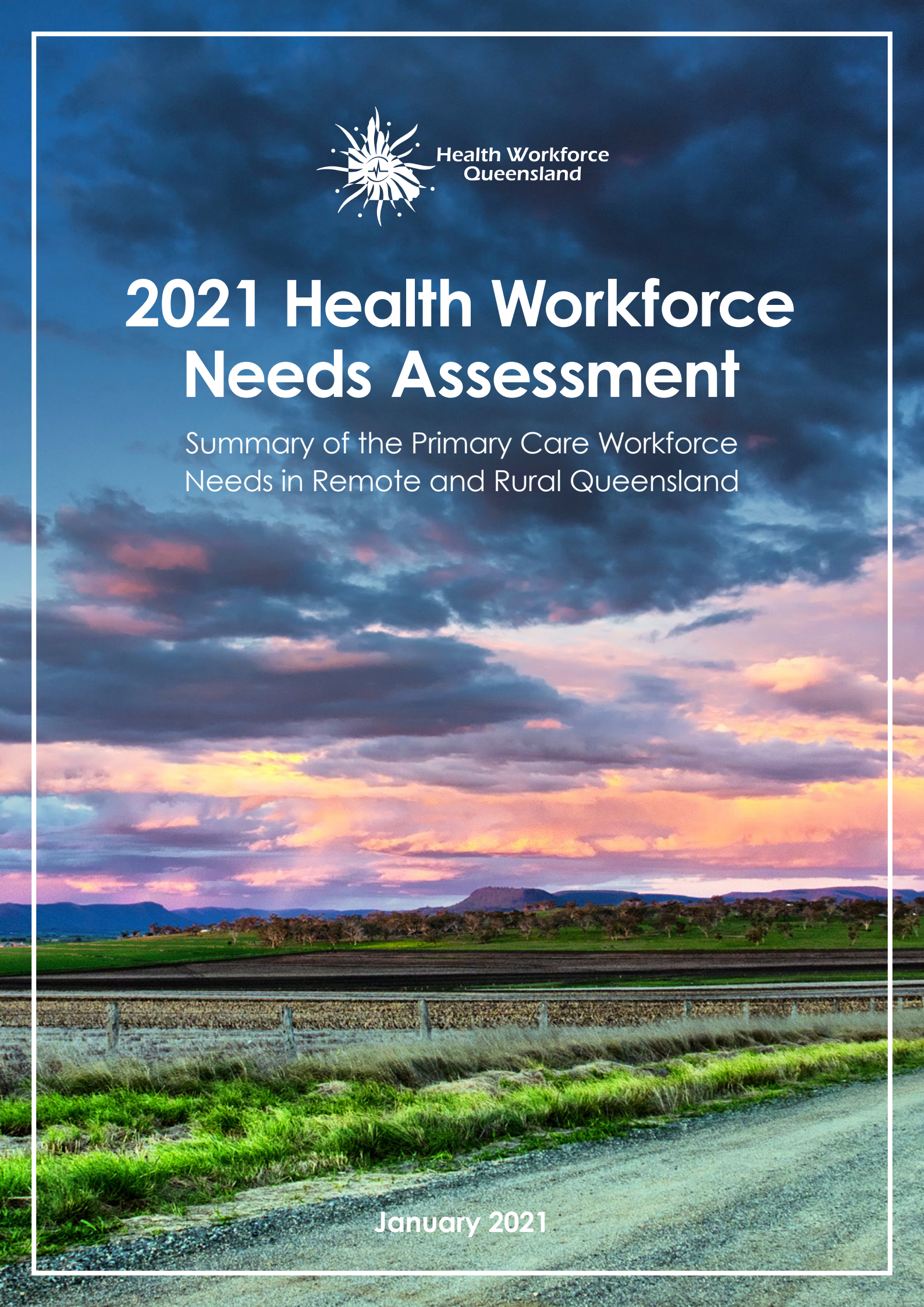

2021 Health Workforce Needs Assessment

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

January 2021

Our Vision

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

Our Purpose

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

Our Values

Our Values are Integrity, Commitment and Equity.

Integrity

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

Commitment

We enhance health services in rural and remote Queensland communities.

Equity

We provide equal access to services based on prioritised need.

Acknowledgements

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

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

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Executive Summary

This report includes the findings from the 2021 Health Workforce Needs Assessment (HWNA) for remote and rural Queensland undertaken by Health Workforce Queensland. The HWNA is conducted every year as part of Health Workforce Queensland's agreement with the Australian Government Department of Health.

The online survey saw 681 health professionals and managers complete the survey and share their perceptions of workforce and service gaps in their communities of practice. Mean workforce and service gap ratings were found to be generally higher than 2020 and have gradually increased each year since the first HWNA survey in 2018. Psychology, speech pathology and occupational therapy workforces had the highest mean gap ratings and the most notable increases from 2020 were for speech pathology and occupational therapy. Health service gap ratings show mental health, community-based rehabilitation services and alcohol and other drugs services were once again the highest gap ratings. Comments provided by survey participants suggested better access to mental health, general practice and alcohol and other drug services is needed.

General Practitioner (GP) workforce maldistribution and shortages in remote and rural Queensland continue with challenges in recruitment and retention of a stable medical workforce within general practice. These shortages have been exacerbated in 2020 by the impacts of the COVID-19 pandemic with reduced access to locum support due to domestic border closures. This was further compounded by the limited number of eligible International Medical Graduates (IMGs) and shortages of GP registrars. Workforce shortages have added to the burden on rural GPs and other health workforce increasing mental fatigue and burnout. In the face of these pressures, health practitioners have embraced the chance to use telehealth to continue to deliver services where practical.

Progression of the current and emerging medical workforce has been challenged with delays in GP training exams, as well as fewer rural clinical placement opportunities in remote and rural Queensland throughout 2020 with many placements being either cancelled or postponed due to the COVID-19 pandemic.

The health workforce overall continues to experience maldistribution with remote and rural areas more likely to experience workforce shortages. More policy enablers are required to increase the appeal and viability of rural general practice and primary care. Greater flexibility in service and workforce models for remote and rural is also required to attract and support capable and culturally responsive health professionals. Priorities could include shared funding models, changes to staffing levels and skill mix, delivery modality, and maximisation of multidisciplinary teams. There is also recognition of the importance of workforce support and training for a sustainable and quality rural and remote health system.

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

Introduction

Health Workforce Queensland undertakes an annual primary care workforce needs assessment (HWNA) for remote and rural areas of Queensland classified as Modified Monash Model (MMM) 2-7 (2019). This report summarises the overall findings from the 2021 HWNA and builds on a baseline understanding of workforce needs established in previous HWNAs.
The purpose of the HWNA is to identify priority locations with regards to health workforce, inform and prioritise the utilisation of Health Workforce Queensland resources, and inform outcomes to the Department of Health for program planning and policy development.

The HWNA also contributes to the 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 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 methodology was largely consistent with previous HWNAs and comprised four main components:

Desktop Audit: Collection and review of key sector reports released throughout 2020.

Online Survey: Online surveys targeting general practitioners (GPs), practice managers, primary health care nurses, allied health professionals, 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 practise. The surveys were open between October 2020, and February 2021.

Stakeholder Engagement: Information was sourced from consultations with key stakeholders, communities, and health professionals throughout 2020. The jurisdictional HWSG also provided input at the annual HWSG meeting.

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

- GP full time equivalent to estimated resident population ratio (ABS 2020)
- Modified Monash Model (MMM) classification of remoteness (2019)
- Index of Relative Socio-economic Advantage and Disadvantage (IRSAD)
- Vulnerable population aged < 5 and > 65 years (ABS 2020)
- Aboriginal and Torres Strait Islander status (ABS 2020)

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, this year, the MMM coding was changed from the older 2016 geography to the 2019 MMM. Some locations have changed coding which has impacted some of the practitioner numbers per coding category, most notably smaller numbers in MMM 2 locations. The change to the 2019 MMM is directly aligned with reporting requirement changes requested by the Australian Government Department of Health.

Remote and Rural Workforce Overview

2020 was a year that has highlighted both shortcomings and opportunities for remote and rural health services and its workforce. While many industries have undergone reform both in workforce and service delivery to meet community need, the health sector has historically been much slower to respond.

COVID-19, whilst being a major disruptor to health service delivery and training, has provided some unique opportunities to enact reform within a short period of time to ensure continuity of care. Primary care service delivery was rapidly propelled into a new era with the rollout of new temporary Medicare Benefits Schedule (MBS) items to allow doctors, nurses, midwives and some allied health professionals, including mental health professionals, to provide telehealth services to reduce the risk of exposure and to enhance access to vital health services. COVID-19 has also highlighted Queensland's reliance on interstate locum medical officers with the State border closures and the need to build a pool of qualified, available medical workforce within our own State boundaries to scale up when required.

At a National level, a chance for reform may also be in the pipeline with major reviews currently underway including the Primary Health Care 10-year Plan; the National Medical Workforce Strategy; and the National Aboriginal and Torres Strait Islander Health Workforce Plan. The extension of the office of the National Rural Health Commissioner (NRHC) and continued focus on the Rural Generalist agenda are strong indicators for the desire to build recognition and reward for those working in primary care in remote and rural Australia. Federal funding has been made available to support the establishment of coordination units for medical rural generalists for each State and Territory. Support for innovative multidisciplinary models at the local level is also a priority for the NRHC and this provides opportunities for further change and reform.

There have also been several key health reports and program evaluations published in 2020. One of these is the ***National Rural Health Commissioner Final Report June 2020: Improvement of Access, Quality and Distribution of Allied Health Services in Regional, Rural and Remote Australia***[1] which talks to the establishment of service and learning consortia, expansion of the allied health rural generalist pathway as well as investing in strategies to increase the number of Aboriginal and Torres Strait Islander allied health practitioners. ***The Independent Evaluation of the Rural Health Multidisciplinary Training Program June 2020***[2] was also published with recommendations directed at selection processes for rural placements, expansion of high quality, innovative and immersive placements, inclusion of rural health and Aboriginal and Torres Strait Islander health in health program curricula and support for the transition of students to rural work. The evaluation also recommended investigating the feasibility of establishing additional University Departments of Rural Health or expanding their current functions.

At a State-level, this year marked the establishment of the Office for Rural and Remote Health (ORRH) within Queensland Health, providing a "policy home" for remote and rural health within the Department and an avenue for the rural primary care sector to engage. The initial priorities of the Office relate to health needs and service optimisation, having the right workforce in the right location at the right time and sustaining comprehensive primary care. *As part of* this, a refresh of the ***Rural and Remote Workforce Strategy to 2026*** is underway and draft recommendations talk to: ensuring comprehensive primary care; increasing and embedding the participation of Aboriginal and Torres Strait Islander people across all healthcare professions including in leadership roles; strengthening networked approaches and virtual care technologies to provide continuity of culturally safe health care closer to home; and considering the impacts of climate change in health care.

Local solutions are essential to support sustainable service delivery as well as providing meaningful, fulfilling work to the health workforce. Models need to support collaborative, place-based planning with community involvement, funding needs to be blended and pay disparities between public and private settings should be addressed. The Western Queensland Health Care Home (WQHCH) initiative is a locally developed model of care that supports private primary care, Aboriginal Community Controlled Health Organisations (ACCHOs) and the Royal Flying Doctor Service (RFDS), as well as supporting the involvement of HHS operated services. Incorporation of both the public and private sectors in the WQHCH model helps to encourage the sustainability of healthcare access in the region. Workforce ***'grow your own'*** strategies and use of technology to support end to end training and supervision for the current and future workforce are also required to grow and sustain the workforce pipeline in remote and rural Queensland.

The primary care sector remains vulnerable in remote and rural Queensland with growing incidences of market failure in general practice and legislative barriers restricting entry to workforce programs designed to support regions with critical workforce shortages. At the national level, there is no singular voice for general practice and no clear, cohesive vision for the future. The split governance and accountability for health services between federal and state compounds this and an endorsed (state and federal) overarching vision is needed for primary care that is proactive, preventative, coordinated and integrated.

[1] KBC Australia. (2020). *Independent Evaluation of the Rural Health Multidisciplinary Training Program: Final Report to the Commonwealth Department of Health.* Canberra: Australian Government, Department of Health. Retrieved from https://www1.health.gov.au/internet/main/publishing.nsf/Content/rural-health-rhmt-evaluation.

[2] 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.* Retrieved from https://www1.health.gov.au/internet/main/publishing.nsf/Content/National-Rural-Health-Commissioner-publications.

General Practitioner Workforce Summary

Longstanding General Practitioner (GP) workforce maldistribution and shortages in remote and rural Queensland were exacerbated in 2020 by the impacts of the COVID-19 pandemic. One of the most significant effects of the pandemic has been the lack of access to regular locum support due to domestic border closures. The fall in the availability of locums has placed an added burden on rural GPs and has increased the incidence of mental fatigue and burnout being reported.[3]

Research undertaken by the Royal Australian ***College of General Practitioners (RACGP), General Practice: Health of the Nation 2020***[4] report indicates one in three GPs ranked their own wellbeing as one of the top three challenges that impacted their ability to provide care to patients during the COVID-19 pandemic. This research also found that GPs in rural areas continue to work longer hours than their colleagues in metropolitan areas. In general, regional/rural GPs are less likely to report they have a manageable workload (43 percent) than GPs in metropolitan areas (53 percent).

At a time when the need in remote and rural communities is arguably higher than ever, the knock-on effect of the GP workforce maldistribution and workforce policy interventions in Queensland have seen practice closures, increased patient wait times, and increased pressure on emergency departments.[3]

> **"The hospital is just so busy, and the Practice has no available appointment slots, we need to go to 3 FTE."**

This year has also seen further downward pressure on the percentage of International Medical Graduates (IMGs) working in private practice in remote and rural Queensland. In 2018, this workforce made up 48 percent of all general practitioners in MMM 2-7 Queensland. In 2020 this figure has fallen to 46.6 percent. Federal government workforce policy settings have been extended to include changes to many programs, including eligibility for the Visa for GPs program, and many practices with high workforce need, formerly able to obtain a Health Workforce Certificate and employ IMGs are no longer able to do so. The goal of self-sufficiency for the medical workforce is the ideal outcome for Australia, however there is still a need to support practices with critical workforce shortages until this is achieved.

> **"All CVs I have personally received for GP's are all overseas trained doctors and now I am unable to recruit due to the change in the DPA [Distribution Priority Area]."**

Current private practice 'fee for service' funding models that don't recognise the unique business and workforce challenges in remote and rural areas, combined with the significant disparity of income and entitlements between hospital-based GPs and those in private practice, are major drivers of current GP workforce maldistribution in Queensland.

[3] Health Workforce Stakeholder Group, (2020), Item 5: Current & Emerging Issues/Opportunities – Stakeholder Perspectives. In Minutes of Health Workforce Stakeholder Group committee meeting 17 September 2020.

[4] The Royal Australian College of General Practitioners, *General Practice: Health of the Nation 2020,* East Melbourne, Vic: RACGP.

These issues also contributed to ongoing shortages of the GP registrar workforce throughout 2020, with the continuation of the trend of undersubscription of Australian General Practice Training (AGPT) places. This trend is expected to improve slightly in 2021 with AGPT reporting a (yet to be finalised) shortfall of only 50 GP Registrars in 2021 as opposed to the shortfall of 171 in 2020.[5]

> **"...No support is given to the private practice... Medicare rebate freezes have severely impacted the financial viability of the private practice. If nothing is done to improve the situation small rural general practices will not survive and greater loads will be placed on the public system with an even more difficult to recruit medical workforce."**

The undersubscription is evidence of a systemic problem in remote and rural general practice, whereby remuneration structures are not reflective of the levels of responsibility and breadth of skills required for these roles. Uncertainties around the future guardianship of general practice training and what it will entail, as well as the lack of a singular, cohesive voice and direction for general practice is leading to a reluctance for trainees to subscribe to general practice.

Reports of longer working hours in rural practice, onerous responsibilities of business ownership and pay disparities also contribute to the declining interest in general practice and perpetuate the current negative narrative about remote and rural practice. Evidence shows however, many GPs working in remote and rural settings express positive feedback about the interesting and rewarding nature of their work and surveys of students completing rural immersion programs, such as the John Flynn Placement Program, also report their rural and remote experiences to be highly positive. Shifting the current narrative to reflect the unique and exciting potential of rural general practice is essential. The progression of the national rural generalist agenda will play a key role in addressing some of the reward and recognition challenges currently facing rural and remote general practice.

General practice is the most efficient part of the healthcare system, and a well-resourced general practice sector is essential to addressing both the sustainability of healthcare services and improving the health outcomes of people living in remote and rural Queensland. Without policy and funding model reforms, it is unlikely that meaningful redistribution of the GP workforce will occur in the foreseeable future.

[5] Personal communication with JCUGP Training

Nursing and Midwifery Workforce Summary

The primary care nursing and midwifery workforce continues to face shortages in remote and rural areas, with both recruitment and retention difficulties. Remote areas in particular face high rates of workforce turnover. Nurses and midwives who work in remote and rural areas must have the right skill sets to meet the needs of the communities they serve. As they can work in a variety of community primary care settings, the skill mix, scope of practice, and training and supervision requirements need to be carefully considered and supported.

The annual survey conducted by the Australian Primary Health Care Nurses Association (APNA) in 2019 found that nurses self-report that they often feel underutilised in their workplaces and feel restricted in carrying out more complex activities even when those activities are within practice scope.[6] Workplace environments should encourage nurses/midwives to work to their full scope of practice along with providing safe staffing levels and an appropriate skill mix to both improve job satisfaction and better assist in meeting community care needs.[7] Overall, the primary care nursing workforce is ageing, with 60 percent of primary health care nurses surveyed by APNA being aged between 45 and 64 years with an average age of 48 years. The ageing primary care nursing/ midwifery workforce is highlighted with results from the 2019 AHPRA Workforce Survey that indicates that the average age of practice nurses in MMM 1 Queensland is 44 years, but it rises to as high as 51 years in MMM 5 locations. The APNA survey also identified factors that influenced nurses' decision to work in primary health care which included improved working hours, ability to balance life and work responsibilities, and ability to stop shift work. The least important factor was found to be 'first employment opportunity'.[8]

Personal safety and security in the work environment has also been highlighted as a major issue for the remote nursing/midwifery workforce, environments where nurses/midwives may be working as sole practitioners. Other issues include geographical, social and professional isolation as well as difficulties delivering services to communities with complex health needs often in cross cultural settings.[9] Furthermore, nurses/midwives often lack the necessary support to best perform their roles in remote and rural areas. [6] Recognition of specialist nursing services, for example maternity nursing, mental health nursing, and aged care nursing, combined with continued training and a supportive team environment may assist to both improve job satisfaction and overall quality of care in remote and rural settings.

> **"…exploring new models of workforce configuration that includes integration across organisations, interprofessional support and of course visiting services designed to strengthen capacity of local workforce."**

Stakeholders have expressed a need to attract and support early career nurses and graduates into practice nursing.[7] More opportunities are needed for undergraduate students to gain exposure to rural and remote primary care through place-based, integrated learning and extended clinical placements in remote and rural areas. There is also a perceived low status of practice nursing among graduates and this, together with higher pay opportunities with Queensland Health, can create disincentives to attracting and retaining primary care nursing staff.[7]

The importance of adequate supervision and leadership, peer support, mentoring, career planning and financially competitive pathways to attract and sustain primary care nurses cannot be understated. In feedback provided through the Health Workforce Stakeholders Group, there was reported a shortage of nurses with more than five years of experience in remote primary care along with increased likelihood of junior nurses leaving after 12 months if they were working in a lone role. Insufficient supervision and peer support can lead to a loss of confidence and increased likelihood of relocation out of remote and rural primary care.

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[6] Australian Primary Health Care Nurses Association (APNA) workforce survey 2018/19.

[7] Health Workforce Stakeholder Group, (2020), *Item 5: Current & Emerging Issues/Opportunities – Stakeholder Perspectives,* Minutes of Health Workforce Stakeholder Group committee meeting 17 September 2020.

[8] Australian Institute of Health and Welfare 2020. *A profile of primary health care nurses*. Cat. no. PHC 2. Canberra: AIHW. Viewed 12 May 2020, https://www.aihw.gov.au/reports/primary-health-care/a-profile-of-primary-care-nurses

[9] CRANAplus (2020), *Position Statement: Remote Health Workforce Safety and Security*, April 2020.

Allied Health Workforce Summary

This past year allied health has been in the spotlight with the release of the National Rural Health Commissioner's (NRHC) report on the *Improvement of Access, Quality and Distribution of Allied Health Services in Regional, Rural and Remote Australia,*[11] as well as various regional summits, planning workshops, and forums.

Workforce data for regulated allied health professions is limited but the situation is even more critical for the self-regulated and non-regulated allied health professions. This reduces the capacity to examine, analyse, plan and address community needs, particularly considering the prominence of allied health disciplines in those with the highest workforce and service gaps in the current and previous HWNA Reports. However, it is generally agreed that there is a widening gap in workforce distribution between rural and metropolitan regions for all allied health professions. Although the need for allied health practitioners may vary from region to region, the biggest perceived workforce gaps across all remote and rural Queensland were for psychology, speech pathology, and occupational therapy (see results page 27).

> **"There are so many gaps... There are still no community supports for people with persistent severe mental illness. There is no Consumer and Carer mental health advisory group with the HHS anymore so there is no consultation with consumers of service. ...Digital poverty has come to the forefront during covid - a lot of marginalised people with mental health issues cannot afford to be online let alone able to access and use online appointments and programming."**

Allied health practitioners are essential in providing multidisciplinary care within communities and can work across various settings including health, disability, education, aged care, and social service sectors. Practitioners in remote areas often work across large geographical areas, visiting multiple communities. This includes being able to provide affordable, culturally safe and responsive services, address chronic disease management, as well as undertake health promotion and prevention. Allied health practitioners may also deal with lower workforce to patient ratios and less infrastructure and resources than those in metropolitan areas.[11]

> **"No funding available for health education, increasing health literacy, health promotion etc. this could be utilised to bolster up already employed allied health employees e.g. dietitians and exercise physiologists to provide health education/ promotion sessions within rural/ remote schools etc. OR conduct food security/healthy choice audits in local shops/roadhouses in smaller rural communities etc."**

The scope and role of allied health practitioners in primary health is not always well defined or governed, and often not understood or utilised effectively within health services or the community.[13] One stakeholder commented on the lack of clarity of allied health roles in their jurisdiction, identifying that clinical silo's, lack of clarity in HHS appointed positions, and the underutilisation of co-commissioning and funding pools of private allied health practitioners has resulted in inadequate integration of allied health staff into local teams. Better ways to improve access to allied health care and integrate this workforce sector is needed with primary care networks, hospital and health services, aged care services, disability services, schools and other community services working together[12]. The utilisation of allied health assistants, as well as outreach services and telehealth will continue to be necessary in many remote areas.[11] Workforce policies must also accommodate the growth of public, not for profit and private service capacity[11].

The NRHC consulted with the allied health sector to develop a set of recommendations aimed at improving the quality of services, and equitable access to and distribution of the regional, rural and remote allied health workforce.[11]

The NRHC report on the Improvement of *Access, Quality and Distribution of Allied Health Services in Regional, Rural and Remote Australia* published in 2020 includes four overarching recommendations:

- **Improving access –** establish an 'own grown' Service and Learning Consortia
- **Enhanced quality –** invest in strategies to increase participation of Aboriginal & Torres Strait Islander people
- **Expand distribution –** develop a National Allied health data strategy
- **National Leadership –** appoint a full-time Chief Allied Health Officer

The viability of small rural allied health businesses is under threat with many returning marginal profits, often relying on multiple revenue streams which adds significant cost and administrative burden.[11] A review of funding models is required, including the fee-for-service model, to recognise the cost of servicing distant and dispersed patient groups, and to streamline the various regulatory frameworks associated with different funding streams.[11] An allied health stakeholder has commented that fund pooling should be explored as an option to alleviate the cost of running a health business in rural and remote Queensland. This becomes increasingly important in communities where many residents are without the capacity to pay for health services.

> **"We do have some community-based organisations that are local to us and they are great. They can find it difficult to get the amount of funding they require for the amount of work that is required.**
>
> **And even if they get the funding, they can't get the health care providers - it's hard to attract allied health providers to the area, they prefer to live and work on the Sunshine Coast."**

There is a continued need for strategies aimed at attracting and retaining allied health professionals to rural areas. This begins with selecting students with rural backgrounds.[11] Some stakeholders suggested that there needs to be improved quality standards for training along with improved capacity for allied health students to undertake rural based training and an expansion of rural placement opportunities.[11,14] Allied health practitioners must then be supported through their development by providing rural career paths and progression, adequate supervision and support, and ongoing professional development.[11] Furthermore, support programs must target training to match the workforce need.[14]

Expanding the allied health rural generalist pathway could provide another means to deliver wrap-around support to new graduates and early career professionals.[11] Increasing engagement and collaboration, such as engaging with National Disability Insurance Scheme (NDIS) and aged care systems to develop shared training and employment models[14] may also help to bolster rural workforce development through student training, clinical placement networks, and support for early career professionals.[12]

Market failure of the allied health workforce is a chronic challenge impacting remote and rural areas. With a clear understanding of the role and impact allied health practitioners can make on an individual's health and in the long-term alleviation of the burden of chronic disease, some system changes are required to support professional sustainability. Co-commissioning and fund pooling appear best suited to support the private/public business mix that will make the allied health workforce sustainable and accessible. Supporting the viable integration of allied health into the primary care workforce mix will support the overall workforces capacity, availability, and quality of output.[15]

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[11] Australian Government 2020, National Rural Health Commissioner, *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*, June 2020. Retrieved from https://www1.health.gov.au/internet/main/publishing.nsf/Content/2922D6D8BBCE122FCA2581D30076D09A/$File/National%20Rural%20Health%20Commissioner's%20Allied%20Health%20Report%20to%20the%20Minister%20June%202020.pdf

[12] SARRAH Summit 2020 Report, *Summary of finding and outcomes from Services for Australian Rural and Remote Allied Health Summit*, held at University of Canberra, Friday 28 February 2020. Retrieved from https://sarrah.org.au/sites/default/files/images/summit_2020_report_mar2020_final.pdf.

[13] Hal Swerissen, Stephen Duckett, and Greg Moran. (2018), *Mapping primary care in Australia*, Grattan Institute. Retrieved from https://grattan.edu.au/report/mapping-primary-care-in-australia/

[14] Health Workforce Stakeholder Group, (2020), Item 5: *Current & Emerging Issues/Opportunities – Stakeholder Perspectives,* Minutes of Health Workforce Stakeholder Group committee meeting 17 September 2020.

[15] Health Workforce Queensland. (2021). Health Workforce Stakeholder Group *Feedback on Draft: "2021 Health Workforce Needs Assessment"*. Unpublished manuscript, Brisbane.

Aboriginal & Torres Strait Islander Health Workforce Summary

Increasing the representation of Aboriginal and Torres Strait Islander peoples in Queensland's primary health care workforce continues to be a key priority for many national and state-wide agencies. The fragmented nature of the primary health care sector and the wide range of health professional disciplines necessitates a focused and coordinated approach to address the low participation rates (refer to Table 1) of Aboriginal and Torres Strait Islander people in the primary care workforce. The development of the national Aboriginal and Torres Strait Islander Health Workforce Plan[16], currently underway, represents a significant opportunity to progress towards a more responsive, coordinated approach.

> **"We have multiple [Aboriginal and Torres Strait Islander] services here in xxx and even free bus pick up and drop off if necessary. One even gives them a voucher when they come in for health checks, it's a win-win situation for all."**

> **"The serious primary health services that are lacking to our community and that would be of benefit and regularly utilised [include] Aboriginal and Torres Strait Islander health services..."**

Retention and support of Queensland's small but critically important Aboriginal and Torres Strait Islander health workforce is vital for both culturally responsive service delivery, and for growing the numbers of Aboriginal and Torres Strait Islander mentors, clinical supervisors and leaders. During 2020, Health Workforce Queensland awarded 70 individual scholarships or bursaries to practitioners who identified as Aboriginal and/or Torres Strait Islander. Health Workforce Queensland also approved 92 scholarships and bursaries for health professionals working in Aboriginal Community Controlled Health Services (ACCHS).

> **"Currently there is no Aboriginal and Torres Strait Islander health worker, and we rely on the Administration officer (identified position) for support."**

> **"Lots of overflow to hospital due to lack of staff & closed books."**

The number of Aboriginal and Torres Strait Islander health professionals in MMM 2-7 in Queensland is slowly growing. This year the HWNA report has been expanded to include data on the number of registered Aboriginal and Torres Strait Islander health professionals working in remote and rural Queensland and will continue to be updated annually. Table 1 below reflects the number of identified Aboriginal and Torres Strait Islander health professionals in MMM 2-7 by profession in Queensland as described in the National Health Workforce Dataset 2019.

[16] National Rural Health Alliance, *A national plan for the Aboriginal and Torres Strait Islander health workforce*, Partyline Issue 68, Sep 2019. Retrieved from https://www.ruralhealth.org.au/partyline/article/national-plan-aboriginal-and-torres-strait-islander-health-workforce

Table 1: Aboriginal and Torres Strait Islander AHPRA Registered Health Professionals in MMM 2-7 in Queensland

Registered Health Profession	2019
Aboriginal and Torres Strait Islander Health Practitioner	91
Paramedic	51
Practice Nurse/Midwife	42
Psychologist	27
Physiotherapist	20
Medical Practitioner	19
Dentist	15
Occupational Therapist	12
Pharmacist	8
Chiropractor	5
Chinese Medicine Practitioner	NA*
Podiatrist	-
Optometrist	-

*Number suppressed because less than 4.

The Queensland Government has progressed a number of initiatives in 2020. In August 2020, the ***Health Legislation Amendment Act 2020*** was passed by Queensland Parliament, requiring each Hospital and Health Service to have a Health Equity Strategy and to appoint one or more Aboriginal or Torres Strait Islander persons as members on each Hospital and Health Service Board.

The first Queensland Health Aboriginal and Torres Strait Islander Workforce Certified Agreement was also ratified in August 2020. The Agreement covers the pay and conditions for Aboriginal and Torres Strait Islander Health Practitioners, health workers, mental health workers and hospital liaison officers working for Queensland Health. While this is a positive initiative, the disparity between the pay rates in this Agreement and those in the national Aboriginal Community Controlled Health Services (ACCHS)Award 2020 has grown, and therefore will have a likely negative impact on the ACCHS sector's ability to attract and retain some of their workforce.

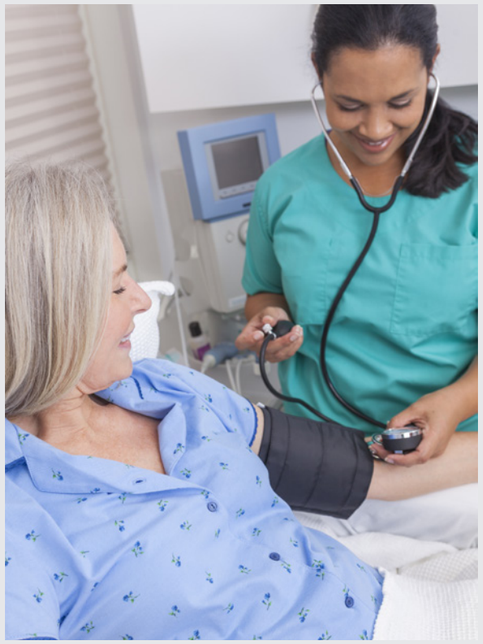
The 2020 Queensland state election commitments included a commitment to develop a First Nations Health Workforce Plan and Queensland Health has indicated their intention to develop the plan in partnership with the primary care sector. Joint workforce and service planning is a critical activity to break down existing silos between primary, secondary and tertiary care.

The commencement of a two-year project, Gateway to Industry Schools Program (GISP), delivered by CheckUP has created an opportunity for Aboriginal and Torres Strait Islander high school students to commence close to home vocational training in health. This program, whilst not specifically targeted at Aboriginal and Torres Strait Islander young people, has attributes such as experiential learning opportunities and defined local pathways into health industry employment that are central factors in supporting Aboriginal and Torres Strait Islander young people into health careers.

The absence of education and training opportunities 'on country' or close to home in remote and rural Queensland is a well-recognised barrier to attracting Aboriginal and Torres Strait Islander people into health careers. Changes to education delivery brought about by the COVID-19 pandemic, however, represent a significant opportunity to redesign existing models of face-to-face education delivery towards virtual delivery, block practicals, and innovative combinations of inter-professional and virtual supervision.

Cultural safety has been identified as one of the key foundations underpinning comprehensive primary health care for Aboriginal and Torres Strait Islander people. During 2020, the Health Workforce Stakeholders Group highlighted the importance of cultural safety extending to Aboriginal and Torres Strait Islander students undertaking placements in primary care settings. Efforts to 'grow our own' by attracting Aboriginal and Torres Strait Islander students into health education programs must be augmented by positive placement experiences in primary care.

The Nukal Murra Alliance in Western Queensland provides a practical example of an approach that can strengthen the cultural responsiveness of primary care services. The Alliance is made up of four ACCHSs who are funded to support culturally informed service delivery through the building of collaborative relationships across local practice networks (especially in central west where there are no ACCHS). Aboriginal and Torres Strait Islander health practitioners and health workers engaged by the Alliance aid private practices who service significant populations of Aboriginal and Torres Strait Islander clients. The sharing of knowledge of local behavioural, social and biomedical factors impacting patient engagement and participation are incorporated into culturally informed service delivery. These gains in cultural responsiveness in primary health care services not only benefit clients but also flow to Aboriginal and Torres Strait Islander students undertaking placements in the primary health care services.

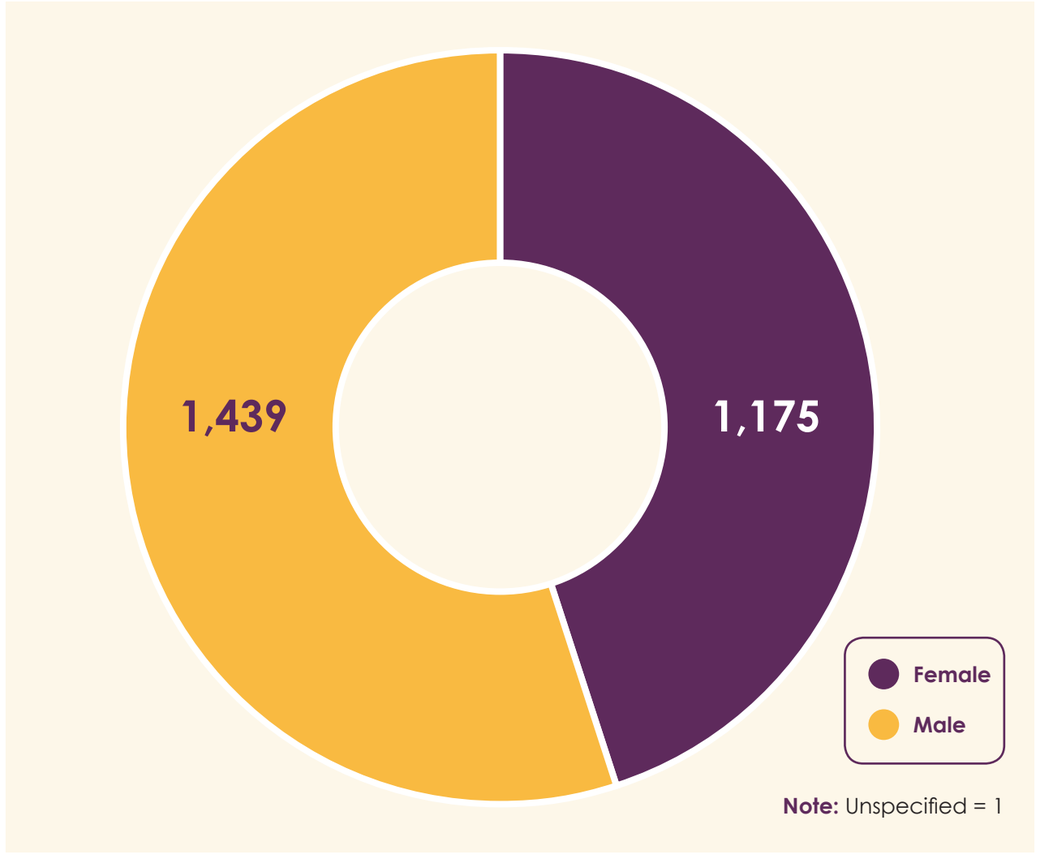


Workforce Data

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

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

For this HWNA report, a snapshot of the workforce was taken on 30 November 2020. In line with reporting requirements to the Department, only doctors working in MMM 2-7 locations were investigated. At the census date there were 2,615 medical practitioners listed on the Health Workforce Queensland database as working in MMM 2-7 locations in Queensland, more than 100 greater than reported in the 2020 HWNA. The average age was 50.4 years, slightly older than the 49.7 years reported in 2020. The number of general practitioners by sex are presented in Figure 1.



Note: Unspecified = 1

Figure 1: Number of general practitioners by sex

Approximately 45 percent of the general practitioners were female, an increase of approximately two percent reported in the 2020 HWNA report. The number and percentage of female and male general practitioners for each of the four mainly rural PHNs are presented in Table 1 (does not include practitioners from Brisbane North, Brisbane South and Gold Coast PHNs).

Table 2: General practitioner by sex and PHN

PHN	Female *n*	%	Male *n*	%	Total *N*
Central Queensland, Wide Bay, Sunshine Coast	295	42.0	408	58.0	703
Darling Downs and West Moreton	248	43.3	325	56.7	573
Northern Queensland	523	48.9	546	51.0	1,070*
Western Queensland	48	38.7	76	61.3	124

Note: One general practitioner of unspecified sex.

Northern Queensland PHN had 366 more general practitioners than any of the other rural PHNs and had the highest percentage of female practitioners (49 percent). In contrast, the Western Queensland PHN had almost 950 fewer general practitioners than Northern Queensland PHN and only 39 percent were female.

Country of basic medical qualification

General practitioners were grouped according to whether they received their basic medical qualification from an Australian university or from an overseas university. Overall, there were 1,396 Australian trained practitioners (53.4 percent), and 1,219 overseas trained practitioners (46.6 percent). The percentage results for each of the rural PHNs are presented in Figure 2.

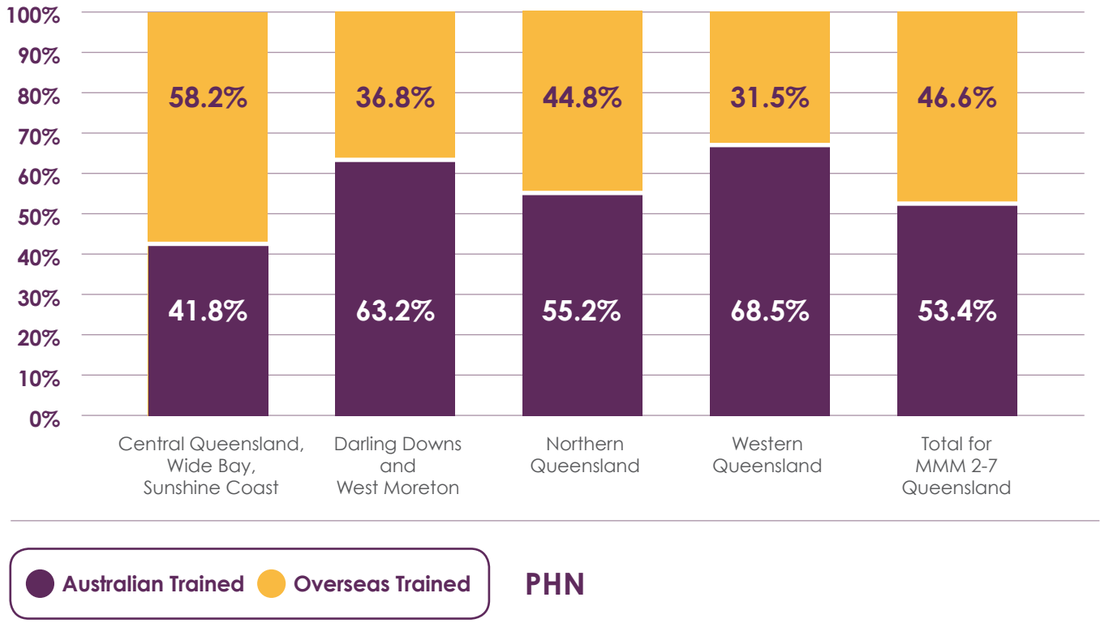


Figure 2: Percentage of general practitioners by country of basic medical qualification and PHN

Compared to the overall MMM 2-7 percentage of Australian trained practitioners (53 percent), the Central Queensland, Wide Bay, Sunshine Coast PHN was the only PHN to have a lower percentage of Australian trained practitioners (42 percent). In contrast, the Australian trained general practitioner workforce in the Western Queensland PHN represented more than an extra 25 percent of the workforce, and in the Darling Downs and West Moreton PHN in was more than 20 percent higher.

National Health Workforce Dataset 2019

The most recent release of the National Health Workforce Dataset has been gathered by the 2019 workforce survey of health practitioners during their annual registration renewal with AHPRA. The National Health Workforce Dataset 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 MMM 2-7 Queensland, that self-described their main role as either 'General Practice' or 'Hospital non-specialist'.

It is important to note that this would not include some medical practitioners that work in hospitals but have qualifications as specialists in general practice (through RACGP and/or ACRRM) or have qualified as Queensland Health Rural Generalists. The total number of medical practitioners likely to be undertaking general practice roles in MMM 2-7 was 2,586.

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

Table 2: AHPRA 2019 workforce survey general practitioners/hospital non-specialists by PHN

PHN	*AHPRA N*	*HWQ N*
Central Queensland, Wide Bay, Sunshine Coast	706	703
Darling Downs and West Moreton	442	573
Northern Queensland	1,239	1,070
Western Queensland	120	124
Total MMM 2-7 Queensland*	**2,586**	**2,615**

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

The total number of general practitioners identified in MMM 2-7 Queensland through the National Health Workforce Dataset 2019 was within 30 of the number identified in the Health Workforce Queensland database (see, figure 1). For two of the PHN regions, the agreement in practitioner numbers between AHPRA and the Health Workforce Queensland database was within four (Western Queensland PHN and Central Queensland, Wide Bay, Sunshine Coast PHN), while the other two PHN general practitioner totals were different by more than130.

Practice Nurse Workforce

Health Workforce Queensland Database

The number of nurses and midwives working in MMM 2-7 general practice settings and captured in the Health Workforce Queensland database was 1,416, a slight decrease from last year.

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

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 nurse practitioners or diabetes nurse educators.

Along with the nurses based in general practice, we are also provided with headcounts from Queensland Health of nurses working at smaller communities in primary care centres. The number of these according to level of registration are presented in Figure 4. Results for diabetes nurse educators were withheld because there were too few to report without possible identification.

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

Almost seventy-five 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 nurse practitioners working in primary health care centres.

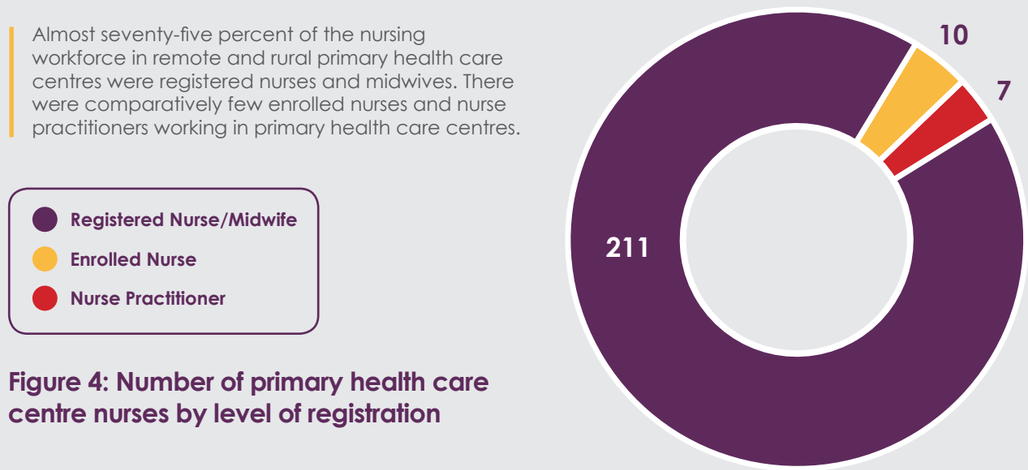


Figure 4: Number of primary health care centre nurses by level of registration

National Health Workforce Dataset 2019

Below is the number of nurses working in MMM 2-7 Queensland by rural PHN that self-described their main role as 'practice nurse' in the 2019 Annual Workforce Survey completed during annual registration renewal. The response rate was 96 percent of nurses across Australia. Results for the four mainly remote and rural PHNs in Queensland are available in Table 3, for both registered and enrolled nurses along with the percent of these that described their primary work as private. For comparison, the number of total practice nurses presented last year are also included.

Table 3: Number of practice nurses by PHN in MMM 2-7 and percent in private employment

PHN	Registered Nurse/Midwife *n*	Enrolled Nurse *n*	AHPRA Total *N*	Percent Private	2019 Total *N*
Central Queensland, Wide Bay, Sunshine Coast	294	110	404	81.3%	679
Darling Downs and West Moreton	219	67	286	88.8%	396
Northern Queensland	412	106	518	84.2%	547
Western Queensland	44	9	53	49.1%	59
Total	**969**	**292**	**1,261**	**88.0%**	**1,681**

Note: Data provided by Queensland Health.

Compared to the numbers reported last year there was a decrease of almost 400 nurses overall who identified their main role as 'practice nurse' in the 2019 AHPRA Workforce Survey. Most of the reduced numbers were for registered nurses/midwives working in the CQWBSC PHN.

A re-analysis of the data reported last year indicated that nurses/midwives working in MMM 1 locations within the CQWBSC region had been included accidentally. For CQWBSC PHN, the registered nurses/midwife number should have been 292, the enrolled nurses count should have been 124, and the total for the region should have been 416. Compared to these adjusted numbers, the current data indicates a small decrease from last year. This year the Northern Queensland PHN region had the most nurses overall and the most registered nurses/midwives. The percentage of enrolled nurses in the composition of all nurses ranged from 17 percent in Western Queensland, to 23 percent in the Darling Downs and West Moreton PHN region.

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 less than 50 percent.

Photo: *Roslyn Budd Photography*

Aboriginal and Torres Strait Islander Health Worker and Health Practitioner Workforce

Health Workforce Queensland Database

There were 208 Aboriginal and Torres Strait Islander health workers and 51 Aboriginal and Torres Strait Islander Health Practitioners in the Health Workforce Queensland database. Figure 5 presents these according to MMM location.

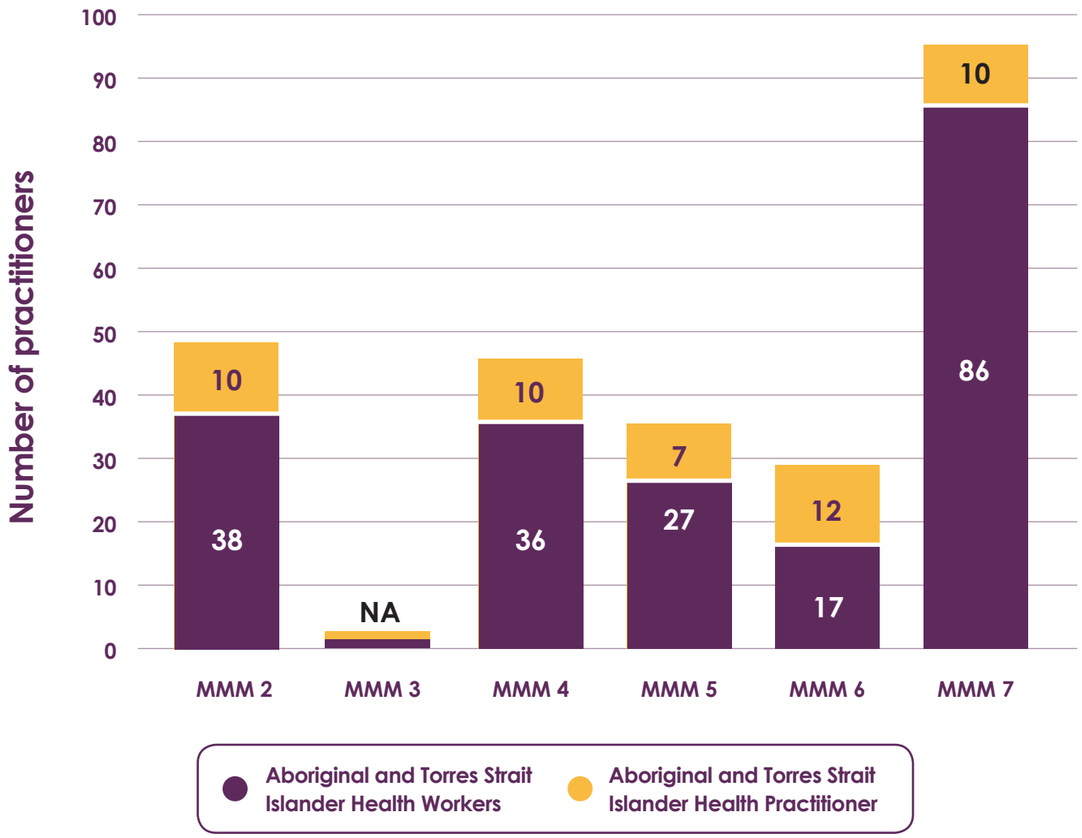
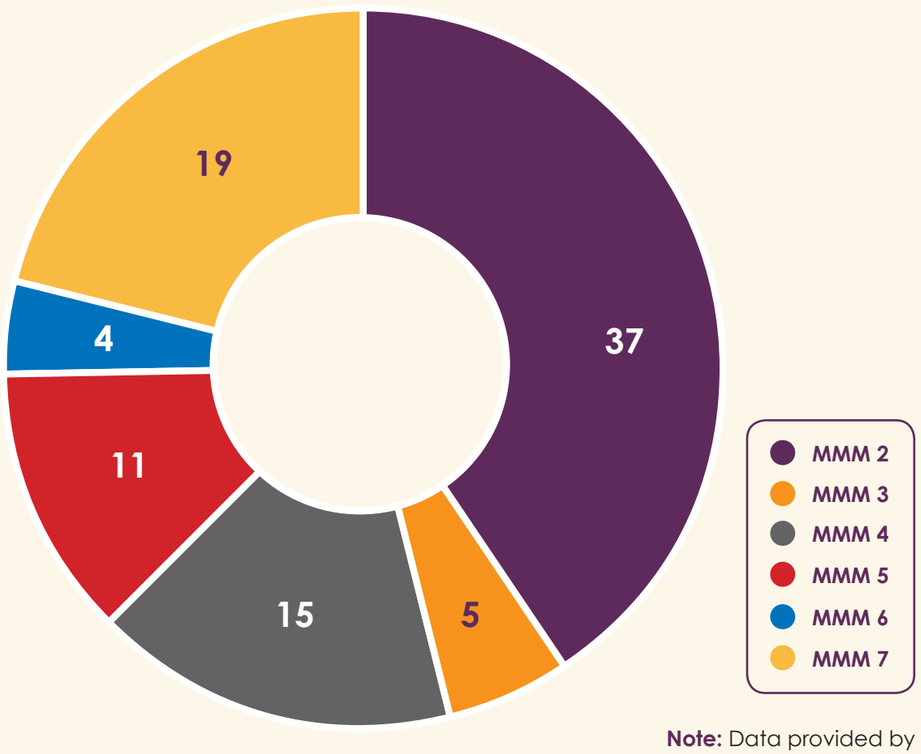


Figure 5: Aboriginal and Torres Strait Islander Health Workers/Practitioners by MMM

More Aboriginal and Torres Strait Islander health workers were working in MMM 7 locations than any other MMM categories. There were more than twice as many in MMM 7 than any of the other classifications. Aboriginal and Torres Strait Islander Health Practitioners were fairly evenly spread across MMM categories except for MMM 3.

National Health Workforce Dataset 2019

The results from the National Health Workforce Dataset 2019 indicate that there were 91 Aboriginal and Torres Strait Islander Health Practitioners working in MMM 2-7 Queensland, very similar to the findings reported last year. Results according to MMM category are provided in Figure 6.



Note: Data provided by Queensland Health

Figure 6: National Health Workforce Dataset (2019) Aboriginal and Torres Strait Islander Health Practitioners by MMM

Approximately 40 percent of the Aboriginal and Torres Strait Islander Health Practitioners were working in MMM 2 locations. MMM 7, MMM 5 and MMM 4 each had more than 10 Aboriginal and Torres Strait Islander Health Practitioners. Approximately 86 percent of the Aboriginal and Torres Strait Islander Health Practitioner workforce were female.

> **"Medical practitioners do not know all the Medicare rebated services that Indigenous people are eligible for. Indigenous and Torres Strait Islander people do not have access to health prevention and promotion especially diabetes education, diet education, physical activity education etc."**

Allied Health Workforce

National Health Workforce Dataset 2019

The allied health workforce data outlined in the following section has been provided by Queensland Health based on National Health Workforce Dataset 2019. The registered allied health professions are:

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

The numbers of practitioners in each of the allied health professions were calculated for all MMM 2-7 locations for each of the mainly rural PHNs. For the Central Queensland, Wide Bay, Sunshine Coast PHN, and the Darling Downs and West Moreton PHN, the number of practitioners in the PHN but working in MMM 1 location were also included. This includes practitioners working in and around Ipswich (Darling Downs and West Moreton PHN) and on the Sunshine Coast in major towns such as Caloundra and Maroochydore (Central Queensland, Wide Bay, Sunshine Coast PHN).

Results are presented in Table 4.

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

Allied Health Professions	MMM 2-7 *N*	Percent Private	MMM 1 *N*
Psychologists	**1,187***	**62 %***	**4,009**
Central QLD, Wide Bay, Sunshine Coast	308	66 %	371
Darling Downs and West Moreton	226	62 %	178
Northern Queensland	579	60 %	-
Western Queensland	28	64 %	-
Physiotherapists	**1,336***	**63 %***	**4,484**
Central QLD, Wide Bay, Sunshine Coast	378	69 %	476
Darling Downs and West Moreton	224	62 %	152
Northern Queensland	640	59 %	-
Western Queensland	46	50 %	-
Podiatrists	**220***	**80 %***	**641**
Central QLD, Wide Bay, Sunshine Coast	74	82 %	65
Darling Downs and West Moreton	46	79 %	27
Northern Queensland	75	77 %	-
Western Queensland	15	50 %	-

Allied Health Professions	MMM 2-7 *N*	Percent Private	MMM 1 *N*
Occupational Therapists	**1,196***	**51 %***	**2,848**
Central QLD, Wide Bay, Sunshine Coast	308	56 %	347
Darling Downs and West Moreton	205	53 %	133
Northern Queensland	619	48 %	-
Western Queensland	44	41 %	-
Optometrists	**282***	**94 %***	**821**
Central QLD, Wide Bay, Sunshine Coast	84	94 %	87
Darling Downs and West Moreton	72	92 %	44
Northern Queensland	117	94 %	-
Western Queensland	5	100 %	-
Pharmacists	**1,413***	**65 %***	**3,778**
Central QLD, Wide Bay, Sunshine Coast	398	66 %	314
Darling Downs and West Moreton	288	70 %	189
Northern Queensland	625	61 %	-
Western Queensland	49	57 %	-
Dental Practitioners	**1,261***	**73 %***	**3,189**
Central QLD, Wide Bay, Sunshine Coast	391	71 %	360
Darling Downs and West Moreton	248	78 %	176
Northern Queensland	544	74 %	-
Western Queensland	36	36 %	-
Radiographers	**649***	**51 %***	**1,842**
Central QLD, Wide Bay, Sunshine Coast	200	64 %	237
Darling Downs and West Moreton	107	48 %	86
Northern Queensland	312	43 %	-
Western Queensland	17	35 %	-

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

The number of practitioners for each of the disciplines in MMM 2-7 ranged from 1,413 for pharmacists to 220 for podiatrists. Generally, the Western Queensland PHN had a considerably smaller percentage of private practitioners than the other PHNs in the disciplines of dentistry (36 percent private), occupational therapy (41 percent private) and radiography (35 percent private). Central Queensland, Wide Bay, Sunshine Coast PHN had more practitioners in MMM 1 locations than MMM 2-7 locations for psychology, physiotherapy, occupational therapy, optometry and radiography. In the Darling Downs and West Moreton PHN region, there were more practitioners for every discipline outside the MMM 1 areas.

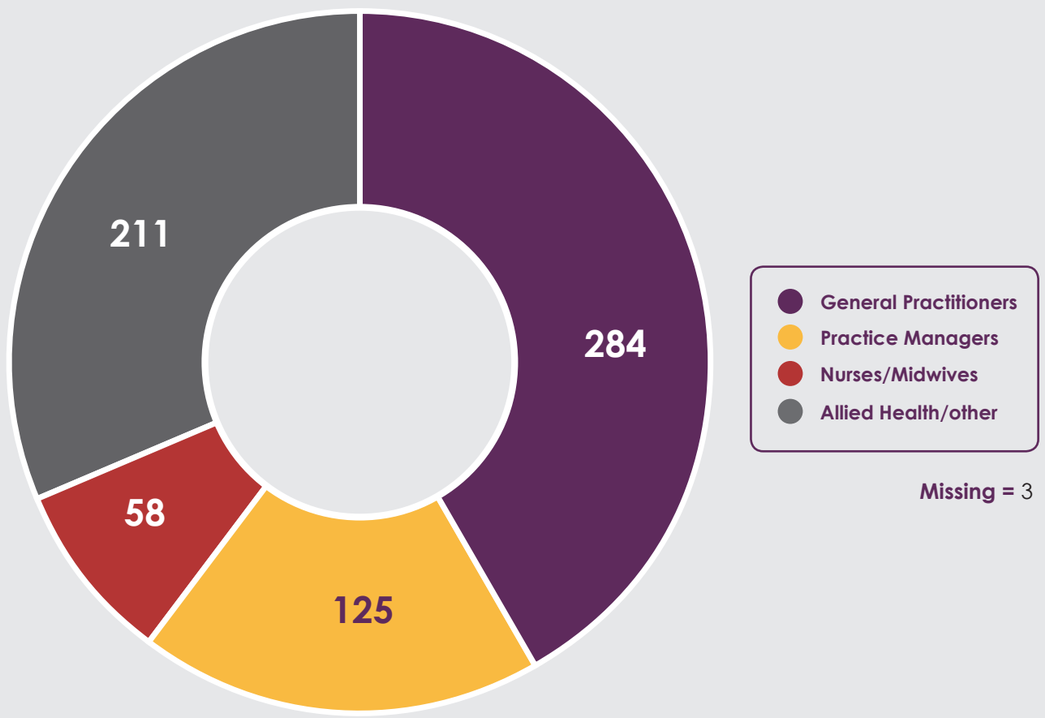
Photo: *Roslyn Budd Photography*

Survey Results

An online survey was conducted targeted at GPs, practice managers, primary health care nurses, Aboriginal and Torres Strait Islander health workers and health practitioners as well as allied health professionals working in MMM 2-7 locations.

Survey items were developed to gauge health practitioner and health service manager beliefs about workforce and primary care service gaps in their community(s) of 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 practitioners; 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 681, a decrease from last year's 825 but expected because of the impacts of COVID-19. The number of participants by their main role (e.g. nurses, allied health professionals) are provided in Figure 7.



Missing = 3

Figure 7: Number of survey participants by main role

General practitioners accounted for 42 percent of survey responses, while allied health professionals/ others represented 31 percent, practice managers 18 percent and nurses/midwives had the smallest representation. The roles of participants for each of the mainly rural PHNs are available in Figure 8.

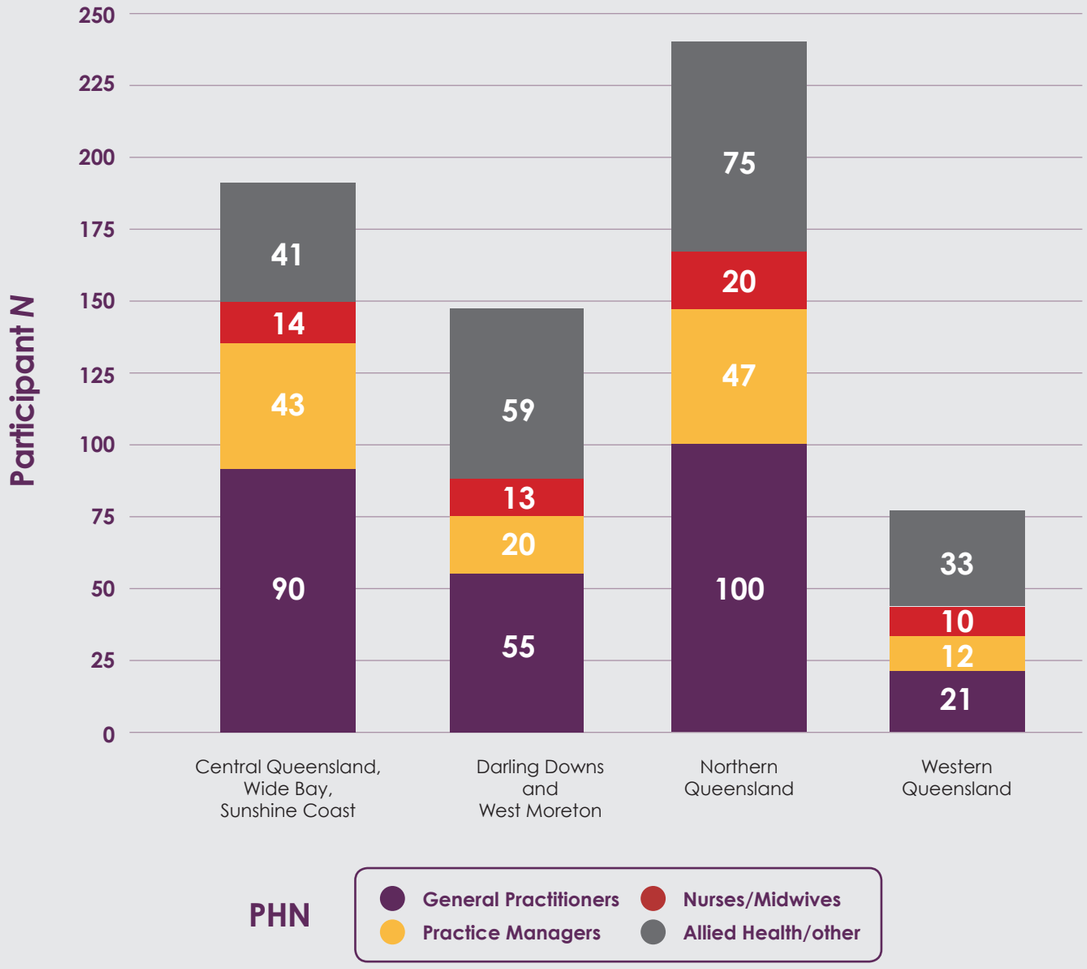


Figure 8: Number of participants by main role and rural PHN

Survey participant numbers ranged from 76 for Western Queensland, to 242 for Northern Queensland. For the Central Queensland, Wide Bay, Sunshine Coast PHN, general practitioners represented almost half of all participants (48%), and this dropped to a low of 28 percent in the Western Queensland PHN region.

Workforce Gap Ratings

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

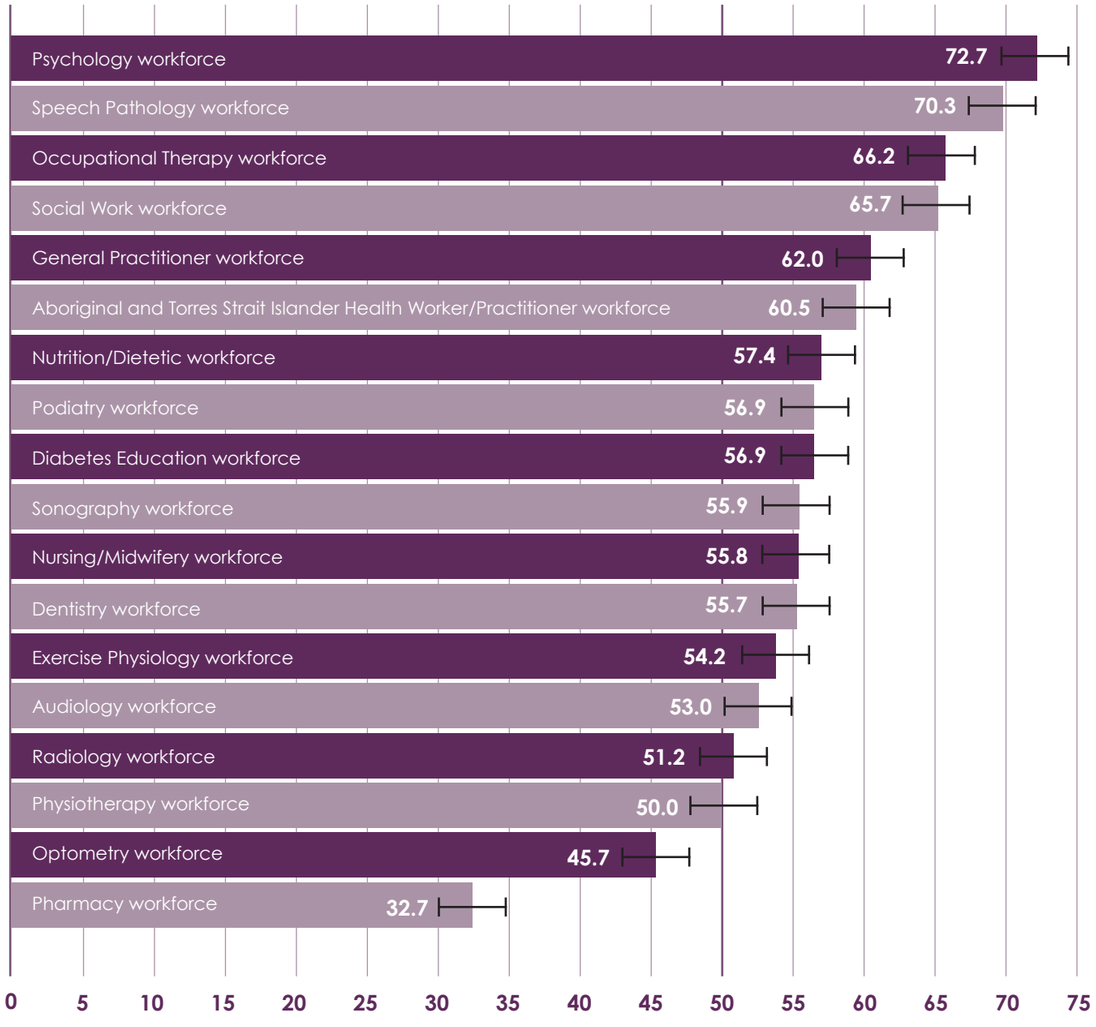


Figure 9: Mean workforce gap ratings

The highest workforce gap rating means were for psychology, speech pathology, occupational therapy, social work and general practitioner workforce, the first two with means of 70 or higher.

There were 6 workforce disciplines with means greater than 60, and 16 with means of 50 or more. Table 5 provides the workforce gap means across 2018 to 2021.

Table 5: Workforce gap rating means for 2018 - 2021

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

All workforce gap rating means increased from last year and the trend shows a gradual increase for most items. The most notable increases from 2020 were for speech pathology, an increase of more than 10 points, and occupational therapy, which increased by almost eight points from 2020. Nutrition/Dietetics workforce gap increased by approximately seven points from last year and the remainder mainly increased between one and four points.

In the four years that HWNA surveys have been conducted, the top five professions that have the greatest increase in workforce gap ratings are psychology (25.95 point increase), speech pathology (24.73 point increase), general practitioners (23.37 point increase), podiatry (22.44 point increase) and Aboriginal and Torres Strait Islander Health Worker/Practitioner (21.81 point increase).

Workforce Gap Comments

A thematic analysis was undertaken of comments provided in response to the workforce gap rating questions in the survey. The two most frequently mentioned workforce gaps were around **mental health** and **general practice**. Mental health sub-themes are provided in Figure 10.

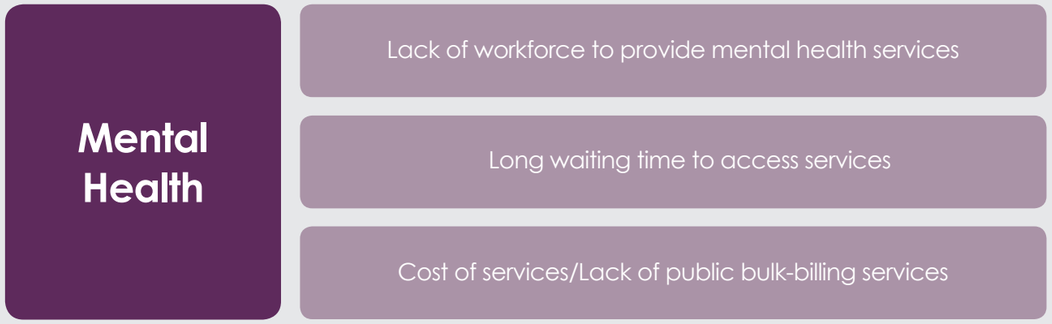


Figure 10: Sub-themes for Mental Health

Mental health comments saw three interrelated challenges that practitioners and consumers face in attempting to access mental health care (Figure 9). For mental health, the main sub-theme was a shortage of workforce able to provide mental health services and address mental health issues within communities. The most frequently asked for professions in these comments were psychologists, followed by social workers, mental health workers, counsellors, mental health nurses, and psychiatrists.

> **"With limited funding for positions and huge barriers for clients to pay for a private service, the gaps in service provision continues to increase."**

Other sub-themes included the cost of services/lack of public bulk billing services, and long wait times to access existing services.

> **"Currently up to 6 months wait (Psychologists) or they have "closed their books." Some of the private billing services charge very high out of pocket fees."**

While telehealth has been celebrated for the way it has increased access to health care for many consumers during the pandemic, some participants mentioned that the pandemic had contributed to greater demand, for mental health services which added to access problems. Further, comments indicated that many clients preferred or required face to face/in person consultations.

> **"The current pandemic caused aggravation of mental health issues and at present almost all of psychologists in town are not accepting new patients. This is affecting access to psychology/counselling services which is further contributing to aggravation of symptomatology."**

> **"Digital poverty has come to the forefront during covid - a lot of marginalised people with mental health issues cannot afford to be online let alone able to access and use online appointments and programming."**

Comments on general practice saw four interrelated themes: difficulties attracting and recruiting GPs, high GP workload and burnout, cost for patients/lack of bulk billing and wait times to see GPs (Figure 10).

General Practice

- Difficulties attracting and recruiting GPs
- High GP workload and burnout
- Cost for patients/Lack of bulk billing
- Wait time to see GPs

Figure 11: Sub-themes for general practice

The first two themes appear to feedback onto each other, whereby it is hard to attract or recruit new GPs to remote and rural locations because of the current, challenging workload and high rates of burnout of the GP workforce.

> **"It is extremely difficult to recruit any Australian & or Fellowed GPs within the XXX region & have recently lost the AoN to recruit OTDs. There are also limited number of GP Registrars requiring placement therefore adding extra pressure on our current GPs (leave, patient load etc)."**

> **"We need at least 2 more doctors to make the hospital and practice work sustainable. We currently have 2 doctors both have burnout."**

Some of the consequences of the GP shortages were said to be long wait times for patients and extra burden placed on hospital emergency departments. Many expressed the need for more incentives to attract and retain GPs to remote and rural areas. Some participants mentioned the loss of Distribution Priority Area (DPA) status and a limited supply of Registrars had impacted on the ability to recruit GPs.

> **"XXX DPA status was changed to non-eligible in July 2019. I have not been able to replace any departed Doctors as the ones that left were not subject to DPA, therefore I cannot replace them!"**

There were also several comments regarding the viability of general practice and that more support is needed to ensure its future.

Across all other comments for workforce gaps, the most common threads related to limited accessibility and availability of affordable and experienced health workforce for most allied health disciplines. This was particularly for smaller communities where the added cost of travel to larger centres further reduced access.

There was a marked increase in the number of comments specifically referring to the low availability of occupational therapists and speech pathologists, particularly for children.

Some participants suggested that there was an increase in people seeking out these services due to extra funding gained though the NDIS, however, in some communities it is not possible to access these services locally.

Workforce Gap Ratings

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

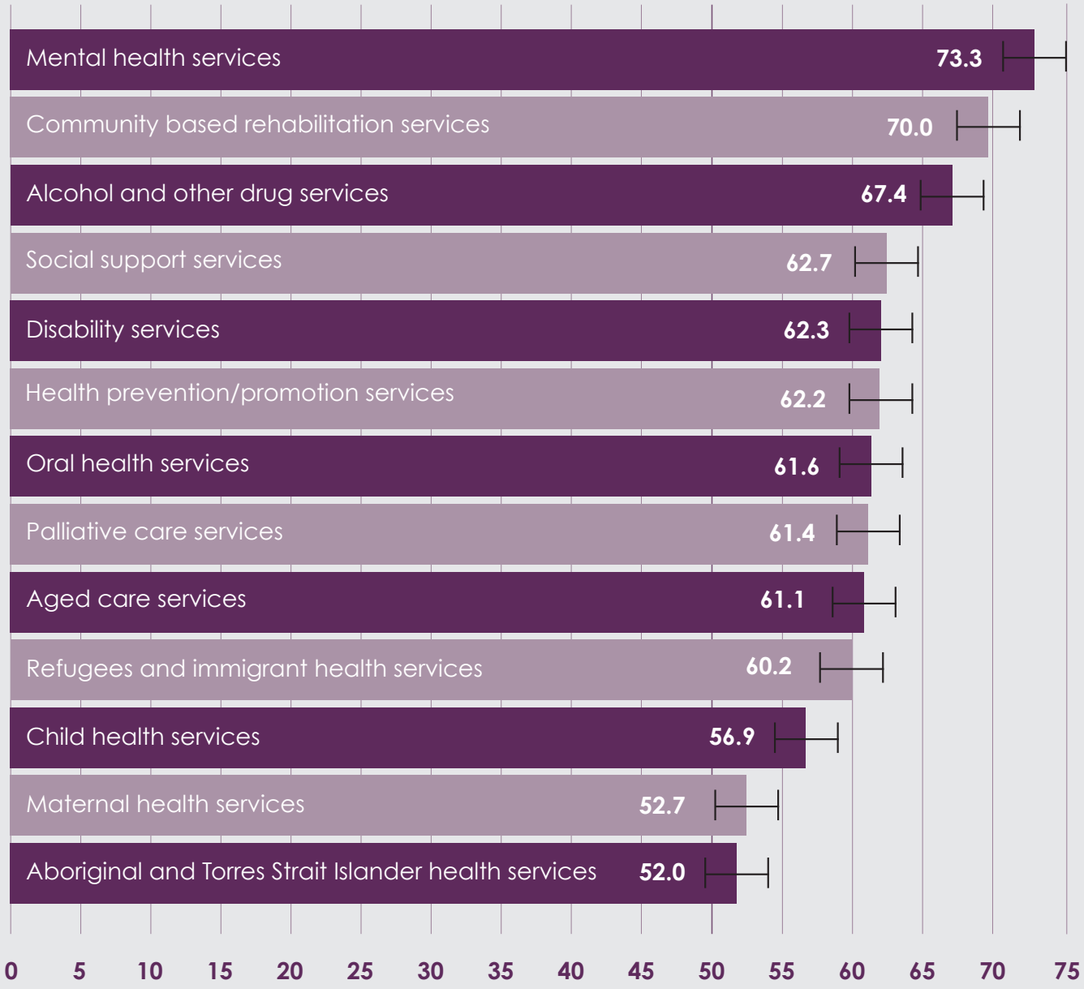


Figure 11: Service gap rating means

The highest service gap rating means were for mental health services, community-based rehabilitation services, alcohol and other drug services, social support services, and disability services, the first two with means of 70 or higher. There were 10 service means of 60 or greater and all means were higher than 50. Table 6 provides the workforce gap means across 2018 to 2021.

Table 6: Service gap rating means for 2018 - 2021

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

Note: *Rating question not contained in survey

The results indicate that there has generally been a gradual increase in the primary care service gap rating means across all services since 2018. All of the service gap rating means were greater than 50, with ten means greater than 60 and one greater than 70 (mental health services). Most service gap rating means were within three points of the results from last year. The results suggest that there are considerable concerns amongst primary care staff and practice managers in remote and rural Queensland about primary care services.

Service Gaps Comments

A thematic analysis was undertaken of comments provided in response to the service gap rating questions. The two most frequently mentioned service gaps related to **mental health** and **alcohol & other drugs** services. The sub-themes for mental health services are available in Figure 12.

Mental Health Services

- High Demand, limited community based services
- Poor continuation and coordination of services
- Lack of workforce (i.e. psychologists, counsellors)
- Cost of services/lack of bulk billing
- Lack of prevention, promotion & early intervention

Figure 12: Sub-themes for mental health services

Access to services in the community was the main sub-theme which was operationalised through the dual drivers of high demand and limited service availability. Other sub-themes included: poor coordination and continuation; lack of workforce; the cost of some services, and a lack of preventative and early intervention services. Some participants commented on the disparity between low need and high need services, and the need for services that can match the level of acuity.

> **"We have no acute mental health service in reality unless you are acutely suicidal. There are long waits for private psychology, few to none of whom bulk bill. This leaves a tremendous gap between those who have mild-mod illness and can be managed with medication temporarily by a GP and trying to kill oneself."**

Further, participants identified the need for expanding bulk billing options, or further innovative treatment and payment options in remote and rural communities where some people may be unable to foot the ongoing cost of treatment or fall outside of the eligibility criteria for bulk billed services.

> **"For Mental Health patients, they are discharged but there is no funding for counselling to support them after discharge - for example we work under XXX (service) which is supposed to be only for low to moderate diagnosis - and the remuneration rate is poor for the level of servicing they require. Better access is not always appropriate for them or they are not eligible due to their particular diagnosis (and the out of pocket for these clients is prohibitive as the rebate is lower for non-'clinical' psychologists)."**

Participants also recounted the low number of practitioners available in rural and remote locations who were able to take on new cases.

One participant provided a comment that included many of the issues for remote and rural clients in Queensland requiring mental health services and mentioned many items included as sub-themes in this section.

"Waiting periods for Medicare rebate psychology appointments or headspace appointments are lengthy and recent extensions to rebateable services will extend these waiting times as there are no more service providers. There is still no community support for people with persistent severe mental illness. There is no Consumer and Carer mental health advisory group with the HHS anymore so there is no consultation with consumers of service. This flies in the face of substantial evidence of best practice. There is no transition care for people discharged from mental health hospital returning to our community and no local inpatient facility.

The hospital only works with acute episodes and are crisis driven. Consideration needs to be given to a more long-term holistic approach - inclusive of but not solely driven by medical model. It would be marvellous to include counsellors to Medicare rebate to make help financially accessible to financially disadvantaged people. Digital poverty has come to the forefront during Covid - a lot of marginalised people with mental health issues cannot afford to be online let alone able to access and use online appointments and programming."

Access to workforce such as psychologists and counsellors was also raised as an issue by some participants, while others mentioned an increased demand for services during 2020 as a result of COVID-19 impacts. For the second main service gap theme, alcohol and other drug services, three main sub-themes were identified. Figure 13 depicts this and the other sub-themes.

Figure 13: Sub-themes for alcohol & other drug services

The main sub-theme identified was around an absence of local services or a lack of the required services. Participants also noted a lack of an appropriately skilled workforce such as alcohol and other drug counsellors and alcohol and other drug workers to deliver services. The need for 'local' or easy to access residential rehabilitation service was the final sub-theme

"There is a big unmet demand for alcohol & drug services in XXX (town)."

"Inadequate residential rehab services locally, only one such service in XXX (town) but small capacity, issue of distance from home and affordability."

"There is a desperate need for AODS rehabilitation services with follow up prevention."

Other Service Gaps

Other frequently mentioned service gaps identified among participant comments are displayed in Figure 14:

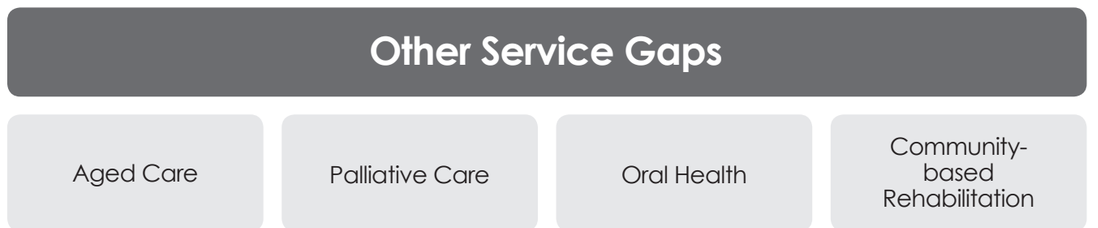


Figure 15: Other frequently mentioned service gaps

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

Northern Queensland PHN

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

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
Crows Nest - Rosalie
Inglewood - Waggamba
Southern Downs - West
Jondaryan
Esk
Nanango
Chinchilla

Central Queensland, Wide Bay, Sunshine Coast PHN

Kilkivan
Maryborough Region - South
Agnes Water - Miriam Vale
Cooloola
Gin Gin
Mount Morgan
Gympie Region
Emu Park
Gayndah - Mundubbera
Central Highlands - East

It should be noted that this list is not a comprehensive reflection of the need in these PHN regions. The findings of the quantitative methodology are a starting point. Further qualification of need in these regions are discovered through ongoing communication and collaboration at the local level 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) that Health Workforce Queensland undertake 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; and
- Aboriginal and Torres Strait Islander communities with critical workforce need are the highest priority.

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

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

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

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) • Lack of 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 • Cost of travel for health professionals for rural outreach/hub and spoke arrangements • Limited/Lack of services available after hours • Cost of services/Lack bulk billing services impacting on populations of lower socio-economic status • Culturally inappropriate services • Service awareness/service understanding
Strategies	• Employ targeted recruitment support and retention packages to priority communities, including locums • Continue to build evidence through collation of workforce data to inform workforce planning • Assist health professionals with relocation grants and incentives • Support clinical and leadership development • Promote the increased use of ICT including telehealth • Streamline processes for patients to access transport subsidies • Develop innovative workforce models to support community need and increase workforce capacity • Encourage workplace cultural training of health professionals to support cultural safety • Encourage interprofessional collaboration and communication • Advocate for further policies and activities to attract health professionals to remote and rural areas including an overarching vision for primary care
Desired Outcomes	• Increased supply of primary care workforce to priority areas • Improved availability of appropriate infrastructure to support health service requirements • Increased availability of affordable and appropriate transport to access health services • Increases in technology and financial supports for health professionals • Greater access to affordable and appropriate primary care within communities • An endorsed overarching vision for primary care (state and federal)

Quality

Building workforce capacity

Key Issues

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

Strategies

- Support for youth to commence vocational training in health-related studies, close to home
- Facilitate and coordinate continuing professional development
- Provision of scholarships and bursaries to support upskilling aligned to community need
- Organisational support for staff to undertake leadership training
- Encourage activities that support role development and enhancing scope of practice
- Support commissioning of providers that embed cultural orientation and training in their organisations
- Support succession planning to ensure a continuous pipeline of strong clinical leaders
- Increase workforce capacity through workforce redesign to deliver quality multidisciplinary care
- Targeted recruiting of Indigenous health professionals to support cultural safety
- Better utilise the Aboriginal and Torres Strait Islander health practitioner role including its role in delivering services to complement activities undertaken by Indigenous Health Workers

Desired Outcomes

- A 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

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
- 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:
  - Challenges to the viability of private health services in remote and rural areas including cost of living, distances to travel, income of clients, access to workforce and economies of scale
  - Current fee for service general practice models in remote and rural areas does not support sustainability
  - Current models don't support 'Easy Entrance, Gracious Exit' of workforce creating financial, administrative and work/life balance burdens
- Lack of workforce retention due to: Lack of access to continuing professional development, professional isolation, burnout due to lack of relief, poor housing and accommodation, high cost of living, spouse/family and lifestyle considerations
- Concerns for the mental health and well-being of the workforce due to climate and natural disasters such as floods, droughts, fires, as well as the impacts of the COVID-19 Pandemic

Strategies

- Offer rural immersion opportunities to attract students into rural health careers
- Support rural high school visits to create interest in a rural health career
- Work with universities to support more student placements in remote and rural Queensland
- Work with universities to identify and support students with a genuine interest in rural health practice and prioritise these students for long term rural placements and activities
- Support navigator and liaison roles to promote better system integration, coordination and collaboration
- Investigate blended funding 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 considers 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

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: Telehealth

An unanticipated consequence of restrictions due to the COVID -19 pandemic in 2020 is the considerable advances in the use of telehealth in primary health care in Queensland. *The National Digital Health Strategy*[17] test bed action items, aimed at embedding telehealth into primary care clinical consultations, were scheduled for completion in 2022.

These targets, however, have been overtaken by the 2020 national roll out of COVID-19 Temporary MBS Telehealth item numbers which are in place until 31 March 2021. As a result of these advancements, telehealth has been chosen as the *Issue in Focus* for this year's HWNA.

The HWNA survey included several questions to gauge the perceptions of practitioners and managers in remote and rural Queensland about the impact and potential for telehealth.

The first item was an agreement rating question where participants were asked to respond to three statements along a 100-point scale from '0 = Strongly disagree' to '100 = Strongly agree'. The statements were:

1. Telehealth has had a positive impact on my professional life
2. Telehealth has had a positive impact on primary care for community members
3. I would like telehealth to be more widely available for rural/remote practitioners

Results are presented in Table 7.

Table 7: Telehealth impact rating means

Telehealth rating item	*N*	*M*	*SD*
Positive impact on professional life	509	72.27	25.70
Positive impact on community members	515	76.54	22.17
Would like telehealth more widely available	523	82.38	20.68

All of the rating means were higher than 70 suggesting that there was overall agreement that telehealth had had a positive impact on professional life, a positive impact on the health of community members and practitioners would like telehealth to be more widely available. In particular, the mean of 82 for the item about increasing the availability of telehealth for remote and rural practitioners indicated strong agreement with the statement.

The next item asked participants to indicate how satisfied they were with both telephone and/or video telehealth provision. Responses were along a scale from '0 = Not at all satisfied' to '100 = Extremely satisfied'. Results are presented in Table 8.

Table 8: Satisfaction ratings with telephone and video telehealth provision

Telehealth Satisfaction	N	M	SD
Telephone telehealth	526	72.01	23.51
Video telehealth	452	65.09	26.90

[17] Australian Government (2017), Australia's National Digital Health Strategy: A Framework for Action. Retrieved from https://www.digitalhealth.gov.au/about-us/national-digital-health-strategy-and-framework-for-action

The satisfaction rating mean for telephone telehealth was approximately seven points higher that video telehealth, indicating a slightly higher level of satisfaction with telehealth delivered through a telephone connection. However, both means were in the top third of responses and suggest that most participants were satisfied with both types of telehealth provision.

In the qualitative survey responses, some primary care clinicians/managers in remote and rural Queensland have indicated that there is a need for these item numbers to continue beyond the 31 March 2021 deadline because they have greatly improved the access to primary care services for people living in remote and rural Queensland. As a survey respondent summed up:

> **“Telehealth was a big learning curve for everyone, and a number of our clients have continued to use telehealth due to convenience and distance etc post COVID lockdowns. We also saw what was possible and as a result employed a virtual Psychologist to serve our clients. We have used her creatively to take a little pressure off our Occupational Therapy waiting list. For example, we looked for children who were waiting on our OT list for help with social and emotional problems and offered them an appointment with our virtual Psychologist. We have also tailored our OT and Speech Pathology recruitment ads to offer working via telehealth as an option.”**

While overall, survey respondents were positive about the advances in telehealth, they were emphatic that it should not replace face-to-face care. Respondents were also clear about the maintenance of the requirement that clinicians can only perform a telehealth or telephone service where they have an established clinical relationship with the patient.

As with any rapid change, the uptake and adoption of telehealth in remote and rural primary care settings has not been without challenges. The two major challenges identified in the 2020 HWNA survey responses relate to accessibility and capability which are also identified as key priorities by the National Digital Healthcare Strategy.

Poor connectivity and availability of infrastructure were identified by survey respondents as the major issues impacting accessibility. Whilst the National Digital Healthcare Strategy's goal of 'embedding telehealth into clinical consultations for very remote and hard to reach population segments' is highly desirable, the reality of poor and/or unstable internet connection makes it difficult to achieve.

> **“Poor internet connection was a consistent factor in not being able to deliver services, as was difficulty for patients who are not technologically inclined to use a new software platform.”**

The cost and availability of suitable infrastructure was highlighted as an area of need, with many practitioners calling for funding to establish a Telehealth hub in remote and rural towns.

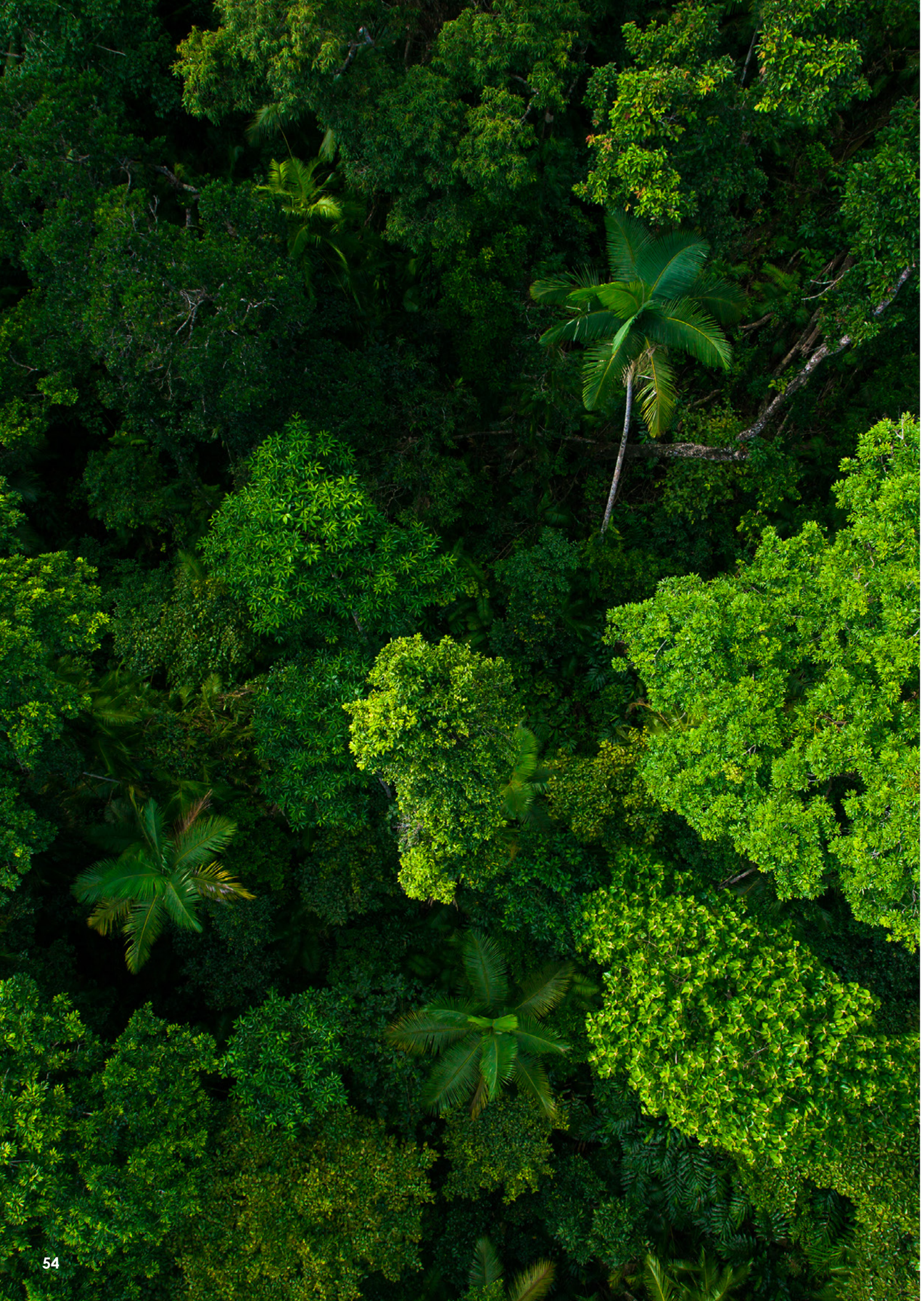
Survey respondents also suggested funding for a dedicated clinical support such as an Aboriginal Health Practitioner, registered nurse or allied health assistant who could both support patients and assist consulting clinicians with observations.

Patient access to hardware and data, along with the ability to use technology were identified as a major challenge for telehealth primary care service delivery. Clinician ability to use the technology effectively and to access technical support when required were also considered barriers to wider uptake of telehealth.

In addition to issues related to accessibility and capability, survey respondents highlighted the urgent need to move away from faxed prescriptions due to the significant workload associated with managing them. The National Digital Health Strategy has a strategic priority for digitally enabled paper-free options for all medication management in Australia by 2022. The attainment of this strategic priority would be welcomed by remote and rural medical practitioners, who already have higher workloads and work longer hours than their urban counterparts.

Whilst the rapid progress with telehealth has come about in response to COVID-19, there is an opportunity to continue to reduce costs associated with healthcare delivery and improve access and quality of services for both consumers and clinicians. Planning is essential to ensure strategies are locally focused, underpinned by financial incentives, built on existing partnerships, enabled through clinical champions, compliant with security and privacy considerations and provide the flexibility to adapt to changing clinical redesign requirements.[18]

18 Western Queensland Primary Health Network (2020), WQPHN Telehealth-Care Guide. Retrieved from https://www.wqphn.com.au/uploads/documents/WQPHN%20Publications/WQPHN_Telehealthcare_Guide_Apr2020_B_V8_WEB.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
- College of Medicine and Dentistry, James Cook University
- CRANAplus
- Darling Downs and West Moreton Primary Health Network (DDWM PHN)
- Department of Health, Queensland
- Faculty of Medicine, The University of Queensland
- General Practice Training Queensland (GPTQ)
- Gidgee Healing
- Goondir Aboriginal and Torres Strait Islanders Corporations for Health Services (Goondir Health Services)
- 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
- North West Remote Health
- 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, Queensland Section
- Rural Clinical School, The University of Queensland
- Rural Doctors Association of Queensland (RDAQ)
- Rural Health Management Services (RHMS)
- Services for Australian Rural and Remote Allied Health (SARRAH)
- State-wide Rural and Remote Clinical Network (SRRCN), Department of Health, Queensland
- 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 along with the many general practices liaised with across remote and rural Queensland for contributing 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.

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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	Crows Nest - Rosalie	Crows Nest Yarraman
5	Inglewood – Waggamba	Inglewood Texas
6	Southern Downs – West	Allora Dalveen Karara
7	Jondaryan	Jondaryan Oakey
8	Esk	Esk Toogoolawah
9	Nanango	Benarkin Blackbutt Nanango
10	Chinchilla	Chinchilla

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	Agnes Water - Miriam Vale	Agnes Water Miriam Vale Seventeen Seventy
4	Cooloola	Cooloola Rainbow Beach Tin Can Bay
5	Gin Gin	Gin Gin
6	Mount Morgan	Mount Morgan
7	Gympie Region (excluding Gympie)	Amamoor Curra Goomboorian Imbil Kandanga
8	Emu Park	Emu Park
9	Gayndah - Mundubbera	Biggenden Gayndah Mundubbera
10	Central Highlands - East	Blackwater Woorabinda

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	Palm Island	Palm Island
7	Kowanyama - Pormpuraaw	Kowanyama Pormpuraaw
8	Cape York	Coen Hope Vale Laura Mapoon
9	Collinsville	Collinsville Mount Coolon
10	Northern Peninsula	Bamaga New Mapoon Injinoo

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