Health Workforce Queensland

2022 Health Workforce Needs Assessment

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

February 2022

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 rural and remote Queensland communities.

Equity

We provide equal access to services based on prioritised need.

Acknowledgements

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

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

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Executive Summary

Health Workforce Queensland undertakes an annual primary care Health Workforce Needs Assessment (HWNA) for remote, rural and regional areas of Queensland. This 2022 report provides an update of current and emerging issues as well as profession specific summaries. The report also identifies priority Statistical Area Level 2 (SA2) locations based on a nationally consistent quantitative methodology and indicates areas of possible current and/or ongoing workforce need.

Access to health workforce in remote and rural communities continues to remain one of the greatest barriers in addressing health need in Queensland, particularly in the primary health care setting. At the heart of primary care in remote and rural communities in Queensland is general practice. Our Issue in Focus topic for this year is practice sustainability and includes several questions to gauge the perceptions of practitioners and managers regarding issues that impact the sustainability and viability of their primary health care practices. Findings reinforce that general practice is very fragile with key themes highlighting challenges in workforce, funding and incentives, support, and infrastructure. The report outlines numerous national and state reviews, reports and strategies that are currently looking at rural general practice and other increasing pressures on the health system.

Primary care workforce data for general practitioners, allied health professionals, nurses and midwives, and Aboriginal and Torres Strait Islander Health Workers/Practitioners are also described through the most recent release of the 2020 National Health Workforce Dataset and Health Workforce Queensland's own database. Of note, between 2019 and 2020 there was an increase of 40 registered practitioners who identified as being of Aboriginal and/or Torres Strait Islander origin.

The report also identifies perceived health workforce and service gaps in remote and rural communities through our annual comprehensive survey. In the five years that the HWNA surveys have been conducted, trends show that all workforce and service gap ratings have increased, further supporting the evidence around growing challenges for the rural and remote health landscape. This year, the highest workforce gap rating means were for the psychology, speech pathology, social work, general practitioner and occupational therapy workforces. The most frequently mentioned service gaps were for mental health, allied health practitioners and GPs, particularly around shortages, wait times and affordability of services.

The highest service gap rating means were for mental health services, community-based rehabilitation services, alcohol and other drug services, social support services, and aged care services. The most frequently mentioned service gaps related to mental health and aged care services. Across all of the primary care services mentioned, the lack of services and health practitioners was clearly identified.

Finally, the HWNA identifies collaborative strategies to address the key issues and findings under the priority areas of Access, Quality and Sustainability. Guiding principles are outlined and serve to support the prioritisation of locations and implementation of strategies in a resource poor, and ever-changing environment.

Introduction

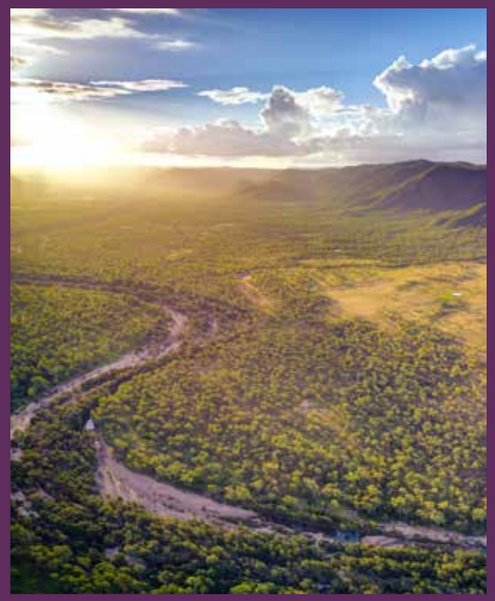
Health Workforce Queensland undertakes an annual primary care HWNA for remote and rural areas of Queensland classified as Modified Monash (MM) 2-7 (2019). This report summarises the findings from the 2022 HWNA and builds upon the baseline understanding of workforce needs established in previous HWNA 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 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 was 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 2021.

Online Survey: Online surveys targeting general practitioners (GPs), practice managers, primary health care nurses, allied health practitioners, 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 2021 and February 2022.

Stakeholder Engagement: Information was sourced from consultations with key stakeholders, communities, and health professionals throughout 2021. The jurisdictional HWSG also provided input at the annual meeting in 2021.

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

- GP full time equivalent to estimated resident population ratio (ABS 2021)
- MM classification of remoteness (2019)
- Index of Relative Socio-economic Advantage and Disadvantage (IRSAD)
- 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.

Of note, in 2020, the MM coding was changed from the older 2016 geography to the 2019 MM. Some locations have changed coding which has impacted some of the practitioner numbers per coding category, most notably smaller numbers in MM 2 locations. The change to the 2019 MM is directly aligned with reporting requirement changes requested by the Australian Government Department of Health. This could impact interpretation of trend data provided in this report.

The Australian Bureau of Statistics (ABS) released the updated Australian Statistical Geography Standard (ASGS) Edition 3 in July 2021. The new edition will be progressively introduced by the ABS over 2022 and 2023. The quantitative methodology used to determine priority SA2 locations in this needs assessment is based on the 2016 ASGS. The SA2 methodology will use the ASGS Edition 3 for the 2023 HWNA.

Remote and Rural Workforce Overview

Access to health workforce in remote and rural communities continues to remain one of the greatest barriers in addressing health need in Queensland, particularly in the primary health care setting. With ongoing restrictions of health workforce movements due to COVID-19, and the desire for many health professionals to be closer to home in a pandemic environment, remote and rural Queensland is experiencing health workforce shortages in many professions, and subsequently placing greater pressures on those that are working at the coalface.

These challenges are not just in health but in many other sectors, with the ongoing decline of investment in rural communities and many key services and supports centralising to metropolitan and regional cities. This has resulted in the loss of jobs and economic opportunity in these communities, contributing to the flow-on loss of local shops, services, and health care.

For health professionals, this often translates to poor accommodation options, limited to no childcare assistance and few options for spousal employment and children's schooling. The fewer incentives available in the local setting, the more pressure there is to provide individual incentives, and these may not be enough to attract and retain health professionals in the long term.

At the heart of primary care in remote and rural communities in Queensland is general practice, and it is in crisis. The decline in the number of doctors choosing general practice as a specialty, workforce design and models of care hamstrung by rigid Medicare billing structures, and the additional pressure of a pandemic are creating an unsustainable tipping point for many practices.

In recognition of these ever-increasing pressures on the health system, and to seek solutions, there are numerous reviews and reports underway.

At the National level, the Senate Community Affairs References Committee is conducting an ***Inquiry into the provision of general practitioner and related primary health services to outer metropolitan, rural, and regional Australians.*** The Inquiry is considering Government reforms and policies, geographical classification systems, GP training reforms and Medicare rebates, as well as the impact of the COVID-19 pandemic on doctor shortages.

In terms of national health plans and strategies, a new ***National Aboriginal and Torres Strait Islander Health Plan for 2021 to 2031***, the ***National Medical Workforce Strategy*** and the ***Australia's Primary Care 10 Year Plan 2022-2032*** were recently released. An independent ***National Mental Health Workforce Strategy Taskforce*** comprised of representatives from across the mental health sector are informing the development of a ***National Mental Health Workforce Strategy*** to identify practical approaches to attract, train and retain the workforce required to meet the increasing demands of the mental health system into the future.

Finally, a consultation paper has been released to inform the development of a ***10-year plan for Nurse Practitioners***. This will be the first national plan for Nurse Practitioners (NPs) and will provide an opportunity for the value of this workforce to be realised, and to enhance diversity in the delivery of care to remote and rural communities.

At a jurisdictional level, the Health and Environment Committee have commenced an ***Inquiry on the provision of primary, allied and private health care, aged care*** and ***National Disability Insurance Scheme (NDIS) care services and its impact on the Queensland public health system*** this year with the report delivered to the Legislative Assembly by 31 March 2022.

Policy and budget changes have also been rolled out over the past 12 months to address continuing challenges. This year's Budget saw a progressive increase in the ***Rural Bulk Billing Incentive*** in a tiered approach across MM 3-7. Regional and larger rural towns in MM 3-4 will join MM 5-7 regions to have automatic access to the Distribution Priority Area (DPA) classification, making it easier for them to recruit international medical graduates (IMGs) and those under bonded service requirements, such as medical scholarship holders.

The Government will also provide a significant incentive for eligible doctors and NPs to practise in rural, remote or very remote areas, by eliminating all or part of their Higher Education Loan Program (HELP) debt, if they satisfy certain criteria. There has also been increased funding and commitment for telehealth. This will support greater flexibility for patients, doctors and allied health providers for the delivery of health care, particularly for remote and rural communities. It will also support increased collaboration between primary, specialist and emergency department providers, which is much needed through the COVID-19 pandemic.

The Regional Australia Institute highlighted a trend of population migrating from capital cities to regional Australia and while the Gold Coast and Sunshine Coast both still make up the largest share of migration by LGA in the nation, regional Queensland picked up 26 percent of net regional inflows in the 12 months to September 2021.[1]

To support this new growth opportunity, governments need to not just provide incentives for individual health professionals, but to also return to a policy of supporting remote and rural towns and their residents by delivering services and jobs locally. Increasing strategic investment in rural place-based community development will support workforce attraction and address the social determinants of health holistically.

A new ***National Preventive Health Strategy 2021-2030*** has been released with a focus on health equity for priority populations with targets that aim to improve the overall health and wellbeing of vulnerable populations.[2] Strengthening the focus on prevention and building systemic change over a 10-year period to reduce the burden of chronic disease is an important step in the right direction.

Local approaches addressing the determinants of health within a region can also be effective over time. Responsive health service and workforce models need to include collaborative, place-based planning and commissioning with community involvement, and funding needs to be blended. Importantly, pay disparities between public and private settings should also be addressed.

Support for the creation and implementation of new models within communities, in line with the recommendations of ***Australia's Primary Care 10-Year Plan 2022 -2032***, to counter the systemic and funding barriers, is a necessary way forward. With that, new opportunities for 'grow your own' and even 'virtual' workforces offering greater flexibility within service models that suit the remote and rural context.

[1] Regional Australia Institute. (2021). *Regional Movers Index - September Quarter 2021*. https://www.regionalaustralia.org.au/common/Uploaded%20files/Files/Regional%20Movers%20Index/RMI-September-Quarter-2021-2.pdf

[2] Department of Health. (2021). *National Preventive Strategy 2021-2030.* Australian Government. https://www.health.gov.au/sites/default/files/documents/2021/12/national-preventive-health-strategy-2021-2030_1.pdf

Allied Health Workforce Summary

This year's HWNA findings show that the majority of the allied health workforce gap ratings continue to reflect growing workforce decline. Although partly attributable to pandemic related border closures, five-year trend analysis reveals allied health workforce shortages in many of Queensland's MM 2-7 locations are longstanding, with occupational therapy, psychology, social work and speech pathology consistently ranked in the top five workforce gaps in the state.

The importance of the allied health workforce in the provision of high-quality primary healthcare can, at times, be overshadowed by other health workforce challenges in remote and rural settings. However, when resources are directed to local and regionally based initiatives, they are often confounded by insufficient workforce supply and/or high turnover. There remains a need to tackle the longstanding allied health workforce shortages in remote and rural communities at a strategic and systemic level to support effective, multidisciplinary primary care.

The strongest evidence concerning recruitment of allied health practitioners to remote and rural practice relates to rural background, curriculum that reflects rural issues, and quality rural placements. Factors that influence retention include safe and supportive work environments, supportive career development opportunities, professional networks, recognition of the role, and appropriate financial incentives. One of the strongest lines of emerging evidence is the 'rural pipeline'; recruiting students from rural backgrounds, delivering regional training, exposure during training to rural curriculum and placements, and then building opportunities for regional postgraduate training.[3] Comparatively limited resources for clinical training in rural areas remains a critical issue for allied health.

Access to clinical supervision where there are small numbers of experienced practitioners is often a major challenge in the development of rural pipelines. Research published this year assessing the effectiveness of interprofessional and cross-organisational models of group clinical supervision found these strategies can help address issues relating to access to quality clinical supervision for rural allied health professionals. Group clinical supervision was perceived to be effective, enhancing reflection, learning and peer support. Organisational support, facilitator training, group structure and planning for sustainability were identified as critical factors for success.[4]

A key factor in the development of a rural allied health pipeline in Queensland is the delivery of regional training. Regional training pathways improve accessibility for regionally based students, allowing them to study, train, and practice in the regions they are from. Literature shows strong associations exist between training in a region and subsequently practising in that or a similar region. With only psychology and social work courses of study delivered in locations MM 3-7 or online, a need to develop greater opportunities for place based end-to-end training is evident.

The Allied Health Rural Generalist Pathway is an innovative workforce development strategy to increase access to a highly skilled allied health workforce for remote and rural Australian communities. The Australian Government allocated $9.6 million over three years in the May 2021 budget to fund the expansion of the Allied Health Rural Generalist Pathway. The Allied Health Rural Generalist Education and Training Scheme (TAHRGETS) includes resourcing and support for early career rural generalist trainees and their employers, which is essential to sustainably support trainees in the primary care setting. The initiative will also include further development of training accreditation systems.

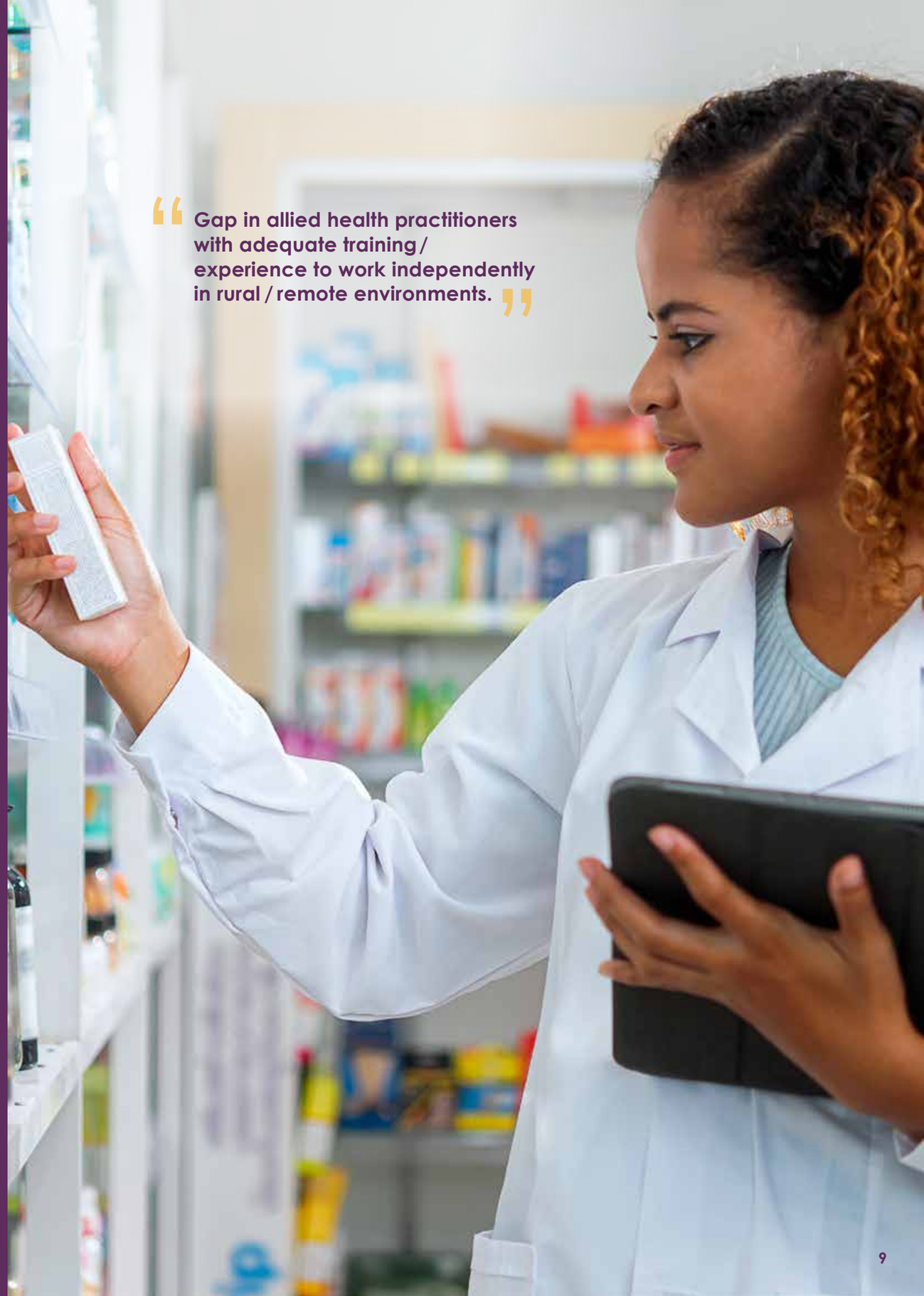
The release of the ***Consultation Draft – Future focused primary health care: Australia's Primary Care 10 Year Plan 2022-2032***[5] in October 2021 signals a focus by the Australian Government on allied health across the health, aged care and disability care systems. Initiatives of note include:

- The development of a data strategy for allied health to develop an allied health primary care minimum dataset.
- Development of secure messaging and software infrastructure to support allied health interaction with general practice and My Health Record.
- Financially rewarding allied health participation in the Medicare Benefits Scheme (MBS) Billing Team Care Arrangements through the Workforce Incentive Program (WIP).
- Development of a National Allied Health Workforce Plan to optimise the allied health workforce.
- Continuation of efforts to re-align workforce education and training programs and update accreditation and compliance standards to reflect advances in multidisciplinary models of care.

[3] Battye, K., Roufeil, L., Edwards, M., Hardaker, L., Janssen, T., & Wilkins, R. (2019). *Strategies for increasing allied health recruitment and retention in Australia: A Rapid Review*. Services for Australian Rural and Remote Allied Health (SARRAH). https://sarrah.org.au/images/rapid_review_-_recruitment_and_retention_strategies_-_final_web_ready.pdf

[4] Garnder, M., McKinstry, C., & Perrin, B. (2021). Group Clinical Supervision for Allied Health Professionals. *The Australian Journal of Rural Health*, 29(4), 538-548. https://doi.org/10.1111/ajr.12775

[5] Department of Health. (2021). *Consultation Draft - Future focused primary health care: Australia's Primary Health Care 10 Year Plan 2022-2032*. Australian Government. https://guides.library.uq.edu.au/referencing/apa7/report#s-lg-box-21144094



First Nations Health Workforce Summary

The health of First Nations people continues to be a focus of both the state and federal governments this year, with major initiatives impacting First Nations health workforce being progressed.

A new ***National Aboriginal and Torres Strait Islander Health Plan for 2021 to 2031*** was launched on 15 December 2021.[6] The Plan has twelve priorities and recognises workforce as a key enabler for change, alongside Aboriginal and Torres Strait Islander community controlled comprehensive primary health care, and shared decision making and partnerships.

The Health Plan is aligned with a refreshed ***National Aboriginal and Torres Strait Islander Health Workforce Strategic Framework and Implementation Plan*** which was launched in early 2022.[7] According to the National Health Leadership Forum, the Strategic Framework and Implementation Plan will aim to accelerate the growth of the Aboriginal and Torres Strait Islander health workforce across all health roles (both clinical and non-clinical) and locations.

This year in Queensland, a discussion paper, framework and implementation toolkit addressing health equity for First Nations people was released. The initiative has been co-designed and jointly written between Queensland Health and the Queensland Aboriginal and Islander Health Council (QAIHC) on behalf of Aboriginal Community Controlled Health Services (ACCHS) and is based on regional consultations which were held across Queensland from April to June 2021.

One of the most significant reforms of the health equity strategy is the amendment to the ***Hospital and Health Boards Act 2011***, requiring each Hospital and Health Service (HHS) to develop and implement a Health Equity Strategy in partnership with First Nations peoples and local ACCHS. HHSs will have 12 months to develop and release their strategies after the regulation has been proclaimed.

Growing the Aboriginal and Torres Strait Islander health workforce is a key priority in both national and state government initiatives. Aboriginal and Torres Strait Islander health professionals play a key role in both the delivery of culturally safe care, and in building the cultural responsiveness of health services.

During 2021, Health Workforce Queensland supported health professionals working in the ACCHS sector through the awarding of 111 scholarships and bursaries for continuing professional development. Of these, 25 recipients identified as being of Aboriginal and/or Torres Strait Islander origin with a further 16 scholarships/bursaries provided to individuals who identified as being of Aboriginal and/or Torres Strait Islander origin.

Table 1 (page 11) reflects the number of Australian Health Practitioner Regulation Agency (AHPRA) registered health professionals who identified as being of Aboriginal and Torres Strait Islander origin in MM 2-7 by profession in Queensland in 2019 and 2020.

[6] Department of Health. (2021). *National Aboriginal and Torres Strait Islander Health Plan 2021-2031*. Australian Government. https://www.health.gov.au/sites/default/files/documents/2021/12/national-aboriginal-and-torres-strait-islander-health-plan-2021-2031_2.pdf

[7] National Health Leadership Forum. (n.d.). *Leadership*. https://www.nhlf.org.au/our-work/

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

Registered Health Profession	2019	2020
Aboriginal and Torres Strait Islander Health Practitioner	91	**114**
Paramedic	51	**59**
Practice Nurse/Midwife	42	**44**
Medical Practitioner	19	**19**
Psychologist	27	**25**
Physiotherapist	20	**20**
Dentist	15	**13**
Occupational Therapist	12	**20**
Pharmacist	8	**7**
Medical Radiation Practitioner	6	**9**
Chiropractor	5	**6**
Optometrist	0	NA*
Total	**296**	**336**

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

Between 2019 and 2020 there was an increase of 40 registered practitioners who identified as being of Aboriginal and/or Torres Strait Islander origin. The largest increases were for those registered as Aboriginal and Torres Strait Islander Health Practitioners, Paramedics and Occupational Therapists. Medical Radiation Practitioner registrations increased by three, which represents a 50 percent increase.

General Practitioner Workforce Summary

The challenges for general practice in remote and rural Queensland continue, with health professionals and practice managers rating a significantly greater workforce gap in 2022.

Workforce shortages brought about by ongoing domestic and international border closures, rising patient pressures caused by delays in accessing healthcare during the pandemic, and increased migration to regional Australia[8] has seen remote and rural GPs come under increasing strain.[9]

In addition, stretched general practices have also delivered more than 80 percent of all COVID-19 vaccine doses.[10]

It is no surprise that potentially preventable GP-Type presentations to emergency departments (EDs), as a percentage of overall ED presentations in MM 2-7 increased by 17 percent in 2021 (*n* = 450,454) compared to 2020 presentations. Figure 1 shows percentage trends of GP-Type presentations to EDs in MM 2-7 locations by month in Queensland over a five-year period.[11]

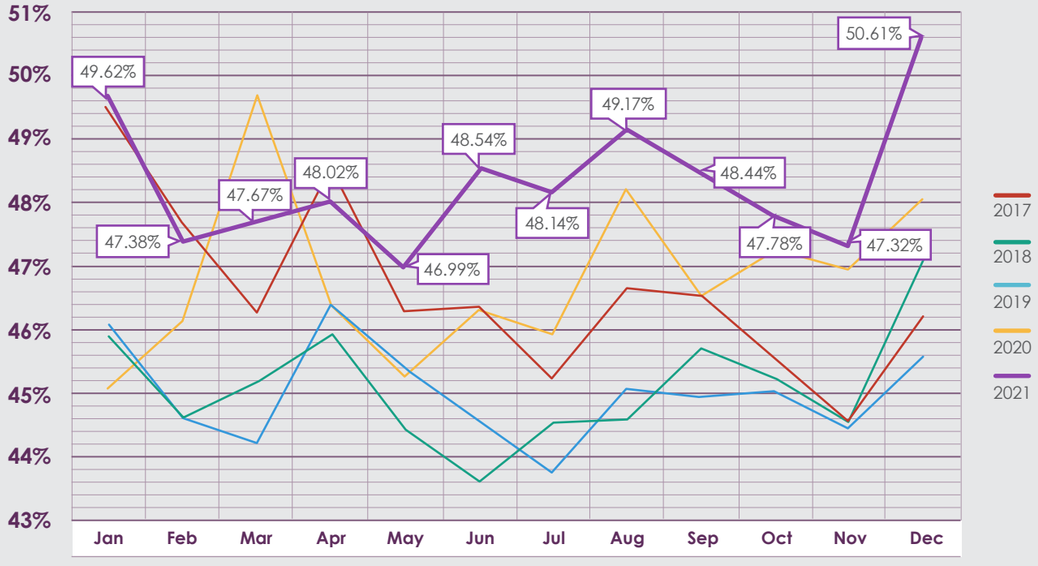
8 Regional Australia Institute. (2021). *Regional Movers Index, September Quarter 2021*. http://www.regionalaustralia.org.au/home/wp-content/uploads/2021/10/RMI-September-Quarter-2021-2.pdf

9 Health Workforce Stakeholders Group Meeting, September 2021

10 Kidd, M., & de Toca, L. (2021). The contribution of Australia's general practitioners to the COVID-19 vaccine rollout. *Australian Journal of General Practice*, 50(12), 871-872. https://doi.org/10.31128/AJGP-11-21-6235

11 Queensland Health, Emergency Data Collection

HWNA: GP-Type ED presentations



Note: *GP-Type presentations are defined as presentations to public hospital emergency departments where the patient was allocated a triage category of 4 or 5, did not arrive by ambulance, police or correctional vehicle, and was not admitted to the hospital, not referred to another hospital, or did not die.*

Figure 1: GP-Type presentations as a percentage of overall Emergency Department presentations in QLD MM 2-7, 2017-2021

In recognition of the challenges facing private practice in remote and rural Australia, several funding and workforce incentives were announced by the Australian Government in 2021. The 2021 Federal Budget provided an increase to the Rural Bulk Billing Incentive to compensate rural practices for the additional complexity and cost of remote and rural practice.[12]

There is now an additional COVID-19 booster incentive for general practices, ACCHS, and community pharmacists who provide COVID-19 booster vaccines[13], and from 1 January 2022, COVID-19 telehealth MBS items become permanently available. Other telehealth services provided by GPs will continue, however, patient eligibility for these services only exists where there is an established clinical relationship with the patient.[14]

While these financial benefits are welcomed, the viability of general practice in remote and rural communities remains in the balance. Findings from our Issue in Focus on Practice Sustainability (page 52) highlights that Medicare/funding reform to better support remote and rural practitioners; strategies to encourage remote and rural careers; and strategies to improve retention of staff are rated as the most important factors to the sustainability and viability of private practice.

This year has seen two major changes to the DPA classification system, which allows general practices to access a larger pool of GPs under section 19AB of Australia's ***Health Insurance Act 1973***. Following a formal review in late 2021, automatic DPA status was expanded from MM 5-7 to MM 3-7 commencing 1 January 2022.[15,16]

In addition to changes to automatic DPA status, from September 2021, areas not automatically eligible for DPA status, excluding MM 1 (inner metro) areas[17], are able to apply for their status to be reviewed under the exceptional circumstances review framework[18]. DPA status reviews will consider areas experiencing unforeseen workforce and population changes impacting access to healthcare.

The ***National Medical Workforce Strategy*** was recently released, and the Strategy aims to address medical workforce issues by exploring actions that fall under the five key priorities. Priority one identifies the need for stronger collaborative planning and information sharing and the establishment of a planning and advisory body with authority to inform and make recommendations to governments regarding the medical workforce. Other priorities include addressing supply and distribution, reforming training pathways and expanding generalist capability to foster a more sustainable and flexible medical workforce.

The transition of GP registrar training to RACGP and ACRRM moves closer, with a 2023 commencement date. The Colleges are in the process of releasing application handbooks regarding eligibility and selection guides for future trainees. In positive developments for remote and rural GP training and the supply of the GP Registrar workforce in Queensland, JCU GP training has seen an increase of 18 percent in GP training places filled for 2022, which represents 92 percent of the allocated training places.[19]

12 The Hon Greg Hunt MP. (2021, May 8). *Budget boost to Rural Bulk Billing to benefit the bush* [Media Release]. https://www.health.gov.au/ministers/the-hon-greg-hunt-mp/media/budget-boost-to-rural-bulk-billing-to-benefit-the-bush

13 The Hon Greg Hunt MP. (2021, December 22). *Strengthening support for front line workforces as booster rollout continues* [Media Release]. https://www.health.gov.au/ministers/the-hon-greg-hunt-mp/media/strengthening-support-for-front-line-workforces-as-booster-rollout-continues

14 Department of Health. (2022). *Continuing MBS Telehealth Services* [Factsheet]. Australian Government. http://www.mbsonline.gov.au/internet/mbsonline/publishing.nsf/Content/2211355D5611CA3DCA2587A70006FF09/$File/Factsheet-telehealth-GPs-OMP.v.13.04.22.pdf

15 Distribution Working Group. (2021, November 10). *Distribution Working Group communique - 7 October 2021* [Communique]. Department of Health. https://www.health.gov.au/sites/default/files/documents/2021/11/distribution-working-group-communique-7-october-2021.pdf

16 The Hon Dr David Gillespie MP. (2021, December 10). *More GPs for Local Clinics to Recruit, New Package to Attract Doctors to Rural* [Media Release]. https://www.health.gov.au/ministers/the-hon-dr-david-gillespie-mp/media/more-gps-for-local-clinics-to-recruit-new-package-to-attract-doctors-to-rural.

17 Department of Health. (2021, December 14). *Request a review of a DPA classification*. Australian Government. https://www.health.gov.au/health-topics/rural-health-workforce/classifications/dpa/request-review

18 The Hon Dr David Gillespie MP. (2021, September 2). *Distribution Priority Areas exceptional circumstances review for GPs* [Media Release]. https://www.health.gov.au/ministers/the-hon-dr-david-gillespie-mp/media/distribution-priority-areas-exceptional-circumstances-review-for-gps

19 JCUGP email advice

The continuation of Australian Government funding to all states and territories to progress the National Rural Generalist agenda saw the extension of the joint project between Queensland Health and Health Workforce Queensland to develop a framework to support post-fellowship rural doctors across primary and secondary service domains. The ***Post Fellowship Support Framework for Rural Doctors*** was published in February 2021.[20]

Development of flexibly delivered advanced skills, close to home; streamlining of skills maintenance requirements and processes; and optimising integrated workforce models for the benefit of local communities are some of the strategies being progressed in phase two of the project.

Recognition of Rural Generalist Medicine as a specialist field within general practice took a step forward in November 2021, with the Medical Board of Australia supporting a progression to stage two of the assessment. Recognition of a specialist field will provide a protected title and quality assure the unique training and skill set of thousands of rural doctors currently working across general practices, emergency departments, birthing units, retrieval services and other health services operating in remote and rural communities.

There have also been some positive developments regarding the medical workforce and GP training pipeline for remote and rural Queensland. The expansion of regional medical training by the University of Queensland (UQ) in both Central Queensland and the South-West with the establishment of end-to-end regional medical pathways is a significant step forward for medical workforce supply in those regions.[21] Previously, the only end-to-end medical training outside of the MM 1 metropolitan centres in the South-East was through James Cook University (JCU) in Townsville.

To address the progressive decline of effective primary health care, Queensland Health's Office of Rural and Remote Health (ORRH) initiated the Future-Proofing Our Rural Workforce CollaborativE (FORCE).

The Collaborative has broad representation and activities include facilitating a shared approach to remote and rural medical workforce data collection, analysis and planning as well as enabling and supporting integrated place-based workforce planning which is responsive to community health needs.

Whilst these are challenging times for general practitioners, a new national strategy document, the creation of two new end-to-end regional training pathways and two years of continued growth to GP registrar numbers provides hope for a brighter future for general practice in remote and rural Queensland.

> **"The biggest issue at present is the lack of relief for doctors. This year both doctors have had to cancel leave because of this."**

20 Dhupelia, D., Van Erp, A., Collins, J., & Butterworth, A. (2021). *Post Fellowship Support Framework for Rural Doctors – A Queensland Pilot Project.* Queensland Health. https://www.healthworkforce.com.au/rails/active_storage/blobs/eyJfcmFpbHMiOnsibWVzc2FnZSI6IkJBaHBBNENBQWc9PSIsImV4cCI6bnVsbCwicHVyIjoiYmxvYl9pZCJ9fQ==--9b05c754cef00e15923c7c9dd0e547acebae161b/20210317%20Post%20Fellowship%20Support%20Framework%20for%20Rural%20Doctors%20-%20Final.pdf?source=google.com

21 The University of Queensland. (2021, December 6). *Partners to deliver end to end medical training for Darling Downs and South West.* https://rcs.medicine.uq.edu.au/article/2021/12/partners-deliver-end-end-medical-training-darling-downs-and-south-west

Nursing and Midwifery Workforce Summary

> **The role of primary care nurses has never been more important as the COVID-19 vaccine program rolls out across Queensland. Of the 19,000 Queensland nurses and midwives working outside of a hospital,[22] 70 percent reported working in a general practice setting where more than 80 percent of the vaccines are being administered.[23]**

A series of ***COVID-19 Pulse Check*** surveys have been undertaken since the start of the pandemic by Australian Primary Health Care Nurses Association (APNA). Primary health care nurses report their function in the vaccine roll out has predominantly been around the management and administration of the vaccine to patients as well as educating patients about the COVID-19 vaccine and addressing vaccine hesitancy. Unfortunately, the focus on the vaccine program has seen a reduced focus on preventative health and chronic disease management, which almost half the survey respondents reported performing less frequently.[24]

In August 2021, almost 30 percent of nurses reported not working to their full scope of practice, an increase of 10 percent since the April 2021 ***COVID-19 Pulse Check survey.*** Effective nurse utilisation appears to be dropping at a time when they should be more fully utilised, particularly given the severe GP workforce shortages across remote and rural Queensland. Role restrictions are in part attributable to the current MBS funding model in general practice which continues to constrain nurse activity and autonomy. However it can also be ascribed to challenges with collaboration time, communication and coordination, training, and leadership.[25]

In addition, the APNA workforce survey signals challenges in retaining the primary health care nursing workforce due to significantly lower wages than the public sector. Predicted nursing workforce shortages are likely to be exacerbated in primary health care if pay and conditions are not addressed.

Workplace safety for nurses in remote areas remains an issue, contributing to understaffing and high turnover. A published literature review in 2021 found many safety recommendations, going as far back as 1995, have not been implemented. The review identified that there was an urgent need for a greater safety culture, a safer environment, and education and training.[26]

Recognising the need to support rural practice, a partnership between the Office of Rural and Remote Health (ORRH), the Office of the Chief Nursing and Midwifery Officer (OCNMO) and the Hospital and Health Services (HHSs) has been created to pilot a rural generalist nursing program to focus on expanding the essential skills and training for early to mid-career registered nurses (RNs).

Those involved in the pilot will undertake a combined program consisting of clinical time, supervisory support and course content which will help inform induction and training requirements to prepare RNs to work in remote and rural locations. Delayed as a result of COVID-19, recruitment to the project is expected to occur in the second half of 2022, with the pilot to be established in the North West, Torres and Cape, Darling Downs, South West and Central West HHS regions.

The ***Consultation Draft – Future focused primary health care: Australia's Primary Care 10 Year Plan 2022-2032***[5] acknowledges that current funding models do not sufficiently incentivise team-based care within general practices. In particular, funding models for allied health, NPs, nurses and others need to be better developed to support the delivery of effective, appropriate care in viable business models. The Plan also acknowledges that funding arrangements need to recognise the different challenges of providing care in urban, regional, rural and remote settings.

In other profession related developments, Queensland's Chief Nursing and Midwifery Officer, Shelley Nowlan, was appointed to the role of Deputy National Rural Health Commissioner this year, and the professional association School Nurses Australia amalgamated with APNA under the APNA banner.[27]

A consultation paper for a ***Nurse Practitioner 10 – Year Plan*** has been circulated and a nursing workforce plan has been flagged as a pending supporting document to the 10 Year Primary Healthcare Plan. Additionally, a new Australian Government initiative to waive Higher Education Loan Program (HELP) debts for NPs choosing to work in MM 3-7 locations is set to commence in January 2022.

22 Australian Institute of Health and Welfare. (2020). *A profile of primary health care nurses. Australian Government.* https://www.aihw.gov.au/reports/primary-health-care/a-profile-of-primary-care-nurses/contents/primary-health-care-nurses

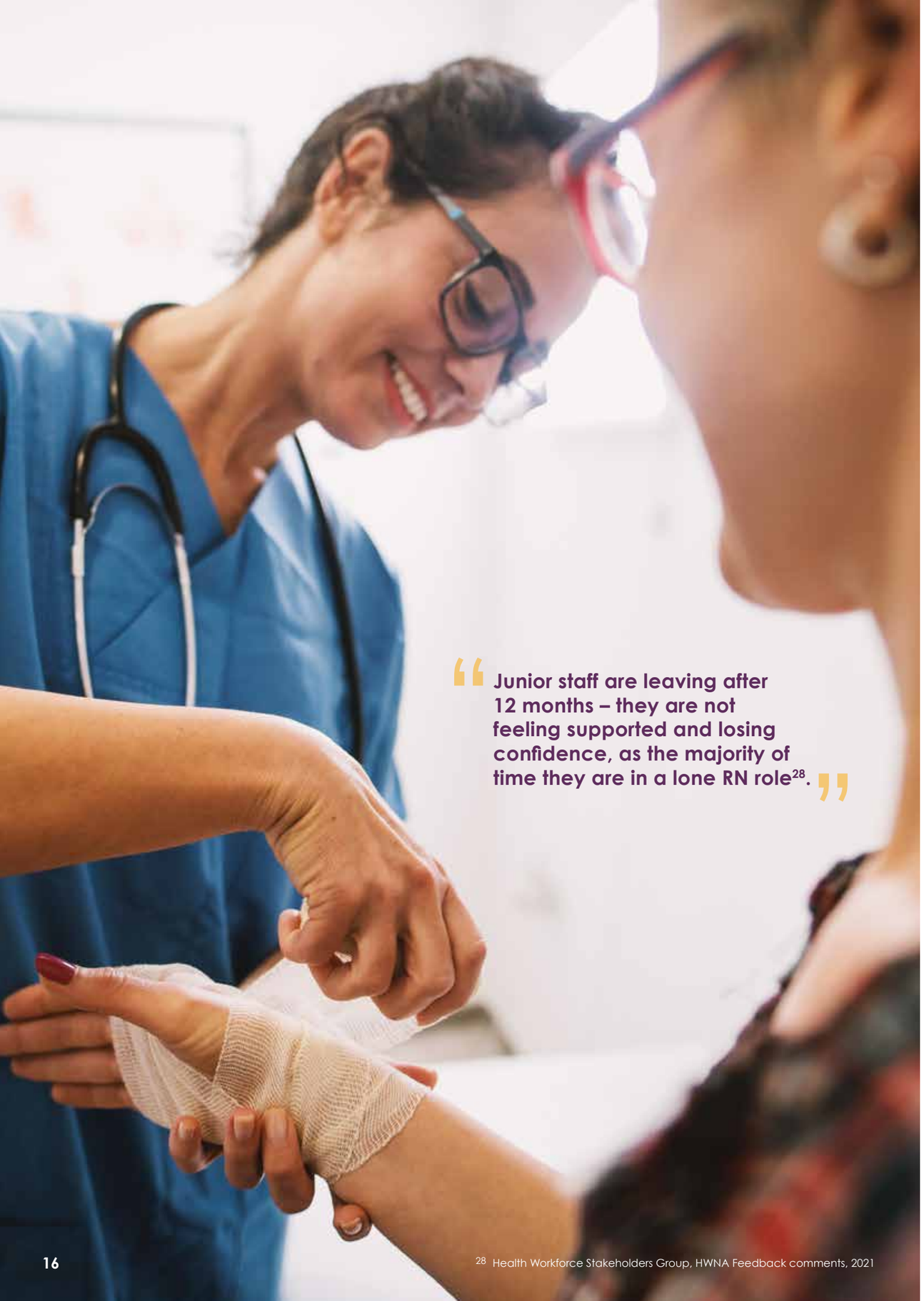
23 Kidd M, de Toca L, *The contribution of Australia's general practitioners to the COVID-19 vaccine rollout,* Australian Journal of General Practice Volume 50, Issue 12, December 2021 https://www1.racgp.org.au/ajgp/2021/december/general-practice-covid-vaccine-rollout

24 Australian Practice Nurses Association. (2021, August). *COVID-19 Pulse Check Survey #3* [Presentation]. https://www.apna.asn.au/docs/58aac3d2-bf16-ec11-80e1-005056be66b1/APNA%20COVID%20Pulse%20Check%20Key%20Data%20Insights%20August%202021.pdf

25 Australian Practice Nurses Association. (2020). *APNA Annual Report 2020.* https://www.apna.asn.au/files/DAM/6%20About/Annual%20Reports/APNA%20Annual%20Report%202020.pdf

26 Wright, L.K., Jatrana, S., & Lindsay, D. (2021). Workforce safety in the remote health sector of Australia: a scoping review. *BMJ Open,* 11(8), 1-16. http://dx.doi.org/10.1136/bmjopen-2021-051345

27 Australian Practice Nurses Association. (2021, December 20). *APNA and School Nurses Australia to amalgamate* [Media Release]. https://www.apna.asn.au/about/media/apna-and-school-nurses-australia-to-amalgamate



> **Junior staff are leaving after 12 months – they are not feeling supported and losing confidence, as the majority of time they are in a lone RN role[28].**

[28] Health Workforce Stakeholders Group, HWNA Feedback comments, 2021

Workforce Data: State-wide Workforce Snapshot

General Practitioners

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

This snapshot of the workforce was taken on 30 November 2021. In line with reporting requirements to the Australian Government Department of Health, only doctors working in MM 2-7 locations were investigated.

At the census date there were 2,655 general practitioners listed on the Health Workforce Queensland database as working in MM 2-7 locations in Queensland, almost 50 more than reported in the 2021 HWNA. The average age was 50.0 years, slightly younger than the 50.4 years reported in 2021.

The number of GPs by sex are presented in Figure 2.

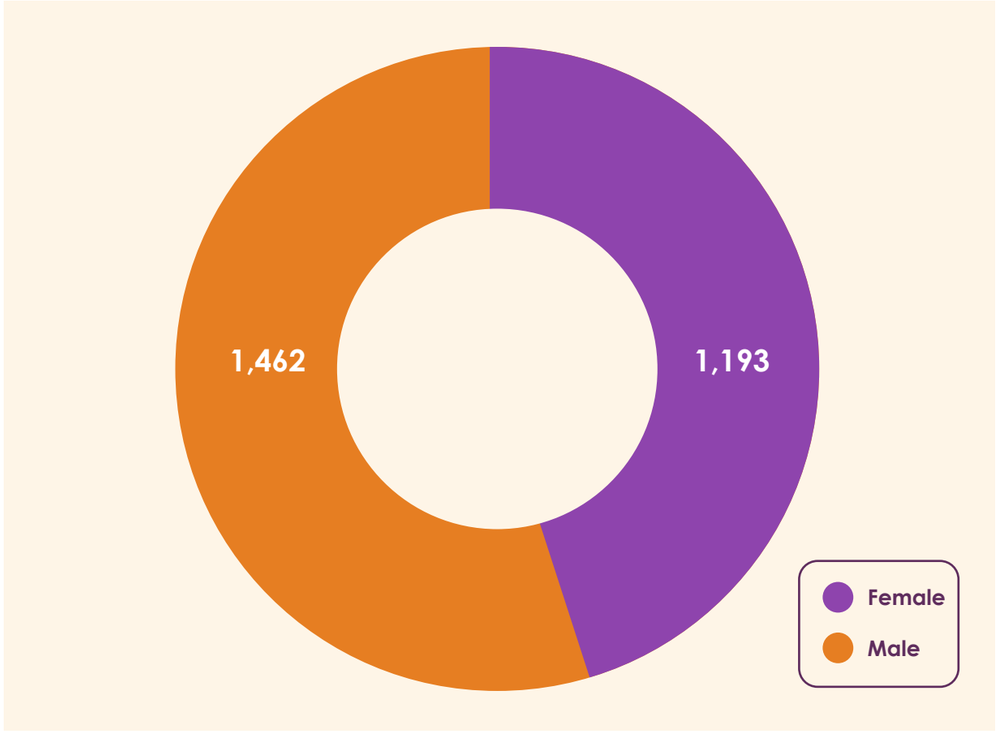


Figure 2: General practitioners in MM 2-7 by sex from HWQ database

Approximately 45 percent of the general practitioners were female, the same proportion reported in the 2021 HWNA. The number and percentage of female and male GPs for each of the four mainly rural Primary Health Networks (PHNs) are presented in Table 2 (excludes practitioners from Brisbane North, Brisbane South and Gold Coast PHNs).

Table 2: General practitioners by sex and PHN from HWQ database

PHN	Female *n*	%	Male *n*	%	Total *N*
Central Queensland, Wide Bay, Sunshine Coast	299	42.00	413	58.00	712
Darling Downs and West Moreton	253	40.94	365	59.06	618
Northern Queensland	534	50.15	531	49.85	1,065
Western Queensland	48	41.74	67	58.26	115

The number of practitioners per PHN region largely reflects population size and remoteness. Northern Queensland PHN had 353 more GPs than any of the other rural PHNs and had the highest percentage of female practitioners (50.2%). In contrast, only 41 percent of practitioners in the Darling Downs and West Moreton PHN region were female.

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 1,397 Australian trained practitioners (52.6%), and 1,258 overseas trained practitioners (47.5%). The percentage results for each of the mainly rural PHNs are presented in Figure 3.

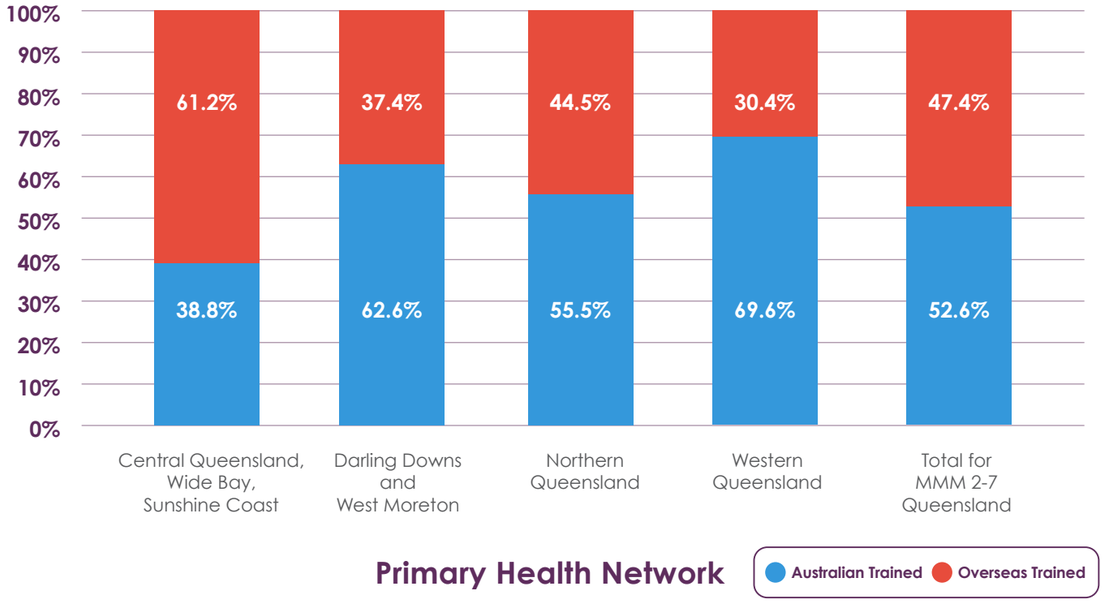


Figure 3: Percentage of general practitioners by country of basic medical qualification and PHN from HWQ database

Compared to the overall MM 2-7 percentage of Australian trained practitioners (52.6%), the Central Queensland, Wide Bay, Sunshine Coast PHN was the only PHN to have a lower percentage of Australian trained practitioners (38.8%).

In contrast, the Australian trained GP workforce in the Western Queensland PHN represented almost 70 percent of the total workforce, and the Darling Downs and West Moreton PHN was above 60 percent.

National Health Workforce Dataset 2020

The most recent release of the National Health Workforce Dataset (NHWDS) has been gathered by the 2020 workforce survey of health practitioners during 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.

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 (GP) – not a specialist'. It is important to note that the survey questions for medical practitioners were changed for 2020 and codings may not be directly comparable. For instance, one response option normally included in this analysis was 'Hospital – non specialist'. However, including this group in the 2020 numbers increased the total medical practitioners to almost 900 more than in the 2019 NHWDS. Although using the two survey response options of 'General Practice', or 'General Practitioner (GP) – not a specialist' may miss some medical practitioners that work in smaller hospitals primarily undertaking general practice activity, it was decided to only include these two options in order to match the 2019 numbers as closely as possible.

The total number of medical practitioners likely to be undertaking general practice roles in MM 2-7 was 2,547, slightly less than the numbers recorded in the Health Workforce Queensland database in the same year (see, Table 3) and 39 less than reported from the NHWDS last year (NHWDS 2019 = 2,586).

The number of GPs in 2020 for each PHN is provided in Table 3 with the 2019 NHWDS data for comparison.

Table 3: 2019 and 2020 NHWDS general practitioners by PHN

PHN	NHWDS 2019 *N*	NHWDS 2020 *N*
Central Queensland, Wide Bay, Sunshine Coast	706	727
Darling Downs and West Moreton	442	486
Northern Queensland	1,239	1,082
Western Queensland	120	116
Total MM 2-7 Queensland*	**2,586**	**2,547**

Note: **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.*

The total number of GPs identified in MM 2-7 Queensland through the NHWDS 2020 was 39 fewer than identified in the 2019 survey. This is probably reflective of the new coding provided this year that may miss some GPs working in the public system mainly in a primary care role. The 2020 NHWDS numbers are 68 fewer than the number identified for 2020 in the Health Workforce Queensland database and presented in the 2021 HWNA (*N* = 2,615).

Practice Nurse Workforce

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 1,479, an increase of 63 from last year.

Similar to last year, almost three-quarters were registered nurses 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 4.

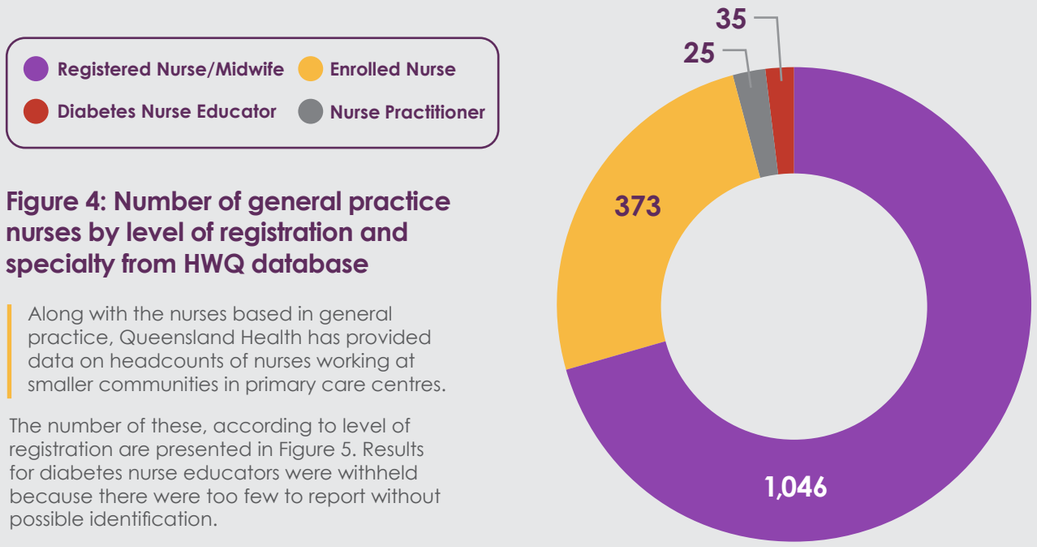


Figure 4: Number of general practice nurses by level of registration and specialty from HWQ database

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

The number of these, according to level of registration are presented in Figure 5. Results for diabetes nurse educators were withheld because there were too few to report without possible identification.

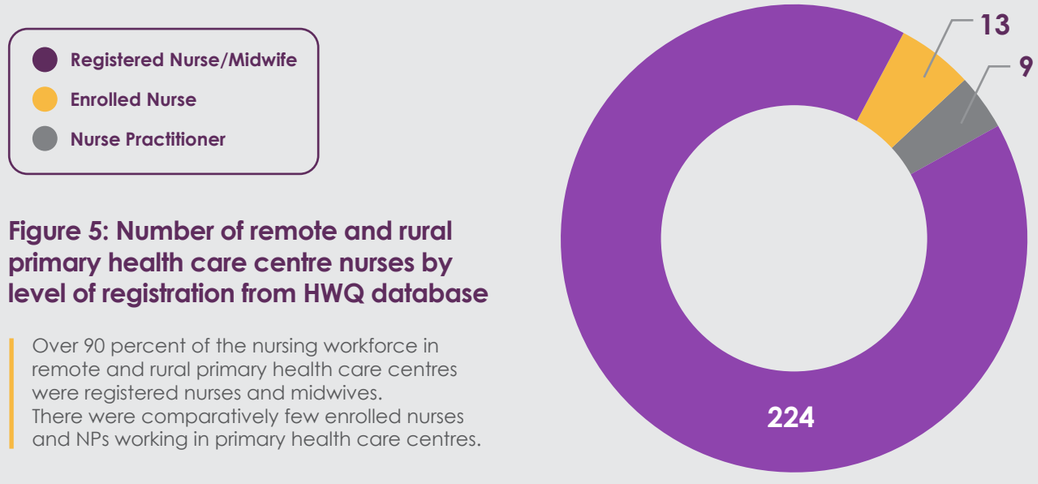


Figure 5: Number of remote and rural primary health care centre nurses by level of registration from HWQ database

Over 90 percent of the nursing workforce in remote and rural primary health care centres were registered nurses and midwives. There were comparatively few enrolled nurses and NPs working in primary health care centres.

National Health Workforce Dataset 2020

Below is the number of nurses working in MM 2-7 Queensland by rural PHN 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 registered and enrolled nurses for the four mainly remote and rural PHNs in Queensland are available in Table 4, inclusive of the percentage that described their primary work as private. For comparison, the number of total practice nurses reported last year (2019) are also included.

Compared to the numbers reported last year there was an increase of almost 100 nurses who identified their main role as 'practice nurse' in the 2020 NHWDS. The PHN with the largest increased numbers was Northern Queensland PHN, with an increase in both registered nurses/midwives and enrolled nurses/midwives.

It is also of note that in Western Queensland, although there were comparatively few practice nurses, there was an increase of 34 percent compared to last year. While three of the PHNs had more than 80 percent of their practice nursing workforce describe their main employment as private practice, this was not the case in the Western Queensland PHN region which had approximately 50 percent.

Table 4: 2020 NHWDS practice nurses by PHN and percent in private employment

PHN	Registered Nurse/Midwife *n*	Enrolled Nurse *n*	2020 Total *N*	Percent Private	2019 Total *N*
Central Queensland, Wide Bay, Sunshine Coast	294	125	419	89.0%	404
Darling Downs and West Moreton	224	65	289	87.9%	286
Northern Queensland	443	128	571	83.9%	518
Western Queensland	55	16	71	50.7%	53
Total	**1,016**	**334**	**1,350**	**88.0%**	**1,261**

Note: *Data provided by Queensland Health.*

Photo: *Roslyn Budd Photography*

Aboriginal and Torres Strait Islander Health Worker and Health Practitioner Workforce

Health Workforce Queensland Database

There were 249 Aboriginal and Torres Strait Islander Health Workers and 40 Aboriginal and Torres Strait Islander Health Practitioners in the Health Workforce Queensland database. Figure 6 presents these according to MM location with numbers suppressed (marked as 'NA') if less than four.

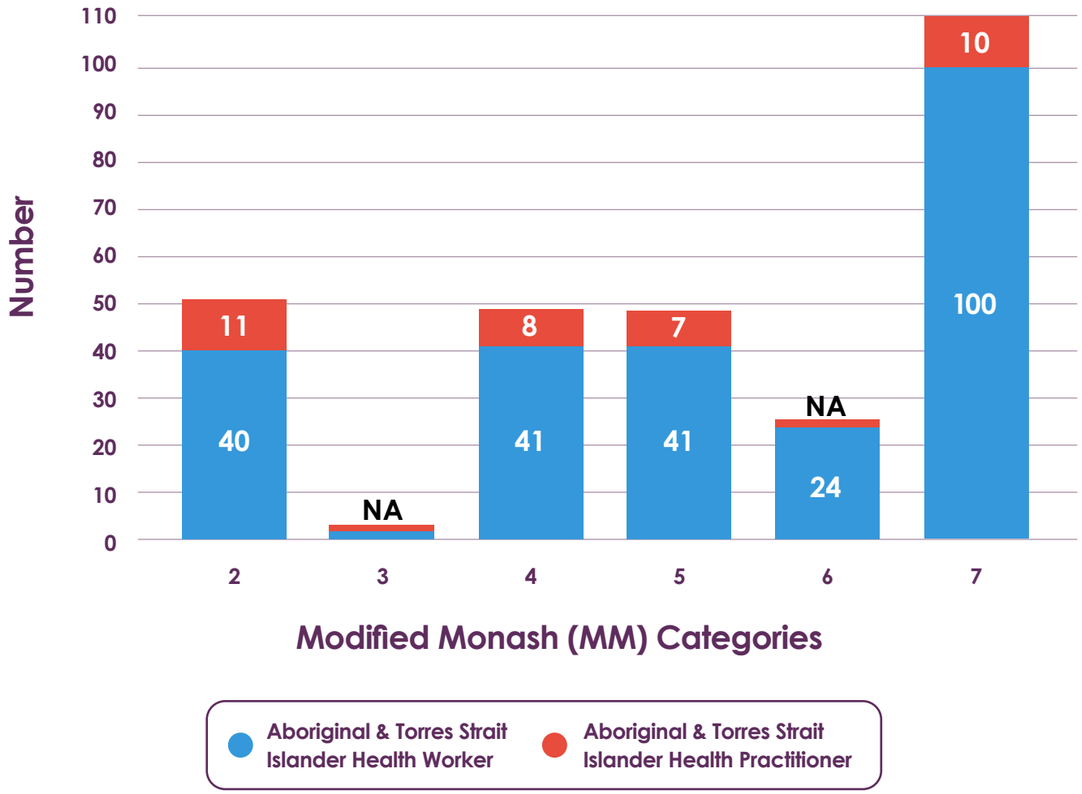
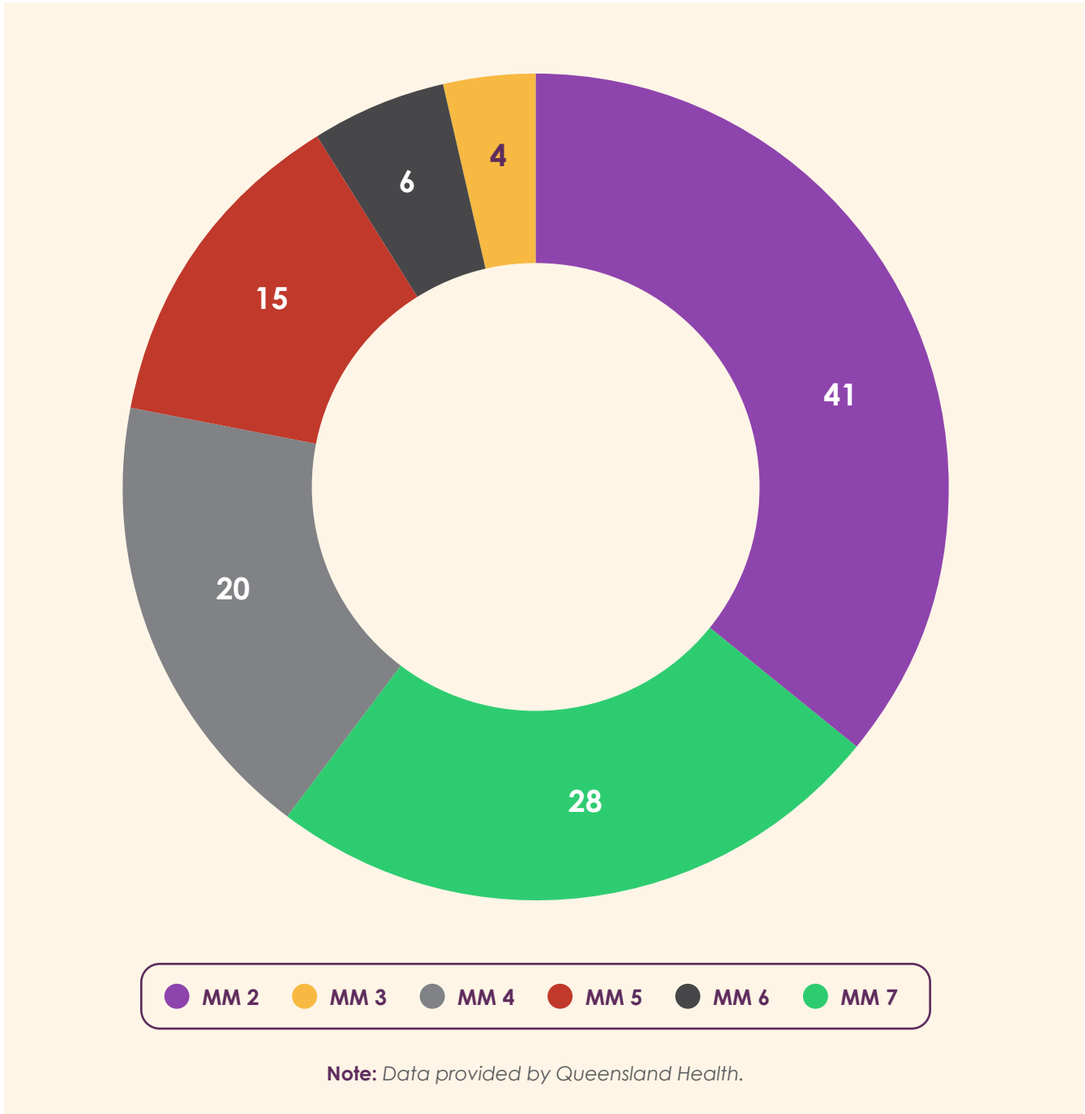


Figure 6: HWQ database Aboriginal and Torres Strait Islander Health Workers/ Practitioners by MM location

More Aboriginal and Torres Strait Islander Health Workers were working in MM 7 locations than any other MM categories. There were more than twice as many in MM 7 than any of the other classifications and very few in MM 3. Aboriginal and Torres Strait Islander Health Practitioners were evenly spread across MM categories except for MM 3 and MM 6 locations.

National Health Workforce Dataset 2020

The results from the NHWDS 2020 indicate that there were 114 Aboriginal and Torres Strait Islander Health Practitioners working in MM 2-7 Queensland, an increase of 23 from the findings reported last year. Results according to MM category are provided in Figure 7.



Note: *Data provided by Queensland Health.*

Figure 7: NHWDS 2020 workforce survey Aboriginal and Torres Strait Islander Health Practitioners by MM location

Approximately 36 percent of the 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.

Allied Health Workforce

National Health Workforce Dataset 2020

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 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 PHNs, based on the main location of work provided in the workforce survey. For the Central Queensland, Wide Bay, Sunshine Coast PHN, and the Darling Downs and West Moreton PHN, the number of practitioners in the PHN but working in MM 1 locations were also included.

This includes practitioners working in and around Ipswich (Darling Downs and West Moreton PHN) and on the Sunshine Coast in major towns such as Caloundra and Maroochydore (Central Queensland, Wide Bay, Sunshine Coast PHN). Results are presented in Table 5.

Table 5: NHWDS 2020 workforce survey allied health practitioners by PHN 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 QLD, 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 QLD, 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 QLD, Wide Bay, Sunshine Coast	77	79%	75
Darling Downs and West Moreton	59	83%	29
Northern Queensland	83	74%	-
Western Queensland	15	53%	-

Allied Health Professions	MM 2-7 *N*	Percent Private	MM 1 *N*
Occupational Therapists	**1,373***	**52%***	**3,399**
Central QLD, 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 QLD, Wide Bay, Sunshine Coast	95	96%	92
Darling Downs and West Moreton	77	95%	48
Northern Queensland	125	97%	-
Western Queensland	7	10%	-
Pharmacists	**1,576***	**65%***	**4,176**
Central QLD, 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 QLD, 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 QLD, 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.*

The number of practitioners for each of the disciplines in MM 2-7 ranged from 1,576 for pharmacists to 246 for podiatrists. Generally, the Western Queensland PHN had a considerably smaller percentage of private practitioners than the other PHNs in the disciplines of dentistry (33% private), podiatry (47% private) and physiotherapy (42% private). The Central Queensland, Wide Bay, Sunshine Coast PHN had more practitioners in MM 1 locations than MM 2-7 locations for psychology, physiotherapy, occupational therapy, and diagnostic radiography. In the Darling Downs and West Moreton PHN region, there were more practitioners for every discipline outside the MM 1 areas. When compared to the figures reported in the National Health Workforce Dataset for 2019, incremental increases were seen across all reported allied health professions servicing MM 2-7 communities this year. The largest increase was seen for occupational therapists with an increase of almost 15 percent, followed by psychologists with an increase of 13 percent. Podiatrists, pharmacists, physiotherapists, and optometrists all experienced an increase of 10 percent or more. The smallest increases were seen for diagnostic radiographers, eight percent, and dental practitioners at five percent.

Survey Results

Quantitative Findings

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

Survey items were developed to gauge health practitioner and health service manager beliefs about workforce and primary care service gaps in their community(s) of practice. The survey items were phrased as statements (e.g.,'There is a serious gap in the physiotherapy workforce in my community') and participants were asked to rate their level of agreement.

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

There were statements for 18 workforce disciplines (e.g., general practice; pharmacy) and 13 primary care services that aligned with identified priorities for the PHNs (e.g., alcohol and other drug services; mental health services). There was a sample size of 837, an increase from last year's 681. The number of participants by their main role (e.g., nurses, allied health practitioners) are provided in Figure 8.

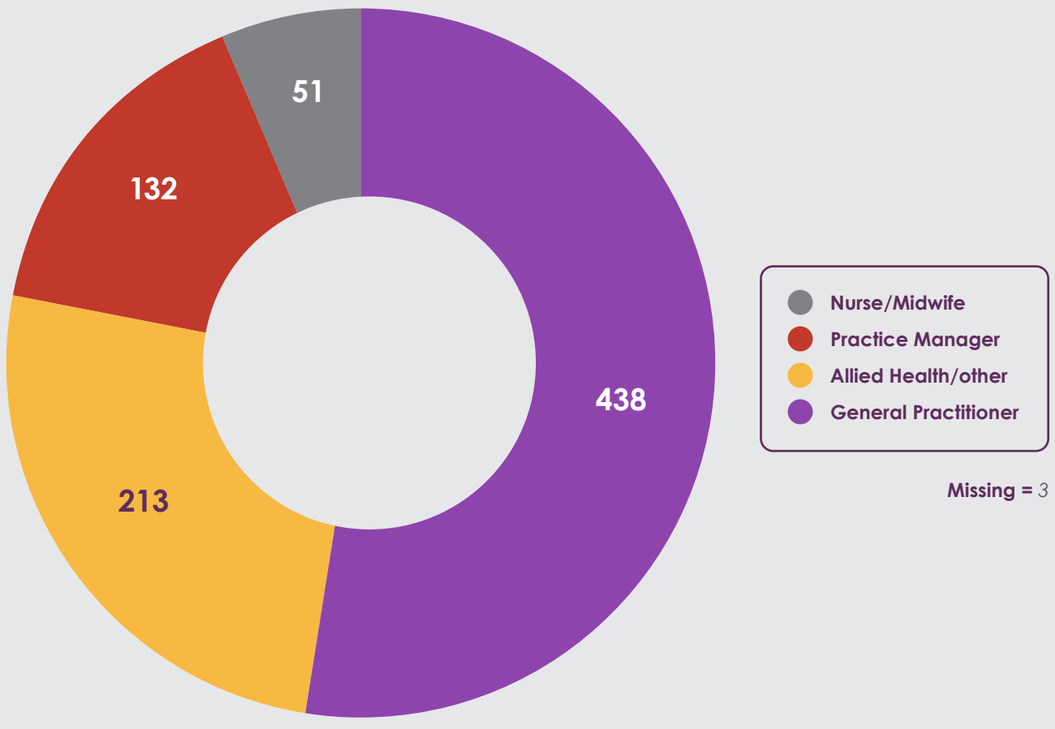


Figure 8: Number of participants by main employment role

The Northern Queensland PHN had the largest number of survey responses (*n* = 291), followed by the Central Queensland, Wide Bay, Sunshine Coast PHN (*n* = 228), Darling Downs and West Moreton PHN (*n* = 204) and Western Queensland PHN (*n* = 69). The roles of participants for each of the mainly rural PHNs are available in Figure 9.

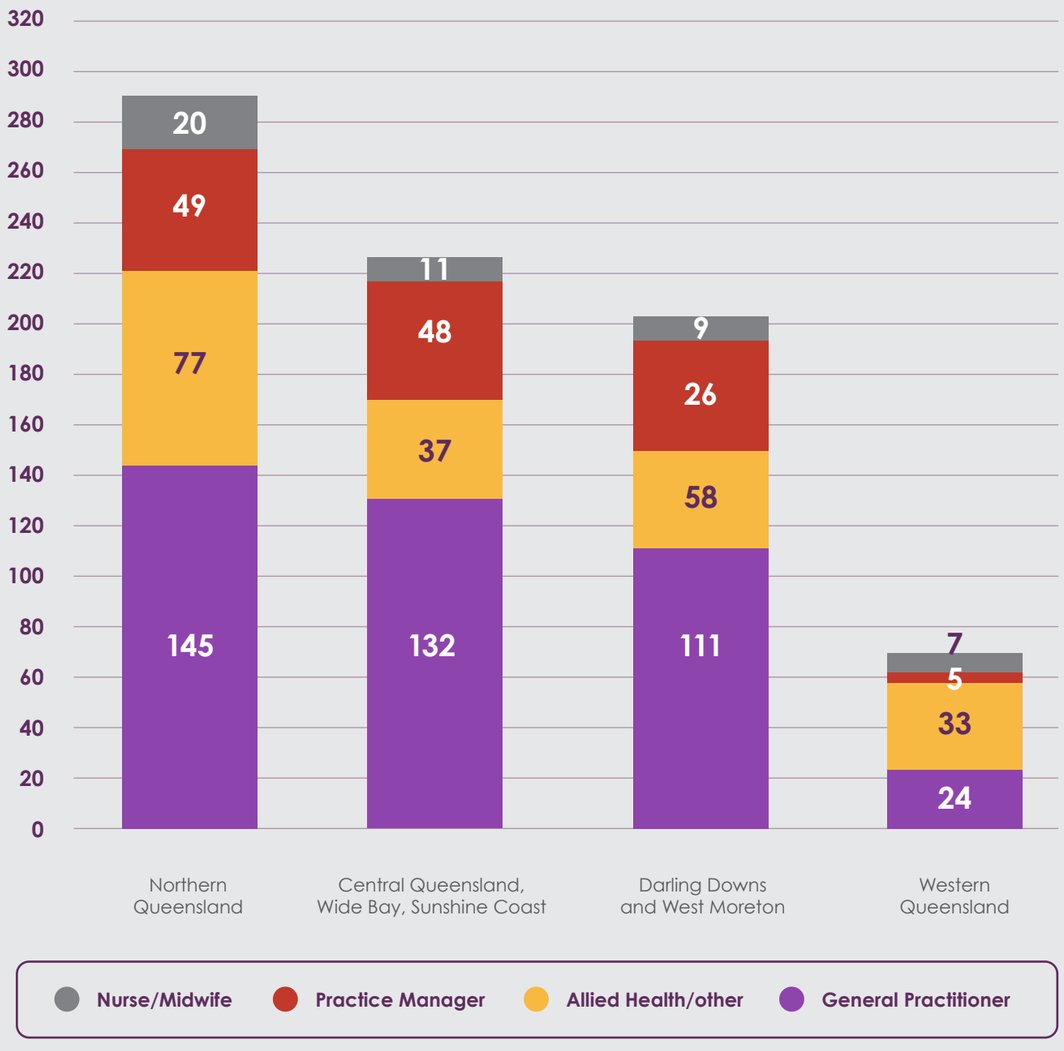
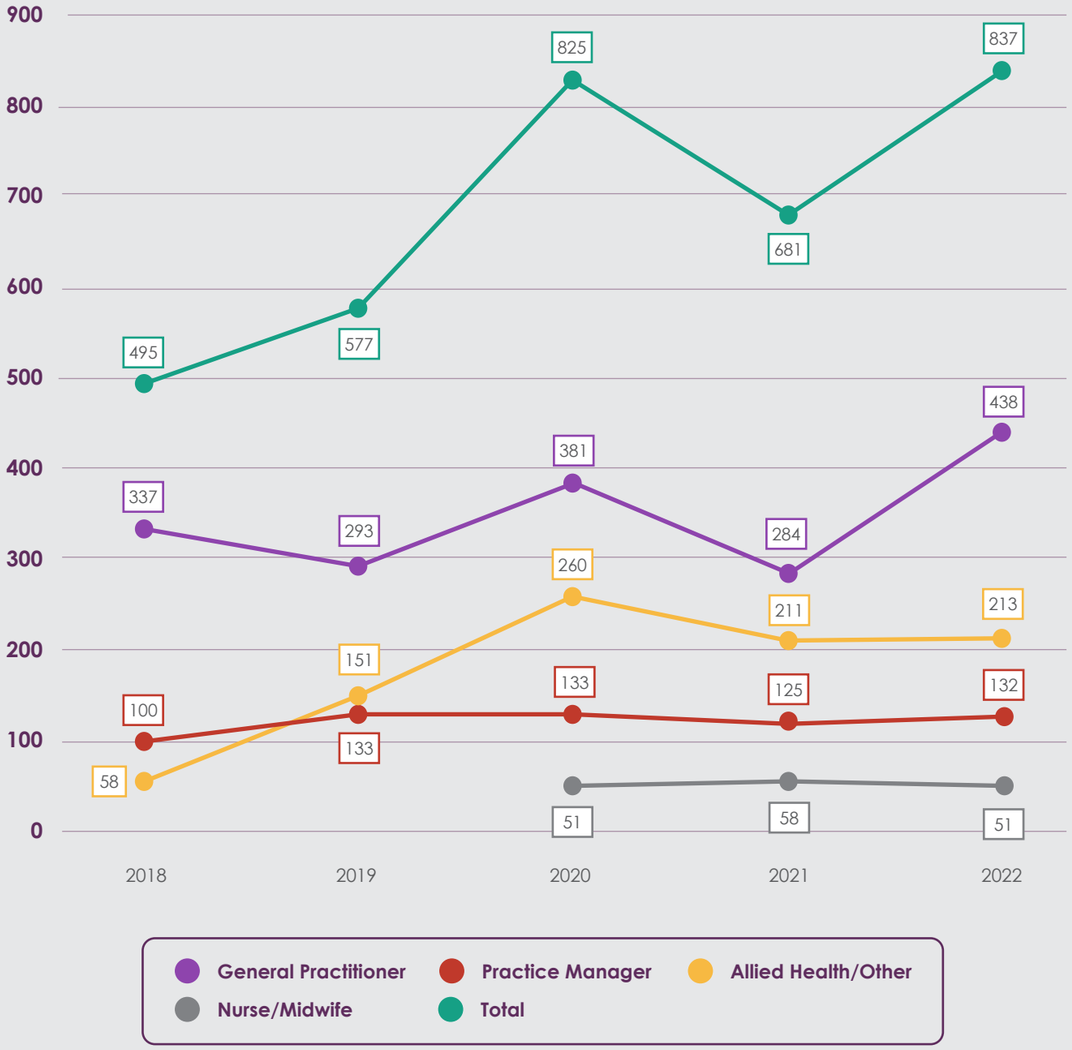


Figure 9: Number of participants by main employment role and rural PHN

In the five years that the HWNA surveys have been conducted, with the exception of 2021, the number of survey participants has been increasing. The proportion of GP responses had been incrementally decreasing since 2018 but increased in 2022 to just over 50 percent of total responses. Figure 10 depicts the total number of responses received for the HWNA since 2018 and the breakdown of these responses to participant employment roles.



Note: *In 2018 and 2019, Allied Health and Nursing participants were classified under the same category of "Nurse and Allied Health Practitioner/Managers."*

Figure 10: Number of participants by main employment role from 2018-2022

Workforce Gap Ratings

Workforce gap rating means for remote, rural and regional QLD are provided in Figure 11.

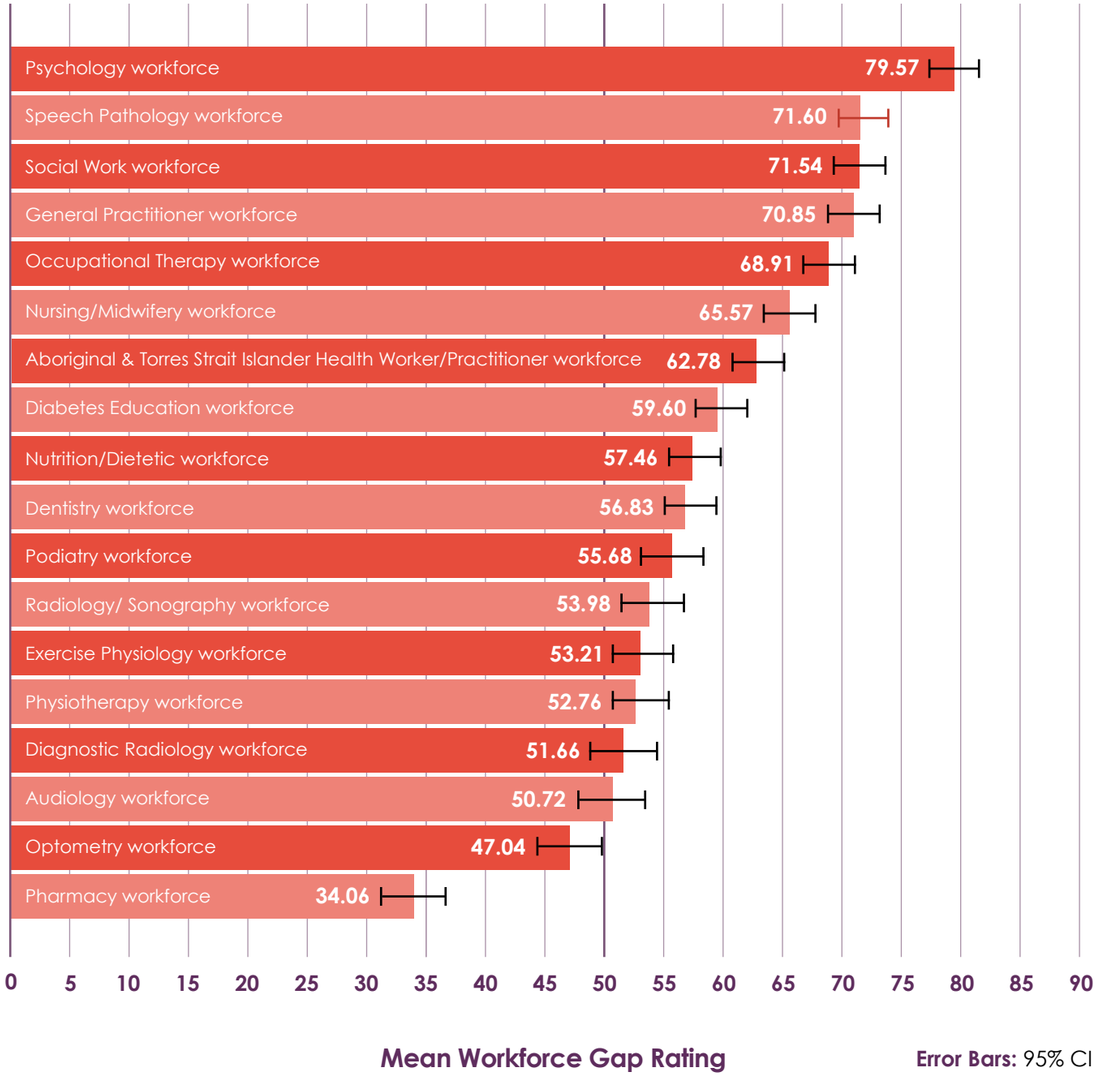


Figure 11: Queensland mean workforce gap ratings

The highest workforce gap rating means were for psychology, speech pathology, social work, and GP workforces; all four had means of 70 or higher. There were seven workforce means of 60 or greater and 16 means were higher than 50.

The optometry and pharmacy workforce gap rating means were the only two lower than 50. Table 6 provides the workforce gap means across 2018 to 2022. All but four (podiatry, radiography/ sonography, exercise physiology and audiology) of the workforce gap rating means increased from last year and the trend shows a gradual increase for most items since 2018. The most notable increases from 2021 were for the nursing/midwifery workforce, increasing by 9.7 points and the GP workforce, increasing by 8.8 points. The psychology workforce gap rating mean increased by 6.9 points and social work increased by 5.9 points from last year, with the remainder increasing or decreasing by between one and three points.

Table 6: Workforce gap rating means for 2018 - 2021

Type of workforce	2018 M	2019 M	2020 M	2021 M	2022 M
Psychology workforce	46.75	59.09	66.63	72.70	79.57
Speech Pathology workforce	45.58	51.33	59.88	70.31	71.60
Social Work workforce	50.27	56.12	63.35	65.68	71.54
General Practitioner workforce	38.66	50.75	58.58	62.03	70.85
Occupational Therapy workforce	48.40	50.48	58.78	66.19	68.91
Nursing/Midwifery workforce	39.02	44.57	51.55	55.84	65.57
Aboriginal & Torres Strait Islander Health Worker/Practitioner workforce	38.69	48.09	57.27	60.50	62.78
Diabetes Education workforce	40.43	43.63	53.76	56.88	59.60
Nutrition/Dietetic workforce	41.34	42.96	50.30	57.40	57.46
Dentistry workforce	46.80	47.92	54.66	55.72	56.83
Podiatry workforce	34.45	40.76	48.51	56.89	55.68
Radiography/Sonography workforce	--*	44.55	52.42	55.88	53.98
Exercise Physiology workforce	37.18	42.22	50.05	54.22	53.21
Physiotherapy workforce	32.29	36.72	45.86	49.95	52.76
Diagnostic Radiology workforce	35.32	39.98	48.63	51.19	51.66
Audiology workforce	33.44	40.73	49.44	53.00	50.72
Optometry workforce	30.08	36.26	42.05	45.73	47.04
Pharmacy workforce	22.11	25.23	31.38	32.75	34.06

In the 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 12 depicts the workforce gap rating means for each of these workforces to show change across time from 2018-2022.

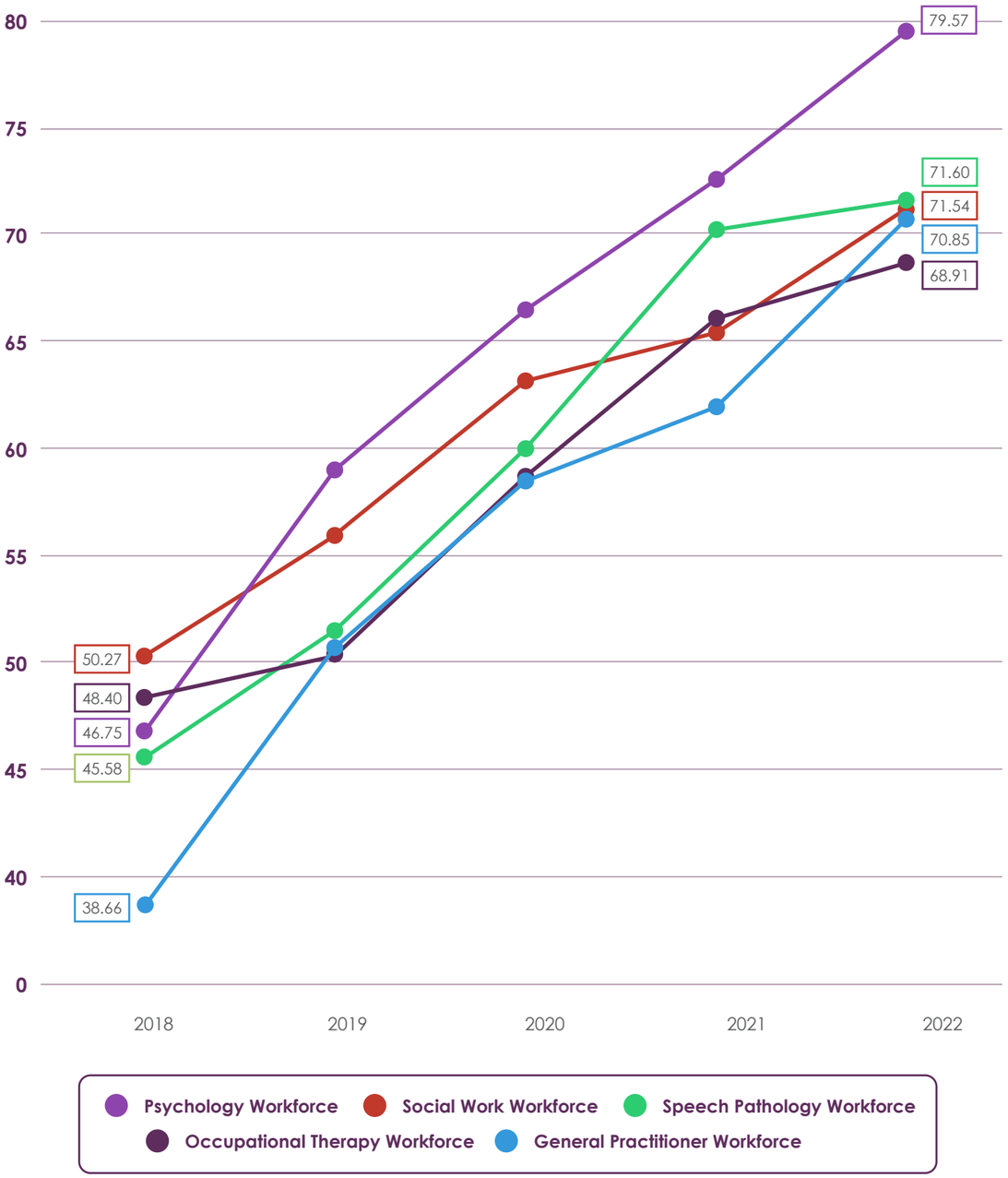


Figure 12: Five highest rated workforce gaps across 2018-2022

The workforce gap rating means for all five workforce disciplines have increased between 2018 and 2022. The psychology workforce experienced the largest increase over the previous 5 years (32.8 points), followed by the GP workforce (32.2 points), speech pathology workforce (26.0 points), social work workforce (21.3 points), and occupational therapy workforce (20.5 points).

Workforce Gap Comments

There were 218 participants that commented on the workforce gap rating questions. The most frequently mentioned workforce gaps identified in a thematic analysis were for:

- **Mental health**
- **Allied health practitioners**
- **General practice**

System issues such as perceptions that management did not understand the needs of the community, funded services not being delivered to the community, and a lack of support for clinical staff were raised. It was also of note that some participants spoke about the impacts of COVID-19, such as increased mental health issues in the community and increased demand for services. Figure 13 below lists the sub-themes identified for mental health.

Figure 13: Mental Health sub-themes

Mental Health Workforce

Mental health workforce gap comments were characterised by three related sub-themes, workforce shortages; long wait times; and cost/lack of public bulk billing services. The main sub-theme of mental health workforce shortages had comments such as:

> **...We have little mental health support in this area and that is only getting worse - there have been so many deaths due to suicides in the past few years, it's becoming very alarming and there needs to be urgent intervention to our health care system. GPs and hospital are struggling, and this is only getting worse by the day due to the ever-growing population.**

Long wait-times to access mental health services were mentioned by many participants and it relates closely to the previous sub-theme (insufficient workforce).

However, rising mental health concerns may have exacerbated wait-times and sometimes special populations were a concern. For instance:

> **There appears to be significant numbers of people in the community suffering from poor mental health but there are not enough psychologists to provide support to them. This leads to significant waiting periods potentially exacerbating mental health symptoms.**

The cost of mental health services and the lack of public bulk billed options were also seen as impacting community members receiving appropriate mental health support. Psychologists were the most frequently mentioned workforce required, followed by social workers, psychiatrists and counsellors.

> **The waitlist for bulk billed psychology and mental health supports is very high - about 6 months in XXX [Town]. Most of my Indigenous patients can't afford private fees. This is unacceptable.**

Amongst other issues, some participants mentioned that the pandemic had contributed to greater demand for mental health services which further increased existing workforce gaps.

Allied Health

For allied health, key sub-themes were the same as mental health: workforce shortages; long wait times; and cost/lack of bulk billing services. The allied health disciplines most frequently mentioned, apart from psychology and social work (mentioned in the mental health theme), were speech pathology, occupational therapy, podiatry, diabetes education and dentistry. The main sub-themes are presented in Figure 14 below.

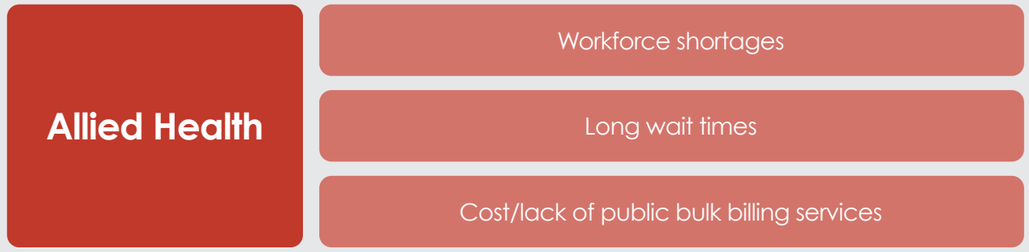


Figure 14: Allied Health sub-themes

Allied health workforce shortages was a central theme for multiple comments, with some emphasising the need for practitioners with remote/rural competency, particularly for more remote settings.

Others mentioned increased workloads and staff burnout as potential contributing factors to workforce shortages with a few also commenting on the paucity of NDIS services.

> **There is a large gap in allied health services on the XXX [Region]. Early intervention for young people is so important and the needs are just not being met. For those families on NDIS, participants struggle to engage in services as there are limited providers available. Other challenges include attracting staff to these areas and retention of staff.**

Some participants highlighted difficulties filling available places and retaining existing staff. Possible contributing factors include high service demand, lack of available graduates, cost of living and affordability of housing, with some organisations being unable to honour service agreements within both the public and private sector.

> **Significant difficulties in recruiting due to regional location are compounded by limited rental availability and higher cost of living. Reduced number of graduate podiatrists, along with very high national demand for our services makes it impossible for a small regional clinic to compete for new employees.**

As a consequence of workforce shortages, several comments highlighted long wait times to access allied health services. Several comments also mentioned that practices had closed their books and were not accepting new referrals.

> **Significant waiting times for podiatry, psychology (adult and child), OT and speech - usually months.**

Additionally, some comments identified the need for bulk billed and affordable allied health services and/or lower gap fees to improve access. The lack of incentives as well as the need for increased support was also recommended.

> **Free dental does not exist in the XXX [Region] but it's available in YYY [Regional town]. Likewise gap fees restrict access to psychology service. ATOD services are underfunded and cannot support outpatient alcohol detox.**

General Practice

For general practice, the main sub-themes were the same as for allied health; workforce shortages, long wait times and the lack of bulk billed services. Some contributing factors included recruitment and retention difficulties, increased demand, practice viability and GP workload and burnout. Figure 15 provides the sub-themes identified for general practice.

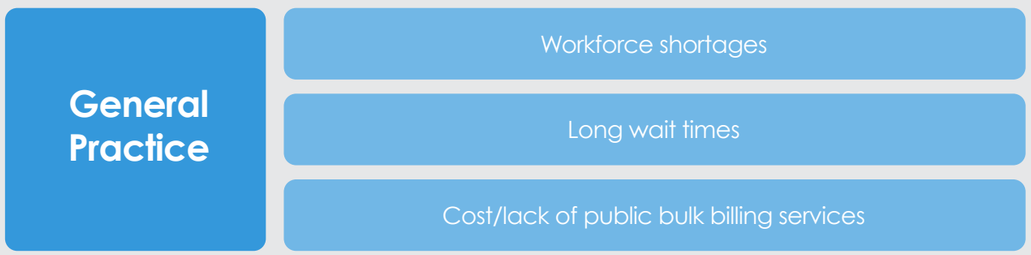


Figure 15: General Practice sub-themes

Workforce shortages was the primary sub-theme. The main factors mentioned under workforce shortages included attraction and retention issues, increased demand and workload, burnout, practice closures and a lack of affordable locum options.

> **Serious issue with General Practitioner service. Lack of staff is creating too much pressure on the existing staff. Unable to take leave and due to the current pandemic unable to get locum service. Unfortunately, this is not sustainable in the medium and long term.**

Some participants discussed how changes to DPA status, a limited supply of registrars, and difficulties for International Medical Graduates (IMGs) passing Pre-Employment Structured Clinical Interviews (PESCIs) had impacted on the ability to recruit and retain staff.

> **There are no GP recruitment possibilities in sight. Rural fully private non-procedural general practice is not represented by any-one. Australian graduates are not interested.**

The sub-theme of long wait times was mentioned by many participants, usually as a result of workforce shortages. Several participants also expressed concern about the complete lack of available appointments.

> **There are very limited GP's available in the area, with most booked out for weeks. I myself have had medical issues and been turned away because no doctors were taking on new patients.**

The lack of bulk billing options in many communities was mentioned by participants in both positive and negative terms.

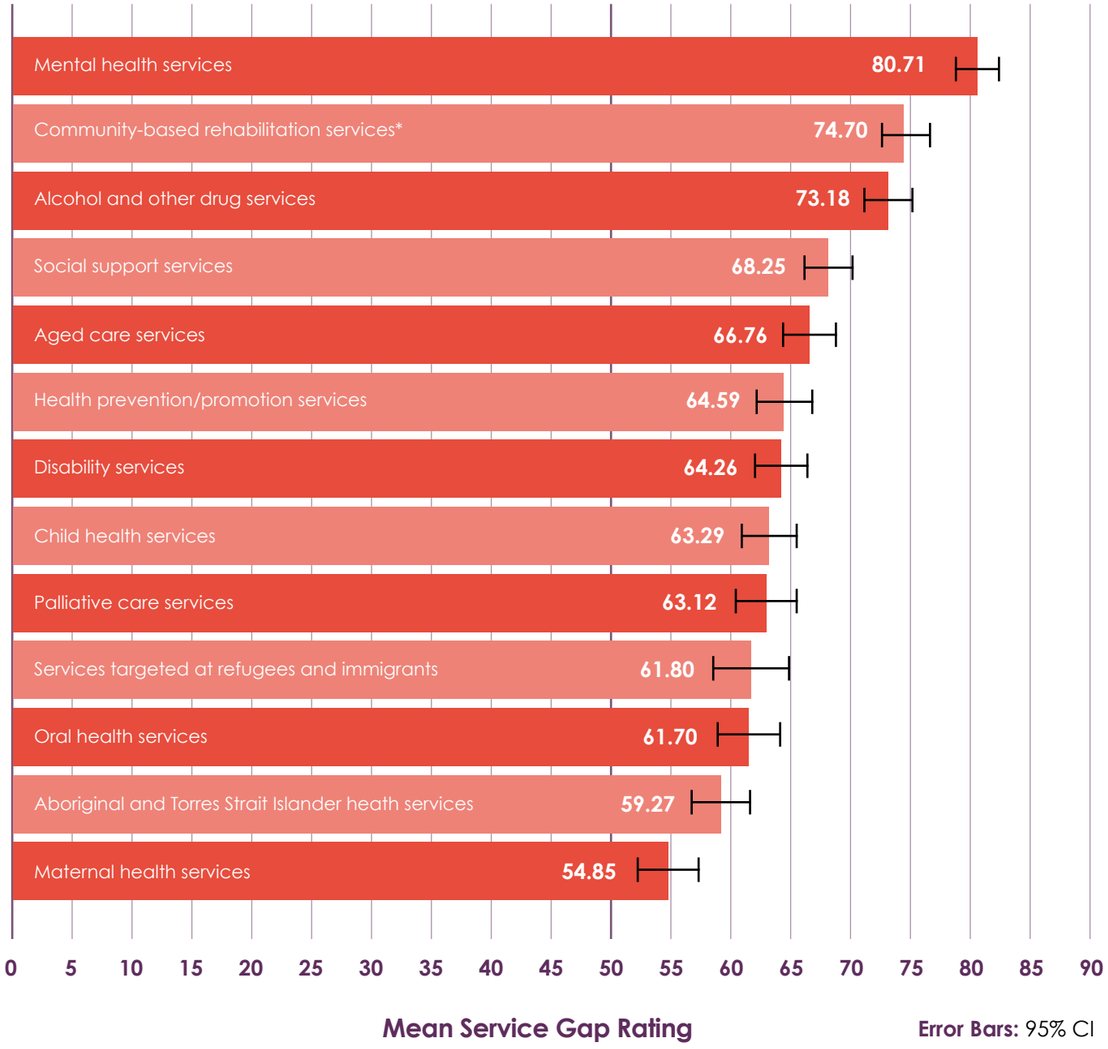
Participants reflected on the impact of government policy, the Medicare billing/structure, the pandemic, and the influence these factors have had on both the viability of private general practice as well the health of the community.

The need for increased awareness of challenges faced by primary care was highlighted, including the impact of pay disparities between public and private GPs.

> **Medicare is a real conundrum. People expect health care providers to be free, show no value for services or skills required and it is incredibly hard to get people to work privately with financial insecurity when QLD Health are so generous with pays. Complicated by QLD health workers having no understanding for the challenges of private practice and demanding that we BB [Bulk Bill] clients. Totally inappropriate but happens often.**

Service Gap Ratings

Primary care service gap ratings are presented in Figure 16.



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

Figure 16: Queensland mean service gap ratings 2022

The highest service gap rating means were for mental health services, community-based rehabilitation services (physical/functional rehabilitation), alcohol and other drug services, social support services, and aged care services; the first three with means of 70 or higher.

There were 11 service means of 60 or greater and all means were higher than 50. This year marks the fifth year the HWNA surveys have been conducted. Five year service gap trend data, from 2018 – 2022, has been provided in Table 7.

Table 7: Service gap rating means for 2018 - 2022

Type of Service	2018 M	2019 M	2020 M	2021 M	2022 M
Mental health services	57.83	65.25	69.72	73.34	80.71
Community-based rehabilitation services	--*	--*	68.56	69.99	74.70
Alcohol and other drug services	58.38	60.14	68.20	67.38	73.18
Social support services	--*	54.97	60.45	62.66	68.25
Aged care services	46.25	51.53	60.51	61.13	66.76
Health prevention/promotion services	46.09	50.84	57.38	62.16	64.59
Disability services	53.44	55.23	61.33	62.33	64.26
Palliative care services	48.37	52.55	58.80	61.41	63.12
Child health services	43.63	47.52	56.04	56.87	63.29
Oral health services	--*	54.44	58.37	61.61	61.70
Refugee and immigrant health services	48.82	50.36	57.82	60.19	61.79
Aboriginal & Torres Strait Islander health services	--*	43.13	50.47	51.95	59.27
Maternal health services	33.01	40.43	49.68	52.66	54.85

Note: **Rating question not contained in survey*

There has been a sustained increase in the primary care service gap rating means across all services since 2018. The most notable increases observed over the last year, from 2021 to 2022, were for mental health services, an increase of just above seven points; Aboriginal and Torres Strait Islander health services, an increase of just above seven points, and child health services with an increase of just above six points.

The remainder of the service gap ratings increased by between one and five points. The results suggest that there are considerable and increasing concerns amongst primary care staff and practice managers in remote and rural Queensland about primary care services.

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

Figure 17 depicts the service gap rating means for these services over the past five years. The service gap rating means for all five services have increased between 2018 and 2022.

Mental health services experienced the largest increase (22.9 points) over the previous five years, followed by aged care services (20.5 points), alcohol and other drug services (14.8 points), social support services (13.3 points) and disability services (10.8 points).

Figure 17: Five highest service gap rating means 2018 – 2022

Service Gaps Comments

There were 85 participants that commented on the service gap rating questions. A thematic analysis was undertaken, and the most frequently mentioned service gaps related to mental health and aged care services.

Other service gaps mentioned were for alcohol and other drug services, palliative care, oral health services and community-based (physical/functional) rehabilitation services. Across all of the primary care services mentioned, the lack of services and health practitioners was clearly identified

Mental Health

The sub-themes identified in the comments relating to mental health services are available in Figure 18.

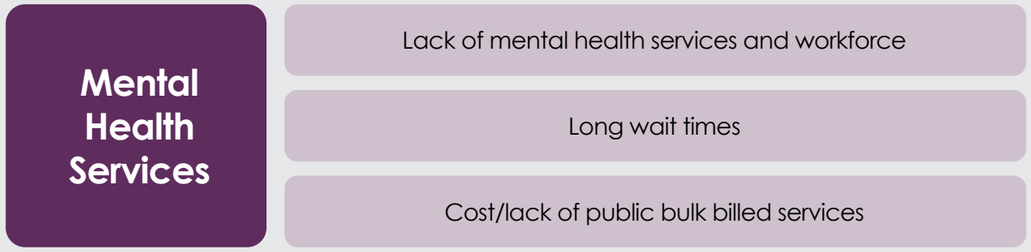


Figure 18: Sub-themes for mental health service comments

The main sub-theme for mental health services was a shortage of services and the workforce to provide services, similar to the workforce gap comments discussed earlier. This was commented on within public, not-for-profit and private settings. Some highlighted an inability to be able to refer patients while others highlighted particular difficulties in the availability of mental health services for particular populations such as children and adolescents.

> **A lot of the time they are so understaffed and over booked that emergency and "bandaid" treatment is supplied. They are then referred back to GP for complex mental health conditions.**

Several comments highlighted the high workforce turnover and subsequent workforce shortages experienced in their community:

> **There is limited health promotion for communities along with mental health. Mental health services in these communities have a high turnover rate.**

Long wait times to receive mental health services was also mentioned by many participants.

> **Very difficult to access services with long waiting lists and acute patients are often discharged to the care of the GP far too early with insufficient support. Case workers seem to come and go and often impossible to speak to a human being in a crisis situation. No problem with in-patient private care (if patient has private fund cover and can afford any gap).**

Some participants highlighted how the lack of mental health service impacted continuity of care. One participant from a remote location mentioned difficulties with both the provision of mental health services via telehealth and a lack of appropriate physical infrastructure for face-to-face consults.

> **No continuity of care with infreq[uent] f2f [face to face]. Slow internet means ph [telephone] not video telehealth which is a poor substitute for psychol[ogy]. No room e.g. consult literally under tree in town park is not private either.**

Many participants identified the lack of suitable bulk billing mental health services in their community as a hurdle for community members.

Aged Care

Aged care services were identified as the second main service gap theme. Within the comments addressing aged care services three main sub-themes were identified. These are provided in Figure 19.

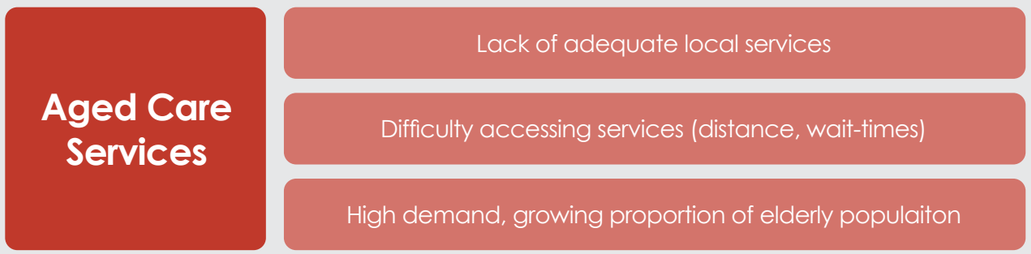


Figure 19: Sub-themes for aged care services

The main sub-theme for aged care services was the lack of adequate local services, including dementia care. Several participants also noted large distances and long wait-times.

The final sub-theme identified was the rising demand for aged care services:

> **There are insufficient - timely available aged care packages to enable our aged residents to be cared for at home which has placed an inordinate load [on] the local nursing home, which are always at capacity. That capacity is currently limited by the number of nurses that they can attract because the COVID-19 response has significantly reduced/eliminated the number of nurses applying for vacant position.**

> **Our local aged care facility does not have a dementia care unit. The closest one is 3 hours away.**

Other frequently mentioned service gaps identified are displayed in Figure 20.

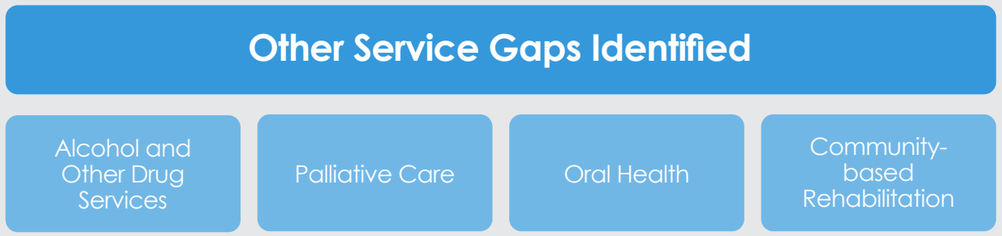


Figure 20: Other service gaps

Amongst other service gaps, there were sub-themes of waiting periods, absence of bulk billing services, increasing demand, low funding and staff shortages across these services.

> **Rehab is almost non-existent. There is a tiny pulmonary rehab program funded by DoH and similar cardiac. Simple 8–12-week prevention and rehab programs would no doubt be hugely effective in avoiding, for example, orthopaedic referrals for knee pain, and rehab is well known to prevent rehospitalisation etc. Govt funds seemingly infinite procedures like scopes, and pills/ medicines, not the practice of medicine or evidence based nonpharmacological interventions.**

Quantitative Methodology Findings: Priority SA2s

Below are the top ranked SA2s by PHN region based on the quantitative methodology described on page four 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

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

Western Queensland PHN

Far South West
Carpentaria
Far Central West
Mount Isa Region
Charleville

Darling Downs and West Moreton PHN

Kingaroy Region - North
Millmerran
Tara
Esk
Crows Nest - Rosalie
Chinchilla
Nanango
Inglewood - Waggamba
Lockyer Valley - East
Southern Downs - West

Central Queensland, Wide Bay, Sunshine Coast PHN

Kilkivan
Maryborough Region - South
Mount Morgan
Agnes Water - Miriam Vale
Gympie Region
Cooloola
Gin Gin
Gayndah - Mundubbera
Central Highlands - East
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 is 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 guiding principles.

Guiding Principles

In addition to identifying the priority SA2 regions, there is also a recognition that there can be emerging critical workforce situations at any given time in other regions. The HWSG proposed that Health Workforce Queensland develop a set of guiding principles to support the prioritisation of SA2 locations in a changing environment; and to assist in prioritising what activities (if any) Health Workforce Queensland undertakes in these regions.

Principles to underpin prioritising locations

The principles are as follows:

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

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

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

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

Key Issues and Strategies

Access

Improving access and continuity of access to essential primary health care

Key Issues

- Shortages of GP, nursing, 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
- 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 (generalist models)
- 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 of 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
- An endorsed overarching vision for primary care (state and federal)

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 to 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 enhancing 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 its role in delivering services to complement activities undertaken by First Nations 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 high visiting/outreach models
- Vulnerable and non-viable workforce models including:
  - o 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.
  - o Current fee for service general practice models in remote and rural areas does not support sustainability
  - o 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

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

Issue in Focus: Practice Sustainability

This year our Issue in Focus was practice sustainability. Private practice for most professions in remote and rural communities is currently only marginally viable and sustainable.

The HWNA survey included several questions to gauge the perceptions of practitioners and managers in remote and rural Queensland regarding issues that impact the sustainability and viability of their primary health care practices. Survey participants were provided a list of 15 factors (e.g., pay disparities, staff retention, place-based education) and were asked to respond to each factor along a 100-point scale from '0 = Not at all Important' to '100 = Extremely Important'.

These factors were:

- Medicare/funding reform to better support remote and rural practitioners
- Strategies to encourage remote and rural careers
- Strategies to improve retention of staff (e.g., ongoing individual support)
- Targeted infrastructure funding for remote/rural services
- Information management systems that support continuity of care across public/private services
- Better access to place-based education and training
- Targeted infrastructure funding for staff housing/accommodation
- Addressing pay disparities between public and private services
- Local cooperation for shared workforce models
- Support for supervision
- Improved access to Continuing Professional Development (CPD) for remote/rural practitioners
- Increased support for family members
- Development of 'Rural Generalist' models across the health care sector to work across primary and secondary care
- Practice management support
- Improved telehealth and/or other technology to support community access.

Responses were received from 554 participants and results are presented in Figure 21. All of the importance rating means were higher than 75 suggesting that there was overall agreement amongst survey participants that all of these factors were important to the sustainability and viability of their remote and rural practices. The highest importance rating means were:

- Medicare/Funding reform to better support remote and rural practitioners (*M* = 88.2)
- Strategies to encourage remote and rural careers (*M* = 86.2) and
- Strategies to improve retention of staff (*M* = 85.7).

Eight of the importance ratings were higher than 80, with approximately 10 points separating the highest importance rating, ***Medicare/funding reform***, from the lowest, ***improved telehealth and other technology (M = 77.7).***

Figure 21: Mean importance ratings for practice sustainability items

Survey participants were additionally asked if there were any 'other' factors which were important in the sustainability and viability of their practice; 68 responses were received for this question with the most common responses being related to:

- **Support for family members**
- **Accommodation**
- **Funding reform**

Finally, survey participants were asked to provide written responses to two questions regarding what would improve the sustainability and viability of their service, and what needs to change to ensure primary care services in their community are sustainable into the future. The questions were worded as follows:

1. What would improve the sustainability/viability of your service?
2. What needs to change to ensure primary care services in your community are sustainable into the future?

A thematic analysis was undertaken of comments provided in response to both questions and several primary themes were identified for each. Close examination and comparison of comments indicated large areas of overlap of responses to both questions. Many participants mentioned sustainability of primary care services in their community in their response to the first question. Similarly, many responses to the second question spoke about the sustainability of the participants' own practice/service. For this reason, responses were combined in a single thematic analysis titled Sustainability of Primary Care.

Sustainability of Primary Care

There were 548 responses to the question regarding improvements to the sustainability and viability of the health practitioner/ manager's service and 514 responses to the question about changes to improve the sustainability of primary care in the community. Thematic analyses identified the following primary themes:

- **Workforce**
- **Funding and incentives**
- **Support**
- **Infrastructure**

Within each of these themes there were sub-themes identified and differences between which primary care disciplines were being mentioned.

For instance, some spoke about sustainability issues for GPs/medical practitioners, others about allied health practitioners and nurses/midwives, while some spoke about the mental health workforce. There were also comments covering more than one discipline. Each of the themes will be discussed.

Workforce

The sub-themes around workforce issues are presented in Figure 22.

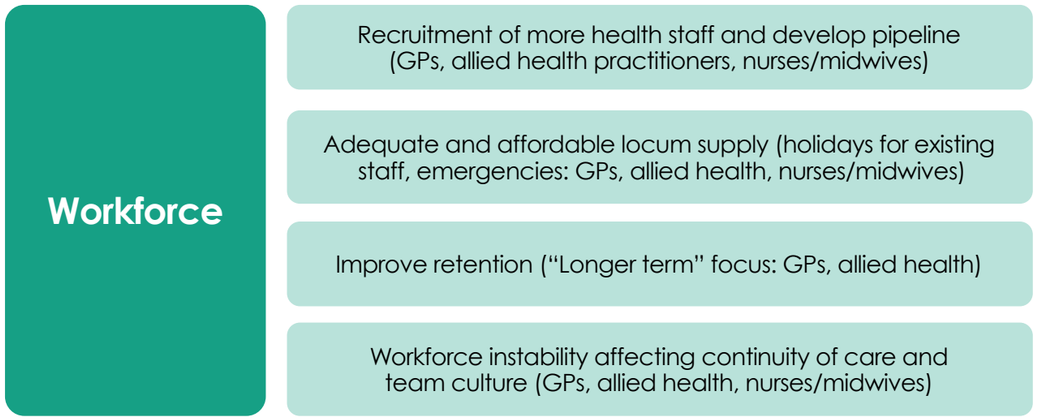


Figure 22: Workforce issues impacting sustainability of participant practices/services

Some comments simply indicated that more staff were required while others emphasised the requirement for new staff to introduce additional primary care services required by the community. Still others suggested that more staff were needed to prevent burnout of those working with the practice/service. Many participants discussed the need to improve the health workforce supply pipeline with an increase in entry level recruits and encouraging local school students to contemplate a career in rural health.

> **"Connecting the recruited workforce with the community to grow connections. Grow our own - education in schools regarding allied health careers in rural communities."**

Many mentioned the importance of access to IMGs to reliably staff general practices. Some centered their responses around being awarded DPA status while others suggested equitable access to health professionals would improve sustainability.

> **More GPs please. Being designated DPA would help attract more doctors. A fair way of ensuring Private Medical Practices are able to recruit from a pool of both DPA and non-DPA applicants.**

A focus on rural placements of health students was mentioned by many as a method to improve the pipeline of health practitioners. A couple of participants outlined strategies that were being employed or strategies that could be used by others.

> **Commencement of student placements - We have nil issues with staff retention as the team culture, work, PD opportunities and lifestyle are great. The issue is getting people to come out here who have never visited the region.**

Related to the issue of retention of workforce staff, there were comments from primary care providers about an inability to match government salaries and entitlements and the impacts of a changing workforce on continuity of care and staff culture.

> **Privately run practices cannot afford to compete with gov[ernment] agencies who offer free/subsidised accommodation, travel allowances, cars etc. Often private organisations cannot match wages either, therefore staff is held by the government and private agencies are without staff. This results in patients not receiving the care they need and without continuity.**

Adequate and affordable locum supply were seen by many as a major issue for maintaining staff and preventing burnout.

> **Relief for current workers (affordability of locums) - when workers take leave other staff have to pick up their load.**

Comments also suggested the provision of longer contracts with improved retention packages and working conditions as an incentive to remain rural, and as a follow-on benefit to the community in the form of continuity of care. It is also of note that some participants mentioned the need for succession planning to ensure sustainability.

> **Changed funding model - capitation with realistic rurality loading. Long term contracts allow for staff retention and developing trust with community.**

There were also comments around the impacts of a constantly changing workforce on continuity of care and staff culture.

> **Communities become distrustful of services with frequently changing staff. This also greatly impacts the existing team culture and stability.**

Funding and Incentives

For the funding and incentives theme, several sub-themes were revealed. These are presented in Figure 23.

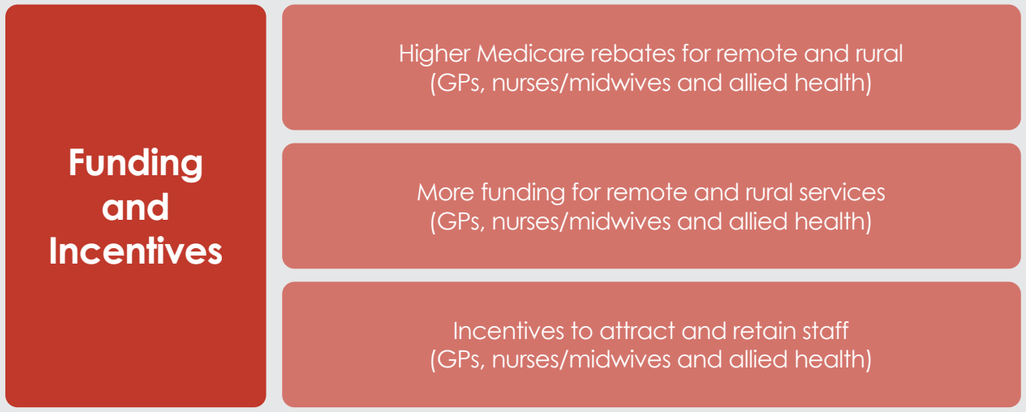


Figure 23: Funding and incentive sub-themes

Many participants wrote about this theme with simple statements such as, 'Better pay and conditions', or 'Increased funding'. Higher bulk billing rates were mentioned by many participants while others mentioned specific billing items such as telehealth, allied health services, longer/complex consultations and nurse billing.

> **Continuation of a better range of telehealth item numbers given the complexity of calls, arranging specialists and transport and coordinating appointments for patients who do have to travel to specialists in the east, north or elsewhere. Perhaps even an admin item number for all this extra work.**

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

For the second sub-theme, issues about more funding for remote and rural services were raised, such as lack of funding continuity and lack of funding for travel, further training and junior staff supervision.

> **Funding is moving to more of a fee for service model which does not allow for down time to provide rural and remote services e.g. 300,000km's travelled in 20-21 just in XXX [service name] AH team, to deliver accessible services to remote communities, (at 80km/hr and with 3-4 clinicians in a car, that is hours of opportunity cost ($3.5Million of costs that cannot be recuperated), it'd be great if a travel allowance to cover workforce costs (hourly rates) were distributed rather than just costs for petrol/kms and accommodation.**

Comments provided also requested financial support to promote prospective health promotion programs and potential rural health opportunities.

> **More funding/review of funding for community health programs - aimed at prevention, and then separately at control/maintenance of chronic disease…**

Further, some comments examined current funding models with calls for rurally based funding reforms tailored to the community.

> **… the way funding for programs is tendered sets up a competitive situation among NGOs. In small communities that is very dangerous. Funding should be allocated by a local organiser or coordinator, someone that knows the local agencies, not a public servant at a desk in Brisbane who reads a well-written submission and thinks that that is the same thing as an organisation who can provide a service.**

The sub-theme covering incentives to attract and retain staff contained a broad range of areas that included comments that more incentives were needed to encourage practitioners to undertake remote and rural practice.

> **Less funding = less $ available to incentivise clinicians to stay in rural and remote areas. Unfortunately, with less funding for rural and remote services the divide between pay scales for rural practitioners compared to metro practitioners is not there anymore. Our staff can get paid the same $ on the coast, closer to family, services etc. There is no monetary value to incentivise staying out here for longer. It'd be great if the Federal government could give rural practitioners cash bonuses for every year of service. (now I'm dreaming...)."**

Support

For the theme of support, several sub-themes were found. These are presented below in Figure 24.

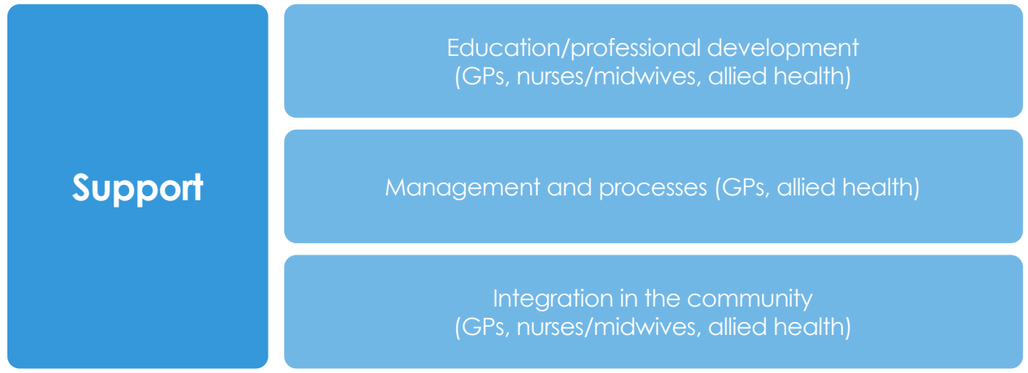


Figure 24: Support sub-themes for sustainability of practices

For the professional development sub-theme there were calls for more and/or continued support for existing health professionals in all disciplines. Participant comments covered aspects such as development of rural pathways for allied health practitioners, access to training in specialist areas (e.g., child mental health), and funded opportunities to develop staff already working in the community.

> **In addition to attraction and retention of staff further support in assisting new and existing practitioners to develop and expand their skills and scope of practice with adequate mentoring either face to face or remotely. Furthermore, rural loading on the delivery of services needs to be applied. We are often facing more complex, less supported patients that require a greater level of care and time. In addition, the wages required to attract and retain health professionals are higher and is becoming a growing problem for sustainability.**

The management and process sub-theme contained comments about issues such as service coordination, common software access, better integration of primary and secondary care services and assistance for succession planning.

> **Integration of Hospital, Community and Private Health & Community Services Needs Planning should be a High Priority. No Service is an Island unto itself. Our Patients/Clients have critical needs across all service areas.**

For the final sub-theme, support to assist young or new health professionals and their families integrate into the community was seen by some as one way to increase the likelihood of practitioners staying for a longer period.

> **Community involvement in welcoming young health professionals to make them very attractive places to live and work.**

Infrastructure

Under the theme of infrastructure, comments mentioned various aspects of physical infrastructure (e.g., housing for staff and lack of physical structures), technology/digital platforms and support for telehealth.

> **Increased rural living support i.e. assistance with accommodation both financially and to source it. Long term outcomes for clinicians who work rural.**

Discussion

Access to primary healthcare workforce and the need to reform funding models ranked most highly in the survey questions about practice sustainability. Although these two issues are differentiated in the survey, they are separate sides of the same problem. Health services are delivered by health practitioners and the majority of costs in the delivery of a health service are workforce related costs.

According to the RACGP ***Health of the Nation 2021 report,***[29] government expenditure on primary healthcare in Australia has been in decline from 2012 – 2019. This decline in expenditure exponentially impacts the ability of remote and rural primary care to offer competitive pay and conditions because of the higher cost of delivering services in these locations.

Innovative workforce solutions and pooled funding are often cited as mechanisms to improve primary care sustainability in remote and rural communities; however, they are not an alternative to funding that reflects the true cost of service delivery. In a funding environment faced with unsustainable growth of costs, appropriate resourcing of primary care to prioritise early intervention and prevention is critical.

> **Better Medicare reimbursement. When you have to push a patient through every 15 minutes you are not providing good health care. It also increases the risk of burn out. 15 min appts barely give you time to take a proper history, let alone examine and come up with a diagnosis/ treatment/ referral process...**

The use of NPs is an example of an innovative workforce model. The model was initially proposed to address gaps in remote and rural healthcare although criticism points out that NPs have not made a marked difference in those gaps.[30]

However, NPs have reported barriers to achieving this include lagging local health service attitudes, limited funding and job opportunities, lack of clarity in scope of practice, and restrictive regulatory policies and frameworks.[31]

> **Look at having more positions as nurse practitioners employed in Primary care services to release some workload and support the GP's.**

In terms of the maldistribution of the health workforce, generalist roles such as those found in remote and rural primary care are perceived as less attractive to health graduates due to their lower earning capacity.

Income disparity significantly affects career decision-making, and it is difficult to recruit workforce to primary care when there is a difference in remuneration and entitlements between secondary and primary care.

The challenges of attracting workforce to remote and rural primary care is further deepened by reported lack of support, clinical isolation, and reduced trainee work-readiness to successfully transition to rural practice.[32]

29 Royal Australian College of General Practitioners. (2021). *General Practice Health of the Nation 2021.* https://www.racgp.org.au/health-of-the-nation/president-s-message

30 Department of Health. (2021). *Nurse Practitioner 10 Year Plan Consultation Paper.* Australian Government. https://consultations.health.gov.au/health-workforce/nurse-practitioner-10-year-plan-survey/results/nursepractitioner10yearplansurveyanalysisreport.pdf

31 Smith, T., McNeil, K., Mitchell, R., Boyle, B., & Ries, N. (2019). A study of macro-, meso- and micro-barriers and enablers affecting extended scopes of practice: the case of rural nurse practitioners in Australia. *BMC Nursing,* 18(4), 1-12. https://doi.org/10.1186/s12912-019-0337-z

32 Department of Health. (2019). *National Medical Workforce Strategy, Scoping Framework.* Australian Government. https://www.health.gov.au/sites/default/files/documents/2021/09/national-medical-workforce-strategy-scoping-framework.pdf

> **It's becoming sadly more apparent that as a clinic GP (vs hospital) I work harder, for less money, and less security and benefits (leave/ training/ sick cover). I keep doing this work because I genuinely believe it is the most important part of my job, but as my family grows & my personal priorities change, I am worried this part of my work will not be sustainable.**

A report from the ***National Rural Health Commissioner*** found that ***"in thin markets, and as remoteness increases, shortfalls in the allied health workforce worsens."*** Reported experiences by allied health clinicians of lack of support, clinical isolation, and high workloads echo that of GPs. Increasingly, administration heavy and complex funding models such as MBS, My Aged Care, and the NDIS are postured as solutions however, in small remote and rural towns these funding models often exacerbate workforce challenges. Faced with complex funding models, providers can be deterred from expanding service delivery to meet the full scope of community need, resulting in reduced per capita provision of allied health services in MM 4-7 locations.[33]

> **The lack of services in this area creates a vicious cycle whereby clinicians who do move out here are placed under tremendous pressure and stress by the community to make up the gaps. These clinicians are often new graduates that are not equipped to deal with this amount of pressure and stress, creating a culture of high turnover and staff that will spend 12 months out here then move on to work elsewhere for similar (or more) money and benefits.**

Remote and rural funding models must encourage satisfying careers in primary and secondary care that operate across the full scope of community need. Successful models must also recognise and counter the additional costs and challenges that are associated in delivering remote and rural care. Use of technological advances, such as virtual and digital health tools, should also form part of the future of rural primary care.

33 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, Rural and Remote Australia.* Australian Government. 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

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

Acknowledgements

Health Workforce Queensland would like to thank the above organisations and the many general practices across remote and rural Queensland who contributed to this report.

We would also like to acknowledge and thank the hundreds of remote and rural health professionals and practice managers who took the time to have their say via the online survey.

Health Workforce Queensland would like to thank Queensland Health's Workforce Strategy Branch for providing access to the Queensland extract of the 2020 National Health Workforce Dataset.

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Appendix A - Priority SA2s by PHN

Western Queensland PHN

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

Darling Downs and West Moreton PHN

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

Central Queensland, Wide Bay, Sunshine Coast PHN

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

Northern Queensland PHN

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

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 Hygienist	Pharmacist
Dentist	Physician Assistant
Diabetes Educator	Physiotherapist
Dietitian	Podiatrist
Exercise Physiologist	Practice Manager
Family Support Worker	Psychologist
Health Promotion	Radiographer
Medical Receptionist	Social Worker
General Practitioner	Speech Pathologist
Midwife	Sonographer
Nurse	

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