Health Workforce Queensland

Health Workforce Needs Assessment

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

February 2025

About Us

Health Workforce Queensland (HWQ) is a not for profit, non-Government Rural Workforce Agency dedicated to improved health outcomes for remote and rural Queenslanders through equitable and effective health workforce solutions.

We work closely with key health stakeholders such as Primary Health Networks, peak bodies, Hospital and Health Services, Aboriginal Community Controlled Health Services, primary care practices and all levels of government to inform health policy and enhance the implementation of workforce solutions.

Our Vision

To ensure an optimal health workforce to enhance the health of Queensland communities.

Our Purpose

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

Our Values

Integrity

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

Commitment

We enhance health services in remote and rural Queensland communities.

Equity

We provide equitable access to services based on prioritised need.

Sustainable Growth

We enhance our financial sustainability and provide additional services by leveraging our resources and collaborations.

Acknowledgements

Health Workforce Queensland is funded by the Australian Government Department of Health, Disability and Ageing.

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

Cania Gorge National Park

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 2025 report provides an update of current and emerging workforce issues for remote and rural Queensland and identifies priority Statistical Area Level 2 (SA2) locations per Primary Health Network (PHN) region, based on a nationally consistent quantitative methodology to indicate areas of possible, current, and/or ongoing workforce need. This methodology is sense-checked on the ground and utilised in parallel with emerging issues to provide HWQ with some direction as to where workforce needs require further exploration. We offer collaborative strategies and solutions to address the key issues and findings discussed in this report.

Encouragingly, the HWQ database shows an increase in the number of general practitioners and nurses working in remote, rural and regional communities throughout Queensland compared to the 2024 HWNA; this includes a large increase in the nursing workforce working within primary healthcare centres. Changes in the number and distribution of the Aboriginal and Torres Strait Islander Health Worker and Practitioner workforce were also noted, with MM 3 and MM 7 communities benefiting from an increased workforce, whilst a reduction was seen in MM 2.

Psychology, speech pathology, social work, and general practitioner (GP) workforces remained in the top five workforce gaps, with occupational therapy re-entering the top five for the first time since 2022. This year, in acknowledgement of the vital role that the paramedic workforce plays in frontline primary care in remote and rural communities, the HWNA survey included paramedics as a new primary care health workforce discipline. Interestingly, nine of the twenty primary care workforces recorded a decrease in their mean workforce gap rating compared to the previous year, with the most notable increases observed in podiatry, dental practitioner, and radiography/sonography workforces. A thematic analysis of workforce gap comments found the main themes related to workforce shortages and attraction/retention, access to services and costs/funding.

The highest service gap ratings were largely consistent with the 2024 report, with the top five being comprised of mental health, community-based rehabilitation, alcohol and other drugs, oral health, and aged care services. A lack of, and access to services, and long wait times were the main issues reported by survey respondents.

This year, we asked the remote and rural workforce to consider their own health and wellbeing as part of the Issue in Focus. Practitioners were asked how well they were doing across eight dimensions of wellbeing, how this compared to two years ago, and how well they were supported by their workplace. We also sought to identify the barriers preventing practitioners from accessing mental health support and understand what would promote better access to these services for themselves, colleagues and their families. Encouragingly, the rural workforce perceived their health and wellbeing as better than it was two years ago. However, it is evident that several barriers prevent practitioners from accessing mental health support including workforce shortages, concerns regarding privacy and confidentiality, as well as cost. It is vital that these barriers are considered and addressed to ensure we support and retain our valued primary care workforces.

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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 2025 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, Disability and Ageing (DHDA) 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 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 2024.

Online Survey: Online surveys targeting Aboriginal and Torres Strait Islander Health Workers/Practitioners, allied health practitioners (AHPs), General Practitioners (GPs), midwives, practice managers and primary care nurses. Survey items gauged participants' beliefs about workforce and primary care service gaps in their community(ies)of practice in addition to enquiring about the health and wellbeing of themselves and their families, how it compared to two years ago, and how well their organisation supported their health and wellbeing. The surveys were open between October 2024 and February 2025.

Stakeholder Engagement: Information was sourced from consultations with key stakeholders, communities, and health professionals throughout 2024. The jurisdictional HWSG also provided valuable input at the 2024 annual meeting.

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

- GP full time equivalent (FTE) (excluding locum and outreach workforces) to estimated resident population ratio (ABS, 2023)
- MM classification of remoteness (2019)
- Index of Relative Socio-economic Advantage and Disadvantage (IRSAD 2021)
- Vulnerable population aged < 5 and > 65 years (ABS, 2023)
- Aboriginal and Torres Strait Islander population (ABS, 2021)

Higher SA2 ratios indicate regions with possible greater workforce need. It is acknowledged that SA2 mapping of GP FTE ratio alone does not produce a complete picture of workforce need, therefore the other four data elements have been utilised to gain the most accurate picture possible of the potential workforce need. The process of undertaking the HWNA is being reviewed nationally to ensure that the methodology captures the most recent dataset development and analysis capabilities.

Remote and Rural Health Workforce Overview

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.

Significant initiatives were launched and key reports were published to address ongoing challenges in health care delivery and workforce distribution across critical areas of workforce need. These reports recognised that greater access to primary care workforce is needed to effectively implement sustainable multidisciplinary team-based care in remote and rural Australia.

The final reports of the *Working Better for Medicare Review* and the *Unleashing the Potential of our Health Workforce: Scope of Practice Review* were released in 2024, both proposing significant reforms to address workforce shortages and health care access issues in underserved areas. The Working Better for Medicare Review recommended retaining Sections 19AA and 19AB to maintain training standards and regulate the distribution of International Medical Graduates (IMGs), while suggesting reforms to the Distribution Priority Area and District of Workforce Shortage classifications to more accurately identify areas of greatest need. *The Unleashing the Potential of our Health Workforce: Scope of Practice Review* outlined enablers for health professionals to work to full scope of practice, advocated for a primary care workforce development program and a blended payment model to support multidisciplinary care. Pertinently, Recommendation 18 in the report compelled governments to commit to prioritise implementation of reforms in remote and rural communities, and to engage with key stakeholders to collaboratively design implementation solutions specific to the local context.

The National Rural Health Alliance (NRHA) launched the *Rural Health Workforce Mapping Tool*, integrating geographic and workforce data to highlight regional health care disparities. The NRHA also submitted a petition to the Australian Parliament for a 10-year National Rural Health Strategy and a $1 billion fund to support local, community-based health care and sustain primary and community health services across rural Australia. The Alliance is seeking to establish a contract between the Commonwealth and state and territory governments via a schedule to the National Health Reform Agreement, which embeds remote and rural policy and funded priorities for action.

The *Regional Australia Institute's Year 2 Progress Report* highlighted improvements in recruitment more broadly across regional Australia but noted persistent challenges with housing supply. HumanAbility, Australia's Jobs and Skills Council which drives education and workforce development in the health and human services, aged care & disability support, sport & recreation, and children's education and care industries, released its first *Workforce Plan*. This plan addresses the unparalleled growth in demand across these sectors and acknowledges that workforce attraction and retention must be a focus to deliver the workforce we all need now and for the future.

Queensland

The annual HWSG meeting brings together 34 key stakeholders pivotal to the primary health workforce in Queensland. Members attending the *HWSG meeting held on September 2024* identified that remote and rural Queensland presents an ideal opportunity to develop and strengthen innovative and flexible place-based approaches based on better coordinated and funded workforce models of team-based care. This conclusion is in alignment with the finding in the recent *Unleashing the Potential of our Health Workforce: Scope of Practice Review* that 'rural and remote regions present the greatest immediate opportunity to establish and spread health workforce innovation and reform'.

In 2024, significant changes and initiatives were announced in Queensland's health care landscape, highlighting the ongoing challenges and opportunities for workforce development in remote and rural areas. Eligible health professionals who commenced in a role with Queensland Health between 1 November 2023 and 31 January 2025 were able to apply for the Workforce Attraction Incentive Scheme which offered up to $70,000 to interstate and international clinicians to take up Queensland Health roles in remote and rural Queensland for a period of 12 months[1]. From 1 February 2025, the scheme will no longer be offered.

It has been recently recognised by the Queensland Department of Health that accessing workforce is the biggest challenge facing the healthcare system amidst widespread workforce shortages. HWQ is advocating for the inclusion of primary care in an anticipated new health workforce plan, in recognition of the importance of the primary care workforce on the effectiveness of the health system, as well as the impact public health system salaries

[1]Queensland Health Careers. (2024). *Workforce attraction incentive scheme*. Workforce attraction incentive scheme | Careers

and incentives have on the ability of primary care health services to attract and retain health professionals.

In an exciting development for Queensland, the NRHA has secured $1.6 million over four years through the Australian Government's Innovative Model of Care (IMOC) grants, to trial the NRHA's Primary Care Rural Integrated Multidisciplinary Health Service (PRIM-HS) model in Mareeba. Mareeba and Communities Family Healthcare (MCFHC) has worked with the NRHA to develop a model that brings all rural stakeholders together to provide the services needed by a local community. The trial will support the co-design, development and testing of flexible employment models, recognising the complex relationship between people, place and health, and the role communities play in identifying needs and creating solutions which are fit for purpose[2]. A further six organisations across the state were also successful in receiving funding to trial various models including a mobile mental health service/telehealth model in rural Queensland (the North Coast Aboriginal Corporation for Community Health) and a work-in-work-out multidisciplinary model to improve access to allied health professionals (Outback Futures)[3]. A list of all successful applicants and model details can be found on the *IMOC website*.

Allied Health Workforce

Consultation for the *National Allied Health Workforce Strategy* took place in 2024, with the final strategy anticipated to be presented for endorsement in early 2025. The consultation sought input on a comprehensive, cross-sectoral strategy aimed at addressing current and future allied health workforce challenges in Australia. Spanning a 10-year horizon, the strategy will be designed to support long-term workforce planning to better align workforce supply with both current and projected demand.

The introduction of a new Commonwealth Prac Payment (CPP) for students to help them manage the costs associated with undertaking a mandatory placement as part of a higher education course in social work, nursing and midwifery, teaching, and nursing in vocational education and training (VET) courses[4], scheduled to begin in July 2025, has elicited a mixed response. While recognition of "placement poverty" as a barrier for health students undertaking placements in remote and rural areas is welcomed, the exclusion of critically undersupplied health professions – such as psychology, occupational therapy, and speech therapy – is concerning. HWQ's workforce gap data clearly demonstrates the longstanding shortages of these essential professionals in MM 2-7 communities. The lack of access to these services in a timely manner has been noted to negatively impact health, particularly of vulnerable populations such as children and older adults with longer interventions often required[5]. HWQ will continue to strongly advocate for the inclusion of these professions in the scheme, and for the government to consider scaling of the CPP according to rurality of student placement undertaken.

Locally, Queensland Health's evaluation of the Allied Health Rural Generalist Pathway (AHRGP) from January 2019 to October 2021 showed promising results. Out of 98 early career professionals who participated, rural generalist trainees had a higher retention rate (42%) compared to non-trainees (30%). On average, AHRGP trainees stayed in remote and rural positions for an additional 25 weeks compared to their non-trainee counterparts[6]. These findings indicate that the AHRGP may be a valuable investment and an effective retention strategy.

General Practice Workforce

Burnout among GPs has decreased to 69 percent in 2024[7], down from 73 percent in 2022, according to the Royal Australian College of General Practitioners' (RACGP) *2024 Health of the Nation* report. This suggests that the pressure on GPs, which has been immense over the past few years, has somewhat eased. However, the viability of general practice remains fragile, with a number of general practices closing in Queensland this year.

[2]Department of Health, Disability and Ageing. (2024). *Innovative Models of Care (IMOC) Program – Primary Care Rural Integrated Multidisciplinary Health Service (PRIM-HS) Mareeba Community Primary Care Trial*. Australian Government. Innovative Models of Care (IMOC) Program - Primary Care Rural Integrated Multidisciplinary Health Service Mareeba Community Primary Care Trial

[3]Department of Health, Disability and Ageing. (2024). *Innovative Models of Care (IMOC) Program*. Australian Government. Innovative Models of Care (IMOC) Program | Australian Government Department of Health, Disability and Ageing

[4]Department of Education. (2024, May 6). *New Commonwealth Prac Payment (CPP)*. Australian Government. New Commonwealth Prac Payment (CPP) - Department of Education, Australian Government

[5]Health Workforce Queensland. (2024). *Health Workforce Needs Assessment: Summary of the Primary Care Workforce Needs in Remote, Rural and Regional Queensland*. 2024_HWQ_HWNA_Final_WEB_2.pdf

[6]Nielsen, I. (2024, October 23). *Queensland Health Allied Health Rural Generalist Pathway 2019-22: workforce outcomes* [Oral presentation]. Services for Australian Rural & Remote Allied Health (SARRAH) Conference, Mildura, Victoria.

[7]The Royal Australian College of General Practitioners. (2024). *General Practice Health of the Nation 2024: An annual insight into the state of Australian general practice*. Health-of-the-Nation-2024.pdf

Despite these ongoing challenges, significant progress has been made in initiatives aimed at strengthening the sector. Notably, the implementation of Queensland Health's Single Employer Model (SEM) pilot, with the proof of concept completed and pilot locations confirmed for a 2025 launch. The SEM pilot will provide GP registrars and rural generalists with a single employer – Queensland Health, via a Hospital and Health Service throughout their training. This model ensures income stability, access to employee benefits such as annual and parental leave, and a seamless transition between rural general practice and hospital work, all while meeting Fellowship training requirements[8].

The pathway to recognition of rural generalism as a specialised field within the discipline of general practice and recognition of 'Rural Generalist' as a protected title is now in the final stages of assessment with the Medical Board of Australia[9].

The Strengthening Medicare Taskforce and the implementation of Australia's Primary Health Care 10 Year Plan (2022–2032) has seen the Australian Government engage an expert advisory panel to review general practice incentives. The *Review of General Practice Incentives – Expert Advisory Panel Report to the Australian Government* recommended:

- a simplification of general practice payments by introducing an opt-in payment architecture that encourages high-quality multidisciplinary care;
- in the short term, retention of the Workforce Incentive Practice – Doctor Stream (WIP-DS) and Workforce Incentive Program — Rural Advanced Skills Stream (WIP-RAS) with an added refinement to incentivise continuity of care;
- investing in an accreditation and performance framework to support the new general practice blended payments architecture while maintaining the principle that general practices can charge fees for medical services that take into account the practice's own costs and economic imperatives; and
- establishing an independent primary care pricing authority to provide advice on the design and pricing of Commonwealth payments to general practices and primary care providers.

In October 2024, the Australian Medical Council released a *survey report* detailing the experiences, perceptions, and decision-making factors of migrating doctors. Over 4,000 IMGs shared their insights, revealing that several challenges persist. Key issues identified included unclear information about pathways, complex and slow bureaucratic processes with limited coordination between agencies, low success rates in assessments, and concerns about the fairness and appropriateness of these assessments. Additionally, rigid interpretations of requirements for specialist skills by some colleges and difficulty finding employment were highlighted. Given Queensland's heavy reliance on overseas-trained doctors to deliver primary care, it is crucial to expedite the implementation of the 30+ recommendations aimed at improving the journey for IMGs.

The recently commenced *Specialist International Medical Graduate (SIMG) Pathway* has been established by the Australian Health Practitioner Regulation Agency (Ahpra) as a response to the *Independent review of Australia's regulatory settings relating to overseas health practitioners* (Kruk Report) in 2023. The SIMG Pathway commenced on 21 October 2024 and fast-tracks the registration of eligible internationally qualified GPs from the United Kingdom, New Zealand and Ireland[10]. Ahpra is expanding the Expedited Specialist Pathway based on workforce priorities, which includes other medical specialities and is anticipated to include allied heath disciplines in the future. HWQ is monitoring workforce developments and actively seeking whether this Expedited Specialist Pathway can make a difference for workforce numbers on the ground in remote and rural Queensland.

First Nations Workforce

The release of the *Professional Scopes of Practice for Aboriginal and/or Torres Strait Islander Health Workers and Health Practitioners* by the National Association of Aboriginal and Torres Strait Islander Health Workers and Practitioners (NAATSIHWP) in 2024 is a significant step forward in the effective utilisation of Aboriginal and Torres Strait Islander Health Workers and Practitioners in the healthcare system. The document highlights the unique role of this critical workforce and will be invaluable for health services, health leaders, and other health practitioners to understand their importance and

[8]Queensland Health. (2024). *Single Employer Model (SEM): Project update 5 – July 2024*. Single Employer Model (SEM)

[9]Liotaa, M. (2025, January 14). *Further progress on rural generalist recognition*. The Royal Australian College of General Practitioners. RACGP - Further progress on rural generalist recognition

[10]Australian Health Practitioner Regulation Agency. (2024, October 14). *Fast track pathway to specialist registration opens 21 October*. *Medical Board of Australia - Fast track pathway to specialist registration opens 21 October*

contributions in the delivery of health care to First Nations people. Furthermore, it adds to the body of evidence surrounding the importance of including Aboriginal and Torres Strait Islander Health Workers and Practitioners in team-based care where team members can all work to top of scope.

This year, the management and delivery of the Puggy Hunter Memorial Scholarship Scheme was transferred from the Australian College of Nursing (ACN) to Indigenous Allied Health Australia (IAHA)[11], in recognition of the need for the scheme to be First Nations-led. IAHA leads a group of agencies, including NAATSIHWP and the Rural Doctors Network (RDN), in delivering a program that facilitates and supports stronger participation by First Nations people in the health workforce, and improved outcomes for First Nations people in remote, rural and regional locations. The scheme is now also guided by the *National Agreement on Closing the Gap* and *Aboriginal and Torres Strait Islander Health Workforce Strategic Framework and Implementation Plan (2021–2031)*.

The number of Indigenous Australians employed within Ahpra registered health professions in MM 2-7 Queensland, according to the 2021 National Health Workforce Dataset (NHWDS), is presented in Table 1. For comparison, numbers for 2019 and 2020 are also provided.

Nursing and Midwifery Workforces

The development of a *National Nursing Workforce Strategy* is in progress, with 2024 seeing the *Consultation Summary Report of Stage 1* released in May and the *Nursing Supply and Demand Study model* published, which forecasts the supply and demand for nurses in Australia over the next 12 years. The evidence in these two reports is informing Stage 2 of draft Strategy development.

2024 saw significant reforms to the scope of practice for primary care nurses and midwives, in line with the *Strengthening Medicare Taskforce Report* and the *Nurse Practitioner Workforce Plan*. Starting 1 July 2024, Nurse Practitioner (NP) attendance and telehealth fees were increased by 30 percent, and amendments to the MBS allow NPs to bill for chronic disease management case conferencing[12]. From 1 November 2024, the requirement for collaborative arrangements between midwives or NPs and medical practitioners when prescribing Pharmaceutical Benefits Scheme (PBS) medications and providing Medicare-subsidised care was removed[13]. Additionally, in early 2025, eligible Registered Nurses (RNs) will be able to undertake endorsement as designated registered nurse prescribers and prescribe scheduled medicines 2, 3, 4 and 8, in partnership with an authorised health practitioner, following the endorsement of a new standard by Health Ministers on 6 December[14].

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; the 2022 NHWDS data was not available at the time of report preparation. Consequently, the data presented is the 2021 data presented in last year's HWNA*

[11]Butler, M. (2024, March 22). *First Nations health leaders and Health Ministers gather to progress Close the Gap reform agenda*. Department of Health, Disability and Ageing. First Nations health leaders and Health Ministers gather to progress Close the Gap reform agenda | Health Portfolio Ministers | Australian Government Department of Health, Disability and Ageing.

The Australian Primary Health Care Nurses Association (APNA) welcomed reforms to support primary care nurses to work to their full scope of practice as a key element of improving access to health care. Results from APNA's 2023 annual workforce survey[16] revealed that more than half (52.2%) of primary health care nurse and midwife respondents agreed or strongly agreed that they often undertake tasks that somebody less skilled or qualified could do. Furthermore, over 30 percent of respondents indicated they only occasionally or rarely worked to their full scope of practice. PHC nurses and midwives reported overall that they wanted to do more health promotion, health education and illness-prevention activities and have more engagement in continuing professional development.

Of particular concern is the short to mid-term retention of this workforce with only 63.5 percent of respondents reporting they were likely or very likely to remain working in primary health care in the following two to five years[16]. Furthermore, following the release of the final report for the *Midwifery Futures Project* on 23 October 2024, it was identified that one third of midwives were considering leaving the profession, with an insufficient number of midwives and midwifery students in the workforce pipeline to meet future need[17]. In an effort to campaign for significant and meaningful primary health care reforms, APNA has formed an alliance with eight other nursing and midwifery organisations and believe that by enabling nurses, NPs and midwives to work to their full scope of practice, access to quality and affordable health care will improve for all Australians, including those in remote and rural areas. Alliance members include the Australian College of Nursing, the Australian Nursing and Midwifery Foundation, the Australian College of Nurse Practitioners, the Congress of Aboriginal and Torres Strait Islander Nurses and Midwives, the Australian College of Midwives, the Australian College of Mental Health Care Nurses, the Council of Remote Area Nurses of Australia and the Council of the Deans of Nursing and Midwifery[18].

In welcome news for students, from 1 January 2024, eligible final year nursing and midwifery students who complete more than four weeks of placement in a Queensland Health facility in a MM 2-7 location may be eligible for a one-off $5,000 *Regional, Rural and Remote Student Placement Allowance*. From 1 September 2024, the requirement to live a minimum of 100 kilometres away from placement location has been removed.

In addition to this allowance, from 1 July 2025, students may also be eligible for the means-tested CPP weekly payments to support them whilst they are undertaking mandatory clinical placements[4].

HWQ has a strong history of advocating for enhanced support for students undertaking placements in remote and rural settings, in recognition that positive, long-term rural placements are an enabler of a rural health career.

[12]Department of Health, Disability and Ageing. (2024). *Nurse practitioner MBS Changes 1 July 2024.* Australian Government. PDF Version - Nurse practitioner MBS changes as of 1 July 2024.pdf

[13]Department of Health, Disability and Ageing. (2024). *Removal of legislated collaborative arrangements.* Australian Government. PDF Version - Removal of legislated collaborative arrangements.pdf

[14]Nursing and Midwifery Board of Australia. (2024, December 11). *Expanded role for registered nurses to improve access to safe and timely healthcare*. Australian Health Practitioner Regulation Agency. Nursing and Midwifery Board of Australia - Expanded role for registered nurses to improve access to safe and timely healthcare

[15]Australian College of Midwives. (2024, November 28). *Midwife Professional Indemnity Commonwealth Contributions Scheme Amendment Bill passes through Parliament*. Midwife Professional Indemnity Commonwealth Contributions Scheme Amendment Bill passes Parliament

[16]Australian Primary Health Care Nurses Association. (2024). *Annual APNA Workforce Survey 2023: Insights for advocacy and change*. Insights for advocacy and change

[17]Australian College of Midwives. (2024, October 23). *Building the Future Australian Midwifery Workforce*. Building the Future Australian Midwifery Workforce

[18]Australian College of Midwives. (2024, November 19). *Joint Statement – Nursing and Midwifery Campaign for Better Primary Health Care for all Australians*. Joint Statement - Nursing and Midwifery Campaign for Better Primary Health Care for all Australians

Workforce Data: State-wide Snapshot

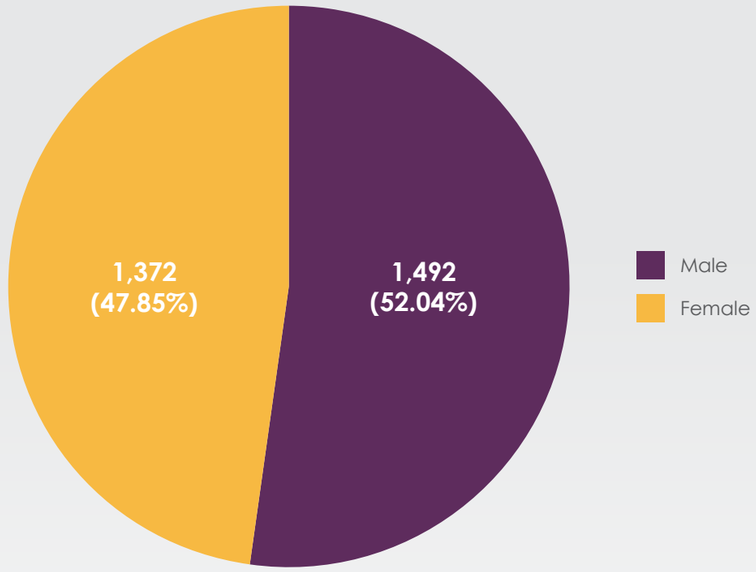
General Practitioner Workforce

Health Workforce Queensland Database

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

This snapshot of the workforce was taken on 30 November 2024. In line with reporting requirements to the Australian Government DHDA, only doctors working in MM 2-7 locations were investigated. At the census date, there were 2,867 GPs listed in the HWQ database as working in MM 2-7 locations in Queensland, 133 more than reported in the 2024 HWNA. The average age was 49.0 years, marginally younger than the 49.1 years reported in 2024.

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



Unspecified = 3

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

The number and percentage of male and female 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). The Northern Queensland region was the only geography to have a majority of female GPs (51.7%), compared to Western Queensland where female GPs were only 40.7 percent of the workforce.

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

PHN Region	Female		Male		Total
	n	*%*	*n*	*%*	*N*
Central Queensland, Wide Bay, Sunshine Coast[a]	376	46.94%	423	52.81%	**801**[b]
Darling Downs and West Moreton	273	45.05%	333	54.95%	**606**
Northern Queensland	587	51.72%	548	48.28%	**1,135**
Western Queensland	57	40.71%	82	58.57%	**140**[c]

Note: [a] This region is administered by Country to Coast, QLD PHN; [b] total figure includes two GPs with sex = unspecified; [c] total figure includes a GP 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 1,396 Australian trained GPs (48.7%), and 1,471 overseas trained GPs (51.3%) in MM 2-7 in Queensland. The percentage results for each of the mainly rural PHN regions are presented in Figure 2.

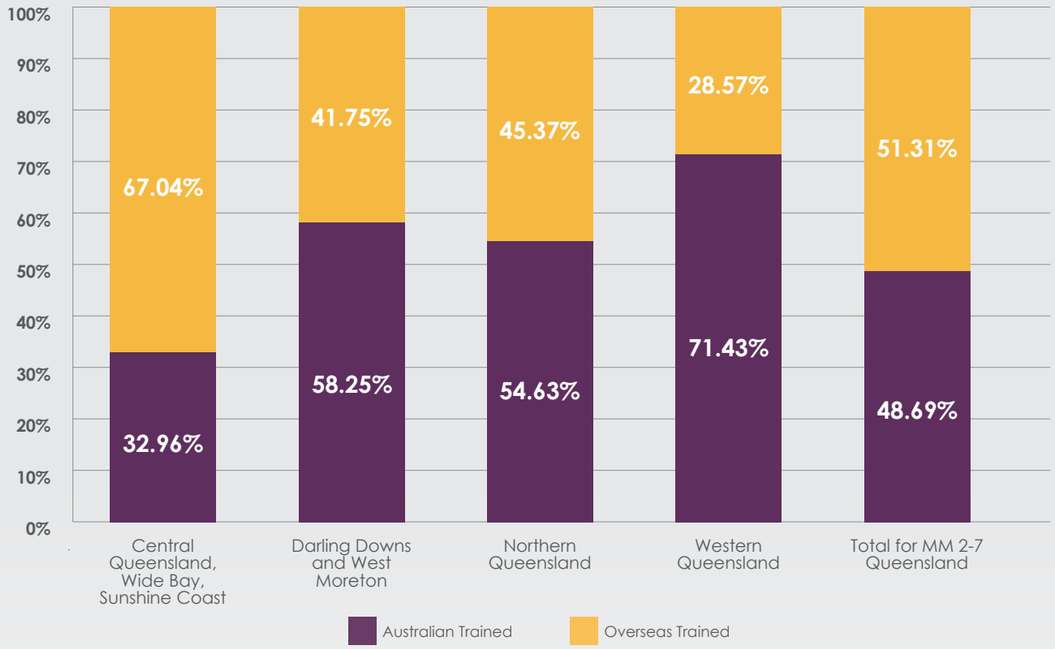


Figure 2: Percentage of GPs by country of basic medical qualification and PHN region from HWQ database

Three of the four mainly rural regions had a majority of Australian trained GPs, led by Western Queensland (71.4%). In contrast, in the Central Queensland, Wide Bay, Sunshine Coast region, approximately one third of the workforce was trained in Australia.

National Health Workforce Dataset (NHWDS) 2021

The NHWDS is administered by the Australian Government, with jurisdictional data released to state governments on an ad-hoc schedule. The 2022 data from the NHWDS was not available at the time of report preparation. Consequently, the data presented is from 2021, the same as last year's HWNA.

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 Queensland, Wide Bay, Sunshine Coast	702
Darling Downs and West Moreton	487
Northern Queensland	1,100
Western Queensland	117
Total MM 2-7 Queensland*	***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.*

Nursing Workforce in General Practice

Health Workforce Queensland Database

The number of nurses working in MM 2-7 general practice settings captured in the HWQ database was 1,599, an increase of 32 from last year.

The number of nurses, according to level of registration and 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, diabetes nurse educators or child health nurses.

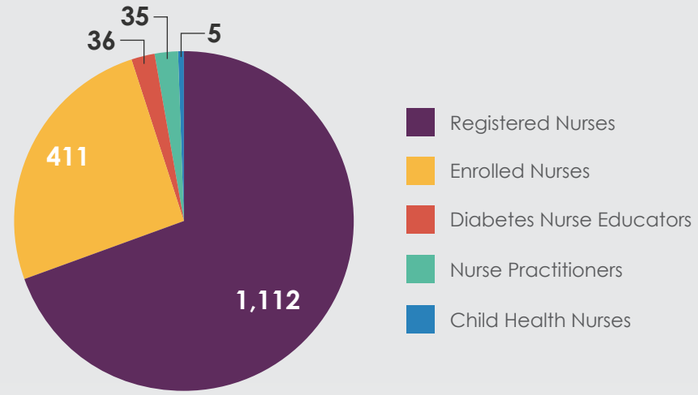


Figure 3: Number of general practice nurses by level of registration and specialty from HWQ database

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.

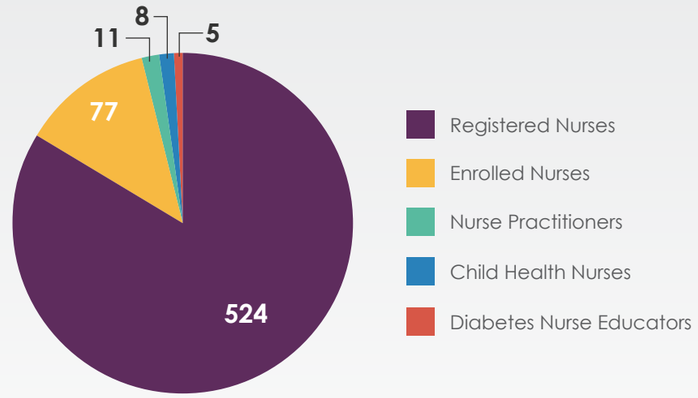


Figure 4: Number of remote and rural primary healthcare centre nurses by level of registration from HWQ database

Over 80 percent of the nursing workforce in remote and rural primary healthcare centres were RNs. Compared to last year, there was a large increase in the number of RNs (183) and ENs (63), with a small increase in diabetes nurse educators (2).

National Health Workforce Dataset (NHWDS) 2021

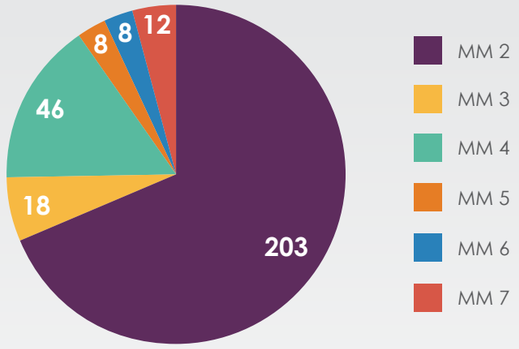
Below is the number of nurses working in MM 2-7 Queensland by rural PHN region that self-described their main role as 'primary care nurse' when they completed the NHWDS survey during 2021 registration renewal. The response rate for the workforce survey is generally above 95 percent for nurses across 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. Due to the removal of the survey self-report category 'Practice Nurse' 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 Queensland, 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%
Other PHN regions*	50	13	***63***	67%
Total*	***984***	***236***	***1,220***	***66%***

*Note: Data provided by Queensland Health * The Total MM 2-7 Queensland numbers are based on all primary health care nurses in MM 2-7 Queensland, including those in the Brisbane North, Brisbane South and Gold Coast PHN regions; The 2022 data from the NHWDS was not available at the time of report preparation. Consequently, the data presented is from 2021, the same as last year's HWNA*

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; The 2022 data from the NHWDS was not available at the time of report preparation. Consequently, the data presented is from 2021, the same as last year's HWNA

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 along with the total percentage of midwives that described their primary work as private.

Table 5: 2021 NHWDS midwives by PHN region

PHN Region	MM 2-7 *n*	MM 2-7 Private %
Central Queensland, Wide Bay, Sunshine Coast	85	28.81%
Darling Downs and West Moreton	66	22.37%
Northern Queensland	109	36.95%
Western Queensland	12	4.07%
Other PHN regions*	23	7.80%
Total	***295***	***100%***

*Note: Data provided by Queensland Health; * The Total MM 2-7 Queensland numbers are based on all midwives in MM 2-7 Queensland, including those in the Brisbane North, Brisbane South and Gold Coast PHN regions; the 2022 data from the NHWDS was not available at the time of report preparation. Consequently, the data presented is from 2021, the same as last year's HWNA*

Aboriginal and Torres Strait Islander Health Worker and Health Practitioner Workforce

Health Workforce Queensland Database

There were 278 Aboriginal and Torres Strait Islander Health Workers and 69 Aboriginal and Torres Strait Islander Health Practitioners in the HWQ database.

This represented an increase of one Aboriginal and Torres Strait Islander Health Worker and a decrease of six Aboriginal and Torres Strait Islander Practitioners since last year. Figure 6 presents this workforce according to MM location with numbers suppressed (marked as 'N/A') if less than four.

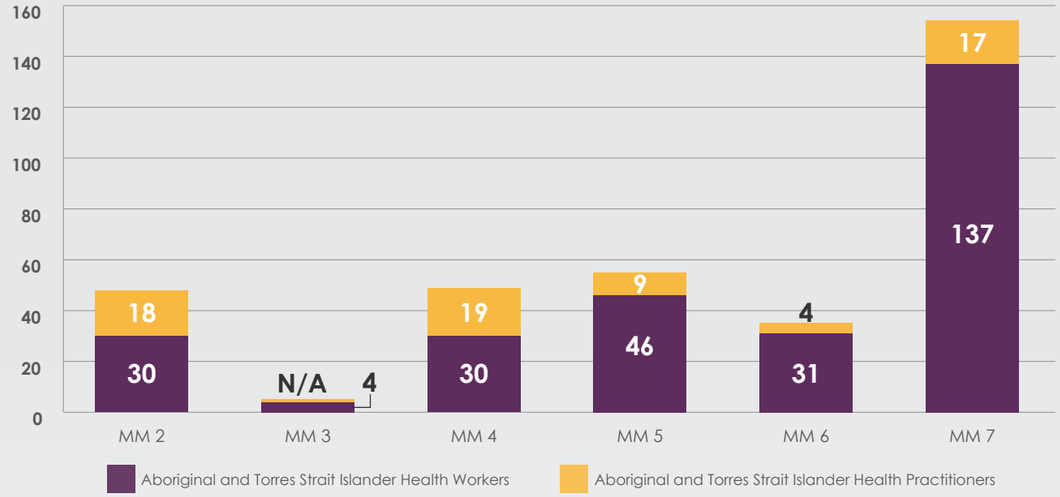
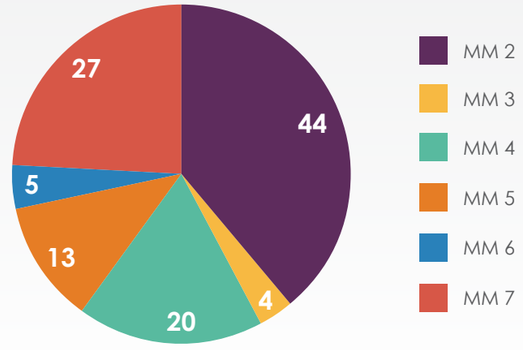


Figure 6: Aboriginal and Torres Strait Islander Health Workers/Practitioners by MM from HWQ database

Aboriginal and Torres Strait Islander Health Workers and Practitioners were represented across all MM categories and, similar to last year, the largest number were working in MM 7 locations. The most pronounced changes to the Aboriginal and Torres Strait Islander Health Worker and Practitioner workforce were increases in MM 3 (20.0%) and MM 7 (17.6%) followed by decreases across the remaining geographies, the largest of which was for MM 2 (- 31.4%).

National Health Workforce Dataset 2021

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



Note: Data provided by Queensland Health; The 2022 data from the NHWDS was not available at the time of report preparation. Consequently, the data presented is from 2021, the same as last year's HWNA

Figure 7: 2021 NHWDS 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 NHWDS 2021. The registered allied health professions for which data is available are:

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

The number 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 Queensland, Wide Bay, Sunshine Coast and the Darling Downs and West Moreton PHN regions, the number of practitioners working in MM 1 locations were also included. This includes practitioners working in and around Ipswich (Darling Downs and West Moreton) and on the Sunshine Coast in major towns such as Caloundra and Maroochydore (Central Queensland, Wide Bay, Sunshine Coast). Results are presented in Table 6.

Table 6: 2021 NHWDS AHPs by PHN region, MM 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 Queensland, 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 Queensland, 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 Queensland, Wide Bay, Sunshine Coast	83	83%	78
Darling Downs and West Moreton	63	85%	31
Northern Queensland	80	72%	-
Western Queensland	15	69%	-
Occupational Therapists	1,452*	55%*	3,729
Central Queensland, 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 Queensland, 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 Queensland, 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 Queensland, 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 Queensland, 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; The 2022 data from the NHWDS was not available at the time of report preparation. Consequently, the data presented is from 2021, the same as last year's HWNA*

HWNA Survey Results

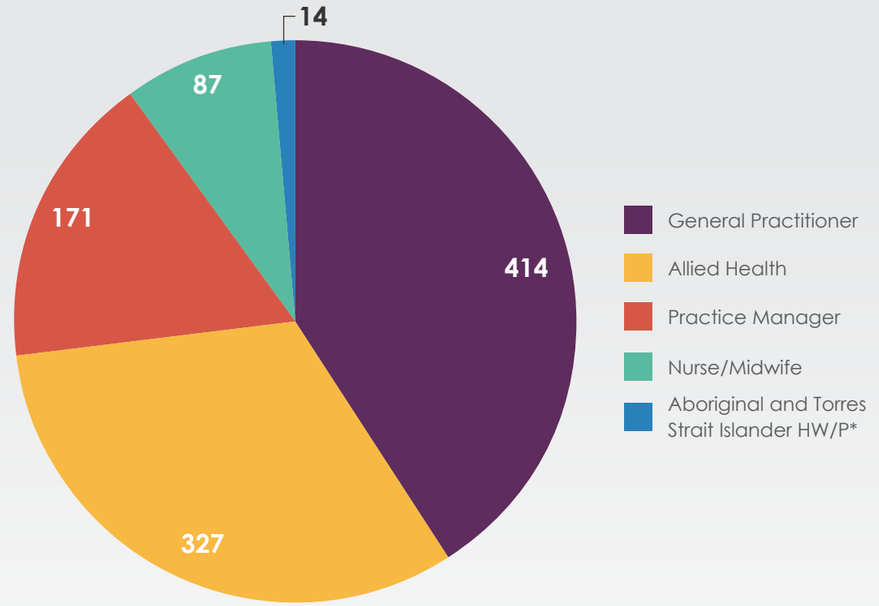
Image Credit: Donna Blaker

Quantitative Findings

An online survey was conducted targeted at Aboriginal and Torres Strait Islander Health Workers and Practitioners, AHPs, GPs, practice managers and primary care midwives and nurses 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(ies). 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 20 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. This year, the HWNA introduced the paramedic workforce as the 20th workforce discipline.

For the first time this year, the HWNA reached over 1,000 participants, receiving a total of 1,013 responses, marking an increase of 38 responses compared to last year's survey. The number of participants by their main role (e.g., nurse, AHP) are provided in Figure 8.



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

Figure 8: Number of participants by main employment role

Northern Queensland had the largest number of survey responses (*n* = 351), followed by Central Queensland, Wide Bay, Sunshine Coast (*n* = 263); Darling Downs and West Moreton (*n* = 224) and Western Queensland (*n* = 109). 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

The largest growth was observed in AHPs, with responses increasing by 45 percent compared to last year's HWNA survey. While GPs were the dominant survey respondents for the Northern Queensland and Central Queensland, Wide Bay, Sunshine Coast regions, for the Darling Downs and West Moreton and Western Queensland regions, there were more responses
from AHPs.

Figure 10 depicts the total number of responses received for the HWNA since 2021 and the breakdown of these responses by main employment role.

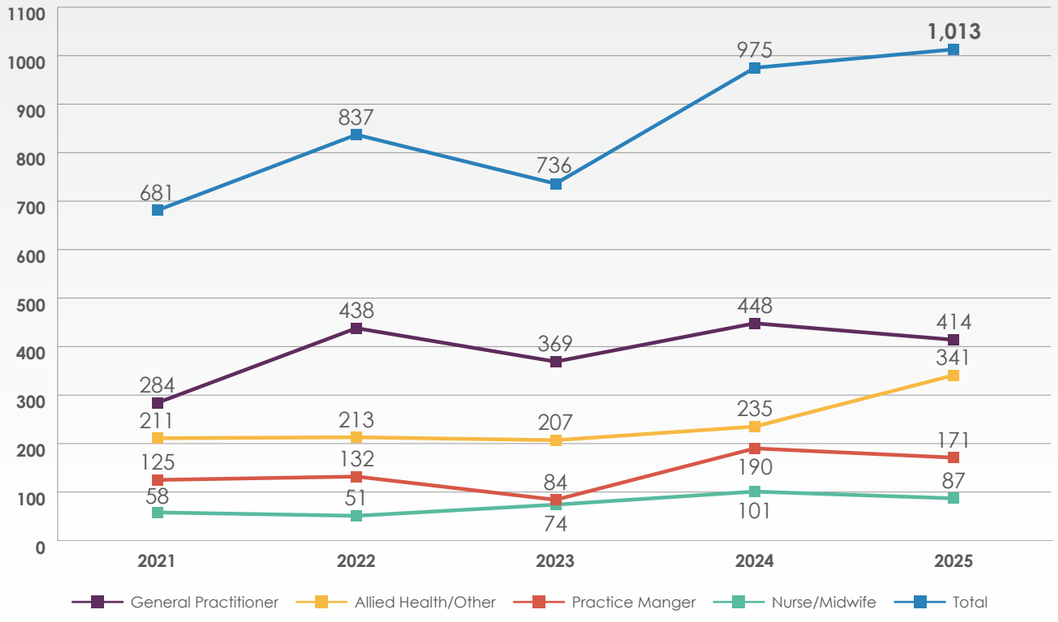
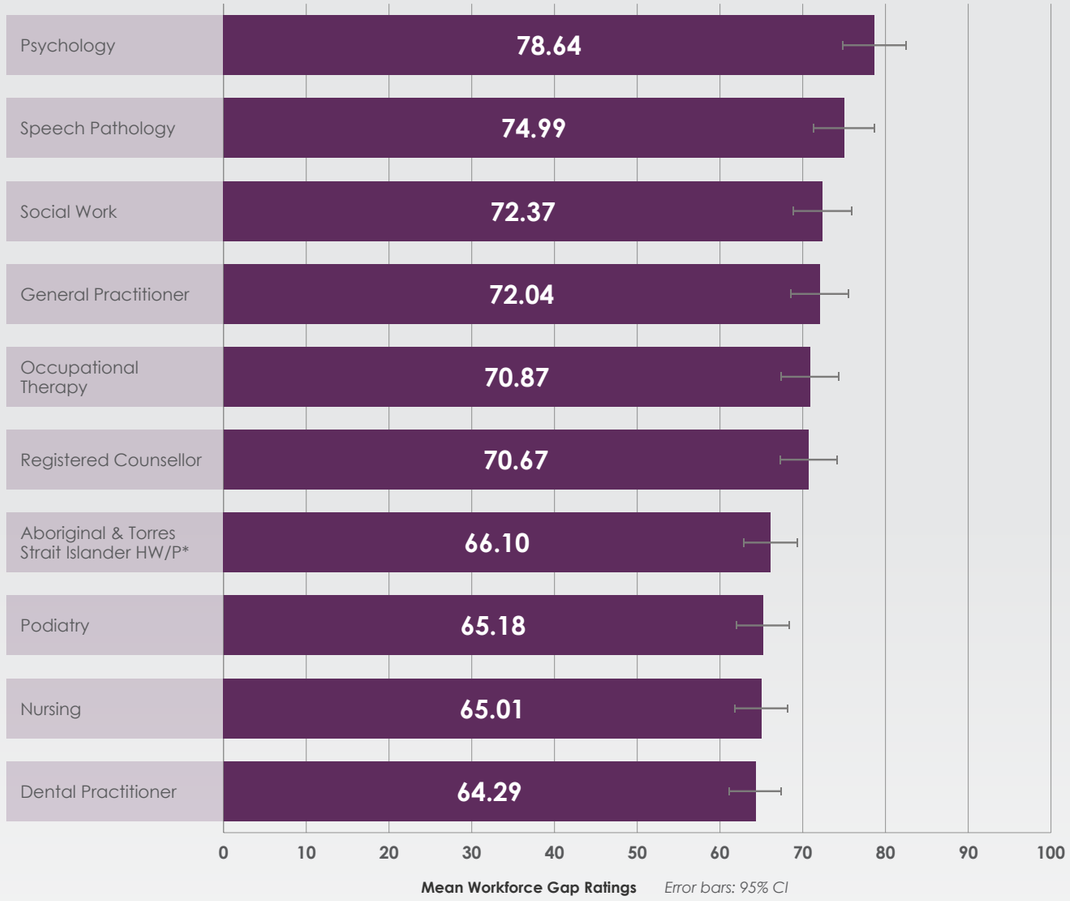


Figure 10: Number of participants by main employment role from 2021-2025

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 7, along with the workforce gap means from 2021 to 2025.



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

Figure 11: Top 10 workforce gap rating means 2025

The highest workforce gap rating means were for the psychology, speech pathology, social work, GP, and occupational therapy workforces. Six of the workforce gap means were higher than 70, with the remaining top ten workforce gap ratings achieving means higher than 60.

Table 7: Workforce gap rating means for 2021-2025

Type of Workforce	2021 *M*	2022 *M*	2023 *M*	2024 *M*	**2025 M**
Psychology	72.70	79.57	80.74	80.78	**78.64**
Speech Pathology	70.31	71.60	73.45	74.79	**74.99**
Social Work	65.68	71.54	73.83	72.40	**72.37**
General Practitioner	62.03	70.85	74.96	72.43	**72.04**
Occupational Therapy	66.19	68.91	71.04	70.78	**70.87**
Registered Counsellor	N/A	N/A	N/A	74.29	**70.67**
Aboriginal and Torres Strait Islander HW/P*	60.50	62.78	66.56	67.80	**66.10**
Podiatry	56.89	55.68	62.45	61.48	**65.18**
Nursing	55.84	65.57	73.16	68.69	**65.01**
Dental Practitioner	55.72	56.83	62.96	61.39	**64.29**
Midwifery	N/A	N/A	N/A	66.34	**63.01**
Radiography/Sonography	55.88	53.98	57.99	60.16	**62.94**
Diabetes Education	56.88	59.60	63.14	65.52	**62.53**
Dietetic	57.40	57.46	60.82	59.62	**59.51**
Audiology	53.00	50.72	55.37	56.36	**56.82**
Exercise Physiology	54.22	53.21	58.04	57.00	**56.52**
Paramedic	N/A	N/A	N/A	N/A	**55.60**
Physiotherapy	49.95	52.76	56.93	53.43	**54.60**
Optometry	45.73	47.04	49.44	49.43	**50.58**
Pharmacy	32.75	34.06	40.71	37.69	**37.80**

*Note: * HW/P = Health Worker & Health Practitioner; N/A indicates rating question not contained in survey*

This year, the means for nine workforce gaps decreased slightly (ranging from -0.1 to -3.7 points) compared to their 2024 standing, with nine workforce categories recording slightly higher gap rating means compared to the previous year. These were for podiatry (3.7 points), dental practitioner (2.9 points), radiography/ sonography (2.8 points), physiotherapy (1.7 points), optometry (1.2 points), audiology (0.5 points), speech pathology (0.2 points), pharmacy (0.1 point), and occupational therapy (0.1 point) workforces.

Psychology (*M* = 78.6) continues to rank as the top workforce gap across remote and rural Queensland, however this year marks the lowest mean score recorded since 2021. This year's newly included paramedic workforce (*M* = 55.6) entered with the fourth lowest workforce gap. Pharmacy was the only workforce that exhibited a gap rating mean lower than 50.

As in previous years, the top five workforce gaps have remained largely consistent. The workforce rankings for psychology (ranked 1), speech pathology (ranked 2), and GP (ranked 4) workforces remained constant from 2024. However, social work's ranking moved from fifth place in 2024 to third place in 2025 and occupational therapy (ranked 5) re-entered the top five for the first time since 2022 which displaced registered counsellor, a top five workforce gap last year. Figure 12 depicts the trends in workforce gap rating means for each of these workforces from 2021-2025.

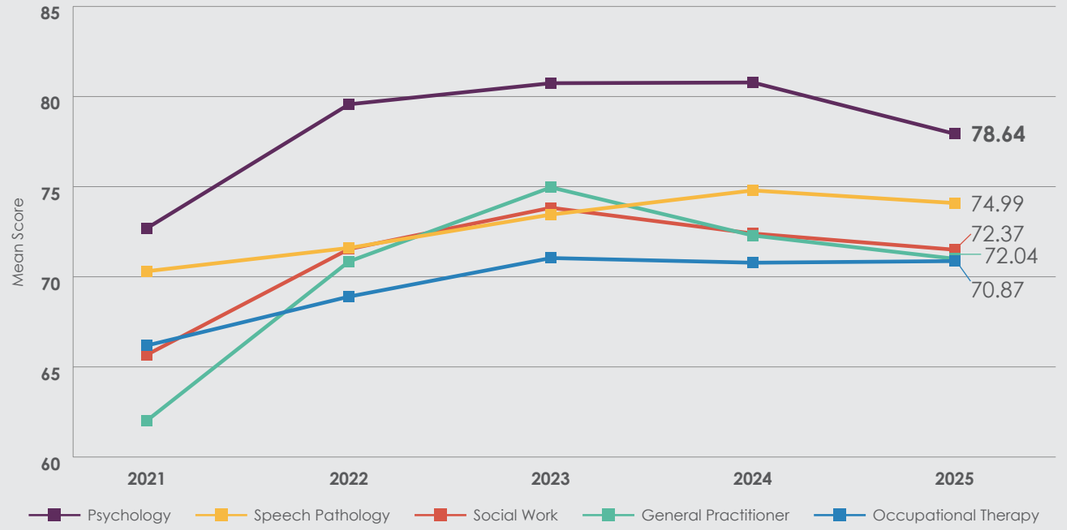


Figure 12: Five highest rated workforce gaps across 2021-2025

All of the top five workforce disciplines have experienced a gap rating increase throughout 2021 to 2025. The largest increase across the five-year period was observed for the GP workforce (10.01 points), followed by social work (6.7 points), psychology (5.9 points), occupational therapy (4.7 points), and speech pathology (4.7 points) workforces. It should be noted that only two of these workforces experienced an increase in the past 12 months.

Workforce Gap Comments

There were 512 participants that commented on the workforce gap rating questions. Following thematic analysis, comments were grouped into three main themes:

1. Workforce (*n* = 265)
2. Access (*n* = 127)
3. Cost and funding (*n* = 75)

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

1. Workforce

The sub-themes for workforce comments are represented in Figure 13.

Figure 13: Workforce issues sub-themes

The **workforce shortages** sub-theme was raised by over half of the participants with numerous mentions of specific primary care workforces such as GPs, various allied health disciplines and mental health practitioners. Comments below highlight difficulties associated with **services reliant on locum** and fly-in, fly-out (FIFO) staffing, as well as the **necessity to work beyond scope** when specific services were not available:

"There is a general issue in the workforce with heavy use of locum and fifo the*[sic]*workers... Non-permanent and non-local workers impact things like continuity of care and the general public is reluctant to use these workers because they do not know them…" (Psychologist, MM 6)

"OT **[Occupational Therapy]** *waitlists are very extensive in our community and as physios we are often asked to complete tasks that are better suited to OTs. There is a high turnover of GP***[s]** *in the area leading to inconsistency of care. There is poor neurological support in the area."* (Physiotherapist, MM 2)

For the **attraction and retention** sub-theme, some comments highlighted the extent of the problem and how it was **impacting remaining practitioners** as others left the community and further **staff could not be sourced**. Other comments specifically referred to issues associated with a **reliance on GP Registrars**:

"Health workers easily experience burn out because of high caseload numbers. Businesses experience high turnover of staff because workers are so highly sought that it is a very competitive field in Speech, OT, etc.." (Speech Pathologist, MM 2)

"Senior supervising doctors are semi-retiring and none of the junior doctors are interested in training roles. Very concerning. More incentives for retention (housing assistance, travel incentives, incentives for training-roles)." (Practice Manager, MM 5)

*"Current***[ly]** *there is an influx of registrars but I worry for the sustainability of this number for XXX* **[Town]**. *It's not a long term solution as the majority will move on each year, and then rolling the dice to see if a similar number apply the following year."* (Medical Practitioner, MM 4)

2. Access

Responses about access were divided into a main sub-theme of long wait times and/or closed books for new patients, and a related minor sub-theme of inconsistent access. These sub-themes are presented in Figure 14.

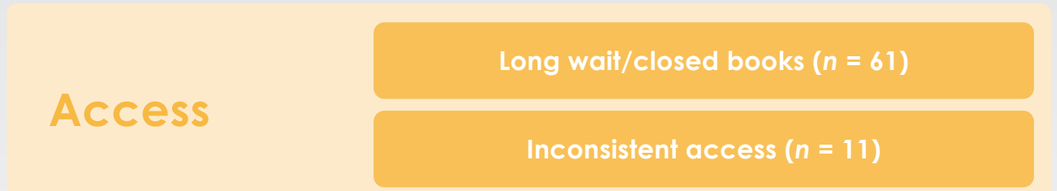


Figure 14: Access sub-themes

Most responses related to **access** were about the sub-theme of patients having to **wait longer for services** than was appropriate and/or not being able to access services because they were already full and had **closed their books**. Comments referred to long wait times and closed books for both allied health services and general practice appointments:

"Psychology, Occupational Therapy and Speech Pathology services have VERY long waitlists and are putting our community at risk - especially in terms of child development, suicide prevention and its eventual impacts on chronic disease burdens." (Occupational Therapist, MM 5)

"Long wait times for a GP appointment drive people into emergency departments unnecessarily including for mental health problems." (Psychologist, MM 3)

For the **inconsistent access** sub-theme, most of the comments were about only being able to **access services infrequently** (e.g. monthly) or intermittently, or a **lack of a consistent workforce** that impacted on **continuity of care**:

"Limited allied health specialists. Visit the practice but often only monthly." (Nurse, MM 6)

"There is a lack of access to primary health care services in general, but definitely the specialist services. Services are available either infrequently or intermittently. In my experience service delivery in these communities are a last priority or ad hoc." (Paramedic, MM 5)

3. Cost and funding

For the cost and funding theme the main sub-themes identified are presented in Figure 15.

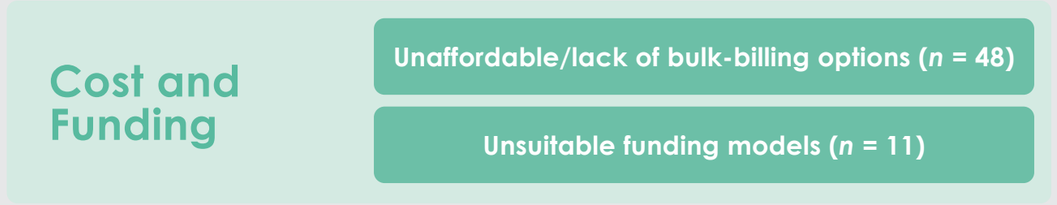


Figure 15: Cost and Funding sub-themes

For the **cost and funding theme**, the most frequently mentioned aspects related to the sub-theme of **services being unaffordable** for many patients, particularly if there were **no bulk-billing options** available in the community. This was mentioned specifically in relation to psychology, GPs, specialists and allied health more generally:

"We have psychology but often **[cost]** *prohibitive with $150 out of pocket with mental health plan and health care card."* (Medical Practitioner, MM 5)

"There is an extensive wait to get in to see GPs. The main practice charges a significant gap payment which is becoming less accessible for people." (Occupational Therapist, MM 4)

"… not everyone can afford to attend specialist whom they require due to financial difficulties. Even with Care Plans in place, a lot of Allied Health Professionals are costing way above the rebates." (Practice Manager, MM 2)

"Our area per ABS is low SES **[socioeconomic status]**, *poor lifestyle and health and older. It's no use having private allied health services because those who need it can't pay. We need more government services e.g. diabetes education - can only access hospital dietitian NOT for weight loss."* (Exercise Physiologist, MM 4)

For the sub-theme of **unsuitable funding models**, many participant responses mentioned the **negative impact of the NDIS** on allied health services in their community for non-NDIS clients:

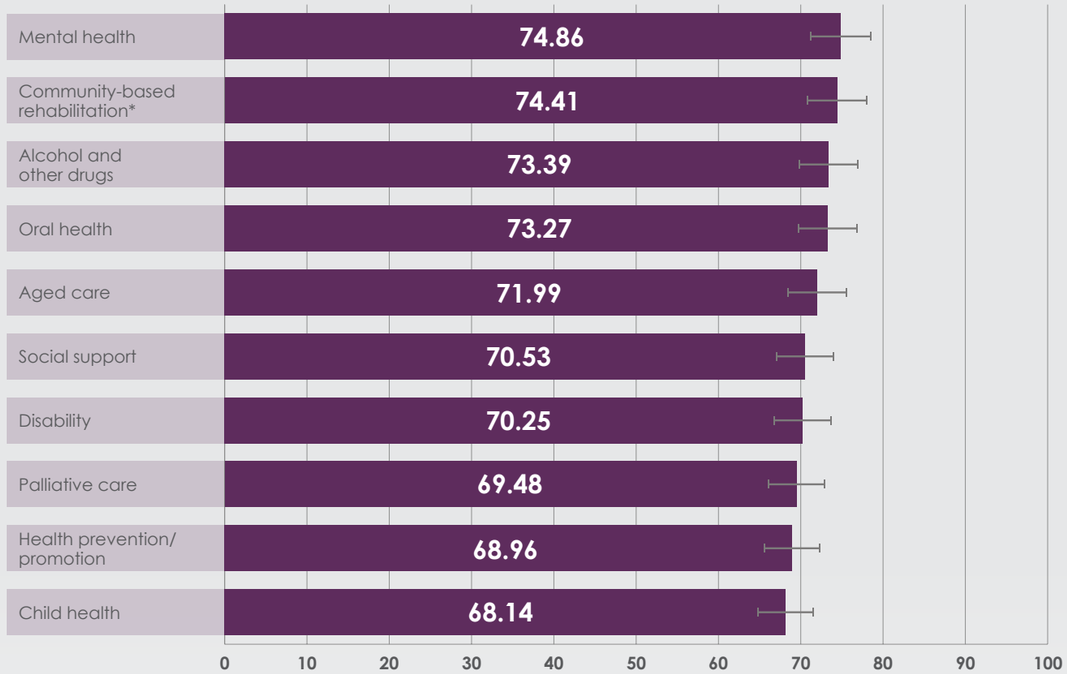
*"The issue is not so much the number of practitioners with allied health; but the affordability for any patient not on NDIS. Affordability has certainly declined since NDIS introduction, bulk-billing is essentially non-existent, and public options are dramatically overwhelmed to the point where only cat***[egory]** *1 cases are being seen."* (Practice Manager, MM 4)

Other participants mentioned specific incentive and program changes impacting their service:

"XXX **[Town]** *went from having 5 private psychologists providing psychology under Medicare to one psychologist with overflow being referred to YYY* **[Town]** *and on-line as a result of withdrawal of financial support incentives for rural practice and promotion of the non-psychology workforce to undertake complex psychological treatments."* (Social Worker, MM 2)

Service Gap Ratings

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



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

Figure 16: Top 10 service gap rating means 2025

The highest service gap rating means were for mental health services (*M* = 74.9), marginally higher than community-based rehabilitation services (*M* = 74.4), followed by alcohol and other drugs services (*M* = 73.4), oral health services (*M* = 73.3), and aged care services (*M* = 72.0). The top seven service gap rating means were all higher than 70 points with all other primary care service gaps above 60 points. Five-year trend data on primary health service gaps from 2021-2025 has been provided in Table 8.

Table 8: Service gap rating means for 2021-2025

Type of Service	2021 *M*	2022 *M*	2023 *M*	2024 *M*	**2025 M**
Mental health	73.34	80.71	81.35	72.52	**74.86**
Community-based rehabilitation	69.99	74.70	75.29	74.62	**74.41**
Alcohol and other drugs	67.38	73.18	73.10	73.81	**73.39**
Oral health	61.61	61.70	66.56	71.71	**73.27**
Aged care	61.13	66.76	71.22	68.83	**71.99**
Social support	62.66	68.25	69.61	70.86	**70.53**
Disability	62.33	64.26	65.84	70.35	**70.25**
Palliative care	61.41	63.12	67.40	69.04	**69.48**

Type of Service	2021 *M*	2022 *M*	2023 *M*	2024 *M*	**2025 M**
Health prevention/promotion	62.16	64.59	68.52	67.71	**68.96**
Child health	56.87	63.29	65.99	67.26	**68.14**
Maternal health	52.66	54.85	60.48	65.41	**64.33**
Refugee and immigrant health	60.19	61.79	63.65	61.78	**63.17**
Aboriginal & Torres Strait Islander health	51.95	59.27	60.63	60.71	**62.29**

In 2025, six service gap rating means increased, while seven declined relative to 2024. The most notable increase was seen in aged care services, which rose by three points. Mental health, Aboriginal and Torres Strait Islander health, oral health, refugee and immigrant health, and health prevention and promotion services all increased by more than one point. Among the service gap rating means that reduced, only maternal health services dropped by more than one point (1.1 point).

Over the past five years, the top five service gap rankings have remained relatively stable. The top four service gap rankings for 2025 comprised mental health, community-based rehabilitation, alcohol and other drugs services, and oral health services. Aged care services (ranked 5) returned to the top five this year, continuing the pattern of dropping in and out of the top five service gaps.

Figure 17 depicts the service gap rating means for this year's top five rated service gaps over the past five years. Between 2021 and 2025, the service gap rating means for all top five services increased, with most of the increases happening in the first two years. The exceptions were oral health and aged care services, both increasing over the first four years and by more than ten points over the five-year timeframe (11.6 and 10.9 points, respectively).

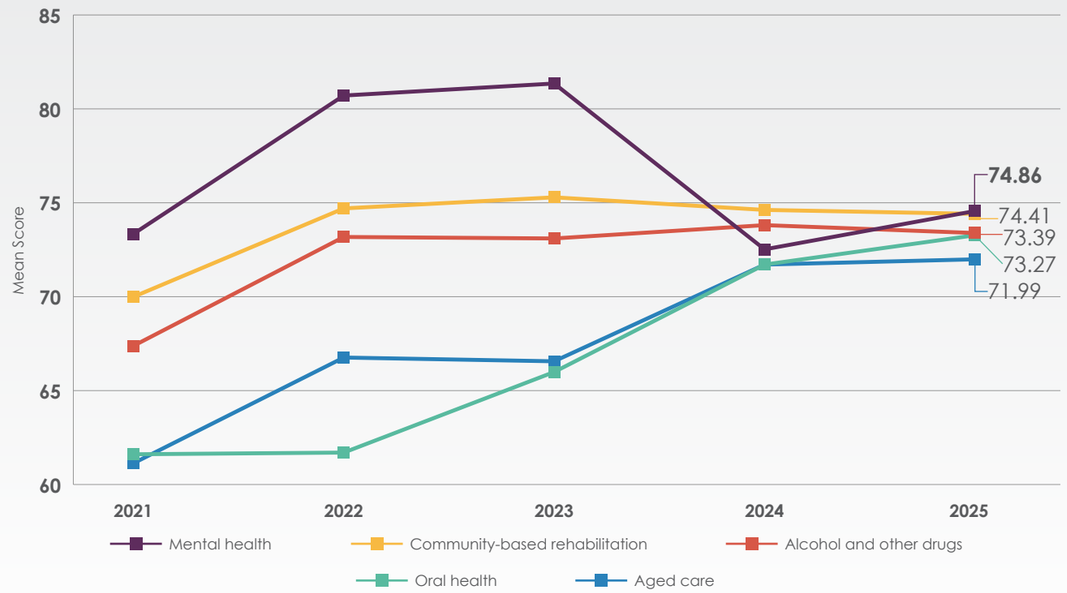


Figure 17: Five highest service gap rating means 2021-2025

Service Gap Comments

There were 113 participants that provided comments on the service gap rating questions. A thematic analysis revealed that the most frequently mentioned service types were mental health, allied health and child health. The three main themes identified were the lack of services; long wait times; and difficulties with access to services. It is of note that all three themes are related, with a lack of services often being the main reason that there are long wait times and access issues for community members.

Primary themes identified from the service gap comments are presented in Figure 18.

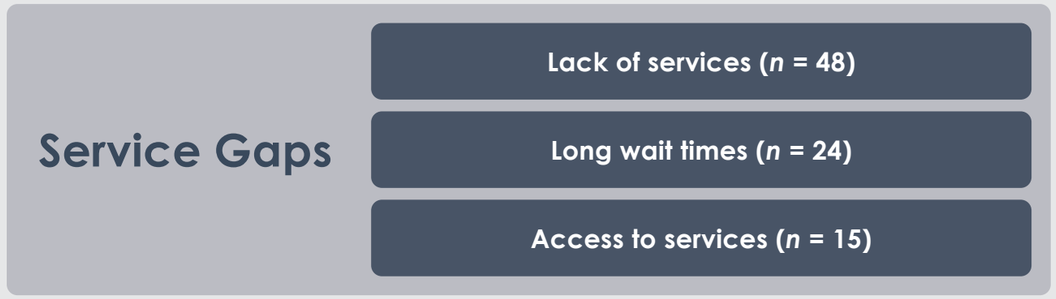


Figure 18: Service gap themes

1. Lack of services

Many participants indicated a lack of adequate **mental health services** in their community. This included comments about the public sector only having capacity to treat patients who required extensive psychiatric care and a lack of services for people with less complex mental health issues:

"Regular reliable access to psychiatric opinion would be valuable. We see a lot of mental health presentations and would often benefit from an experienced opinion. There was a private psychiatrist visiting until a few years ago, but this has ceased. The public mental health team is just set up to provide support to the most severe MH [mental health] patients with psychosis, or acute crises such as suicidality or acute psychosis. We often need opinions on dual diagnosis issues." (Medical Practitioner, MM 7)

"Nil mental health supports for mid [mild] to moderate risk for adults, only support is headspace for under 25. SI [Suicidal Ideation] and self harm risk scales significantly higher in XXX [Region]." (Occupational Therapist, MM 5)

There was also a lack of **allied health services** reported, with specific mentions mainly of psychology, oral health, podiatry and social support services. This lack of allied health services was seen as having a compounding effect on patient health, with negative consequences for remote communities:

"Mental health services are a major gap in community. We regularly see patients on EEAs [Emergency Examination Authorities] and with self-harm issues. Indigenous people are more likely to suicide and the lack of support available is significant. I think that this is a major area of need, and I know that the previous psychologist was well accessed. Dental is also an issue - dental hygiene is terrible and although the dentist is here once a fortnight, the queues waiting are always more than the team can see." (Practice Manager, MM 6)

"Obtaining qualified Podiatrist [sic] that want to stay in the position for over 2 years. The patients have inconsistent care and, in some cases, have not seen a pod[iatrist] for over 3 years." (Podiatrist, MM 4)

For **maternal health services**, some participants commented on the lack of specialised midwifery practices within their community:

"We could have more Midwifery Group Practices as there are long waitlists. There is a great need to increase the antenatal continuity of care until more MGP [Midwifery Group Practice] teams are on board. There is a need for groups such as NESB [Non English-Speaking Background] and teenagers to be on a continuity of care model." (Registered Nurse, MM 2)

In addition, the ability to access **health promotion** services, particularly for children and youth was identified as an area of need:

"More preventative healthcare or health promotion is needed. So many people; children; teens engage with services too late and then have to go down the path of getting a diagnosis from a psychologist or paediatrician which are often four hours away in XXX [Town] and costs money or a 12 month wait for public services. This issue is mainly in YYY [Town] and ZZZ [Town] where most of my clients present at school or high school aged [sic] with undiagnosed conditions like ADHD, intellectual impairment and autism. Or they have a diagnosis and no NDIS package." (Speech Pathologist, MM 4)

Lack of services and staff in **aged care and disability services** was also mentioned by some participants, leading to poor quality of care:

"Shortage of quality disability services; much of the current available is low quality… Massive shortage in aged care options for community care." (Medical Practitioner, MM 4)

"Many services are understaffed or are working with antiquated approaches to disability and aged care, leading to reduced quality in services if they exist at all…" (Speech Pathologist, MM 2)

2. Long wait times

Participants indicated that **staff shortages** across health services was resulting in **long patient wait times**:

"Dental care is the worst, waiting list one year." (Practice Manager, MM 4)

"Lead time to TCP [Transition Care Programme] is long. Little preventative health care in a community of chronic disease sufferers." (Physiotherapist, MM 4)

Some participants attributed **funding issues** as the cause of delayed health service delivery. One participant believed it was affecting the **continuity of care** required in palliative care, child health and aged care services:

"There is poor funding for public allied health child services leading to extensive wait times. There can be limited palliative care follow up in the community particularly from an allied health perspective. Wait times for aged care approvals are averaging >12 months." (Physiotherapist, MM 2)

3. Access to services

Participants expressed that **access to available health services** was problematic due to the distance community members had to **travel**. Patients who live in remote areas or live in towns with **limited health care** must travel to larger centres where there is a higher concentration of health services:

"XXX [Region] is extremely underserviced in many ways. People in this catchment travel to YYY [Town] and ZZZ [Town] for pretty much all hospital services." (Practice Manager, MM 5)

"Most of the services above are provided by healthcare teams in neighbouring towns or by the local community health facility and are generic [sic] or have little uptake due to community members not trusting confidentiality with local community members working in the facility." (Paramedic, MM 5)

The **lack of transportation** was seen to be an access barrier for patients from low socio-economic backgrounds:

"Less desirable postcode in my immediate catchment have no care providers, and people living there for cheaper housing with no transport cannot access support. Transport is extremely poor, without a licence or family friend support you cannot attend appointments." (Medical Practitioner, MM 4)

"Although many of the services are available in XXX [Town], transport for many patients makes it difficult to access services." (Practice Manager, MM 5)

One participant described a problem for community members **accessing aged care support** based on the **service providers** in the community being **unwilling to travel** outside of the main town centre:

"Access to My Aged Care providers. Many providers only service the central district- getting providers to the edges of the community are becoming more difficult." (Registered Nurse, MM 3)

Issue in Focus: Practitioner/ Manager Health and Wellbeing

The Issue in Focus for this year was the health and wellbeing of the remote and rural health workforce. Findings in the HWNAs over the last five to six years have highlighted that mental health and access to mental health professionals have consistently been to the fore amongst the highest rated workforce gaps and primary care service gaps identified as impacting care in remote and rural communities.

This year, it was decided to focus on how practitioners and managers viewed their own health and wellbeing, whether this was perceived to have changed over the last two years and how supportive their organisation was. Another goal was to identify what the barriers were to accessing mental health support and what would promote better access to mental health support for practitioners, managers and their families.

Health and wellbeing of health practitioners is a concern for remote, rural and regional communities in Queensland. Practitioners that have a good sense of wellbeing will be more likely to remain in the community. It has been proposed, by Swarbrick (1997), that "Wellbeing" encompasses **eight** mutually interdependent dimensions:

Figure 19: Swarbrick's Eight Dimensions of Wellbeing

Given the importance of cultural wellbeing for many Aboriginal and Torres Strait Islander people and others, we have added the word 'Cultural' to the Spiritual dimension above and in the survey questions.

Participants were asked the following rating questions:

1. *Rate **how well** you are currently along each of the eight dimensions of wellbeing*
2. *Rate **how well** you believe your current **workplace supports you** along each of the health and wellbeing dimensions*
3. *Rate each dimension for whether it is **better or worse** for you now than it was 2 years ago*

For the first two of the rating questions, response options were from '0 = Not at all well', to '100 = Extremely well'. For the third rating question, response options were from '0 = Much worse than 2 years ago', to '100 = Much better than 2 years ago', with '50 = Neither (better or worse)'. Results are presented in Figures 20-22.

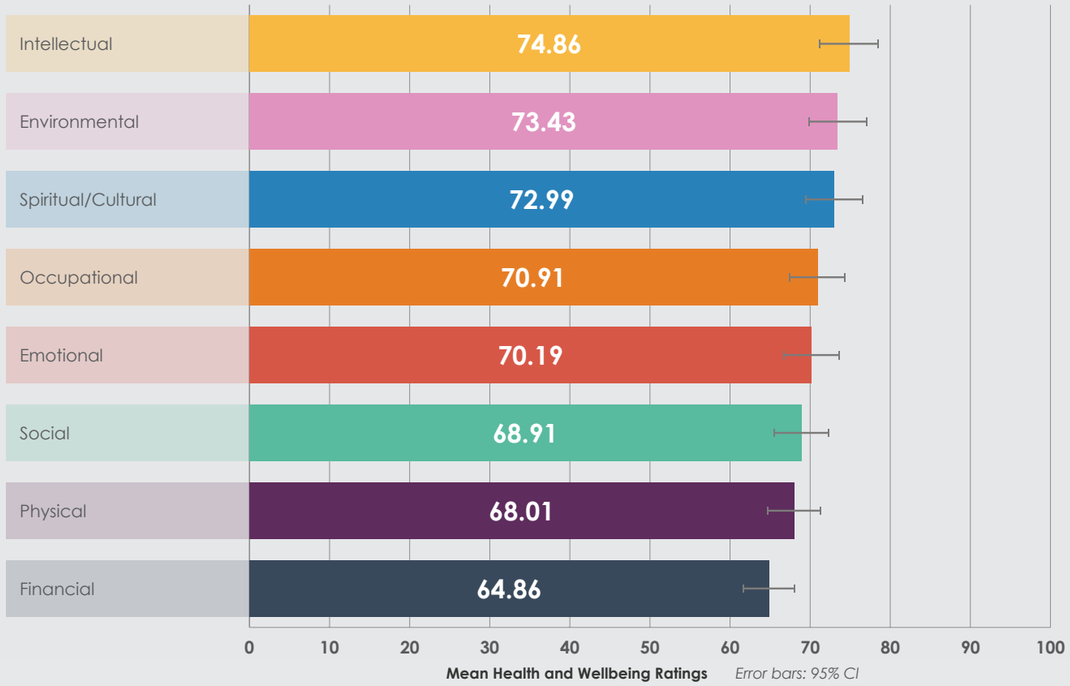


Figure 20: Mean ratings for current personal health and wellbeing across the eight dimensions

Participants rated their current wellbeing across the eight dimensions of health and wellbeing quite highly. Five of the eight health and wellbeing dimensions received mean rating scores over 70. The highest mean was for the intellectual dimension (*M* = 74.9), followed by environmental (*M* = 73.4), spiritual/cultural (*M* = 73.0), occupational (*M* = 70.9), and emotional (*M* = 70.2) dimensions. All other health and wellbeing dimensions received mean ratings above 60 with the lowest mean observed for the financial dimension (*M* = 64.9).

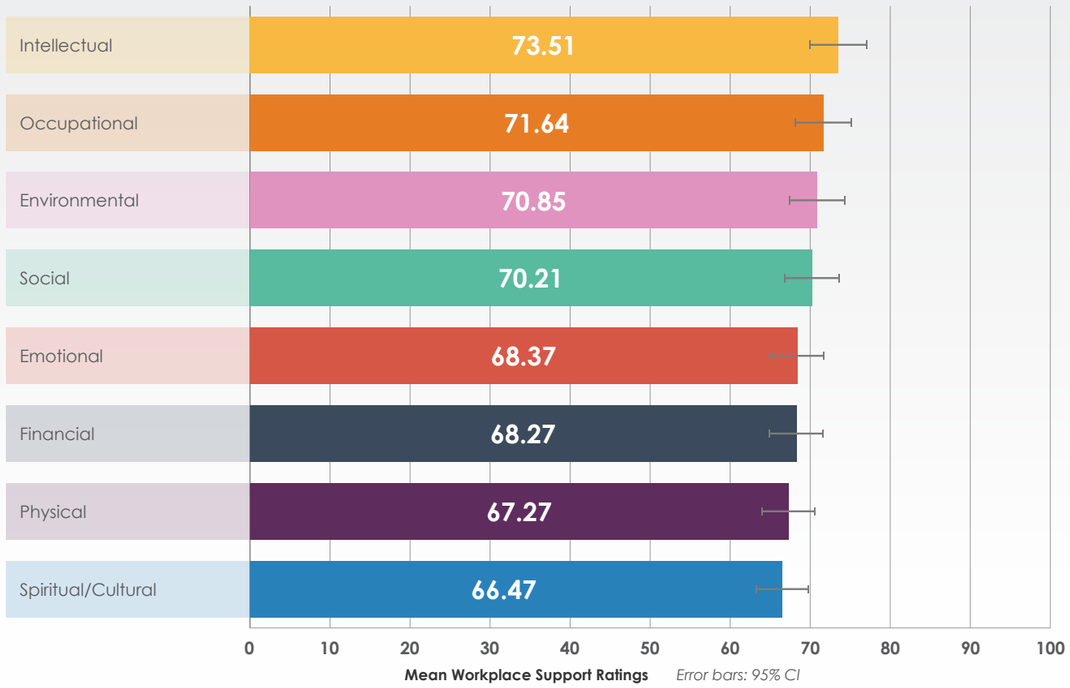
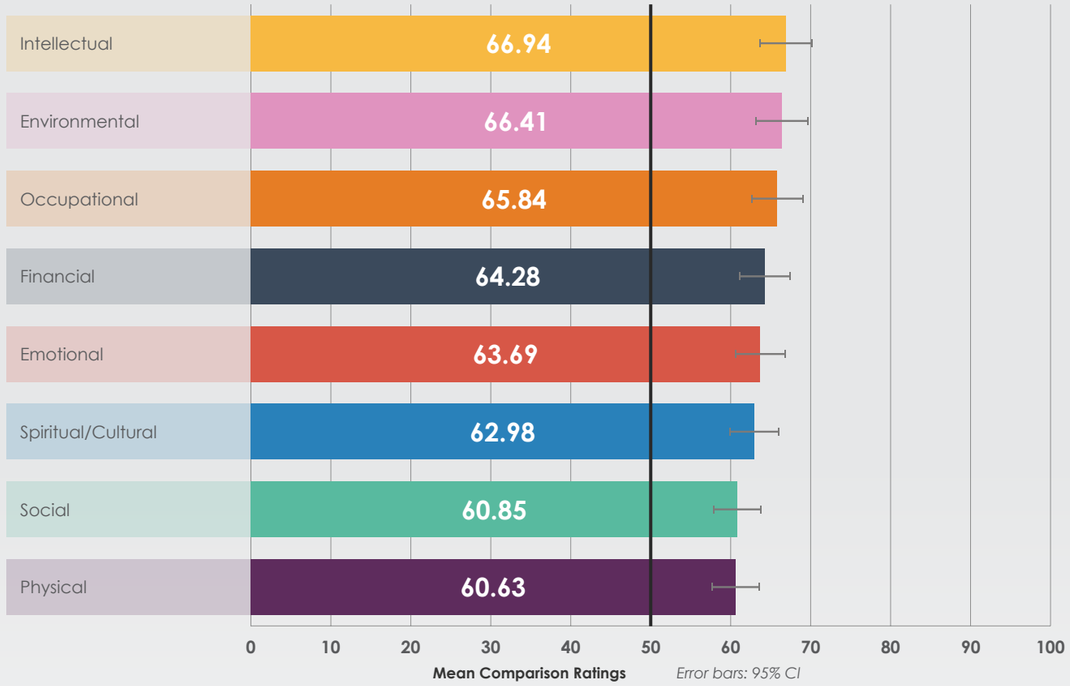


Figure 21: Mean ratings for perceived workplace support across health and wellbeing dimensions

Participants rated how well they believed their current workplace supported them across each of the eight health and wellbeing dimensions. Generally, these scores tended to be lower than the personal dimension means. Four of the eight dimension means were higher than 70, which included the intellectual (*M* = 73.5), occupational (*M* = 71.6), environmental (*M* = 70.9), and social (*M* = 70.2) dimensions. The remaining four dimensions all had mean ratings above 65, with the lowest mean observed for spiritual/cultural wellbeing (*M* = 66.5).



Note: The black bar represents neither better nor worse than two years ago

Figure 22: Mean ratings of health and wellbeing dimensions compared to two years ago

Participants rated each of the eight health and wellbeing dimensions to assess whether their current health and wellbeing was better or worse than it was two years ago. All eight dimensions received mean rating scores above 50, suggesting that participants perceived their current health and wellbeing as better than it was two years ago. The largest mean, indicating the most improvement over the two years, was observed for the intellectual dimension (*M* = 66.9). This was followed by the environmental (*M* = 66.4), occupational (*M* = 65.8), financial (*M* = 64.3), emotional (*M* = 63.7), spiritual/cultural (*M* = 63.0), social (*M* = 60.9), and physical (*M* = 60.6) dimensions.

An additional rating question sought to identify what type of **mental health service** delivery option would be most appropriate for health practitioners/managers and/or their family members. The item was:

4. *If you and/or a family member were to require access to services to support mental health and wellbeing, rate **how likely** you would be to use each of the following options*

Six options were presented that varied from local services delivered face-to-face to online or virtual services delivered from a metropolitan location. Participants could also select 'Other' which provided the opportunity to comment. Rating responses were from '0 = Not at all likely' to '100 = Extremely likely'. The results are presented in Figure 23.

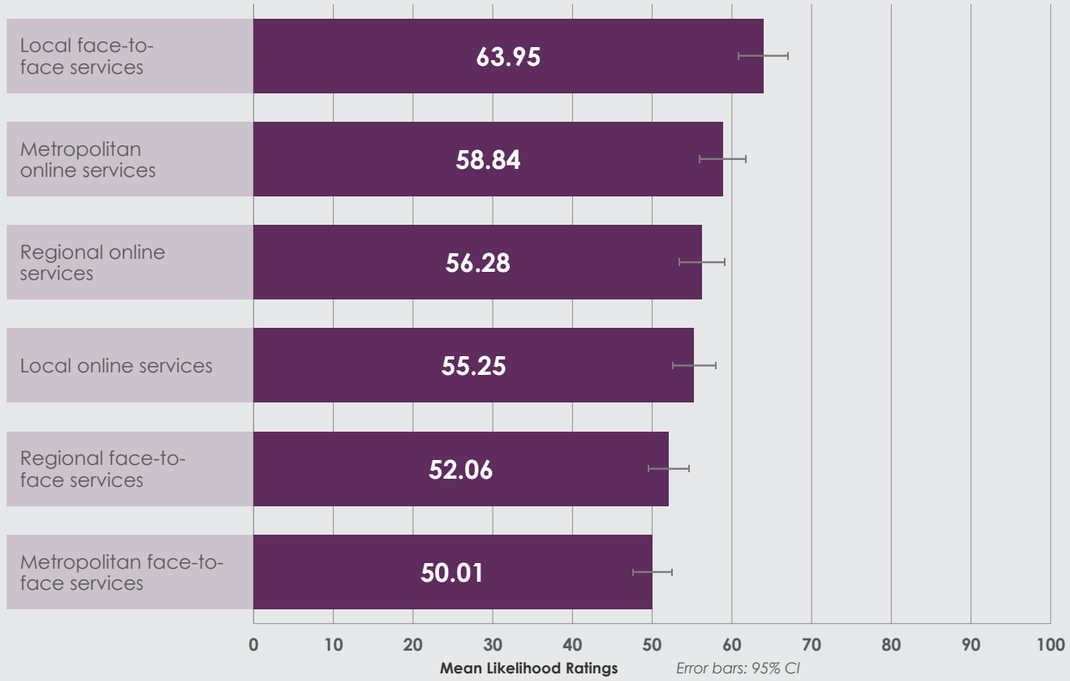


Figure 23: Mean ratings for mental health service delivery options

The results indicated that participants would prefer to access local face-to-face services (*M* = 64.0) to help support their own or their family's mental health and wellbeing. Interestingly, the results suggest that participants would be more likely to access online services in a metropolitan (*M* = 58.8), regional (*M* = 56.3), or local (*M* = 55.3) location than they would face-to-face services in regional (*M* = 52.1) or metropolitan (*M* = 50.0) locations.

Twenty-eight comments were received giving insight into 'other' preferred modalities practitioners/managers would be likely to use to support mental health and wellbeing. Some comments spoke to the lack of mental health services within their community, two comments mentioned having no current need to access mental health services but would if their circumstances changed. Two participants noted that they lived outside of the communities in which they practiced, while others indicated they would be more likely to utilise social and family networks for mental health support. One comment mentioned that, were they to seek mental health services, they would not want Ahpra to be notified. Five comments were variations of 'not applicable'.

Additional qualitative questions were asked to find out what would/has made it difficult for health practitioners or managers to access mental health services for themselves and/or family members, identification of possible barriers, and factors that would improve mental health and wellbeing among health practitioners/managers. The first of these items was about 'barriers', and the second was about factors to 'improve' access:

> *a. In some communities, health practitioners experience barriers to access for health and mental health services for themselves and/or family members. In your community, what* ***would make/has made*** *it* ***difficult*** *to access health and mental health services for you and/or your family?*
>
> *b. In your opinion, what is/are the most important factor(s) that would* ***improve*** *mental health and wellbeing among health practitioners in your community?*

Mental Health Barrier Comments

Comments were received from 637 participants. A thematic analysis was undertaken which identified three main themes:

1. Workforce Shortages (*n* = 341)
2. Privacy/Confidentiality Concerns (*n* = 154)
3. Cost (*n* = 74)

Responses for each of these themes are discussed below.

1. Workforce Shortages

Comments around workforce shortages were provided by over 50 percent of the participants. Interestingly, workforce shortages were mentioned for **mental health** services, **GP referral** appointments and within practitioners' **discipline of practice**. For instance, some comments about mental health workforce shortages were about not having any practitioners/services in the community or not enough to cope with demand:

"There is no mental health service in XXX* [Town]. *They have to go to YYY* [Town] *for this."
(Practice Manager, MM 6)

"Lack of services re mental health support, particularly private therapists."
(Social Worker, MM 4)

Comments about **GP workforce shortages** highlighted this as an issue for both accessing timely referrals to specialised mental health services and also for health and wellbeing support from the GP:

"Lack of GP access to gain referrals." (Podiatrist, MM 6)

"Getting a GP appointment to get referral and for the referral to be to someone who has availability."
(Occupational Therapist, MM 3)

Comments about workforce shortages indicated that some practitioners found it difficult to find time for health and wellbeing care for themselves and family members because of **their own workload**:

"Isolation and minimal support network. Working long hours 55+hr* [hour] *weeks and I have had no chance to meet other doctors. I feel like I literally would have no time to access support for myself even if it was needed, only option would be to reduce hours or leave the community." (Medical Practitioner, MM 6)

"Time away from work. I would prioritise the health of my children obviously but for myself and my husband (both allied health professionals), we are both fully booked for 6+ weeks. Taking time off and rescheduling our patients for our own medical appointments is just too difficult." (Exercise Physiologist, MM 2)

"Time off work. Feeling stressed about my work not being done whilst I am away and the huge catch up when I get back to work. It makes the whole experience not worth it!" (Nurse, MM 2)

Other participants mentioned the lack of appointment availability for services **outside of work hours** as being an important barrier:

"Working in the health care industry makes it challenging to access mental health services because of how our work is structured. It is not easy to take time off during the day to access mental health supports for yourself due to the nature of seeing clients consistently throughout the day. There is a limited availability* [of] *counselling psychology supports available after work hours, meaning health care workers are required to take time off during their day, unpack their mental health needs with a counsellor psychologist, then come back to work and walk* [sic] *with families again who have their own mental health concerns that are very often shared with us." (Speech Pathologist, MM 2)

Other participants noted that there were extensive **wait times** due to the lack of workforce:

"Waiting periods are exhausting." (Anonymous, MM 4)

"The wait lists for mental health and speech pathology have been very challenging for my children."
(Practice Manager, MM 5)

The other main issue related to workforce shortages was around the **lack of services**, particularly mental health services that were present in the community:

"Just the distance. I regularly see a psychologist, but it is a 3 hour round trip each time. There are closer counsellors, but I choose to travel further away." (Practice Manager, MM 5)

"Long wait lists and limited services. Need to travel for health appointments." (Occupational Therapist, MM 4)

"Telehealth services, as great an advancement as they are, are somehow just not the same as sit down face-to-face consultation. There is something to be said for being "present", both physically and mentally." (Practice Manager, MM 7)

2. Privacy/Confidentiality Concerns

Approximately 25 percent of participants commented about issues related **to privacy and confidentiality**. For many, the issue was tied to small communities and professional relationships, especially for mental health concerns; whereas privacy issues linked to **conflicts of interest** were thought to come into play if a dual relationship was developed when a professional colleague became a therapist:

"Difficult to access mental health support with people who either are, or one day could be, your colleagues. I access support outside of my working community for this reason." (Speech Pathologist, MM 4)

"The privacy factor. I often seek services away from the area in an effort to protect my privacy. Sometimes this means travelling to metropolitan areas, or using online services. Locally we have sought support for family members, however the level of care has been inconsistent." (Counsellor, MM 4)

"Working with all the GPs - knowing them as friends and colleagues can make it difficult to have discussions around personal health and mental health issues." (Practice Manager, MM 6)

For **GPs** in particular, there was concern expressed that it would be **too difficult to consult a mental health practitioner** that was also one of their patients or someone that they referred their patients to:

"Feeling unable to see practitioners who I refer to and/or see as patients." (Medical Practitioner, MM 4)

"I refer to and work closely with medical and allied* [health] *colleagues and don't want to see them for my personal health due privacy concerns. I see professionals in XXX* [Town] *if I can but with two very young children and a partner who works and all of us having health concerns it is very challenging to schedule appointments and maintain our work and home lives." (Medical Practitioner, MM 5)

Some participants wrote that the size of the town and/or the physical location of mental health services made it **difficult to use services** and keep it private:

"We are familiar with the providing service personnel, so there are blurred professional boundaries. Also - patients seeing you in waiting room etc." (Medical Practitioner, MM 4)

"The size of the community means that I struggle to have confidential sessions due to working with most practitioners or having social connections." (Social Worker, MM 4)

And finally, some participants labelled the **stigma** associated with mental health concerns as a primary reason that they would not use local mental health services:

"I'd say being health practitioners ourselves we feel vulnerable to the social stigma it may entail." (Dental Practitioner, MM 4)

"Stigma, worried about professional implications." (Medical Practitioner, MM 4)

"In rural communities it can almost be embarrassing to access local mental health services as people can get worried about what others think. I think the accessibility is fairly good for my community, but the stigma remains very negative and this can deter people." (Physiotherapist, MM 4)

3. Cost

Under the theme of **cost**, most participants mentioned either the cost **of services,** the cost of **taking time off** work, or the cost to seek those services in **other communities**:

"Cost of services - hardly any bulk billed service." (Medical Practitioner, MM 3)

"Time and money are the biggest factors. Life expenses in general leave little funds to allow for anything other than regular medication purchases and a rare visit to the dentist or optometrist." (Practice Manager, MM 2)

"Financial barriers, conflict of interest with practitioners, travel time needed to go to metropolitan areas, difficulty accessing patient travel services (e.g. no accommodation available for the rebate provided leaving significant out of pocket expenses)." (Psychologist, MM 4)

Improve Mental Health Comments

Comments were received from 632 participants about how mental health could be improved for them and their family members. A thematic analysis was undertaken which identified four main themes:

1. Increase Staffing (*n* = 241)
2. Management and Policies (*n* = 191)
3. Networking and Collaboration (*n* = 108)
4. Financial Support (*n* = 97)

Responses for each of these themes are outlined below.

1. Increase Staffing

Comments regarding increased staffing highlighted the need for **more mental health professionals** to address challenges in **accessing face-to-face services**:

"Greater access to face to face visiting mental health specialists." (Nurse, MM 3)

"More GPs and face-to-face psychology options." (Practice Manager, MM 2)

"More mental health providers, more practitioners to reduce burnout of health practitioners." (Occupational Therapist, MM 5)

Other comments emphasised the need to increase non-mental health staffing overall to **reduce caseloads**, **mitigate burnout**, and enable **shorter working hours**, thereby supporting a better **work-life balance**:

"More hands on deck to spread the load…" (Medical Practitioner, MM 3)

"Shared work load - use of nurse practitioner or RIPRN* [rural and isolated practice registered nurses] *nurses at hospital ED* [emergency department] *to reduce call outs, improve fatigue management." (Practice Manager, MM 6)

Some comments called for better access to **online/telehealth** services, and the ability to access services **without community knowing**:

"Access to telehealth online mental health supports, as well as leave to access non-local mental health supports face-to-face." (Medical Practitioner, MM 5)

"Access to anonymous providers - possibly telehealth, outside of business hours. Low cost." (Podiatrist, MM 3)

"Better access to virtual services to maintain better confidentiality and trust in accessing services." (Occupational Therapy, MM 4)

For GPs, having **mental health services** available specifically designed **for health practitioners** was considered important for some:

"Dedicated online and potential face to face access with professional help designed to assist medical practitioners." (Medical Practitioner, MM 6)

"Having separate services for health practitioners would be great to support mental health wellbeing of the practitioners. Also, giving regular health education to health practitioners about mental health well being and where to seek help would be great." (Medical Practitioner, MM 2)

2. Management and Policies

The management and policies theme encompassed comments suggesting the need to **reduce work hours**, **reduce administrative tasks**, and introduce **flexible workplace options**:

"Less workload and shorter working hours/less days. More down time to just collaborate and chat as a team..." (Speech Pathology, MM 4)

"Value GP's and their time - improve streamline Medicare claiming - reduce Medicare numbers (there are so many!); stop adding to the paperwork 'more things to do' list; change paperwork requirements i.e.. how long referral valid for and ensure Hospitals don't continue to put work on GP's i.e.. not accepting referrals because of something minor; or discharge someone and don't provide info to GP's or say to them - make appoint[ment] with your GP tomorrow for follow up care (when there has been no confirmation with GP that this is feasible)." (Practice Manager, MM 3)

"Work flexibility, more easily being able to take leave, less night shifts for registrars." (Medical Practitioner, MM 4)

Some comments called for practices to **prioritise staff health and wellbeing**, and increase **local CPD opportunities**:

"Prioritise mental and physical well-being of employees." (Physiotherapist, MM 6)

"Professional development and integration opportunities." (Psychologist, MM 3)

3. Networking and Collaboration

Comments under the networking and collaboration theme highlighted the need for **networking events** to help health staff improve their mental health and wellbeing through social connections:

"Networking amongst ourselves but discussing matters or engaging in activities other than work related ones." (Dentist, MM 4)

"Locally held social networking events may be beneficial. The PHN does a bit of this, but it's not very often… Events of this nature are an opportunity for people to meet, decompress in a relaxed atmosphere, and improve social connectedness…" (Registered Counsellor, MM 4)

Many comments spoke to better collaboration between service providers in order to get to **know other health professionals** in the community, and look to **integrate services** to meet community needs:

"Increased scope of practice and working well in multidisciplinary team. Working together for greater good of communities." (Nurse Practitioner, MM 2)

"Opportunity to work together/interact and get to know what makes each other's life easier." (Dentist, MM 3)

Comments also identified the need to understand **pathways for mental health support**, and gain awareness of all **services available**:

"Potentially setting up formal links with organisations and providers e.g. contracts, direct referral pathway. This ensures there is accessibility and a safe environment for the providers." (Occupational Therapist, MM 4)

4. Financial Support

Comments falling under the financial support theme were mainly focused on **increased funding for mental health services**, as well as **better pay** for workers generally:

"The financial side of things always improves mental health. We have been forced to private bill patients due to the low Medicare rebate available that has not matched inflation. We still BB [bulk bill] pension and concession card holders, but this is not sustainable long term, and we live in a very low socio-economic area that these concession patients would not be able to afford private fees. This creates mental strain on the health practitioners who want to change to private bill[ing] to supplement the lost income, but the pressure of still being able to provide affordable health care to patients. It is sacrificing themselves to accommodate." (Practice Manager, MM 5)

"What our community does need however is the availability of physical and mental rehab and regularly required allied health services so those with disability (accessing NDIS funding) can stay locally to receive the care they need. It also needs better support financially for those services so it is viable for them to stay practising in the community, so there is a balance between public and private health care providers." (Physiotherapist, MM 6)

"…Presently we work over our capacity daily and still receive a disappointing low remuneration. This leads to stress burnout and poor job satisfaction." (Medical Practitioner, MM 4)

Some allied health participants called for **rural incentive** changes to include payments for those already working rurally:

"70k incentive to stay working rurally, not to attract staff and then they leave as soon as they can. More senior opportunities." (Physiotherapist, MM 5)

"… a bonus payment if staying in the community and reaching milestones, like the newcomers receive…" (Physiotherapist, MM 4)

Quantitative Methodology Findings: Priority SA2s

Below are the top 10 highest rated SA2s for each region (except Western Queensland, where five are provided to reflect fewer SA2s within the region), based on the quantitative methodology described on page five of this report. The methodology incorporates; GP FTE to population ratio (excluding locum, outreach and secondary roles), MM classification of remoteness, Socio-Economic Indexes for Areas [SEIFA (IRSAD)], vulnerable population aged < 5 or > 65 years, and Aboriginal and Torres Strait Islander population. Priority SA2s indicate areas of possible current and/or ongoing workforce need. Newly featured priority SA2 regions have been highlighted in bold and movement relative to last year has been indicated in brackets. Appendix A outlines the main towns or communities located within each SA2.

Central Queensland, Wide Bay, Sunshine Coast PHN Region

Kilkivan
Burrum – Fraser
Monto – Eidsvold (+2)
Cooloola (+4)
Maryborough Surrounds – South (-1)
Gayndah – Mundubbera (+4)
Bundaberg Surrounds – North (-4)
Central Highlands – East (+1)
Agnes Water – Miriam Vale (-2)
Gin Gin (-4)

Darling Downs and West Moreton PHN Region

Stanthorpe Surrounds
Crows Nest – Rosalie (+8)
Millmerran (+4)
Miles – Wandoan (-3)
Southern Downs – West (+1)
Kingaroy Surrounds – North (-1)
Esk (-4)
Chinchilla (-6)
Inglewood – Waggamba
Southern Downs – East (-2)

Northern Queensland PHN Region

Croydon – Etheridge
Tablelands
Northern Peninsula
Collinsville (+14)
Kowanyama – Pormpuraaw (-1)
Burdekin (+2)
Torres Strait Islands (-1)
Herberton (-1)
Babinda
Aurukun

Western Queensland PHN Region

Far Central West
Mount Isa Surrounds
Balonne (+2)
Far South West (-1)
Carpentaria (-1)

It should be emphasised that this list is not a comprehensive reflection of the health workforce need in these regions. The findings of the quantitative methodology are triangulated at the local level to further explore workforce need through ongoing communication and collaboration. HWQ also utilises the guiding principles that were developed to support prioritisation of SA2 locations in a constantly changing environment, and to assist in prioritising our services and activities.

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
- 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 and their families
- 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 all 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 in 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 enhance 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 to complement activities undertaken by Aboriginal and Torres Strait Islander 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
- Reduced interest in rural health, general practice and primary care as career choices
- Placement poverty - health students unable to afford costs associated with completing remote and rural practicum placements, with limited financial support available
- Lack of suitable and affordable accommodation for students completing remote and rural 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
  - Not all current models support 'Easy Entrance, Gracious Exit' of workforce creating financial, administrative and work/life balance burdens
- Poor retention due to lack of access to continuing professional development, professional isolation, burnout due to lack of relief, lack of suitable 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 workforce shortages and lack of access to appropriate services

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
- Collaborate with universities to prioritise long-term student placements, providing suitable accommodation and financial support, including subsidised or free housing for placements in remote or rural areas
- Availability of end-to-end training in remote and regional 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 dependents, 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:

- Allied Health Assistants National Association (AHANA)
- Australian College of Midwives (ACM)
- Australian College of Rural and Remote Medicine (ACRRM)
- Australian Health Practitioner Regulation Agency (Ahpra)
- Australian Indigenous Doctors' Association (AIDA)
- Australian Institute of Paramedic Practitioners (AIPP)
- Australian Primary Health Care Nurses Association (APNA)
- Central Queensland Centre for Rural and Remote Health (CQRRH)
- CheckUP Australia
- Congress of Aboriginal and Torres Strait Islander Nurses and Midwives (CATSINaM)
- Country to Coast, QLD
- CRANAplus (Council of Remote Areas Nurses Australia)
- Darling Downs West Moreton Primary Health Network (DDWM PHN)
- Indigenous Allied Health Australia (IAHA)
- James Cook University (JCU)
- Murtupuni Centre for Rural and Remote Health (MCRRH), James Cook University
- My Midwives
- National Association of Aboriginal and Torres Strait Islander Health Workers and Practitioners (NAATSIHWP)
- Northern Queensland Primary Health Network (NQ PHN)
- Office of the Chief Allied Health Officer, Department of Health Queensland
- Office of the Chief Nurse Officer, Department of Health Queensland
- Office of Rural and Remote Health, Department of Health Queensland (ORRH)
- Queensland Aboriginal and Islander Health Council (QAIHC)
- Queensland Country Practice, Queensland Rural Medical Service, Darling Downs Hospital & Health Service
- Queensland Mental Health Commission
- Remote Vocational Training Scheme (RVTS)
- Royal Flying Doctors Service (RFDS), Queensland Section
- Rural Doctors Association of Queensland (RDAQ)
- Services for Australian Rural & Remote Allied Health (SARRAH)
- Southern Queensland Rural Health (SQRH)
- The Parenthood Alliance
- The Royal Australian College of General Practitioners (RACGP)
- The University of Queensland (UQ)
- Tropical Australian Academic Health Centre (TAAHC)
- Western Queensland Primary Health Network (WQ PHN)
- Workforce Strategy, Clinical Planning and Service Strategy Division, Department of Health Queensland

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Appendix A – Priority SA2s by PHN Region

Central Queensland, 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	Monto – Eidsvold	Eidsvold Yandaran Mulgildie Mount Perry
4	Cooloola	Cooloola Rainbow Beach Tin Can Bay
5	Maryborough Surrounds – South	Brooweena Mungar Tiaro
6	Gayndah – Mundubbera	Biggenden Gayndah Mundubbera
7	Bundaberg Surrounds – North	Bucca Yandaran
8	Central Highlands – East	Blackwater Dingo Woorabinda
9	Agnes Water – Miriam Vale	Agnes Water Miriam Vale Seventeen Seventy
10	Gin Gin	Gin Gin

Appendix A – Priority SA2s by PHN Region Continued

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

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	Collinsville	Collinsville Mount Wyatt Scottville
5	Kowanyama – Pormpuraaw	Kowanyama Pormpuraaw
6	Burdekin	Brandon Home Hill
7	Torres Strait Islands	Badu Island Boigu Island Mabuiag Island Saibai Island
8	Herberton	Herberton Mount Garnett Ravenshoe
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	Balonne	Dirranbandi Mungindi St George Thallon
4	Far South West	Cunnamulla Thargomindah Quilpie
5	Carpentaria	Burketown Carpentaria Mornington Island Normanton Karumba

Appendix B – Professions and Occupations

Aboriginal and Torres Strait Islander Health Worker and Health Practitioner	Occupational Therapist
Alcohol and Other Drugs Worker	Optometrist
Allied Health Assistant	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 (Enrolled/Registered/Practitioner)	Speech Pathologist

Acronyms and Abbreviations

Below is a list of frequently used acronyms throughout the report.

ABS	Australian Bureau of Statistics
AHP	Allied Health Professional/Practitioner
Ahpra	Australian Health Practitioner Regulation Agency
AHRGP	Allied Health Rural Generalist Pathway
APNA	Australian Primary Health Care Nurses Association
CPP	Clinical Prac Placement
DHDA	Department of Health, Disability and Ageing
EN	Enrolled Nurse
FIFO	Fly-in, fly-out
FTE	Full Time Equivalent
GP	General Practitioner
HWNA	Health Workforce Needs Assessment
HWQ	Health Workforce Queensland
HWSG	Health Workforce Stakeholder Group
IAHA	Indigenous Allied Health Australia
IMG	International Medical Graduate
IRSAD	Index of Relative Socio-economic Advantage and Disadvantage
MBS	Medicare Benefits Scheme
MM	Modified Monash

Acronyms and Abbreviations Continued

NAATSIHWP	National Association of Aboriginal and Torres Strait Islander Health Workers and Practitioners
NDIS	National Disability Insurance Scheme
NHWDS	National Health Workforce Dataset
NRHA	National Rural Health Alliance
NP	Nurse Practitioner
PHN	Primary Health Network
RACGP	Royal Australian College of General Practitioners
RN	Registered Nurse
SA2	Statistical Area Level 2

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