult Medicine, Internal Medicine; Physician	Preferred	19.4%	16.4%	14.5%	16.8%	15.8%
	Actual in 2020	13.4%	13.3%	14.3%	12.3%	7.5%
No Specialty achieved as of 2020		*24.4%*	*27.4%*	*34.5%*	*44.1%*	*59.2%*

Recognition of Rural Generalist Medicine as a specialised field of general practice has continued to progress this year with ACRRM and RACGP submitting a stage two application to the Australian Medical Council (AMC). The AMC assessment team will review and use the application as a basis for public consultation. It is anticipated the AMC consultation and assessment will be a 12-month process. Once complete, the AMC will deliver a final report to the Medical Board of Australia, which in turn will make recommendations to the Council of Australian Governments to amend the medical registration laws to recognise Rural Generalist Medicine as a specialised field. It is hoped these measures, alongside other proposed solutions such as radical Medicare reform will increase the attraction of a career in remote and rural general practice.

General Practitioner Profession Priorities – Insights from the HWSG

In September 2022, the Health Workforce Stakeholder Group for Queensland met and were invited to contribute to a 'pitch' to key policy makers about what was needed most for their professions in 2023.

- AHPRA through the Pre-Employment Structured Clinical Interview (PESCI) is currently restricting solutions to the GP workforce crisis.
- The PESCI needs to be changed from a barrier to enabler.
- Implement a system that encourages all qualified GPs into employment.
- Getting international medical graduates (IMGs) up to speed in a structured program / process to lead toward Fellowship more quickly will allow those that are in remote and rural locations to enter or re-enter the GP workforce.
- Must be underpinned by quality and safety.

Nursing and Midwifery Workforce Summary

Nurses and midwives are the frontline support for healthy and resilient remote and rural Queensland communities. Embedded within communities, nurses and midwives promote public health and disease prevention and empower individuals and families to improve their health outcomes.

Much of what nurses and midwives do is necessarily small-scale and invisible to the wider world and their collective impact, capability and potential needs to be much better understood.

With regards to workforce shortages among remote and rural primary care nurses as well as midwives, this year's HWNA findings reflect a steady increase of the mean workforce gap rating from 39.02 in 2018, to 73.16 in 2023. The 2021 Australian Primary Care Nurses Association (APNA) Workforce survey reports a continuing underutilisation of the primary care nursing workforce's scope of practice, in a time of worsening GP workforce shortages.[14] Other drivers contributing to the widening workforce gap include burnout, pay disparities between primary care and the hospital system, management ability, and emotional exhaustion[15]. Structural drivers of shortages in remote and rural Queensland include a lack of available housing, lack of access to professional development, insufficient access to childcare, and lack of access to casual and locum workforces[16].

On top of these pressures, in October 2022, legislation was passed requiring residential aged care services to have 24/7 access to a registered nurse. Furthermore, there was a commitment to increase the average minimum care minutes requirement in these facilities to an average of 215 minutes, including 44 minutes of RN time, in line with Recommendation 86 of the Royal Commission into Aged Care Quality and Safety. These factors will be certain to have a push-pull effect on the primary health care nursing workforce employed in a variety of settings in the remote and rural space and will require close monitoring to assess the potential drain of nursing workforce from the acute and primary health care sectors.

14 Australian Primary Health Care Nurses Association (2022). APNA Workforce Survey 2021

15 Smith, S., Lapkin, S., Halcomb, E., & Sim, J. (2022). *Job satisfaction among small rural hospital nurses: A cross-sectional study. J Nurs Scholarsh.* https://doi.org/10.1111/jnu.12800

16 Waugh, G. (2022a). HWSG - G Waugh Notes. [Personal Communication].

17 International Confederation of Midwives. (2017). International Definition of the Midwife. https://www.internationalmidwives.org/assets/files/definitions-files/2018/06/eng-definition_of_the_midwife-2017.pdf

To meet further need due to widespread GP workforce shortages, funding to expand nurses and midwives' roles, including nurse-led and midwife-led models in primary care, will improve continuity of care, job satisfaction and reduce patient wait times and practitioner burnout. For example, although visibility is low, private midwifery services in remote and rural Queensland are expanding. In 2020, according to the NHWDS, there were 6,237 midwives in Queensland, the largest components consisting of Registered Nurses and Midwives (RN/MWs; *n* = 4,908) and Registered Midwives only (MWs; *n* = 1,298). A little over one-third of the midwifery workforce (*n* = 2,282) were employed in QLD MM 2-7. The majority of the remote and rural midwifery workforce were RN/MWs (*n* = 2,000) with 272 MWs only. Since 2019, the remote and rural midwifery workforce increased by nearly 14 percent. The midwifery workforce employed in a private setting in QLD MM 2-7 decreased from 17 percent in 2019 to approximately 16 percent in 2020.

Midwives are well educated, highly skilled and competent clinicians and work within a defined scope of practice[17] and across a broad range of clinical practice settings. Endorsed Midwives meet an additional registration standard to that which is met by a Midwife. This enables an Endorsed Midwife to undertake private midwifery services for their communities in collaboration with a GP, obstetrician or hospital service. They can provide Medicare-funded care and order diagnostic tests and ultrasounds as well as prescribe and administer medications relating to pregnancy, birth and the newborn period. Endorsed Midwives can gain visiting/admitting rights to hospitals and their clients can be admitted to hospital as a private patient, in the same way that women can be admitted under the care of a private obstetrician.

As well as providing hospital birth services, Endorsed Midwives may also attend women for homebirths or provide stand-alone antenatal and postnatal care. These models of care, including virtual options, open up further choices for women, particularly in communities with limited service availability. Nurse Practitioners (NPs) have also improved primary health care access for marginalised and geographically isolated populations. Currently access to NP services are limited by MBS restrictions on requests and referrals, such as diagnostic imaging investigations, despite this being a part of their scope of practice. These restrictions are a barrier to the provision of timely, effective, accessible services as a private practitioner[18]. Extending the services NPs can provide reduces fragmentation of care by facilitating comprehensive assessment, evaluation, and treatment, often without requiring people to leave their communities.

Evidence suggests that NPs, nurses and midwives utilising their full scopes of practice not only provide high quality health care but also increases the accessibility, availability and choice of care provider, avoids duplication and fragmentation of care, reduces costs, and prevents delays to diagnosis and treatment.

In relation to the future workforce, programs aimed at increasing demand for nursing and midwifery student places need to be accompanied by investment in training pathways, particularly in primary care and remote and rural settings. Recent efforts to develop primary care and remote and rural training pathways include Queensland Health's development of a remote and rural generalist nurse career pathway (RRGRN) for RNs; involving the provision of lateral entry points for the current workforce to incentivise and lead to a formal recognition process for remote and rural registered nurses. Coinciding with the development of the National Remote and Rural Generalist Nurse Framework public consultation, the Queensland RRGRN project commenced in November 2021 with a wide range of stakeholder engagement activities to establish a shared vision. The project has developed a profile and description of the RRGRN and an outline of a specific program for the 2022 cohort, for which recruitment of nurses to trial the program commenced in July 2022[19].

The future workforce challenges faced by an ageing primary care practice nurse workforce are being tackled by APNA with the Student Nurse Placement Program (SNPP) and the Transition to Private Practice (TPP) program. The SNPP program facilitates student nurse placements in primary care settings, allowing students to contribute to their community while also accruing clinical placement time, under the supervision of experienced primary care nurses. Almost 70 percent of participants reported they would consider primary care as a career option upon completion of the program, and 38.5 percent of participants received employment offers [20,21]. The TPP program transitions nurses from the hospital system into primary care practice and includes supervision, mentoring and education support. The success of the program is evidenced through participants reporting increases of 88 percent in their knowledge, skills and confidence and 87 percent reporting an intention to remain working in primary care[22].

18 Australian Nursing and Midwifery Federation, (2022). *Australian Nursing and Midwifery Federation Submission to: Australian Government Department of Health Nurse Practitioner 10 Year Plan Consultation.* https://www.anmf.org.au/media/njli5lro/anmf_submission_to_nurse_practitioner_10_year_plan_20december2021.pdf

19 Nowlan, S.,Turvey, J.,Hammonds, A., Schumacher, U., (2022) *Establishing a state-wide remote and rural generalist nurse career pathway for registered nurses,* CRANAplus conference

20 Australian Primary Health Care Nurses Association, (2022). *APNA's Student Nurse Placement Program (SNPP). [Presentation].*

21 Australian Primary Health Care Nurses Association, (2022). *Next Generation of nurses impressed with primary health care.* Next-generation of nurses impressed with primary health care (apna.asn.au)

22 Australian Primary Health Care Nurses Association, (2022). *Transition to Practice Programs: Support for 'the fish out of water' aka nurses new to primary health care.* [Presentation].

Nursing and Midwifery Profession Priorities – Insights from the HWSG

In September 2022, the Health Workforce Stakeholder Group for Queensland met and were invited to contribute to a 'pitch' to key policy makers about what was needed most for their professions in 2023.

Remote and rural Primary Health Care Nurses and Midwives are key providers of health care in small remote and rural areas of Australia and require increased professional recognition and support to enable the delivery of quality care and services to their communities. Key areas that need to be addressed include:

a) Career development pathway for future RRPHC nurses to develop their skills in, for and with rural and remote nurses and communities.

b) Access for all nurses and midwives to Clinical Reflective Supervision and Support to alleviate pressures related to current skill mix and staff shortages (Australian Nursing & Midwifery Federation Position Statement - August 2020).

c) Recognition that advanced general practice primary health care nurses and midwives can support and deliver effective, quality primary health care within the general practice setting.

d) Recognition that advanced practice in nursing is based on skill set and scope of practice not role - as defined by Gardner & Gardner and adopted by the Chief Nursing and Midwifery Officers of Australia.

e) Establishing advanced practice nursing positions in general practice and primary care settings to create pathways from registered nurse to nurse practitioner.

f) Recognition that current MBS billing models do not support general practice or primary care nurses or midwives working to their full scope of practice.

g) Nurse practitioner, practice nursing, endorsed midwives and GP MBS items require review to ensure the viability of nurse practitioners and advanced practice nursing and midwifery in primary care, multipurpose services and general practice settings.

Workforce Data:
State-wide Snapshot

General Practitioners

Health Workforce Queensland (HWQ) Database

Health Workforce Queensland maintains a database of GPs working in a general practice context (private practice, small hospitals, Royal Flying Doctor Service [RFDS] and Aboriginal Community Controlled Health Services [ACCHS]) in remote, rural and regional Queensland.

This snapshot of the GP workforce was taken on 30 November 2022. In line with reporting requirements to the Australian Government Department of Health and Aged Care, only doctors working in MM 2-7 locations were investigated. At the census date there were 2,727 GPs listed in the Health Workforce Queensland database as working in MM 2-7 locations in Queensland, 72 more than reported in the 2022 HWNA. The average age was 49.94 years, marginally younger than the 49.95 years reported in 2022.

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

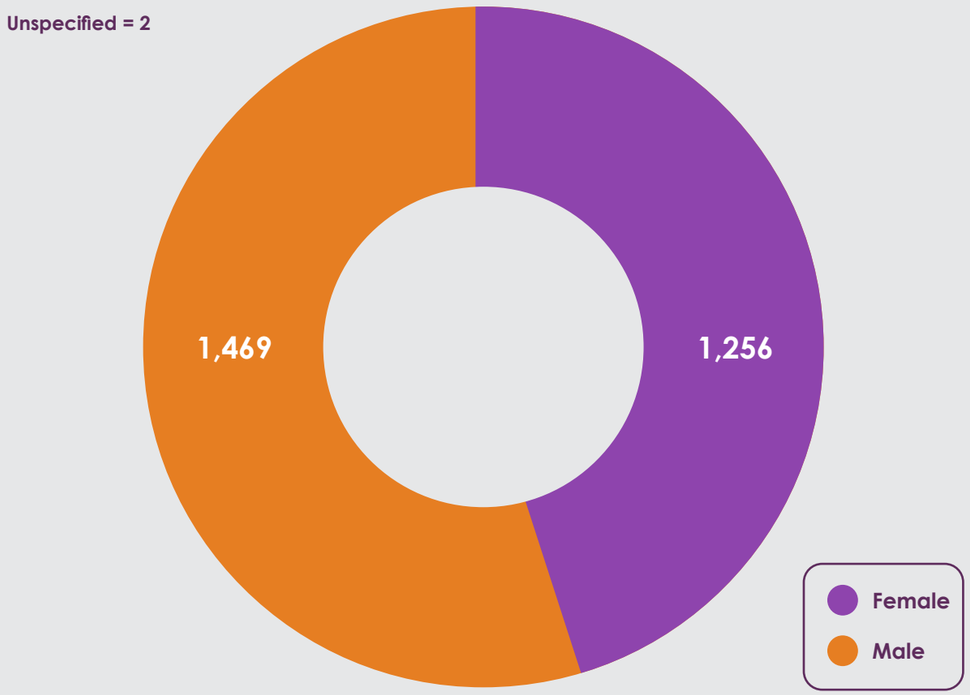


Figure 1: GPs in MM 2-7 by sex from HWQ database

The number and percentage of female and male GPs for each of the four mainly rural PHN regions are presented in Table 3 (excludes practitioners from Brisbane North, Brisbane South and Gold Coast PHN regions).

Table 3: GPs by sex and PHN region from HWQ database

PHN Region	Female		Male		Total N
	n	%	n	%	
Central Queensland, Wide Bay & Sunshine Coast	329	42.86%	437	56.98%	767*
Darling Downs and West Moreton	257	42.27%	351	57.73%	608
Northern Queensland	562	51.65%	525	48.25%	1088*
Western Queensland	48	42.11%	66	57.89%	114

**Indicates one practitioner who did not specify this information.*

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. Overall, there were 1,424 Australian trained practitioners (52.22%), and 1,303 overseas trained practitioners (47.78%). The percentage results for each of the mainly rural PHN regions are presented in Figure 2.

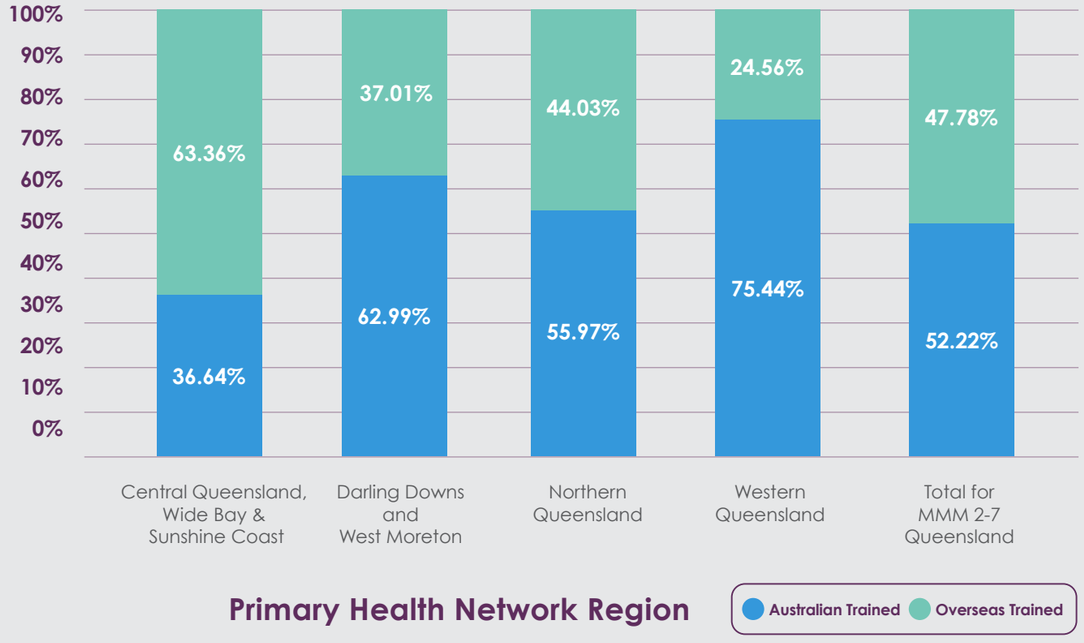


Figure 2: Percentage of GPs by country of basic medical qualification and PHN region from HWQ database

National Health Workforce Dataset 2020/21

The most recent release of the NHWDS has been gathered through the 2020 workforce survey of health practitioners as part of their annual registration renewal with AHPRA.

The NHWDS is administered by the Australian government, with jurisdictional data released to state governments on an ad-hoc schedule. The 2021 dataset was not available at the time of writing this report. Consequently, the 2020 data has been retained from last years report until it can be updated.

Queensland Health have provided an analysis to Health Workforce Queensland of the number of medical practitioners working in MM 2-7 Queensland, that self-described their main role as either 'General Practice', or 'General Practitioner' – not a specialist'. The number of GPs in 2020 for each PHN region is provided in Table 4.

Table 4: 2020 NHWDS general practitioners by PHN region

PHN Region	NHWDS 2020 N
Central Queensland, Wide Bay & Sunshine Coast	727
Darling Downs and West Moreton	486
Northern Queensland	1,082
Western Queensland	116
*Total MM 2-7 Queensland**	*2,547*

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

Practice Nurses

Health Workforce Queensland Database

The number of nurses and midwives working in MM 2-7 general practice settings captured in the Health Workforce Queensland database was 1,531, an increase of 52 from last year. Similar to last year, almost three-quarters were RNs and midwives, with the majority of the remainder being enrolled nurses.

There were comparatively few general practice nurses identified as NPs or diabetes nurse educators.

The number of nurses and midwives, according to level of registration and diabetes education specialty, are presented in Figure 3.

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

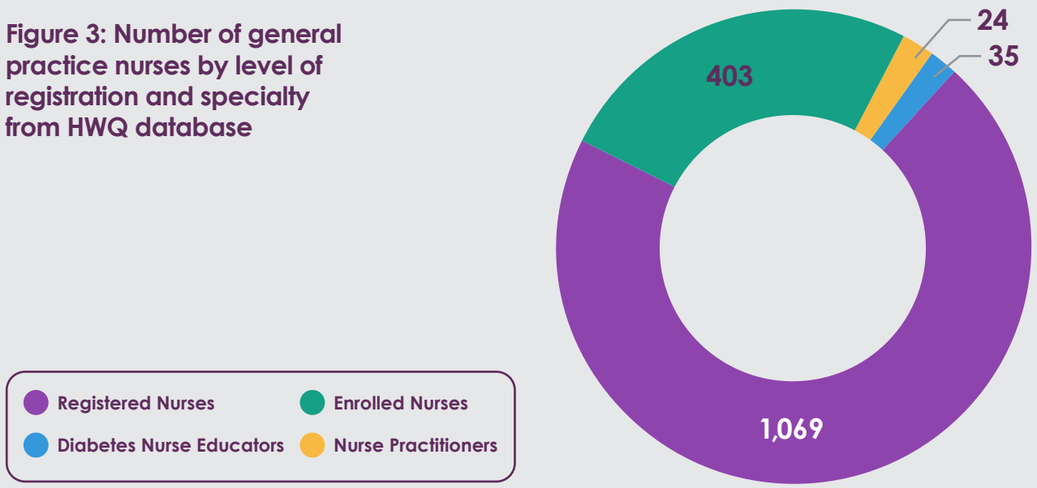
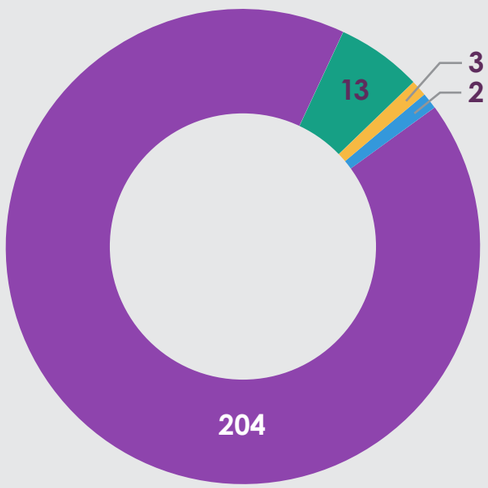


Figure 4: Number of remote and rural primary health care centre nurses by level of registration from HWQ database

Along with the nurses based in general practice, Queensland Health has provided data on headcounts of nurses working in Queensland Health operated primary care centres within smaller communities.

The number of these nurses, according to level of registration are presented in Figure 4.

Over 90 percent of the nursing and midwifery workforce in remote and rural primary health care centres were RNs and midwives. There has been an increase of two diabetes nurse educators, a decrease of six NPs and 20 RNs since last year.



National Health Workforce Dataset 2020/21

The 2021 data from the NHWDS was not available at the time of report preparation. Consequently, the data presented is from 2020, the same as last year's HWNA.

Below is the number of nurses working in MM 2-7 Queensland by rural PHN region that self-described their main role as 'practice nurse' when they completed their workforce survey during their 2020 registration renewal. The response rate to the workforce survey is generally above 95 percent for nurses across Australia. Results for both RNs and enrolled nurses (ENs) for the four mainly remote and rural PHN regions in Queensland are available in Table 5, inclusive of the percentage that described their primary work as private. For comparison, the number of total practice nurses reported last year (2020) are also included.

Table 5: 2020 NHWDS practice nurses by PHN region and percent in private employment

PHN Region	Registered Nurse/Midwife *n*	Enrolled Nurse *n*	2020 Total *N*	Percent Private
Central Queensland, Wide Bay & Sunshine Coast	294	125	***419***	89%
Darling Downs and West Moreton	224	65	***289***	87%
Northern Queensland	443	128	***571***	84%
Western Queensland	55	16	***71***	50%
Other PHN Region*	46	22	**68**	76%
Total MM 2-7	*1,062*	*356*	*1,418*	*84%*

Note: *Data provided by Queensland Health *Other PHN region refers to practice nurses working in MM 2-7 in the Brisbane North, Brisbane South and Gold Coast PHN regions.*

Photo by Tourism Tropical North Queensland

Photo by Tourism Tropical North Queensland

Aboriginal and Torres Strait Islander Health Worker & Health Practitioner Workforce

Health Workforce Queensland Database

There were 269 Aboriginal and Torres Strait Islander Health Workers and 45 Aboriginal and Torres Strait Islander Health Practitioners in the Health Workforce Queensland database, the majority working in MM4-7 locations as presented in Figure 5. This represented an increase of 20 Aboriginal and Torres Strait Islander Health Practitioners and five Aboriginal and Torres Strait Islander Health Practitioners last year.

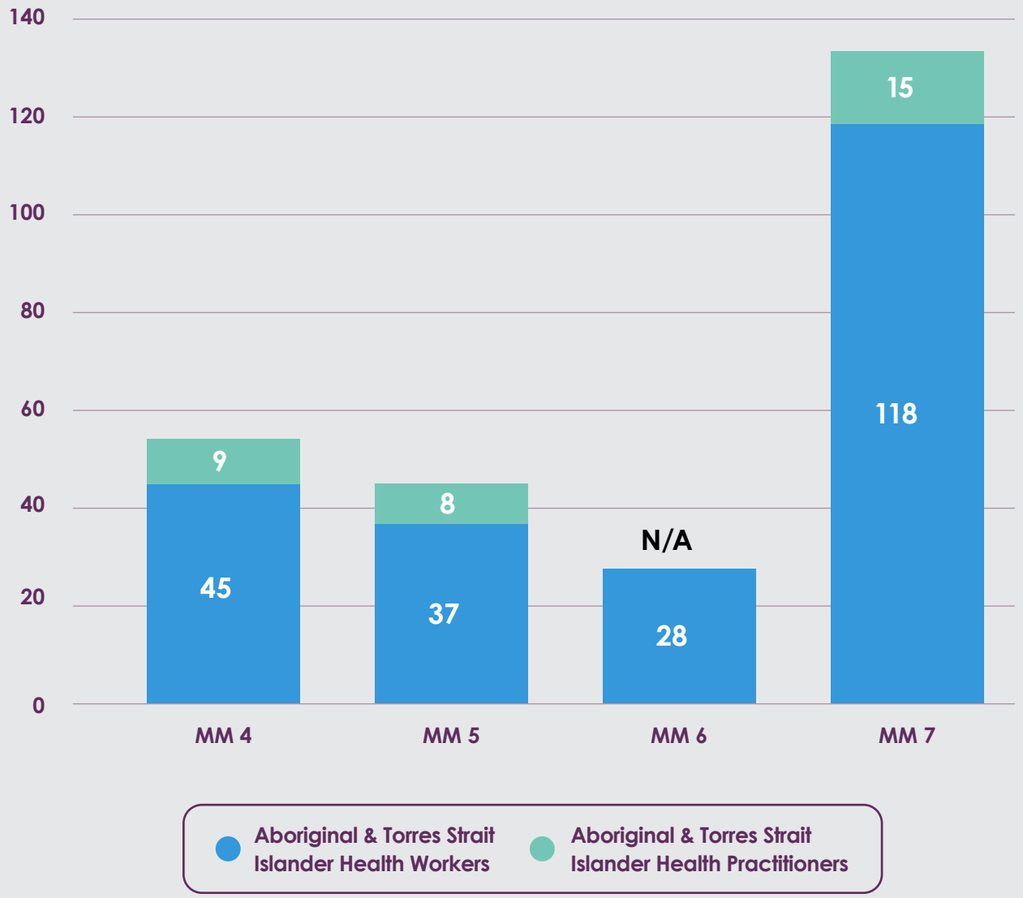


Figure 5: Aboriginal and Torres Strait Islander Health Workers/Practitioners by MM in HWQ database

Similar to last year, the largest number of Aboriginal and Torres Strait Islander Health Workers and Practitioners were working in MM 7 locations. There were more than twice as many in MM 7 than any of the other MM classifications.

The Health Workforce Queensland database had less than four Aboriginal and Torres Strait Islander Health Practitioners recorded as working in MM 3 and MM 6 locations.

National Health Workforce Dataset 2020/21

The 2021 NHWDS data was not available at the time of report preparation. Consequently, the data presented is the 2020 data presented in last year's HWNA. Results according to MM category are provided in Figure 6.

Note: *Data provided by Queensland Health*

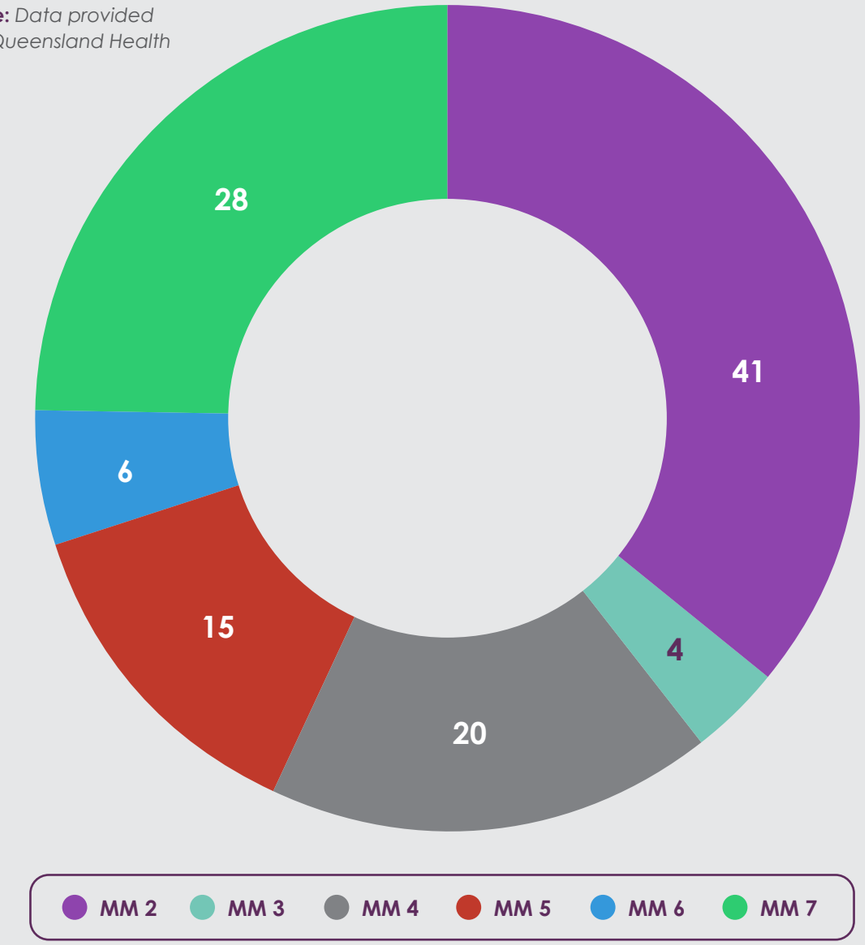


Figure 6: NHWDS 2020 workforce survey Aboriginal and Torres Strait Islander Health Practitioners by MM location

According to the NHWDS 2020, approximately 36 percent of the 114 Aboriginal and Torres Strait Islander Health Practitioners were working in MM 2 locations. MM 7 had 25 percent of the Aboriginal and Torres Strait Islander Health Practitioners, while MM 4 had approximately 18 percent of the workforce. Approximately 86 percent of the Aboriginal and Torres Strait Islander Health Practitioner workforce were female.

National Health Workforce Dataset 2020/21

The 2021 NHWDS allied health data was not available at the time of report preparation. Consequently, the data presented is the 2020 data presented in last year's HWNA. The allied health workforce data outlined in the following section has been provided by Queensland Health based on NHWDS 2020. The registered allied health professions for which data is available are:

- Psychology
- Optometry
- Podiatry
- Dentistry
- Physiotherapy
- Pharmacy
- Occupational Therapy
- Diagnostic Radiography

The numbers of practitioners in each of the allied health professions were calculated for all MM 2-7 locations for each of the mainly rural PHN regions, based on the main location of work provided in the workforce survey. For Central Queensland, Wide Bay & Sunshine Coast and the Darling Downs and West Moreton PHN regions, the number of practitioners working in MM 1 locations were also included. This includes practitioners working in and around Ipswich (Darling Downs and West Moreton PHN region) and on the Sunshine Coast in major towns such as Caloundra and Maroochydore (Central Queensland, Wide Bay & Sunshine Coast). Results are presented in Table 6.

Table 6: NHWDS 2020 workforce survey AHPs by PHN region and percent mainly in private employment

Allied Health Professions	MM 2-7 *N*	Percent Private	MM 1 *N*
Psychologists	**1,338***	**64%***	**4,702**
Central Queensland, Wide Bay & Sunshine Coast	371	66%	470
Darling Downs and West Moreton	272	65%	201
Northern Queensland	618	61%	-
Western Queensland	25	76%	-
Physiotherapists	**1,483***	**60%***	**4,999**
Central Queensland, Wide Bay & Sunshine Coast	429	67%	538
Darling Downs and West Moreton	244	61%	169
Northern Queensland	710	55%	-
Western Queensland	52	42%	-
Podiatrists	**246***	**78%***	**703**
Central Queensland, Wide Bay & Sunshine Coast	77	79%	75
Darling Downs and West Moreton	59	83%	29
Northern Queensland	83	74%	-
Western Queensland	15	53%	-
Occupational Therapists	**1,373***	**52%***	**3,399**
Central Queensland, Wide Bay & Sunshine Coast	352	57%	414
Darling Downs and West Moreton	219	53%	148
Northern Queensland	717	48%	-
Western Queensland	59	46%	-
Optometrists	**310***	**96%***	**878**
Central Queensland, Wide Bay & Sunshine Coast	95	96%	92
Darling Downs and West Moreton	77	95%	48
Northern Queensland	125	97%	-
Western Queensland	7	100%	-
Pharmacists	**1,576***	**65%***	**4,176**
Central Queensland, Wide Bay & Sunshine Coast	454	66%	345
Darling Downs and West Moreton	307	71%	211
Northern Queensland	689	60%	-
Western Queensland	55	58%	-
Dental Practitioners	**1,330***	**72%***	**3,441**
Central Queensland, Wide Bay & Sunshine Coast	405	72%	385
Darling Downs and West Moreton	252	80%	182
Northern Queensland	585	71%	-
Western Queensland	36	33%	-
Diagnostic Radiographers	**705***	**50%***	**2,040**
Central Queensland, Wide Bay & Sunshine Coast	216	60%	251
Darling Downs and West Moreton	119	50%	103
Northern Queensland	338	43%	-
Western Queensland	19	47%	-

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

HWNA Survey Results

Quantitative Findings

An online survey was conducted targeted at GPs, practice managers, primary health care nurses and midwives, Aboriginal and Torres Strait Islander Health Workers and Practitioners as well as AHPs working in MM 2-7 locations.

Survey items were developed to gauge health practitioner and health service manager beliefs about primary care workforce and service gaps in their community(s) of practice. The survey items were phrased as statements (e.g., 'There is a serious gap in the psychology workforce in my community') and participants were asked to rate their level of agreement. Ratings were along a 101-point scale 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 17 workforce disciplines (e.g., GPs; pharmacy) and 13 primary care services (e.g., alcohol and other drug services; mental health services) that aligned with identified priorities for the PHN regions. There was a sample size of 800, a decrease from last year's 837. The number of participants by their main role (e.g., nurse, AHP) are provided in Figure 7.

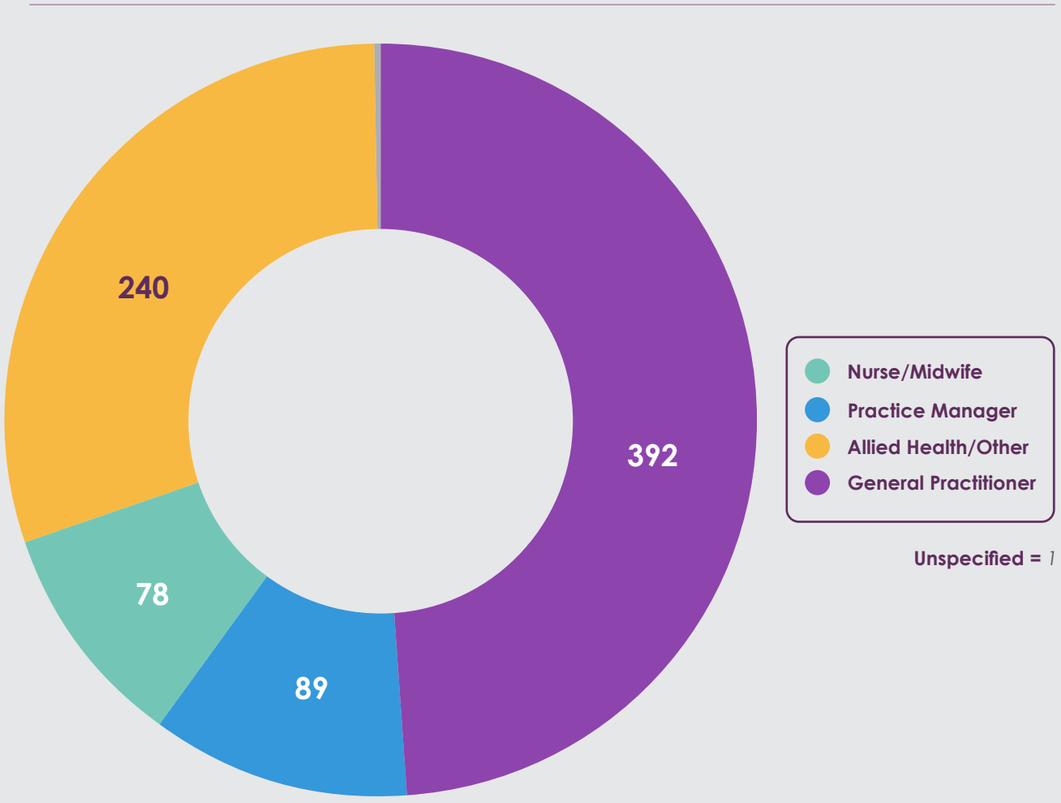


Figure 7: Number of participants by main employment role

The Northern Queensland PHN region had the largest number of survey responses (*n* = 257), followed by Central Queensland, Wide Bay & Sunshine Coast (*n* = 189), Darling Downs and West Moreton PHN region (*n* = 159) and Western Queensland PHN region (*n* = 77). The main employment role of participants for each of the mainly rural PHN regions are available in Figure 8.

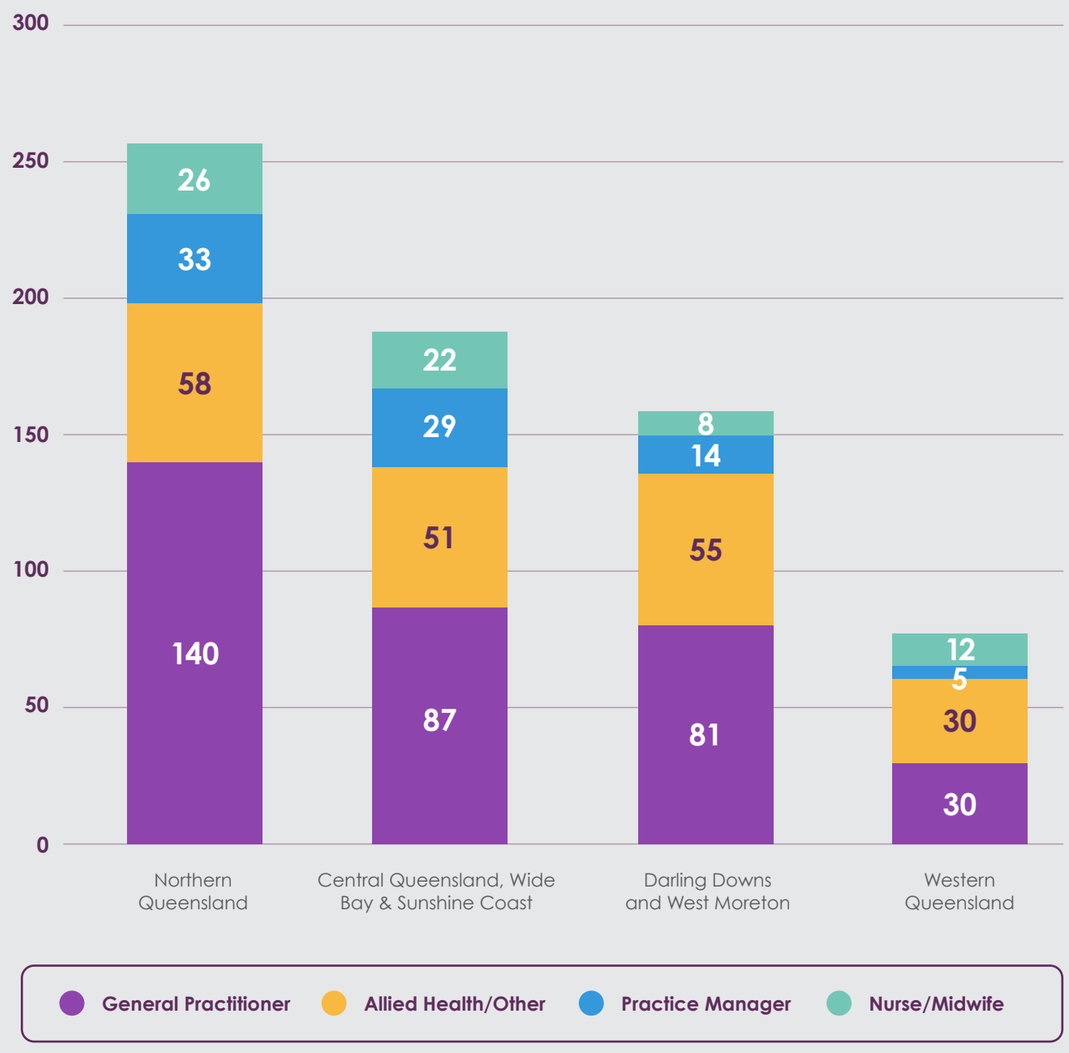
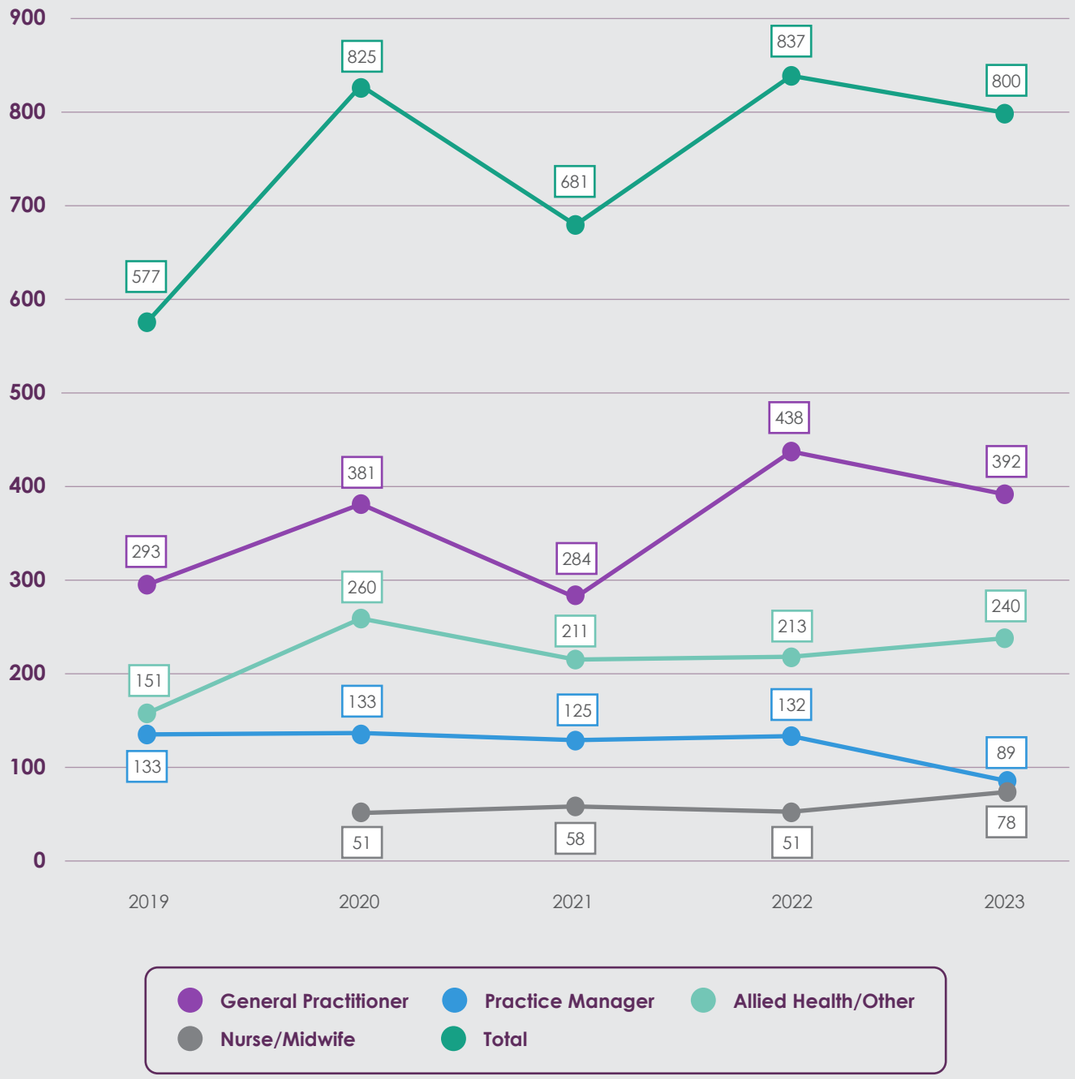


Figure 8: Number of participants by main employment role and rural PHN region

The proportion of GP responses was similar to the 2022 survey at just over 50 percent. Figure 9 depicts the total number of responses received for the HWNA since 2019 and the breakdown of these responses by participant employment role.



Note: *In 2019, Allied Health and Nursing participants were classified under the same category of 'Nurse and Allied Health Professionals/Managers'*

Figure 9: Number of participants by main employment role from 2019-2023

Workforce Gap Ratings

The 'Top 10' Workforce gap rating means for remote, rural and regional Queensland are provided in Figure 10. The full list is available in table format in Table 7 along with the workforce gaps means from 2019 to 2023.

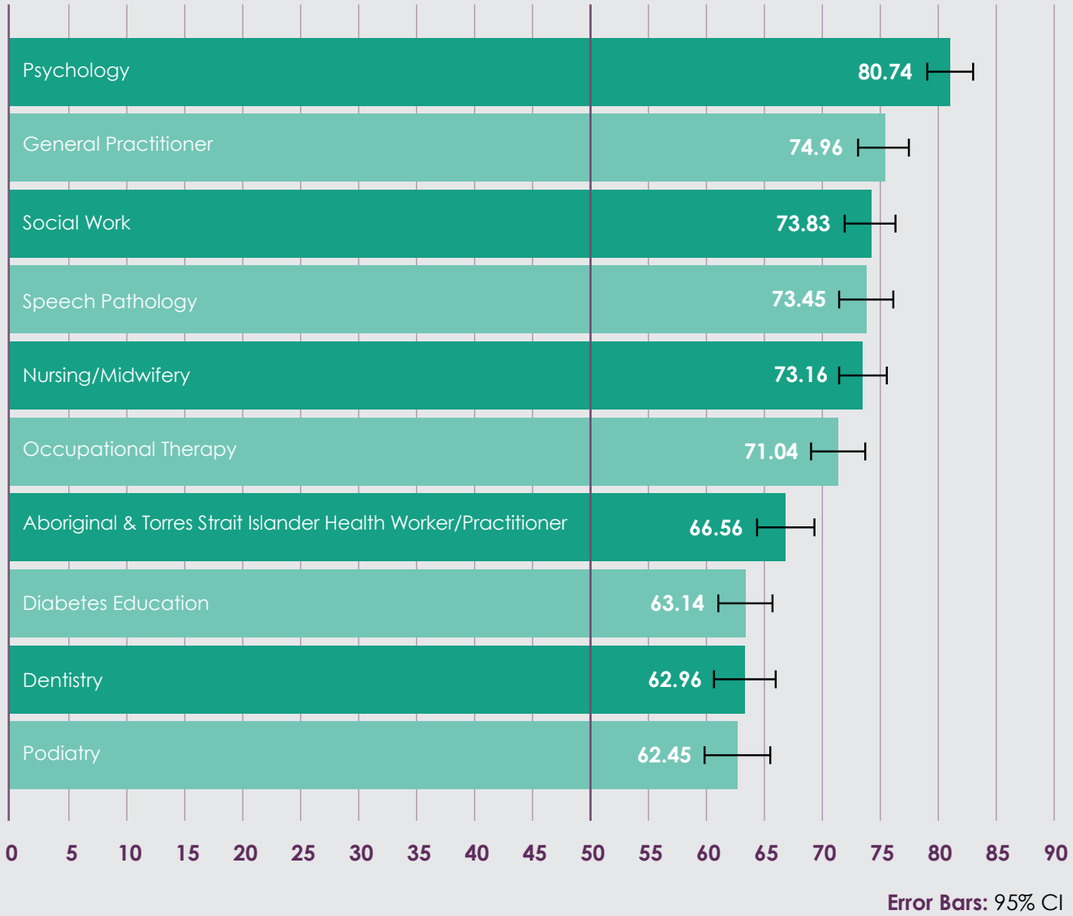


Figure 10: Top 10 workforce gap rating means

The highest workforce gap rating means were for the psychology, GP, social work, and speech pathology workforces. Six of the workforce gap means were higher than 70. The remaining top 10 workforce gap rating means were higher than 60. The optometry and pharmacy workforce gap rating means were the only two lower than 50 (see, Table 7).

Table 7: Workforce gap rating means for 2019-2023

Type of workforce	2019 M	2020 M	2021 M	2022 M	2023 M
Psychology workforce	59.09	66.63	72.70	79.57	**80.74**
General Practitioner workforce	50.75	58.58	62.03	70.85	**74.96**
Social Work workforce	56.12	63.35	65.68	71.54	**73.83**
Speech Pathology workforce	51.33	59.88	70.31	71.60	**73.45**
Nursing/Midwifery workforce	44.57	51.55	55.84	65.57	**73.16**
Occupational Therapy workforce	50.48	58.78	66.19	68.91	**71.04**
Aboriginal & Torres Strait Islander HW/P* workforce	48.09	57.27	60.50	62.78	**66.56**
Diabetes Education workforce	43.63	53.76	56.88	59.60	**63.14**
Dentistry workforce	47.92	54.66	55.72	56.83	**62.96**
Podiatry workforce	40.76	48.51	56.89	55.68	**62.45**
Nutrition/Dietetic workforce	42.96	50.30	57.40	57.46	**60.82**
Exercise Physiology workforce	42.22	50.05	54.22	53.21	**58.04**
Radiography/Sonography workforce	44.55	52.42	55.88	53.98	**57.99**
Physiotherapy workforce	36.72	45.86	49.95	52.76	**56.93**
Audiology workforce	40.73	49.44	53.00	50.72	**55.37**
Optometry workforce	36.26	42.05	45.73	47.04	**49.44**
Pharmacy workforce	25.23	31.38	32.75	34.06	**40.71**

Note: **HW/P = Health Worker & Health Practitioner*

Overall, there has been an increase in workforce gap rating means across all disciplines since 2019. The most notable increases observed over the last year, from 2022 to 2023, were for the nursing and midwifery workforce which appeared in the top five workforce gaps for the first time, with an increase of over seven points; the podiatry workforce with an increase of almost seven points, and the pharmacy and dentistry workforces, both of which experienced an increase of just over six points.

All other workforce gap rating means increased by between one and five points. In the previous five years that the HWNA surveys have been conducted, psychology, social work, speech pathology, occupational therapy, and GP workforces have consistently ranked in the top five workforce gaps by survey participants. Figure 11 depicts the workforce gap rating means for each of these workforces to show change across this period from 2019-2023.

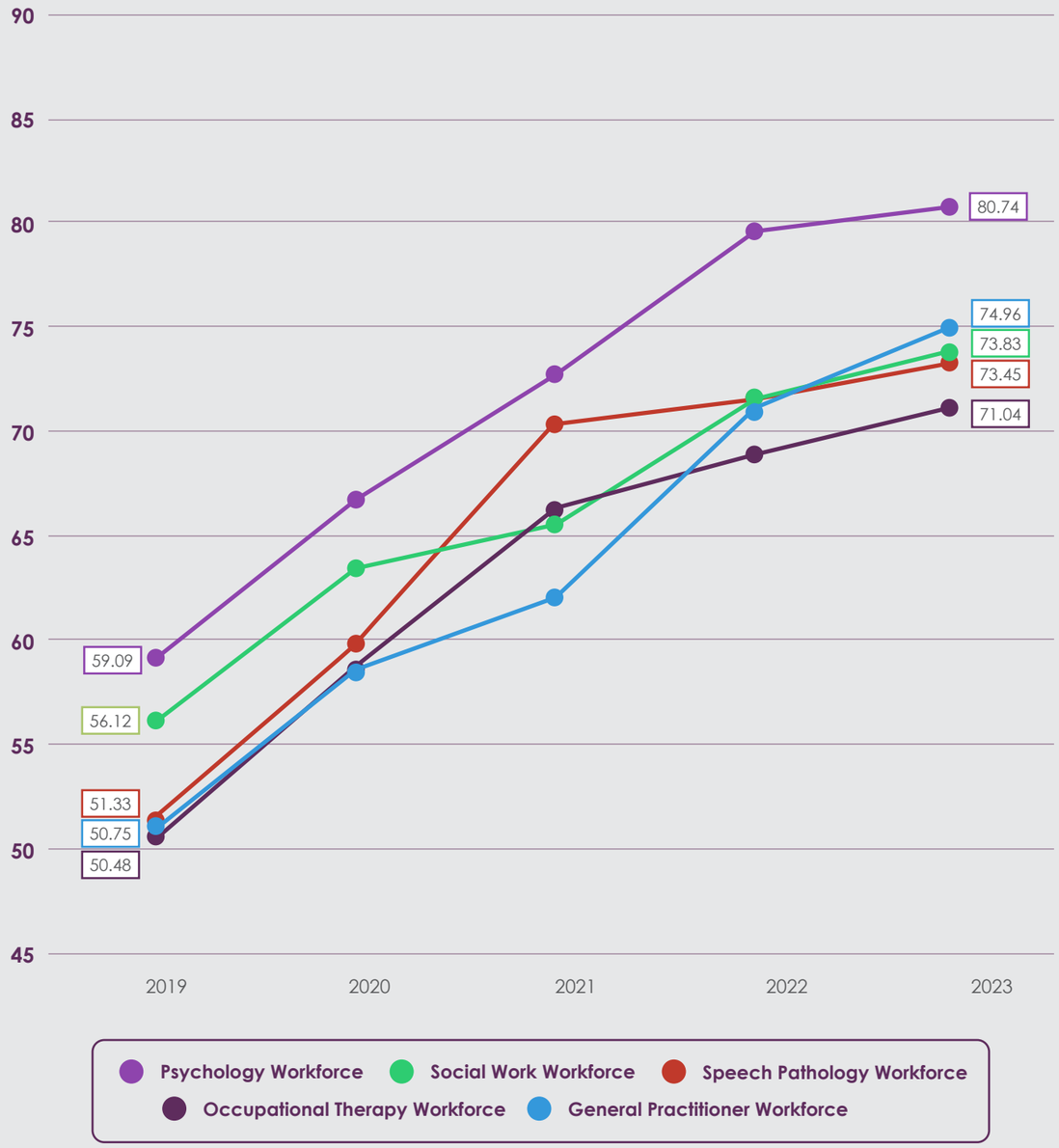


Figure 11: Five highest rated workforce gaps across 2019-2023

The workforce gap rating means for all five workforce disciplines have increased between 2019 and 2023. The GP workforce experienced the largest increase over the previous five years (24.21 points), followed by the speech pathology workforce (22.12 points), psychology workforce (21.65 points), occupational therapy workforce (20.65 points), and the social work workforce (17.71 points).

Workforce Gap Comments

There were 200 participants that commented on the workforce gap rating questions. The most frequently mentioned workforce gaps identified in a thematic analysis were grouped into the following four themes:

1. **Workforce (*n* = 136)**
2. **Access (*n* = 81)**
3. **Remuneration and Cost (*n* = 36)**
4. **Infrastructure and Transport (*n* = 26)**

Each of the sub-themes will be discussed individually.

1. Workforce

Comments about workforce issues were characterised by two related sub-themes: shortages of workforce and difficulties with attraction and retention of workers. The sub-themes are represented in Figure 12.

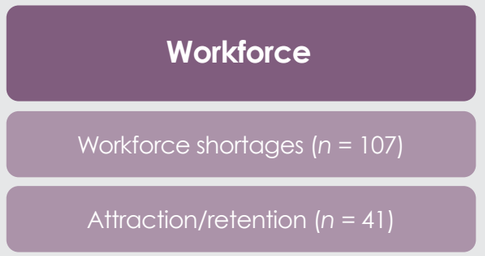


Figure 12: Workforce sub-themes

Comments in the first sub-theme (workforce shortages), spoke about the lack of qualified health professionals in remote and rural communities and how this impeded the provision of primary care resulting in an increased use of emergency departments. For example, comments such as:

"Get many reports that people moving to town are unable to secure access to a regular GP. For urgent appointments many people present to ED as they cannot get into a GP. Non-urgent GP appointments have a wait of 4-6 weeks, many practices have closed their books."

The second sub-theme of attraction and retention was mentioned by many participants. Some comments focussed on difficulties attracting new graduates while other comments mentioned difficulties attracting and retaining a skilled and experienced health workforce. Others mentioned both aspects, for example:

"Difficult to attract and retain skilled clinicians across all of our areas - this includes new graduate and experienced staff. Graduating classes have progressively decreased and it is more difficult to source applicants for our positions."

The lack of incentives for health professionals to reside in the community long-term were mentioned by some participants, including the limited impact of offering wages competitive with those of metropolitan practitioners:

"There is no incentive to be a rural practitioner that is any different from being in metro. We need to define the difference with some incentives to come and stay rural."

2. Access

For the theme of access, participant comments centred around three sub-themes: inconsistent access to health services; difficulty in accessing mental health services; and long wait times to see a health professional. The sub-themes are presented in Figure 13.

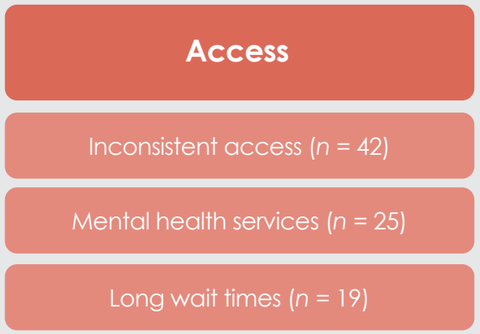


Figure 13: Access sub-themes

Comments related to the first sub-theme, inconsistent access to health services, comprised more than half of the participants comments. Some expressed discontent with services that were provided by practitioners living in a larger community:

"XXX [Town] region is 126 km from the next regional towns of YYY [Town] or ZZZ [Town], and we have almost zero medical services. I am now booked out for 5 weeks ahead. I get nearly 200 people daily wanting to see me. If the only other nearby Dr and I get sick or injured or retire, there will be 10,000 people here with no medical services."

The second sub-theme was the difficulty in accessing appropriate mental health care services. Some participants suggested that the availability of social work services could provide patients with initial and ongoing support, and some expressed the need for a change in psychology bulk billing services:

"There needs a lot of more social work services for patients to easily access to assist them, as much of their medical problems they come to for GP care, could be improved greatly with improved social services and support."

"Many presenting with neurodevelopment delays and requiring assessment do not have the funds to pay for these assessments. Yet, psychiatry is now doing these assessments via Telehealth with huge rebates through Medicare. Psychology receives no rebates for assessment, and we are highly trained in assessment and write thorough reports needed to provide best outcomes for individuals, especially children."

The third sub-theme was the long wait times to see a health professional. Some mentioned that patients may not be able to see a health professional for several weeks whilst others indicated practices had closed their books to new patients. For instance:

"Access to GPs has been a major issue with patients waiting over 4 weeks for appointments and practices having to turn away new patients. Allied health have long wait lists and there is a lack of bulk billing services."

Some participants spoke of how providers were being poorly reimbursed for their services.

"Bulk billing telehealth/face to face psychology and psychiatry needed. Medicare rebate not reflective of GP skills/time and resources. My GP's are saying they are under paid for services."

Complex funding models and salary disparities were mentioned by some participants. This included disparities between NDIS and Medicare funding for some services, as well as the gap between wages for public and private health practitioners.

"Massive gap in allied health workforce as a result of increasing demands in AHP services from NDIS and MAC. Extremely poor remuneration under Medicare for OT services makes it non viable to provide Medicare funded OT services. Currently the rebate is $56 for bulk billed services for MBS Item 10958. This is not viable for OT services. Example: home visit for home safety assessment 1 hour, travel to and from rural location 1 hour, report with recommendations and diagrams 1 hour for minor mods & referral to installation service. The equivalent NDIS service would be funded at $193.99 per hour = $581.97. Medicare cannot compete with NDIS funding so most OTs no longer provide any services under Medicare. This means the most marginalised people, low SES, low literacy, poor health, rural/ regional/remote miss out on any service. It is impossible to seek gap payment from these patients as Medicare does not facilitate this by allowing just the gap to be paid to AH practitioner."

3. Remuneration and Funding

For remuneration and funding, the main sub-themes were unaffordable services, particularly for allied health services outside of NDIS and Medicare funded services, and also the complexity of funding models. The sub-themes are represented in Figure 14.

Remuneration & Funding

- Remuneration for services (*n* = 27)
- Complex funding models (*n* = 10)

Figure 14: Remuneration and funding sub-themes

4. Infrastructure and Transport

For the theme of infrastructure and transport the main sub-themes were difficulties for health practitioners who had to travel to deliver services and a lack of accommodation and clinical spaces for health practitioners. The sub-themes are represented in Figure 15.

Infrastructure and Transport

- Travel to services (*n* = 27)
- Lack of accommodation/ clinical spaces (*n* = 9)

Figure 15: Infrastructure and transport sub-themes

Participants comments mentioned there were long distances for community members to travel to services as there was a lack of locally available services, leading to a reliance on telehealth options and/or the need to also find accommodation while accessing services in other locations.

"The main difficulty we have living in the rural is travelling to appointments. It can make it very difficult. We do have availability to occupational therapy as in podiatrist, dietitian, physiotherapist. However, they are monthly or fortnightly so if you were to require it on a daily basis or weekly you need to travel or have accommodation which is very costly."

"Significant difficulty finding speech therapy services locally, referral to services often over 1 hour drive away, very challenging for families whose children do not travel well. I recommend daily families to access therapy services via telehealth."

Some participants mentioned the lack of physical infrastructure to provide services.

"Continued difficulty or barrier to service is the accessibility of clinic spaces from which to see clients…"

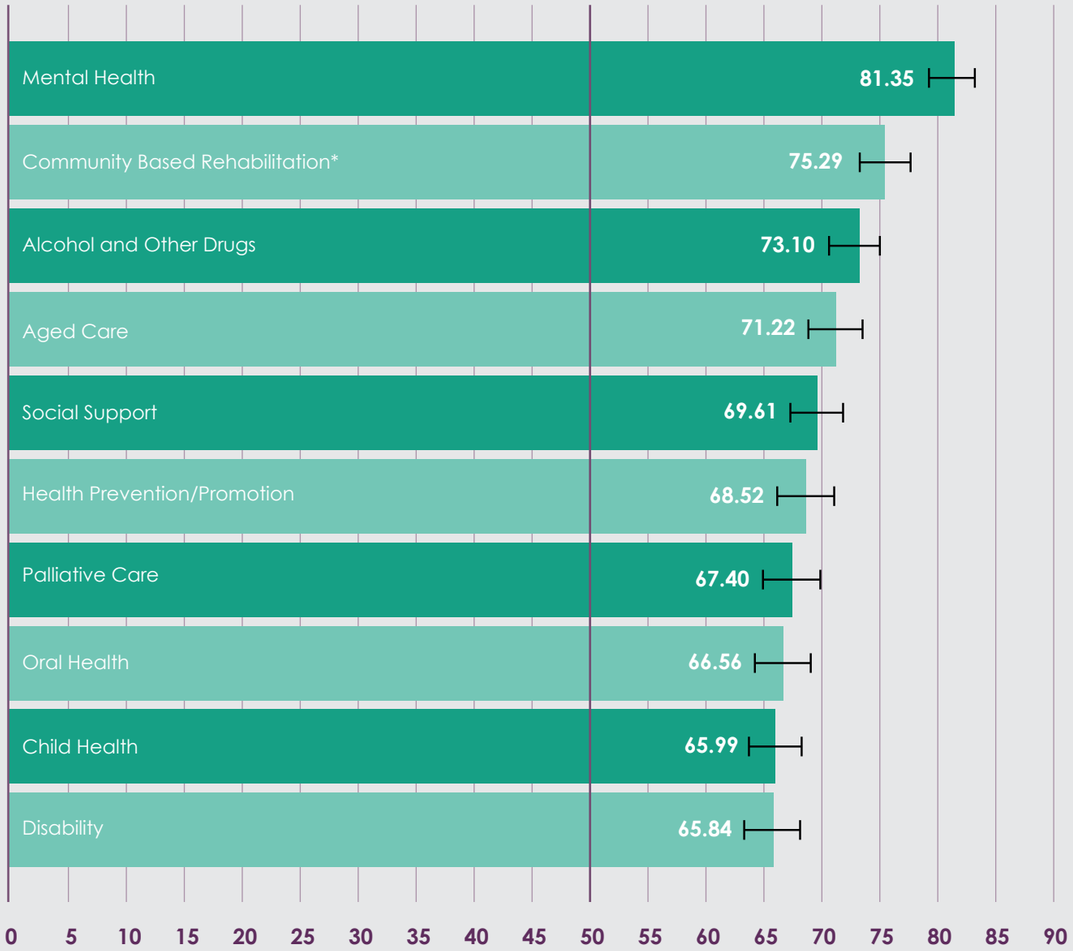
Some participants mentioned that housing availability was an added issue, particularly in attracting new staff:

"There is [are] no rental properties and a severe shortage of staff housing. It is difficult to fill positions when there is no housing or poor quality housing. Health worker positions do not come with housing."

"Even if I could hire a Physio in my town, there is a bigger problem of not being able to house them! The rental market here is dire, with sometimes as little as [sic] places available to rent in a town of 10,000 people! Rents have also gone up by 15-20% in the past year."

Service Gap Ratings

The 'Top 10' primary care service gap ratings are presented in Figure 16.



**Community-based rehabilitation refers to physical/functional rehabilitation.*

Error Bars: 95% CI

Figure 16: Top 10 service gap rating means

The highest service gap rating means were for mental health, community-based rehabilitation, alcohol and other drug services, aged care and social support services. The mental health mean was higher than 80, with the next three means higher than 70. All primary care service means were 60 or greater for the first time including the lowest rated primary care service, maternal health. Five-year trend data from 2019 – 2023 has been provided in Table 8.

Table 8: Service gap rating means for 2019 – 2023

Type of Service	2019 M	2020 M	2021 M	2022 M	2023 M
Mental Health Services	65.25	69.72	73.34	80.71	**81.35**
Community-Based Rehabilitation Services	-*	68.56	69.99	74.70	**75.29**
Alcohol and Other Drug Services	60.14	68.20	67.38	73.18	**73.10**
Aged Care Services	51.53	60.51	61.13	66.76	**71.22**
Social Support Services	54.97	60.45	62.66	68.25	**69.61**
Health Prevention/Promotion Services	50.84	57.38	62.16	64.59	**68.52**
Palliative Care Services	52.55	58.80	61.41	63.12	**67.40**
Oral Health Services	54.44	58.37	61.61	61.70	**66.56**
Child Health Services	47.52	56.04	56.87	63.29	**65.99**
Disability Services	55.23	61.33	62.33	64.26	**65.84**
Refugee and Immigrant Health Services	50.36	57.82	60.19	61.79	**63.65**
Aboriginal & Torres Strait Islander Health Services	43.13	50.47	51.95	59.27	**60.63**
Maternal Health Services	40.43	49.68	52.66	54.85	**60.48**

Note: **Rating question not contained in survey*

Overall, there has been a gradual increase in primary care service gap rating means across all services since 2019. The most notable increases observed over the last year from 2022 to 2023 were for maternal health services, an increase of almost six points, and aged care and oral health services, an increase of approximately five points each. Most of the other primary care service gap ratings increased by less than four points and there was a slight reduction (0.08) in the alcohol and other drug services mean.

In the previous five years that the HWNA surveys have been conducted, five service gaps have consistently been ranked highly (within the top five) by survey participants; these service gaps are mental health, alcohol and other drugs, community-based rehabilitation, social support, and aged care services.

Figure 17 below depicts the service gap rating means for each of these services over the past five years. The service gap rating means for all five service disciplines have increased between 2019 and 2023. Aged care services experienced the largest increase (20 points) over the previous five years followed by mental health services (16 points), social support services (14.64 points), alcohol and other drug services (13 points) and community-based rehabilitation services (7 points over four years).

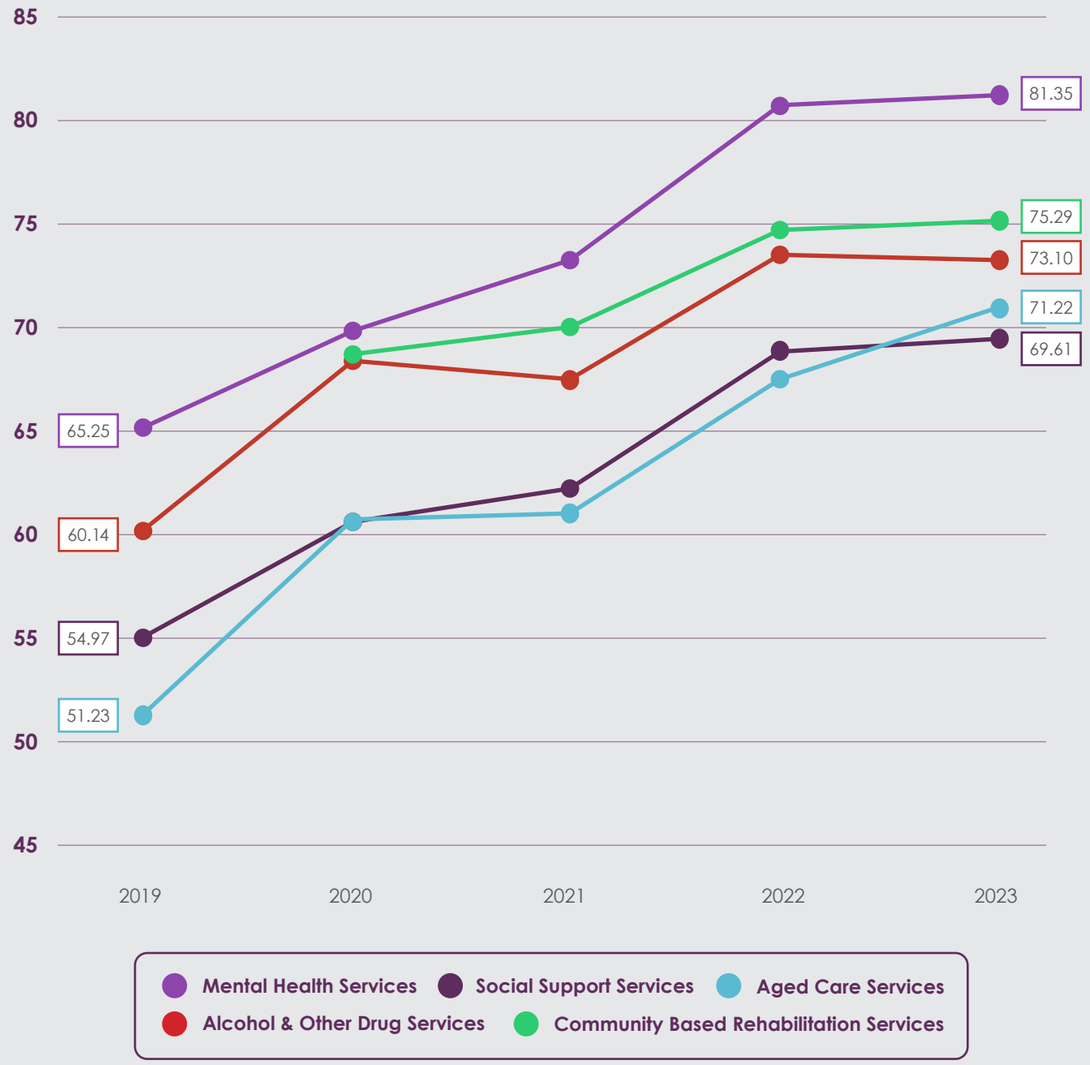


Figure 17: Five highest service gap rating means 2019 – 2023

Service Gaps Comments

There were 92 participants that commented on the service gap rating questions. A thematic analysis was undertaken, and the most frequently mentioned gaps related to services for mental health and alcohol and other drugs, allied health and community- based rehabilitation.

Other service gaps mentioned were for palliative care, aged care and disability. Across all primary care service gaps mentioned, the lack of services was highlighted.

Primary sub-themes identified for service gap comments were:

1. **Lack of services (*n* = 48)**
2. **Workforce shortages/Long waitlists/ Increased workload (*n* = 27)**
3. **Access to and cost of services (*n* = 22)**

Figure 18: Service gaps sub-themes

1. Lack of Services

Participants commented on services offered by both public and private sectors and several comments simply stated that there were '*gaps across all domains of healthcare*' or that '*services don't exist*' and were available '*only in major areas*'.

"All services are missing or deficient or not being properly administered toward the people of this community. It is difficult to obtain appointments and most times people are being referred away from [MM 6 location]. Highly unsatisfactory."

Many comments indicated that communities needed and would benefit from increased availability of local **mental health and drug and alcohol services.** Comments also highlighted the lack of support and the need for improvement of existing services.

A community affected by the flow-on-effects of mental health problems and substance misuse was discussed by one participant in relation to adolescents.

"Substances in our region are ruining lives abroad with many adolescents engaging in illicit substance activities to seek a sense of belonging, self-empowerment, and relief from psychosocial/ mental health stressors. This is leading to (further) disempowered and struggling families to seek non-specialist support at community mental health services at times when the young people are struggling to see a life worth living (and contributing to overdoses) and reluctant to engage, and additionally results in impacts to young people's education (and thereby employment and quality of life prospects), engagement in healthy social situations, engagement in higher risk behaviours including crime which then impacts other families (including traumatising break-ins or stolen goods) and parts of society including businesses (including property damage). And this list of impacts is not even near exhaustive!! We need specialist substance use services for young people, not just adults."

Comments also addressed limited allied health services and the inability to provide best practice care cycles for their patients. In addition to the lack of local referral services, other allied health gaps mentioned were for podiatry, dietetics, dental, eye health and social support services.

"The public health system is not able to adequately service the community in allied health - specifically physiotherapy from my viewpoint, and there is no community rehabilitation and very little aged care services that provide access to physiotherapy."

A number of participants mentioned the overall lack of rehabilitation services that ranged from cardiac and stroke to general physical and functional rehabilitation services. While all comments indicated the lack of services, participant responses varied with respect to their community and some described rehabilitation services as requiring '*a larger roll out*', closed or non-existent.

"We have a definite lack of service for rehabilitation clients, currently we have someone who had a leg amputation and there are no services here who we can refer this person to who can help with home modifications and rehab exercises."

For aged care, palliative care and disability services, several comments indicated the lack or inadequacy of services, compelled clients to often leave the community to access services.

"NDIS providers are scanty, limited. Palliative etc., often means leaving community."

Despite a growing need, the lack of or inconsistent access to child and maternal health services were mentioned by a number of participants.

"Primary maternity care for women in a continuity of care model from early pregnancy through to six weeks postnatal is lacking and there is a narrow focus on services that are hospital based. The use of endorsed midwives in primary care settings would radically alter this."

In communities with a large proportion of Aboriginal and/or Torres Strait Islanders, comments expressed insufficient services to adequately support the community.

"We have a large [Aboriginal and/or Torres Strait Islander] population and although we do have a few services available, it is not enough to support this population."

2. Workforce Shortages/Long Waitlists/Increased Workload

Workforce shortages were commonly mentioned across disciplines that ranged from mental health to allied health and aged care. Participant comments provided insight into the struggle to meet patient needs. In some cases, shortages were due to transient workforces and in others to policy changes.

"In relation to disability, there are too many referral services (e.g., support coordinators) but nobody to do the actual work, e.g., support workers. Similarly with mental health, there are supports to get people linked in with services, but not enough therapeutic services to work intensively with people to help them towards recovery…. We need more psychologists and social workers providing intensive mental health interventions (not referrals)."

Participants further provided responses that indicated that workforce shortages had led to increased workloads for staff and increased wait lists for residents. This impacted the ability to provide quality services to meet community needs.

"Mental health services in my community are regularly operating over-capacity, which in turn leads to lower quality care for clients, a higher risk of staff burnout, lower retention rates, lower job satisfaction, and unrealistic expectations from all parties involved."

"We have services but not enough to supply to [the] public or wait list exceeds life expectancy with palliative care."

3. Access to and Cost of Services

Several participants noted that the lack of access to services restricted effective service provision and uptake within their communities. Barriers to accessing services were identified as distance to travel, the lack of bulk billed services/gap fees, and the lack of community awareness of services available. Comments most frequently mentioned access issues for mental health, allied health and palliative care services.

"No AODS services, no accessible mental health services for people needing bulk billing."

"I work in XXX [MM 7 location]. Patients rely on visiting services which have variable frequency. They need to travel long distances for follow up. Increased visiting schedules would help. Replacing empty positions promptly would help."

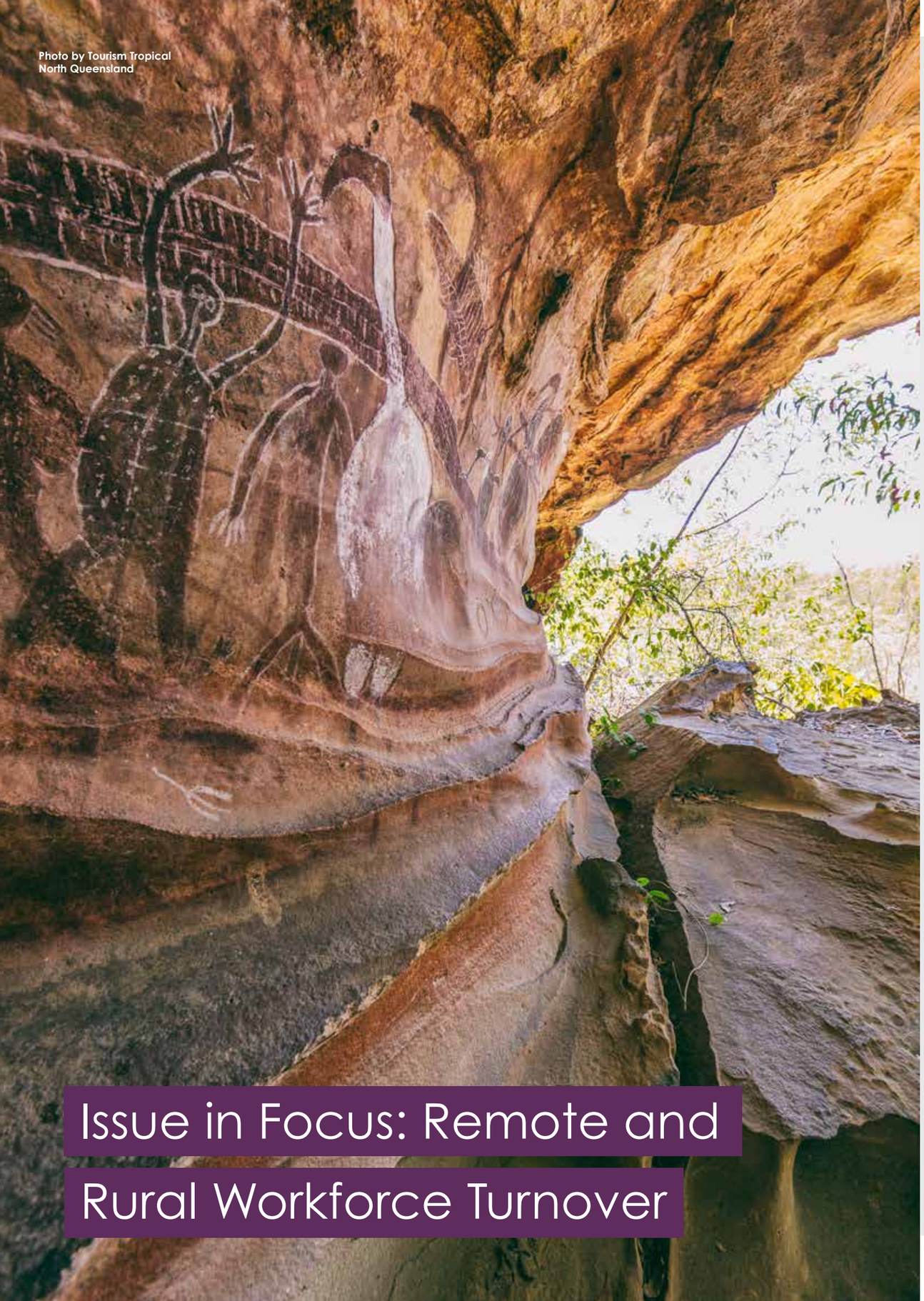


Photo by Tourism Tropical North Queensland

Issue in Focus: Remote and Rural Workforce Turnover

It is known that there is a large turnover of health practitioners in remote and rural Queensland. Sometimes health practitioners leave a practice for personal reasons and sometimes it may be because of workplace or community factors.

Turnover may reflect a move away from remote and rural Queensland to a metropolitan area, interstate or overseas, while other departures may reflect movement to a different remote or rural community or to another practice in the same community. For instance, a health practitioner may move to a capital city when children reach a certain age so that their educational needs can be met, while another practitioner may change their practice in the same town because of better pay or conditions.

This year's *Issue in Focus* examined workforce departures from two perspectives. First, the Health Workforce Queensland database of medical practitioners and general practices was used to provide data about how many years doctors had been at their primary practice as of 30 November 2022. This data provides a de facto measure of the long-term stability of the GP workforce.

Second, results of a survey conducted as part of the 2023 HWNA were examined, investigating practitioner and manager perceptions of why health staff tended to leave practices in remote and rural Queensland in the previous year.

GP Length of Stay

The length of stay of the remote and rural GP workforce data provided is drawn from the **Minimum Dataset** (MDS). The MDS is a collection of remote and rural GP workforce metrics gathered and reported annually for the past 20 years. Unfortunately, there is no similar dataset to investigate the length of stay of the equally important allied health, First Nations or nursing and midwifery workforces.

Figure 19 depicts the number of GPs (including registrars), by their length of employment (tenure) at their current primary practice as of the 30 November 2022.

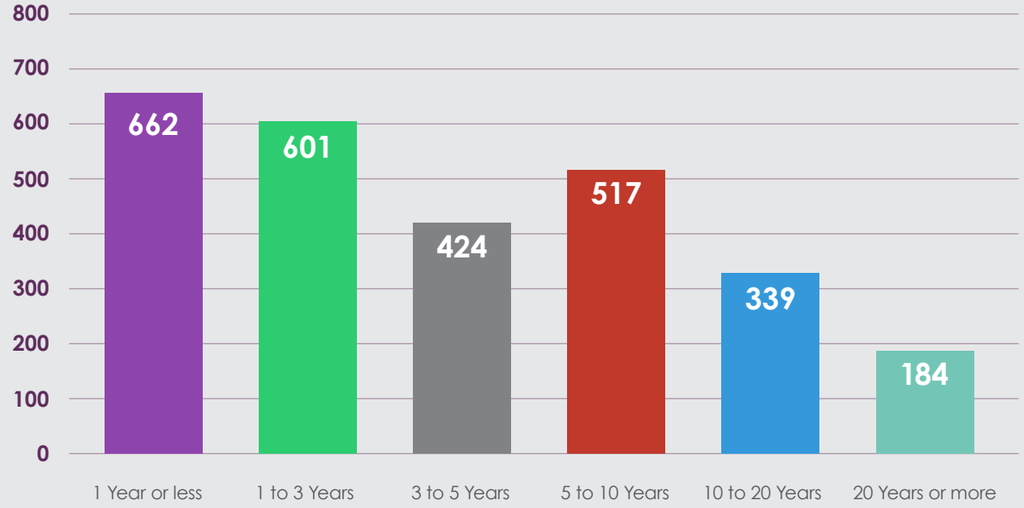


Figure 19: Length of stay for MM 2-7 QLD GPs November 2022

Almost half of the GPs in MM 2-7 QLD (46%) had been employed at their current primary practice for less than three years, suggesting considerable turnover in the general practitioner workforce within a three-year period. Of the 568 GPs whose length of stay was one year or less, 53 percent were Registrars. The 674 GPs that had a length of stay one to three years included 19 percent Registrars.

Further, 52 percent of these GPs had been at their current employment for less than a year. The smallest group were practitioners that had been employed at their primary practice for 20 years or more (7%).

Factors Influencing Health Staff Departures

The HWNA survey included two questions to gauge practitioners and managers perceptions on factors impacting health staff departures in their service/community in the previous 12 months. Question one asked survey participants to rate the importance of a total of 19 individual factors that could impact health staff departures. Survey participants were asked to respond to each factor along a 101-point scale from '0 = Not at all Important' to '100 = Extremely Important'.

Results are presented in Figure 20.

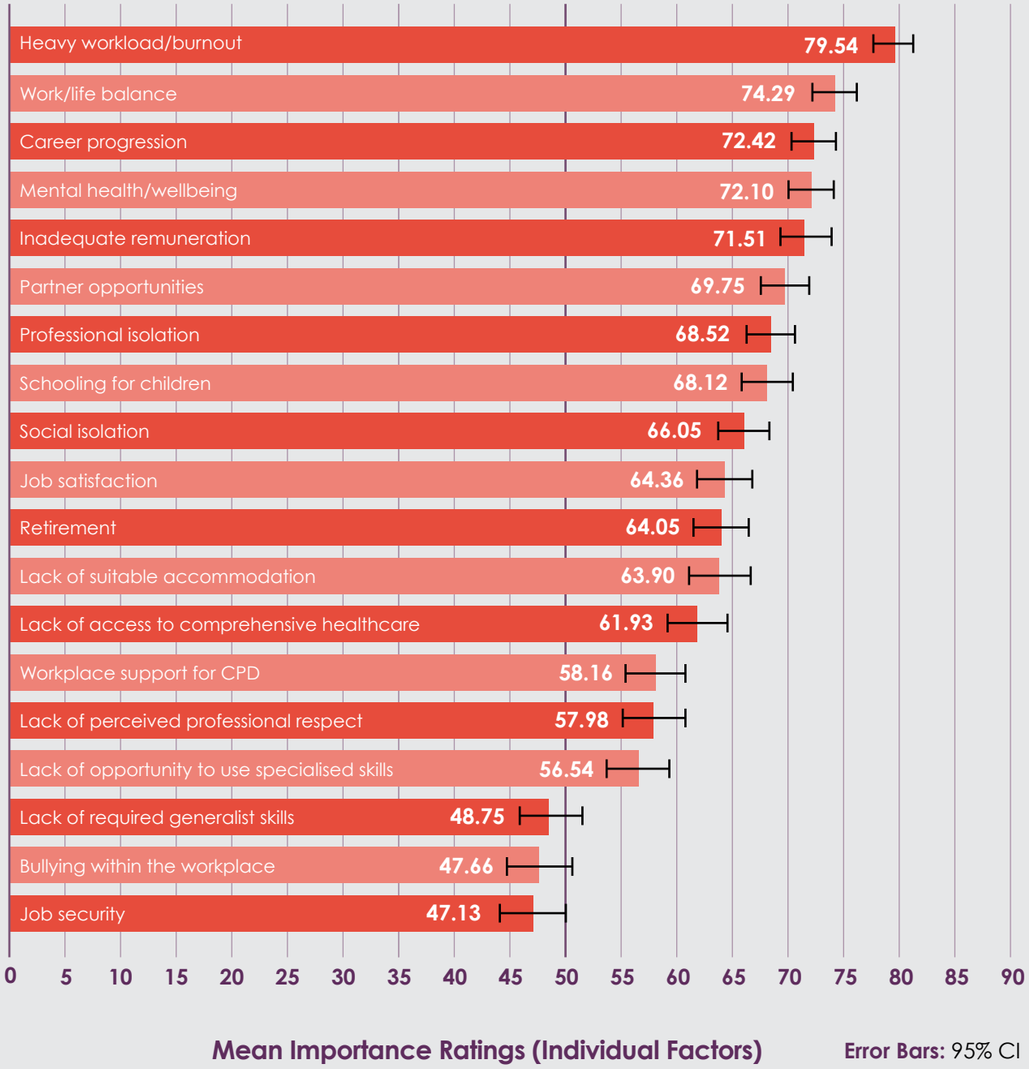


Figure 20: Mean importance ratings for individual factors influencing health staff departures

All individual factors recorded importance ratings of 45 points or higher indicating general agreement amongst participants of the importance of these factors. Participants identified 13 individual factors that had importance ratings higher than 60. The higher scores reflected greater agreement amongst participants about the importance of each of these factors on health staff departures. The highest importance rating means (above 70 points) were for heavy workload/burnout, work/life balance, career progression, mental health and wellbeing, and inadequate remuneration.

Question two asked survey participants to rate the importance of 19 workplace factors that could influence health staff departures outlined in Figure 21 below.

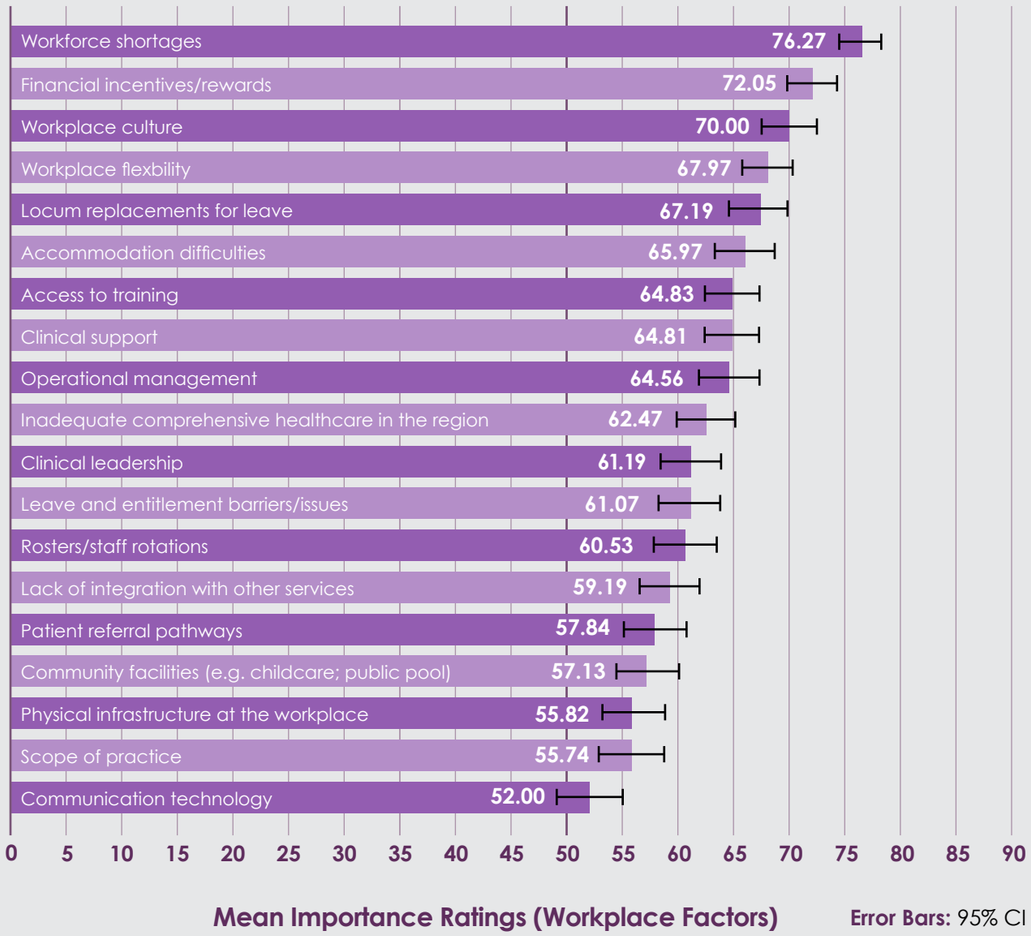


Figure 21: Mean importance ratings for workplace factors influencing health staff departures

All workplace factors recorded importance ratings means of 50 points or higher, which indicates overall agreement amongst survey participants that the factors may be contributing to health staff departures. Of the 19 factors, participants rated 13 factors higher than 60. The highest workplace importance rating means were for workforce shortages, financial incentives/rewards and workplace culture - all with means of 70 or more. Workplace flexibility, locum replacements for leave and accommodation difficulties had means higher than 65 points.

Comments about Health Staff Departures

Photo by Aimee Najdovski

For each *Issue in Focus* question, survey participants were asked to outline any 'other' factors influencing health staff departures over the last year, either from their service and/or their community. There was also an opportunity to comment more generally on any unique or other factors.

Participants recorded 42 comments for the question on individual factors, and 97 comments for the question on workplace or 'other' factors. Thematic analysis was undertaken of comments provided in response to both questions and several primary themes were identified for each.

Individual Factors

Three primary sub-themes were identified for individual factors influencing health staff departures: workplace culture, distance and isolation, and lack of infrastructure and services.

Individual Factors

- Workplace culture (*n* = 24)
- Distance and isolation (*n* = 12)
- Lack of infrastructure and services (*n* = 6)

Figure 22: Individual factor sub-themes

Most comments to question one discussed workplace culture. However, as this aspect is not an individual factor, minimal data is provided in this section and the full analysis of these responses has been included in the next section of the report dealing with workplace factors influencing health staff departures.

Comments related to workplace culture included the following sub-themes: the perceived lack of respect for the knowledge and experience of practitioners from management and sometimes community members; feelings of exploitation; lack of locally available career progression options; and inadequate leadership, collaboration, or relief support from management. Some comments touched upon vaccine mandates and policy constraints as other drivers of staff departures.

Distance and isolation was the next most frequently mentioned sub-theme. Comments emphasised the professional and personal costs of social isolation, the added impost to access professional development, and having to travel from and return to community as required. Health staff providing outreach services echoed this sentiment where services are delivered across large geographical areas with transport challenges negatively impacting clinician work-life balance.

Comments from the final sub-theme related to a lack of or inadequate infrastructure and services such as unsuitable or unavailable health facilities/services for practitioners and their families, unreliable internet and lack of suitable accommodation options.

Workplace Factors

Four primary sub-themes were identified for workplace factors influencing health staff departures which were workplace culture, community and lifestyle, remuneration and cost of services, and workload and burnout. These are presented in Figure 23.

Workplace Factors

- Workplace culture (*n* = 42)
- Community and lifestyle (*n* = 33)
- Remuneration and cost of services (*n* = 24)
- Workload and burnout (*n* = 19)

Figure 23: Workplace factor sub-themes

1. Workplace culture

The sub-theme of workplace culture identified poor leadership/management and internal disagreements as drivers contributing to staff departures. Participants also associated staff departures with factors such as bullying and a lack of respect in the workplace, which is exacerbated by existing workforce shortages, high workloads, and other unfavourable working conditions. Many comments touched on perceived inadequacies in the delivery of public services to smaller communities, such as advertising the availability of allied health services that were not easily accessible.

Other participants wrote specifically about the need to improve resources to train new staff and the lack of growth and specialisation opportunities. Further, some participants mentioned the lack of multidisciplinary collaboration, and workforce poaching by corporates and larger practices as well as public health services.

"I have left XXX [MM 6 location] for many of the reasons outlined above. I have based my answers on this. The HHS executive behaved in a way that was not aligned with their stated values and goals for service delivery clearly indicating a lack of valuing of their staff and the community they were supposed to be caring for. Fatigue, short staffing and the XX information systems made it a very difficult place to continue working and feel safe and supported. The negative impact on patients and staff were and continue to be enormous. I loved that community and did not want to leave but I could not cope staying there when management chose to treat its staff and patients this way. I would have stayed on in the community working in private general practice if it was financially viable to do so but it was not."

"Within another remote community I practiced in recently - bullying from medical management has resulted in turnover of 50% of doctors in 12 months."

2. Community and lifestyle

Community and lifestyle factors mentioned by participants included lack of practitioner privacy and safety, and increased patient demands and expectations which prompted some participants to additionally voice concerns about prevailing 'community culture' as affecting workforce morale and intention to stay.

"Violence in the community - feeling unsafe."

"Community demands because of other workforce vacancies e.g., our exercise physiologist received negative feedback and complaints about our service because we have been without a podiatrist. Our clinicians are met with regular disgruntled community members because of other staff vacancies."

Other community and lifestyle factors contributing to staff departures was focused on the needs of practitioner's families, such as children's education, spouse employment, and support for family members. Distance and isolation from family and/or services was also cited as a cause for relocation, several participants simply stating that they aspired for a 'better life'. Finally, some comments spoke to the lack of access to basic community services such as locally accessible comprehensive healthcare, domestic maintenance services, and adequate housing resources.

"One of the reasons we have not moved back to [MM 4 location], and we choose to live in the city is because I have a young child, no family support locally and there are no vacancies at the local day-care (with a very long waiting list). My husband can also not get a job in town."

"Less on call work, less weekend work in more populated areas. They move there instead. Doctors' partners not always able to get work locally. Severe housing shortage, even doctors struggle (lots of homelessness in the general population)."

3. Remuneration & cost of services

The third sub-theme for this question was remuneration and cost of services. Comments that aligned with this theme addressed 'low wages' or 'poor pay', but participants also highlighted other factors impacting staff departures, including the rising cost of health care, lack of basic community services, and availability of accommodation in remote and rural communities. Pay disparities between disciplines as well as pay disparity between public and private sector staff were also mentioned.

A few participants believed staff departures were due to better financial rewards being offered in other locations. Others mentioned high travel costs and the lack of adequate reimbursement in the provision of outreach services and upkeep of required hours of CPD.

"Remuneration is generous for medical staff, but allied health & nursing it is not, while they also struggle to get accommodation, their own health care costs them more than if they were living in metropolitan area as they spend time to travel etc. - so disappointing when you spend your time looking after others but struggle to access the care you & your family need because of your decision to live here."

"Pay scale when competing against Queensland Health and staff being approached and offered positions by Hospital service."

"Time and financial cost of accessing required hours of CPD, particularly for experienced therapists, needing to travel and access higher level CPD."

4. Workload and burnout

The final sub-theme for this question was 'workload and burnout'. Participants indicated that staff departures were attributable to high workloads, long waitlists, long travel times and fatigue, and being 'overworked and on call 24/7'. Some indicated that they were impacted by 'covid stress, burnout and existential crisis'. A few comments mentioned that vaccine mandates also contributed to some staff departures. The lack of adequate locum relief and time off also contributed to higher rates of burnout and staff departures.

"Overwork with having to handle the strain while not getting as much time off to recover from the increased workload/demands."

"Impact of travel on staff travelling in/out of rural community from metro areas leads to high degree of fatigue, burnout and staff resignation even with flexible work arrangements, 9-day fortnights, work from home, reimbursement for travel costs. As a result, staff really need to be based in rural communities, not visiting from other more metro areas."

"Enforcing the no Covid vaccination no employment policy. There were a lot of health staff that chose to leave their jobs and not have the vaccine, making the pressured health care services more under the pump."

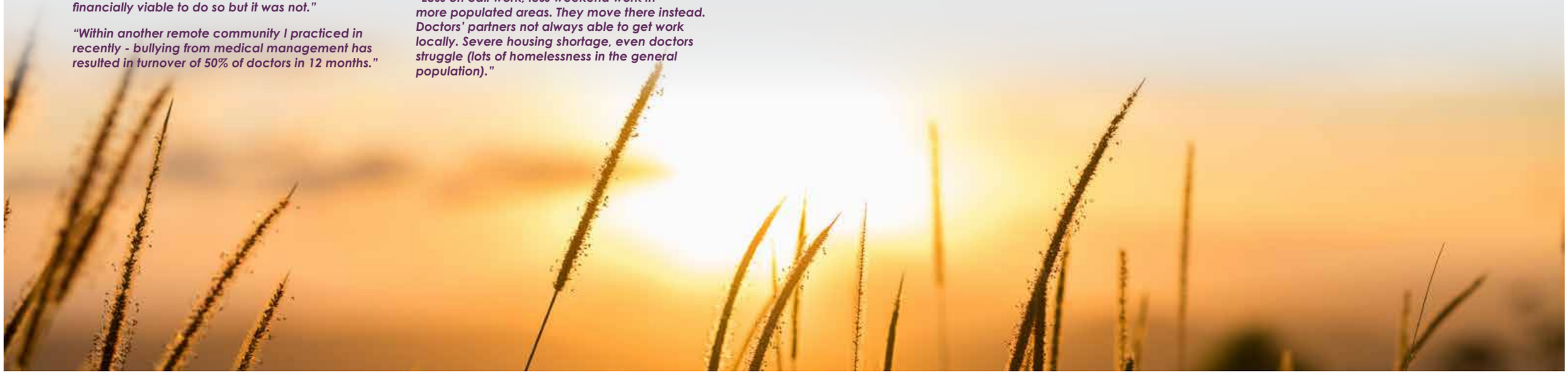


Photo by Krishna Doshi

Photo by Desolee Cowlee

Quantitative Methodology Findings: Priority SA2s

Below are the top ranked SA2s by PHN region based on the quantitative methodology described on page seven of this report.

The methodology incorporates; GP FTE to population ratio, MM classification of remoteness, SEIFA (IRSAD), vulnerable population aged < 5 or > 65 years, and Aboriginal and Torres Strait Islander status. Priority SA2s indicate areas of possible current and/or ongoing workforce need. Appendix A outlines the main towns or communities located within each SA2.

Northern Queensland PHN Region

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

Western Queensland PHN Region

Carpentaria
Far South West
Far Central West
Mount Isa Surrounds
Charleville

Darling Downs and West Moreton PHN Region

Kingaroy Surrounds - North
Tara
Crows Nest - Rosalie
Esk
Millmerran
Southern Downs - West
Nanango
Chinchilla
Inglewood - Waggamba
Lowood

Central Queensland, Wide Bay & Sunshine Coast PHN Region

Kilkivan
Maryborough Surrounds - South
Agnes Water - Miriam Vale
Gympie Surrounds
Cooloola
Gin Gin
Central Highlands - East
Mount Morgan
Gayndah - Mundubbera
Monto - Eidsvold

It should be noted that this list is not a comprehensive reflection of the need in these regions. The findings of the quantitative methodology are a starting point. Further qualification of need in these regions are discovered through ongoing communication and collaboration at the local level as well as the use of Health Workforce Queensland's guiding principles that were developed to support the prioritisation of SA2 locations in a changing environment, and to assist in prioritising what activities (if any) that Health Workforce Queensland undertakes in these regions.

Key Issues and Strategies

Access

Improving access and continuity of access to essential primary health care

Key Issues

- Shortages of GP, nursing, midwifery, allied health, and Aboriginal & Torres Strait Islander health worker/practitioner workforce in remote and rural Queensland
- Inequitable distribution of health workforce
- Lack of or inadequate infrastructure (ICT, physical)
- Insufficient funding for workforce and services in priority locations
- Long distances to travel to access services/lack of locally available services
- Lack of affordable and appropriate transport to access services
- Lack of suitable housing for health professionals
- Limited/lack of services available after hours
- Cost of services/lack of bulk billing services impacting on populations of lower socio-economic status
- Lack of culturally safe health service options in some rural communities
- Health literacy around health service access and availability

Strategies

- Employ targeted recruitment support and retention packages to priority communities, including locums
- Continue to build evidence through collation of workforce data to inform workforce planning
- Assist health professionals with relocation grants and incentives
- Utilise fly-in, fly-out employment options to support and supplement the local workforce
- Support clinical and leadership development
- Promote the increased use of virtual and digital tools including telehealth
- Streamline processes for patients to access transport subsidies
- Develop innovative workforce models to support community need and increase workforce capacity
- Ongoing workplace cultural training and embedding culturally responsive practices to support culturally responsive services
- Encourage interprofessional collaboration and communication
- Advocate for further policies and activities to attract health professionals to remote and rural areas

Desired Outcomes

- Increased supply of primary care workforce to priority areas
- Improved availability of appropriate infrastructure to support health service requirements
- Increased utilisation for virtual and digital tools to support health service delivery
- Increased availability of affordable and appropriate transport to access health services
- Increased availability of appropriate housing for health professionals
- Increases in technology and financial supports for health professionals
- Greater understanding of services and access to affordable primary care within communities

Quality

Building workforce capability

Key Issues

- Skill mix of workforce not aligned to local needs
- Lack of experienced, long stay workforce
- Care is episodic rather than comprehensive, continuous and person-centred
- Workforce not equipped to deliver culturally appropriate health care
- Low representation of First Nations people delivering health care
- Difficulty accessing quality professional development and clinical upskilling
- High representation of early career graduates in allied health
- Challenges in training and developing a local workforce
- Lack of mentoring and leadership opportunities
- Barriers to expanding or utilising full scope of practice
- Workforce data and patient information is siloed

Strategies

- Support to commence vocational training in health-related studies, close to home
- Organisational support to access continuing professional development
- Provision of scholarships and bursaries to support upskilling aligned to community need
- Organisational support for staff to undertake leadership training at all levels
- Encourage activities that support role development and enhance scope of practice for all professions
- Support commissioning of providers that embed cultural, clinical, and organisational orientation and training in their organisations to support transitions to rural practice
- Support succession planning to ensure a continuous pipeline of strong clinical and administrative leaders
- Increase workforce capacity through workforce redesign to deliver quality multidisciplinary care
- Strengthen the First Nations health workforce training pipeline to support culturally responsive health service delivery to First Nations people
- Better utilise the Aboriginal and Torres Strait Islander Health Practitioner role including delivering services to complement activities undertaken by Indigenous Health Workers
- Shared patient records across organisations to support quality care
- Shared workforce data across organisations to assist with workforce and service planning at the local level

Desired Outcomes

- An experienced and capable workforce that is responsive to local needs
- Increased availability and continuity of quality primary health care services
- Increased availability of quality training, close to home
- Work environments that enable staff to work to the top of their scope providing workforce satisfaction and quality care
- Increased capability of the health workforce to deliver culturally appropriate health care
- A greater cohort of clinical and administrative leaders in remote and rural communities
- Workforce data is accessible and supports workforce planning at the local level
- Patient information is accessible across organisations to support quality care

Sustainability

Growing the sustainability of the health workforce

Key Issues

- Ongoing challenges for recruiting and retaining health workforce
- High turnover of health professionals in remote and rural communities
- Limited pipeline of locally trained workforce
- Decline in interest in rural health, general practice and primary care as career choices
- Lack of end-to-end training in remote and rural communities, preventing the development of required community-based skills
- Inefficient and fragmented care due to workforce instability
- Vulnerable and non-viable workforce models including:
  - Challenges to the viability of private health services in remote and rural areas including cost of living, distances to travel, income of clients, access to workforce and economies of scale.
  - Current fee for service general practice models in remote and rural areas does not support sustainability
  - Current models don't support 'Easy Entrance, Gracious Exit' of workforce creating financial, administrative and work/life balance burdens
- Lack of workforce retention due to: lack of access to continuing professional development, professional isolation, burnout due to lack of relief, poor housing and accommodation, high cost of living, spouse/family and lifestyle considerations
- Concerns for the mental health and well-being of the workforce due to climate and natural disasters such as floods, droughts, fires, as well as the impacts of the COVID-19 Pandemic

Strategies

- Offer rural immersion opportunities to attract students into rural health careers
- Support rural high school visits to create interest in a rural health career
- Work with universities to identify and prioritise students interested in rural health practice for long term placements and to expand support of remote and rural Queensland student placements and first jobs
- Availability of end-to-end training in regional and remote sites, for all professions
- Collaborate at the local level to support essential worker accommodation solutions
- Support navigator and liaison roles to promote better system integration, coordination and collaboration
- Investigate blended funding workforce models to support financial viability and skills retention
- Work within priority communities to assess and develop innovative workforce models that expand scope of practice and that consider emerging health workforce roles
- Family support opportunities including schooling and childcare for children, employment opportunities for partners
- Prioritise collaborative, place-based workforce and service planning with communities in order to meet community need
- Encourage local health professionals and community members to mentor and support students on long term placements
- Availability and promotion of mental health and wellbeing services for the remote and rural health workforce
- Advance practice sustainability by expanding the types of professions in remote and rural practice that can access MBS items and explore alternate funding models

Desired Outcomes

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

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 state-wide:

- Australian College of Midwives
- Australian College of Remote and rural Medicine (ACRRM)
- Australian Indigenous Doctors' Association (AIDA)
- Australian Primary Health Care Nurses Association (APNA)
- Central Queensland Centre for Remote and rural Health (CQRRH)
- CheckUP Australia
- College of Medicine and Dentistry, James Cook University
- CRANAplus
- Country to Coast, QLD (previously known as Central Queensland, Wide Bay & Sunshine Coast PHN)
- Darling Downs West Moreton Primary Health Network (DDWM PHN)
- General Practice Training Queensland (GPTQ)
- Indigenous Allied Health Australia (IAHA)
- James Cook University General Practice Training
- Murtupuni Centre for Remote and rural Health (MCRRH)
- My Midwives
- Northern Queensland Primary Health Network (NQ PHN)
- Office of Remote and rural Health, Department of Health Queensland
- Office of Remote and rural Health, Future-Proofing Our Rural Workforce Collaborative (FORCE)
- Queensland Aboriginal and Islander Health Council (QAIHC)
- Queensland Country Practice, Queensland Rural Medical Service, Darling Downs Hospital & Health Service
- Queensland Health
- Remote Vocational Training Scheme (RVTS)
- Royal Flying Doctors Service, Queensland Section
- Rural Clinical School, Faculty of Medicine, The University of Queensland
- Rural Doctors Association of Queensland (RDAQ)
- Services for Australian Remote and rural Allied Health (SARRAH)
- Southern Queensland Rural Health (SQRH)
- The Royal Australian College of General Practitioners (RACGP)
- Western Queensland Primary Health Network (WQ PHN)

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Appendix A - Priority SA2s by PHN Region

Western Queensland PHN Region

Rank	SA2 Name	Towns/Communities within SA2
1	Carpentaria	Burketown Carpentaria Mornington Island Normanton Karumba
2	Far South West	Cunnamulla Thargomindah Quilpie
3	Far Central West	Birdsville Bedourie Boulia Windorah Jundah Winton
4	Mount Isa Surrounds (not including Mount Isa)	Camooweal Cloncurry Dajarra
5	Charleville	Charleville Morven Murweh Augathella

Darling Downs and West Moreton PHN Region

Rank	SA2 Name	Towns/Communities within SA2
1	Kingaroy Surrounds - North	Cherbourg Murgon Proston Wondai
2	Tara	Glenmorgan Meandarra Moonie Tara
3	Crows Nest - Rosalie	Crows Nest Yarraman
4	Esk	Esk Toogoolawah
5	Millmerran	Cecil Plains Millmerran
6	Southern Downs – West	Allora Dalveen Karara
7	Nanango	Benarkin Blackbutt Nanango
8	Chinchilla	Chinchilla
9	Inglewood – Waggamba	Inglewood Texas
10	Lowood	Fernvale Lowood

Central Queensland, Wide Bay & Sunshine Coast PHS Region

Rank	SA2 Name	Towns/Communities within SA2
1	Kilkivan	Goomeri Kilkivan
2	Maryborough Surrounds - South	Brooweena Mungar Tiaro
3	Agnes Water - Miriam Vale	Agnes Water Miriam Vale Seventeen Seventy
4	Gympie Surrounds (excluding Gympie)	Amamoor Curra Goomboorian Imbil Kandanga
5	Cooloola	Cooloola Rainbow Beach Tin Can Bay
6	Gin Gin	Gin Gin
7	Central Highlands - East	Blackwater Woorabinda
8	Mount Morgan	Mount Morgan
9	Gayndah - Mundubbera	Biggenden Gayndah Mundubbera
10	Monto - Eidsvold	Eidsvold Monto Mulgildie Mount Perry

Northern Queensland PHN Region

Rank	SA2 Name	Towns/Communities within SA2
1	Aurukun	Aurukun Wallaby Island
2	Torres Strait Islands	Badu Island Boigu Island Mabuiag Island Saibai Island
3	Northern Peninsula	Bamaga New Mapoon Injinoo
4	Croydon - Etheridge	Croydon Georgetown
5	Collinsville	Collinsville Mount Coolon
6	Tablelands	Almaden Dimbulah Mount Malloy
7	Cape York	Coen Hope Vale Laura Mapoon
8	Herberton	Herberton Mount Garnett Ravenshoe
9	Kowanyama - Pormpuraaw	Kowanyama Pormpuraaw
10	Tully	Cardwell Tully

Appendix B – Professions

Aboriginal and Torres Strait Islander Health Worker and Health Practitioner	Nutritionist
Allied Health Assistant	Occupational Therapist
Alcohol and Other Drugs Worker	Optometrist
Audiologist	Paramedic
Dental Practitioner	Pharmacist
Diabetes Educator	Physician Assistant
Dietitian	Physiotherapist
Exercise Physiologist	Podiatrist
Family Support Worker	Practice Manager
Health Promotion	Psychologist
Medical Receptionist	Radiographer
General Practitioner	Social Worker
Midwife	Speech Pathologist
Nurse	Sonographer

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