CONSULTATION DRAFT: Not government policy

Measuring our health workforce challenges

PART B: The Professional Lens

DELIVERING FOR QUEENSLAND

Queensland Government

Queensland Health Workforce Gap Analysis

Published by the State of Queensland (Queensland Health), November 2025.

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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 **Outdated models:** Too often, services are shaped by existing workforce structures rather than by community and patient needs.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.

Introduction

Queensland Health operates within a complex and dynamic delivery system. Any analysis of workforce demand and supply needs to be understood in this context. When taking a profession or work group view, this interconnectedness is even more important to consider when interpreting findings.

This report, Part B of the gap analysis findings, examines workforce demographics, current workforce gaps, market dynamics, and projected supply and demand trends for workforce streams within Queensland Health.

Queensland's health workforce in context

Health and social care is Queensland's largest employing sector. As of 2023–24, the sector contributed approximately $44.4 billion, or 9.3% of the total state economy, and employed approximately 455,900 Queenslanders, more than any other industry[1]. In August 2025, health and social care accounted for 16.5% of total jobs in Queensland, reinforcing its significance within the broader labour market[2].

Within the broader health and social care sector, Queensland Health is the largest public sector employer. At the end of 2024–25, Queensland Health reported employing 115,743.84 full-time equivalent (FTE) staff across Queensland Health. This figure includes:

- 95,006 FTE across the Hospital and Health Services (HHSs)
- 9,789.99 FTE in the Department of Health, and
- 6,023.54 FTE in the Queensland Ambulance Service (QAS).[3]

In parallel, the private and for-purpose (not-for-profit) sectors deliver a significant share of acute and community-based care. Nationally, private hospitals account for approximately 41% of all hospital admissions[4], and Queensland is home to major private providers such as Mater Health and UnitingCare. The latter employs around 17,000 staff across Queensland, offering acute hospital services, aged care, and community-based health support[5].

The primary care workforce in Queensland comprises general practitioners (GPs), practice nurses, Aboriginal and Torres Strait Islander health workers, and allied health professionals, most of whom operate in privately run practices or community-based services. These practitioners are essential to the delivery of frontline care, chronic disease management, and preventive health services. While primary care is primarily an area of Commonwealth responsibility, the operation of this sector has significant impacts on state populations and health service delivery. As of 2023, there were approximately 39,449 FTE GPs nationally, with 29,215 FTE working, representing a marginal increase from 2018. The Health Workforce Needs Assessment (HWNA) undertaken by Health Workforce Queensland consistently identifies significant geographic maldistribution of the health workforce, impacting access and continuity of care[6].

Understanding the breadth, diversity, and challenges of Queensland Health's large workforce from the perspective of each professional stream, is important for informing future workforce initiatives and plans. As models of care and service delivery evolve, ensuring we have the right supply of health professionals will remain critical, even with the introduction of complementary and supporting workforces.

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[1] Queensland Treasury. Queensland's Economy – Health care and social assistance. 2025. Available from: https://www.treasury.qld.gov.au/policies-and-programs/economy/queenslands-economy/

[2] Australian Bureau of Statistics (August 2025), Labour Force, Australia, Detailed, ABS Website, accessed 1 October 2025.

[3] Department of Health Annual Report 2024-2025. *Accessed 14 October 2025.* Data is Public Sector Commission Minimum Obligatory Human Resource Information (MOHRI) FTE.

[4] Australian Private Hospitals Association. Private hospital facts. 2025. Available from: https://www.apha.org.au/private-hospital-facts.html

[5] UnitingCare Queensland. Annual Reports. 2024. Available from: https://www.unitingcareqld.com.au/about-us/news-and-publications/annual-reports

[6] Health Workforce Queensland. Health Workforce Needs Assessment 2023. Available from: https://www.healthworkforce.com.au/

Overview of Part B

This report presents a profile for nine Queensland Health workforce streams, ordered by workforce size. For the purpose of this analysis, the nine workforce streams are:

- nursing
- clinical support
- allied health
- medical
- enabling workforce
- Queensland Ambulance Service
- midwifery
- oral health
- Aboriginal and Torres Strait Islander health workforce (defined by the *Aboriginal and Torres Strait Islander Health Workforce (Queensland) Certified Agreement*).

Streams were grouped based on current operational and industrial structures, and available data. It should be noted that it was not always possible to identify someone's area of practice or work in a high degree of detail, which may impact interpretation of the findings. For example, all nurses were counted in the nursing analysis, but the sub-segmentation of each workforce stream does not account for the multitude of leadership, education, management, clinical specialist, informatics, and research roles nurses undertake across Queensland Health.

Extensive work was undertaken across the HHSs and the Department of Health to classify positions within this framework, as there is currently no classification structure built into Queensland Health's enterprise systems that enables analysis of the workforce by profession or role type. This is an area for continued improvement, and the analysis should be interpreted as a starting point for understanding our large and diverse workforce.

Workforce stream profiles

Nursing workforce

Nurses deliver direct care in hospitals and communities, promote health and prevent disease, advocate for patients and coordinate care across services. They also take on roles in leadership, education, management, clinical specialties, informatics and research. Nurses work across specialised and generalist positions to support both individual and population health outcomes.

Queensland's nursing workforce is essential to the state's healthcare system but faces multiple challenges that need strategic, data-informed approaches to support sustainable staffing and quality patient care for diverse communities.

Key challenges

Maldistribution	Rural, remote and some regional centres experience persistent nursing shortages and limited supply pipelines, compared to metro areas. This uneven distribution can lead to increased pressure and higher workloads for teams in underserved areas and can affect equitable access to care.
Retaining early career nurses	Observed higher separation rates for nurses at grades 5.1 to 5.2 classifications indicate elevated attrition during early career stages. This pattern reflects the distinct challenges faced by nurses transitioning into the workforce. Sustained turnover at these levels can impact workforce capability, contribute to resourcing inefficiencies, and affect continuity of care.
Departure of experienced nurses	Approximately 18% of the nursing workforce is approaching retirement age. In 2024–25, 2,949 FTE nurses, grades 5, 6, and 7, were within the 60 to 84 age range, with 500 FTE already separated. This trend signals a significant loss of highly experienced staff, which may impact clinical leadership and service continuity. Currently, there are no systematic mechanisms in place to reassign or support these staff in mentoring roles where they could provide guidance to early career nurses.
Managing the graduate pipeline	Ensuring alignment between graduate nurses, early career workforce supply, graduate preferences, available positions, and capacity for adequate clinical supervision is critical for workforce sustainability. A lack of effective modelling of current vacancy data and workforce pipelines prevents the reliable mapping of early career nurse opportunities against workforce demand. Such data systems would enable nursing graduates from underrepresented cohorts to be considered for prioritisation for placement and supported in their transition to practice.
Workforce profile	The trend toward part-time work continues to grow, with more than 33,000 nurses employed in permanent part-time positions, representing approximately 73% of the permanent nursing workforce. While part-time work arrangements offer flexibility that aligns with employee preferences, they also require additional staffing to cover rosters and maintain safe nurse-to-patient ratios.

Who we are

In the last pay period of 2024–25, Queensland Health employed 54,689 nurses across Queensland, representing 41,957 FTE.

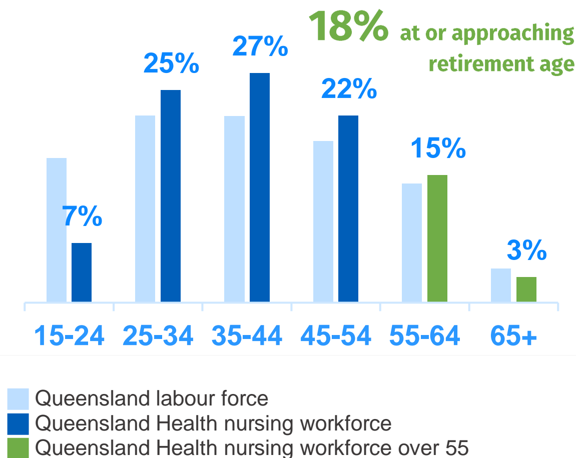
This workforce is made up of the following key segments:

- students in nursing
- critical care
- theatres
- paediatrics
- neonatal
- aged care
- mental health
- general – medical and surgical nursing
- leadership.

Age profile

The age profile of the nursing workforce generally mirrors that of the Queensland Health workforce, with most of the workforce aged between 25 and 54, though there are fewer younger entrants compared to the broader workforce.

Figure 1: Age profile of the nursing workforce compared to Queensland labour force.



Source: Queensland Health workforce data; Queensland labour force statistics sourced from Australian Bureau of Statistics (June 2025), Labour Force, Australia, Detailed, ABS Website, accessed 13 August 2025 and Queensland Health payroll data at end of June 2025

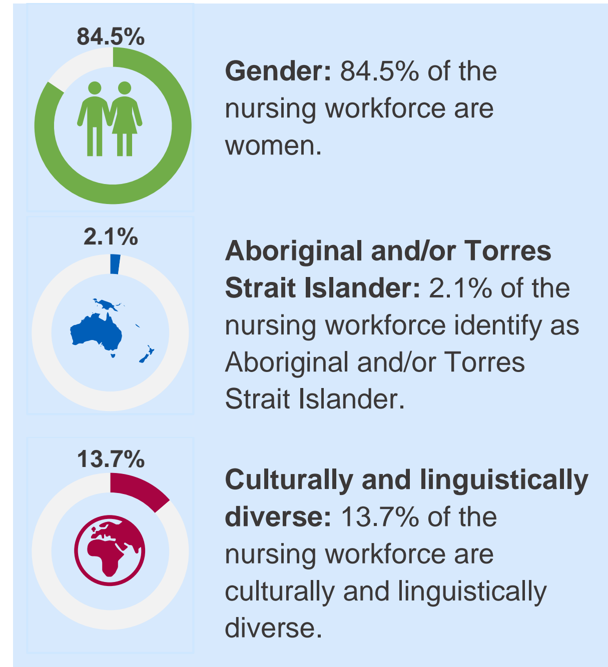
Around 18% of nurses are aged 55 years or older, suggesting a potential retirement shift within the next decade. This points to a strategic need to attract and retain younger nurses to support future workforce stability.

Workforce diversity

The nursing workforce is predominantly made up of women (84.5%), reflecting the profession's longstanding gender imbalance.

The nursing workforce shows relatively strong representation of culturally and linguistically diverse groups, but has comparatively low representation of Aboriginal and/or Torres Strait Islander peoples.

Figure 2: Nursing workforce demographics.



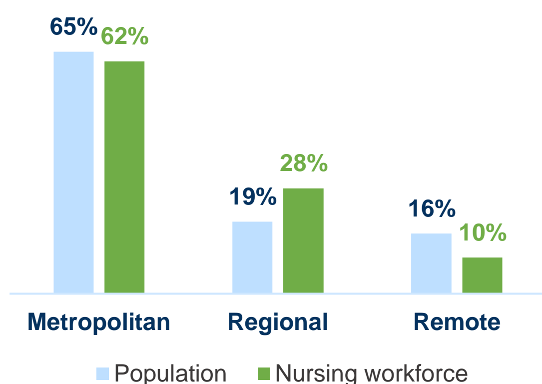
Source: HRBI analysis of Queensland Health HR data.

A relatively low 2.1% of the nursing workforce identifies as Aboriginal and/or Torres Strait Islander, highlighting the need for stronger recruitment, retention, and leadership pathways to support greater representation.

Where we work

In the last pay period of 2024–25, almost two-thirds (62.2%) of the nursing workforce were concentrated in metro areas, with 28.2% in regional and 9.7% in rural and remote locations.

Figure 3: Geographic distribution of the nursing workforce.



Source: Queensland Health workforce data; Population data from the Department of Health and Aged Care's MMM[7] 2023.

Current workforce trends and analysis

Workforce profile and distribution

Location

- The metro nursing workforce accounts for 62.2% of FTE, is well-resourced and offers broad specialty coverage, particularly in general, critical care, and theatre nursing.
- Regional areas account for 28.2% of FTE, where the workforce is moderately spread across specialties, but has the lowest proportion of senior roles (1.5%). This can negatively impact local leadership and clinical oversight.
- Rural and remote areas make up just 9.7% of the total nursing workforce yet have the highest share of entry-level roles (17.3%). This suggests early career opportunities but also indicates potential supervision gaps.

Specific roles

- Student nurses work across all geographic areas, although they are more highly represented within rural and remote nursing workforces than within metro or regional ones.
- General nursing makes up the majority of nursing specialties across all settings (54.3% in metro, 54.1% in regional, and 68.5% in rural and remote), indicating broad coverage but limited specialty depth in remote settings.
- Critical care nursing is well represented in metro (8.8%) and regional (4.5%) areas but drops to just 0.8% of the workforce in rural and remote areas, highlighting reduced access to high-acuity care in remote communities.
- Theatre nursing is a larger proportion of the nursing workforce in metro (6.1%) and regional (2.6%) areas, with minimal presence in rural and remote (0.3%) areas, reflecting centralised surgical infrastructure and workforce.
- Mental health nursing is relatively stable across metro and regional areas (approximately 10% of the workforce) but remains low in rural settings (3.7% of the workforce).
- Aged care nursing is most prominent in rural and remote areas (8.1% of the local workforce), with 42.5% of roles classified as junior, indicating a high reliance on early career staff and potential supervision challenges.

Career progression and seniority

- Leadership roles represent a very small portion of the nursing workforce (5% of all nursing positions compared to 14% of total positions), highlighting a limited leadership base.

Employment type

- Of the nursing workforce 65% of FTE works part-time. The workforce is highly fractionalised with nurses working on average 0.77 FTE, which requires additional headcount to meet service delivery demands.

Current gaps

Location

- Rural and remote areas have the highest gaps, with a gap of 189.1 FTE (4.8%) between approved and filled FTE. The identified gap in regional areas was 225.1

[7] Modified Monash Model (MMM)

FTE (1.9%). There was no identified gap in the last pay period of 2024–25 in metro areas.

Specific roles

- Paediatric mental health nursing shows the highest segment-level gap as a proportion of approved FTE at 5.2%, indicating difficulty attracting and/or retaining staff.
- Mental health nursing in rural areas has a 29.3% gap, suggesting significant service delivery risk.
- Persistent gaps (>12 months) are most common in neonatal nursing (16.4%), student nurses (15.8%), paediatric nursing (12.8%), and critical care nursing (12.7%).

Leave usage

- At the time of analysis, leave taken across the workforce totalled 8,599.6 FTE, representing more than 20% of the total FTE.
- High leave rates in core service areas contribute to short-term staffing gaps and increase reliance on temporary or casual staff. Combined with persistent workforce gaps (>12 months), these leave patterns suggest instability and reduced continuity of care.

Employment type

- Given the high proportion of part-time positions in the nursing workforce, a higher headcount of nurses is required to fill the FTE gap.

Overtime utilisation

- Nursing and midwifery overtime utilisation is only available as a combination of both professional groups.
- Average monthly overtime of 50,905 hours was worked by nurses and midwives in 2024–25. In the last pay period of 2024–25, this was equivalent to 691 FTE or 1.6% of the total workforce.

Temporary workforce utilisation

- Across Queensland, the temporary nursing workforce averages 10.4%, with variation by geography across metro (12.3%), regional (9.1%), and rural and remote (9.9%) locations. A significant portion of this workforce consists of student nurses, whose roles are intentionally temporary to support clinical training.
- Casual FTE accounts for 4.3% of FTE statewide, with elevated usage in rural and remote (5.7%) and regional (5.5%) areas. High casualisation in student nurse roles (up to 49.6% in regional areas) inflates overall temporary workforce figures.
- The nursing and midwifery stream utilised 4,315 agency staff in the final quarter of 2024–25, at an average cost of $53,494 per agency worker.

Workforce attrition

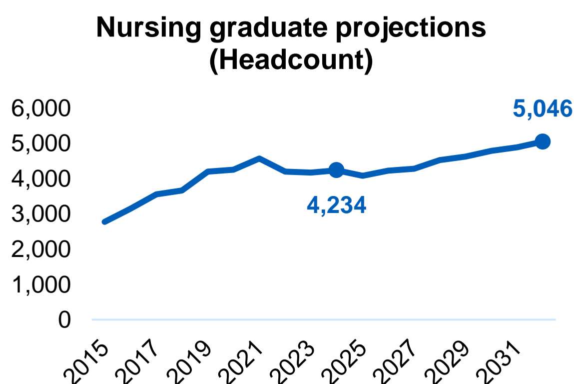
- The attrition rate for the nursing workforce has remained consistently lower than the Queensland Health average, declining from 4.9% in 2022–23 to 4.3% in 2023–24, and stabilising at 4.4% in 2024–25.
- Aged care nursing has experienced a steady rise in attrition, reaching 8.3% in 2024–25, the highest among all segments.

Future workforce projections

Graduate projections

Based on historical trends, combined graduate numbers from registered and enrolled nursing programs are projected to increase by 29% by 2032.

Figure 4: Nursing graduate projections.



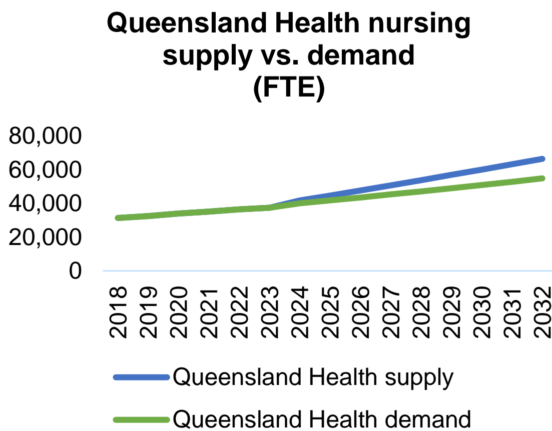
Source: Queensland Health analysis.

Supply and demand

Demand for nurses is projected to increase by 50.5% from 2023 to 2032. To meet this demand in 2032, Queensland Health will need to employ an additional 21,331 nursing FTE.

If current attrition rates and trends in FTE per person and headcount working in nursing are maintained, Queensland Health will have sufficient nursing supply overall to meet demand in 2032 at a whole-of-state level. Challenges may remain in specialist roles or in certain geographical areas.

Figure 5: Nursing supply and demand.



Source: Queensland Health analysis

The Australian Government Department of Health, Disability and Ageing has recently published the *Nursing Supply and Demand Study*[8] which projects a significant gap in the future nursing workforce (an undersupply of 70,707 FTE nationally by 2035).

What this means for the future nursing workforce

- Nursing supply in regional, rural and remote areas is not currently sufficient, however there is some oversupply in metro areas.
- Specialty areas such as paediatrics, mental health, and aged care experience persistent workforce pressures.
- Sustaining supply depends on maintaining Queensland Health's nursing market share. The expansion required in aged care and other health sectors, like primary care, will increase competition for the nursing workforce in the future.
- Early career attrition highlights the need for stronger transition support, help in navigating clinical settings of choice, mentoring, and improved support for the junior workforce.
- Retention strategies should focus on structured career pathways, advanced practice opportunities, and flexible working arrangements.
- Optimising scope of practice through expansion of job roles, micro-credentialing, technical integration, and digital enablement, will assist the delivery of care in all settings, particularly remote and virtual care.
- Leadership and decision-making roles will be important for navigating change, advocating for quality and safety, and balancing clinical risk and resilience in care delivery.

[8] Department of Health Disability and Ageing (Australian Government), Nursing Supply and Demand Study.

Clinical support workforce

The clinical support workforce includes diverse roles that work directly or indirectly with clinicians to support the delivery of effective patient care.

Some clinical support roles are technical in nature. For instance, pathology and scientific services staff provide information and analysis to support clinical decision-making, while biomedical technology staff provide technical support through the expert management of medical devices and equipment. Staff in BreastScreen Queensland provide a statewide clinical screening service, and assistants in areas including anaesthetics, theatre, therapy, science, and environmental health work alongside clinicians to provide support and patient care.

Alongside these clinical support roles, wardspeople, cleaners, food service, trade, facilities, security, and supply chain staff help to ensure the smooth operation of hospitals and health facilities. Additionally, many administrative, logistics, management, and support roles contribute to smooth patient experiences and efficient flow through public hospitals.

There is increasing recognition of the value of the clinical support workforce within the healthcare team, and their contribution to the patient journey. Barriers to the availability and retention of this workforce should be considered alongside challenges faced by the clinical workforce.

Key challenges

Workforce supply	Critical workforce gaps have been identified among some facilities, trades and maintenance roles, pathology and laboratory services roles, and public health roles. Persistent, long-term gaps (>12 months) are evident among roles in aged and home care, security, and peer and consumer support. Further efforts to address these gaps in a sustainable manner are required.
Rural and remote workforce	Rural and remote services continue to report challenges in attracting and retaining clinical support staff. Pressures on clinical support workforce supply are most evident in rural and remote locations. This is especially pronounced where health services are competing with other sectors for scarce labour resources, as is the case with non-clinical support roles including trade, security, and administration.
Wellbeing	The clinical support workforce faces unique challenges working in healthcare due to the support nature of their role. These staff may have less access to professional development opportunities than clinical staff and may experience barriers to skills development and career progression as a result. Wellbeing challenges can arise due to workload and work pressures, challenging work environments and workplace culture, and lack of professional recognition for their contribution.
Workforce models	A consequence of staff shortages and poor coordination of the support workforce is clinicians performing operational and administrative tasks. This results in clinicians being professionally less satisfied with their roles and reduces their capacity to provide patient care. Existing workforce models do not consistently or effectively utilise the administrative and assistant workforce to perform support functions. This prevents clinicians from working to their full scope of practice, exacerbates system inefficiencies, and negatively impacts patient care.

Who we are

In the last pay period of 2024–25, Queensland Health employed 28,077 people in clinical support roles across Queensland, representing 23,532 FTE.

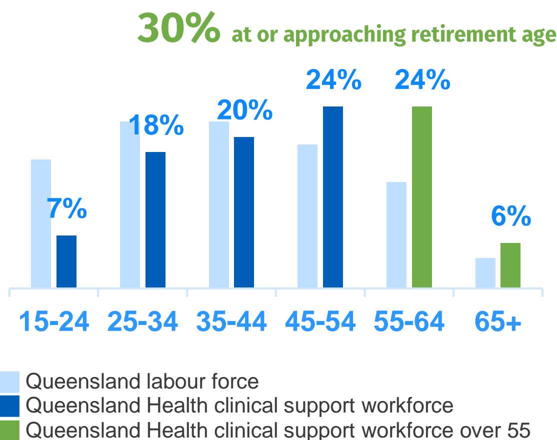
This workforce is made up of the following key roles and functions:

- administrative staff, including patient flow
- pathology and laboratory services staff
- public health
- technicians
- peer and consumer workforce
- aged and home care staff
- operational staff
- wardspeople
- store and supply chain
- security staff
- facilities, trades and maintenance staff.

Age profile

The age profile shows that 30% of the clinical support workforce are approaching retirement age, highlighting a strong retirement risk. Early and strategic intervention is required to effectively manage the impending departure of this large cohort of staff, who will take with them extensive experience and organisational knowledge.

Figure 6: Age profile of the clinical support workforce compared to Queensland labour force.



Source: Queensland Health workforce data; Queensland labour force statistics sourced from Australian Bureau of Statistics (June 2025), Labour Force, Australia, Detailed, ABS Website, accessed 13 August 2025 and Queensland Health payroll data at end of June 2025

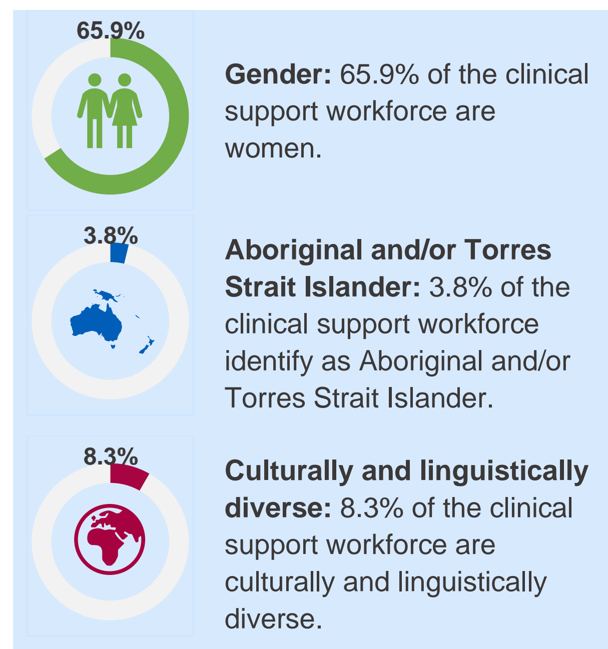
Investing in the next generation of clinical support staff and ensuring effective knowledge transfer are essential to maintaining service continuity and workforce sustainability.

Workforce diversity

Around two-thirds (65.9%) of the clinical support workforce are female which is lower than Queensland Health as a whole (73% of the workforce are female). Almost 4% of the clinical support workforce identifies as Aboriginal and/or Torres Strait Islander, which is higher than in other workforce streams (excluding the Aboriginal and Torres Strait Islander stream).

A higher proportion of the clinical support workforce (8.3%) identifies as culturally and linguistically diverse compared with the total Queensland Health workforce (3.6%).

Figure 7: Clinical support workforce demographics.



Source: HRBI analysis of Queensland Health HR data.

Where we work

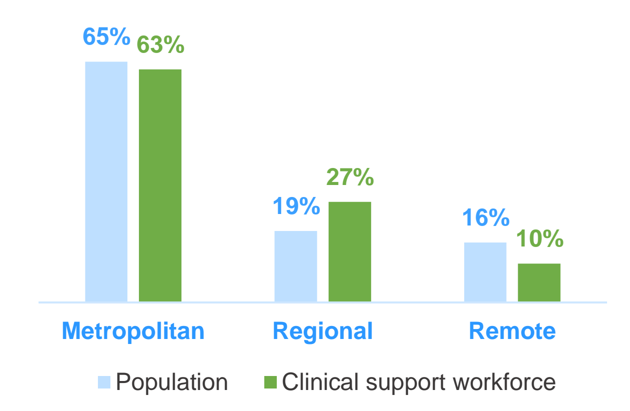
In the last pay period of 2024–25, 62.6% of the clinical support workforce worked in metro areas, 27.0% in regional areas and 10.4% in rural and remote areas.

In metro areas, 40% of clinical support staff are administrative, and almost 26% are operational. By contrast, in rural and remote locations,

operational staff hold more than 50% of clinical support roles, while administrative staff account for around 29% of positions. This reflects adaptive workforce practices in rural and remote locations, where all available skills are utilised, and staff may fulfil multiple roles and work flexibly to meet community needs.

Some roles, including those in security, patient support, and stores and supplies, are evenly distributed across all geographical areas. For example, facilities, trades and maintenance roles make up 3.7% of the clinical support workforce in metro locations, 4.4% in regional locations, and 4.8% in rural and remote locations. The strong presence of this workforce across all locations reflects their essential role in supporting the delivery of clinical care.

Figure 8: Geographic distribution of the clinical support workforce.



Source: Queensland Health workforce data; Population data from the Department of Health and Aged Care's MMM 2023.

Current workforce trends and analysis

Workforce profile and distribution

Location

- The challenges of maldistribution are evident in the clinical support workforce distribution data. For example, pathology and laboratory services staff make up 10.5% of the clinical support workforce, with most of these roles in metro areas (8.2%), compared to regional areas (2.0%) and rural and remote locations (0.3%).

Specific roles

- Administrative staff are the largest cohort within the clinical support workforce (38.8%), highlighting their important role in supporting clinical care and patient flow. Operational staff (29.2%) are also well-represented. Pathology and laboratory services (10.5%), facilities, trades and maintenance staff (4.0%) and security staff (3.7%) also provide critical support.

Career progression and seniority

- Senior positions within the clinical support workforce equate to 4%, while 39.4% are in junior or entry-level positions. Senior clinical support positions are a greater proportion of roles in metro areas (5.1%) compared to rural and remote areas (0.9%), reflecting fewer opportunities for career progression in smaller locations.

Employment type

- In keeping with the trend observed in most of the other streams, the clinical support workforce has experienced a shift towards more part-time workers, with this cohort working an average 0.84 FTE per worker. Part-time employment rates are consistent across metro, regional, and rural and remote areas.
- Particularly high rates of part-time employment can be seen among aged and home care workers in both metro (45.9%) and rural and remote locations (46.3%). Similarly, operational staff work part-time consistently across locations – 26.1% in metro, 28% in regional, and 29.8% in rural and remote areas.

Current gaps

Location and specific roles

- In the last pay period of 2024–25, the clinical support workforce had a gap of 493.7 FTE (3.3%) in metro areas and 54.3 FTE (2.2%) in rural and remote areas. At the same time, no gap was recorded for the clinical support workforce in regional areas.
- The areas of the clinical workforce experiencing significant workforce gaps include pathology and laboratory services

(389 FTE), public health (160 FTE), facilities, trades and maintenance (128 FTE), aged and home care (53 FTE), and peer and consumer support (32 FTE).

- Persistent gaps (>12 months) are apparent across all locations, particularly in security, aged and home care roles, and among the peer and consumer workforce.
- In metro areas, significant gaps were reported in aged and home care (28%) and public health (31.2%).
- In rural and remote areas, the gaps are fewer in total FTE, however, they represent a higher proportion of total workforce FTE. Reported gaps of almost 14 FTE in the rural and remote security workforce equate to 23% of the security workforce. Similarly, the reported gap of 18 FTE in the rural and remote facilities, trades and maintenance workforce, represents 15% of the cohort.

Leave usage

- At the time of analysis, leave taken across the workforce totalled 4,171.2 FTE, representing almost 18% of the total FTE.

Overtime utilisation

- Data on overtime is only available by pay stream.
- Overtime in the clinical support workforce is relatively low, except for the trades and artisans stream[9]. In the last pay period of 2024–25, overtime for this stream was the equivalent of 35 FTE (<6.5% of total FTE).
- For the managerial and clerical stream[10], in the last pay period of 2024–25, overtime was the equivalent of 132 FTE (<1% of total FTE).
- For the operational stream[11], in the last pay period of 2024–25, overtime was the equivalent of 132 FTE (<1% of total FTE).

Temporary workforce utilisation

- Of the clinical support workforce, 14% are employed on a temporary basis.
- Rates of **temporary employment** are slightly higher in metro (14.5%) and regional (13.8%) areas, compared to rural and remote locations (11.3%).
- Conversely, rates of **casual employment** are highest in rural and remote locations (10%) compared to metro (5.6%) and regional (5.3%) areas.
- **Across all geographical areas**, the highest rates of casual workforce usage occur among staff working in aged and home care (53%), security (32%), wardspeople and patient support (21%) and operations (10%). Temporary workforce is also high for these cohorts, as well as among wardspeople and patient support staff.
- While the use of temporary and casual staff adds flexibility and responsiveness to the clinical support workforce, it can also impact workplace culture, workforce sustainability and service delivery.

Workforce attrition

- The attrition rate for the clinical support workforce is concerning, as it is consistently higher than the overall Queensland Health attrition rate for the 3-year period 2022–23 to 2024–25.
- The clinical support workforce attrition rate for 2024–25 was 6.7%; 0.2% higher than the previous year and 1.5% higher than the Queensland Health attrition rate for the same period.
- Attrition rates for administration staff were between 5.8% and 6.5% over the 3-year period. Rates for operational staff were high and relatively steady at 7.0% to 7.3% during the same period.

[9] This pay stream broadly aligns with the facilities, trades and maintenance workforce segment used in this report.
[10] This pay stream broadly aligns with the administration workforce segment but also includes some positions in the enabling workforce stream in this analysis.
[11] This pay stream broadly aligns with the operational staff workforce segment.

- Acknowledging the relatively small cohort sizes of some clinical support workforce groups, attrition rates of particular concern include the rate for aged and home care workers (17.7%), and facilities, trades and maintenance staff (8.9%).
- High attrition is costly for the organisation and the reported attrition rates for the clinical support workforce highlight the need for programs to optimise staff retention.

What this means for the future clinical support workforce

- New models of care will increasingly rely on the deployment of clinical support staff to facilitate and enable the delivery of care, allowing clinicians to prioritise working to their full scope of practice and deliver direct clinical care.
- Administrative, operational, security, and ward staff are integral to effective patient flow and efficient resource utilisation. In the future, they will play a larger role at the point of patient transfers and in interacting with other service systems to streamline patient care. Staff in these roles will be increasingly called upon for their digital and technology skills to support interaction with advanced infrastructure, equipment and practices.
- Pathology and laboratory services staff will continue to be in demand, with the supply of laboratory scientists and technicians a concern for the future, particularly in rural and remote areas. Similarly, ongoing shortages in the public health workforce point to the need to expand workforce pipelines for these key roles, particularly outside of metro areas.
- Growing demand for personal, home and aged care, and peer support staff will place ongoing pressure on the health and social services sectors. Investment in the supply, attraction, and retention of these workforce groups will be necessary to ensure workforce sustainability within the public healthcare system.

Allied health workforce

Allied health professionals are skilled practitioners who provide diagnostic, therapeutic, and preventative healthcare services, and have specialised expertise in health promotion, disease prevention, and treatment.

Together, the professions that comprise allied health make up Queensland Health's second largest workforce after nursing and midwifery. Allied health professionals practise across the continuum of care and in a broad range of sectors, including primary care, hospitals and acute care, mental health, alcohol and other drugs services, disability, and aged care. They work independently or as part of multidisciplinary healthcare teams, often supported by allied health assistants who enable them to work to their full scope of practice and enhance allied health service delivery.

The National Health Workforce Dataset provides the data needed for workforce planning of Australian Health Practitioner Regulation Agency (Ahpra) regulated allied health professions (such as psychologists, pharmacists, and podiatrists). However, there is limited workforce information for self-regulated allied health professions (such as social workers and speech pathologists), complicating workforce planning for these professions.

As demand for allied health services grows and models of care evolve, ensuring a highly trained and capable allied health workforce is vital to support sustainable service delivery that meets current and future health needs of Queenslanders.

Key challenges

Workforce supply	While some allied health professions currently report low workforce gaps, there are concerns about long-term workforce availability for some professions. This may be due to limited supply pipelines (e.g., podiatry), complex training pathways (e.g., psychology), or planned service expansions driving increased demand (e.g., medical radiation professions). Challenges also exist for small, critical workforces without local education programs (e.g., prosthetics and orthotics), and for professions with low and declining student numbers that threaten the viability of education programs (e.g., audiology). A lack of regional programs (e.g., optometry), and/or programs without flexible delivery (e.g., physiotherapy), that enable students to “train in place” reduces access to allied health education programs.
Regional, rural and remote	Approved allied health workforce structures in rural and remote areas are generally characterised by limited staffing, commonly with multidisciplinary teams comprised of one or only a few members of each allied health profession. Practitioners are often less experienced, with limited access to profession-specific supervision and support for developing the generalist skillsets required to meet the service and community needs. Workforce gaps are as high as 50% in some allied health professions and a single vacancy can cause significant service disruption (e.g., paediatric speech pathology), or even the suspension of essential services (e.g., pharmacy).

Attraction and Retention	Attracting and retaining allied health professionals is an ongoing challenge, with an average workforce gap of 6.2% and average retention rate of six years across Queensland Health. Attraction remains challenging in some practice areas (e.g., mental health, alcohol and other drugs services), and in roles requiring advanced or specialised skills (e.g., cardiac sonography), due to limited labour market supply of suitably qualified practitioners. There are challenges in retaining skilled and experienced practitioners due to competition from other sectors (e.g., occupational therapy), and a lack of opportunities for career progression (e.g., advanced practice roles).
Workforce profile and career pathways	There are no dedicated workforce educator roles for allied health, with supervision of junior staff, clinical education and quality improvement activities typically falling to senior allied health staff. A growing proportion of senior allied health staff work part-time (e.g., 47% of HP4s) which limits their capacity to perform these key functions that support safe delivery of services, in addition to their clinical workloads. There is a lack of dedicated graduate roles and structured graduate programs in most professions, leading to variation in core skill development. Additional support is needed to ensure a safe transition to clinical practice, and to help practitioners develop the skills required to manage high clinical caseloads and prevent early career burnout.
Representation	There is significant underrepresentation of Aboriginal and Torres Strait Islander peoples within the allied health workforce, likely due in part to limited awareness of the breadth of allied health professions, barriers to entry, and higher attrition rates during study.
Scope of practice	Despite Australian and international evidence supporting innovative allied health service models that improve access, patient flow, and efficiency, these models have not been widely adopted or integrated into standard care. Increased efforts to improve understanding and support for these models are necessary to facilitate their acceptance and application. Further work is required to support widespread implementation of these models across sites, and to develop standardised statewide vocational training pathways to ensure service sustainability. Without sufficient optimisation of the allied health assistant workforce in clinical care delivery, allied health professionals are currently limited in their ability to work to their full scope of practice.

Who we are

In the last pay period of 2024–25, Queensland Health employed 16,134 allied health professionals across Queensland, representing 13,663 FTE.

This workforce is made up of 28 professions plus the allied health assistant workforce, including:

- audiology
- breast imaging radiography
- cardiac perfusion
- clinical measurements science
- dietetics
- exercise physiology
- genetic counselling
- leisure therapy
- music therapy
- neurophysiology
- nuclear medicine science
- nutrition
- occupational therapy
- optometry
- orthoptics
- orthotics and prosthetics
- pharmacy
- medical physics
- physiotherapy
- podiatry
- psychology
- radiation therapy
- radiography
- rehabilitation engineering
- social work and welfare
- sonography
- speech pathology.

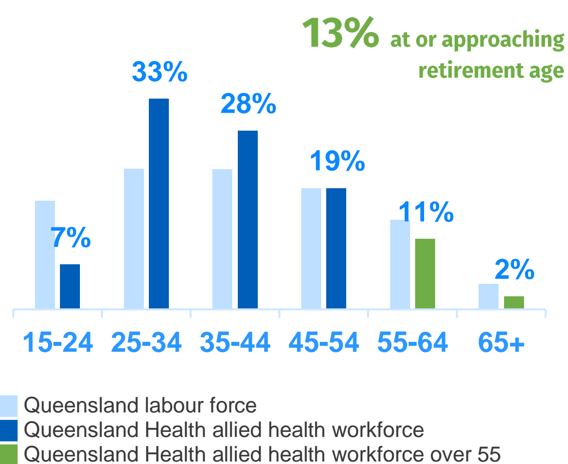
Age profile

The age profile of the allied health workforce shows 68% are aged 25 to 44 years. This segment often experiences career breaks due to family and carer responsibilities, contributing to workforce instability and higher rates of part-time work.

Some allied health professions have a significant proportion of their workforce nearing retirement age. More than 70% of those in rehabilitation engineering, breast imaging radiography, and leisure therapy are aged 45 years or older. Cardiac perfusion (63%), nutrition (48%), social work and welfare (48%), and genetic counselling (40%) also have a large proportion aged 45 years or older.

In contrast, exercise physiology (44%), occupational therapy (32%), radiography (31%), and physiotherapy (30%) all have a higher proportion of younger (<30 years) workforce. This may reflect generational preferences for roles with high levels of flexibility and autonomy.

Figure 9: Age profile of the allied health workforce compared to Queensland labour force.



Queensland labour force
Queensland Health allied health workforce
Queensland Health allied health workforce over 55

Source: Queensland Health workforce data; Queensland labour force statistics sourced from Australian Bureau of Statistics (June 2025), Labour Force, Australia, Detailed, ABS Website, accessed 13 August 2025 and Queensland Health payroll data at end of June 2025

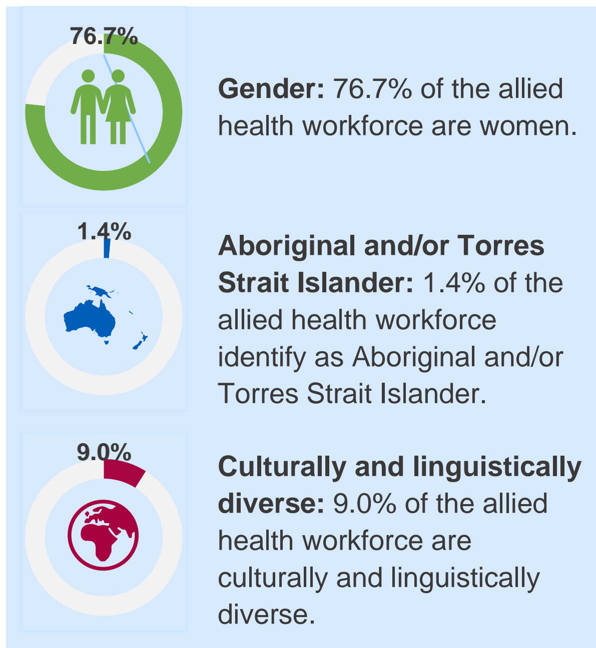
Workforce diversity

The demographics of the allied health workforce being predominately female (76.7%), contribute to patterns of workforce participation associated with career pauses. These may relate to parental responsibilities, including a greater uptake of part-time roles, flexible work arrangements, and increased use of temporary workforce arrangements to backfill prolonged leave.

Aboriginal and Torres Strait Islander peoples remain significantly underrepresented within the allied health workforce, and training programs currently lack pathways and supports to facilitate entry to practice for this cohort.

The allied health workforce has a lower percentage of individuals from culturally and linguistically diverse backgrounds (9%) compared to the medical, nursing and oral health workforces. This may reduce the accessibility of allied health services for related patient cohorts.

Figure 10: Allied health workforce demographics.

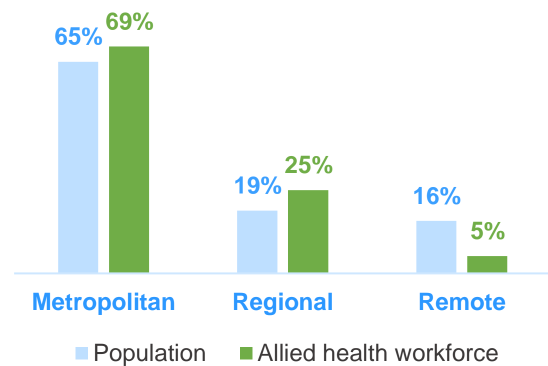


Source: Human Resources Business Intelligence analysis of Queensland Health Human Resources data.

Where we work

- In the last pay period of 2024–25, 69.3% of the allied health workforce worked in metro areas, with lower proportions in regional (25.4%) and rural and remote (5.3%) areas.
- In contrast to the medical and nursing workforces, a lower proportion of allied health professionals work in rural and remote areas (5.3% of the total workforce). Of note, regional locations have had limited allied health FTE growth, with some sites seeing decreased FTE over time, likely due to persistent vacancies.
- The proportion of the allied health workforce who are junior increases with rurality (25.7% in metro, 27.4% in regional, and 32.6% in rural and remote areas). This indicates a reliance on early career professionals in regional and rural services and may suggest that mid-career workers relocate to metro areas for professional or career development reasons.
- The proportion of senior roles decreases in regional locations (4.2%) and further decreases in rural and remote locations, where they make up 1.6% of the workforce.
- The lower ratio of senior to junior allied health staff in regional, and rural and remote areas may limit the capability to deliver adequate training, supervision, leadership, and professional support to early career professionals in these regions.

Figure 11: Geographic distribution of the allied health workforce.



Source: Queensland Health workforce data; Population data from the Department of Health and Aged Care's MMM 2023.

Current workforce trends and analysis

Workforce profile and distribution

Career progression and seniority

- The allied health workforce is primarily made up of health practitioner (HP) 3 (28.2%) and HP4 (37.2%) positions. A smaller proportion of the workforce are in advanced HP5 (15.7%) and HP6 and above leadership positions (3.9%). New graduates comprise 8.6% of the workforce, while allied health clinical assistants account for 12% of the total allied health workforce.
- The workforce profile highlights the need to increase graduate pipelines for allied health

professions and to ensure adequate career pathways for existing staff. This is particularly the case in some services, such as mental health, alcohol and other drugs, where 83% of the workforce are in HP3 and HP4 roles, and there are limited clinical career progression opportunities to HP5 and above roles.

Employment type

- Forty-six percent of the HP4 allied health workforce and 38% of the HP5 allied health workforce are observed as working part-time. This impacts capacity to undertake essential senior role functions such as supervision of junior staff, quality improvement, and clinical governance.
- Professions with high part-time employment (>40%) across their entire workforce (HP3-HP8) include audiology, neurophysiology, psychology, optometry, sleep science, and sonography. In addition, moderate levels of part-time employment (>35%) exist in nutrition and dietetics, cardiac science, and speech pathology.

Current gaps

- Across all allied health professions, the average proportion of unfilled approved positions is 6.3%, with no significant variation across HP levels.

Specific roles and locations

- Significant statewide vacancies exist in neuropsychology (26%), radiography/ sonography (15%), and psychology (14%), with smaller gaps in podiatry (8.1%) and social work (7.1%).
- There is a high percentage (18.9%) of unfilled approved allied health positions within mental health, alcohol and other drug services across all roles and levels.
- Workforce gaps widen for allied health as remoteness increases, with unfilled approved positions identified as 501.4 FTE (5%) in metro areas, 308.6 FTE (8.3%) in regional settings, and 101.9 FTE (13.3%) in rural and remote locations.
- Within **regional** areas, nuclear medicine science (19%), neurophysiology (14%), and medical physics (13%) have a high percentage of unfilled approved positions.
- In **rural and remote areas**, occupational therapy (15%), nutrition and dietetics (10%) and social work (10%) have a high percentage of unfilled approved positions.
- Higher staff turnover rates, particularly in rural and remote areas, result in service disruption and require frequent recruitment to maintain staffing levels. This is particularly challenging for small, critical workforces (e.g. podiatry), where there are sole practitioner positions, and services cease until the vacancy can be filled.

Persistent workforce gaps

- In addition, persistent workforce gaps (>12 months) result in substantial service disruption for all professions. Within regional areas, persistent workforce gaps are present in radiography/sonography (37.5%), prosthetics/orthotics (33.3%), neuropsychology (28.6%), radiation therapy (28.6%), podiatry (27.3%), nuclear medicine science (16.7%), and sonography (14.0%).
- Similarly, in rural and remote areas, persistent workforce gaps are significantly higher for psychology (30.8%), sonography (28.6%), speech pathology (17.4%), and physiotherapy (11.4%).

Leave usage

- At the time of analysis, leave taken across the workforce totalled 2,177 FTE, representing 15.9% of the total FTE.

Overtime utilisation

- Overtime utilisation within the allied health workforce is concentrated among medical radiation professionals (e.g. radiographers) and physiotherapists. This reflects the high service demand and extended hours required for these roles in 7-day service models and extended hours care.
- Data on overtime is only available by pay stream. Allied health is contained within the professional and technical stream.
- In the last pay period of 2024–25, overtime in the professional and technical stream was 14,022 hours, equating to 184.5 FTE.

Temporary workforce utilisation

- Overall, 17.5% of the allied health workforce is employed on a temporary basis, 79.5% are permanent, and 3% are casual.
- Allied health professions with a larger **temporary** workforce include exercise physiology (36%), audiology (24%), and speech pathology (24%).
- The highest proportion of temporary workforce are HP3 positions (35%), likely reflecting the temporary nature of dedicated graduate positions. Additionally, there is a growing reliance on temporary backfill arrangements to maintain service continuity during extended leave (e.g. parental leave), secondments, and higher duties opportunities.
- The allied health workforce has low utilisation of more costly **casual** workforces (5%).

Workforce attrition

- The average attrition rate for allied health professionals (5.1%) has remained slightly lower than the overall Queensland Health workforce (5.4%) over the 3-year period from 2022–23 to 2024–25.
- However, several professions have had significantly higher attrition rates (as a percentage of their total workforce) over the **3-year period**. These include rehabilitation engineering (16.5%), optometry (11.4%), cardiac perfusion (10.1%), neurophysiology (8.0%), psychology (7.2%), allied health assistants (7.2%), respiratory science (7.0%), and podiatry (6.47%).
- Professions with a large volume of workforce attrition **in 2024–25** include social work (63.8 FTE), radiography and sonography (49.9 FTE), and occupational therapy (31.3 FTE).
- Retaining mid-career allied health professionals remains a significant challenge, with this group experiencing the highest attrition rate (37.9%).
- Anecdotal factors contributing to attrition among allied health professionals include limited opportunities to work to their full scope of practice, and challenges in career progression for those working part-time.

Future workforce projections

Projections have been developed for 11 allied health professions where there was sufficient data to inform modelling.

Significant gaps in the availability of workforce information for self-regulated allied health professions have led to difficulties in understanding workforce supply and distribution for these professions. Census data was used to model these cohorts where appropriate. Limitations with this data prevented the inclusion of professions with inconsistent classification (e.g., exercise physiology and cardiac science/clinical measurement science) or undifferentiated data (e.g., dual qualified radiography/sonography).

Modelling was not completed for smaller allied health professions (total FTE < 100), due to data quality constraints and limitations in producing reliable forecasts.

Graduate projections

Graduate numbers for most of the 11 allied health professions modelled are forecast to grow or remain constant from 2023 to 2032.

Figure 12: Allied health graduate projections.

Profession	2023 Graduate Numbers	2032 Projected Graduate Number	Annual Growth Rate
Pharmacy	500	789	5.2%
Occupational therapy	351	524	4.5%
Physiotherapy	472	595	2.6%
Podiatry	25	48	7.5%
Psychology	255	502	7.8%
Medical radiation practitioners[12]	177	187	0.6%
Social work	855	1257	4.1%
Audiology	34	42	2.4%
Speech pathology	165	221	3.3%
Dietitian[13]	178	183	0.3%

Workforce supply and demand

Demand for allied health professionals is projected to increase by 45.1% between 2023 and 2032. All professions will need to grow to meet future service demand, with growth of 3,676 FTE required by 2032[14].

Based on maintaining current market share, attrition rates, and trends in FTE per person, Queensland Health is projected to experience workforce shortages in several allied health professions, including, but not limited to, pharmacy, physiotherapy, podiatry, psychology, radiography, radiation therapy, and speech pathology. By 2032, the gap between supply and demand in these professions is expected to exceed 900 allied health professionals.

Figure 13: Allied health supply and demand.

Supply	Demand	Gap[15]	Growth from 2023 FTE required to meet demand
Pharmacy			
2,055	2,070	16	643
Occupational therapy			
2,031	1,717	-317	532
Physiotherapy			
1,869	2,217	347	689
Podiatry			
109	168	59	52
Psychology			
340	692	353	215
Medical radiation practitioners			
1,295	2,075	781	645
Social work			
2,474	1,742	-732	541
Audiology			
145	136	-9	49
Speech pathology			
559	715	156	238
Dietitian			
891	708	-182	220

Source: Queensland Health analysis.

[12] Medical radiation practitioners include radiation therapists, radiographers and nuclear medicine scientists/technologists.
[13] Excludes graduates from degrees for nutritionists. Forecast volume of graduates is sufficient to maintain this workforce within Queensland Health.

[14] Growth required from end of 2022-23 financial year to end of 2031-32 financial year.
[15] Gaps are the difference between projected demand and projected supply. Where the gap is a positive number (shaded red), demand exceeds supply. Where the gap is negative (shaded green), surplus supply is projected for that profession.

What this means for the future allied health workforce

- Overall, student enrolments in allied health programs continue to rise, indicating strong future supply, particularly in professions such as occupational therapy, speech pathology, and exercise physiology. Despite this strong growth, demand continues to exceed supply for some allied health professions.
- For allied health professions like podiatry, sonography, and psychology, there has been limited student and workforce growth, which is impacting service availability.
- For a small number of allied health professions, including pharmacy and nuclear medicine science, student numbers have declined over time. This has resulted in constrained workforce supply and, in some cases, critical national workforce shortages.
- The demand for some allied health professions is expected to increase with planned service and model of care expansions.
- Factors known to contribute to intentions to leave the allied health workforce include mental burnout, retirement, lack of recognition/feeling undervalued, and lack of professional satisfaction and fulfillment.
- At a system level, allied health workforce planning will need to prioritise:
    - expansion of graduate and early career support structures and development pathways
    - career progression and leadership opportunities to retain mid-career practitioners
    - sustainable succession planning, especially for advanced practice roles and small, critical workforces.

Medical workforce

Medical officers in Queensland's public health system provide evidence-based, patient-centred care through diagnosing and treating illness, managing emergencies, and supporting chronic disease care across a range of specialties. They also promote public health through vaccination, disease prevention, and health education.

Growth in healthcare services across HHSs requires a sustainable and well-supported medical workforce to ensure the provision of high-quality healthcare where it is needed. Queensland continues to experience workforce challenges across the medical career continuum, from medical students and junior doctors, through to vocational training and specialist practice.

Key challenges

Supply pipeline	The medical workforce pipeline is at risk from the earliest stage, impacted by insufficient university places, increasing mature-aged entry, and increasing demand for clinical placements. A national agreement guiding medical intern allocation requires modernisation to reflect Queensland's medical workforce shortages. Progression through accredited vocational training is constrained by competition and externally set training numbers, resulting in system bottlenecks and an increase in unstructured and unsupported non-accredited roles. Specialist workforce shortages – driven by externally set training numbers, ageing, sector fragmentation, and rural recruitment challenges – limit clinical supervision and training capacity, further exacerbating workforce gaps.
International workforce	As work progresses to build and retain the domestic medical workforce, current gaps, particularly for junior doctors, are often filled with international medical graduates (IMGs). Challenges remain for the transition and integration of IMGs into local settings, with processes for IMGs to fulfil visa and registration requirements identified as complex and a source of delays. Further, IMGs may experience difficulties adapting to new professional and cultural contexts and accessing career development and progression opportunities.
Wellbeing	The medical workforce reports reduced wellbeing across the career spectrum. Medical students are vulnerable to placement poverty. Junior doctors and vocational trainees report high workloads, long hours, frequent paid and unpaid overtime, workplace stress, accredited vocational training constraints, and limited access to examination leave. Workforce shortages continue to intensify demands on clinicians for on-call and supervisory duties, contributing to burnout and attrition.
Regional and rural workforce	Maintaining a medical workforce for rural and regional healthcare is challenging and relies on diverse service models, workforce flexibility, and continued investment in grow-your-own workforce strategies. Persisting attraction and retention challenges are compounded by local capacity barriers, like accommodation availability and cost, supervisor capacity, and the availability of opportunities to meet training or career progression requirements. These factors affect both access to vocational training and exposure to the required case-mix breadth and depth needed to grow the specialist workforce in regional and rural health services.

Who we are

In the last pay period of 2024–25, Queensland Health employed 15,624 medical officers, representing 13,128 FTE.

This workforce is made up of the following roles:

- senior medical officers (includes visiting medical officers, staff specialists, career hospital doctors)
- registrars
- resident medical officers
- interns
- students in medicine.

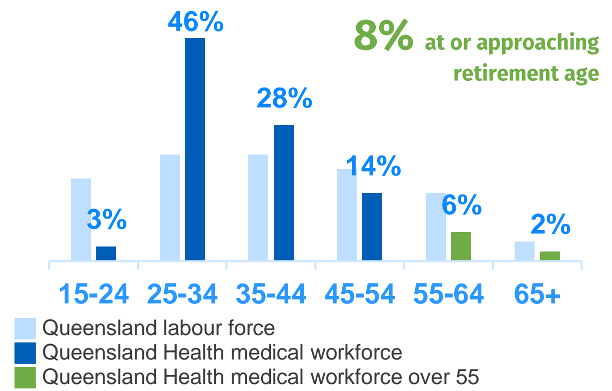
Medical officers may also undertake additional roles such as conjoint academic appointments, private practice, and professional college representation. These roles further enhance their clinical practice and strengthen the expertise they contribute to patient care.

Age profile

The age profile of the medical workforce shows substantial variation compared with broader Queensland labour force trends. With 74% of the medical workforce aged between 25 and 44 years, family and caring responsibilities, and associated career breaks, commonly occur during prevocational and vocational training or early specialist years.

This also reflects the role of public hospitals as the main providers of medical training. As doctors advance in their careers, they disperse across public, private, and primary care employment settings.

Figure 14: Age profile of the medical workforce compared to Queensland labour force.



Source: Queensland Health workforce data; Queensland labour force statistics sourced from Australian Bureau of Statistics (June 2025), Labour Force, Australia, Detailed, ABS Website, accessed 13 August 2025 and Queensland Health payroll data at end of June 2025

The commencement of family responsibilities is often delayed to accommodate career progression through specialty training.

While the data shows a lower retirement risk compared with Queensland labour force trends, the medical workforce is ageing, and higher concentrations in younger age brackets may compound workforce shortages, particularly within certain specialties.

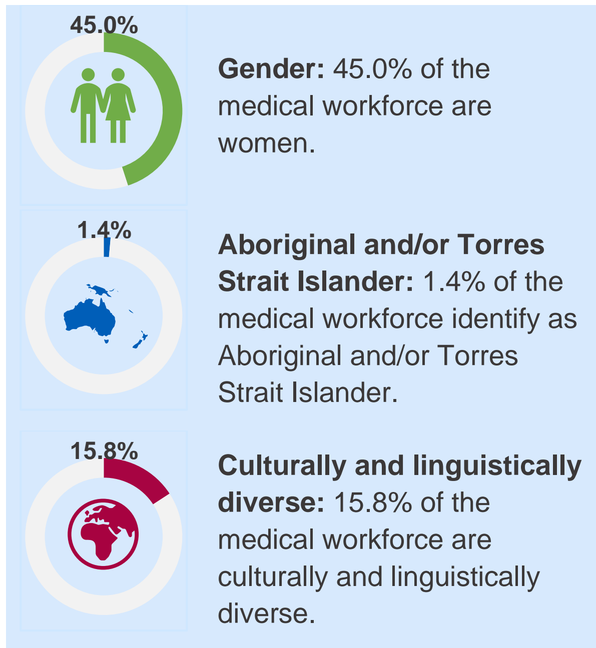
Workforce diversity

Gender representation varies across medical career stages and specialties. While women remain underrepresented, the pipeline of domestic and Queensland medical students shows a significantly higher proportion of women.

Aboriginal and Torres Strait Islander peoples are significantly underrepresented in the medical workforce.

15.8% of the medical workforce are culturally and linguistically diverse, exceeding the whole of Queensland Government's current workforce representation (8.96%) and target (12%).

Figure 15: Medical workforce demographics.

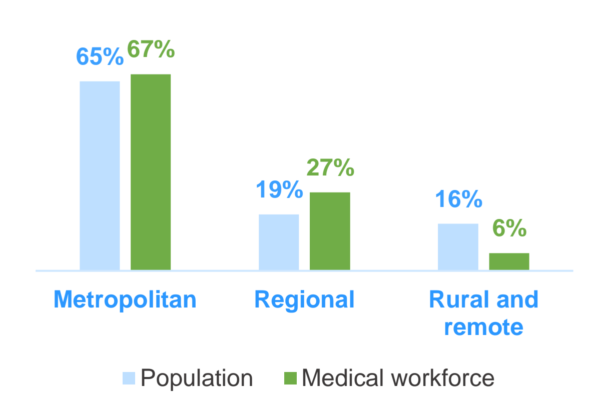


Source: HRBI analysis of Queensland Health HR data.

Where we work

In the last pay period of 2024–25, 67.2% of the medical workforce was working in metro areas, 26.8% in regional, and 6% in rural and remote areas.

Figure 16: Geographic distribution of the medical workforce.



Source: Queensland Health workforce data; Population data from the Department of Health and Aged Care's MMM 2023.

Current workforce trends and analysis

Workforce profile and distribution

Location

- Overall, the workforce is concentrated in metro areas. Distribution across workforce segments is reasonably consistent when comparing metro and regional areas.
- Most vocational training is undertaken in metro (69%) and regional (29%) areas.

Career progression and seniority

- Of the approved medical workforce FTE, 42.5% are in senior positions (specialist, senior or visiting medical officer, medical superintendent), 26.2% are in vocational training (accredited and provided through a medical specialist college), 9.9% are in non-accredited service roles (principal house officer), and 21.4% are in prevocational training (intern, resident medical officer).
- Senior doctors comprise 69.6% of the rural workforce, 41.3% of the metro workforce, and 36.6% of the regional workforce.
- An imbalance between current vocational, prevocational and non-vocational workforces highlights training bottlenecks, with a growing number of principal house officers unable to progress to specialist training[16].

Employment type

- There is an increasing tendency toward fractional work hours, with the average FTE per medical officer decreasing from 0.92 FTE in 2015 to 0.86 FTE in 2024[17].
- Analysis of Queensland Health's medical workforce in the last pay period of 2024–25 identified an average FTE per worker of 0.83 FTE.
- Fractionalisation is more pronounced in senior roles.

[16] Australian Government Department of Health. (2021). National Medical Workforce Strategy 2021–2031. Retrieved from https://www.health.gov.au/resources/publications/national-medical-workforce-strategy-2021-2031.
[17] Queensland Health payroll data 30 June 2015-2024, FTE per headcount by stream, extracted 15 October 2025.

- An overall medical workforce gap exists, and utilisation of supplementary medical workforces (e.g. IMGs and locums) masks the extent of the imbalance between demand and supply. The impact of this is most significant in rural and remote areas.

Current gaps

Location

- Regional and rural health services are the most burdened by persistent workforce gaps (>12 months), with 71.4 FTE (2%) in regional areas and 167.4 FTE (21.0%) in rural and remote areas, reflecting the compounding effects of both undersupply and maldistribution. There was no overall gap identified in metro areas.
- Specialist gaps in regional areas exacerbate service strain. A minimum number of specialists is required to maintain a viable service and on-call roster. Too few specialists at a single location make on-call requirements unsustainable and lead to burnout, attrition, and sometimes, service closure or bypass.

Specifics roles

- IMGs are supplementing the domestic medical workforce across all segments, with increasing reliance in early career stages, highlighting pipeline inadequacies.
- In June 2025, Queensland Health reported that IMGs represented 10% of the total medical workforce headcount. Approximately half of this cohort were employed in regional or remote health services.
- Deficits across senior positions impact both service delivery and supervisory capacity for prevocational and vocational training.

Employment type

- Locums are also supplementing domestic shortages *(see temporary workforce utilisation).* Protracted recruitment timelines and inflated costs impact their viability as a long-term solution.

Overtime utilisation

- Overtime is utilised as a temporary measure to support workforce imbalances, but cost and the risk of burnout and attrition make it unsustainable.
- For the medical stream, an average of 80,344 overtime hours per month was worked in 2024–25. This was the equivalent of 13,131 FTE, or an additional 7% on top of the total FTE.
- There is a growing generational expectation for improved work-life balance with international evidence showing a linear relationship between working more hours and having higher rates of anxiety, depression and psychological distress[18].

Temporary workforce utilisation

- The proportion of temporary medical officers (66.5%) reflects Queensland Health's medical employment framework, with short-term contracts across early career years (prevocational through vocational training).
- Locum workforces are engaged across levels where there are deficits in the salaried workforce. There has been significant and sustained reliance on medical locums in recent years, making this an economically inefficient workforce model.
- Reflecting maldistribution challenges, rates of locum engagement are proportionally higher in regional, rural and remote services, representing more than 80% of Queensland Health's locum expenditure between 1 April 2024 and 31 August 2025.
- Temporary workforce utilisation may also relate to leave. At the time of analysis, leave taken across the workforce totalled 1,899.3 FTE, representing 14.5% of total FTE.

[18] Australian Government Department of Health. (2021). National Medical Workforce Strategy 2021–2031. Retrieved from https://www.health.gov.au/resources/publications/national-medical-workforce-strategy-2021-2031.

Workforce attrition

- The medical workforce attrition rate is lower than for the overall workforce, at 3.2%, and has declined over the 3-year period from 2022–23 to 2024–25.
- Attrition rates vary across specialties, with proportionally greater impact on smaller workforces and specialties in undersupply.

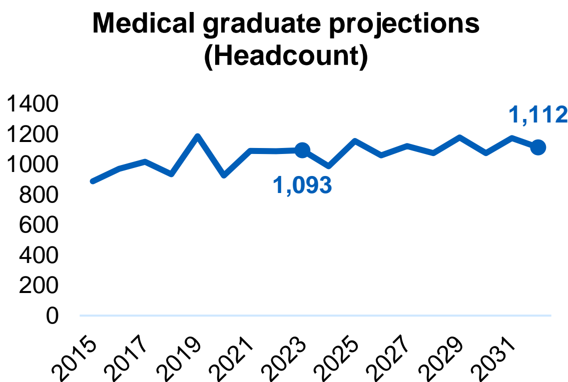
Future workforce projections

Graduate projections

Medical graduate numbers have continued to increase gradually in recent years. From 2015 to 2023, graduate numbers increased by 23%. Based on this trend, graduate numbers are projected to continue increasing through to 2032.

There are active plans at a Commonwealth level to increase medical school places nationally, with an additional 100 places per year from 2026, increasing to 150 per year from 2028. These places will be allocated via a competitive bid process.

Figure 17: Medical workforce graduate projections.



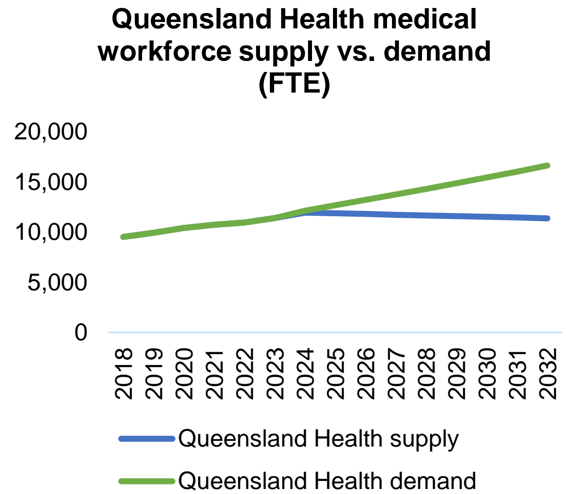
Source: Queensland Health analysis.

Supply and demand

Assuming current attrition rates and trends in FTE per person working in medicine are maintained, demand for doctors is projected to increase by 52% from 2023 to 2032. To meet this demand in 2032, Queensland Health will need to employ an additional 5,247 medical FTE, based on current models of care and service utilisation patterns.

Queensland Health's services are projected to experience continued supply shortages. The gap between medical workforce supply and demand will increase to nearly 5,300 FTE by 2032.

Figure 18: Medical workforce supply and demand.



Source: Queensland Health analysis

What this means for the future medical workforce

- Queensland Health's medical workforce is growing, but not fast enough to meet significantly increasing demand for health services, driven by population growth and an ageing population.
- Current domestic graduate supply from Queensland institutions is insufficient to meet intern workforce demand. In 2024, there were 723 Queensland domestic graduates and 915 intern positions (2025 clinical year).
- Projected specialty shortfalls include ophthalmology, surgery, sexual health medicine, radiology, obstetrics and gynaecology, physician and general practice.
- Workforce enablers include diversified models of care and training settings, new technologies, and national policy reforms (e.g. to streamline and simplify IMG regulatory settings).
- Challenges include career attrition, national and international competition for a relatively finite resource, and potential global burdens of disease (e.g. pandemics).
- Generational shifts are changing patterns of workforce participation, including fractionalisation of hours and shorter working lives among mature-aged graduate cohorts.
- Following the approval of rural generalist medicine as a new field of speciality practice, facilitating regional and rural career pathways will be essential to building a sustainable workforce where it is needed.
- Collaboration among medical education and training stakeholders is essential to driving greater alignment between vocational training opportunities and specialty workforce priorities.

Enabling workforce

In addition to the large clinical and clinical support workforces, Queensland Health employs teams of professionals in roles that support and enable these workforces to deliver healthcare services to patients.

Across the Department of Health and public health services, professionals in finance, human resources, infrastructure and other corporate functions, work to ensure that services are supported and resourced effectively.

Information and communication technology (ICT) professionals provide ICT systems, leadership and specialist technical support to Queensland Health staff and stakeholders across the state. They also manage patient data recording and tracking systems that are critical to patient care and to health service operations, management, and funding.

The enabling workforce also includes executive leadership and specialist governance roles that ensure clinical, regulatory and legislative compliance, and patient safety. Research teams within this workforce explore new service models and approaches, supporting innovation and new methods in practice.

Although diverse, the enabling workforce faces many of the same challenges as other non-clinical workforce groups.

Key challenges

Attraction	Queensland Health must compete across sectors to attract a skilled enabling workforce to careers in public healthcare. This challenge is felt most acutely in rural and remote health services. Attracting a skilled corporate services and ICT workforce to public healthcare relies on raising awareness about the breadth of opportunities available outside of clinical roles. Further work is required to strengthen and clarify education-to-employment pathways and career paths for the enabling workforce, and to develop a compelling employer value proposition for Queensland Health.
Retention	As a non-clinical workforce, corporate services and ICT professionals can pursue careers across many sectors beyond healthcare. This flexibility and broad access to employment opportunities make retaining the enabling workforce more challenging than retaining health professionals. Retention relies on investment in leadership, culture, professional development, and contemporary organisational systems and processes. Critically, it also requires organisational programs that recognise and value non-clinical contributions, and support career progression within a healthcare context.
Wellbeing	Wellbeing is closely linked to attraction and retention outcomes for the enabling workforce. Workforce wellbeing is challenged by unhealthy workplace cultures, high workloads and job pressure, limited opportunity for skills utilisation, lack of recognition, and poor organisational systems.
Skills and knowledge	While many enabling roles can successfully leverage transferrable skills from other organisations or sectors, some of these roles are highly specialised and require extensive knowledge of departmental, health sector, or government systems, which is generally developed over time. Retaining and continuing to develop skilled staff with deep public health sector and Queensland Health corporate knowledge is critical to enhancing system outcomes.

Who we are

In the last pay period of 2024–25, Queensland Health employed 13,965 people in enabling roles across Queensland, representing 13,162.5 FTE.

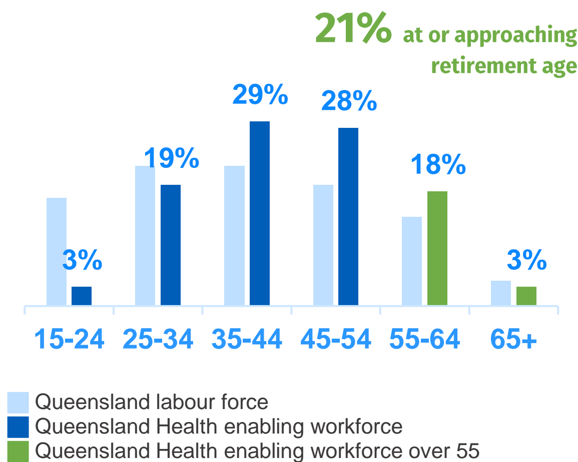
This workforce is made up of the following key roles and functions:

- corporate services (finance, human resources, governance, policy, project and other roles)
- data and ICT
- governance and leadership
- research.

Age profile

The age profile of the enabling workforce shows a relatively even distribution across age groups. This balanced profile suggests a healthy proportion of early career entrants emerging to respond to, and eventually replace, the cohort aged 55 years or older who are approaching retirement.

Figure 19: Age profile of the enabling workforce compared to Queensland labour force.



Source: Queensland Health workforce data; Queensland labour force statistics sourced from Australian Bureau of Statistics (June 2025), Labour Force, Australia, Detailed, ABS Website, accessed 13 August 2025 and Queensland Health payroll data at end of June 2025

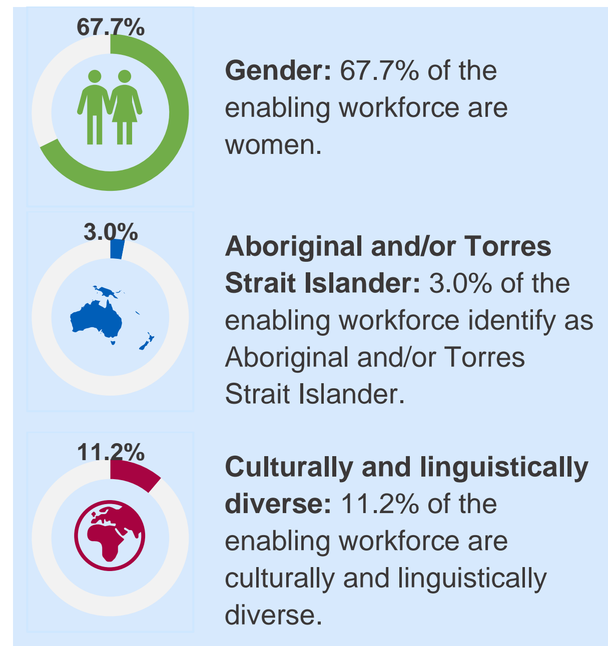
Workforce diversity

Over two-thirds (67.7%) of the enabling workforce are women, which is lower than the Queensland Health female representation rate of 73%.

Of the enabling workforce, 3% identify as Aboriginal and/or Torres Strait Islander, which is similar to most other workforce streams (excluding the Aboriginal and Torres Strait Islander stream).

A high proportion of the enabling workforce identifies as culturally and linguistically diverse (11.2%).

Figure 20: Enabling workforce demographics.

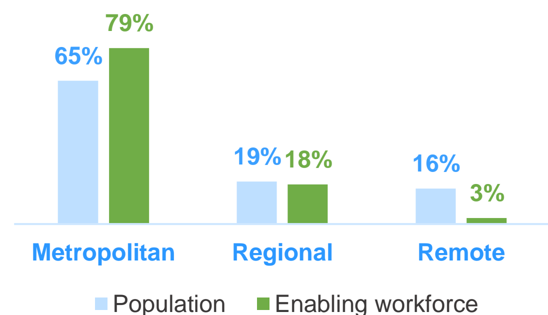


Source: HRBI analysis of Queensland Health HR data.

Where we work

In the last pay period of 2024–25, 79.4% of the enabling workforce was working in metro areas, 17.9% working in regional areas, and 2.7% in rural and remote areas.

Figure 21: Geographic distribution of the enabling workforce.



Source: Queensland Health workforce data; Population data from the Department of Health and Aged Care's MMM 2023.

While this profile shows a marked skew towards metro locations, this partly reflects the nature of

corporate, ICT and other non-clinical roles. These functions rely less on patient or clinician interaction and can more effectively harness remote access technology to support service delivery and achieve outcomes across Queensland.

Current workforce trends and analysis

Workforce profile and distribution

Location and specific roles

- Most of Queensland Health's enabling workforce is made up of corporate services staff (62.6%), and data and ICT staff (35.2%).
- The proportion of data and ICT staff is much lower in rural and remote locations, where they make up only 14.5% of the enabling workforce, compared to 33.0% to 36.4% in metro and regional areas.

Career progression and seniority

- Overall, 17.6% of the enabling workforce are in senior positions, while 11.6% hold junior or entry level positions. Senior roles are concentrated in metro locations (19.4%), compared to 10.8% to 11.4% in regional, rural and remote locations. The enabling workforce is more likely to hold junior roles in regional areas (16.5%) and rural and remote areas (20.5%).

Employment type

- Part-time employment is not a key feature of the enabling workforce, with staff working on average 0.95 FTE per worker. Although a small segment, research staff have the highest proportion of part-time employment at 0.86 FTE per worker in metro locations and 0.84 FTE per worker in regional locations.

Current gaps

Location and specific roles

- Across the enabling workforce, the overall workforce gap is 2,395 FTE (7.3%), with most gaps occurring in metro (17.8%) locations. This is a relatively high gap rate compared to other professional workforce streams.
- Corporate services, data and ICT roles experience the largest gaps across all regions, particularly in metro areas.
- Within corporate services, the gap is 1,275.7 FTE (17.0%) in metro areas,120.3 FTE (6.8%) in regional areas and 6.4 FTE (1.9%) in rural and remote areas.
- As paper-based systems are phased out, demand for data and ICT skills continues to increase in regional, rural and remote locations. However, workforce availability remains limited, with recorded gaps of 15.4% (9.4 FTE) in rural and remote areas and 7.7% (70.2 FTE) in regional areas.
- Gaps in data and ICT roles in metro areas are significantly higher at 19.7% (885.7 FTE).
- Long-term workforce gaps (>12 months) indicate ongoing challenges filling metro research roles (14.1%), metro data and ICT roles (10.9%), metro corporate services roles (9.3%), and rural and remote data and ICT roles (7.7%).
- Overall, the data highlights ongoing challenges in the supply, attraction and retention of the enabling workforce, particularly in metro areas, and across corporate services, data and ICT roles.

Leave usage

- At the time of analysis, leave taken across the workforce totalled 1,911.7 FTE, representing more than 14.5% of total FTE.
- High rates of leave correlate with reported workforce gaps (albeit at a lower level), suggesting positions may not be backfilled during periods of long-term, unpaid leave. This aligns with standard business practices.

Overtime utilisation

- Data on overtime is only available by pay stream.
- Overtime in the enabling workforce is relatively low, estimated at less than 1% of total FTE in the last pay period of 2024–25.

Temporary workforce utilisation

- Of the enabling workforce 15.5% are employed on a temporary basis. Of these, almost 2,000 FTE are corporate services, and data and ICT staff.
- This rate of temporary workforce utilisation is slightly higher than that of other professional streams within Queensland Health.
- Temporary employment is higher in metro (16.2%) and regional (13.1%) areas, than in rural and remote (12.4%) locations.
- Casual employment is rarely utilised for enabling workforce roles.
- While temporary employment supports workforce agility and responsiveness to operational needs, it also. contributes to job instability, lower job satisfaction and higher attrition. This is undesirable within a workforce where organisational systems and corporate knowledge are key success factors.

Workforce attrition

- The attrition rate of the enabling workforce has been variable over the 3-year period from 2022–23 to 2024–25. The headline rate for this workforce has improved from 6.4% three years ago to 5.4% in 2024–25.
- Some workforce segments show positive trends, particularly the data and ICT workforce, where attrition declined from 5.7% to 3.9% over the 3-year period. Although a smaller cohort, research staff also recorded improvement, with attrition decreasing from 8.8% to 5.6%.
- Attrition for corporate services staff has remained relatively steady but comparatively high at 6.2% in 2024–25.
- The enabling workforce has potentially greater employment mobility and broader career options than clinical professional streams, including opportunities outside the health sector. Therefore, retention strategies for this workforce may need to differ from those targeting the clinical and clinical support workforce.

What this means for the future enabling workforce

- Better planning for the enabling workforce is needed to define, scope and enhance its efficiency.
- With the rapid advancement of medical, and communication technologies, including artificial intelligence, there is already an increased demand for advanced workforce skills in these areas.
- Workforce data shows that skilled professionals across all enabling workforce roles continue to be in strong demand. This includes corporate services, research and executive leadership roles, as well as data and ICT. This workforce is critical to driving the modernisation and digital transformation of health services to align with best practice and patient expectations.
- Alongside strategies to develop new and expanded workforce pipelines, investment is needed in contemporary, responsive attraction and retention initiatives that resonate with the target market.
- Queensland Health will need to compete with organisations across multiple sectors to attract and retain these skilled professionals. Competitive employment offerings, a strong organisational culture, and structured professional, career and leadership development opportunities will be essential to attract and sustain this workforce.

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Queensland Ambulance Service workforce

The Queensland Ambulance Service (QAS) comprises a broad range of professions, including clinically qualified personnel, medical practitioners, allied health practitioners, and specialist business personnel. Frontline health and ambulance services are delivered by paramedics, emergency medical dispatchers, patient transport officers, doctors, nurses, pharmacists, and other allied health practitioners. This diverse workforce is represented within the QAS workforce profile.

QAS, including Retrieval Services Queensland, provides ambulance response services, emergency and non-urgent patient care and transport services, interfacility ambulance transport, casualty room services, planning and coordination for multi-casualty incidents and disasters, and confidential health assessment and information services.

QAS is a critical partner within Queensland's health system, delivering care to Queenslanders 24 hours a day through telephone and virtual models of communication. It operates across all regions of the state, serving diverse communities and locations.

QAS also collaborates closely with other health and emergency services to maintain public safety, deliver care during disasters, and support both urgent and non-urgent patient transport needs.

Key challenges

Workforce supply for operational staff	While QAS recruits from a ready supply of graduates, there is a smaller pool of experienced, fully 'qualified' paramedics available. Maintaining an appropriate balance between graduate and qualified cohorts remains a challenge. Newly qualified personnel are required to consolidate their knowledge with in-field experience prior to becoming suitably qualified to work in some rural and remote locations. Given the specialist skills required for some roles, QAS is responsible for developing much of its own workforce supply. This includes recruiting, training and developing suitable personnel, such as emergency medical dispatchers.
Workforce supply for corporate support roles	For corporate support roles, there strong competition across both public and private sectors for suitably qualified professionals in disciplines such as information technology, human resources, and finance. These challenges are amplified in regional areas, where competition is high, and workforce pools are smaller.
Attraction and retention in regional, rural and remote locations	Attracting, recruiting and retaining suitably qualified QAS personnel in regional, rural and remote locations continues to be a focus. Attraction and retention challenges also persist for roles requiring highly specialised skills, like emergency medical dispatchers. QAS has implemented a range of flexible and agile service delivery models and workforce strategies to maintain continuity of health and ambulance services across communities. However, sustaining a permanent workforce in some locations remains difficult.

Who we are

In the last pay period of 2024–25, QAS employed 7,134 people across Queensland, representing 6,023.54 FTE.

This workforce is made up of the following key workforce streams:

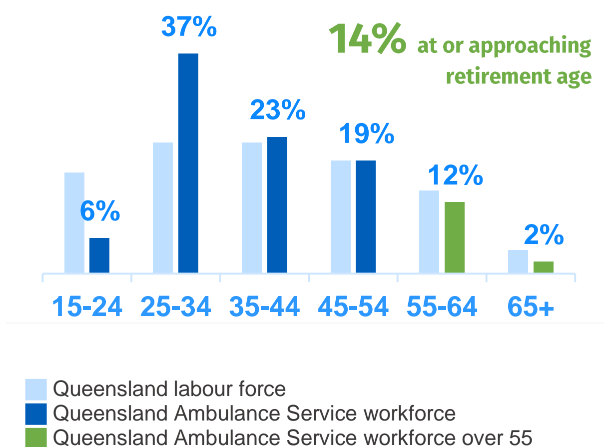
- paramedics
- emergency medical dispatchers
- patient transport officers
- clinicians (medical officers, nursing, and allied health practitioners)
- frontline supervisors
- frontline support roles
- corporate roles.

Age profile

More than a third (37%) of the QAS workforce is aged between 25 and 34 years, which is significantly above the Queensland average of 22%. The workforce is expected to remain in the younger age brackets in the coming years as new graduates continue to enter the service.

This age profile suggests that a large proportion of the workforce is yet to enter their family formation years.

Figure 22: Age profile of the QAS workforce compared to Queensland labour force.

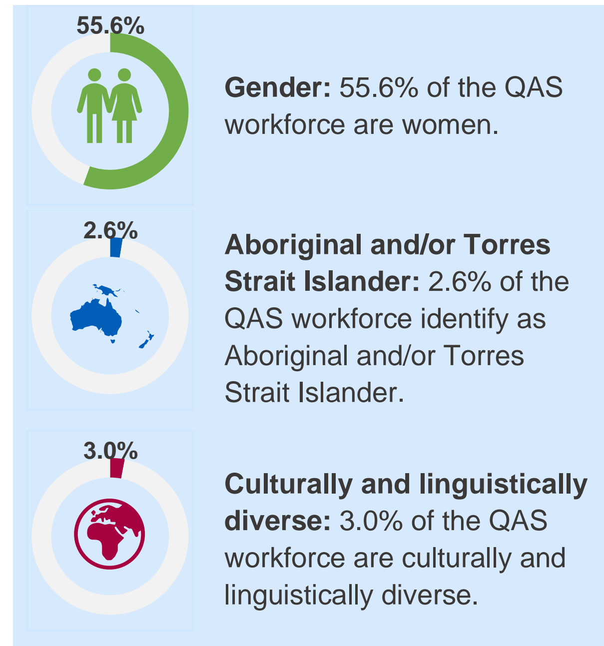


Source: QAS FTE and Positions report PPED 29 June 2025; Queensland labour force statistics sourced from Australian Bureau of Statistics (June 2025), Labour Force, Australia, Detailed, ABS Website, accessed 13 August 2025.

Workforce diversity

With 55.6% of the QAS workforce being female, QAS demonstrates stronger gender parity than other workforce streams.

Figure 23: QAS workforce demographics.

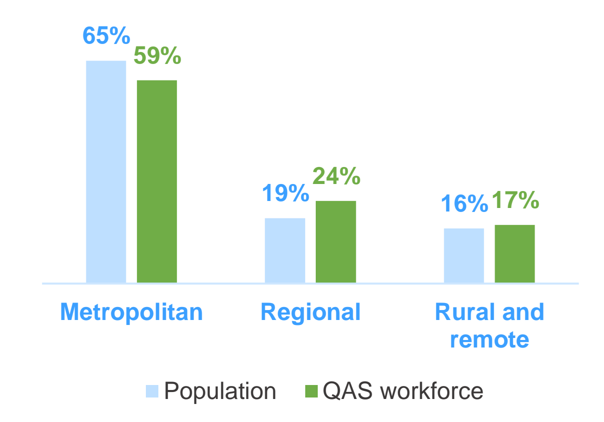


Source: QAS Aurion – PPED 29 June 2025.

Where we work

In the last pay period of 2024–25, 59% of the QAS workforce was working in metro locations, and 41% working in regional, rural and remote areas.

Figure 24: Geographic distribution of the QAS workforce.



Source: QAS Aurion – PPED 29 June 2025; Population data from the Department of Health and Aged Care's MMM 2023.

Current workforce trends and analysis

Workforce profile and distribution

Specific roles

- Of the QAS workforce, 88% are classified as frontline, 5% as frontline support staff, and 7% as corporate support.

Career progression

- With 14% of the workforce at or approaching retirement age, QAS has recognised the need for transition to retirement pathways.

Attrition

- QAS has a relatively low permanent attrition rate with 5.13% for 2024–25.
- Aligned with the overall low attrition rate, the clinical attrition rate is also low, 2.59% in 2024–25.

Current gaps

- For most workforce streams in most locations, QAS is able to manage its workforce effectively. There were no gaps between MOHRI FTE and approved FTE for QAS overall and in South Queensland.
- The exception is frontline staff in the north Queensland and rural and remote region, where attraction, recruitment, and retention of paramedics and emergency medical dispatchers presents challenges for the QAS. The gap rate in the last pay period of 2024–25 was 1.8% for frontline clinical staff.
- Retrieval Services Queensland continues to experience an increase in demand for services which is expected to continue in the future.

Overtime utilisation

- Overtime within QAS is undertaken primarily by frontline personnel.
- Paramedics account for approximately 99% of all overtime worked.

Temporary workforce utilisation

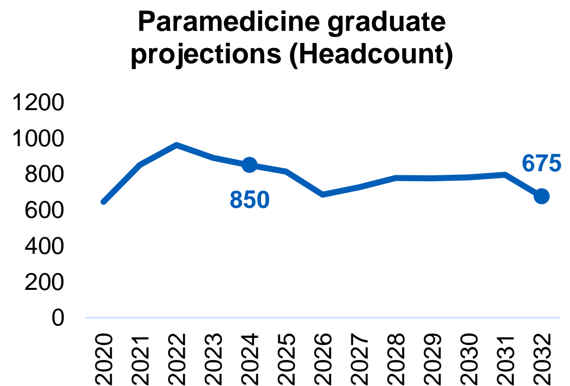
- QAS directly recruits and employs temporary and casual frontline ambulance personnel, as there are no options available to source suitably qualified staff through external employment agencies.
- Across QAS, 7% of the workforce is employed on a temporary or casual basis, varying by geography: South East Queensland (9%) and northern, rural and remote (2%).
- This flexible and agile cohort is utilised to support the existing QAS workforce and to provide additional resourcing during times of operational need and increased demand.

Future workforce projections

Graduate projections

Based on historical trends, combined graduate numbers from nursing/paramedicine and paramedicine programs are projected to decrease 20% by 2032.

Figure 25: QAS workforce graduate projections.



Source: QAS analysis

Supply and demand

Demand for the QAS workforce is projected to increase by 50% from 2025 to 2032. To meet this demand, QAS will need to employ an additional 3,105 FTE staff by 2032.

The graduate supply pipeline remains sufficient to meet projected workforce requirements. QAS recruits up to 400 graduate paramedics per year, consistent with current pipeline projections.

What this means for the future ambulance service workforce

- The university sector continues to produce more graduates than QAS appoints. Graduates represent the majority of base-grade paramedic recruitment, with more than 80% of all paramedics employed annually being graduates.
- Given the proportion of the workforce approaching retirement, there is a growing need for transition to retirement pathways.
- To address the identified gap in the north Queensland and rural and remote frontline workforce, QAS will need to consider targeted attraction and recruitment strategies for this critical workforce.
- Investment in the workforce to meet projections based on population trends and service utilisation will be required to maintain service performance as demand grows.

Midwifery workforce

Midwives provide comprehensive maternity care, supporting women throughout pregnancy, birth, and the postnatal period. Midwives are essential to maintaining birthing services, particularly outside metropolitan areas. There is a significant midwifery workforce shortfall in regional, rural and remote facilities.

At a state level, 18% of midwives are eligible to retire. This is coupled with an inadequate workforce pipeline and high rates of attrition. As a result, the midwifery workforce shortfall is anticipated to continue to increase over the period to 2032. There is a high risk to maintaining services and a potential for a negative impact on patient outcomes.

Current midwife shortages also exist within a context of worsening outcomes and increasing birthing intervention rates, some of which are associated with higher maternal and infant mortality and morbidity, increasing perinatal mortality and growing community expectations of being able to receive care from a known provider.

Queensland women expect access to safe, contemporary maternity care close to home. The availability of a skilled and responsive midwifery workforce is critical to delivering this care, and to sustaining quality, accessible birthing services.

Key challenges

Midwifery workforce supply	There are not enough midwifery student graduates to meet current and projected demand, and university enrolments are falling. As a priority, specific action is required to support an uplift in midwifery student enrolments and clinical placements, particularly in rural settings, to address the critical workforce shortfall.
Skills balance	Currently, 44.24% of midwives have four or fewer years of experience as a clinical midwife. At the other end of the career spectrum, 12.24% of midwives are older than 60 years of age. This is an alarming situation as the data describes only a small, experienced mid-career workforce available to deliver core services.
Regional, rural and remote services	Midwives are essential to maintaining maternity and, more critically, the birthing services in regional, rural and remote locations. Workforce shortages increase pressure and workloads for existing staff, in turn leading to staff burnout, attrition and, in some cases, service closure. Initiatives to build the midwifery workforce are hampered by reduced opportunity for grow-your-own models, limited education support, clinical placements and supervision, and accommodation challenges.
Scope of practice	Current models of care are preventing midwives from working to their full scope of practice and utilising the breadth of their skills. Increasing rates of surgical births also impact midwives' skill retention and confidence. Scope of practice restriction contributes to lack of professional fulfilment, which leads to higher attrition rates for midwives.
Wellbeing	Midwives may experience high levels of burnout[19] and vicarious trauma[20] which impact on wellbeing and retention.

[19] Homer CSE, Small K, Warton C, Bradfield Z, Baird K, Fenwick J, Gray JE, Robinson M. (2024). Midwifery Futures – Building the future Australian midwifery workforce. A research project commissioned by the Nursing and Midwifery Board of Australia, Burnet Institute, Curtin University and the University of Technology Sydney.
[20] New South Wales Parliament – Legislative Council, Select Committee on Birth Trauma. Report no. 1. 2024, Sydney: NSW Parliament.

Who we are

In the last pay period of 2024–25, Queensland Health employed 3,205 midwives across Queensland, representing 2,355 FTE.

This workforce is made up of the following key workforce segments:

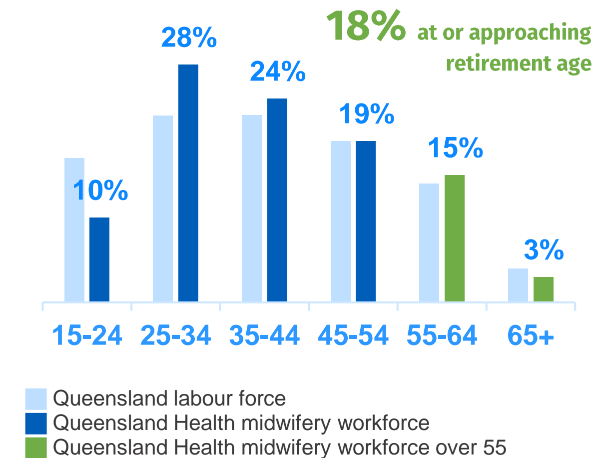
- midwives in hospital and midwifery group practice settings
- midwifery students
- midwifery leaders.

Age profile

The age profile shows 18% of the midwifery workforce are 55 or over. This figure is higher among the rural midwifery workforce, where 23% are 55 or over, presenting a significant retirement risk to the profession in those locations.

Of the midwifery workforce, 52% are 25 to 44 years. This cohort often has career breaks due to family and carer responsibilities, contributing to workforce instability. Smaller maternity units are particularly vulnerable.

Figure 26: Age profile of the midwifery workforce compared to Queensland labour force.

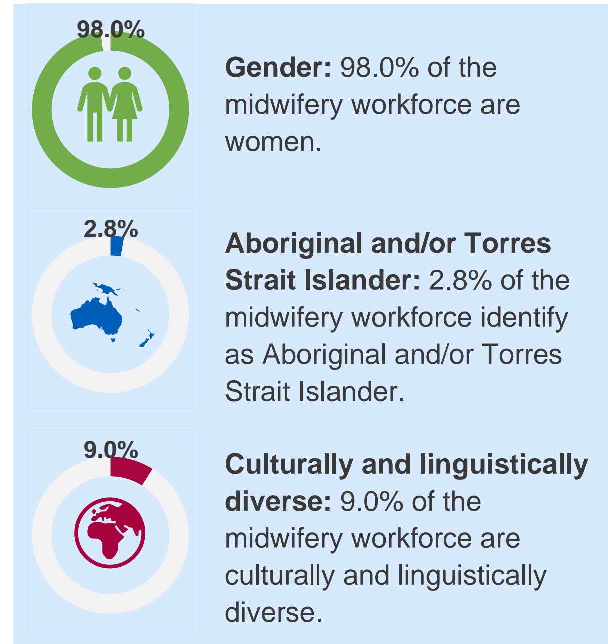


Source: Queensland Health workforce data; Queensland labour force statistics sourced from Australian Bureau of Statistics (June 2025), Labour Force, Australia, Detailed, ABS Website, accessed 13 August 2025 and Queensland Health payroll data at end of June 2025

Workforce diversity

At 98%, the midwifery workforce is overwhelmingly female. The proportion of the midwifery workforce that identify as Aboriginal and/or Torres Strait Islander is relatively low at 2.8%. The proportion of midwives that identify as culturally and linguistically diverse (9%) is comparable to other professional streams.

Figure 27: Midwifery workforce demographics.

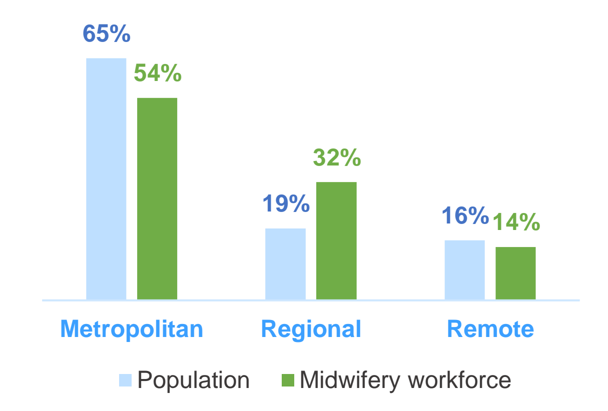


Source: HRBI analysis of Queensland Health HR data.

Where we work

In the last pay period of 2024–25, 54.1% of the midwifery workforce was working in metro areas, 31.6% in regional areas, and 14.3% in rural and remote areas.

Figure 28: Geographic distribution of the midwifery workforce.



Source: Queensland Health workforce data; Population data from the Department of Health and Aged Care's MMM 2023.

Current workforce trends and analysis

Workforce profile and distribution

Specific roles

- Across Queensland Health, 81.5% of midwives work in hospital-based models of care, and 16.7% in midwifery group practice (MGP). Evidence of the growth in midwifery-led models of care can be found in maternity services across Queensland[21,22] and Australia[23]. As the largest provider of midwifery services in Queensland, this trend is expected to be similar for Queensland Health.

Location

- The proportion of midwives working in MGP services varies across the state. In metro and regional areas, MGP midwives make up a smaller share of the workforce (12% and 12.7% respectively) compared to rural and remote areas (43.5%). This indicates the greater role MGP services play in maternity and birthing care in rural and remote areas.

Employment type

- There is 66.9% of the midwifery workforce FTE that works part-time.
- The workforce is highly fractionalised, with midwives working on average 0.73 FTE, requiring additional headcount to meet service delivery demand.

Career progression and seniority

- Rural and remote areas have 6.4% entry level midwifery positions, which is more than double metro (2.6%) and regional (2.6%) locations.
- Only 6.3% of midwifery positions are senior, suggesting more work may be required to develop leadership capacity to create a stronger, more responsive workforce.

Current gaps

Location

- In the last pay period of 2024–25, there were no workforce gaps recorded in the midwifery workforce in metro areas. In contrast, regional, rural and remote areas had significant gaps and widespread, localised staffing shortfalls.
- There were high numbers of persistent gaps (>12 months) of approximately 41 FTE (13.0%) in regional areas and approximately 39.3 FTE (14.6%) in rural and remote locations. This exceeded the Queensland Health average of 11%. Workforce gaps have a more pronounced impact on smaller sites. Metro areas also reported persistent gaps of approximately 101 FTE (8.1%).

Leave usage

- In the last pay period of 2024–25, leave taken across the workforce totalled 511.0 FTE, representing more than 21% of total FTE.

Overtime utilisation

- Overtime data for nursing is combined across both professional groups.
- In 2024–25, nurses and midwives worked an average of 50,905 overtime hours per month. In the last pay period of 2024–25, this was the equivalent of 691 FTE.

Temporary workforce utilisation

- There is a high reliance on temporary contracts and the casual midwifery workforce to maintain service delivery.
- A significant proportion (10.7%) of the midwifery workforce work in **temporary** positions.12.5% of temporary positions are in metro areas, 7.5% in regional, and 10.3% in rural and remote areas.
- These positions are challenging to fill in all locations, compared to permanent roles.

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[21] Australian Institute of Health and Welfare 2023. Maternity modes of care. Cat. no. PER 123. Canberra: AIHW.
[22] Australian Institute of Health and Welfare 2023. Maternity models of care in Australia, 2023 Web report.
[23] Australian Institute of Health and Welfare 2023. Maternity models of care in Australia, 2024, Web report.

- A high proportion of MGP positions are temporary, with 17.9% in metro, 7.7% in regional, and 12.2% in rural and remote being temporary.
- The nursing and midwifery stream utilised 4,315 agency staff in the final quarter of 2024–25, at an average cost of $53,494 per agency worker[24].

Workforce attrition

- The attrition rate for the midwifery workforce has been reasonably consistent over the 3-year period from 2022–23 to 2024–25, 4.7% in 2022–23, 4.3% in 2023–24, and 4.8% in 2024–25.
- In 2024–25 the attrition rate for midwives in MGP was 7.4%, and 8.8% for leadership positions. These rates are significantly above the Queensland Health average attrition rate of 5.2% and do not align with historical or national trends.
- Lack of flexible work arrangements plays a key role in MGP attrition, particularly in rural and remote areas, while retirement is a primary factor in leadership attrition.

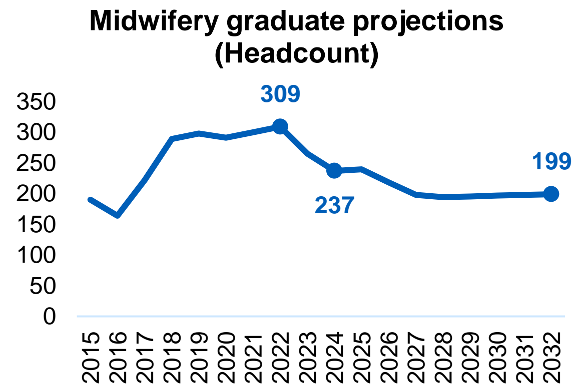
Future workforce projections

Graduate projections

Midwifery graduate numbers have declined in recent years, from a peak of 309 graduates across single and dual degrees in 2022, to 237 graduates in 2024.

Based on this trend, graduate numbers are projected to decline through to 2032 impacting future workforce supply.

Figure 29: Midwifery graduate projections.



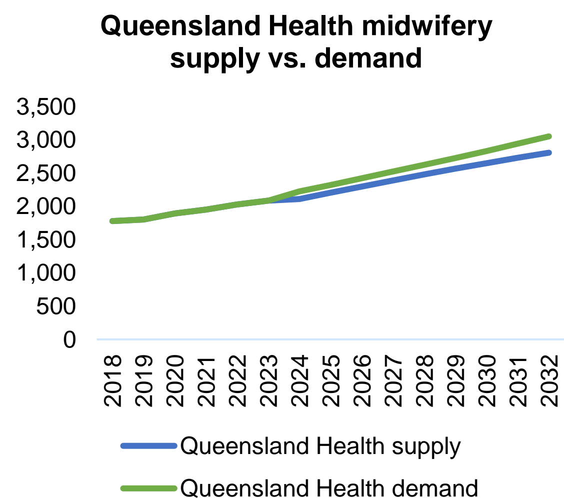
Source: Queensland Health analysis.

Supply and demand

Demand for midwives is projected to increase by 50.5% from 2023 to 2032. To meet demand in 2032, Queensland Health will need to employ an additional 967 midwifery FTE.

Based on maintaining current attrition rates, and trends in FTE per person working in midwifery, Queensland Health's midwifery services are projected to experience continued supply shortages. The gap between supply and demand is expected to increase to approximately 250 midwives by 2032.

Figure 30: Midwifery supply and demand.



Source: Queensland Health analysis

[24] Agency data is only available as combined nursing and midwifery stream data.

What this means for the future midwifery workforce

- The current midwifery workforce shortage is projected to get worse, particularly in regional, rural and remote locations.
- The workforce shortage is being exacerbated by an insufficient midwifery student pipeline with graduate numbers inadequately replacing attrition.
- Urgent attention is required to uplift student enrolments and to enable clinical placements in rural and regional areas. This includes a focus on opportunities to employ students alongside their education pathway.
- Strategies to address elevated early career midwife attrition rates should be investigated with a focus on skill utilisation and career pathways.
- Retention strategies require urgent consideration and investment. MGP is demonstrated to reduce attrition, is an efficient use of workforce, and should be prioritised to retain midwives. Strategies to maximise flexible working arrangements, particularly in MGP, are required to ensure sustainability of the workforce.
- Removal of barriers for midwives to work to full scope has commenced and should continue.
- Increasing dedicated midwifery leadership roles is an important workforce strategy to retain and grow the profession.

Oral health workforce

Queensland's public oral health workforce delivers preventive, general and specialist dental care to eligible populations, including children, concession card holders, and priority groups such as Aboriginal and Torres Strait Islander peoples. This workforce promotes oral health through education, early intervention and community outreach, aiming to improve the overall wellbeing of Queenslanders.

Services are delivered by multidisciplinary teams across a range of clinical and community settings, with a strong emphasis on equitable access, cultural safety, and integration within the broader public health system. The oral health workforce also plays a crucial role in contributing to the development of the next generation of dental practitioners, through facilitating student clinical placements.

Public oral health services are challenged by limited workforce growth, an ageing profile, and significant gaps across all oral health professions, while demand for public dental care increases with growth in the eligible population.

Key challenges

Workforce supply	Supply pipelines are particularly limited for dental specialists and for oral health therapists whose graduate numbers are lower in Queensland than all other states with comparable programs. Currently, training places are restricted and there are insufficient higher education pathways for existing staff. Low level of engagement with graduates and tertiary education providers, along with ineffective coordination of recruitment strategies are also impacting workforce supply and sustainability. Competition with the private sector is an ongoing challenge across most professions but especially for dentists and dental specialists.
Retention	Retention of experienced dental practitioners is increasingly challenging in the context of changing workforce preferences, including a trend towards part-time and dual-sector employment. Many skilled and experienced dental practitioners move on to private sector roles seeking broader clinical practice and better remuneration. There is a growing desire for improved flexible employment opportunities and long-term oral health career development pathways in both clinical and management streams.
Rural and remote workforce	Oral health attraction and retention difficulties are most acute in rural and remote locations, as reflected by high workforce gaps in these areas. This workforce faces additional challenges, including social and professional isolation, high cost of independent living, restricted accommodation options and limited career progression.
Scope of practice	Models of care that restrict scope of clinical practice are a disincentive for dental practitioners to work in public oral health services and limit the potential for this workforce. Oral health professions should be supported to work to their full scope of practice, to help improve practitioner satisfaction, workforce retention and service effectiveness.
Professional development	This workforce experiences significant exposure to complex and high acuity dental care. This creates a uniquely challenging service delivery environment which can lead to stress and burnout, potentially contributing to increased attrition rates from public oral health services. Expanded opportunities in professional development tailored to public sector dentistry, peer support networks, and for career progression are required to support the public oral health workforce.

Who we are

In the last pay period of 2024–25, Queensland Health employed 1,585 people in public oral health services across Queensland, representing 1,305 FTE.

The oral health clinical workforce is made up of the following key workforce streams:

- dentists
- dental specialists
- oral health therapists
- dental therapists
- dental prosthetists
- dental technicians
- dental assistants.

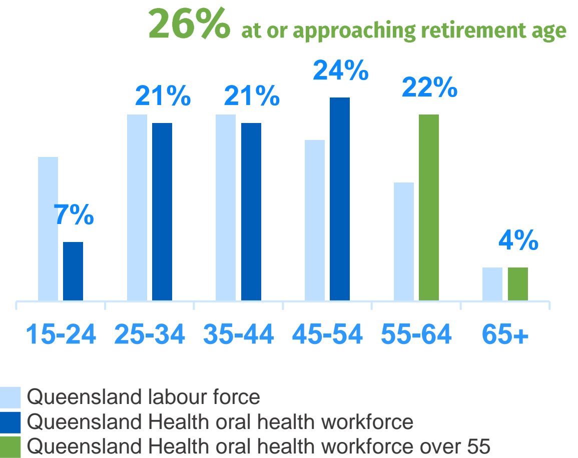
Age profile

The oral health workforce has an older age profile than the Queensland workforce overall, with 50% being 45 years or over, compared with 37% in this age group across Queensland. With a high proportion of the oral health workforce at, or approaching, retirement age (26% aged 55 years or over), there is a looming risk of workforce gaps without an adequate transition to the next generation.

In contrast, only 7% of the oral health workforce are aged 15 to 24 years compared with 17% of the state's total workforce. This suggests an underrepresentation of early career professionals, placing long term workforce sustainability at risk.

The 25 to 34-year (21%) and 35 to 44-year (21%) age cohorts are broadly aligned with the state workforce. Clinicians in the middle age bands are likely to have acquired sufficient experience that positions them well to provide support for developing practitioners, lead service delivery and provide clinical leadership.

Figure 31: Age profile of the oral health workforce compared to Queensland labour force.



Source: Queensland Health workforce data; Queensland labour force statistics sourced from Australian Bureau of Statistics (June 2025), Labour Force, Australia, Detailed, ABS Website, accessed 13 August 2025 and Queensland Health payroll data at end of June 2025

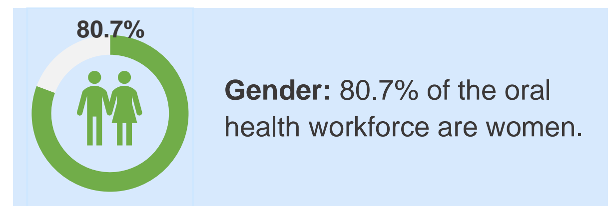
Workforce diversity

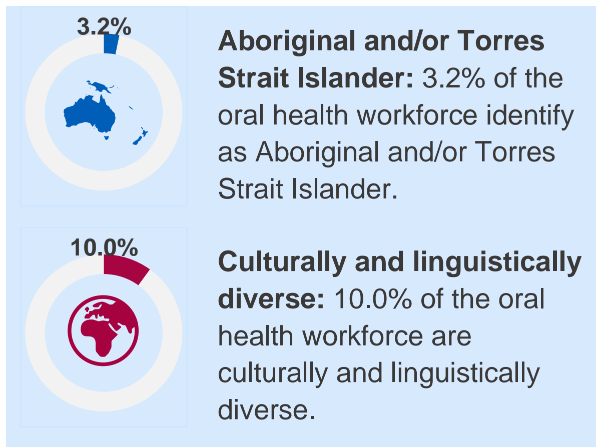
Of the oral health workforce, 80.7% are women. This gender profile has implications for workforce participation patterns, with higher prevalence of part-time work, flexible work arrangements, and career interruptions, than in the broader labour force.

Of the oral health workforce 3.2% identify as Aboriginal and/or Torres Strait Islander, which is similar to most other professional streams.

Ten per cent of the workforce are from culturally and linguistically diverse backgrounds, reflecting Queensland's diverse population base. Culturally and linguistically diverse members of the workforce bring valuable perspectives, language skills, and community links, enhancing the accessibility of oral health services for diverse patient groups.

Figure 32: Oral health workforce demographics.



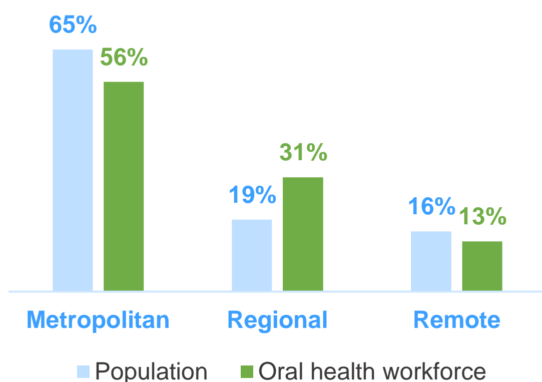


Source: HRBI analysis of Queensland Health HR data.

Where we work

- In the last pay period of 2024–25, more than half of the oral health workforce (56%) was working in metro areas, with 30.6% in regional areas, and 13.4% in rural and remote locations.

Figure 33: Geographic distribution of the oral health workforce.



Source: Queensland Health workforce data; Population data from the Department of Health and Aged Care's MMM 2023.

- The workforce profile also varies across regions with dental specialists almost entirely metropolitan-based (20.5 FTE of 22.9 FTE approved positions).
- Dentists (22.3%) and dental assistants (54.9%) make up the largest proportion of the workforce in all areas.
- This geographic maldistribution limits equitable access to services, increases the reliance on alternative workforce sources such as locums, and increases service delivery costs.

Current workforce trends and analysis

Workforce profile and distribution

- In the last pay period of 2024–25, the Queensland public oral health workforce comprised 1,447.8 approved FTE, with 1,305.3 FTE filled and a workforce gap of 142.4 FTE (9.8%).

Specific roles

- Dental assistants form the largest workforce group (55%), followed by dentists (21%), dental technicians (10%), dental and oral health therapists (8.0%), dental prosthetists (2.6%) and dental specialists (1.6%).

Employment type

- A high prevalence of part-time employment was identified in the oral health workforce. On average, practitioners work 0.82 FTE per worker. This signals the need for flexible employment models and integration of practitioners working across sectors.
- Preference for part-time hours with dentists (0.74 FTE metro, 0.82 FTE regional, 0.96 FTE rural) and dental specialists (0.47 FTE metro, 0.45 FTE regional), reflect preferred employment conditions across public and private sectors.
- Part-time work is most common among dentists (41.6% metro, 27.9% regional), dental specialists (63.5% metro, 71.9% regional), and dental therapists (51.5% regional, 63.4% rural).

Current gaps

Location and specific roles

- Workforce gaps were identified across all areas with 75.4 FTE (9.3%) in metro areas, 25.2 FTE (5.7%) in regional areas, and 41.8 FTE (21.5%) in rural and remote areas. With low established workforce numbers in rural and remote areas, these gaps present a disproportionate risk to service continuity compared to metro and regional areas.
- Gaps identified for dentists were 14.7% for metro, 9.0% in regional areas and 27.6% in

rural and remote areas, while for dental specialists it was 20.5% for metro areas.

- For dental therapists the workforce gaps were identified as 15.0% in metro areas, 15.2% for regional areas, and 40.2% rural and remote areas.
- High rates of persistent gaps (>12 months) are most common in regional and rural and remote areas, where approved public oral health FTE is already low. The highest number of persistent gaps are dentist positions (7.6%) and dental assistant positions (14.1%) in metro, and dentist (12.5%) and dental assistant (14.0%) positions in rural and remote areas.

Leave usage

- At the time of analysis, leave taken across the workforce totalled 259.2 FTE, which is almost 20% of the total FTE for this stream.

Overtime utilisation

- Overtime for this workforce is minimal. Roles do not operate on a 24-hour roster, with staff working a Monday to Friday business hours roster.

Temporary workforce utilisation

- Across the oral health workforce, 10.2% of roles are employed on a temporary basis, with variation by geographic location: metro 7.9%, regional 14.7%, and rural and remote 9.0%. Temporary employment is highest amongst dentists and dental assistants.
- Locum and agency staffing is concentrated in rural and remote areas. In the last quarter of 2024–25, oral health services engaged 15 locums at an average cost of $78,925 per locum.
- While this workforce helps to address critical service gaps, it can add to service delivery costs and impact on continuity of care.
- Workforce planning should prioritise the conversion of temporary into permanent positions, strengthening employment security and enhancing workforce retention.

Workforce attrition

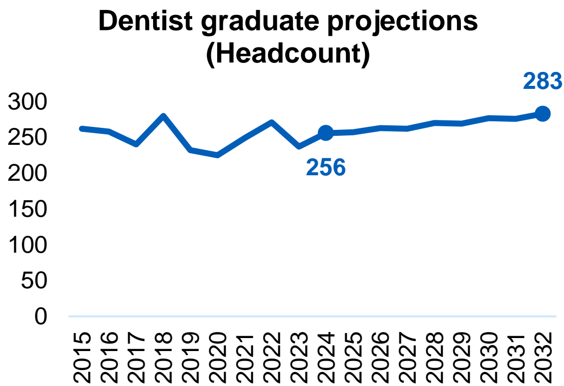
- The attrition rate for the oral health workforce has been reasonably consistent over the 3-year period from 2022–23 to 2024–25; 7.2% in 2022–23, 7.3% in 2023–24, and 7.0% in 2024–25.
- This was higher than the Queensland Health attrition rate which varied between 5.2% and 5.9% during this period.
- The attrition rate for the dental assistant workforce varied between 5.8% and 6.7%. As the largest single occupational group within the oral health workforce, even small increases in attrition will have a significant system impact for this cohort.
- Dental specialists have the highest attrition of any group, despite declining from 17.8% in 2022–23 to 8.1% in 2024–25. While there have been some improvements it remains, an ongoing risk given the specialist workforce's critical role and limited replacement supply.
- Dental and oral health therapist attrition remains high at more than 10% in 2024–25. The risk is significant with this workforce due to low domestic graduate numbers, ageing workforce and competition from the private sector.
- Attrition rates for dentists have remained consistently high for the past 3 years and still sits at 10.5% in 2024–25. This trend is concerning given dentists are our largest dental practitioner workforce with the broadest scope of practice.

Future workforce projections

Graduate projections

Combined graduate numbers are projected to grow by 15% by 2032. This is in the context of dentistry having a historically small graduate cohort.

Figure 34: Dentist graduate projections.



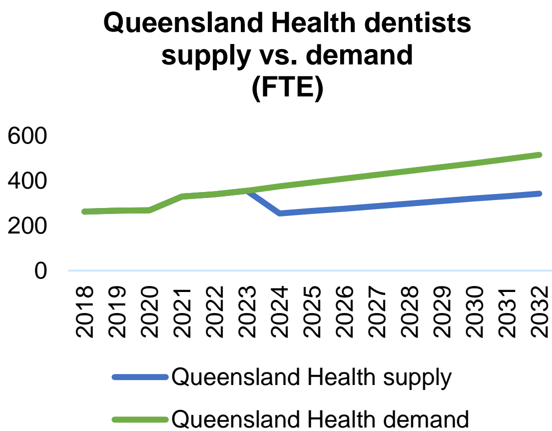
Source: Queensland Health analysis.

Supply and demand

Demand for dentists is projected to increase by 62% from 2023 to 2032. To meet demand in 2032, Queensland Health will need to employ an additional 160 FTE dentists.

Based on maintaining current attrition rates and trends in FTE per person working in dentistry, Queensland Health's services are projected to experience continued supply shortages. The gap between dentist supply and demand will increase to more than 170 FTE by 2032.

Figure 35: Dentist supply and demand.



Source: Queensland Health analysis

While future workforce supply projections have been developed for dentists, similar work is required for all oral health professions. The entire oral health workforce will need to grow to meet the needs of Queenslanders who require public oral health services.

What this means for the future oral health workforce

- Workforce gaps are persistent and significant in rural and remote and regional oral health services. Targeted strategies to address workforce maldistribution are needed to ensure sustainability of public oral health services outside of metro areas.
- Modelling suggests a need to significantly expand the oral health workforce to address the expected growth in demand for public dental care.
- While there are currently 565 FTE dental practitioners employed across public oral health services in Queensland, projections suggest an additional 280 to 400 FTE will be needed by 2031–32.
- Maintaining market share in metro areas remains a challenge due to competition from the private sector. Increasing the attractiveness of Queensland Health as an employer is important to maintain our workforce supply.
- Growth in the number of dental practitioners will require a commensurate increase in dental assistants and other support workforce to enable delivery of services.
- Supply pipelines are limited for oral health therapists and dental specialists, with few local graduates from Queensland. Strategies to develop sustainable pipelines into the profession are key.
- Given the ageing workforce, strategies should prioritise succession planning, knowledge transfer, and flexible retention approaches for late career staff.

Aboriginal and Torres Strait Islander health workforce

The Aboriginal and Torres Strait Islander health workforce includes registered Aboriginal and Torres Strait Islander health practitioners and self-regulated professionals including Aboriginal and Torres Strait Islander health workers, Liaison Officers and Mental Health, Alcohol and Other Drug health workers, employed in Queensland's public health system. They work autonomously and in multidisciplinary care teams to deliver clinical healthcare, provide advice, patient advocacy and health promotion, as part of holistic healthcare services.

Unique to Queensland is the Aboriginal and Torres Strait Islander health workforce professional structure, recognising the value of combining lived experience, cultural and community knowledge, and clinical skills to improve the quality of care delivered to Aboriginal and Torres Strait Islander people and their communities.

Despite its potential to strengthen health outcomes, the role of this workforce is often misunderstood and faces challenges with integration, professional recognition, capability and career development. This workforce plays an important role in improving health equity for Aboriginal and Torres Strait Islander people, however, several challenges must be surmounted before its full potential can be realised.

Key challenges

Workforce shortages	The Aboriginal and Torres Strait Islander health workforce faces gaps of around 30%, with greatest shortages in rural and remote areas, but gaps exist across all settings. These shortages limit access to culturally appropriate care and stem from complex recruitment processes, limit training opportunities, weak supply pipelines, limited career progression, and challenges attracting Aboriginal and Torres Strait Islander people into health careers.
Retention	Retention challenges are evident in high attrition rates and significant workforce gaps. Early separations reflect limited orientation and onboarding, cultural responsibilities and community expectations, and negative workplace experiences including low role recognition, limited psychosocial supports, racism, lateral oppression, and low job satisfaction. Retention of early-career Aboriginal and Torres Strait Islander staff requires stronger investment in support, development, and leadership.
Cultural safety	The effectiveness of this workforce is limited by poor integration into services and models of care across HHSs, where the skills and experience of this workforce are often undervalued, affecting Aboriginal and Torres Strait Islander patient care. Integration challenges include limited role recognition, poor understanding of cultural considerations such as trauma, loss and grief, exclusion and disempowerment, and systemic racism and cultural responsibilities. These factors collectively undermine job satisfaction, workforce participation, and retention.

Skills and scope of practice	A large proportion of the Aboriginal and Torres Strait Islander health workforce have been working in non-clinical roles, and clinical upskilling is needed to enable staff to work to their full scope of practice. This would also address limited understanding among other health professions of the core and extended clinical scope of these roles. Better alignment between training and practice is required to support workforce attraction and retention, reduce burnout, maintain skills and confidence, and close workforce gaps impacting service delivery, especially in rural and remote communities.
Career paths	These roles often function across teams rather than within them, limiting visibility of career pathways, opportunities for mentorship, and opportunities to backfill senior positions. Many roles are filled by early-career staff who require structured support and development. The lack of career opportunities undermines attraction, retention, workplace culture, and succession planning, often leaving roles vacant for extended periods.

Who we are

In the last pay period of 2024–25, Queensland Health employed 654 Aboriginal and/or Torres Strait Islander health professionals across Queensland, representing 626 FTE.

This workforce includes registered clinical practitioners, and self-regulated professional roles, comprising:

- Aboriginal and Torres Strait Islander health practitioners
- Aboriginal and Torres Strait Islander health workers
- Aboriginal and Torres Strait Islander liaison officers
- mental health, alcohol and other drugs workers
- executive directors of Aboriginal and Torres Strait Islander health.

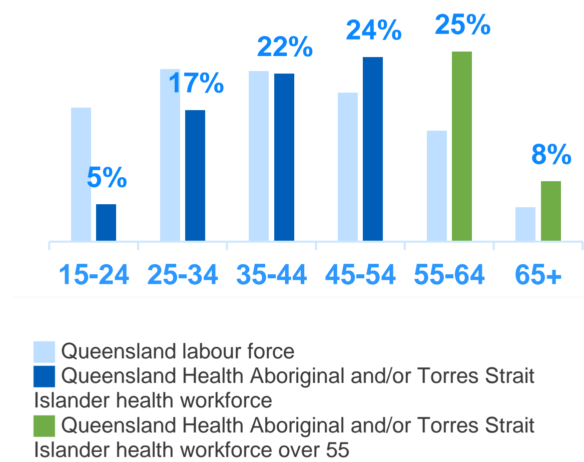
All professional roles include trainees, clinicians and senior clinicians and leaders across each career pathway.

Age profile

The age profile of the Aboriginal and Torres Strait Islander health workforce comprises 25–34 (17%) and 45–54 (24%) cohorts, highlighting both early career and mid-career stages. A significant proportion are in the 55–64 group (25%), highlighting emerging retirement risks if succession planning is not prioritised.

While younger cohorts (15–24) remain underrepresented (5%), the presence of older age groups (65+ at 8%) further indicates an ageing workforce, consistent with broader labour force trends over the past 5 years.

Figure 36: Age profile of Aboriginal and/or Torres Strait Islander health workforce compared to Queensland labour force.



Queensland labour force
Queensland Health Aboriginal and/or Torres Strait Islander health workforce
Queensland Health Aboriginal and/or Torres Strait Islander health workforce over 55

Source: Queensland Health workforce data; Queensland labour force statistics sourced from Australian Bureau of Statistics (June 2025), Labour Force, Australia, Detailed, ABS Website, accessed 13 August 2025 and Queensland Health payroll data at end of June 2025

Workforce diversity

Women make up 75.2% of the Aboriginal and Torres Strait Islander health workforce. Men are underrepresented, limiting capacity to meet

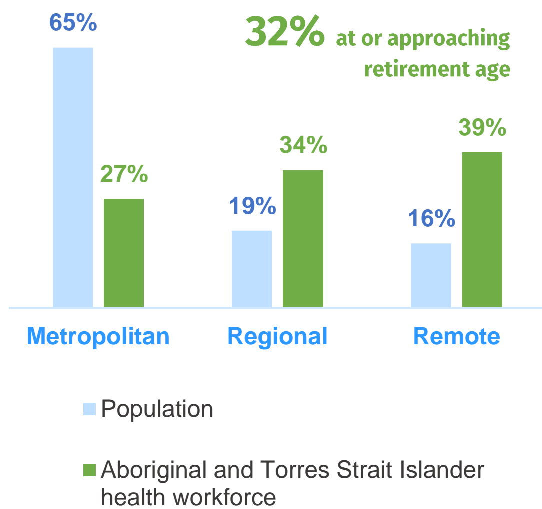
cultural needs in rural, remote and discrete communities.

Where we work

In the last pay period of 2024–25, 27.1% of the Aboriginal and Torres Strait Islander health workforce was working in metro areas, 34.3% in regional areas and 38.7% in rural and remote areas.

This distribution reflects the tendency for Aboriginal and Torres Strait Islander populations to have high representation in regional, rural and remote communities, noting that a higher absolute number of Aboriginal and Torres Strait Islander people live in metro areas.

Figure 37: Geographic distribution of the Aboriginal and Torres Strait Islander health workforce.



Source: Queensland Health workforce data; Population data from the Department of Health and Aged Care's Modified Monash Model (MMM) 2023.

- Aboriginal and Torres Strait Islander health workers and health practitioners are more likely to work in rural and remote locations, where they make up 97.3% of the Aboriginal and Torres Strait Islander workforce, compared to metro locations, where they represent 72.6%.
- Aboriginal and Torres Strait Islander liaison officers are distributed across geographical areas, making up 23.7% of the metro, 18.9% of the regional, and 11.9% of the rural and remote Aboriginal and Torres Strait Islander workforce.
- Executive directors of Aboriginal and Torres Strait Islander health are more likely to be found in metro (9.6 FTE) and regional (7.0 FTE) areas than rural and remote areas (3.0 FTE).

Current workforce trends and analysis

Workforce profile and distribution

Specific roles

- Of approved FTE within the Aboriginal and Torres Strait Islander health workforce stream, 73.6% is made up of Aboriginal and Torres Strait Islander health workers. Of the other roles in the stream, Aboriginal and Torres Strait Islander liaison officers make up 17.5%, Aboriginal and Torres Strait Islander health practitioners represent 6.8%, and 2% are executive directors of Aboriginal and Torres Strait Islander health.

Career progression and seniority

- Of the total workforce 5.6% are in junior or entry level positions, signalling a limited early career pipeline.
- There is a lack of progression pathways, with minimal structured advancement for Aboriginal and Torres Strait Islander health workers, practitioners, and liaison officers into senior or advanced practice roles.
- Retirement risk is highest for executive directors of Aboriginal and Torres Strait Islander health.

Attrition

- For frontline clinical Aboriginal and Torres Strait Islander health workforce roles, the risk lies with ongoing vacancy and attrition cycles.

Current gaps

Locations and specific roles

- The Aboriginal and Torres Strait Islander health workforce faces significant challenges in attraction and retention across all roles. Workforce gaps identified for this professional stream were 86.8 FTE (33.4%) in metro areas, 109.1 FTE (33.2%) in regional areas and 138.1 FTE (37.2% in

rural and remote. Gap rates for Aboriginal and Torres Strait Islander health workers are above one-third of total approved FTE.

- Aboriginal and Torres Strait Islander **health practitioners** face severe workforce shortages, with rural and remote workforce gaps of 54.5% and regional gaps of 47.5%.
- Aboriginal and Torres Strait Islander **liaison officers**, while a smaller workforce cohort, face consistent workforce gaps across metro (13.0%), regional, (14.3%) and rural and remote areas (27.3%).
- **Executive directors** of Aboriginal and Torres Strait Islander health are adequately covered in metro areas. Regional, rural and remote gaps range from 28%–33%, raising concerns with leadership continuity in areas where governance stability is critical.

Career progression

- Systemic factors continue to drive workforce shortages with limited availability of mandatory qualifications and accredited pathways leading to reduced applicant pools, especially in rural and remote areas.
- Recruitment campaigns rarely target Aboriginal and Torres Strait Islander health workforce roles, resulting in low interest and repeated unsuccessful recruitment cycles.
- A lack of understanding of the unique value of Aboriginal and Torres Strait Islander health workforce roles leads to inconsistent prioritisation within models of care.
- Inadequate housing in remote areas deters external applicants, reinforcing dependence on overstretched staff.

Overtime utilisation

- Overtime for this workforce is minimal. Roles do not operate on a 24-hour roster and the largest proportion of staff work Monday to Friday.
- In the last pay period of 2024–25, overtime was the equivalent of 6.45 FTE, which is around 1% of FTE.
- At the same time, leave taken across the workforce totalled 100.9 FTE, which is more than 10% of the total FTE.

Temporary workforce utilisation

- Of Aboriginal and Torres Strait Islander health workforce roles, 16.2% are temporary. This profile is relatively even across metro, regional, and rural and remote areas.
- Unlike other professions, there is no higher-cost temporary workforce, such as locum or agency staff, available to backfill these positions. Instead, when roles cannot be filled permanently, they remain vacant, creating sustained service gaps.
- This means that the impact of temporary roles is not reflected as higher labour costs but rather as reduced service coverage, delays in follow-up care, and additional workload for existing staff.

Workforce attrition

- The attrition rate for the Aboriginal and Torres Strait Islander health workforce has reduced from 11.8% in 2022–23 to 8.5% in 2024–25. Despite this, this workforce has higher attrition rates the Queensland Health overall.
- For **executive director** roles, attrition fell from 12.5% to 0% over the same 3-year period, reflecting small workforce size and improved retention.
- Aboriginal and Torres Strait Islander **health practitioners** show an upward attrition trend from 0% to 10% over the 3-year period, reflecting recruitment challenges in this newly established workforce across the state.
- Attrition rates for Aboriginal and Torres Strait Islander **health workers** improved from 12.2% to 7.6% over the 3-year period, however, this workforce remains a large contributor to overall attrition.
- Aboriginal and Torres Strait Islander **liaison officers** show consistently high attrition rates of between 9.9% and 12.1% during the 3-year period), signalling stability challenges.
- The persistence of high attrition in liaison roles, combined with a sizeable portion of

the workforce aged 45–64, underscores risk of both early and retirement-related exits.

- Limited training pipelines for mandatory qualifications and lack of targeted recruitment, restricts backfill capacity and succession planning.
- Workforce retention challenges are driven by geographic isolation, workplace cultures, limited progression pathways, and high workload pressures when roles remain unfilled.

What this means for the future Aboriginal and Torres Strait Islander health workforce

- The Aboriginal and Torres Strait Islander health workforce is a small but important workforce. Better utilisation and inclusion of this workforce in future models of care is key to providing culturally safe care that improves health outcomes for Aboriginal and Torres Strait Islander people and communities.
- Without targeted investment in education, training, and workforce pipelines, supply for the Aboriginal and Torres Strait Islander health workforce will remain constrained. Sustainable development requires building a dedicated talent pool that reflects community needs.
- This is only reinforced by the significant retirement risk in the current workforce.
- While there are existing, dedicated Queensland Health programs that offer additional entry points into early career opportunities, they do not meet the specific qualification requirements for this workforce.
- Students are often still required to travel long distances for placements, especially in high-shortage areas.

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