Health Workforce Queensland

Health Workforce Needs Assessment Summary Report

Western Queensland Region

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Authors

David Wellman

Christian Hughes

Our Vision

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

Our Purpose

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

Our Values

Our Values are Integrity, Commitment and Equity.

Integrity

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

Commitment

We enhance health services in rural and remote Queensland communities.

Equity

We provide equal access to services based on prioritised need.

Acknowledgements

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

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

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Introduction

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

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

Western Queensland Region

General Practitioner Workforce Snapshot

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

A snapshot of medical practitioners working in a general practice context was taken on the 30th of November 2021 for Health Workforce Queensland's 2021 MDS. As of the census date there were 115 medical practitioners working their primary role in the WQ region, approximately 10 fewer than was reported in the 2020 MDS. For those where date-of-birth data was available, the average age of these practitioners was 47.02 years, approximately 3 years younger than the MM 2-7 Queensland average of 49.95.

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

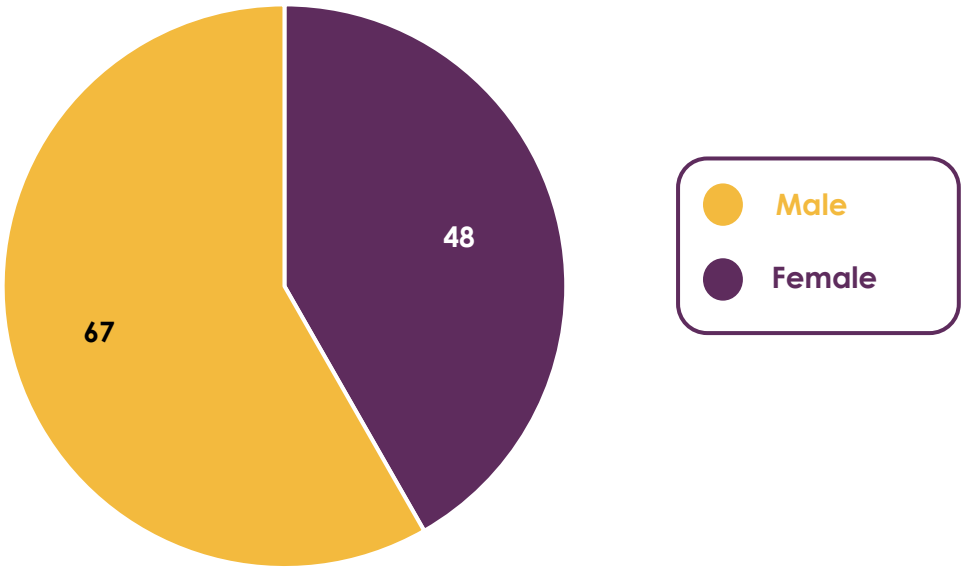

Figure 1: General practitioners in the WQ region by sex.

Approximately 42 percent of the general practitioners in the WQ region were female, slightly lower than the MM 2-7 Queensland average of 45 percent.

Country of basic medical qualification

General practitioners were grouped according to whether they received their basic medical qualification from an Australian university or from an overseas university. In the WQ region, there were 80 Australian-trained practitioners (69.6%) and 35 overseas trained practitioners (30.4%). The percentage result for the WQ region and MM 2-7 Queensland are presented in ***Figure 2***.

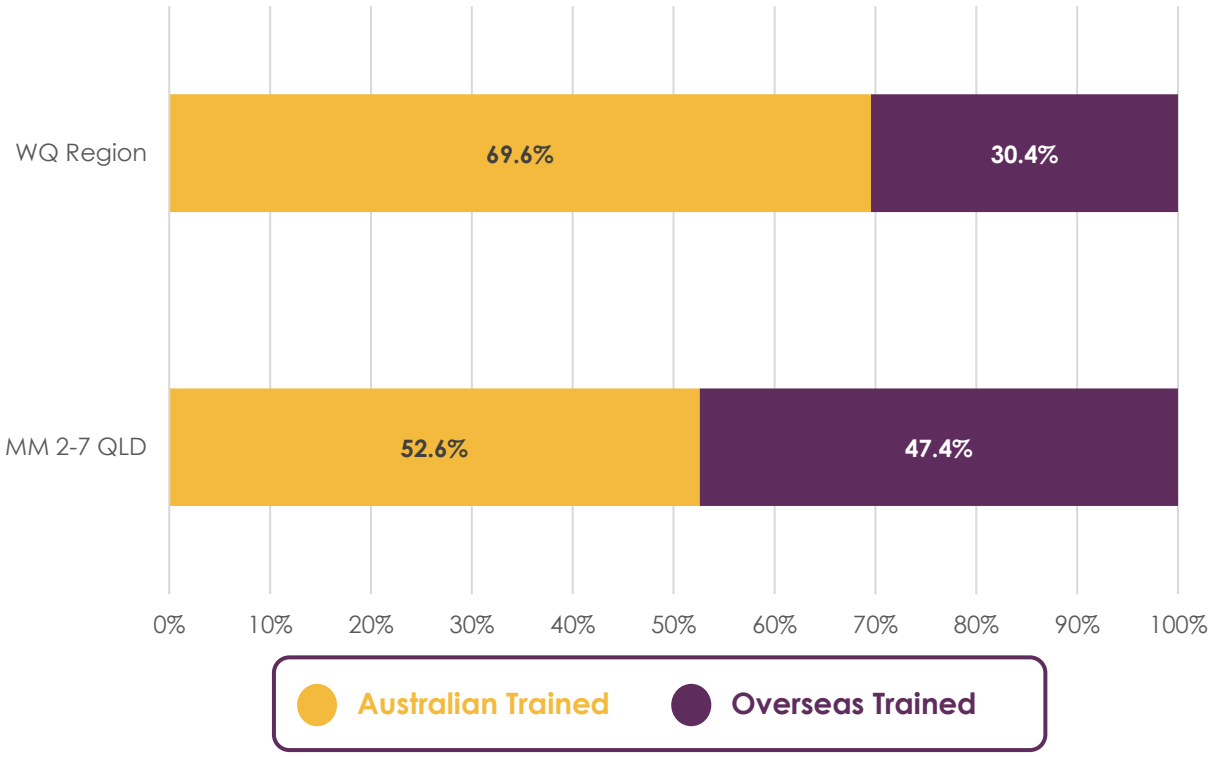

Figure 2: Percentage of general practitioners by country of basic medical qualification in the WQ region **and overall MM 2-7 Queensland.**

The WQ region had a substantially larger proportion (69.6%) of Australian-trained practitioners when compared to the MM 2-7 Queensland average (52.6%)

HWNA Survey Participants

Surveys were distributed to GPs, health service practice managers, primary health care nurses/midwives, Aboriginal and Torres Strait Islander health workers/practitioners and AHPs. The total number of participants in the WQ region was 74, which consisted of 25 general practitioners, 5 practice managers, 36 allied health practitioners/others and 8 nurses/midwives. The distribution of survey participants by employment type and **Hospital and Health Service (HHS)** area is provided in ***Table 1***.

Table 1: WQ region survey participants by employment type

Type	North West HHS *n (%)*	Central West HHS *n (%)*	South West HHS *n (%)*	*Total N (%)*
General practitioners	10 (29%)	5 (71%)	10 (30%)	25 (34%)
Practice managers	1 (3%)	0	4 (12%)	5 (7%)
Nurses / Midwives	2 (6%)	0	6 (18%)	8 (11%)
Allied health practitioners/others	21 (62%)	2 (29%)	13 (39%)	36 (48%)
Total	**34**	**7**	**33**	**74**

Workforce and Service Gaps

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

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

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

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

Type of workforce	*WQ region Total* *M (Rank)*	North West HHS M (Rank)	*Central West HHS* *M (Rank)*	South West HHS *M (Rank)*
Psychology	**79.41 (1)**	**86.24 (2)**	**66.14 (7)**	**77.46 (2)**
ATSI Health	**76.41 (2)**	**86.42 (1)**	**91.25 (1)**	**65.57 (6)**
General Practice	**75.42 (3)**	**76.75 (8)**	58.29 (11)	**79.16 (1)**
Social Work	**74.18 (4)**	**82.59 (4)**	**66.50 (6)**	**69.50 (3)**
Audiology	**70.51 (5)**	**79.73 (6)**	52.60 (13)	**68.39 (5)**
Radiography/Sonography	**69.46 (6)**	**78.93 (7)**	**82.00 (2)**	**60.76 (9)**
Podiatry	**69.38 (7)**	**76.40 (9)**	**69.14 (5)**	**64.87 (7)**
Optometry	**68.03 (8)**	**69.33 (16)**	**62.40 (8)**	**68.47 (4)**
Nursing/Midwifery	**66.42 (9)**	**73.50 (11)**	**75.17 (3)**	59.22 (11)
Occupational Therapy	**65.77 (10)**	**81.53 (5)**	54.71 (12)	58.55 (12)
Dentistry	**65.72 (11)**	**73.35 (12)**	**62.20 (9)**	**61.04 (8)**
Speech Pathology	**64.93 (12)**	**83.69 (3)**	**72.17 (4)**	50.00 (15)
Exercise Physiology	**63.18 (13)**	**73.00 (13)**	49.00 (15)	59.96 (10)
Physiotherapy	**61.55 (14)**	**72.41 (14)**	**60.43 (10)**	53.87 (13)
Nutrition/Dietetic	56.43 (15)	**70.81 (15)**	43.29 (16)	50.67 (14)
Diabetes Education	55.11 (16)	**74.06 (10)**	51.00 (14)	42.35 (17)
Pharmacy	45.73 (17)	56.77 (17)	17.50 (17)	44.46 (16)

In the WQ region there were 14 workforce gap rating means of 60 or more. The highest were for psychology, Aboriginal and Torres Strait Islander health, and general practice workforces. The only mean lower than 50 was for pharmacy workforce.

For the **North West HHS** there were 16 means higher than 60, with Aboriginal and Torres Strait Islander health, psychology, and speech pathology workforces having the highest means.

The **Central West HHS** had 10 workforce gap ratings of 60 or more and the highest rated were the Aboriginal and Torres Strait Islander health, radiography/sonography and nursing/midwifery workforces.

In contrast, the **South West HHS** had only 9 means of 60 or more, with the highest ratings for general practice, psychology, and social work workforces.

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

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

Type of service	*WQ region Total* *M (Rank)*	*North West HHS* *M (Rank)*	Central West HHS *M (Rank)*	South West HHS *M (Rank)*
Mental health	**81.35 (1)**	**89.61 (1)**	50.80 (9)	**81.55 (1)**
Community-based rehabilitation	**77.42 (2)**	**84.88 (2)**	**74.40 (2)**	**71.29 (2)**
Disability	**73.10 (3)**	**82.67 (3)**	**76.00 (1)**	**63.26 (6)**
Social support	**71.10 (4)**	**79.44 (9)**	58.25 (7)	**65.29 (5)**
Alcohol & other drugs	**70.23 (5)**	**78.57 (10)**	50.67 (10)	**70.26 (3)**
Aged care	**68.51 (6)**	**81.56 (5)**	40.00 (11)	**65.50 (4)**
Health prevention/promotion	**66.15 (7)**	**79.76 (8)**	**67.20 (3)**	53.68 (9)
ATSI health	**64.65 (8)**	**82.47 (4)**	**63.00 (6)**	48.05 (12)
Palliative care	**63.53 (9)**	**80.23 (7)**	34.20 (13)	59.61 (7)
Refugee & immigrant health	**62.69 (10)**	**80.75 (6)**	55.50 (8)	48.23 (11)
Child health	**61.65 (11)**	**78.57 (11)**	**64.40 (5)**	47.72 (13)
Oral health	**61.30 (12)**	**67.62 (13)**	**66.25 (4)**	56.20 (8)
Maternal health	57.75 (13)	**78.55 (12)**	38.25 (12)	48.88 (10)

There were twelve service gap means of 60 or more in the WQ region, with the highest being mental health, community-based rehabilitation, and disability services.

The **North West HHS** had all 13 service means over 60 and the highest were for mental health, community-based rehabilitation, and disability services.

For the **Central West HHS** there were six service gap means above 60 and the highest means were for disability, community-based rehabilitation, and health prevention/promotion services.

In the **South West HHS** there were also six means of 60 or more. The highest of these were for mental health, community-based rehabilitation and alcohol and other drug services.

Comments about workforce and service gaps were thematically analysed. There were 48 comments received concerning workforce gaps. The main workforce gap themes were centred around difficulties attracting and retaining health practitioners, GP shortages, issues with allied health practitioners and mental health services. The main workforce gap themes and issues are presented below:

Workforce and Service Gaps Qualitative Analysis

Figure 3: Workforce Gap Themes for the WQ region

There were only 14 comments received for the primary care service gap comments. The main themes were concerning general lack of primary care services locally and the absence of disability support and services:

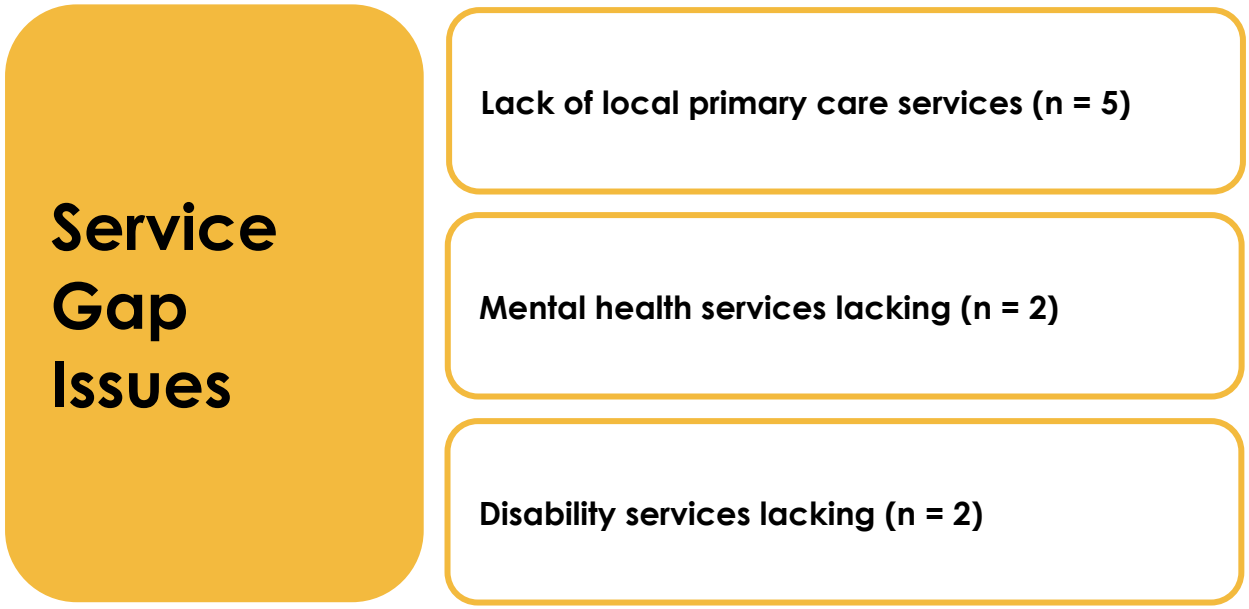

Figure 4: Service Gap Themes for the WQ region

Sustainability in Focus

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

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

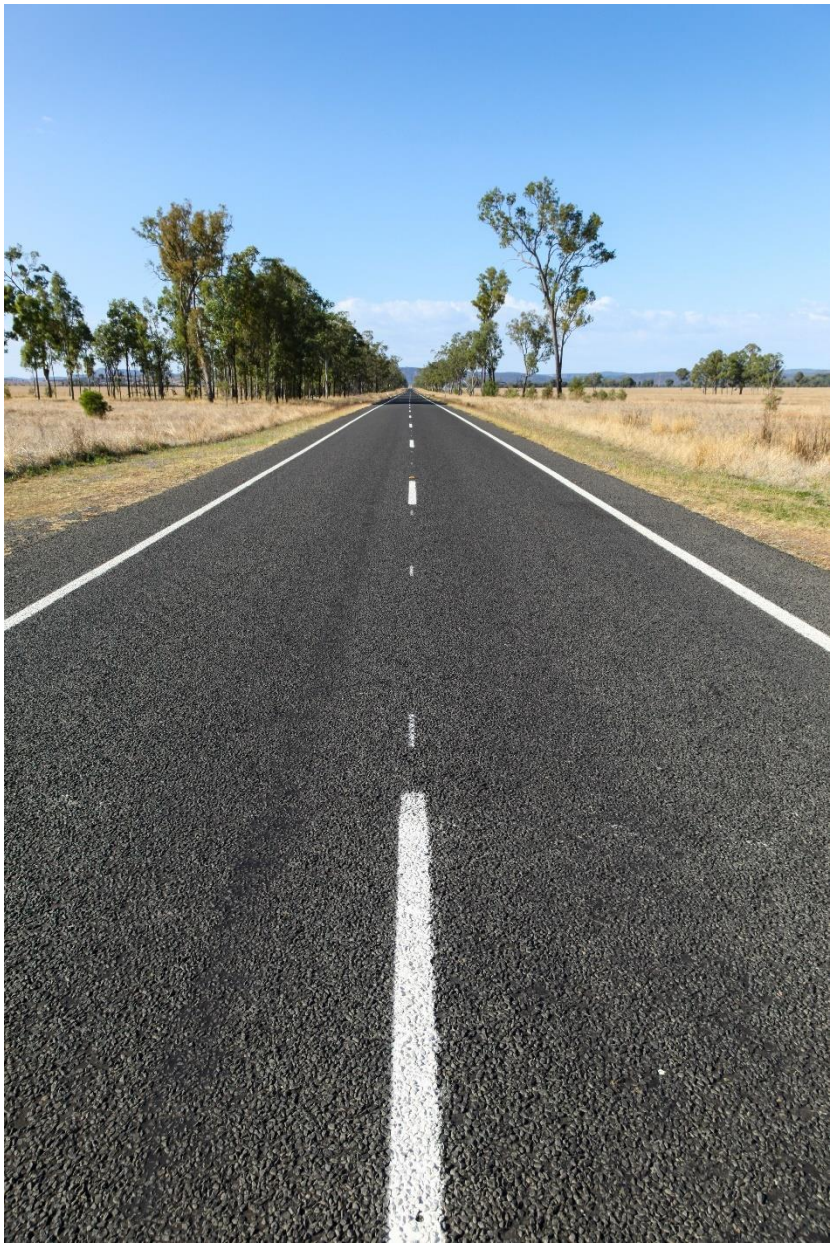

Table 4: Mean Sustainability Importance Ratings for WQ region and each HHS area

Sustainability Item	MM 2-7 QLD M (Rank)	*WQ region Total M (Rank)*	North West HHS M (Rank)	*Central West HHS M (Rank)*	South West HHS *M (Rank)*
Strategies to encourage remote and rural careers	**86.48 (2)**	**91.36 (1)**	**93.00 (1)**	**83.71 (5)**	**91.52 (1)**
Targeted infrastructure funding for staff housing/accommodation	**80.61 (7)**	**90.37 (2)**	**91.48 (3)**	**97.14 (1)**	**87.38 (3)**
Strategies to improve retention of staff (e.g., ongoing individual support)	**85.84 (3)**	**89.97 (3)**	**91.67 (2)**	**88.43 (3)**	**88.71 (2)**
Increased support for family members	78.92 (12)	**86.74 (4)**	**88.78 (4)**	**83.17 (6)**	**85.72 (5)**
Medicare/funding reform to better support remote and rural practitioners	**88.33 (1)**	**86.41 (5)**	**85.57 (10)**	**96.17 (2)**	**85.00 (7)**
Support for supervision	**80.42 (10)**	**85.95 (6)**	**87.96 (5)**	73.17 (10)	**87.00 (4)**
Development of 'Rural Generalist' models across the health care sector to work across primary and secondary care	78.40 (13)	**84.76 (7)**	**85.59 (9)**	**86.00 (4)**	**83.62 (8)**
Targeted infrastructure funding for remote/rural services	**83.26 (4)**	**84.38 (8)**	**86.46 (7)**	71.67 (11)	**85.38 (6)**
Improved access to Continuing Professional Development (CPD) for remote/rural practitioners	**80.49 (9)**	**83.32 (9)**	**86.13 (8)**	74.43 (9)	**83.14 (9)**
Information management systems that support continuity of care across public/private services	**81.18 (5)**	**82.86 (10)**	**87.58 (6)**	78.33 (7)	79.54 (11)
Better access to place-based education and training	**80.90 (6)**	**81.00 (11)**	**81.08 (13)**	76.83 (8)	**81.88 (10)**
Local cooperation for shared workforce models	**80.34 (11)**	79.09 (12)	**82.42 (12)**	65.40 (14)	78.38 (12)
Practice management support	78.21 (14)	78.80 (13)	**84.75 (11)**	61.43 (15)	77.87 (13)
Addressing pay disparities between public and private services	**80.51 (8)**	73.63 (14)	**80.00 (14)**	65.50 (13)	70.12 (14)
Improved telehealth and/or other technology to support community access.	77.81 (15)	73.27 (15)	78.81 (15)	68.83 (12)	68.70 (15)

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

Sustainability in Focus

In the WQ region, all importance rating means were higher than 73, indicating that there was agreement amongst survey participants that all of the factors were important to the sustainability and viability of their remote and rural practices.

There were 11 importance rating means higher than 80, the highest were for strategies to encourage remote and rural careers, followed by infrastructure funding for staff housing/accommodation, and strategies to improve retention of staff. The WQ region ratings were substantially different from the findings of overall MM 2-7 QLD. For example, infrastructure funding for staff housing ranked six places lower and addressing pay disparities between public and private sectors six places higher in the WQ region when compared to MM 2-7 QLD.

Results were summarised by HHS area:

- The **North West HHS** had 14, importance rating means higher than 80. Similar to the WQ region overall, the highest three ratings were for strategies to encourage remote and rural careers, strategies to improve retention of staff, and infrastructure funding for staff housing/accommodation. The **North West HHS** had the highest rating for addressing pay disparities between public and private services in the WQ region.

- In the **Central West HHS** there were six importance rating means higher than 80. The three highest ratings were for infrastructure funding for staff housing, Medicare funding reform, and strategies to improve retention of staff. At 97 points the **Central West HHS** had the highest mean importance rating for infrastructure funding for staff housing in the WQ region.

- The **South West HHS** had 10 importance rating means higher than 80. Consistent with the WQ region overall the three highest were for strategies to encourage rural and remote careers, strategies to improve retention of staff, and infrastructure funding for staff housing.

Sustainability Importance Qualitative Analysis

Participants were asked to comment on the following:

1. What would improve the sustainability of your service? (*N* = 53)
2. What needs to change to ensure primary care services in your community are sustainable into the future? (*N* = 48)

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

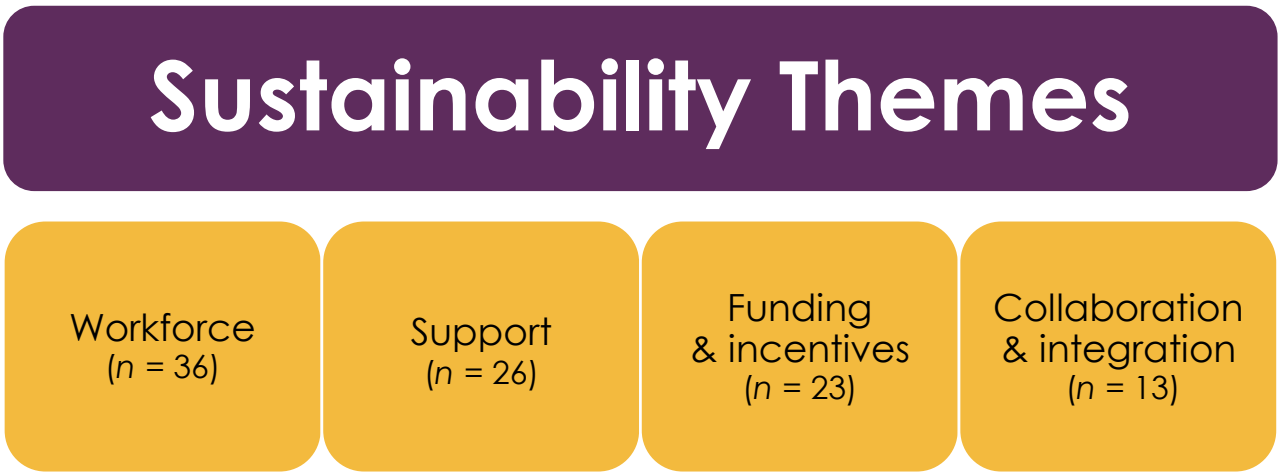

Figure 5: Sustainability Themes for the WQ region

Theme 1: Workforce

Many participant responses mentioned the need for either **more staff or more GPs**, but there were also specific mentions of **occupational therapists and other allied health practitioners**. In contrast, others stressed the importance of having a consistent workforce and consistent services. Others mentioned service inconsistencies at public health services in the region while others suggested more staff would enable existing staff to **take time off for CPD or vacations**. Retention of staff was also a focus of some participants. This was seen as being one way to improve both continuity of care as well as responsibilities within the community. One participant highlighted retention difficulties:

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

Theme 2: Support

Under the theme of 'support', there were four main subthemes: **CPD and training; general support; telehealth and IT; and infrastructure**. Participant comments around the 'CPD and training' sub-theme focused on the provision of locally based education/training. Others stressed the need for training geared towards rural generalist skills specific for remote communities, particularly for allied health practitioners. There were a variety of comments for the 'general support' sub-theme. Some of the comments included mental health support, support for allied health practitioners staffing, and support to provide relief from ***'grueling on-call requirements'***. Comments on the 'telehealth and IT' sub-theme included mentions of a better range of telehealth items for patients in remote communities or when unable to attend face-to face, education to use telehealth, and more IT and telehealth availability in community clinics. 'Infrastructure' sub-theme comments were around improved resources, accommodation for staff and transport options to collect outlying patients.

Theme 3: Funding and incentives

Many participant comments simply stated **increased or adequate funding** would improve their situation, with a few specifically mentioning the need to **increase Medicare**. However, others highlighted a requirement for **consistent and robust funding or recurrent grants to alleviate short-term funding issues** impacting continuity of service provision and staffing. One participant highlighted issues for private services compared to government services:

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

Incentives were mentioned by seven participants, mostly in terms of increasing incentives so that they outweigh the **financial, social, and logistical impacts** of living and working in remote and rural communities. As one participant stated,

'When it's all broken down, I barely make more than my colleagues living in metro areas, and the incentives I receive for working rurally barely even out the costs of living and barely address the other emotional and social impacts.'.

Theme 4: Collaboration and integration

Collaboration and integration comments highlighted the importance of collaboration to sustainability of services in smaller communities. Collaboration across and between services were mentioned in terms of **flexible working arrangements** including working at more than one service and options to live elsewhere and work part time in remote Western Queensland. Many suggested that **rationalising services** by **reducing the number of fragmented services** and workforce duplications would be of benefit to communities in the region. As one participant wrote,

> *'Stop duplicating services and maximise the number of patients seen in a timely manner. Shared workforce to again stop presentations to the hospital and maximise patient visits.'*

Others highlighted the benefits of an **increased collaborative approach** from some hospitals in terms of referral pathways and communication from specialists including the possibility of a **coordination service to lessen the burden on private practices**. One participant mentioned better integration of health databases across public and private services.

Quantitative Methodology Findings: WQ region

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

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

Western Queensland Region: Statistical Area Level 2 (SA2) Ranked by Need

1.	**Far South West**	Cunnamulla | Thargomindah | Quilpie
2.	**Carpentaria**	Burketown | Carpentaria | Normanton Mornington Island | Karumba
3.	**Far Central West**	Birdsville | Bedourie | Boulia | Windorah Jundah | Winton
4.	**Mount Isa Region**	Camooweal | Cloncurry | Dajarra
5.	**Charleville**	Charleville | Morven | Murweh Augathella

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

GPO Box 2523, Brisbane
Queensland Australia 4001

Level 4/348 Edward Street,
Brisbane QLD Australia 4000

+61 7 3105 7800

+61 7 31057801

admin@healthworkforce.com.au

healthworkforce.com.au

Health Workforce Queensland