Queensland Health Workforce Gap Analysis

Measuring our health workforce challenges

PART A: The System View

DELIVERING FOR QUEENSLAND | Queensland Government

Queensland Health Workforce Gap Analysis

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Disclaimer

Foreword

As Minister for Health and Ambulance Services, I witness the dedication and expertise of more than 130,000 skilled professionals who deliver world class public healthcare services to Queenslanders every day. Over the past 12 months, as I've travelled across the state, I have made it my priority to listen to and learn from our hardworking frontline staff. I have seen firsthand that the Queensland Health workforce is resilient and determined, but it is also facing growing challenges that require timely attention, investment, and action.

The Queensland Health Workforce Gap Analysis represents an important step toward a fresh start for our health workforce, underpinned by data, evidence, and clinical insight.

Queensland Health's workforce is increasingly expected to deliver more complex services, to the highest standard, for a growing and ageing population. Both the data and clinical perspectives tell a similar story; staff shortages across certain locations and professions are real and are deeply felt across the state and country. These workforce gaps add unnecessary pressure on already busy teams who continue to go above and beyond to meet patient needs and deliver excellent care.

We also recognise that workforce gaps impact access to timely care for patients. In many of our rural and remote sites, even small workforce shortages can create significant risk of service closure, which affects individuals, and has flow-on effects for communities. We recognise that workforce gaps are the result of specific causes or circumstances, such as a historical lack of investment, innovation, or coordination. The Queensland Government is working to better understand Queensland Health's workforce challenges in order to identify the system changes that will have the biggest impact, both now and into the future.

This comprehensive body of work is a critical first step to understanding the problem in detail so that efforts can be targeted to provide the greatest advantage for our workforce and our patients. This is the key to developing a cohesive and coordinated **systemwide workforce plan** for action, in line with the Queensland Government's election commitment. These reports outline what has been learned from the analysis of current workforce data, and from projections about future workforce supply and demand. The work done to produce this gap analysis will ensure the foundation of the new workforce plan is driven by detailed data, robust analysis of a broad evidence base, and engagement across the health sector.

As part of this process, Queensland Health reached out to all 16 Hospitals and Health Services (HHSs) and the Queensland Ambulance Service. Listening to our clinicians and local teams is at the centre of how we move forward. Their insight and expertise are essential to building a system that adapts and improves every day to meet community expectations, service demand, and workforce needs.

The workforce analysis is detailed and provides evidence, details, and confirmation of apparent and emerging issues and trends facing the health workforce. The findings demonstrate maldistribution and workforce growth rates that continue to favour metropolitan areas. There are significant workforce gaps, particularly in rural and remote services, the Aboriginal and Torres Strait Islander health workforce, oral health, podiatry, psychology, and laboratory science. Emerging challenges are evident in the retention and supply of midwives, medical officers, and some allied and oral health professions.

The professionalism shown every day by Queensland Health staff is the foundation on which we can build solutions to the shortages identified by this analysis. I am pleased to share the findings of the Queensland Health Workforce Gap Analysis and invite you to contribute to the development of a unified plan that will respond to these challenges. We are committed to working together to strengthen the health workforce and ensuring a public health system Queenslanders can continue to be proud of.

Tim Nicholls MP
Minister for Health and Ambulance Services

Contents

Summary

Our analysis and consultation across the health system reveals four core problem areas that are impacting the operation and future effectiveness of Queensland's health workforce. These challenges directly affect the system's ability to deliver the care that Queenslanders need. The chronic and serious nature of the challenges should increase the urgency of delivering meaningful, sustainable change.

Key findings - Part A

Part A of the report outlines the four system-level challenges and presents evidence from the analysis of the Queensland Health workforce relating to each one.

1. **Inequitable access**: Workforce maldistribution leaves some communities, especially rural and remote areas, without sustainable access to services.

2. **Outdated models:** Too often, services are shaped by existing workforce structures rather than by community and patient needs. The balance between specialists and generalists means the health system is less flexible to respond to changing need.

3. **Demand outstripping supply:** Workforce growth is not keeping pace with population growth, an ageing population and increasing demand for health care.

4. **Barriers to growth:** Issues with culture, career pathways, and inconsistent investment in development limit our ability to develop, sustain and grow our workforce.

Part A explores each of these challenges through a series of problem statements. These are supported by quantitative and qualitative evidence revealing current gaps and estimates of future supply and demand patterns. Part A concludes with an overview of system enablers to support responses to the identified challenges for consideration in the new workforce plan. A review of the limitations of the analysis is also included.

Key findings - Part B

Part B of the report presents findings at a profession-specific level. The results show changing workforce and community demographics, emerging patterns in ways of working and, in several cases, significant maldistribution. Some cross-professional themes from the analysis in Part B are presented below.

1. **We are losing too many early and mid-career professionals**: Training as a member of the health workforce is a substantial personal and system investment. Too many early career (nursing, midwifery and oral health) and early-mid career (allied health and medicine) professionals leave Queensland Health and, at times, the health sector completely.

2. **More of the same may not be what Queenslanders need**: The methods used do not account for emerging models, professions or treatments and so can only guide some of the way forward. This is also reflected in the lack of uptake of newer roles, such as Aboriginal and Torres Strait Islander health practitioners.

3. **Low volume, hard to fill roles**: While our large professions get a lot of focus, securing the pipeline for low volume, hard to fill roles takes deliberate and thoughtful intervention to support succession planning and sustainable service delivery.

4. **The pipeline is uncertain**: While some models of our workforce appear robust, others show significant future gaps. The high variability in model outcomes shows projections are uncertain and demonstrates that small changes in assumptions result in very different conclusions. Planning needs to account for uncertainty and a wide range of potential outcomes.

The analysis presented in Part B provides valuable inputs for developing a workforce plan that is a practical roadmap to building a stronger, more sustainable health workforce for Queensland.

Understanding the gap analysis

Purpose

The workforce gap analysis aims to provide a comprehensive overview of the composition, profile, distribution, and work patterns of the health workforce in Queensland, with a focus on Queensland Health workforce, including the Queensland Ambulance Service (QAS) and primary care. There is a particular emphasis on identifying where there are current, persistent, and emerging workforce gaps[1], within the limitations of current data and selected methodologies.

Why this work is important

Health workforce shortages present a critical challenge for services that are already under pressure from a rapidly advancing health sector, a growing and ageing population, and community expectations for increasing standards of care.

At the end of 2024–25, Queensland Health had a workforce gap of approximately 3,500 full-time equivalent (FTE)[2] staff with the allied health, oral health, and Aboriginal and Torres Strait Islander health workforce most affected. Around 11% of identified gaps persisted for more than a year (referred to as persistent gaps throughout the report)[3].

Next steps

Understanding our workforce better, including where our workforce gaps are, provides Queensland Health with a clear pathway for action. While the gaps may indicate a need for workforce growth or further investment, they also provide an opportunity to examine existing service and workforce models to determine if innovation or new ways of working are needed.

The outputs of the gap analysis will be used to guide the identification of evidence-based priorities and the development of actions in a new systemwide workforce plan that will lead to positive workforce change for the Queensland health system.

Scope

Inclusions

The scope of the gap analysis includes quantifying current and future workforce shortages and maldistribution across the Queensland health system, using Queensland Health workforce data and publicly available data on the wider health system. Throughout the gap analysis, there are some considerations of the whole health sector, including both public and private workforce. Where Queensland Health data has been analysed, this is only inclusive of the public sector workforce. Data includes the clinical, clinical support, and enabling workforce streams across Queensland Health and QAS.

The data was considered in the context of broader workforce trends across the health and social care sectors, including primary care.

Qualitative insights from consultations with Hospital and Health Services (HHSs), Queensland Health and QAS were used to inform and shape the gap analysis, particularly in areas where quantitative data was not available.

The assessment of the *current* workforce state involves analysis of workforce gaps, workforce distribution, demographics, attrition rates, patterns of temporary and part-time work, and overtime utilisation.

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[1] Defined for this work as where approved full-time equivalent (FTE) (establishment) does not match Minimum Obligatory Human Resource Information (MOHRI) FTE. MOHRI FTE is the data Queensland Government agencies provide for official reporting. MOHRI is a measure of all active and paid positions remunerated through the Queensland Health payroll system within a set period. MOHRI FTE excludes workforce associated with outsourced service delivery.

[2] Queensland Health Payroll data as at end of June 2025.

[3] Queensland Health Payroll data as at end of June 2025.

The evaluation of the *future* workforce state includes evaluating future health workforce supply and demand. Workforce supply analysis considers geography and education pipelines (capacity and output) for the clinical professional areas, while future demand assessment is based on demographic health service delivery trends and historical trends in workforce utilisation.

Exclusions

The scope of the workforce gap analysis purposefully does not include operational workforce planning, service-specific workforce modelling, or financial modelling and analysis. While the analysis facilitates the identification of workforce gaps and challenges, the scope excludes developing solutions, strategies, policies, or implementation plans to respond to them until the gaps and challenges have been explored in partnership with the sector.

Methodology

The different methodological approaches employed in the gap analysis are reflected in the outputs presented in the two reports:

- Part A reflects a systems-based approach, bringing together the quantitative and qualitative analysis of current workforce market dynamics, expressing them as problems and challenges to be solved to support and enable service delivery.

- Part B takes a traditional, vertical approach, drawing on a detailed analysis of Queensland Health and external health sector workforce data to assess the current state, emerging trends, and potential future needs across each professional area.

Identification and presentation of Queensland Health's workforce challenges and gaps was enabled through diverse and detailed analyses of current and future gaps at both the Queensland Health and whole-of-health sector level. Table 1 summarises the methods and data sources used to analyse current and future gaps for the Queensland Health workforce and for the entire health sector.

Table 1: How the gap analysis was undertaken.

	Current gaps	Future gaps
Whole-of-sector	Analysis of Queensland's registered health workforce is based on the National Health Workforce Dataset. This was supplemented with analysis of some self-regulated allied health professions[4] using the Australian Bureau of Statistics' Census of Population and Housing (Census), where this was available.	Projection of workforce supply at whole-of-sector level for Queensland is based on: • workforce counts from registration data and Census data • workforce exits from registration data or Queensland Health data • workforce entries from higher education pipeline data.
Queensland Health	There is no single workforce metric that can demonstrate where Queensland Health has current workforce shortages and gaps. As such, the approach to assessing current gaps has been developed by bringing together analysis of Queensland Health's payroll data and data from other sources to identify where:	The methodology for assessing future workforce <u>demand</u> is based on the historical relationship between Queensland Health MOHRI FTE and population growth. The population has been weighted by age based on service utilisation patterns from 2013 to 2023. The methodology for modelling future workforce <u>supply</u> uses Australian Health Practitioner Regulation Agency (Ahpra)

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[4] Data is not available for all self-regulated allied health professions. Analysis focussed on audiology, speech pathology, nutrition/dietetics, sonographers and social workers as this data was available in the Census using ANZSCO occupation codes and these workforces comprise a considerable proportion of Queensland Health's allied health workforce.

Current gaps	Future gaps
• approved positions[5] are assessed as unoccupied at a point in time (last pay period of 2025) • leave utilisation is contributing to workforce gaps • we have persistent vacancies in permanent roles • we rely on temporary workforce through use of casuals, locums, agency staff, or temporary positions • we overutilise our workforce (measured through overtime hours) • our workforce is leaving Queensland Health (attrition rates) • workforce composition and demographics are altering workforce expectations and needs (analysis of workforce demographics).	registration data for registered professions and Census estimates for self-regulated allied health professions. The projection of the supply of the Queensland Health workforce is based on applying historical market share data to statewide projections and then modelling the impact of workforce fractionalisation trends (FTE per headcount).

Interpretation of findings

The workforce gap analysis findings should be interpreted with consideration to the intentions and limitations of the analysis.

Our intention was to understand current gaps, workforce trends, and future needs to develop targeted and effective actions and initiatives that respond to current and emerging service and workforce needs.

Queensland Health needs to grow the health workforce as our population increases and ages. The demand projections in this report highlight the extent of the gap and need for change, but they are not precise growth targets. The intention is to show why we need to think about doing things differently by innovating, providing care in different settings, and building alternative workforces.

The limitations of the analysis should be understood as we explore the findings across both the Part A and Part B reports. Below are some of the key limitations.

- The availability of reliable, accurate, and complete workforce data is limited, both within Queensland Health and across the health sector.

- Supply and demand projections are based on historical trends rather than future consumer needs and have methodological limitations.

- Workforce projections do not consider changes to models of care, professional boundaries, or community demand. Some of these factors are expected to change through the impact of the new workforce plan.

- Workforce is critical to service effectiveness, however, other factors negatively impacting the achievement of activity targets, including resource adequacy and system inefficiencies, are considered outside of this body of work.

The final section of the Part A report discusses the limitations of the analysis in more detail.

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[5] Defined for this work as where approved FTE (establishment) does not match MOHRI FTE. MOHRI FTE is the data Queensland Government agencies provide for official reporting. MOHRI is a measure of all active and paid positions remunerated through the Queensland Health payroll system within a set period. MOHRI FTE excludes workforce associated with outsourced service delivery.
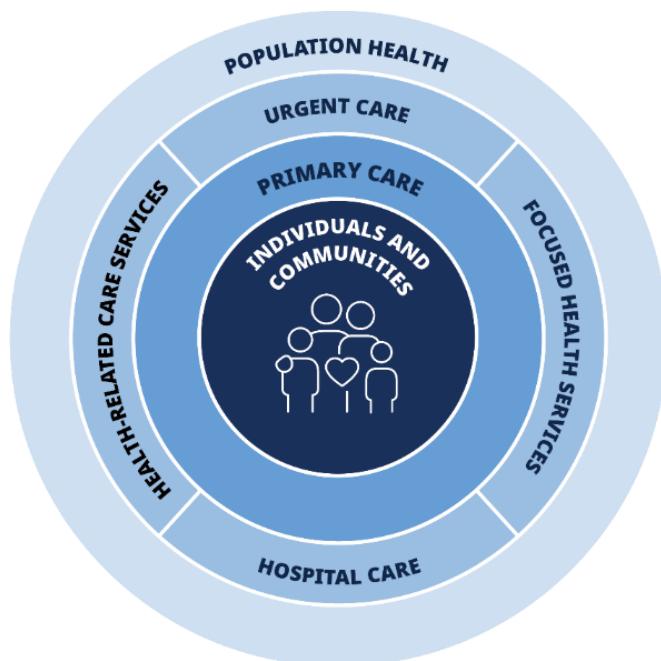
Current context

Understanding the context in which the health workforce operates provides a foundation to effectively analyse, plan, train, and deploy Queensland's future health workforce. This knowledge supports a more integrated and adaptive approach, aligning workforce strategies with community needs rather than traditional professional boundaries or institutional silos.

A broad system of healthcare

Queensland's health and social care system is a complex, interconnected network of services, providers, and professionals working together to meet diverse community needs. It encompasses public and private hospitals, general practices and primary care providers, Aboriginal community-controlled health organisations, pharmacies, aged care services, disability services, ambulance, and aeromedical retrieval services, among others.

Instead of focusing on individual providers or professions, it is useful to think of the system as having a set of core functions, including prevention, diagnosis, treatment, rehabilitation, and support that are delivered by various providers and connected services. This functional perspective, illustrated in Figure 1, facilitates flexible, responsive, and community-specific service delivery.

Primary care: Person-centred preventative and subacute care for individuals and families, provided by a trusted team in clinics, homes, or virtually.

Urgent care: 24-hour emergency response, retrieval, and evacuation for serious conditions.

Hospital care: Complex care with monitoring, tests, or procedures in hospital settings.

Focused health services: Specialised care for specific health needs.

Health-related care services: Personal support for older people or those with disability, including home, residential, transport, and access assistance.

Population health: Organised action to improve community wellbeing.

Figure 1: The healthcare system.

Challenges facing the health workforce

There are four broad types of challenges impacting Queensland's health workforce. These are described below through problem statements that capture the key findings from the data analysis undertaken, supported by stakeholder feedback.

The systemwide health workforce plan is a subsequent body of work that will consider and respond to these challenges.

1	Workforce maldistribution creates inequitable access to sustainable healthcare.	
1.1	**Geographic maldistribution of workforce limits equitable access to care.**	The health workforce in Queensland is unevenly distributed, with a high concentration in metropolitan centres and persistent shortages in rural and remote areas. This imbalance strains our services and our workforce, and increases the risk of poorer health outcomes for vulnerable communities[6].
1.2	**Critical workforce shortages and inflexible service delivery and funding models impact capacity to deliver rural, remote and some regional services.**	Small changes in the availability of healthcare providers in rural areas can have significant impacts on the sustainability of local service delivery. The loss of even one clinician can result in the closure or bypass of a service, as seen historically with regional birthing services. In small communities, this can pose critical risks to continuity of care.
1.3	**Lack of sustained investment in subacute and preventative care has limited the capacity of these service providers, causing a shift in demand to acute settings.**	Service and capacity limitations in sectors like primary care (including maternity services), aged care, and disability services increase demand for high-cost acute care services. This leads to high volumes of emergency department presentations, preventable hospital admissions, extended hospital stays for patients who are older or who have a disability, and poorer patient experiences and health outcomes.
		Pressure on the health workforce is greater due to the complex care needs of patients who may be best cared for in alternative settings, and due to the increased need to manage the delivery of care at the interface of health and other sectors, such as the aged care and disability sectors.

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[6] Stewart R. Building a rural and remote health workforce: an overview of effective interventions. Med J Aust 2023; 219 (3) S3-S4.

2	Our current ways of working do not always meet community expectations or needs.	
2.1	Our workforce culture and structures are inflexible and are built upon professional silos instead of care needs.	Existing workforce structures are rigid, with roles that are increasingly subspecialised, services that are siloed, and professional scopes of practice that limit the delivery of patient-centred models of care by multidisciplinary teams. This inflexibility restricts responsiveness and agility, and contributes to productivity challenges, difficulty accessing healthcare, and negatively affects rural and remote communities.
2.2	Our workforce should represent the communities we care for.	Broadening workforce participation, especially for underserved and under-represented cohorts, does more than just grow the workforce to the size we need to meet future demand. A diverse and representative workforce that reflects the population it serves contributes positively to the safety and quality of services provided[7]. Existing pathways into the health workforce can be limited, unclear, or inaccessible for people from under-represented communities or diverse backgrounds.
2.3	Our services need to be culturally safe.	Healthcare consumers, including Aboriginal and Torres Strait Islander peoples, continue to report experiences of care that feel culturally unsafe, unresponsive, or exclusionary. These experiences can lead to delays in accessing care, avoidance of care, poorer health outcomes, and preventable hospitalisations. Embedding cultural safety and responsiveness across the health workforce is essential for breaking down these barriers. Cultural safety is equally important within the health workforce environment. Despite their critical role in care delivery, Aboriginal and Torres Strait Islander peoples seeking to enter the health workforce experience barriers to employment, training, and career development[8].

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[7] Buh A, Kang R, Kiska R, Fung SG, Solmi M, Scott M, Salman M, Lee K, Milone B, Wafy G, Syed S, Dhaliwal S, Gibb M, Akbari A, Brown PA, Hundemer GL, Sood MM. Effect and outcome of equity, diversity and inclusion programs in healthcare institutions: a systematic review protocol. BMJ Open. 2024 Apr 18;14(4).

[8] Bailey J, Blignault I, Renata P, Naden P, Nathan S Newman J. Barriers and enablers to Aboriginal and Torres Strait Islander careers in health: A qualitative, multisector study in western New South Wales. Aust J Rural Health. 2021; 29:897-909.

CONSULTATION DRAFT: Not government policy.

3	Workforce supply is not keeping pace with growth in demand.	
3.1	**Queensland Health is experiencing statewide workforce shortages.**	The health and social care sectors are now Queensland's largest employers. In 2005, these sectors made up 9.4% of the state's workforce. By early 2025, that figure had grown to 16.5%[9]. The number of health workers per capita has risen from 19 per 1,000 people in 2013 to 26 per 1,000 in 2023. In 2023, Queensland had around 141,000 registered health professionals working in clinical roles – nurses, midwives, doctors, physiotherapists, pharmacists, psychologists, dentists, Aboriginal and Torres Strait Islander health practitioners, paramedics, and other health professionals – representing a 58% increase from 2013[10]. This growth reflects the increasing demand for care. The health workforce is not confined to registered clinicians. It also includes self-regulated allied health practitioners with accredited training, and a diverse clinical support and non-clinical workforce, including technical, administrative, operational and professional staff who are essential to delivering modern healthcare.
3.2	**Health workforce supply is not keeping pace with service demand.**	The availability of education, training, and ongoing development and career progression opportunities is higher in metropolitan locations, which contributes to long-term workforce maldistribution. Strategic partnerships with universities, TAFEs, and other education providers are necessary to accelerate training pathways and align graduate output with Queensland Health's evolving workforce needs. Greater collaboration is needed between education and health service providers to ensure growth in trainee numbers aligns with clinical placement and training opportunities, as well as staff capacity to supervise and provide training.

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[9] Australian Bureau of Statistics (March 2025), Labour Force, Australia, Detailed, ABS Website, accessed June 2025.
[10] Queensland Health analysis of the National Health Workforce Dataset.

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4	Workforce growth and retention are hindered by culture and leadership gaps, and fragmented approaches to career and professional development.	
4.1	**Retention of our workforce is crucial for addressing current and future supply challenges.**	In 2024–25, the overall Queensland Health attrition rate was 5.17%. While it has been higher in the past, some professional streams are experiencing elevated attrition rates. At a time when the health workforce is in significant demand, retaining the existing workforce is top priority. High retention rates have many benefits, including protecting valuable investment in training, supporting the retention of corporate and clinical knowledge, contributing to future leadership and mentoring capacity and capability, and supporting continuity and quality of care[11].
4.2	**Workplace culture, career pathways, and leadership are key factors in workforce attrition, including early career departure.**	Skilled, mobile healthcare professionals seek opportunities for professional development and career advancement, job satisfaction, and professional fulfilment. Without access to development opportunities, and a clear line of sight for career progression, these professionals may seek alternative employment locations, pathways, organisations, careers, or sectors[12]. Early career professionals may leave due to challenges with transition to professional practice or unsupportive workplace cultures[13]. Other factors may include limited support, heavy workloads, inflexible ways of working, unclear development pathways, and poor leadership and culture.
4.3	**Workforce and leadership capabilities are not well aligned with health system needs, reducing adaptability and engagement.**	The health workforce operates within a complex, rapidly changing, and geographically dispersed environment that requires agility, collaboration, and innovation to deliver sustainable and high-quality care. Disconnected workforce capability planning, delivery, and evaluation processes limit visibility of systemwide challenges, increasing the complexity and cost of aligning investment with need. Prioritising a coordinated approach would sharpen focus, enabling efficient and timely investment in outcome-focused solutions to lift workforce capability, adaptability, mobility, career progression, and overall engagement.

[11] De Vries N, Lavreysen O, Boone A, Bouman J, Szemik S, Baranski K, Godderis L, De Winter P. Retaining Healthcare Workers: A Systematic Review of Strategies for Sustaining Power in the Workplace. Healthcare (Basel). 2023 Jun 29;11(13):1887.
[12] Lantz B, Fagefors C. Assessing factors associated with nurses leaving the profession: A secondary analysis of cross-sectional data. Internat J Nursing Studies Vol 8, June 2025.
[13] Donnelly E, Lee J Donnellan-Fernandez R. Understanding attrition of early career midwives in Australia. J Aust College Midwives Vol 37, Iss 4, July 2024.

The findings

1. Workforce maldistribution creates inequitable access to sustainable healthcare
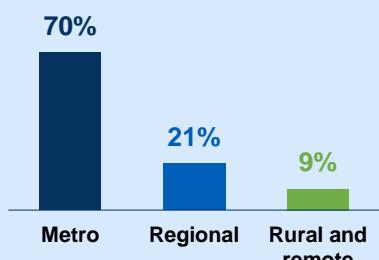
This section presents three targeted problem statements, each supported by evidence, to illustrate the broader challenge of workforce maldistribution across Queensland. It highlights how the uneven distribution of the health workforce directly affects the state's ability to deliver service stability and high-quality care, particularly in rural, remote, and underserved communities.

Rather than viewing maldistribution as a static issue, the analysis demonstrates its dynamic impact on service accessibility, workforce sustainability, and system resilience. The analysis reveals that health workforce availability and growth are lower in rural and remote areas, and that gaps continue to be greatest in these locations, impacting what services can be delivered. These insights are critical to informing strategic workforce planning and policy responses that address not just the quantity of services, but *where, how* and *by whom* care is delivered across Queensland.

1.1: Geographic maldistribution of workforce limits equitable access to care.
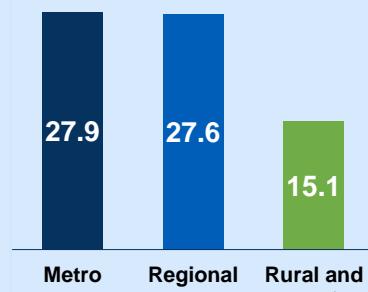
The evidence

The distribution of the registered health workforce is skewed toward metro areas[14].

Metro	Regional	Rural and remote
70%	21%	9%

This varies by profession – see Appendix A.
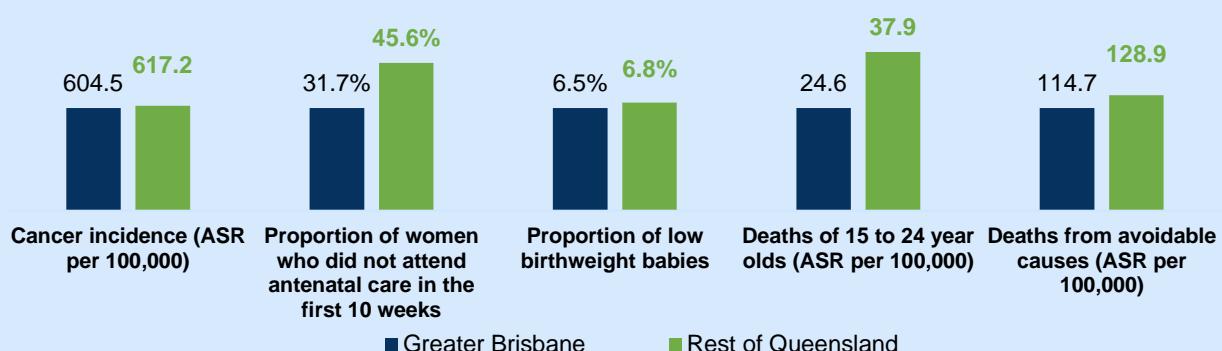
Health workforce per 1,000 population is significantly lower in rural and remote areas[14].

Metro	Regional	Rural and remote
27.9	27.6	15.1

Workforce growth over the last 10 years has occurred primarily in metro areas[14].

72%

This is associated with poorer health outcomes outside of our metro areas[15].

	Greater Brisbane	Rest of Queensland
Cancer incidence (ASR per 100,000)	604.5	617.2
Proportion of women who did not attend antenatal care in the first 10 weeks	31.7%	45.6%
Proportion of low birthweight babies	6.5%	6.8%
Deaths of 15 to 24 year olds (ASR per 100,000)	24.6	37.9
Deaths from avoidable causes (ASR per 100,000)	114.7	128.9

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[14] QH analysis of the National Health Workforce Dataset inclusive of clinicians registered to practice in Queensland. Population data from the Department of Health and Aged Care's Modified Monash Model (MMM) 2023.
[15] Social Health Atlas of Australia (2024), PHIDU, Torrens University Australia.

1.2: Critical workforce shortages and inflexible service delivery and funding models impact capacity to deliver rural, remote, and some regional services.

The evidence

Workforce per capita is lower in rural and remote areas[16].
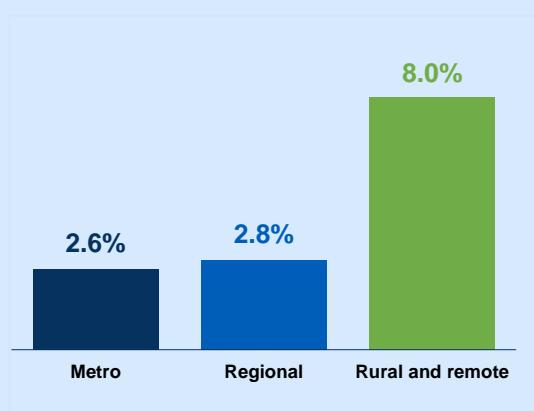
16% of Queensland's **population live in rural and remote areas**

However, only **9%** of the health workforce **works in rural and remote areas**

Current staffing gaps in the Queensland Health workforce (shown as a proportion of total FTE) are largest in rural and remote areas[17].

	8.0%
Metro	Regional	Rural and remote
2.6%	2.8%	8.0%

This impacts delivery of core services:

- Clinical shortages are forcing the **closure of rural birthing units**, recently impacting Gladstone, Biloela and Cooktown leaving communities without safe, local maternity care.

- **Rural and remote services** often rely on the same small teams to deliver **interdependent essential services** like birthing and surgical procedures. While this workforce model supports flexible service delivery, it also means workforce shortages may impact multiple services.

- **58%** of Queensland Health rural and remote facilities operate with fewer than 10 FTE staff, exposing the fragility of service delivery and the urgent need for new workforce solutions.

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[16] Queensland Health analysis of the National Health Workforce Dataset inclusive of clinicians registered to practice in Queensland.
[17] Queensland Health Payroll data as at end of June 2025.

1.3: Lack of sustained investment in subacute and preventative care has limited the capacity of these service providers, causing a shift in demand to acute settings.

The evidence

Queensland's population is projected to age rapidly over the next 10 years, driving a sharp increase in demand for aged care services[18]. Planning for this shift is critical to ensure the system can meet complex care needs.
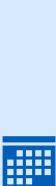
The share of the population aged over 65 will grow from 17% to **20% by 2032[19]**.

Without significant expansion, **there will be insufficient supply to meet demand for aged care beds by 2032[20]**. As a provider of public residential aged care services, Queensland Health's HHSs can expect increased service demand.

Growth in aged care will have flow on workforce impacts, with increasing demand for general practitioners (GPs), registered nurses (RNs) and personal care workers in the aged care sector.

As of 25 August 2025, there were **837 long-stay older patients** in acute hospitals. **75% were waiting on an aged care bed**. The **daily cost** to Queensland's health system of these patients was approximately **$1.91 M[21]**.

As of 25 August 2025, there were **289 long-stay younger patients** in acute hospitals. **88% identified as eligible for the National Disability Insurance Scheme.** The **daily cost** to the health system of these patients was approximately **$660,000[22]**.

Despite population growth and increasing complexity of care, Queensland's per capita primary care workforce has remained static since 2013. This highlights the need for reform in workforce planning and distribution.

0.6 nurses per 1,000 population worked in general practices in 2013 and 2023[23].

1.0 GP per 1,000 population worked in Queensland in 2013, increasing to **1.3 per 1,000 population** in 2023[23].

Queensland's primary care workforce per capita is comparable to the national average, reflecting similar challenges across Australia. In 2022–23, **30% of Australians waited longer than they felt acceptable for an appointment with a GP[24]**, up from 23% in 2013–14.

Projections of supply and demand for GPs show a projected **undersupply of 721 GPs by 2032[25]**.

Hospitalisation rates have risen. Age-standardised hospitalisation rates have increased 51%, from 350.8 per 1,000 in 2002–03 to 490.5 per 1,000 in 2022–23[26].

In 2022–23, **6.4% of all hospitalisations were potentially preventable[26]**.

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[18] Welfare workforce: demand and supply. Australia's welfare 2023 - Data insights. Australian Institute of Health and Welfare.
[19] Queensland Government Statisticians Office, Population projections by age group and sex, Queensland and regions. (2023 update)
[20] Queensland Health Aged Care in Queensland Demand and Capacity Analysis – September 2025.
[21] Queensland Health Long Stay Patient Census Dashboard August 2025.
[22] Queensland Health Long Stay Patient Census Dashboard August 2025.
[23] Queensland Health analysis of National Health Workforce Dataset.
[24] Australian Bureau of Statistics (2023-24), Patient Experiences, ABS Website, accessed September 2025.
[25] Based on Queensland Health analysis of medical training pipelines. This includes rural generalists registered a general practitioners.
[26] Queensland Health. The health of Queenslanders. Report of the Chief Health Officer Queensland. Queensland Government. Brisbane 2025.

Why this matters

Equity of access: Workforce maldistribution leaves rural and remote communities facing significant barriers to care, such as long travel times, limited local care options, and widening health inequities. For Aboriginal and Torres Strait Islander Queenslanders, culturally safe services and a representative workforce are essential for meaningful access.

Service sustainability: In rural and remote communities, the loss of even a single provider can disrupt continuity of care and result in service closures. This fragility puts local access to critical services at risk, increases patient travel costs, heightens reliance on costly temporary staffing, and forces Queensland Health to act as a provider of last resort in areas of Commonwealth responsibility.

Increased pressure on hospitals: Gaps and underinvestment in areas of Commonwealth responsibility, such as primary care and residential aged care, shift avoidable demand onto hospitals, driving up admissions and length of stay for conditions better managed in community settings.

Service quality and safety risks: Persistent workforce gaps in critical services heighten the risk of delayed diagnoses, increase reliance on temporary staff, and contribute to staff burnout. These issues directly affect patient and staff safety and service quality. Utilisation of temporary staff via locum and agency arrangements is also higher cost and limits the capacity of the system to invest elsewhere.

Workforce wellbeing and retention: Maldistribution places unsustainable pressure on small teams, especially Aboriginal and Torres Strait Islander staff in rural and regional areas, who often carry high cultural and community responsibilities with limited support.

2. Our current ways of working do not always meet community expectations or needs

This section presents three key problem statements that reveal how limitations in workforce and service models are affecting the way care is delivered. While many services are planned and structured around robust, patient-centred models of care, system limitations and workforce availability can impact service capacity and delivery at an operational level.

2.1: Our workforce culture and structures are inflexible and reflect professional silos.
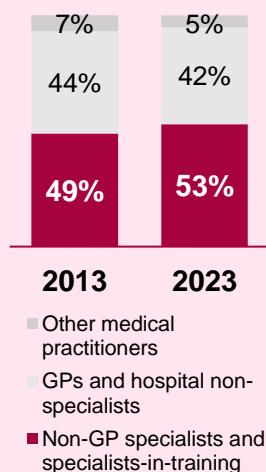
The evidence

Our workforce is becoming increasingly specialised. From 2013 to 2023, the share of the medical workforce registered as specialist generalists (working in hospital and community settings) decreased by 2%[27]. Over the same period, the share of medical practitioners registered as specialists increased by 4%[28].

This trend of increasing specialisation is also reported in nursing and allied health professions, but for these professions, specialisation is not captured in registration data so this cannot be verified.

The right balance between specialisation and generalism in our workforce is essential[29]. While specialisation can be needed to manage growing complexity in acute settings, increasing chronic disease and population ageing makes generalists well-placed to support people with multiple conditions, coordinate care and prevent unnecessary acute admissions.

	2013	2023
Other medical practitioners	7%	5%
GPs and hospital non-specialists	44%	42%
Non-GP specialists and specialists-in-training	49%	53%

This specialisation is associated with reduced productivity. From 2013 to 2023, Queensland Health workforce per capita increased by 29%[30]. Though some of this increase relates to greater complexity and workload (more care required per patient), over the same period in Queensland, total Weighted Activity Unit (WAU)[31] per FTE declined by 9%. This indicates that in 2023, more workforce was required to deliver the same amount of care across public and private health services[32].

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[27] Queensland Health analysis of the National Health Workforce Dataset inclusive of clinicians registered to practice in Queensland. Specialist generalists are general practitioners, doctors working in general practice settings, and hospital non-specialists.

[28] Queensland Health analysis of the National Health Workforce Dataset inclusive of clinicians registered to practice in Queensland. Specialists include doctors that are registered with an Ahpra-recognised specialty that is not general practice, or are in training to become a specialist.

[29] Australian Medical Association. (2019). Fostering Generalism in the Medical Workforce: AMA Position Statement (Revised 2019). Retrieved from http://www.ama.com.au/sites/default/files/documents/Revised_Fostering_generalism_in_the_medical_workforce_2019_.pdf. This has also been explored in the international context:
Jerjes W. Balancing specialist roles with generalist responsibilities in primary care: have we gone too far? Front Health Serv. 2025 Mar 13;5:1438711. doi: 10.3389/frhs.2025.1438711. PMID: 40182209; PMCID: PMC11965900.
Health Education England. (2020). *Future Doctor Programme: A Co-Created Vision for the Future Clinical Team*. NHS. Retrieved from https://www.hee.nhs.uk/sites/default/files/Future%20Doctor%20Co-Created%20Vision%20-%20FINAL%20%28typo%20corrected%29.pdf.

[30] Queensland Health Payroll data at end of June 2025 and QGSO Queensland population estimates.
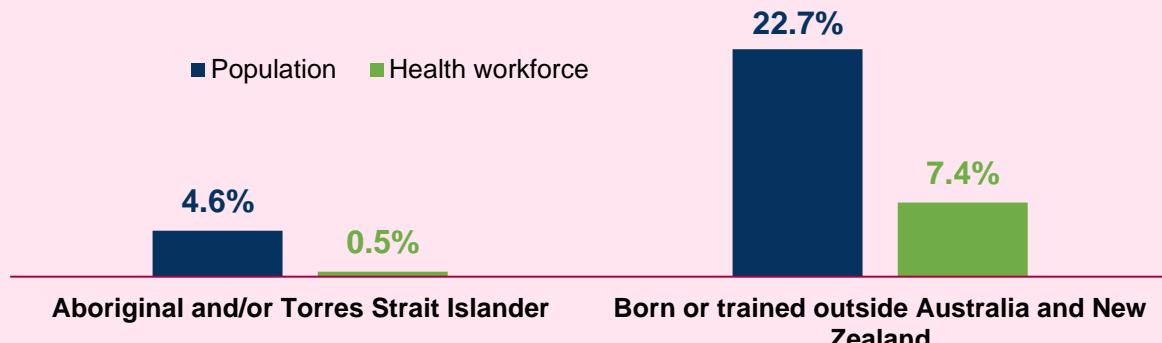
[31] Weighted Activity Unit, a measure of health service activity that accounts for patient and service complexity and is used to fund health services under the National Health Reform Agreement.

[32] Analysis uses national weighted activity units sourced from https://www.publichospitalfunding.gov.au/public-hospital-funding-reports/220339/251661/estimated-nwau-each-state-and-territory-monthly-ytd-and-annual. FTE numbers are sourced from the National Health Workforce Dataset and capture registered health professionals working in clinical roles.

2.2: Our workforce should represent the communities we care for.

The evidence

People from culturally and linguistically diverse backgrounds and Aboriginal and Torres Strait Islander peoples are under-represented in the current Queensland Health workforce[33].

■ Population ■ Health workforce

22.7%

7.4%

4.6%

0.5%

Aboriginal and/or Torres Strait Islander

Born or trained outside Australia and New Zealand
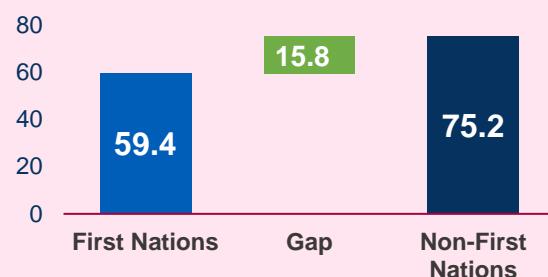
The literature highlights the benefits to Aboriginal and Torres Strait Islander patients of having Aboriginal and Torres Strait Islander health professionals involved in the delivery of healthcare. These **benefits include enhanced quality of care, reduced levels of disease, improved participation in care, and reduced rates of self-discharge[34].**
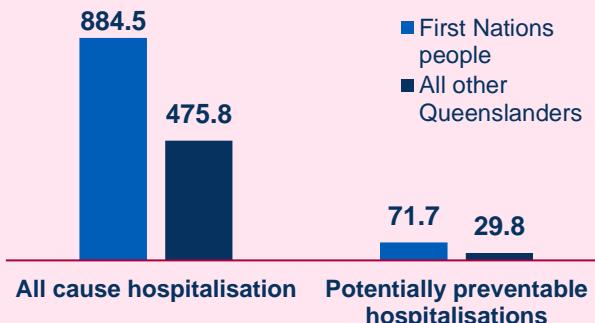
2.3: Our services need to be culturally safe.

The evidence

Aboriginal and Torres Strait Islander peoples in Queensland have a health-adjusted life expectancy of 59.4 years, 15.8 years less than other Queenslanders[35].

15.8

59.4

75.2

First Nations   Gap   Non-First Nations

Aboriginal and Torres Strait Islander peoples are hospitalised at much higher rates (rates are per 1,000 persons)[36].

884.5

475.8

■ First Nations people
■ All other Queenslanders

71.7   **29.8**

All cause hospitalisation   **Potentially preventable hospitalisations**

Culturally and linguistically diverse Queenslanders from Oceania, North Africa and the Middle East also have **significantly higher rates of potentially preventable hospitalisations compared to other Queenslanders[37].**

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[33] Queensland Health analysis of the National Health Workforce Dataset inclusive of clinicians registered to practice in Queensland compared to Census of Population and Housing demographics in Queensland in 2021. There are limitations to using survey data to assess workforce diversity as identification is voluntary and results only capture what clinicians are willing to share.
[34] Lahn J, Puszka S, Lawton P, Dinku Y, Nichols N and Markham F, Beyond Parity in Aboriginal and Torres Strait Islander Health Workforce Planning: Achieving equity through needs-based and strengths-based approaches, Centre for Aboriginal Economic Policy Research, Australian National University, Oct 2020.
[35] The health of Queenslanders. Report of the Chief Health Officer Queensland. Burden of Disease. Queensland Government. Brisbane 2025. Accessed October 2025.
[36] The health of Queenslanders. Report of the Chief Health Officer Queensland. Queensland Government. Brisbane 2025. Accessed October 2025.
[37] Queensland Health, 2023. Exploring the health of culturally and linguistically diverse (CALD) populations in Queensland: 2016–17 to 2019–20. Accessed September 2025.

Why this matters

Community-centred care: Workforce models and service settings need to be flexible and able to respond to the different care needs, preferences, and expectations of various community groups. Contemporary service design considers local context and patient priorities to avoid the potential for outdated models and legacy structures to limit the delivery of effective care to diverse cohorts.

Access and efficiency: Rigid workforce boundaries, narrow scopes of practice, and high levels of specialisation may impact patient flow and care. Patients treated under traditional models of care may be required to navigate a series of disconnected consultations with multiple practitioners. As well as extending the patient journey, a lack of information sharing may inhibit the delivery of holistic patient care. In contrast, patients cared for by multidisciplinary teams, working to broad scopes of practice may experience streamlined, timely and connected care that provides an enhanced patient experience and more effective, responsive care.

Workforce representation: Diverse, culturally capable teams are essential to delivering inclusive care and addressing health inequities. Growing the Aboriginal and Torres Strait Islander workforce across all professions is an important step towards improving the cultural safety of care.

System sustainability and growth: Broad scopes of practice and workforce generalism support agile, responsive service delivery. Flexible, multidisciplinary roles are vital to strengthening the health sector's ability to meet future demand and evolving community needs.

Health equity and outcomes: When care feels culturally unsafe or exclusionary, people are less likely to seek help, deepening inequities, especially for Aboriginal and Torres Strait Islander peoples. Building cultural safety and responsiveness across the workforce is essential for closing the gap.

3. Workforce supply is not keeping pace with growth in demand

This section outlines two key problem statements, showing how shortages in critical roles are limiting Queensland Health's ability to meet current service demands and prepare for future growth. Without targeted action, supply gaps will continue to undermine access, quality, and system sustainability.
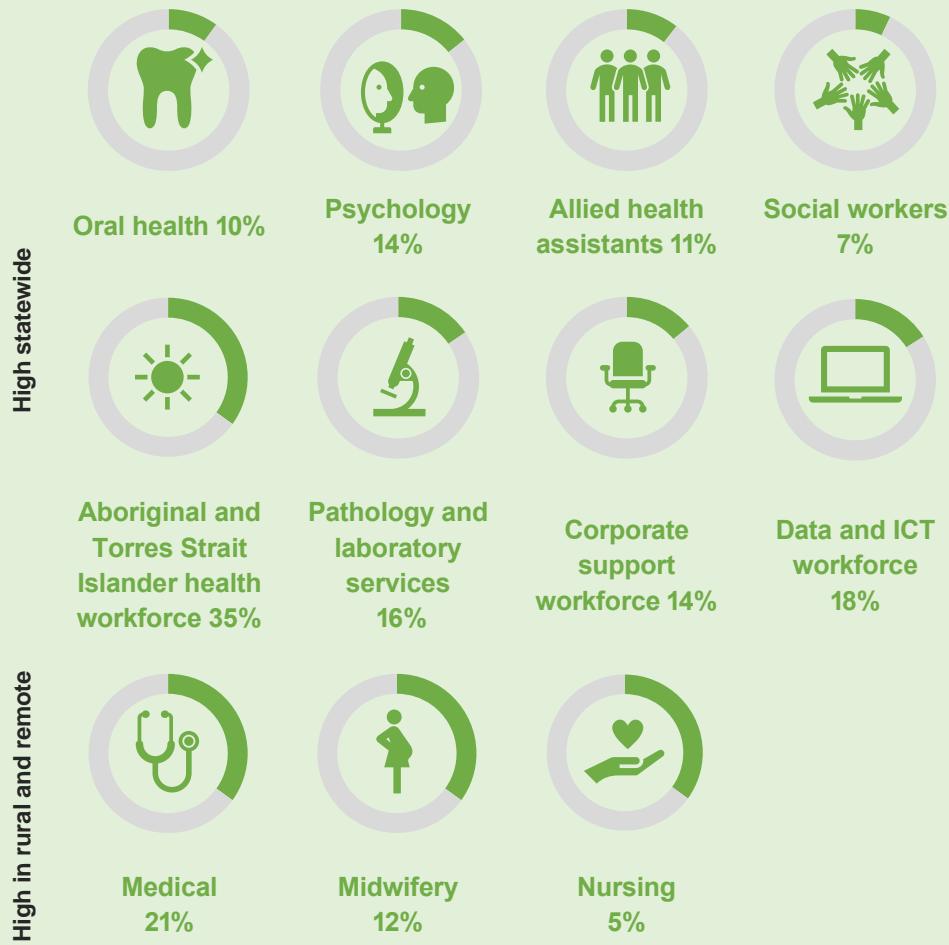
3.1: Queensland Health is experiencing statewide workforce shortages.

The evidence

3,482 FTE

In the last pay period of 2025, **Queensland Health had a gap of ~3,500 FTE** between established positions and MOHRI FTE. Eleven per cent of these positions had gaps persisting for more than a year[38].

Workforce groups with significant gaps include **oral health, allied health professions, Aboriginal and Torres Strait Islander health workforce[39], pathology and lab services, corporate, and data and ICT[40] workforces**.

High statewide

Oral health 10%

Psychology 14%

Allied health assistants 11%

Social workers 7%

Aboriginal and Torres Strait Islander health workforce 35%

Pathology and laboratory services 16%

Corporate support workforce 14%

Data and ICT workforce 18%

For some professions, gaps as a proportion of total FTE are **high in rural and remote areas.**

High in rural and remote

Medical 21%

Midwifery 12%

Nursing 5%

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[38] A persistent gap is defined as a gap in the last 27 pay periods, or for more than one year. This may indicate failed recruitment, or it could indicate an unbudgeted position, a position offsetting other over-establishment or an unrequired position that has not been delimited.

[39] Includes staff employed under the Aboriginal and Torres Strait Islander Health Workforce (Queensland Health) Certified Agreement.
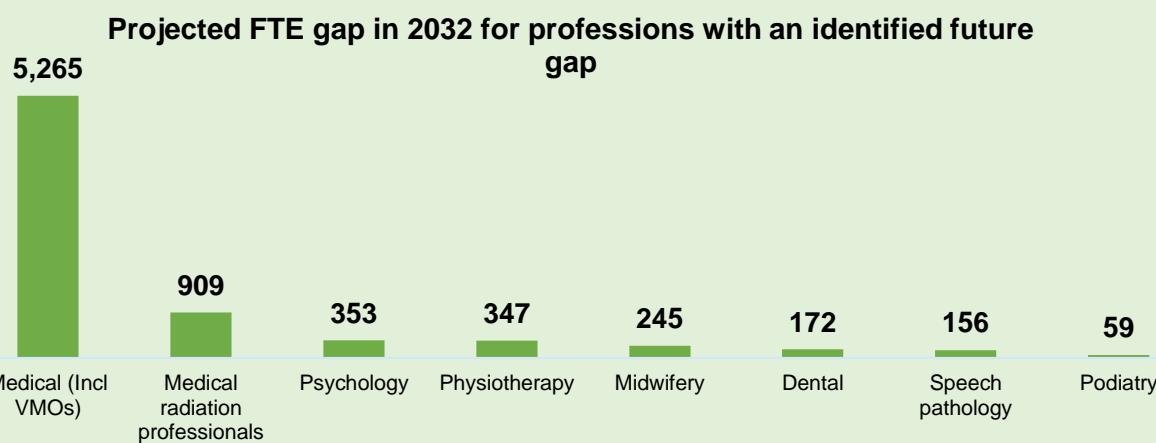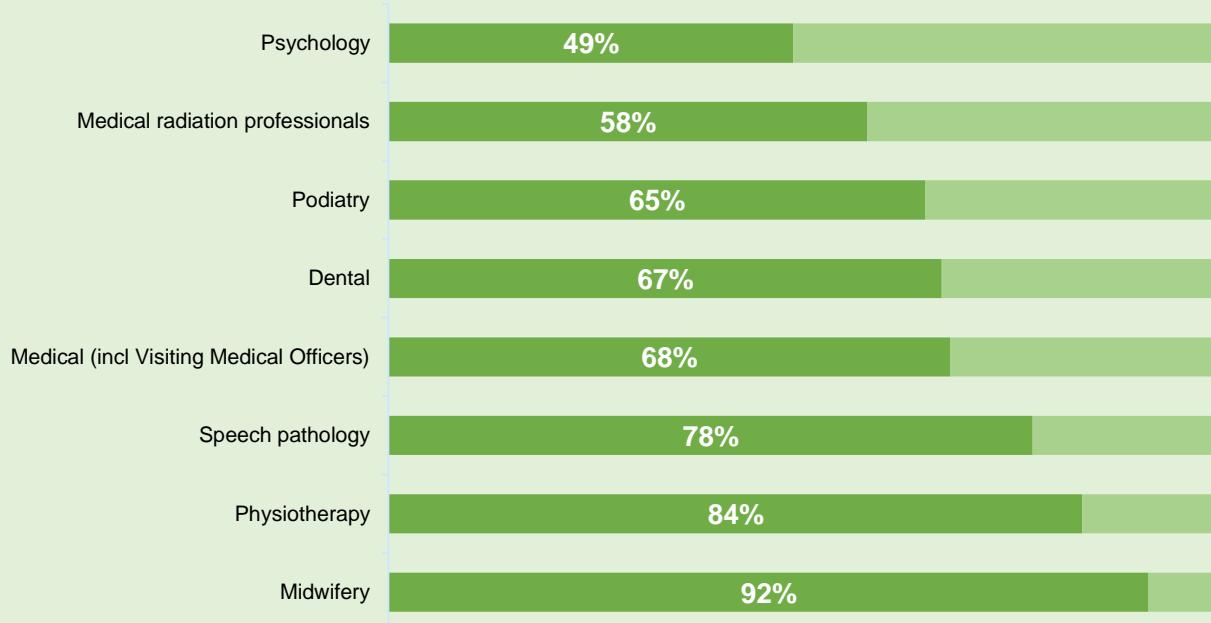
[40] Information and communication technology

3.2: Health workforce supply is not keeping pace with service demand.

The evidence

Based on historical trends, the Queensland Health workforce will need to grow by approximately 46,000 FTE over the period 2023–32. This 30% increase in workforce will be needed to meet the expected growth in service demand[41]. **For some professions, based on current workforce pipelines and Queensland Health market share, supply will not meet demand[42].**

Proportion of projected demand able to be met with projected supply in 2032 for professions with an identified future gap

Profession	%
Psychology	49%
Medical radiation professionals	58%
Podiatry	65%
Dental	67%
Medical (incl Visiting Medical Officers)	68%
Speech pathology	78%
Physiotherapy	84%
Midwifery	92%

Projected FTE gap in 2032 for professions with an identified future gap

Profession	FTE gap
Medical (Incl VMOs)	5,265
Medical radiation professionals	909
Psychology	353
Physiotherapy	347
Midwifery	245
Dental	172
Speech pathology	156
Podiatry	59

Note: Medical radiation professionals include radiographers, nuclear medicine scientists/technologists and radiation therapists.

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[41] Queensland Health, Health Workforce Strategy for Queensland to 2032. https://www.health.qld.gov.au/__data/assets/pdf_file/0039/1339995/Health-Workforce-Strategy_Digital.pdf. Accessed October 2025. Modelling based on FTE data over a 10-year period and applying a weighted population method taking into account changes in population, ageing trends, market changes and how people use services.
[42] Based on Queensland Health supply and demand modelling. For paramedics, nursing, pharmacy, occupational therapy, social work, audiology and dietetics, if market share and attrition are maintained at historical levels and if there are no changes in models of care increasing demand for these professions, projections indicate sufficient supply to meet demand for Queensland Health services in 2032.

Why this matters

Increased service and workforce demand: Based on historical trends, we estimate that Queensland Health will require approximately 46,000 additional workers by 2032. Coupled with factors including an ageing population, increasing rates of chronic disease, and enhanced medical technology-based service offerings, there is likely to be ongoing upward pressure on health workforce supply. Targeted investments in broader and more diversified workforce pipelines across specific professions and locations will be critical to meeting future workforce demand.

Workforce participation: With many healthcare workers choosing part-time work arrangements to balance work and personal responsibilities, more than the equivalent number of workers is needed to fill each FTE gap. Participation rates vary across professional streams and locations, but currently average 0.82 FTE per worker. Rates for nursing (0.77 FTE) and midwifery (0.73 FTE) are lower. The organisational infrastructure required to accommodate, manage, train, and support higher numbers of part-time workers is an important planning consideration.

Service quality and safety: Workforce shortages directly threaten the system's ability to maintain safe and high-quality care. When service areas such as medical imaging, pathology, maternity, mental health, and alcohol and other drugs face persistent gaps, patient safety, timely access, and health outcomes are put at risk.

System efficiency: Significant vacancies across clinical roles and key supporting functions such as data and ICT, slow service delivery, increase wait times, and drive inefficiencies in care pathways. The resulting bottlenecks can reduce the system's overall effectiveness.

Workforce growth and sustainability: With Queensland education and training providers concentrated in South East Queensland, rural and remote regions can struggle to train local workforce and sustainably retain staff throughout their training requirements and career progression. Strategic partnerships with education providers offering decentralised course offerings are important for establishing 'grow your own' workforce initiatives and expanding local recruitment and career pathways.

Skills shortages beyond clinical care: Workforce pressures extend beyond frontline clinicians, with growing gaps in technical and digital roles limiting the health system's ability to innovate, use data-driven planning tools, and access timely workforce and patient data to modernise service delivery.

System resilience: Queensland's statewide workforce shortages limit flexibility to redeploy staff when local services come under strain, reducing resilience in responding to surges, disasters, or future health system shocks. Without adequate supply and targeted workforce development, the health system cannot adapt quickly to emerging pressures.

Workforce design: Effective workforce design, such as multidisciplinary team models with flexible, skills-based roles, supports responsiveness to changes in workforce market supply. Taking a systemwide view of workforce shortages may identify opportunities for more flexible use of available workforces.
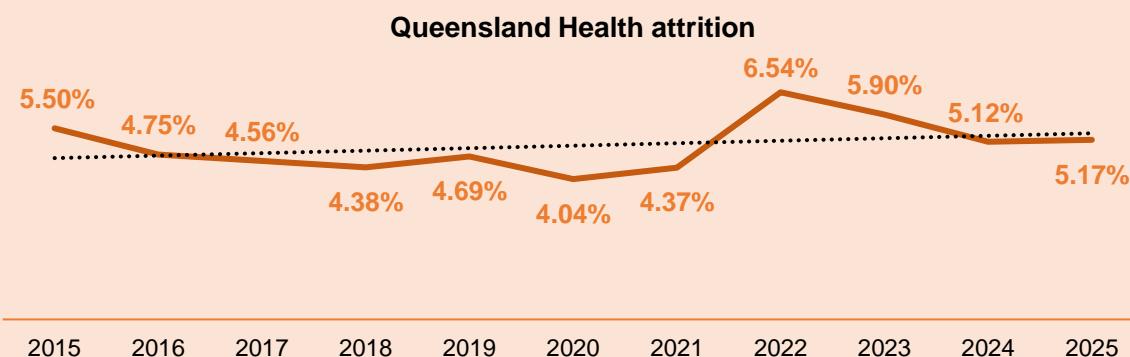
4. Workforce growth and retention are hindered by culture and leadership gaps, and fragmented approaches to career and professional development

This section examines three specific problem statements and supporting evidence regarding the importance and impact of culture, capability, professional and career development on workforce retention and skills development.

4.1: Retention of our workforce is crucial for addressing current and future supply challenges.

The evidence

Attrition peaked in 2022[43]. Improving and optimising staff retention remains critical to achieving sustainable workforce growth targets and ensuring future workforce supply.

Queensland Health attrition

2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025
5.50%	4.75%	4.56%	4.38%	4.69%	4.04%	4.37%	6.54%	5.90%	5.12%	5.17%

Systemwide themes[44] from employee engagement and consultation surveys show **persistent challenges requiring sustainable and accessible solutions** to improve workforce retention.

Onboarding, engagement and collaboration	Capability and career development	Talent and succession management	Wellbeing and culture	Management and leadership effectiveness
• Onboarding for staff and leaders • Team cohesion, inter-team collaboration and dynamics • Change management and communication • Support for positive and inclusive workplaces • Empowering staff to speak up	• Innovation, design thinking and continuous improvement • Critical thinking and emotional intelligence • Interpersonal and written communication • Project and change management • Data and digital literacy	• Frameworks to identify and develop future leaders • Workforce and succession planning for critical roles • Upskilling and cross-skilling for career progression • Improve collaborative knowledge management • Strengthen leadership networks	• Workforce demand management • Psychosocial risk • Proactive focus on building positive workplace culture • Wellbeing leadership to strengthen resilience • Lift capability to manage stress and burnout	• Frontline, middle, senior and executive leadership capability • Governance, performance and accountability • Coaching, mentoring and peer learning • Psychosocial safety and positive workplace interactions • Systems thinking and leading through complexity

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[43] Queensland Health analysis of payroll data from FY23 – FY25.
[44] Themes from HHS employee engagement and exit surveys, HHS consultations, Culture Improvement projects, and DoH FY25 Internal Audit Report.
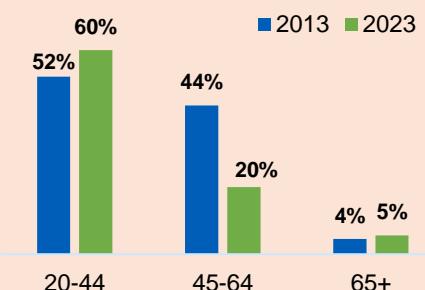
4.2: Workplace culture, career pathways and leadership are key factors impacting workforce attrition, including early career departure.

The evidence

20% of Queensland's registered health workforce is at, or approaching, retirement age[45].
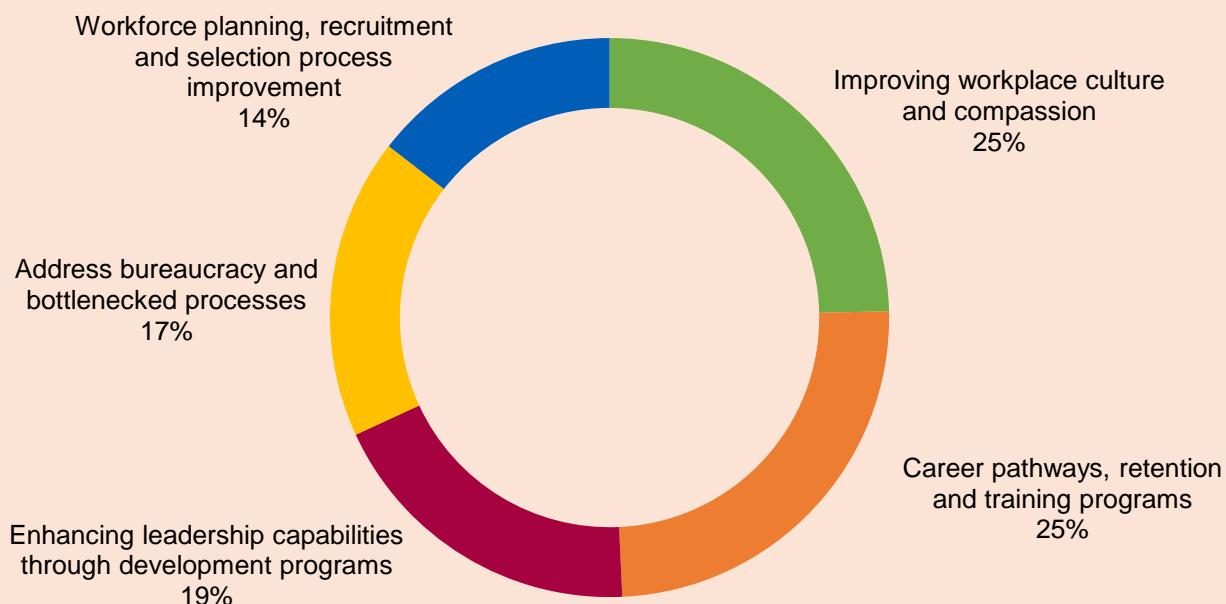
The **age distribution of the registered health workforce has also shifted since 2013,** with more younger workers and significantly less workers aged 45 to 64[46].

This has implications for supervisory capacity, leadership and opportunities for mentorship.

Recognising and addressing the drivers of workforce attrition must be a priority to ensure our employees are supported to continue their careers in health care, including with Queensland Health.

Top 5 themes to support existing employees and reduce attrition

Workforce planning, recruitment and selection process improvement
14%

Address bureaucracy and bottlenecked processes
17%

Enhancing leadership capabilities through development programs
19%

Improving workplace culture and compassion
25%

Career pathways, retention and training programs
25%

Source: Queensland Health workforce consultation data 2023

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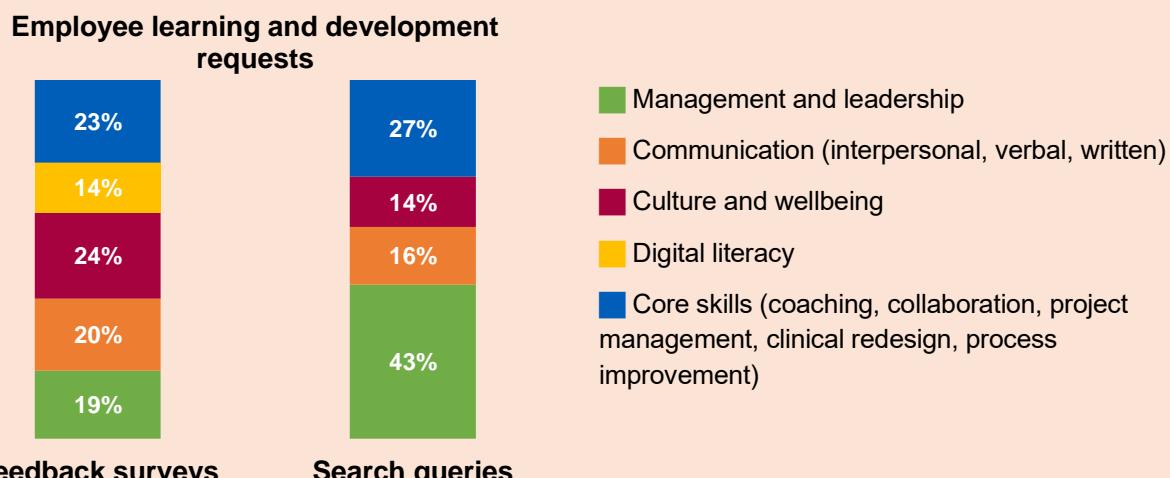
[45] Queensland Health analysis of the National Health Workforce Dataset inclusive of clinicians registered to practice in Queensland. At or approaching retirement age is defined as age over 55 years.

[46] Queensland Health analysis of the National Health Workforce Dataset inclusive of clinicians registered to practice in Queensland.
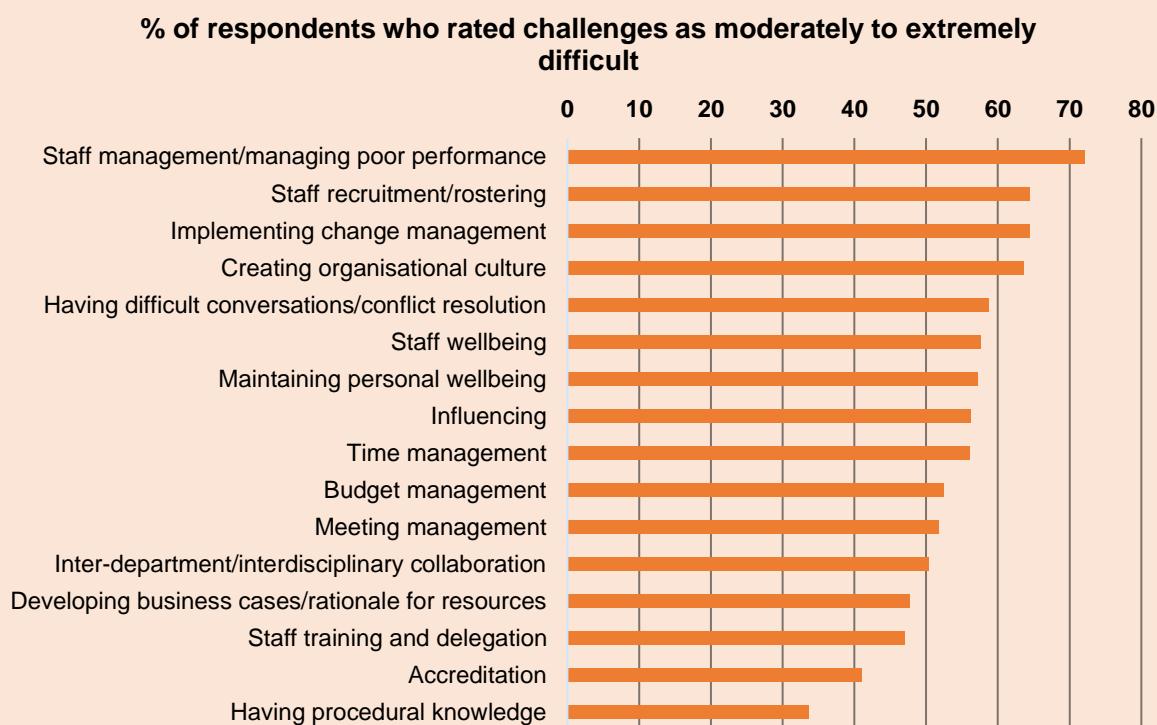
4.3: Workforce and leadership capabilities are not well aligned with health system needs, reducing adaptability and engagement.

The evidence

Feedback from HHSs and QAS identifies the **core and interprofessional capability priorities** across Queensland Health that would support career longevity, develop adaptive skills to deal with increasing complexity, enable workforce mobility, and create alternative progression pathways.

Employee learning and development requests

Feedback surveys:
- 23%
- 14%
- 24%
- 20%
- 19%

Search queries:
- 27%
- 14%
- 16%
- 43%

Legend:
- Management and leadership
- Communication (interpersonal, verbal, written)
- Culture and wellbeing
- Digital literacy
- Core skills (coaching, collaboration, project management, clinical redesign, process improvement)

Contemporary research into perceptions of **sustainable leadership** in Australian healthcare highlights **areas of focus** with relevance for consideration in the Queensland context[47].

% of respondents who rated challenges as moderately to extremely difficult

- Staff management/managing poor performance
- Staff recruitment/rostering
- Implementing change management
- Creating organisational culture
- Having difficult conversations/conflict resolution
- Staff wellbeing
- Maintaining personal wellbeing
- Influencing
- Time management
- Budget management
- Meeting management
- Inter-department/interdisciplinary collaboration
- Developing business cases/rationale for resources
- Staff training and delegation
- Accreditation
- Having procedural knowledge

Why this matters

Training and development capacity contributes to gaps in our workforce pipelines: Insubstantial entry pathways, limited educator capacity, and shortages of education providers, particularly in rural and remote areas, threaten Queensland Health's ability to reliably sustain the health workforce. This impacts service continuity, patient safety, and effective leadership succession, undermining long-term workforce sustainability.

Fragmented capability development: Inconsistent, siloed approaches to workforce development result in duplication, wasted investment, and variable leadership standards across the system. Gaps in core management and culture-building capabilities weaken accountability, governance, and staff wellbeing, reducing organisational performance and patient outcomes.

Unclear career pathways: Complex and inconsistent development opportunities make progression difficult to navigate, leading to disengagement, reduced confidence, and higher attrition. Without clear, accessible pathways, Queensland Health risks losing talent, limiting mobility, and weakening leadership capacity needed to sustain services into the future.

Organisational culture and workforce growth: A positive workplace culture that supports ongoing learning, productive communication and behaviour, diversity, and inclusion is essential for attracting and retaining talent. Addressing these cultural factors can help reduce turnover, build workforce capacity and morale, and improve service delivery quality across Queensland Health.

Leadership capacity and capability: Inconsistent approaches to leadership undermine employee engagement, leading to unsustainable levels of workforce attrition. Strengthening management and leadership capability and confidence across all competency areas will improve workplace culture, engagement, and capacity, resulting in increased workforce retention and an uplift in systemwide performance.

System enablers

Foundations of a future ready health workforce

To build a sustainable, responsive health system, Queensland must improve how we anticipate future healthcare needs and align workforce planning accordingly. The long lead times required to educate and train health professionals demand timely, coordinated, and sustained action.

Too often, reforms in healthcare delivery or funding are implemented without consideration of the long-term impact on workforce supply, particularly in education and training. A more integrated approach to strategy, policy, and planning, which connects service design with workforce capability and future demand, is needed. This requires:

- fuller, more reliable, and better standardised datasets on population health, workforce dynamics, education pipelines, and international labour flows
- stronger mechanisms for cross-sector collaboration and shared forecasting at local, regional, and national levels
- a shift from reactive planning to proactive system design, grounded in evidence, equity, and long-term sustainability.

Enabler 1: Data collection, sharing and use

Current challenges

Current workforce data systems have been built for payroll rather than workforce planning, and are fragmented, inconsistent and poorly structured. This limits Queensland Health's ability to:

- accurately assess workforce availability and capability
- track training status, qualifications, and scope of practice
- align workforce supply with service delivery needs.

Inconsistencies in role classification, naming conventions, and establishment data across HHSs further complicate analysis. For an organisation of Queensland Health's scale (115,734.84 FTE and $15.94 billion p.a. in workforce expenditure[48]) this is a critical barrier to informed decision-making.

While progress has been made in data sharing, significant gaps remain. Privacy, governance, and interoperability challenges must be addressed to unlock the full value of workforce intelligence.

Opportunities for improvement

Emerging data science capabilities offer new opportunities for real-time insights into workforce performance, patient outcomes, and career trajectories. We must modernise our systems to harness these opportunities.

> **Behind every great health service is a system that sees ahead.**
>
> To enable smarter, faster, and more strategic workforce planning, Queensland Health must:
> - modernise data platforms and curate workforce datasets
> - standardise role classification across payroll systems for consistent analysis
> - map positions to service types to align workforce with service planning
> - implement a consistent process for multidisciplinary roles to avoid double counting or under-reporting
> - integrate human resources (HR), finance, and workforce planning to ensure establishment data reflects actual service delivery capacity
> - separate people from positions in data structures to track qualifications, skills, and capability gaps.

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[48] Department of Health Annual Report 2024-2025. Accessed October 2025.

Enabler 2: Integrated planning linking workforce to health need

Current challenges

While data is essential, international experience shows that relying solely on quantitative modelling based on historical patterns of care has repeatedly failed to deliver effective health workforce planning. There is a growing consensus that we must move beyond reactive forecasting to embrace deliberate, collaborative design of the future health system. This means planning not just for how many workers we may need, but for how care will be delivered, by whom, and in what settings.

Opportunities for improvement

Modern workforce planning must:

- be grounded in systems thinking and complexity science
- involve stakeholders from across the spectrum, including clinicians, consumers, educators, providers, and governments
- include place-based planning that reflects the unique needs of rural, remote, and underserved communities
- align closely with emerging models of care, not just existing service structures.

Future-ready planning is more than just the number of health workers. It is about designing a workforce to deliver the care that consumers will need in the future.

The way we plan today shapes the care Queenslanders receive tomorrow.

While Queensland Health has a strong commitment to integrated planning, operationalising this vision remains a challenge. Fragmented planning processes across services, workforce, and funding limit our ability to deliver consistent, high-quality care.

The integrated planning framework provides a strategic foundation, but to realise its full potential, we must:

- strengthen organisational structures to support joint planning
- align data systems and planning cycles across services and the workforce
- embed shared accountability for outcomes across all levels of the system
- ensure workforce modelling is tested against, and aligned with, new models of care.

By embedding integrated planning into how we design, fund, and deliver care, Queensland Health can build an agile, equitable, and sustainable health system.

Analysis limitations

This workforce gap analysis draws on many data sources and methodologies to provide a comprehensive picture of Queensland Health's workforce challenges. While this breadth strengthens the findings, it is important to acknowledge limitations in data availability, collection, quality, and consistency that affect interpretation.

Recognising these limitations is not a weakness, but instead a critical opportunity toward building a stronger, more transparent, and future ready workforce intelligence system.

Data completeness, coverage, and quality

Due to existing data collection structures, Queensland Health knows more about some professional groups than others. Coverage of allied health professions is limited when considering just registration data. Analysis shows only 30% of the total allied health workforce work in registered professions. For self-regulated professions, such as social work and speech pathology, limited data is available on workforce entries and exits, impacting the accuracy of supply projections.

Nursing and midwifery are often grouped as a single profession, creating challenges in reporting disaggregated midwifery data. Current data collection processes do not consistently count dual nursing and midwifery registrants across the system, and no standardised framework exists for analysis. For this report, it is assumed that all registrants maintaining a midwifery registration should be counted in the supply of midwifery workforce.

Capturing specialised workforce roles is challenging at a whole-of-sector level. The National Health Workforce Dataset records where people work and their main practice area, but it does not clearly define specialised roles for non-medical professions, limiting analysis of sub-professional groups.

Payroll data is also variable, as across the 16 HHSs and the Department of Health, similar roles have different position titles and classification fields are not consistent for similar roles. A significant amount of time was spent developing a classification framework for the workforce to allow analysis of professions and roles based on their functions, rather than based on the award they are paid under.

Management of establishment and approved FTE also varies across HHSs, making the data difficult to interpret. An extensive data validation exercise was undertaken with the HHSs to identify variation in approved FTE (i.e. where establishment needed to be updated) and confirm the mapping of positions into the analysis framework. While this feedback has been incorporated and the data reconciled with Queensland Health corporate systems, some errors may remain where old positions have not been delimited and where vacancies are used to offset over-establishment elsewhere.

Interpreting gaps in multidisciplinary roles is further complicated, as some positions are established across multiple professional streams and may show as a gap in one stream while filled in another.

These challenges underscore the need for consistent data standards and structured collection processes to enable accurate, comparable, and timely workforce analysis that supports informed decision-making and effective planning.

Challenges quantifying current workforce gaps

Defining current workforce gaps is complex and relies on aligning multiple metrics, yet appropriate, reliable data is not always available. The key limitations of the analysis include:

- workforce adequacy was not assessed relative to actual service delivery requirements or population health needs

- no standardised data exists on role requirements or workforce skills, so skill gaps and capability mismatches were not explored in detail

- the impact of temporary leave backfilling of positions, although this is recognised as important to workforce stability and meeting service delivery requirements

- roster data, which may enable analysis at a shift level, was not included.

Methodological limitations in supply projections

Future workforce supply modelling for the clinical workforce is based on Ahpra registration data for registered health professions and Census estimates for self-regulated allied health professions. Workforce entries and exits were estimated using graduate data and attrition rates under a stock and flow methodology. Limitations of this approach are outlined below.

- Modelling is undertaken at a whole-of-profession level. Modelling of specialised groups within professions (e.g. neonatal nurses) is complicated by relatively small sample sizes and lack of data availability.

- The impact of age and demographics on probability of entry or exit from the workforce is not modelled. This can have compounding impacts on workforce numbers if rates of exit are different in different workforce cohorts, and if the composition of the workforce is changing.

- Census data for self-regulated professions is collected every five years. Queensland Health's public sector estimates are based on a single point in time rather than annual data. Estimates of exits are also based on Queensland Health attrition rates, rather than whole-of-sector exits.

- No projections have been developed for the non-clinical workforce, which represents one-third of the total Queensland Health workforce due to the lack of available data on this cohort and the small size of individual professions within this workforce.

Methodological limitations in demand projections

The methodology for assessing future demand for workforce is based on the historical relationship between Queensland Health MOHRI FTE and population growth. Population data is weighted by age, based on service utilisation patterns from 2013 to 2023. The projections assume continuation of these historical patterns rather than being based on future service needs.

As a baseline demand projection, changes in workforce requirements due to service, role, skill, and technology changes, are unable to be included in the modelling. For example, the increased technical demands of building and maintenance staff working in new and upgraded facilities would impact workforce roles, skills, and staff numbers.

Demand projections also exclude outsourced services where FTE is not captured on the Queensland Health payroll. The projections assume current outsourcing arrangements continue to apply in the future.

The gap analysis is the baseline to highlight the need to change. By improving how we collect, structure and use workforce data we can:

- make more informed decisions, faster
- plan for future needs with greater confidence
- ensure every Queenslander has access to the care they need, closer to home, because better data enables better care.

What next

Gaps as catalysts for change

This analysis identifies Queensland Health's most pressing workforce challenges, both current and emerging. It highlights critical shortages, workforce gaps and structural barriers that, if left unaddressed, will render the system unable to meet future healthcare needs.

The gaps identified in this analysis should not be seen as limitations or even growth targets; they are signals for where opportunities lie to reimagine and reshape the health and care system for the future.
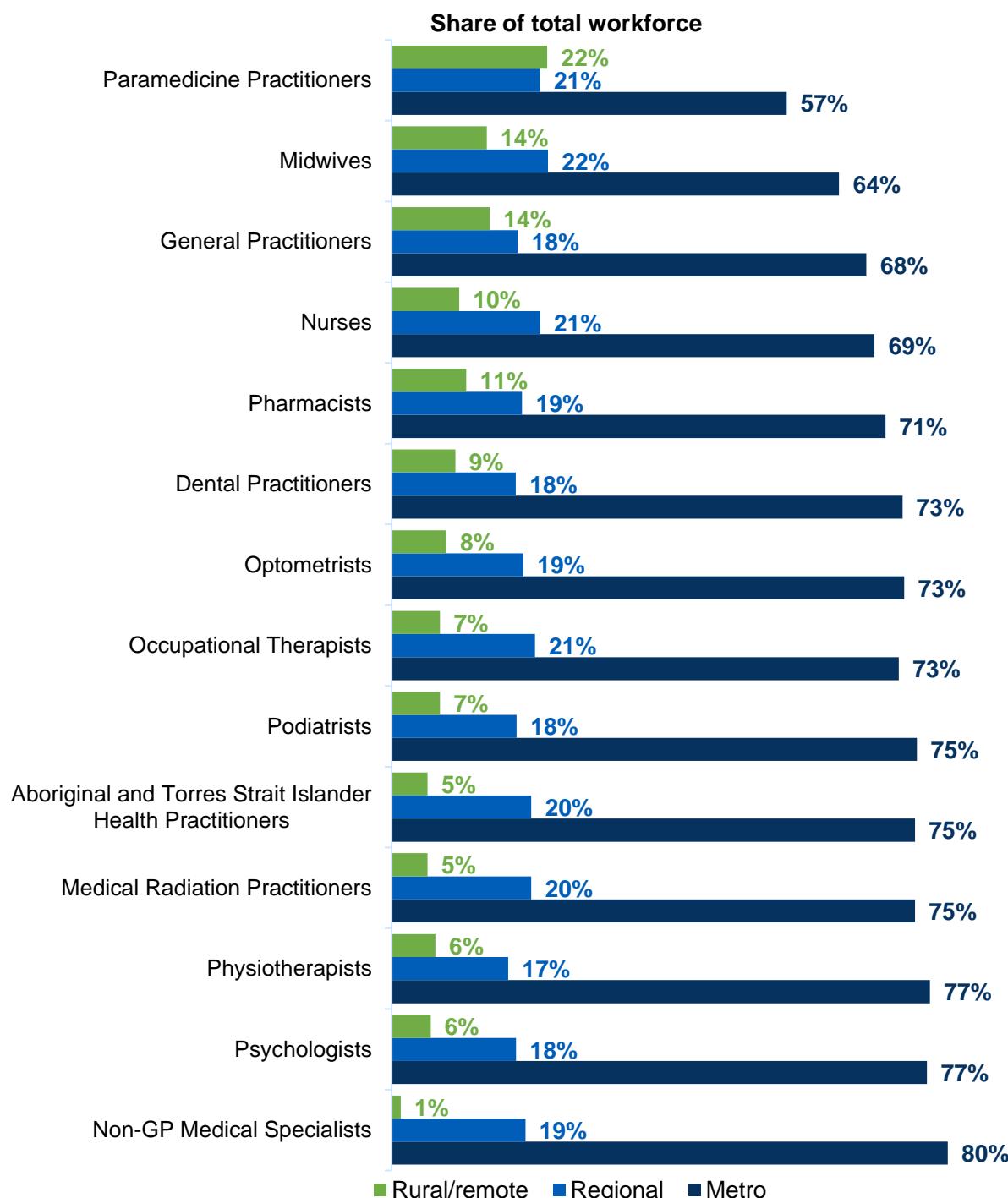
Addressing these gaps requires deliberate, coordinated action across governments, health service providers, professional bodies, education institutions, communities, and other stakeholders. It also requires a systems-thinking approach that reflects the complexity of healthcare delivery, training pathways, technological change and regulation.

These findings form the evidence base for the Queensland Government's new systemwide health workforce plan, which will outline targeted, practical actions to close priority workforce gaps, strengthen capability and retention, and build a more flexible, inclusive, and sustainable workforce.

Appendix A
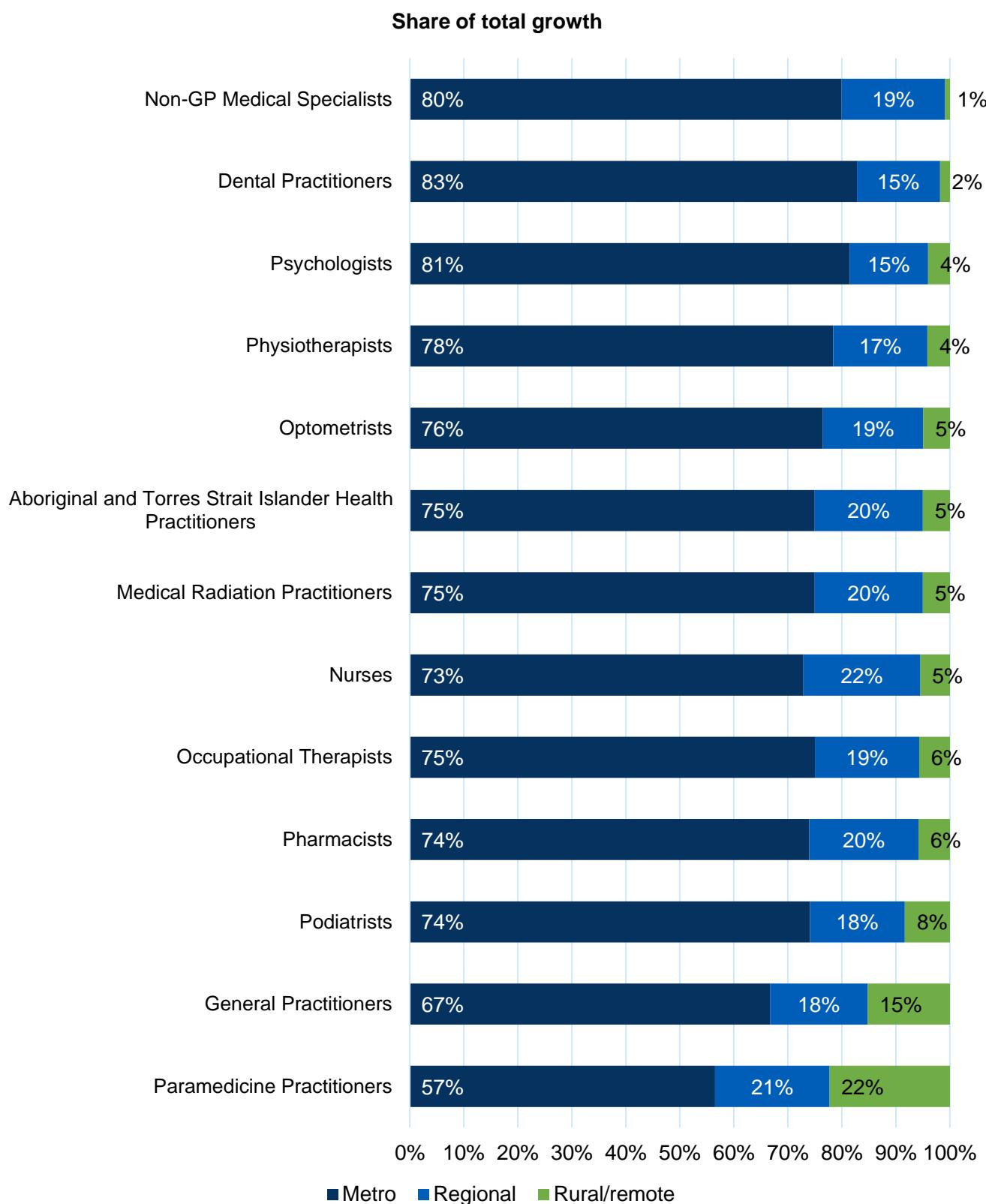
Maldistribution analysis by profession

The distribution of the health workforce varies by profession, although workforce concentration in metropolitan areas is apparent. Non-GP medical specialists have the highest representation in metropolitan areas with 80% of the workforce employed in these locations. In contrast, paramedicine practitioners have a comparatively distributed workforce with only 57% employed in metro areas.

Share of total workforce

| Profession	Rural/remote	Regional	Metro
Paramedicine Practitioners	22%	21%	57%
Midwives	14%	22%	64%
General Practitioners	14%	18%	68%
Nurses	10%	21%	69%
Pharmacists	11%	19%	71%
Dental Practitioners	9%	18%	73%
Optometrists	8%	19%	73%
Occupational Therapists	7%	21%	73%
Podiatrists	7%	18%	75%
Aboriginal and Torres Strait Islander Health Practitioners	5%	20%	75%
Medical Radiation Practitioners	5%	20%	75%
Physiotherapists	6%	17%	77%
Psychologists	6%	18%	77%
Non-GP Medical Specialists	1%	19%	80%

■ Rural/remote ■ Regional ■ Metro

Source: Queensland Health analysis of the National Health Workforce Dataset inclusive of clinicians registered to practice with Ahpra in Queensland.

Most of the growth in registered health workers from 2013–23 occurred in metropolitan areas, except among Aboriginal and Torres Strait Islander health practitioners, whose workforce growth was primarily in rural and remote regions.

Share of total growth

Category	Metro	Regional	Rural/remote
Non-GP Medical Specialists	80%	19%	1%
Dental Practitioners	83%	15%	2%
Psychologists	81%	15%	4%
Physiotherapists	78%	17%	4%
Optometrists	76%	19%	5%
Aboriginal and Torres Strait Islander Health Practitioners	75%	20%	5%
Medical Radiation Practitioners	75%	20%	5%
Nurses	73%	22%	5%
Occupational Therapists	75%	19%	6%
Pharmacists	74%	20%	6%
Podiatrists	74%	18%	8%
General Practitioners	67%	18%	15%
Paramedicine Practitioners	57%	21%	22%

■Metro ■Regional ■Rural/remote

Source: Queensland Health analysis of the National Health Workforce Dataset inclusive of clinicians registered to practice with Ahpra in Queensland.

Growth in the midwifery workforce has also been concentrated in metropolitan areas, while numbers have declined in regional, rural and remote areas, making workforce trends more challenging to interpret for the midwifery profession. The number of registered midwives working in clinical roles grew marginally from 2013 to 2023 by 87 registrants, with all growth in metropolitan areas. In regional, rural and remote areas, the number of midwives declined over the decade.

This trend is mirrored in overall registration numbers, which have declined from 6,701 registrants in 2013 to 6,331 registrants in 2023. As a proportion of the total midwifery workforce, the share of registrants with a clinical job has increased from 74% in 2013 to 79% in 2023.