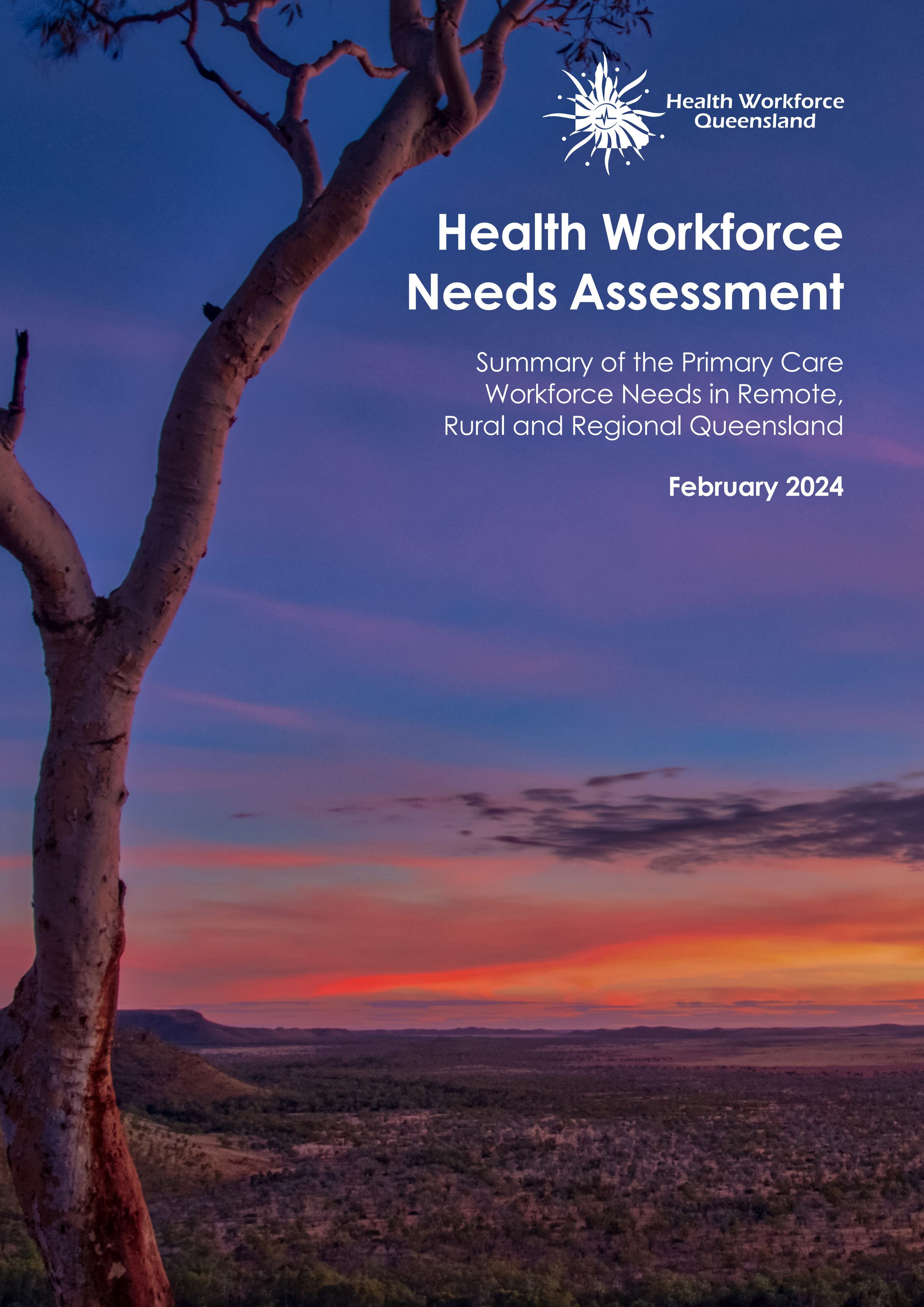


Health Workforce Queensland

Health Workforce Needs Assessment

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

February 2024

Our Vision

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

Our Purpose

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

Our Values

Integrity

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

Commitment

We enhance health services in rural and remote Queensland communities.

Equity

We provide equal access to services based on prioritised need.

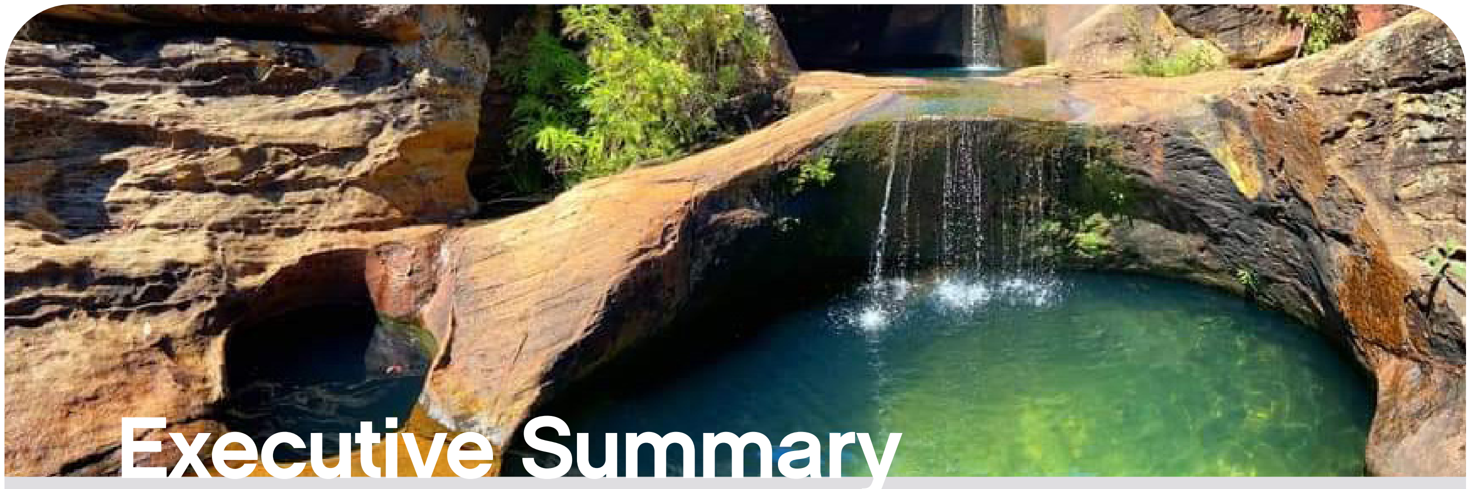
Acknowledgements

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

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

Front Cover Photo

The front cover photo was taken by Todd Stein.



Executive Summary

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

This 2024 report provides an update of current and emerging issues for remote and rural Queensland as well as profession specific summaries. The report also identifies priority Statistical Area Level 2 (SA2) locations based on a nationally consistent quantitative methodology and indicates areas of possible current and/or ongoing workforce need.

Access to health workforce in remote and rural communities continues to remain one of the greatest barriers in addressing health need in Queensland, particularly in the primary healthcare setting. Our Issue in Focus topic this year is multidisciplinary team-based healthcare. The survey included questions seeking the perceptions of practitioners and managers about issues that impact the provision of team-based care in their primary healthcare practices. The findings revealed themes encompassing funding to support a multidisciplinary workforce/team, finding the workforce, physical infrastructure, collaboration across private and public services, and allocating time for team-based engagement and activities.

Primary care workforce data for general practitioners (GPs), allied health professionals (AHPs), nurses, midwives, and Aboriginal and Torres Strait Islander Health Workers/Practitioners are also described, drawing on the most recent release of the 2021 National Health Workforce Dataset (NHWDS) and HWQ's own database. Of note, between 2019 and 2021 there was an increase of 77 registered health practitioners who identified as being of Aboriginal and/or Torres Strait Islander origin.

The report also identifies perceived health workforce and service gaps in remote and rural communities through our annual comprehensive survey. This year the registered counsellor workforce was included in the survey and debuted at the third highest mean workforce gap ranking behind psychology, which again remained the highest. The other workforce gap means in the top five were speech pathology, GP and social work. A thematic analysis of workforce gap comments found the main themes related to access, funding, remuneration, infrastructure and transport.

The highest service gap rating means were for community-based rehabilitation services, alcohol and other drugs services, mental health services, oral health services, and social support services. For the first time since the HWNA commenced in 2017, mental health services moved from the highest service gap rating to the third highest. However, in the comments the most frequently mentioned service gap remained mental health. Across all the primary care services mentioned, the lack of services and access to services were the major themes.

Finally, the HWNA identifies priority locations for each Primary Health Network (PHN) region drawn from an evidence based quantitative methodology and offers collaborative strategies and solutions to address the key issues and findings from the report under the priority areas of access, quality and sustainability.

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Introduction

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

This report summarises the findings from the 2024 HWNA and builds upon the baseline understanding of workforce needs established in previous HWNA reports. The purpose of the HWNA is to identify priority locations with regards to health workforce; inform and prioritise the utilisation of HWQ resources; and inform outcomes to the Department of Health and Aged Care (DHAC) for program planning and policy development. The HWNA also contributes to the evidence base for the development and implementation of HWQ's Activity Work Plan (AWP) and assists in addressing priorities related to localised health workforce needs and primary care service gaps. As part of the process, the jurisdictional Health Workforce Stakeholder Group (HWSG) provides strategic advice and expertise to inform planning, analyses, and strategy development as well as provide validation of findings. The HWNA aims to identify workforce issues and develop collaborative strategies to address these issues under the priority areas of:

Access: Improving access and continuity of access to essential primary healthcare.

Quality: Building health workforce capability.

Sustainability: Growing the sustainability of the health workforce.

Methodology

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

Desktop Audit: Collection and review of key sector reports, reviews and policy documents released throughout 2023.

Online Survey: Online surveys targeting GPs, practice managers, primary care nurses, midwives, AHPs, and Aboriginal and Torres Strait Islander Health Workers/Practitioners. Survey items gauged participants' beliefs about workforce and primary care service gaps in their community(s) of practice in addition to enquiring about the extent of their current involvement in team-based care. The surveys were open between October 2023 and February 2024.

Stakeholder Engagement: Information was sourced from consultations with key stakeholders, communities, and health professionals throughout 2023. The jurisdictional HWSG also provided input at the 2023 annual meeting.

Quantitative Methodology: Data was used to prioritise need at Statistical Area Level 2 (SA2) level locations based on:

- GP full time equivalent (FTE) to estimated resident population ratio (ABS 2022)
- MM classification of remoteness (2019)
- Index of Relative Socio-economic Advantage and Disadvantage (IRSAD) (2021)
- Vulnerable population aged < 5 and > 65 years (ABS 2022)
- Aboriginal and Torres Strait Islander status (ABS 2021)

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

Remote and Rural Health Workforce Overview

Ongoing shortages and maldistribution of the health workforce has driven a multitude of initiatives at the federal, state, and local levels in an effort to identify innovative opportunities and solutions to support access to primary healthcare in rural communities.

Regionalisation Ambition 2032 - Year 1 Progress Report, compiled by the Regional Australia Institute (RAI) stated that the 'Achilles heel' in the growth of regional Australia will be down to workforce shortages and lack of housing, as these are key barriers in supporting equitable health outcomes for these communities[1].

All Australians should expect reasonable access to primary healthcare, no matter where they live. The report released by the Royal Flying Doctor Service (RFDS) - *Best for the Bush* calls for an agreed and comprehensive definition of what constitutes 'reasonable' access to provide a common reference point or benchmark for the services Australians should reasonably expect to receive[2].

Members attending the annual HWSG meeting held in September 2023 identified some key challenges specific to Queensland. They highlighted that lack of visibility of health workforce data to fully understand the supply required to support increasing demand, particularly for allied health self-regulated professions, was hindering effective workforce planning. The current narrative on 'market failure' was also challenged with the HWSG asserting that it was more a system design failure, and that more sustainable and attractive enterprise models must be implemented in thin markets. The HWSG also acknowledged that some fundamental barriers sit outside of the health sector and noted poor health outcomes would continue if social determinants were not addressed through cross-sectoral planning and community partnerships.

Policy and Reform

There have been several reviews and reports relating to rural health workforce and the systems and regulations that oversee them over the past twelve months.

National

Some of the recent National reviews and reports for health workforce include:

The Strengthening Medicare - Support for Health, Care and Support Services in Thin Markets rapid consultation process which was undertaken to gain advice and input to support establishment of a clear definition and criteria for sites to be considered a 'thin market' and a framework for prioritising rollout of support for eligible locations. Since publication, chosen sites have been announced including Cardwell and Mission Beach in Queensland.

Engagement of KPMG Australia to undertake an *Effectiveness Review of General Practice Incentives* including the Practice Incentives Program (PIP) and Workforce Incentive Program (WIP).

The release of the final report of the *Independent review of Australia's regulatory settings relating to overseas health practitioners* (Kruk report). The report recommends a number of reforms to streamline regulatory settings to make it simpler, quicker and cheaper for international health practitioners to work in Australia.

The Working Better for Medicare Review is underway to examine the effectiveness of our current distribution levers. The Review will look at Medicare's role in locating the workforce, as well as the three main policy levers used to distribute the workforce: Modified Monash Model, District of Workforce Shortage, and Distribution Priority Area with findings expected to be provided to government in mid-2024.

The *Unleashing the Potential of our Health Workforce - Scope of Practice Review*, to examine the barriers and enablers health practitioners face working to their full scope of practice in primary care with the anticipation that the recommendations will propel broader workforce reform.

State (Queensland)

Some of the recent state plans and initiatives related to health workforce include:

The Queensland Health *Health Workforce Strategy for Queensland to 2032* Consultation Paper is open for consultation and aims to build a supported workforce to deliver high-quality healthcare across Queensland by developing new pipelines of talent and contemporary attraction approaches with a focus on areas where workforce supply is challenged in both the public and private healthcare settings.

[1]Regional Australia Institute. (2023). *Regionalisation Ambition 2032: 2023 Progress Report*. Regional Australia Institute: Canberra. https://rebalancethenation.com.au/common/Uploaded%20files/Files/Regionalisation%20Ambition%202032/Regionalisation%20Ambition%20-%20Year%201%20Progress%20Report%20-%20FINAL.pdf

[2]Bishop, L., Gardiner, F.W., Spring, B., Gale, L., Schofield, Z. and Quinlan, F. (2023). *Best for the Bush*. Canberra, Royal Flying Doctor Service of Australia. https://www.flyingdoctor.org.au/download-document/best-bush-rural-and-remote-health-base-line-2022

The Single Employer Model (SEM) – where state and territory health departments will participate in the federally funded SEM pilot trials with the aim of improving the attractiveness of choosing a career in general practice to improve the distribution and retention of GPs. In Queensland, a proof of concept will commence at the start of the 2024 medical year involving a limited number of Hospital and Health Services (HHSs) and their nominated private practice partners to work collaboratively to refine an operating model. This model will then be used to inform broader implementation of the four-year SEM pilot from 2025-2028.

The Parliamentary Joint Select Committee on Northern Australia has published an issues paper for its *Inquiry into Workforce Development in Northern Australia* to determine barriers including Indigenous employment participation, housing, health, childcare, education, infrastructure and internet and telecommunications.

Nursing and Midwifery

Nursing and Midwifery are in the spotlight in the current budget and reform initiatives. A National Nursing Workforce Strategy consultation paper has recently been released alongside a supply and demand study to develop the first national-level strategy to inform nursing policy and workforce planning. A *Nurse Practitioner (NP) Workforce Plan* has also been released by the Commonwealth DHAC and aims to expand the services of NPs to address increasing demands for health and aged care services and the chronic workforce shortages across the country. Alongside this, there has been a 30 percent increase in Medicare rebates for NP care and a new scholarship program to support registered nurses (RNs) to train to become NPs.

Strengthening Medicare funding will expand the nursing workforce to improve access to primary care by supporting 500 RNs who have left the profession to return to the health workforce and increasing clinical placements for nurses in primary care through 6,000 Commonwealth supported nursing student placements in the sector[3].

This may assist in addressing the growing demand for nurses in aged care services with residential aged care facilities now requiring a RN/NP on duty 24/7. New figures from the Commonwealth DHAC point to a shortfall of 8,400 RNs and 13,300 personal care workers and it is hoped the approved 15 percent pay increase for aged care workers will support attraction to the sector.

Endorsed midwives no longer need to work under collaborative arrangements. They are now recognised as primary maternity care providers who can prescribe Pharmaceutical Benefits Scheme (PBS) medicines and services under Medicare without any legislative impediment. Queensland Health has also committed $16 million over four years for midwife-led and midwife supported models of care in remote and rural communities. These initiatives support the desire of these communities to have a choice, continuity of care and services closer to home as reinforced at the National Rural Maternity Services Forum held in August 2023 at Parliament House.

The Office of the National Rural Health Commissioner (ONRHC) released a *National Rural and Remote Nursing Generalist Framework 2023–2027* (the Framework) as a world first. It describes the unique practice setting and contextualises the comprehensive skill set necessary for nurses to work to their full scope of practice as remote and rural nursing generalists. This work complements the National Rural Generalist Pathway (NRGP) for medicine, and the National Allied Health Rural Generalist Pathway, as vital health workforce reforms underway to improve remote and rural health outcomes.

The personal safety of practitioners working in remote communities remains an issue with a recent study finding the recruitment, retention and wellbeing of remote area nurses (RANs) continues to be negatively impacted by poor and inconsistent workplace health and safety practices, weak policy frameworks and unenforced workplace health and safety legislation. Having local knowledge, familiarity with people and places within the community and an understanding of cultural norms were identified as being protective factors for staff safety[4].

Retention continues to be a challenge and needs to be addressed for nurses through: improved leadership opportunities; better use

[3]Norman, R. (9 Mar 2023). *Aged care sector facing worker crunch to meet 24/7 nurse requirements by July*. Retrieved from https://www.abc.net.au/news/2023-03-09/no-way-aged-care-staff-labor-election-promise-met/102070392

[4]Wright, L. K., Jatrana, S. & Lindsay, D. (2024). Remote area nurses' experiences of workplace safety in very remote primary health care clinics: A qualitative study. *Journal of Advanced Nursing*, 00: 1-11. https://doi.org/10.1111/jan.16028

[5]Rose, H., Skaczkowski, G., & Gunn, K. M. (2023). Addressing the challenges of early career rural nursing to improve job satisfaction and retention: Strategies new nurses think would help. *Journal of Advanced Nursing*, 79, 3299–3311. https://doi.org/10.1111/jan.15636

of skills and knowledge; flexibility around scope of practice and roles; innovative care models to increase practice options. In terms of the future workforce, research by Rose, Staczkowski and Gunn (2023) regarding factors which would improve job satisfaction and retention of newly registered nurses working in remote and rural areas, highlighted assistance with accommodation and transport; social gatherings to enhance connection; sufficient orientation and supernumerary time; increased frequency of contact with clinical facilitators and multiple mentors; prioritising clinical education across diverse topics; greater involvement in choice of rotations and clinical areas; and desire for more flexible work hours and rostering. The good news in these findings is that many of the strategies could be actioned at a local level, with little financial or time investment[5].

First Nations Workforce

First Nations people continue to face individual and systemic barriers which affect their education and employment outcomes. These barriers may be complex and have compounding impacts. Despite this, the number of First Nations people working in the health workforce is growing. Greater increases are still needed however, to ensure the percentage of First Nations staff working in healthcare matches the percentage of the population who identify as Aboriginal and/or Torres Strait Islander.

The number of Indigenous Australians employed within Australian Health Practitioner Regulation Agency (Ahpra) registered health professions in MM 2-7 QLD, according to the 2021 NHWDS, are presented in Table 1. For comparison, numbers for 2019 and 2020 are also provided. It is of note that the coding 'Practice Nurse' was not an available option for nurses completing the survey in 2021, the coding option being changed to 'Primary Care Nurse'. A comparison with 2020 nurses who selected 'Practice Nurse' suggests that most nurses selecting 'Primary Care Nurse' in 2021 were the same registrants.

While the number of Indigenous Australians registered as health practitioners in most disciplines remained fairly constant, there were increases in the numbers of paramedics, primary care nurses, GPs, psychologists, dental

Table 1: Aboriginal and Torres Strait Islander Ahpra registered health professionals in MM 2-7 Queensland 2019-2021

Registered Health Profession	2019	2020	2021
Aboriginal and Torres Strait Islander Health Practitioner	91	114	113
Paramedic	51	59	62
Practice Nurse *('Primary Care Nurse' in 2021)*	42	44	54
General Practitioner	19	19	23
Psychologist	27	25	32
Physiotherapist	20	20	20
Dental Practitioner	15	14	17
Midwife	10	9	12
Occupational Therapist	12	20	24
Pharmacist	8	7	7
Medical Radiation Practitioner	6	9	13
Chiropractor	5	6	6
Optometrist	0	*	*
Podiatrist	*	*	*
Total	**306**	**346**	**383**

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

practitioners, midwives, occupational therapists and medical radiation practitioners.

Growing and retaining the First Nations workforce is a long-term process. A review of strategies to strengthen the workforce in the Indigenous primary healthcare sector found that the engagement and retention of Indigenous Australian health professionals has been supported in a number of ways, including: co-worker support and peer mentoring; inclusiveness, workplace cultural safety and culturally competent human resources policy and practice; role recognition and clear definition of roles; job security and adequate remuneration; and support for expanded roles and career progression[6].

In Queensland, the First Nations health equity agenda has been propelled by legislation passed by the Queensland Parliament in 2020 and 2021 requiring HHSs to partner with Aboriginal and Torres Strait Islander peoples and organisations to design, deliver and monitor the delivery of healthcare through Health Equity Strategies. All sixteen HHSs across Queensland have now published their inaugural Health Equity Strategy, and commenced their initial three-year implementation cycle.

Allied Health

Despite the lack of a National Allied Health Strategy or comprehensive allied health workforce datasets and benchmarks to evidence supply and demand, it is widely accepted that there are national allied health workforce shortages. Addressing the maldistribution of AHPs requires a detailed knowledge of the workforce and the need for services in different communities. This information will allow targeted efforts to incentivise practitioners to work in underserved regions, such as offering financial incentives, improving professional support networks, and implementing rural placement programs during education and training.

The cost of student placements, particularly in rural primary care settings, continues to be a barrier and there is a growing call to address how student placements are funded. The Australian Council of Heads of Social Work Education (ACHSWE) commissioned a survey about work experience placements. More than 96 percent of students said they did not have enough money to pay for food, clothes and travel required for placements, and more than 79 percent said they knew of other students who have had to defer their social work studies or withdraw from the degree altogether due to placement requirements[7].

The *Unleashing the Potential of our Health Workforce Review* is offering the opportunity to showcase AHPs as a valued and efficient part of the multidisciplinary team however, without increased access to Medicare item numbers, allied health services will remain unaffordable to a significant number of the population.

The use of allied health assistants (AHAs) goes even further to deliver value for money and reduce the current long waiting lists for some services. Barriers to implementing these roles is often the cost and the knowledge bank to develop fit-for-purpose delegation and supervision frameworks for AHAs that provide clarity around the roles and responsibilities of both the AHA and the supervising AHP, as well as having enough senior staff in rural areas who also have the skills to delegate and supervise AHAs. The revised *Transition to Remote and Rural Allied Health Practice Toolkit* developed by Services for Rural and Remote Allied Health (SARRAH) is a resource for both AHPs as well as AHAs to support some of these key delegation and supervision barriers.

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[6]Jongen C, McCalman J, Campbell S & Fagan R (2019). *Working well: strategies to strengthen the workforce of the Indigenous primary healthcare sector*. BMC health services research 19:910.

[7]Morley, C. (23 May 2023). *We can no longer justify unpaid labour: why uni students need to be paid for work placements*. Retrieved from https://theconversation.com/we-can-no-longer-justify-unpaid-labour-why-uni-students-need-to-be-paid-for-work-placements-203421

General Practitioner

Despite recent focussed initiatives for general practice and the GP workforce, the Royal Australian College of General Practitioners (RACGP) General Practice: Health of the Nation 2023 reflects that the profession as a whole has concerns about workload, burnout, and fragmentation of care. There is waning interest in the profession among both medical students and working GPs and workforce issues are worsening, with increasing numbers of GPs intending to retire or cease practicing over the next 10 years[8].

General practice viability and sustainability remains fragile despite the tripling of the bulk billing incentive. It is hoped over time other funding initiatives such as indexation of Medicare Benefits Scheme (MBS), the introduction of MyMedicare to support continuity of care, continuation of general practice incentives and expansion of workforce incentive payments to support multidisciplinary primary care teams will contribute to strengthening general practice, however, fundamental system and funding reform is still required in many remote and rural settings.

A recent Medical Deans position paper highlights that whilst the number of GP Registrar training places has remained constant at 1,500 per year, the number of both eligible applicants applying and training positions being filled has dropped annually since 2017. The report acknowledges medical schools are pivotal in building medical graduate interest in careers in general practice and recommend universities align student recruitment and admission to incorporate best evidence for primary care workforce outcomes. Proactive recruitment of students with aptitude for and interest in careers as GPs and increased clinical experiences and learning about general practice across the entirety of their medical curriculum including visible role models will further and meaningfully build the cohort of prospective GPs. Exposure of postgraduate doctors to general practice, and community and primary care, was also cited as important to keep general practice as a viable option for these doctors as they plan their vocation[9].

International Medical Graduates (IMGs) remain a vital pipeline in remote and rural Queensland with HWQ's Minimum Data Set (MDS) 2022 reporting 47.8 percent of the medical workforce in MM 2-7 were trained outside of Australia. With crippling bureaucracy and barriers to onboarding the IMG medical workforce, the Kruk Report's interim findings recommended equivalence testing be transferred to the Australian Medical Council (AMC), with RACGP and the Australian College of Rural and Remote Medicine (ACRRM) relegated to an advisory role. However the final report now recommends the AMC only take over if the medical colleges fail to meet agreed timelines for expanding and streamlining their expedited pathways.

The MDS Report also measured a turnover of 17 percent of the total medical workforce in MM 2-7 between 2021 and 2022 with remote locations having the greatest movements with approximately a 21 percent turnover rate, compared to inner regional locations with a 16 percent turnover. These numbers point to considerable change over a 12-month period and highlights the need for greater retention strategies.

Recognition of Rural Generalist Medicine as a new field of specialty practice within the current specialty of general practice is a key approach in both attracting and retaining rural doctors. The Medical Board of Australia is undertaking a public consultation on a joint application from RACGP and ACCRM for this recognition as a key part of enabling the success of NRGP and its aims of increasing opportunities for doctors to train and practice and stay in both hospital and primary care settings in remote, rural and regional communities. To complement this, a new workforce incentive payment for undertaking rural advanced skills in MM 3-7 locations is now being rolled out to encourage doctors to take up or further utilise these advanced skills in remote and rural areas to broaden the range of services available to rural communities.

With the myriad of initiatives underway, it is hoped that meaningful workforce reform will follow to support the growth and sustainability of the health workforce in remote and rural Queensland and in turn improve the health outcomes of the communities they strive to serve.

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[8]The Royal Australian College of General Practitioners. *General Practice: Health of the Nation 2023*. East Melbourne, Vic: RACGP, 2023.

[9]Medical Deans Australia and New Zealand (2023) Position Paper: *The Doctors our Communities Need: Building, Sustaining and Supporting the General Practice Workforce in Australia and New Zealand*. Sydney, Australia.

Workforce Data: State-wide Snapshot

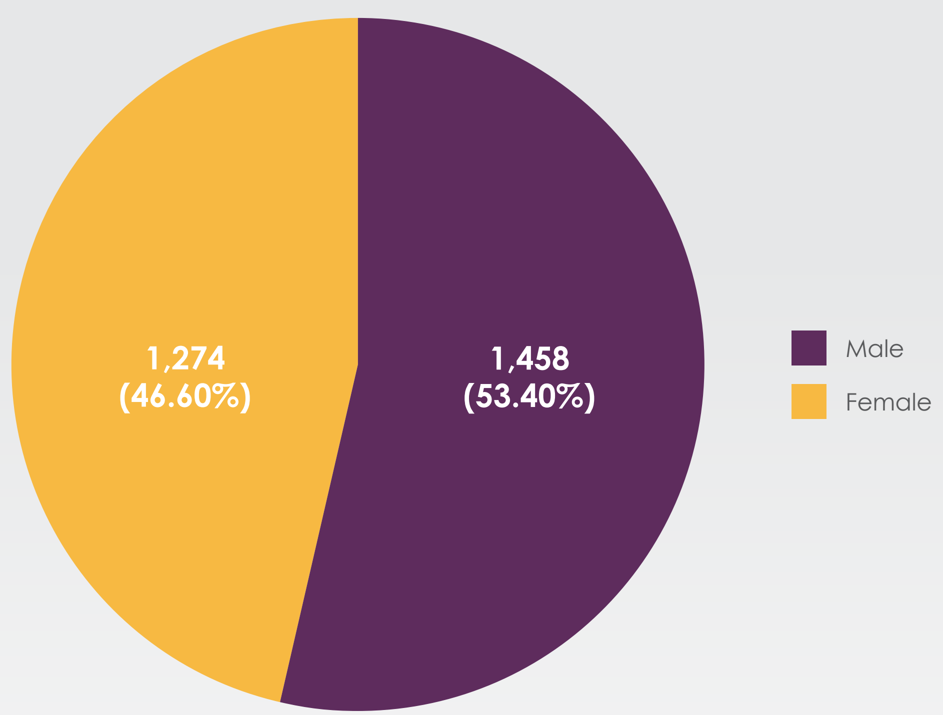
General Practitioner Workforce

Health Workforce Queensland Database

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

This snapshot of the workforce was taken on 30 November 2023. In line with reporting requirements to the Australian Government DHAC, only doctors working in MM 2-7 locations were investigated. At the census date there were 2,734 GPs listed on the HWQ database as working in MM 2-7 locations in Queensland, eight more than reported in the 2022 HWNA. The average age was 49.09 years, marginally younger than the 49.94 years reported in 2022.

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



Unspecified = 2

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

The number and percentage of female and male GPs for each of the four mainly rural PHN regions are presented in Table 2 (excludes practitioners from Brisbane North, Brisbane South and Gold Coast PHN regions).

Table 2: GPs by sex and PHN region from HWQ database

PHN region	Female		Male		Total
	n	%	*n*	%	*N*
Central QLD, Wide Bay, Sunshine Coast	344	44.91%	420	54.83%	**766[a]**
Darling Downs and West Moreton	255	42.71%	342	57.29%	**597**
Northern Queensland	548	51.21%	522	48.78%	**1,070**
Western Queensland	56	41.18%	80	58.82%	**136**

Note: [a]Total figure includes two GPs with sex = unspecified

Country of basic medical qualification

GPs were grouped according to whether they received their basic medical qualification from an Australian university or from an overseas university. Overall, there were 1,369 Australian trained GPs (50.1%), and 1,365 overseas trained GPs (49.9%) in MM 2-7 in Queensland (one GP had missing data). The percentage results for each of the mainly rural PHN regions are presented in Figure 2.

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

National Health Workforce Dataset (NHWDS) 2021

The most recent release of the NHWDS has been gathered through the 2021 workforce survey of health practitioners as part of their annual registration renewal with Ahpra. The NHWDS is administered by the Australian government, with jurisdictional data released to state governments on an ad-hoc schedule.

Queensland Health have provided an analysis to HWQ of the number of medical practitioners, working in MM 2-7 Queensland, that self-described their main role as either 'General Practice', or 'General Practitioner (GP) – not a specialist'. The number of GPs in 2021 for each PHN region is provided in Table 3.

Table 3: 2021 NHWDS general practitioners by PHN region

PHN region	NHWDS 2021 *N*
Central QLD, Wide Bay, Sunshine Coast	702
Darling Downs and West Moreton	487
Northern Queensland	1,100
Western Queensland	117
Total*	***2,529***

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

Practice Nurse Workforce

Health Workforce Queensland Database

The number of nurses and midwives working in MM 2-7 general practice settings captured in the HWQ database was 1,567, an increase of 36 from last year.

The number of nurses, according to level of registration and diabetes education specialty, are presented in Figure 3. Similar to last year, almost three-quarters were RNs or RN/Midwives, with the majority of the remainder being enrolled nurses (ENs). There were comparatively few general practice nurses who identified as NPs or diabetes nurse educators.

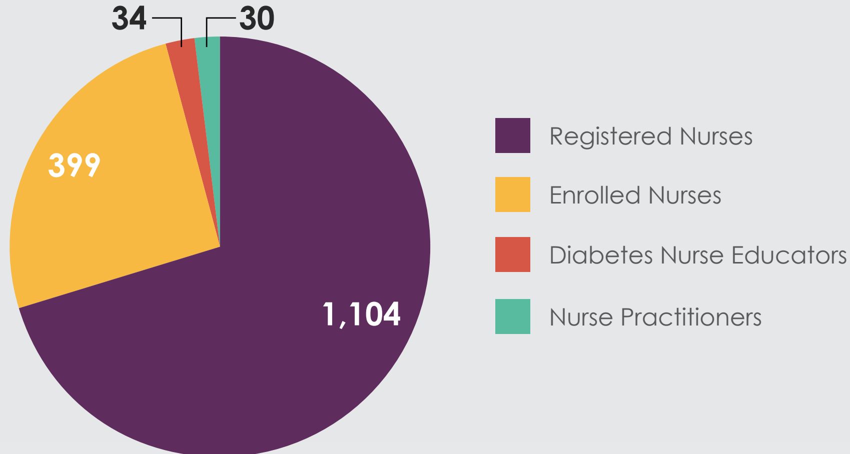


Figure 3: Number of general practice nurses by level of registration and specialty from HWQ database

Along with the nurses based in general practice, Queensland Health has provided data on headcounts of nurses working in Queensland Health operated primary care centres within smaller communities. The number of these nurses, according to level of registration are presented in Figure 4.

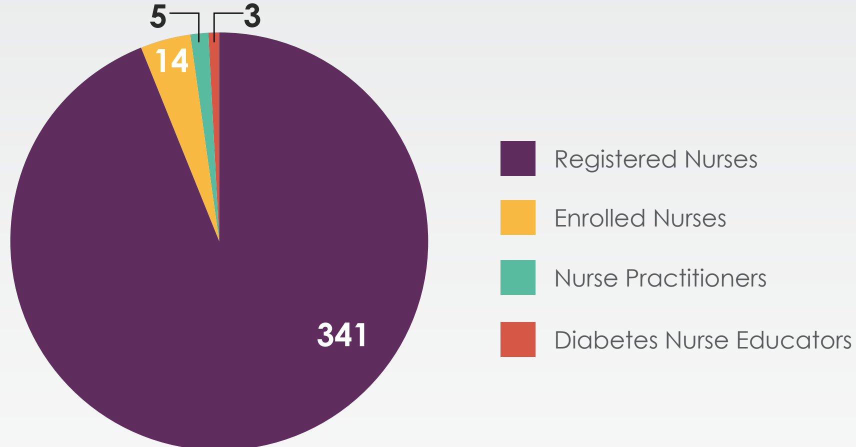


Figure 4: Number of remote and rural primary healthcare centre nurses by level of registration from HWQ database

Over 90 percent of the nursing workforce in remote and rural primary healthcare centres were RNs. Relative to last year, both EN and diabetes nurse educator categories have had an increase of one, while RNs have increased by 137.

National Health Workforce Dataset (NHWDS) 2021

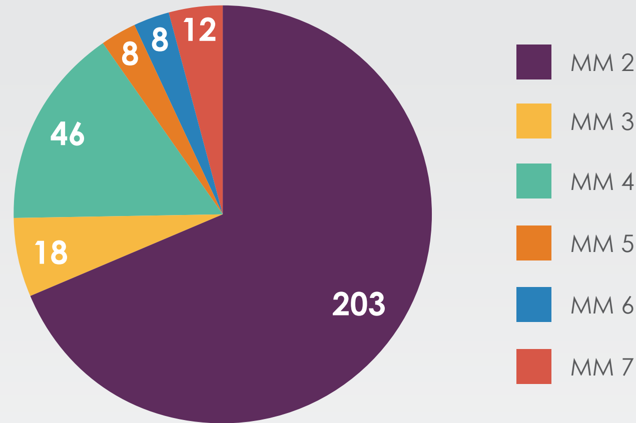
Below is the number of nurses working in MM 2-7 Queensland by rural PHN region that self-described their main role as 'primary care nurse' when they completed the NHWDS survey during 2021 registration renewal. The response rate to the workforce survey is generally above 95 percent for nurses across Australia. Results for both RNs and ENs for the four mainly remote and rural PHN regions in Queensland are available in Table 4, inclusive of the percentage that described their primary work as private. Because the survey self-report category of 'Practice Nurse' was removed in the 2021 survey, these results are not directly comparable to previous years.

Table 4: 2021 NHWDS primary care nurses by PHN region and percent in private employment

PHN region	Registered Nurse/Midwife *n*	Enrolled Nurse *n*	*Nurse Total N*	Percent Private
Central QLD, Wide Bay, Sunshine Coast	250	64	***314***	81%
Darling Downs and West Moreton	171	42	***213***	75%
Northern Queensland	421	110	***531***	60%
Western Queensland	92	7	***99***	32%
Total*	***984***	***236***	***1,220***	***66%***

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

Below is the number of registered midwives only working in MM 2-7 Queensland by rural PHN region that self-described their main role as 'midwifery' when they completed the NHWDS survey during 2021 registration renewal. Midwife headcount data by MM is presented in Figure 5.



Note: Data provided by Queensland Health
Figure 5: NHWDS 2021 workforce survey midwives by MM

Results for the four mainly remote and rural PHN regions in Queensland are available in Table 5, inclusive of the MM 1 numbers and total percentage of midwives that described their primary work as private.
Only 14 percent described their primary workplace as 'private', and the mean age of the workforce was a comparatively young 38 years.

Table 5: 2021 NHWDS midwives by PHN region

PHN region	MM 2-7 *n*	MM 2-7 *%*	*MM 1 n*
Central QLD, Wide Bay, Sunshine Coast	85	28.81%	***100***
Darling Downs and West Moreton	66	22.37%	***78***
Northern Queensland	109	36.95%	***N/A***
Western Queensland	12	4.07%	***N/A***
Total*	***295***	***100%***	***178***

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

Aboriginal and Torres Strait Islander Health Worker and Health Practitioner Workforce

Health Workforce Queensland Database

There were 277 Aboriginal and Torres Strait Islander Health Workers and 75 Aboriginal and Torres Strait Islander Health Practitioners in the HWQ database.

This represented an increase of eight Aboriginal and Torres Strait Islander Health Workers and 30 Aboriginal and Torres Strait Islander Health Practitioners since last year. Figure 6 presents this workforce according to MM location with numbers suppressed (marked as 'NA') if less than four.

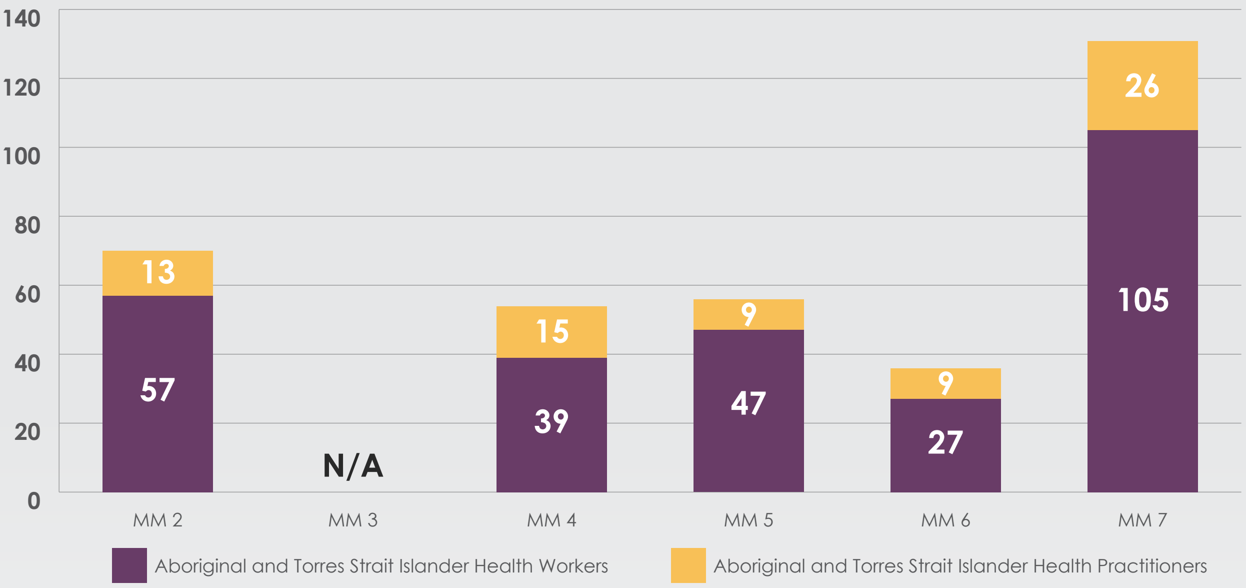
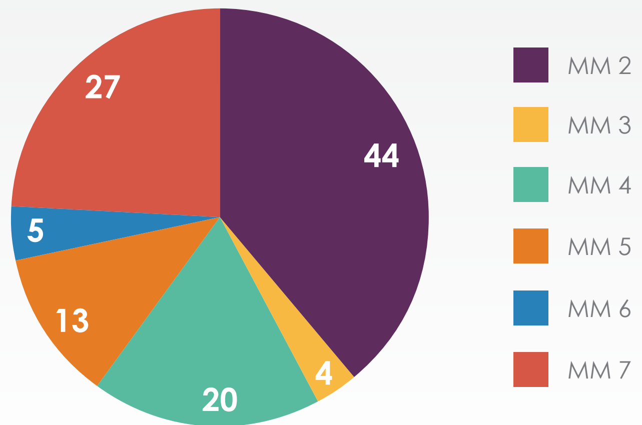


Figure 6: HWQ database Aboriginal and Torres Strait Islander Health Workers/Practitioners by MM

This year, Aboriginal and Torres Strait Islander Health Workers and Practitioners were represented across all MM categories. Similar to last year, the largest number of Aboriginal and Torres Strait Islander Health Workers and Practitioners were working in MM 7 locations. The Aboriginal and Torres Strait Islander Health Worker and Practitioner workforce grew substantially in MM 2 (39%), MM 5 (22%), and MM 6 (25%) locations relative to last year's report.

National Health Workforce Dataset (NHWDS) 2021

The distribution of Aboriginal and Torres Strait Islander Health Practitioners in Queensland by MM (provided in Figure 7) has been drawn from the 2021 NHWDS survey.



Note: Data provided by Queensland Health

Figure 7: NHWDS 2021 workforce survey Aboriginal and Torres Strait Islander Health Practitioners by MM

Approximately 39 percent of the 113 Aboriginal and Torres Strait Islander Health Practitioners were working in MM 2 locations. MM 7 had 24 percent of the Health Practitioners, while MM 4 had approximately 18 percent of the workforce.

Allied Health Workforce

National Health Workforce Dataset 2021

The allied health workforce data outlined in the following section has been provided by Queensland Health based on the 2021 NHWDS. The registered allied health professions for which data is available are:

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

Table 6: 2021 NHWDS AHPs by PHN region and percent mainly in private employment

Allied Health Professions	MM 2-7 *N*	Percent Private	MM 1 *N*
Psychologists	1,366*	67%*	4,718
Central QLD, Wide Bay, Sunshine Coast	366	72%	486
Darling Downs and West Moreton	278	68%	194
Northern Queensland	635	63%	-
Western Queensland	24	52%	-
Physiotherapists	1,527*	62%*	5,491
Central QLD, Wide Bay, Sunshine Coast	444	70%	577
Darling Downs and West Moreton	273	64%	199
Northern Queensland	713	55%	-
Western Queensland	46	43%	-
Podiatrists	251*	79%*	734
Central QLD, Wide Bay, Sunshine Coast	83	83%	78
Darling Downs and West Moreton	63	85%	31
Northern Queensland	80	72%	-
Western Queensland	15	69%	-

Allied Health Professions	MM 2-7 *N*	Percent Private	MM 1 *N*
Occupational Therapists	1,452*	55%*	3,729
Central QLD, Wide Bay, Sunshine Coast	371	62%	480
Darling Downs and West Moreton	235	55%	173
Northern Queensland	757	52%	-
Western Queensland	58	46%	-
Optometrists	323*	99%*	909
Central QLD, Wide Bay, Sunshine Coast	102	100%	95
Darling Downs and West Moreton	81	100%	47
Northern Queensland	126	100%	-
Western Queensland	6	100%	-
Pharmacists	1,635*	68%*	4,304
Central QLD, Wide Bay, Sunshine Coast	467	71%	361
Darling Downs and West Moreton	316	74%	214
Northern Queensland	724	63%	-
Western Queensland	64	64%	-
Dental Practitioners	1,344*	73%*	3,541
Central QLD, Wide Bay, Sunshine Coast	425	72%	396
Darling Downs and West Moreton	257	79%	176
Northern Queensland	577	74%	-
Western Queensland	39	50%	-
Diagnostic Radiographers	746*	50%*	2,107
Central QLD, Wide Bay, Sunshine Coast	230	65%	266
Darling Downs and West Moreton	125	52%	100
Northern Queensland	355	40%	-
Western Queensland	20	53%	-

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

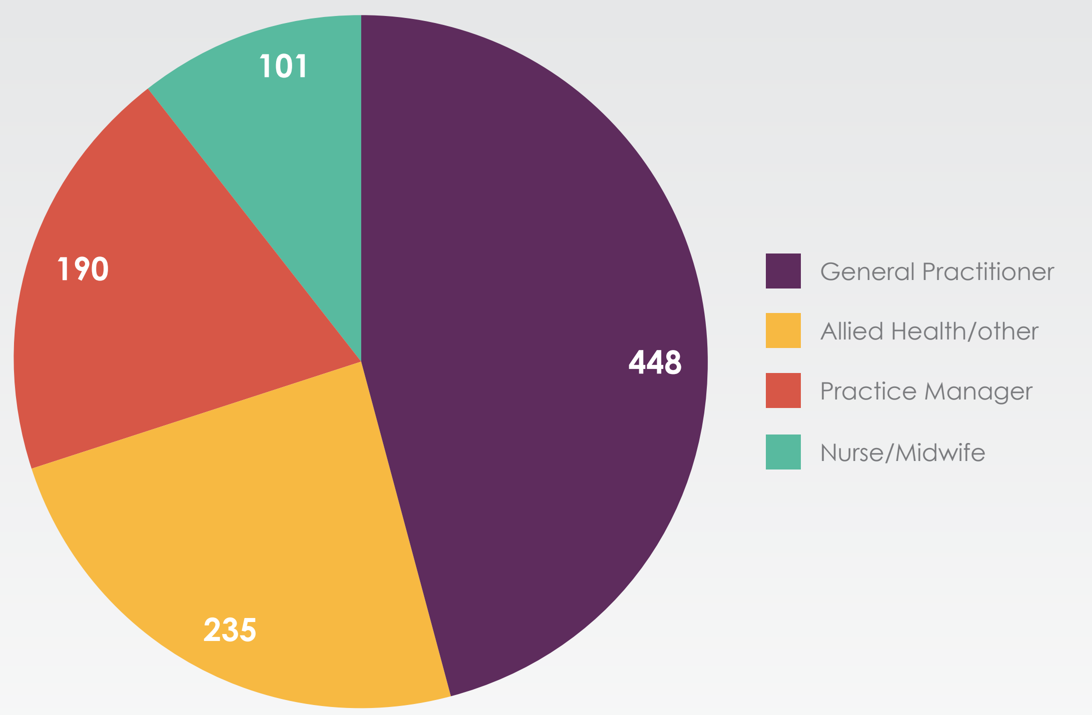
HWNA Survey Results

Quantitative Findings

An online survey was conducted targeted at GPs, practice managers, primary healthcare nurses and midwives, Aboriginal and Torres Strait Islander health workers and practitioners, and AHPs working in MM 2-7 locations. Survey items were developed to gauge health practitioner and health service manager beliefs about primary care workforce and service gaps in their community(s). The survey items were phrased as statements (e.g., 'There is a serious gap in the psychology workforce in my community') and participants were asked to rate their level of agreement. Ratings were 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 19 workforce disciplines (e.g., GPs; pharmacy) and 13 primary care services (e.g., alcohol and other drugs services; mental health services) that aligned with identified priorities for the PHN regions. A notable change has occurred this year with the separation of the formerly unified nursing and midwifery category into two distinct disciplines. This year, in recognition of the growing role registered counsellors play in meeting the mental health service needs in remote and rural settings, the HWNA survey included degree level registered counsellors as a new primary care health workforce discipline. Degree level registered counsellors are mental health professionals regulated through the Australian Counselling Association (ACA) which oversees training standards and codes of ethical practice, as well as accrediting education courses and Continuing Professional Development (CPD) courses for the discipline.

There was a sample size of 975, an increase of 239 from last year. The number of participants by their main role (e.g., nurse, AHP) are provided in Figure 8.



Missing = 1

Figure 8: Number of participants by main employment role

The Northern Queensland PHN region had the largest number of survey responses (*n* = 344), followed by the Central QLD, Wide Bay, Sunshine Coast region (*n* = 277), the Darling Downs and West Moreton region (*n* = 191) and the Western Queensland PHN region (*n* = 100). The main employment role of participants for each of the mainly rural PHN regions are available in Figure 9.

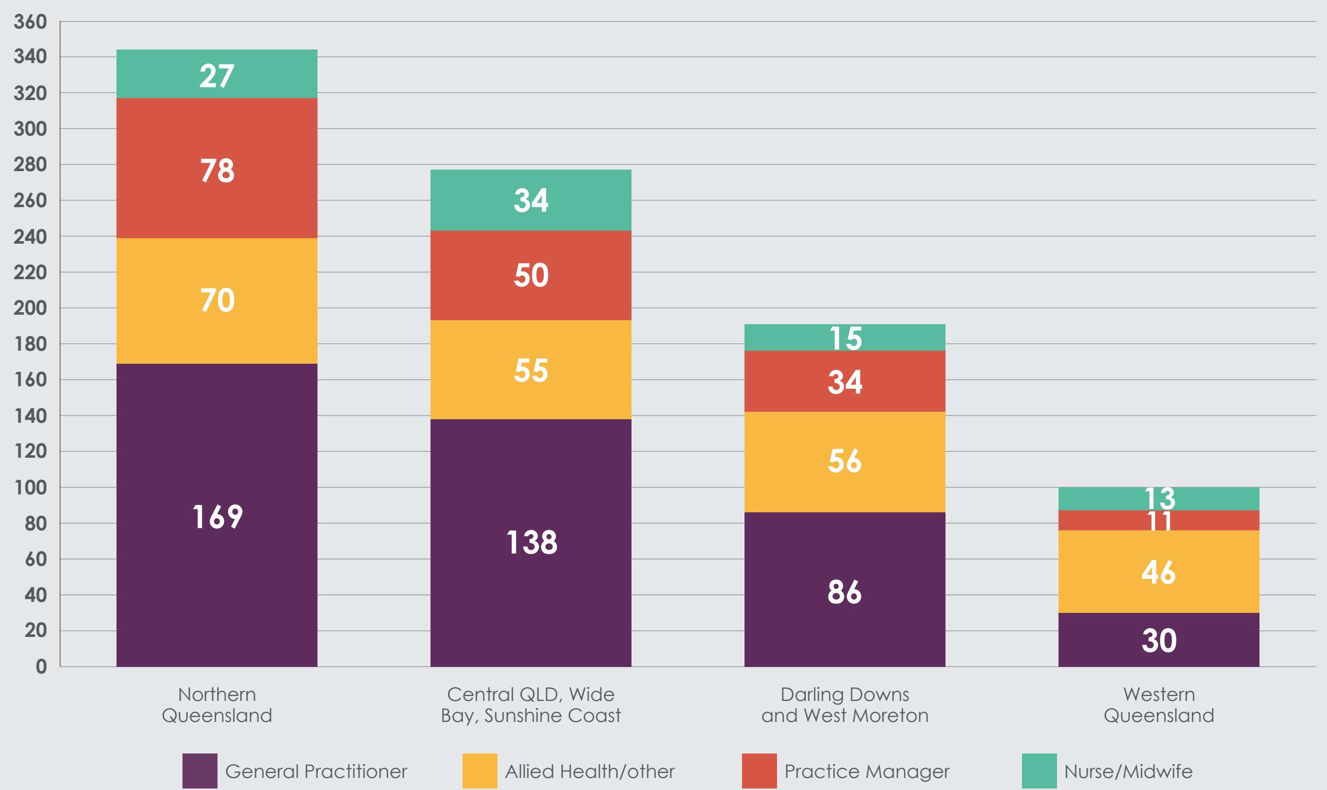


Figure 9: Number of participants by main employment role and rural PHN region

Responses from each main employment role were received in record numbers, with practice managers experiencing the most impressive growth (126%) relative to last year's HWNA survey. Figure 10 depicts the total number of responses received for the HWNA since 2020 and the breakdown of these responses by participant employment role.

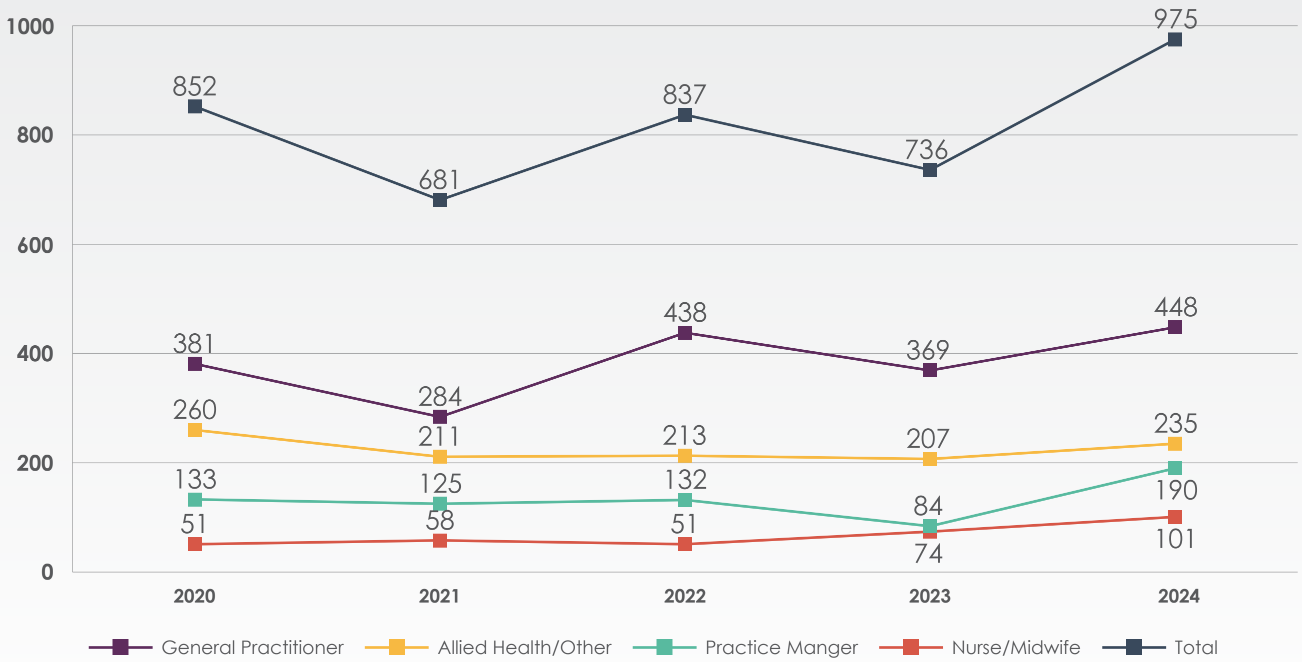
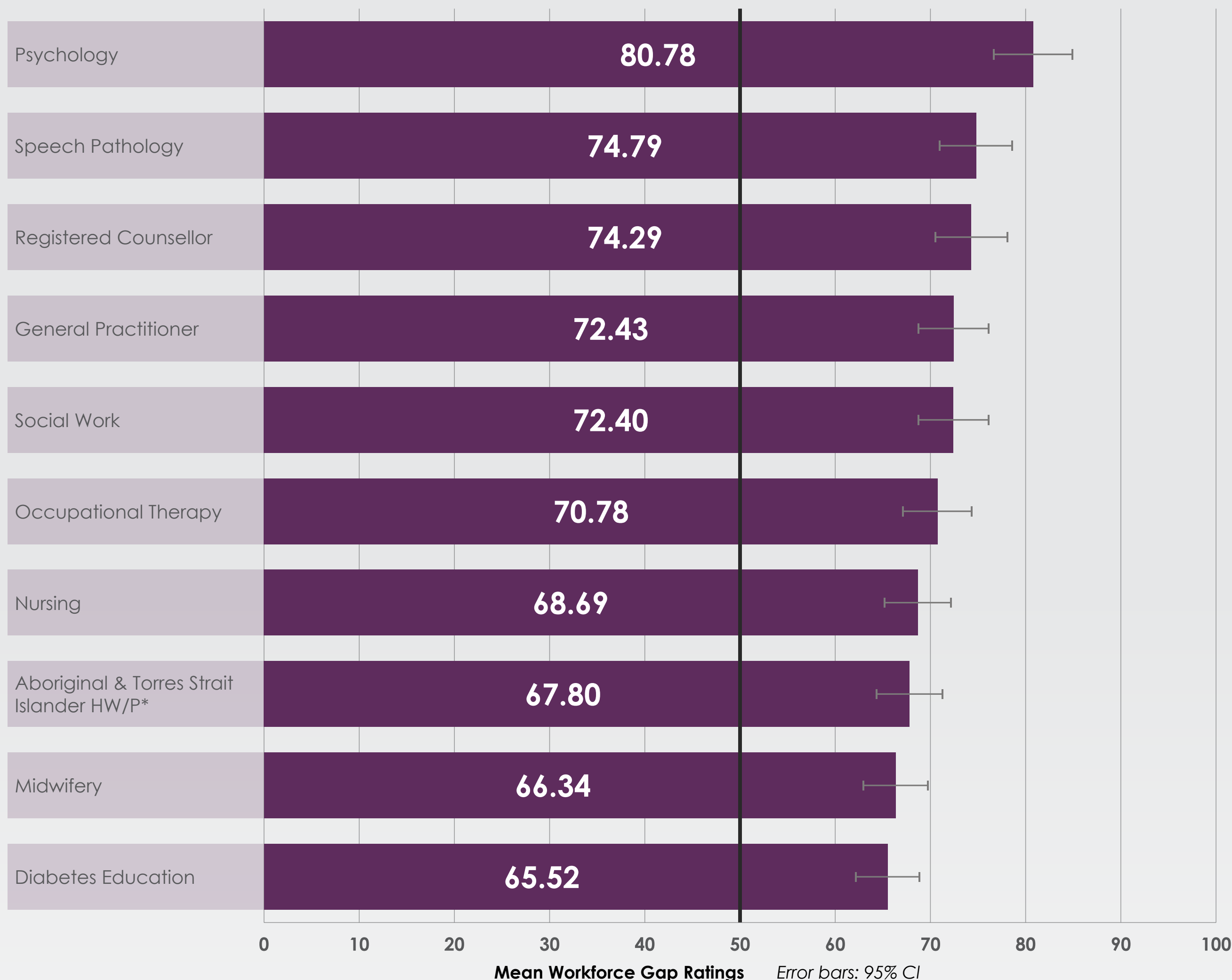


Figure 10: Number of participants by main employment role from 2020-2024

Workforce Gap Ratings

The 'Top 10' Workforce gap rating means for remote, rural and regional Queensland are provided in Figure 11. The full list is available in table format in Table 7 along with the workforce gap means from 2020 to 2024.



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

Figure 11: Top 10 workforce gap rating means 2024

The highest workforce gap rating means were for the psychology, speech pathology, registered counsellor, GP, and social work workforces. Interestingly, the newly included (registered counsellor) and adjusted workforce disciplines (nursing, and midwifery) were all represented within the top 10 (ranked 3, 7, and 9 respectively). Six of the workforce gap means were higher than 70 with one larger than 80. The remaining top 10 workforce gap rating means were higher than 60.

Table 7: Workforce gap rating means for 2020-2024

Type of Workforce	*2020 M*	*2021 M*	*2022 M*	*2023 M*	**2024 M**
Psychology workforce	66.63	72.70	79.57	80.74	**80.78**
Speech Pathology workforce	59.88	70.31	71.60	73.45	**74.79**
Registered Counsellor workforce	N/A	N/A	N/A	N/A	**74.29**
General Practitioner workforce	58.58	62.03	70.85	74.96	**72.43**
Social Work workforce	63.35	65.68	71.54	73.83	**72.40**
Occupational Therapy workforce	58.78	66.19	68.91	71.04	**70.78**
Nursing workforce[a]	51.55	55.84	65.57	73.16	**68.69**
Aboriginal and Torres Strait Islander HW/P* workforce	57.27	60.50	62.78	66.56	**67.80**
Midwifery workforce	N/A	N/A	N/A	N/A	**66.34**
Diabetes Education workforce	53.76	56.88	59.60	63.14	**65.52**
Podiatry workforce	48.51	56.89	55.68	62.45	**61.48**
Dental Practitioner workforce	54.66	55.72	56.83	62.96	**61.39**
Radiography/Sonography workforce	52.42	55.88	53.98	57.99	**60.16**
Dietetic workforce	50.30	57.40	57.46	60.82	**59.62**
Exercise Physiology workforce	50.05	54.22	53.21	58.04	**57.00**
Audiology workforce	49.44	53.00	50.72	55.37	**56.36**
Physiotherapy workforce	45.86	49.95	52.76	56.93	**53.43**
Optometry workforce	42.05	45.73	47.04	49.44	**49.43**
Pharmacy workforce	31.38	32.75	34.06	40.71	**37.69**

*Note: *HW/P = Health Worker/Health Practitioner; [a]2024 nursing mean reflects the 'nursing' employment category and may not be directly comparable to 2020-23 means which reflect the 'nursing and midwifery' employment category; N/A indicates rating question not contained in survey.*

While there has been an overall increase in workforce gap rating means across all disciplines since 2020, the increasing growth trend appears to be reducing, suggesting a possible plateau in 2024. Nine workforces (nursing, physiotherapy, pharmacy, GP, dental practitioner, social work, dietetic, exercise physiology, and podiatry) reported mean reductions ranging from approximately one to five points. However, mean increases ranging from one to two points were observed for the audiology, Aboriginal and Torres Strait Islander health worker/practitioner, speech pathology, radiography/sonography, and diabetes education workforces. For the second consecutive year, the psychology workforce gap rating mean exceeded 80 points. The optometry and pharmacy workforce gap rating means were the only two lower than 50 (see Table 7).

Consistent with previous years, psychology (ranked 1), speech pathology (ranked 2), GP (ranked 4), and social work (ranked 5) workforces are represented in the highest workforce gap rankings. Interestingly, the registered counsellor workforce category debuted as the third largest workforce gap. Figure 12 depicts the workforce gap rating means for each of these workforces to show change across this period from 2020-2024.

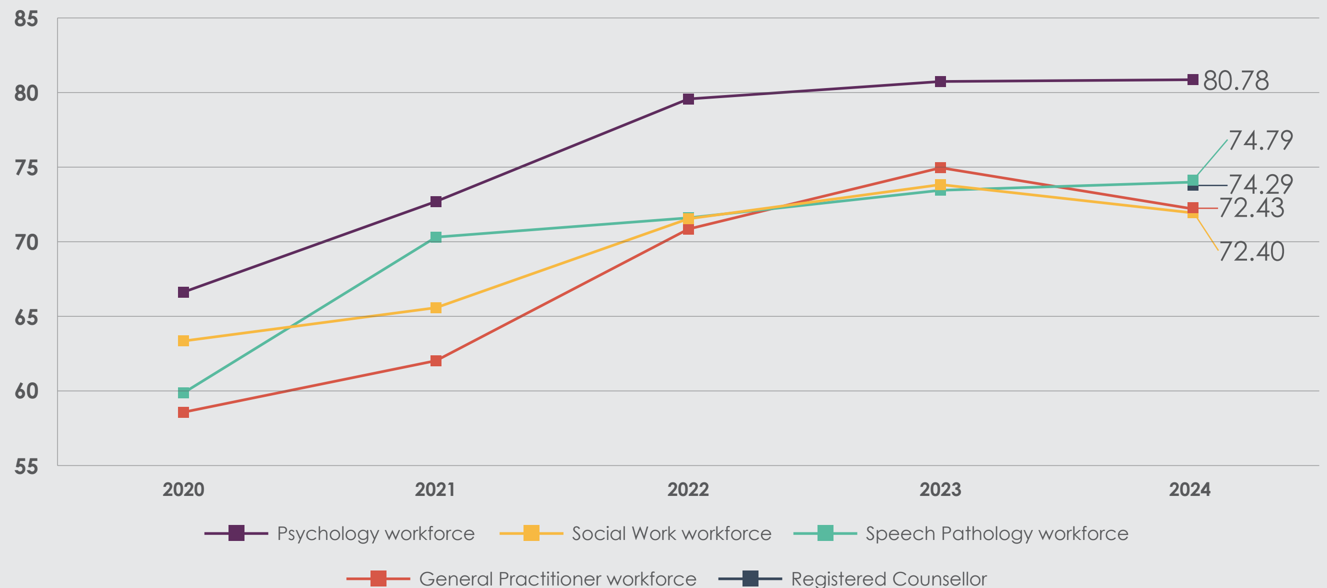


Figure 12: Five highest rated workforce gaps across 2020-2024

Excluding the newly included registered counsellor workforce, the workforce gap rating means for the remaining workforce disciplines have generally increased between 2020 and 2024. The speech pathology workforce experienced the largest increase over the previous five years (14.9 points), followed by psychology (14.2 points), GP (13.9 points), and the podiatry workforces (13.0 points). Occupational therapy, a previous top five position holder, fell to number 6 due to the registered counsellor workforce placement within the top five.

Workforce Gap Comments

There were 268 participants that commented on the workforce gap rating questions. The most frequently mentioned workforce gaps identified in a thematic analysis were grouped into the following four themes:

1. Workforce (*n* = 166)
2. Access (*n* = 74)
3. Funding and Remuneration (*n* = 44)
4. Infrastructure and Transport (*n* = 29)

Each of the main themes will be discussed individually and sub-themes identified.

1. Workforce

Comments about workforce were characterised by two related sub-themes: **workforce shortages** and, difficulties with **attraction and retention** of workers. The sub-themes are represented in Figure 13.

Figure 13: Workforce issues sub-themes

The first sub-theme of workforce shortages was mentioned by nearly half of all participants with responses citing primary care services such as **mental health**, **allied health**, **child health**, **palliative care**, **disability** and **aged care** being impacted. Participant comments offered valuable insights into the challenges of meeting patient needs:

"The gaps that are occurring across disability, aged care and Aboriginal and Torres Strait Islander health are due to vacancies and not due to decreased funding."

"Health services above and beyond the basics is not supported and the community need to travel two hours to reach these services. Due to demand on these services by local and outlying communities the waiting times for an appointment can be weeks or months."

"Not enough available psychology services, wait lists are too long. Dental waitlist is 3 months at XXX [Community Controlled Health Service]. Referrals for child health and development take 1-2 years if non emergency."

The second workforce sub-theme, **attraction and retention**, was mentioned by many participants. For instance, some mentioned the difficulty in retaining qualified practitioners, including the impact this has on patients:

"When we get qualified people, they don't stay. Patients fail to build rapport with medical professionals because they know that they aren't going to be here in the future."

"All disciplines are limited by high turnover rates, relatively junior staff and long periods of no service while positions are recruited to."

2. Access to services

For the theme of **access to services**, participant comments centred around two sub-themes: **allied health workforce shortages** and **long wait times.** The sub-themes are presented in Figure 14.

Access	Insufficient allied health workforce (*n* = 45)
	Long wait times (*n* = 21)

Figure 14: Access sub-themes

Over 40 percent of the participant comments were related to the first sub-theme, difficulty in **accessing** allied health services due to insufficient allied health workforce. Several comments highlighted how wide the variety of allied health disciplines that were not accessible was in their community:

"Allied health practitioners such as SP, OT are desperately needed. Psychologists, OT, SP have closed books, or are taking bookings for 3 months time. It is very daunting for allied health practitioners to set up a business, as well as practising their profession."

"Very difficult to access services for anyone with a disability - OT/speechie/psychology/counselling. Particularly difficult if you are trying to find services for kids."

The second sub-theme was the **long wait times** to see a health professional. Some participants expressed that when **vulnerable age groups** are not seen in a timely manner, it causes a ripple effect on other parts of the health and aged care systems:

"I am looking forward to the aged care overhaul. It is near impossible to get services for our elderly patients in a reasonable timeframe."

"Lack of Speech Pathology and Occupational Therapy practitioners has resulted in long waiting lists that often miss the most important developmental windows. Hence, children are entering services later and needing services for longer periods."

3. Funding and Remuneration

For remuneration and funding, the main sub-themes were **complex funding models** and **unaffordable services**. The sub-themes are represented in Figure 15.

Funding and Remuneration	
	Complex funding models (*n* = 24)
	Remuneration (*n* = 18)

Figure 15: Funding and remuneration sub-themes

Complex funding models were mentioned by nearly half of the participants. The issues identified included providers preferring to treat National Disability Insurance Scheme (NDIS) funded patients over non-NDIS funded patients for the higher fees, **inadequate Medicare reimbursement** for allied health and medical services, and a persistent **salary disparity** between public and private health practitioners:

"The high fees for NDIS services has also created an interesting situation of high fees for non-NDIS [patients] or practitioner[s] who exclusively see NDIS patients for high income."

"Medicare gap is inadequate for providing allied health/medical services, clients would have to be seen at a loss of Medicare [if] we're to cover sessions at current rate."

"GPs aren't enticed by salary compared to working in hospital which is leading to less upstream health care and more reactive health care i.e. present to ED as can't see a GP in reasonable time frame."

Remuneration expectations were also mentioned as impacting attraction and service delivery:

"Affordability: those most in need cannot afford good quality care. The reality is that trained professionals are not prepared to work for a pittance and are no longer able to subsidise both state and federally funded health care out of their own pockets, and the rural and regional areas are always hardest hit as there are more socially and economically disadvantaged people per capita in non-metropolitan areas."

"New graduates across all disciplines are now expecting significant support clinically and high salaries, which no longer stand out from metropolitan areas. As a primary health care provider and not for profit, it is difficult to provide them the desired supports, thus making recruitment even more challenging."

4. Infrastructure and Transport

For the theme of **infrastructure and transport** the main sub-themes were difficulties for health practitioners who had to **travel to deliver services** and a **lack of accommodation** for health practitioners. The sub-themes are represented in Figure 16.

Infrastructure and Transport	
	Travel to services (*n* = 20)
	Lack of accommodation/clinical spaces (*n* = 6)

Figure 16: Infrastructure and transport sub-themes

Participant comments also mentioned how community members **travel long distances** to access specialist and allied health services. There are no suitable public transport options to **reduce the cost of travel**, and health professionals working in remote and rural communities must themselves travel to receive private healthcare:

"Travel is big factor as nearest services 1 1/2 hours away, aging population, [high] workload for solo GP, [long] waiting list for specialised primary care workforce."

"Very minimal private options. I.e., If a staff member of the hospital, [they] have to travel to access private options if not wanting to be treated by colleagues."

Some participants mentioned that the **lack of accommodation** was an issue for potential staff contemplating a move to their community:

"We have thousands of people in this area living in hundreds of cars, tents and caravans on private property, not showing in the census data. Ten thousand people have been getting mail delivered, not 4,500 [Census numbers]."

"Healthcare providers are unwilling to relocate to rural areas if the pay is not enticing. Rentals are additionally hard to get and may be a barrier to anyone considering a scene change."

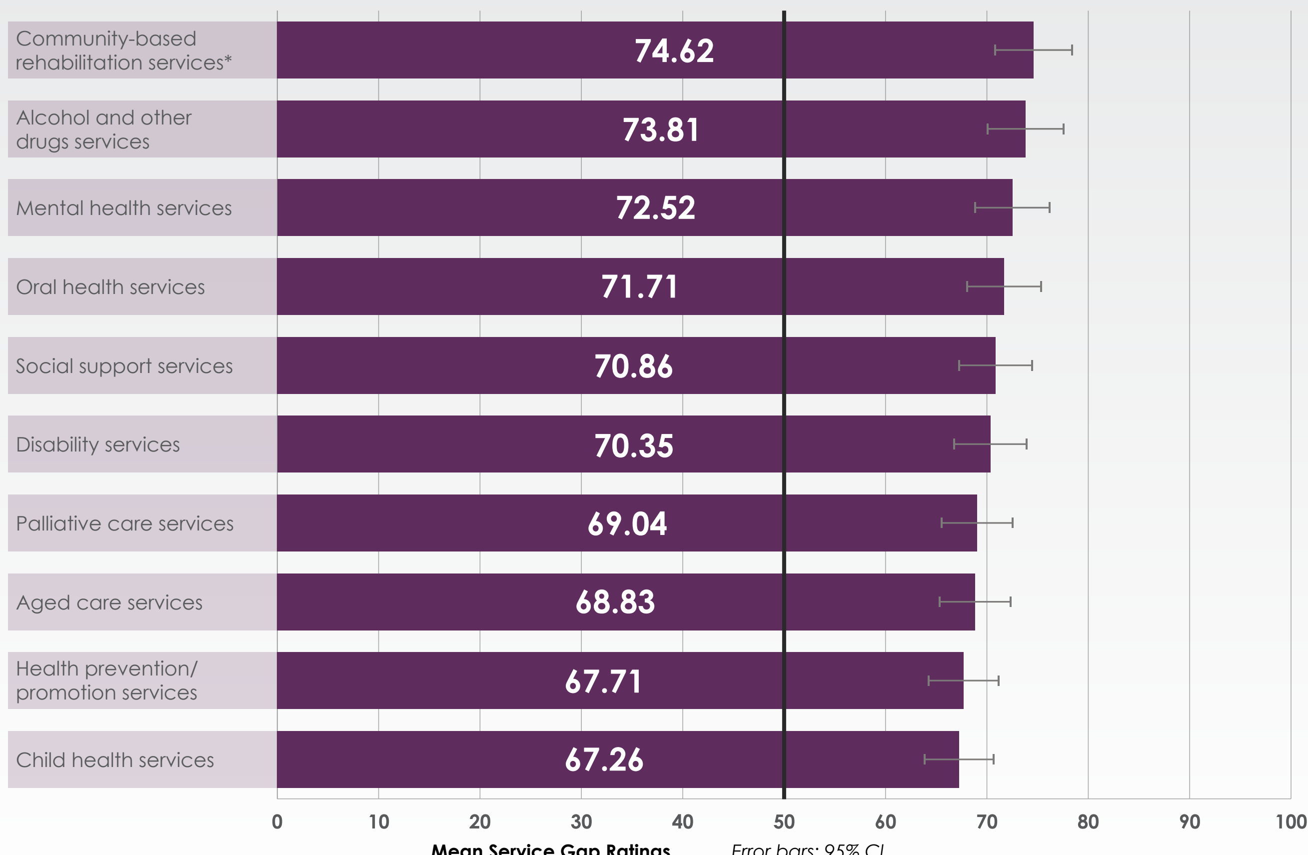
"Even if I could hire another professional there is a severe shortage of housing in XXX [Town] at present."

One participant mentioned the negative impact that post-Covid flight disruptions had on fly-in, fly-out (FIFO) staff members:

"The airlines are unreliable, this alone has been a reason some colleagues have had to quit because too many cancelled and delayed flights were too disruptive to FIFO persons home schedule."

Service Gap Ratings

The 'Top 10' primary care service gap ratings are presented in Figure 17.



*Note: *Community-based rehabilitation refers to physical/functional rehabilitation*

Figure 17: Top 10 service gap rating means 2024

The highest service gap rating means were for community-based rehabilitation services (*M* = 74.6), alcohol and other drugs services (*M* = 73.8), mental health services (*M* = 72.5), oral health services (*M* = 71.7), and social support services (*M* = 70.9). The top six service gap means were all higher than 70 points and all other primary care service gaps means were above 67 points.

Five-year trend data from 2020–2024 has been provided in Table 8, along with the remain service gap means.

Table 8: Service gap rating means for 2020-2024

Type of service	*2020 M*	*2021 M*	*2022 M*	*2023 M*	***2024 M***
Community-based rehabilitation services	68.56	69.99	74.70	75.29	**74.62**
Alcohol and other drugs services	68.20	67.38	73.18	73.10	**73.81**
Mental health services	69.72	73.34	80.71	81.35	**72.52**
Oral health services	58.37	61.61	61.70	66.56	**71.71**
Social support services	60.45	62.66	68.25	69.61	**70.86**
Disability services	61.33	62.33	64.26	65.84	**70.35**
Palliative care services	58.80	61.41	63.12	67.40	**69.04**
Aged care services	60.51	61.13	66.76	71.22	**68.83**
Health prevention/promotion services	57.38	62.16	64.59	68.52	**67.71**
Child health services	56.04	56.87	63.29	65.99	**67.26**
Maternal health services	49.68	52.66	54.85	60.48	**65.41**
Refugee and immigrant health services	57.82	60.19	61.79	63.65	**61.78**
Aboriginal and Torres Strait Islander health services	50.47	51.95	59.27	60.63	**60.71**

In 2024, there were eight service gap rating means that increased and five service gap rating means that decreased relative to the 2023 HWNA report. The most notable increases observed across 2023 to 2024 were for oral health services and maternal health services, each with an increase of approximately five points, and disability services, with an increase of over four points. Palliative care increased nearly two points, and both social support and child health services increased approximately one point relative to last year. Aboriginal and Torres Strait Islander health remained relatively constant. The most notable mean decrease was observed for mental health services (*M* = 72.5) with a decrease approaching nine points. Aged care, refugee and immigrant health, and health prevention/promotion services all experienced mean decreases ranging from one to two points. The top service gap, community-based rehabilitation services, experience a slight decrease (0.7) relative to last year's HWNA report.

For the past five years, the top five service gap rankings have been relatively consistent. Like previous years, the top five service gap rankings for 2024 comprised community-based rehabilitation (ranked 1), alcohol and other drugs services (ranked 2), mental health (ranked 3), and social support (ranked 5) services. However, this year oral health services ranked fourth making its debut within the top five. Figure 18 below depicts the service gap rating means for this year's top five rated service gaps over the past five years. The service gap rating means for all five service disciplines have increased between 2020 and 2024. Aside from mental health services' notable nine-point decrease, and oral health services top five debut (displacing aged care services from its top five position).

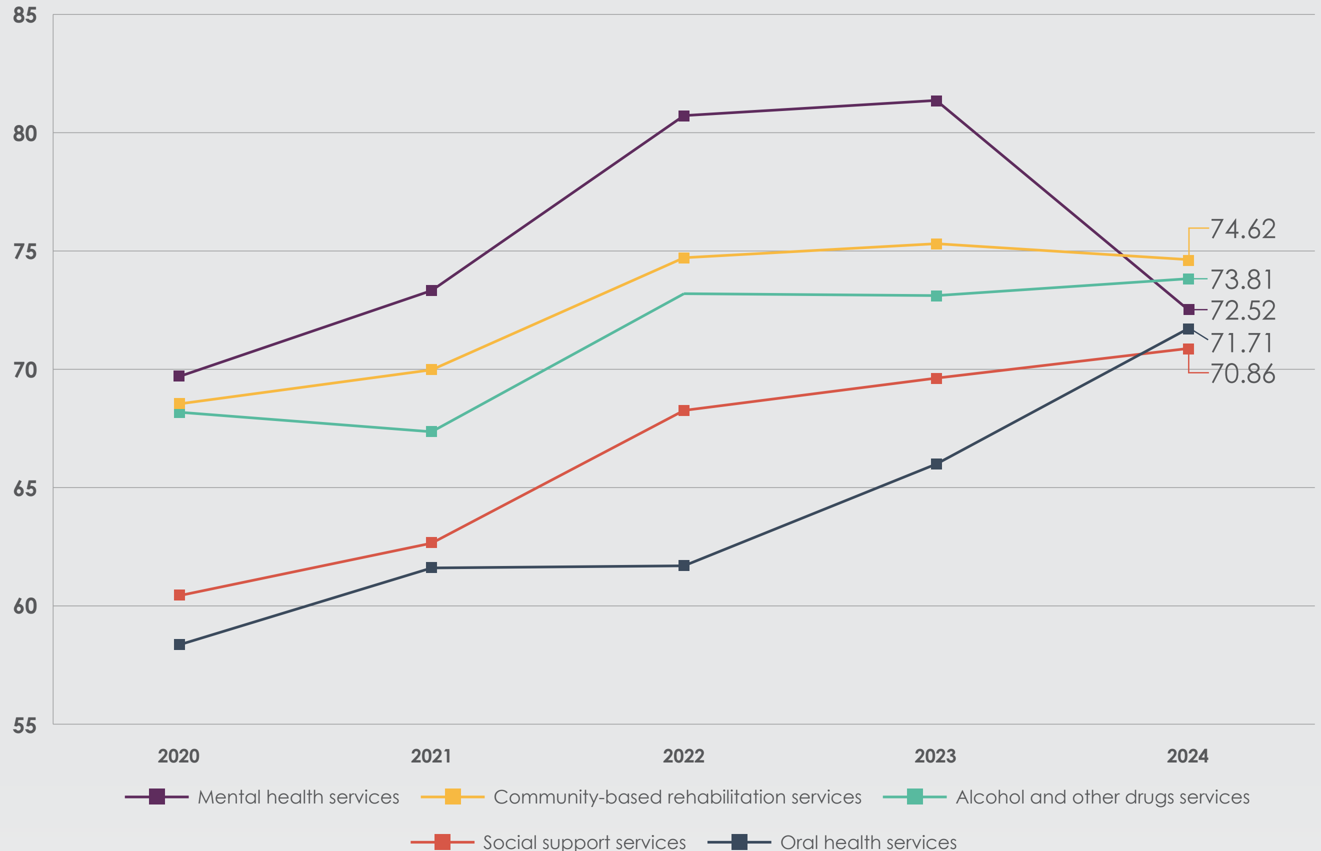


Figure 18: Five highest service gap rating means 2020–2024

Service Gap Comments

There were 100 participants that provided comments on the service gap rating questions. A thematic analysis revealed that the most frequently mentioned gaps were services for mental health, alcohol and other drugs, allied health, palliative care, aged care, disability services, child health and maternal and women's health. The three main themes identified were:

1. Access to and cost of services (*n* = 24)

2. Lack of services (*n* = 23)

3. Difficulty in accessing mental health services (*n* = 20)

1. Access to services

Several participants emphasised that limited access to primary care services posed a significant constraint on effective service provision and uptake within their communities. Barriers to access included **long distances** to travel, **affordability**, **referral pathways** and **limited transport options**. **Mental health**, **allied health**, and **palliative care** services were most frequently mentioned in participant comments regarding access issues:

"Community based palliative care is an issue in rural and remote areas. The service that is currently funded to deliver this across the state does not provide service 50 km outside of regional setting."

"If Rural Allied Health Practitioners can make referrals to orthopaedic surgeons and bulk bill all investigations for MSK [musculoskeletal health] concerns, this will assist and alleviate the load on GP's and enhance recovery timelines for patients."

Participants also mentioned that **service costs** were often a **barrier** for patients rather than workforce availability, for example:

"Access to private services and access to these services without a copayment or private fees means significant barriers to access for people without financial means to pay or private health insurance to assist with costs."

2. Lack of services

Participants highlighted issues with both public and private sectors, and several comments stated that there was either '**no service**' or '**very strained services**' and at times it was '**dangerous**' because of restrictive criteria for admitting patients:

"Palliative care: there is not a private respite service in XXX* [MM 2] *nor a full-time pall care physician, I admit my own pallcare patients to the Mater if they have private health but this is difficult for VAD* [voluntary assisted dying] *patients at a Catholic Hospital and for those that do not have private health there are few beds and few physicians."

"There is a very strained ATODS* [alcohol, tobacco and other drugs service] *with few private beds for admissions for alcohol detox etc."

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

"[Lack of] Dentists. How are we supposed to prevent infections including RHD* [rheumatic heart disease] *if we never see a dentist in community. There is no closing the GAP in life expectancy if we do not do the basics."

"Health promotion and prevention funding has been reduced significantly in the last 10 years. NGO/Primary Health Care orgs used to be able to provide education sessions to school children about sugar in soft drinks, healthy eating advice, 'cough breath blow' to reduce Otitis Media, 'Mr Germs' to increase hygiene etc. All funding is moving to fee for service and must require an individual referral to see an AH* [allied health] *professional. When literacy and health literacy is so low in rural and remote communities, health education is key to increase participation in the health care system. More funding is required in the health promotion space. The gaps that are occurring across disability, aged care and Aboriginal and Torres Strait Islander health are due to vacancies and not due to decreased funding."

In **Aboriginal and/or Torres Strait** Islander communities, comments consistently highlighted the inadequacy of existing services in meeting the needs of the community:

"More mental health services, preventative services and oral health services need to be provided to Aboriginal and Torres Strait Islander people."

Some participants noted a shortage of services and staff in **child, maternal, and women's health,** posing a considerable challenge to the effective provision of essential care:

"There is a need to have central health planning and provision of services. For example I have skills in Obstetrics and Gynaecology but is not used for the benefit of the community."

"No birthing services due to GPO* [general practitioner obstetricians] *shortage."

Some comments highlighted challenges in **palliative, aged care, and disability services,** citing limited availability, inadequate care, and a shortage of staff:

"Aged care services are generally underwhelming with no assisted living options people have to leave community when they reach high care needs. It seems the only help is a daily meal. There isn't staff for cleaning help. NDIS is similar - there are no services or staff to assist with home help or activities - they mostly only get items for ADLs* [activities of daily living] *like shower chairs and wheelchairs."

3. Mental Health Services

The third theme was **difficulty in accessing mental health services.** Many participants mentioned the difficulty in finding psychologists and/or psychiatrists, with some specific mentions of affordable services:

"Serious gap for those with chronic or even medium term mental health challenges - lots of services do not provide for those deemed 'chronic' and Medicare provides very limited psychology support for anyone who needs regular help."

Issue in Focus: Team-based primary healthcare

The *Issue in Focus* for this year was Team-based primary healthcare. In December 2022, the Australian Government released the *'Strengthening Medicare Taskforce Report'*, which outlined a vision of team-based primary healthcare in which:

'... coordinated multidisciplinary teams of health care professionals work to their full scope of practice to provide quality person-centred continuity of care, including prevention and early intervention; and primary care is incentivised to improve population health, work with other parts of the health and care systems, under appropriate clinical governance, to reduce fragmentation and duplication and deliver better health outcomes.'

Participants were asked:
'To what extent are you and/or your service currently involved in providing this type of team-based primary care?'

Response options were, '*Never*', '*Sometimes*', '*About half the time*', '*Most of the time*', or '*Always*'. Responses were received from 870 participants and results are presented in Table 9.

Table 9: Team-based primary care response option frequencies and proportions

Response Option	N	%
Never	60	6.90
Sometimes	235	27.01
About half of the time	138	15.86
Most of the time	276	31.72
Always	161	18.51
Total	**870**	**100.00**

Missing = 105

Approximately 34 percent of participants selected the '*never*' or '*sometimes*' option and slightly more than 50 percent indicated that they provided this type of team-based primary healthcare either '*most of the time*' or '*always*'.

There were several questions to gauge the perceptions of participants regarding potential barriers to practicing team-based primary healthcare. Survey participants were provided a list of 16 factors (e.g., funding, staff willingness, time) across two domains (operational factors and management and staff factors). The factors are provided below against each domain:

Operational Factors

- Funding to support a multidisciplinary workforce/team
- Finding the workforce
- Physical infrastructure
- Information technology
- Regular multidisciplinary team meetings
- Support from clients/patients for a team-based approach
- Collaboration between private primary care services
- Collaboration across private and public service
- Sharing client/patient information with other service

Management and Staff Factors

- Staff willingness to embrace a team-based approach
- Staff capability (skill) to work to full scope of practice
- Staff confidence to work to full scope of practice
- Management support for staff to work full scope of practice
- Management encouragement for staff to work full scope of practice
- Time for team-based engagement/ activities
- Client/patient engagement to support team-based primary care

Participants were asked to rate how difficult it would be to address each factor on a scale ranging from '*0 = Not at all difficult*' to '*100 = Extremely difficult*'. Team-based primary healthcare operational factors and management and staff factors means are provided in Figure 19 and 20.

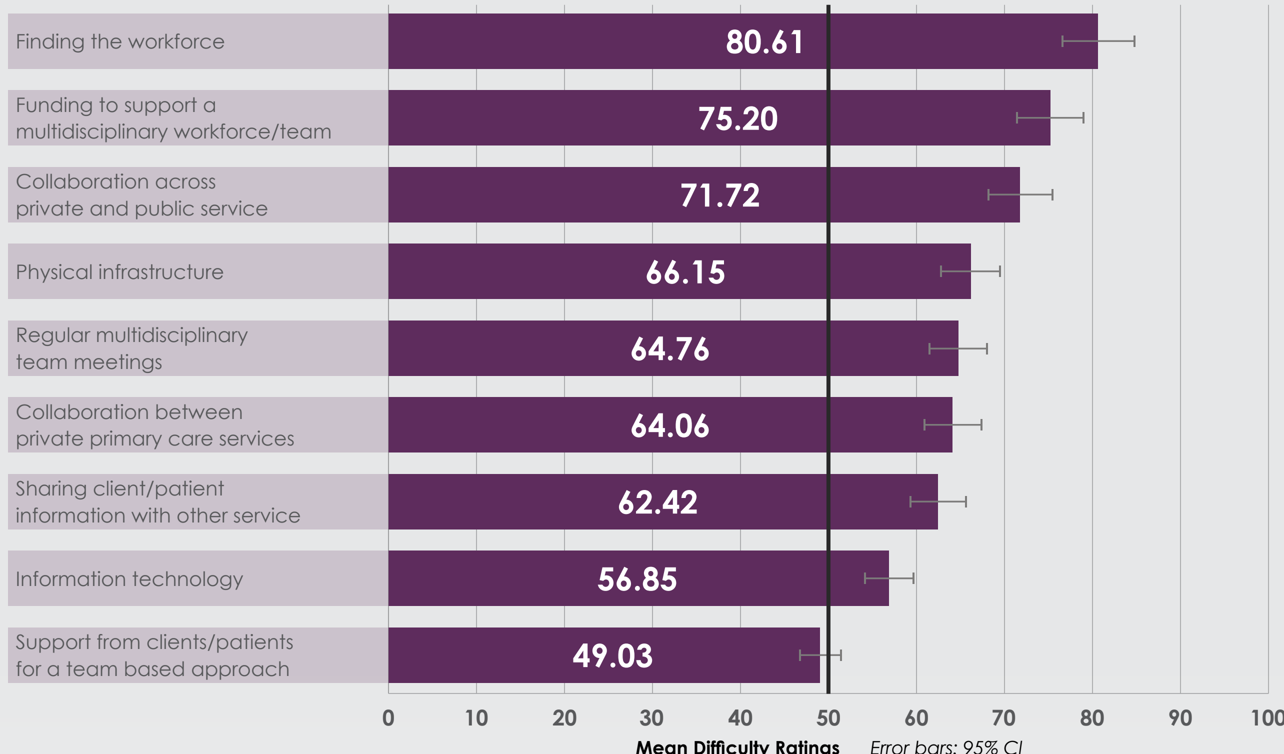


Figure 19: Team-based primary healthcare operational factor means

Finding the workforce (M = 80.6) was the highest rated factor and the only operational factor with a mean over 80 points. This was followed by *funding to support a multidisciplinary workforce/team* (M = 75.2) and *collaboration across private and public service* (M = 71.7). Mean scores for *physical infrastructure, regular multidisciplinary team meetings, collaboration between private primary care services*, and *sharing client/patient information with other services* ranged from 62.4 to 66.2 points. The two operational factors with the lowest mean scores were *information technology* (M = 56.9), and *support from clients/patients for a team-based approach* (M = 49.0).

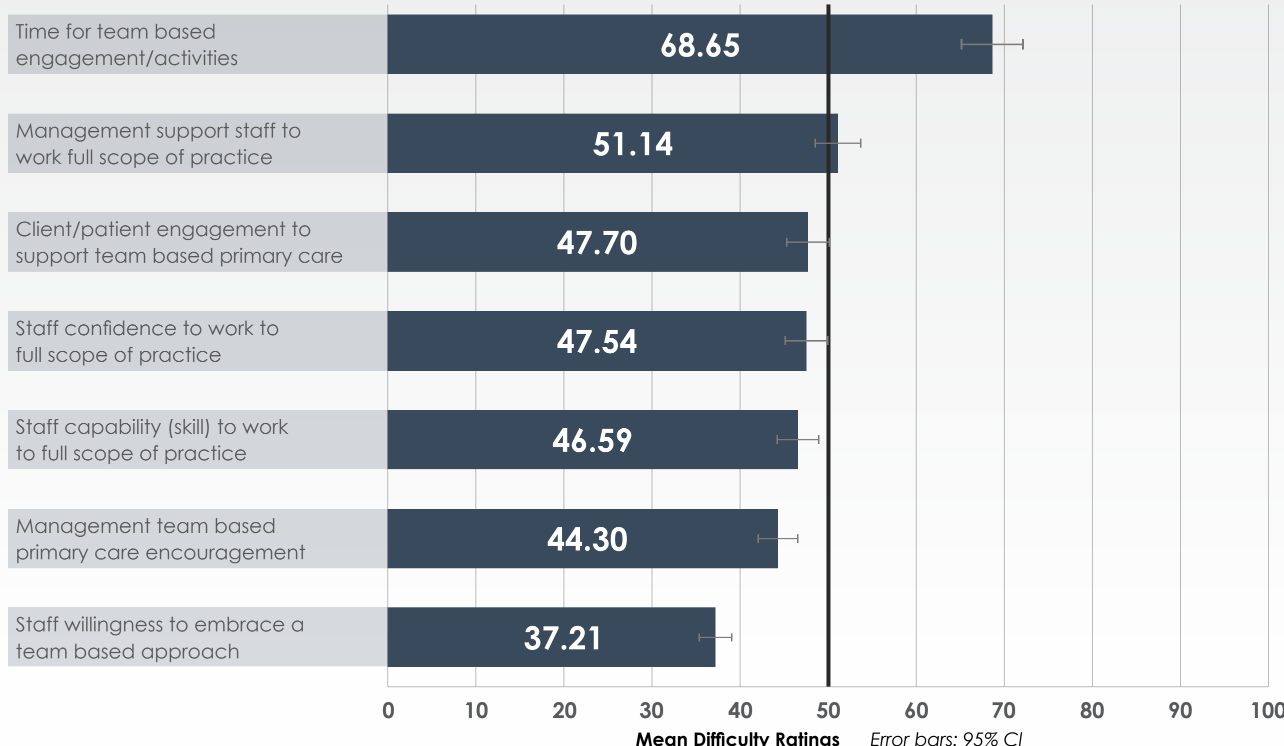


Figure 20: Team-based primary healthcare management and staff factor means

Time for team-based engagement/activities (*M* = 68.7) was the largest management and staff factor with a mean 17 points higher than *management support for staff to work full scope of practice* (*M* = 51.1). Mean scores for *management encouragement for staff to work full scope of practice, client/patient engagement to support team-based primary care, staff capability (skill) to work to full scope of practice*, and *staff confidence to work to full scope of practice ranged* from 44.3 to 47.7. The management and staff factor with the lowest mean was *staff willingness to embrace a team-based approach* (*M* = 37.2).

Team-based primary healthcare Comments

After the rating questions for team-based primary care, survey participants were asked to outline what they believed was the most **essential factor(s)** to successfully enable implementation of this type of team-based primary healthcare approach with their service/community. Comments were received from 564 participants. A thematic analysis was undertaken and several main themes were identified:

1. Funding and incentives (*n* = 218)
2. Implementation concerns (*n* = 176)
3. Communication and collaboration (*n* = 160)
4. Workforce (*n* = 160)

1. Funding and incentives

Comments classified in the funding and incentives theme revolved around **Medicare payment changes** that would make team-based primary healthcare sustainable for private providers (*n* = 147). There were special mentions of the need for **increased GP payments** to cover team meetings and the inclusion of **extra Medicare items** to cover costs for nurse and AHP involvement in providing team-based care. Other participants (*n* = 32) looked at the same aspect but from the view of requiring adequate **remuneration** to cover financial losses in the reduced time available for treating patients because of the need to attend team meetings and planning. Several practice managers indicated that funding for practices should also be a priority if less income was coming in from GPs. For a small number of participants (*n* = 9) there was concern that team-based care would involve extra costs for patients that would impact uptake of treatment options:

"I minimise Medicare team care referrals as I lose money on them and only do it for community engagement. The GP TCA or MHP rules require at least 2 reports /letters to be sent to referrers BUT THESE ARE NOT FUNDED and hence this requirement removes any profitability to zero and reduces any incentive to take on Medicare referrals from GP's or Specialists. Medicare required reporting costs are difficult to pass on to patients as Medicare rebates for Allied Health are highly insufficient already and if passed on as a gap fee, patients will not use Medicare rebates as costs them more to pay for required reporting and then the whole team care goes out the window - there is no team."

"Need much more finance to employ more staff to be able to do this type of team-based primary care work. Finding the staff **[would be]** ***difficult I expect as well. Untrained NDIS staff get more money as do hospital staff then what a GP can pay under current funding."***

"That GPs aren't the lead or main revenue generator. I think the reliance on the GP to lead is a big barrier. GPs have an expectation to be well compensated for activities like team care which is at a detriment to other providers. I believe we need nurses to be the leads as they are typically better at coordinating care, liaising and bringing groups together. The issue is the funding is attached to a GP and I think this needs to change."

2. Implementation concerns

Implementation concerns were spread over several different sub-themes. Most comments (*n* = 73) were about the **time required** to implement team-based primary healthcare, more specifically finding the time for regular team meetings. This was followed by implementation concerns about **infrastructure and resources** (*n* = 51), **awareness, education and training** for practitioners/managers/clients (*n* = 49), and the perceived problem of **adopting** the team-based care model and involving practitioners in an engaged way (*n* = 36).

"TIME [is an issue]. The hour or two a week that are required from all members of the Team, simply don't exist when everyone is working overtime all the time just to provide services."

"Successful team-based models of primary care require a combination of interprofessional education and learning; organisational and management policies and systems; and practice support systems."

"Understanding the benefits, the 'why', and making the why provide a better experience and at least not a reduction in renumeration."

3. Communication and collaboration

The most frequently mentioned communication and collaboration comments were the difficulty of organising **teams** to work together, and **alignment of goals** between private providers or between private and public health services (*n* = 56). Other respondents mentioned **engaging and motivating** staff members to participate in team-based primary care (*n* = 44), difficulties in **sharing information** across services (*n* = 20), and concerns about formulating **collaborative interdisciplinary** relationships (*n* = 20).

"Education of health professionals to truly understand interprofessional collaborative practice; and a cultural shift for clinicians to work outside of their silos."

"Convincing specialist GPs like me that a team-based approach would deliver better patient focused care than a GP Leader/GP employee team can."

"Collaboration between the public and private sectors which is the lowest now than it has ever been in my opinion. Since things like aged care and disability have become more privatised, the gap between government services and community or private services working together is widening. There is almost no engagement between QLD Govt and community providers now due to reported privacy and regulatory conflicts, and financial/funding conflicts. It has significantly impacted on the quality of client and patient care."

"[We need] ***increased engagement from local GPs. We are continually trying to organise utilisation of case conferencing for collaboration and consistently receive feedback that GPs don't have time for this, despite there being a line item for this."***

4. Workforce

Workforce theme comments echoed some of the concerns expressed in earlier sections of this report in terms of a difficulty in finding a sufficient **number** of skilled practitioners (*n* = 108). Other comments highlighted ongoing problems for the community to **attract and retain** staff members (*n* = 25). Many comments in this section specifically mentioned ongoing issues in attracting GPs and AHPs:

"[We need] ***funding models to appropriately support all members of the team. GPs need to be the centre of the team-based care models and for them to be able to do this, funding and time are the biggest barriers. Due to the workforce shortages of the different team members, it is also hard to undertake team-based care, especially with private providers. In my community quite a few Allied Health professionals only do NDIS clients, limiting their availability for the rest of the population."***

Quantitative Methodology Findings: Priority SA2s

Below are the top ranked SA2s by PHN region based on the quantitative methodology described on page five of this report. The methodology incorporates; GP FTE to population ratio, MM classification of remoteness, Socio-Economic Indexes for Areas [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. Newly featured priority SA2 regions have been highlighted in bold. Appendix A outlines the main towns or communities located within each SA2.

Central QLD, Wide Bay, Sunshine Coast PHN Region

Kilkivan
Burrum - Fraser
Bundaberg Surrounds - North
Maryborough Surrounds - South
Monto - Eidsvold
Gin Gin
Agnes Water - Miriam Vale
Cooloola
Central Highlands - East
Gayndah - Mundubbera

Darling Downs & West Moreton PHN Region

Miles - Wandoan
Chinchilla
Esk
Tara
Kingaroy Surrounds - North
Southern Downs - West
Millmerran
Southern Downs - East
Inglewood - Waggamba
Crows Nest - Rosalie

Northern Queensland PHN Region

Croydon - Etheridge
Tablelands
Northern Peninsula
Kowanyama - Pormpuraaw
Tully
Torres Strait Islands
Herberton
Burdekin
Babinda
Aurukun

Western Queensland PHN Region

Far Central West
Mount Isa Surrounds
Far South West
Carpentaria
Balonne

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

Key Issues and Strategies

ACCESS Improving access and continuity of access to essential primary healthcare	
KEY ISSUES	• Shortages of GP, nursing, midwifery, allied health, and Aboriginal and Torres Strait Islander health worker/practitioner workforce in remote and rural Queensland • Inequitable distribution of health workforce • Lack of or inadequate infrastructure (ICT, physical) • Insufficient funding for workforce and services in priority locations • Long distances to travel to access services/lack of locally available services • Lack of affordable and appropriate transport to access services • Lack of suitable housing for health professionals • Limited/lack of services available after hours • Cost of services/lack of bulk billing services impacting on populations of lower socio-economic status • Lack of culturally safe health service options in some rural communities • Health literacy around health service access and availability
STRATEGIES	• Employ targeted recruitment support and retention packages to priority communities, including locums • Continue to build evidence through collation of workforce data to inform workforce planning • Assist health professionals with relocation grants and incentives • Utilise fly-in, fly-out employment options to support and supplement the local workforce • Support clinical and leadership development • Promote the increased use of virtual and digital tools including telehealth • Streamline processes for patients to access transport subsidies • Develop innovative workforce models to support community need and increase workforce capacity • Ongoing workplace cultural training and embedding culturally responsive practices to support culturally responsive services • Encourage interprofessional collaboration and communication • Advocate for further policies and activities to attract health professionals to remote and rural areas
DESIRED OUTCOMES	• Increased supply of primary care workforce to priority areas • Improved availability of appropriate infrastructure to support health service requirements and multidisciplinary team-based care • Increased utilisation for virtual and digital tools to support health service delivery • Increased availability of affordable and appropriate transport to access health services • Increased availability of appropriate housing for health professionals • Increases in technology and financial supports for health professionals • Greater understanding of services and access to affordable primary care within communities

Key Issues and Strategies Continued

QUALITY **Building workforce capacity**	
KEY ISSUES	• Skill mix of workforce not aligned to local needs • Lack of experienced, long stay workforce • Care is episodic rather than comprehensive, continuous and person-centred • Workforce not equipped to deliver culturally appropriate healthcare • Low representation of First Nations people delivering healthcare • Clinicians feel isolated and have limited support for decision making • 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 • Inefficient and fragmented care due to workforce instability • Lack of mentoring and leadership opportunities • Barriers to expanding or utilising full scope of practice • Workforce data and patient information is siloed
STRATEGIES	• Support to commence vocational training in health-related studies, close to home • Organisational support to access continuing professional development • Provision of scholarships and bursaries to support upskilling aligned to community need • Organisational support for staff to undertake leadership training at all levels • Encourage activities that support role development and enhancing scope of practice for all professions • Utilise existing levers to enhance scope of practice. E.g. Extended Practice Authority for Registered Nurses as part of The Queensland Medicines and Poisons Legislation • Support commissioning of providers that embed cultural, clinical, and organisational orientation and training in their organisations to support transitions to rural practice • Support succession planning to ensure a continuous pipeline of strong clinical and administrative leaders • Increase workforce capacity through workforce redesign to deliver quality multidisciplinary care • Strengthen the First Nations health workforce training pipeline to support culturally responsive health service delivery to First Nations people • Better utilisation of the Aboriginal and Torres Strait Islander Health Practitioner role including its role in delivering services to complement activities undertaken by Indigenous Health Workers • Shared patient records across organisations to support quality care
DESIRED OUTCOMES	• An experienced and capable workforce that is responsive to local needs • Increased availability and continuity of quality primary healthcare 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 healthcare • A greater cohort of clinical and administrative leaders in remote and rural communities • Workforce data is accessible and supports workforce planning at the local level • Patient information is accessible across organisations to support quality care

Key Issues and Strategies Continued

SUSTAINABILITY

Growing the sustainability of the health workforce

KEY ISSUES

- Ongoing challenges for recruiting and retaining health workforce
- High turnover of health professionals in remote and rural communities
- Limited pipeline of locally trained workforce
- Decline in interest in rural health, general practice and primary care as career choices
- Lack of accommodation and financial support for students doing rural and remote placements
- Lack of end-to-end training in remote and rural communities, preventing the development of required community-based skills
- 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 prioritise long term student placements supported with appropriate accommodation facilities and financial support whilst on placement including subsidised or free accommodation for students undertaking placement in a remote or rural location
- Availability of end-to-end training in regional and remote sites, for all professions
- Collaborate at the local level to support essential worker accommodation solutions
- Support connector roles to promote better system integration, coordination and collaboration
- Investigate blended funding workforce models to support financial viability and skills retention
- Work within priority communities to assess and develop innovative workforce models that expand scope of practice and that consider emerging health workforce roles
- Family support opportunities including schooling and childcare for children, employment opportunities for partners
- Prioritise collaborative, place-based workforce and service planning with communities in order to meet community need
- Invest in growing the local First Nations health workforce in remote and rural communities to meet legislated workforce targets utilising grow your own strategies
- 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

Stakeholder List

Below is a list of stakeholders we have engaged with throughout the year through face-to-face meetings, forums and teleconferences to discuss key workforce issues in Queensland locally and state-wide:

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

Acknowledgments

HWQ would like to thank the above organisations and the many primary healthcare practices across remote and rural Queensland who contributed to this report.

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Appendix A – Priority SA2s by PHN Region

Central QLD, Wide Bay, Sunshine Coast PHN Region		
Rank	**SA2**	**Towns/Communities within SA2**
1	Kilkivan	Goomeri Kilkivan
2	Burrum - Fraser	Aldershot Burrum Heads Toogoom Walligan
3	Bundaberg Surrounds - North	Bucca Yandaran
4	Maryborough Surrounds - South	Brooweena Mungar Tiaro
5	Monto - Eidsvold	Eidsvold Monto Mulgildie Mount Perry
6	Gin Gin	Gin Gin
7	Agnes Water - Miriam Vale	Agnes Water Miriam Vale Seventeen Seventy
8	Cooloola	Cooloola Rainbow Beach Tin Can Bay
9	Central Highlands - East	Blackwater Dingo Woorabinda
10	Gayndah - Mundubbera	Biggenden Gayndah Mundubbera

Appendix A – Priority SA2s by PHN Region Continued

Darling Downs and West Moreton PHN Region		
Rank	**SA2**	**Towns/Communities within SA2**
1	Miles - Wandoan	Miles Wandoan
2	Chinchilla	Chinchilla
3	Esk	Esk Toogoolawah
4	Tara	Glenmorgan Meandarra Moonie Tara
5	Kingaroy Surrounds - North	Cherbourg Murgon Proston Wondai
6	Southern Downs - West	Allora Victoria Hill
7	Millmerran	Cecil Plains Millmerran
8	Southern Downs - East	Emu Vale Killarney Maryvale Swanfels
9	Inglewood - Waggamba	Inglewood Texas
10	Crows Nest - Rosalie	Crows Nest Goombungee Yarraman

Appendix A – Priority SA2s by PHN Region Continued

Northern Queensland PHN Region		
Rank	**SA2**	**Towns/Communities within SA2**
1	Croydon - Etheridge	Croydon Georgetown Forsayth
2	Tablelands	Almaden Dimbulah Mount Malloy
3	Northern Peninsula	Bamaga New Mapoon Injinoo
4	Kowanyama - Pormpuraaw	Kowanyama Pormpuraaw
5	Tully	Cardwell Tully
6	Torres Strait Islands	Badu Island Boigu Island Mabuiag Island Saibai Island
7	Herberton	Herberton Mount Garnett Ravenshoe
8	Burdekin	Brandon Home Hill
9	Babinda	Babinda Bramston Beach
10	Aurukun	Aurukun

Appendix A – Priority SA2s by PHN Region Continued

Western Queensland PHN Region		
Rank	**SA2**	**Towns/Communities within SA2**
1	Far Central West	Bedourie Birdsville Boulia Jundah Windorah Winton
2	Mount Isa Surrounds *(not including Mount Isa)*	Camooweal Cloncurry Dajarra
3	Far South West	Cunnamulla Thargomindah Quilpie
4	Carpentaria	Burketown Carpentaria Mornington Island Normanton Karumba
5	Balonne	Dirranbandi Mungindi St George Thallon

Appendix B – Professions & Occupations

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

Acronyms and Abbreviations

ABS	Australian Bureau of Statistics
ACA	Australian Counselling Association
ACCHS	Aboriginal Community Controlled Health Service
ACHSWE	Australian Council of Heads of Social Work Education
ACRRM	Australian College of Rural and Remote Medicine
AHA	Allied Health Assistant
AHP	Allied Health Professional
Ahpra	Australian Health Practitioner Regulation Agency
AMC	Australian Medical College
CPD	Continuing Professional Development
DHAC	Department of Health and Aged Care
DPA	Distribution Priority Area
EM	Enrolled Midwife
EN	Enrolled Nurse
FIFO	Fly in fly out
FTE	Full Time Equivalent
GP	General Practitioner
HHS	Hospital and Health Service
HWNA	Health Workforce Needs Assessment
HWSG	Health Workforce Stakeholder Group
IMG	International Medical Graduate
IRSAD	Index of Relative Socio-economic Advantage and Disadvantage

Acronyms and Abbreviations Continued

MBS	Medicare Benefits Scheme
MDS	Minimum Data Set
MM	Modified Monash
NDIS	National Disability Insurance Scheme
NHWDS	National Health Workforce Data Set
NP	Nurse Practitioner
NRGP	National Rural Generalist Pathway
ONRHC	Office of the National Rural Health Commissioner
PBS	Pharmaceutical Benefits Scheme
PHN	Primary Health Network
PIP	Practice Incentives Program
RACGP	Royal Australian College of General Practitioners
RAI	Regional Australia Institute
RAN	Remote Area Nurse
RFDS	Royal Flying Doctor Service
RN	Registered Nurse
SA2	Statistical Area Level 2
SARRAH	Services for Rural and Remote Allied Health
SEIFA	Socio-Economic Indexes for Areas
SEM	Single Employer Model
WIP	Workforce Incentives Program

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