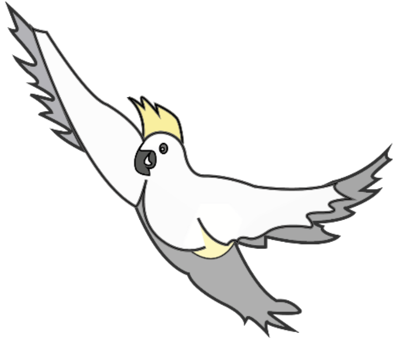

SARRAH

Services for Australian Rural and Remote Allied Health

13 December 2022

Joint Select Committee on Northern Australia
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Joint Select Committee Inquiry into Workforce Development in Northern Australia: SARRAH submission

Thank you for agreeing to accept our submission to the Joint Select Committee Inquiry into Workforce Development in Northern Australia.

SARRAH is the peak body representing rural and remote allied health professionals (AHPs) working in the public, private and community sectors, across primary and other health settings, disability, aged care, and other service systems. SARRAH was established in 1995 by a network of rurally based allied health professionals and continues to advocate on behalf of rural and remote communities to improve access to allied health services and support equitable and sustainable health and well-being. SARRAH maintains that every Australian should have access to health services wherever they live and that allied health services are fundamental to the well-being of all Australians.

Several of SARRAHs founding members lived and worked in Northern Australia: several continue to. Our membership includes individual practitioners, service providers, allied health students and universities involved in education, training and support of allied health professionals and services in rural and remote Australia. Our representation from Northern Australia remains strong.

Context and overarching comments

What is allied health?

The allied health workforce includes professionals like physiotherapists, occupational therapists, speech pathologists, dietitians, psychologists and many more. They are trained to help people stay well, regain strength and capacity in physical, sensory, psychological, cognitive, social and cultural functioning. They provide expert care to every age group and across the health, aged care, education and disability service sectors. There are around 200,000 of them in Australia, but not enough to meet community need. Allied health services are needed across the entire health system and for every age group. The following examples help explain why allied health is important.

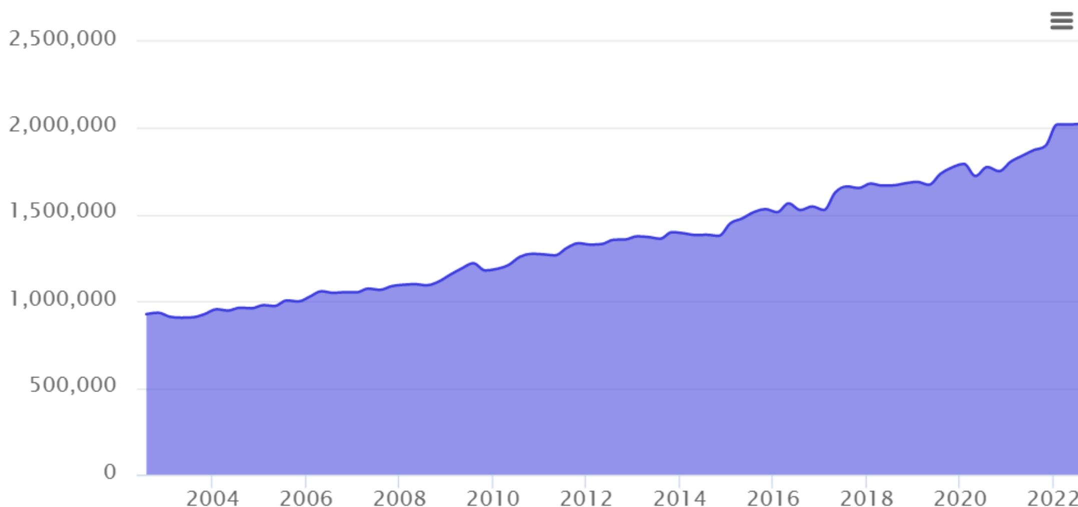
- If someone has a stroke and needs help to speak, swallow, move, deal with stress and isolation – the care provided by a physiotherapist, speech pathologist, a dietitian, an occupational therapist, a psychologist and more can be critical to recovery and the person’s future quality of life.

- When a three-year old child has a developmental issue with serious implications for their future that needs attention now, their parents don't want to hear the next available appointment is in 12 months' time.
- If someone has a serious accident, they want to know paramedics on the way.
- People want pharmacists to provide medication and tell them how to use it safely.
- People with diabetes at risk of losing a leg are very interested in how podiatrists can help.
- And if a person loses their leg, how prosthetists can help them retain as much mobility and independence as possible.
- When someone has an accident at work and needs rehabilitation - to keep their job, pay the bills and mortgage they understand what allied health therapies are about.

Health and Social Assistance: The largest and fastest growing workforce

As with doctors, nurses, midwives and allied health professionals are categorised as part of the Health and Social Assistance sector. Earlier this year, the National Skills Commission released national employment data showing employment levels by sector and projected future employment growth out to November 2026. They reported the Health and Social Assistance sector (which also includes aged and disability carers etc) is the largest employment sector nationally – employing 2,025,400 people[1], and the fastest growing sector, with a projected increase of 301,000 further jobs to be created between November 2021 and November 2026. That represents a projected increase in jobs of 15.8% compared with 9% across the economy as a whole.

The following graph shows the strength of this long-term workforce trend.



From: https://labourmarketinsights.gov.au/industries/industry-details?industryCode=Q#1

The fundamental nature of the shift in Australia's employment profile – and the challenges faced nationally – is also clearly described in the report The Big Care Shift published by the Human Services Skills Organisation (HSSO) in November 2022.

- The report shows the top 102 Australian cities ranked by the proportion of the workforce comprised of Health Care and Social Assistance workers, using 2021 Census data (pages 10-11),

[1] Around 14.8% of the workforce having their main job in this sector.

which include: Alice Springs (23%); Broome (19%); Rockhampton (18%); Mackay (15%); Darwin (14%); Yeppoon (13+%); Mount Isa 12.5%); Gladstone (11%); Port Hedland (9%) among others.

- Importantly, the demand for workers in the Health and Social Assistance sector is increasing rapidly not only in the locations listed, but in every population centre in Australia, with competition especially for the more highly trained health professionals.

Allied health demand growing fastest of all

While the Health and Social Assistance sector is leading jobs growth, allied health are the leading professions in projected demand. Projected demand indicates growth of over 25 per cent over 5 years among several professions. More detail is provided at **Attachment A**, together with a selection of other in-demand professions for comparative purposes.

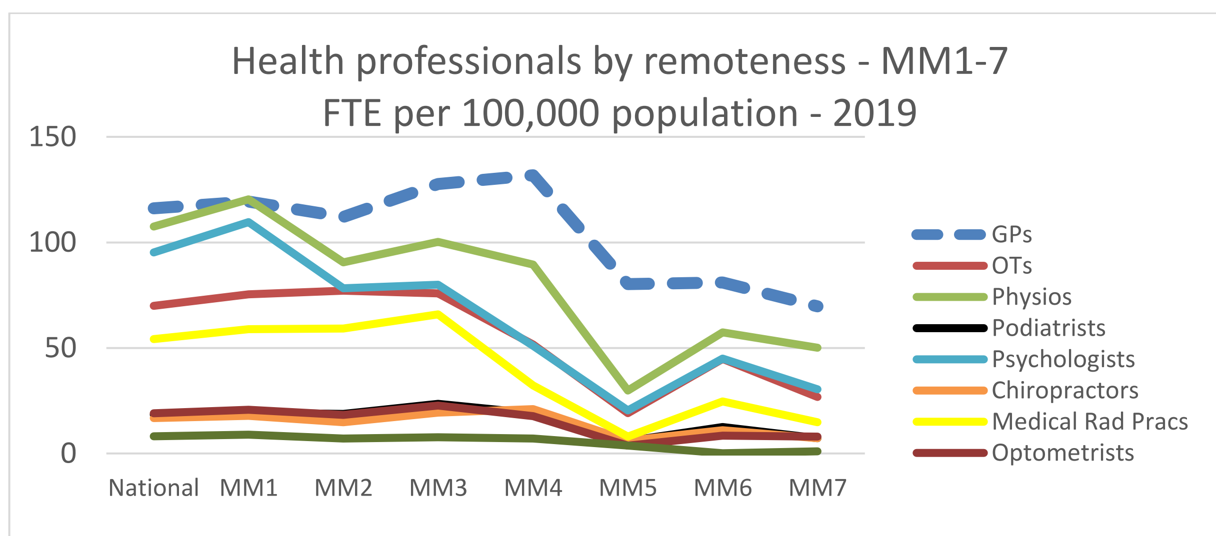
Critical shortages in allied health across rural and remote Australia

The challenge for Northern Australia (and other areas predominantly identified as rural and remote) is **the additional demand comes on top of pre-existing, chronic severe workforce shortages**. Workforce shortages with regard to the medical workforce (especially in rural and remote Australia) receive regular political, media and community attention, as it should. However, the workforce and service shortages for allied health practitioners (AHPs) – which impact access to health, disability support, aged care, veterans' services, education, workers' compensation and rehabilitation are more – are less well understood and more severe. In terms of distribution (on a per head of population comparison basis):

- Medical practitioners are heavily skewed toward inner metro areas, generally reducing / worsening with remoteness (and worst for non-GP specialists);
- For AHPs mal-distribution / workforce shortages in rural and remote Australia are about twice as severe as for medical practitioners (on a comparative per head of population basis versus metropolitan areas). Numbers drop sharply with remoteness.

The following graph shows the distribution by remoteness (where MMM1 is inner metropolitan and MMM7 is very remote) for a selection of AHPS, compared with GPs. Most of Northern Australia is classified as MMM 5 – MMM 7[2].

More recent data is available than is represented in the graph, however the pattern has not changed significantly and in some cases (at least) has worsened. The substantial drop off in GP to population numbers is a serious concern but is considerably more marked for AHPs.



[2] Noting some exceptions, such as Townsville, Darwin and Rockhampton which are MMM2, while Alice Springs, Broome and Kununurra are categorised as MMM6).

In addition, for all health professions and services, it is important to note that those working in remote and very remote settings are dealing with both a larger per clinician population load and may be working over an area the size of Victoria, compared with a few square kilometres in a major city: this greatly amplifies the challenges of access for rural and remote residents and effective service delivery for any primary health care professional. The extent of allied health mal-distribution is also evident in information held on the Commonwealth Department of Health's website.

Further, people living in rural and remote Australia face higher levels of chronic disease; are more likely to be hospitalised for conditions that could have been prevented if they could get the right care when they needed it; shorter average life spans than their counterparts in metropolitan areas; greater rates of disability; and poorer access to health services they need – because the workforce is not there, they are too far away or the costs and wait times are too great.

The situation in Northern Australia.
It would be possible to interrogate the data to obtain a more specific profile of the workforce size and distribution across Northern Australia, however SARRAH does not have the resource capacity to undertake this analysis at present. Nonetheless, there is ample evidence already available to back up what is broadly known across the health and social services sectors that chronic workforce shortages, high turnover rates and consequent service access challenges are long-standing issues for Northern Australia. The point is further illustrated by the reports of the Rural Health Workforce Agencies (RHWAs) engaged in each State and Territory by the Commonwealth to support health workforce development and distribution. For instance, each RHWA is required to conduct health workforce needs analyses on a regular basis. The **Queensland** RHWA, Health Workforce Queensland, publishes detailed report on the analyses they conduct. For example, at a state-wide level (2022 Health Workforce Needs Assessment) and at the broad regional level.

The widespread extent of the problem across geographic areas and for most health professions is evident in the excerpts at **Attachment B** (from page 7 of the respective reports) – showing:

- the Northern Queensland Region Health Workforce Needs Analysis; and
- the Western Queensland region Health Workforce Needs Analysis.

THE **Northern Territory** RHWA (and NT Primary Health Network) also produces and has published (a less up to date) Workforce Needs Analysis. SARRAH is aware that the NT RHWA is taking active steps to build their workforce development and support capacity and linkages, with pro-active engagement with NT based and national organisations, including SARRAH, over the past 12 months.

Rural Health West (WA) are also actively seeking to support a more sustainable health workforce across rural and remote WA, but also deal with major supply issues.

Attracting and retaining health workforce in Northern Australia would deliver major benefits in terms of:

- Continuity and quality of patient care – and outcomes
- Hell contain / alleviate demand for expensive and more intrusive emergency interventions; and
- Reduce the very high costs associated with staff turnover – which we understand may be 100% pa or higher in some cases in Northern Australia.

Health and service workforce as a contributor to overall economic growth?

Investment in enabling health and social services helps drive economic development, directly and indirectly, delivering:

- highly skilled, moderate-well paid, stable employment in a sector in high demand and which is less prone to fluctuations that can impact other industries severely – such as changes in commodity prices, weather events etc.
- provide income sources into communities that help bolster local economies, services and workforce demand;
- help to attract and retain workers across other industries, who value the availability of such services in making choices about where they live;
- increased productivity of the entire workforce through higher participation rates and reduced lost work hours;
- increased self-reliance, reduced reliance of welfare payments and contributions to revenue;
- better health and education outcomes for children and increased capacity for people to remain in communities and age in place;
- increasing opportunities for Aboriginal and Torres Strait Islander communities, including specific closing the gap targets and more broadly; and
- opportunity for people with disability to participate in the social and economic aspects of life.

Numerous reports identify economic benefits associated with the provision of heath and related care activities, including specific allied health interventions. For instance:

- The Report *FALSE ECONOMY: The economic benefits of the National Disability Insurance Scheme and the consequences of government cost-cutting* (November 2021), produced by Per Capita found "*the economic impact of the scheme is likely very large, even compared to other types of government spending. A conservative estimate of the multiplier effect of the NDIS would be in the range of 2.25*." https://teamwork.org.au/wp-content/uploads/2021/11/Per_Capita_Report_teamworks.pdf
- SARRAH released a report in 2015 titled *'The Impact of allied health professionals in improving outcomes and reducing the cost of treating diabetes, osteoarthritis and stroke'* which reviewed all available evidence and evaluated the economic impact of allied services provided to Australians with three common health conditions – stroke, diabetes and osteoarthritis. The report identified potential annual savings of $175 million (2015$) to the Australian healthcare budget from the implementation of eight allied health

It is essential that any plan to bolster workforce development in Northern Australia in the immediate or long-term include the Health and Social Assistance workforce.

Specific comments – the Terms of Reference

The Terms of Reference for the Inquiry are broad.

The Joint Select Committee on Northern Australia shall inquire into and report on workforce development in Northern Australia, considering the impediments to building the economic and social infrastructure and workforce needed to support economic development, with particular reference to:

a. ***trends in Northern Australia that influence economic development and industry investment including population growth, economic and business growth, workforce development, infrastructure development, and Indigenous economic participation;***

Many of the numerous inquiries and reports on the development of Northern Australia over recent decades have emphasised export-oriented industries and the infrastructure needs to support them. There has been some focus on service-related industries to support to facilitate business and employment growth and to some, lesser extent (generally) local workforce development (education, skills etc) has received attention as have some core health services. Ideally development strategies would take a balanced and wide-ranging approach, recognising the mutual benefits and complementarity of the full range of employment sectors required to support complex and developing communities. SARRAH has previously addressed similar issues in detail in submissions to Australian Parliamentary Inquiries, including:

- ***Senate Select Committee on the effectiveness of the Australian Government's Northern Australia agenda***: Submission Number 66 https://www.aph.gov.au/Parliamentary_Business/Committees/Senate/NorthernAustraliaAgenda/NorthernAustraliaAgenda/Submissions and
- ***Senate Select Committee into the Jobs for the Future in Regional Areas***: Submission number 148. https://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Jobs_for_the_Future_in_Regional_Areas/JobsRegionalAreas/Submissions

To reinforce points made earlier, according to the Regional Australia Institute (RAI) *"The Health Care and Social Assistance sector is regional Australia's largest employer, and demand here has grown; the number of people employed in this sector in the three months to May 2022 some 10 per cent more than a year earlier".* [3]

The following excerpt from the RAIs Regional Labour Market Update, June Quarter 2022, shows that advertised vacancies in the NT (for example) increased by 20.4% in the 12 months to June 22. Regional Qld increased by 30.4% and regional WA by 22.8% over the same period (noting these figures would include the southern regional areas of those States).

In terms of the occupations being demanded, vacancies are largest for professional roles (24%) of all vacancies in June, followed by Technicians and Trades roles (16%), and Clerical and Administrative roles (14 %).

Number of advertised job vacancies	Jun-21	May-22	Jun-22	% change (monthly)	% change (annual)
Regional Australia	67,593	85,928	83,349	-3.0%	23.3%
Regional NSW	20,829	24,415	23,690	-3.0%	13.7%
Regional VIC	9,590	13,319	12,790	-4.0%	33.4%
Regional QLD	18,781	24,986	24,482	-2.0%	30.4%
Regional SA	1,387	1,824	1,839	0.8%	32.6%
TAS	2,629	3,494	3,487	-0.2%	32.6%
Regional WA	5,054	6,463	6,209	-3.9%	22.8%
NT	2,610	3,238	3,142	-2.9%	20.4%
ACT	6,713	8,190	7,711	-5.8%	14.9%
Mainland Capital Cities	159,716	208,162	200,131	-3.9%	25.3%

Source: National Skills Commission, RAI

A key point to note is that workforce demand across the economy is extremely high. There is intense competition across nationally, across jurisdictions and across regions (and internationally) for available workforce, especially skilled workforce.

As noted already, demand for workforce in the health and social assistance sector (especially among professionals) is extremely high and on a major long-term growth trajectory. There is already a critical shortage of health workforce professionals, especially among allied health professions and in rural and

[3] https://www.regionalaustralia.org.au/Web/Toolkits-Indexes/Regional-Jobs-Update/Updates/2022/Regional-Labour-Market-Update-June-Quarter-2022.aspx?WebsiteKey=b039eaff-5e30-4d14-864e-e815ef400da0

remote Australia, in particular. People want access to health and related social support services, regardless of the industry they work in, and this is a major factor in decisions to relocate.

The RAI Regional Movers Index shows substantial movement to the regions from capital cities, nationally, a trend associated with, but not wholly related to the COVID pandemic. The information in the Index indicates there is significant ongoing movement to regional Australia, but also that Northern Australia is not among the major destinations of internal migrants. It is highly likely that access to health and related services is a factor in many peoples' decisions about if and where to relocate.

b. impediments to building the economic and social infrastructure required to support industry and business to expand and create regional jobs;

There are many issues, that if addressed, could facilitate economic and social development. Some factors that would need to be considered include:

- Better coordination of programs within spheres of Government and across the spheres of Government:
- For example, supporting the development of community and/or place based services/workforce reflecting local need and coordinated at a local/regional level, rather than being program- or process-oriented fundamentally and lacking the flexibility to adapt to the specific circumstances and needs of communities – a particular issue given the shared (different seasonal conditions) and variable circumstances of communities in Northern Australia (geographic, resource, distance, transport, population etc).
- Committing and sustaining investment long enough to provide assurance for partners / co-investors to put their investment in a collaboration/ initiative etc, noting the experience of short-term commitments which can be highly disruption and entail significant risks for communities with limited resources and capacity and where the consequences of failed investments can be severe;
  - This would be particularly warranted in areas where future demand and supply needs are largely unquestionable – as in health workforce and service capacity;
- Mechanisms that facilitate and enable shared leadership and accountability with performance monitoring and measurement that favours cross-sector impacts and long-term measures of progress. The National Agreement on Closing the Gap provides a possible example.

c. challenges to attracting and retaining a skilled workforce across Northern Australia; and

Several of the major challenges are identified and discussed earlier in this submission.

d. empowering and upskilling the local Indigenous population.

Northern Australia has a proportionately higher population of Aboriginal and Torres Strait Islander people than anywhere else in Australia. The National Agreement on Closing the Gap and associated national or other Strategies, Plans etc provide a clear basis to prioritise delivery of programs that address the fundamental social and economic determinants of inequality experienced by Aboriginal and Torres Strait Islander people. Crucially, given the obvious benefits of "growing your own" workforce across Northern Australia and the relative youth of the Aboriginal and Torres Strait Islander population compared with non-Indigenous Australians, the downstream benefits not communities, Northern Australia and the nation of empowering and upskilling Aboriginal and Torres Strait Islander people is amplified.

In terms of the health and social assistance sector, the *National Aboriginal and Torres Strait Islander Health Workforce Strategic Framework and Implementation Plan 2021–2031*, provides a blueprint for negotiated and agreed action, around which further investments could be made and leveraged. The Health and Social Assistance sector is among the largest employers of Aboriginal and Torres Strait Islander people. While there must be massive growth of in representation of Aboriginal and Torres Strait Islander people in the health and related sectors to even reach population parity (a target of the Framework for 2031) there are well established First Nations peak workforce organisations and service provider systems that have successfully built and strengthened the capacity of the sector and workforce to expand (if supported) substantially with appropriate support.

One example is the Indigenous Allied Health Australia (IAHA), Aboriginal Health Academy initiative and model. The first Academy was established in Darwin by IAHA, has since expanded to several sites nationally and is delivering increasingly positive results as the model develops and matures. There is considerable potential for further growth across Northern Australia.

Other workforce development and support initiatives are being implemented – such as expansion of the Allied Health Rural Generalist Pathway into private and community settings and the Building the Rural Allied Health Assistant Workforce initiative, both of which are being implemented in sites across Northern Australia (and elsewhere). SARRAH has developed and is implementing these initiatives with funding from the Commonwealth Government. There is great potential for these initiatives to be expanded beyond present funding capacity and to contribute to supporting the development of Northern Australia.

Unfortunately, we have not had the capacity to prepare a more extensive submission to the Inquiry. We would welcome the opportunity to be further involved in the Inquiry if the opportunity is available. If you would like to discuss issues raised in SARRAHs submission or require further information, please contact me at catherine@sarrah.org.au or Allan Groth at allan@sarrah.org.au. More information about SARRAH is available on our website.

Yours Sincerely

Cath Maloney
Chief Executive Officer

BACKGROUND INFORMATION

Health and Social Assistance is by far the leading sector of jobs growth across the economy. It has been the dominant sector for jobs growth over the past 2 decades and is projected by the National Skills Commission to continue to be lead jobs growth through until November 2026 at least.

The following table provides a summary snapshot, comparing the size and proportion of jobs growth projected for several key sectors.

Sector	Projected increase in jobs for the 5 years to Nov 26	% Increase of existing workforce
Health and Social Assistance	**301,000**	**15.8%**
Accommodation and Food Services	112,400	13.2%
Construction	66,400	5.8%
Mining	15,900	5.9%
Manufacturing	23,100	5.9%
Financial and Insurance Services	33,200	6.3%

Refer - https://labourmarketinsights.gov.au/industries/industry-details?industryCode=Q

SARRAH estimates that around 100,000 or more of the 301,000 are needed in regional, rural and remote Australia, noting:

- Massive current shortages
- Population shifts to those communities
- Unidentified demand.

At a more detailed level, the following table shows that even within the Health and Social Assistance sector allied health professions (bolded) lead demand. A small number of other sector professional groups are included for comparative purposes.

Projected Employment Growth for the five years to November 2026: National Skills Commission: selected

Audiologists and Speech Pathologists	**34.7%**
Podiatrists	**31.8%**
Physiotherapists	**28.7%**
Dental Practitioners	**27.8%**
Social Workers	**23.2%**
Early Childhood Teachers	21.6%
Optometrists and Orthoptists	**15.1%**
Drillers, Miners and Shot Firers	14.9%
Medical Imaging Professionals	**14.7%**
Registered Nurses	13.9%
Psychologists and Psychotherapists	**13.3%**
General Practitioners and RMOs	10.2%
Accountants	9.2%
TOTAL PROJECTED EMPLOYMENT GROWTH - AUSTRALIA	**9.1%**
Pharmacists	**9%**
Ambulance Officers and Paramedics	**8.4%**
Industrial, Mechanical and Production Engineers	5.5%

Note: Data has been drawn from the National Skills Commission's Employment Projections material, updated in March 2022 and accessed 13 April 2022.

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

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

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

Type of workforce	NQ Region Total *M* (*Rank*)	Cairns & Hinterland HHS *M* (Rank)	Mackay HHS *M* (Rank)	Torres & Cape HHS *M* (Rank)	Townsville HHS *M* (Rank)
Psychology	**78.69 (1)**	**74.80 (2)**	**84.76 (1)**	**79.77 (1)**	**78.12 (1)**
General Practice	**73.20 (2)**	**80.51 (1)**	**75.29 (4)**	**75.00 (5)**	57.53 (8)
Speech Pathology	**73.06 (3)**	**73.32 (3)**	**78.67 (2)**	**64.53 (10)**	**68.93 (2)**
Social Work	**70.29 (4)**	**71.23 (4)**	**75.70 (3)**	**63.13 (11)**	**65.24 (3)**
Nursing/Midwifery	**69.37 (5)**	**70.66 (5)**	**71.12 (7)**	**77.57 (3)**	**63.67 (4)**
Occupational Therapy	**66.92 (6)**	**68.18 (6)**	**73.75 (5)**	**61.38 (13)**	58.40 (6)
ATSI Health	**65.57 (7)**	**65.62 (7)**	**66.46 (9)**	**73.71 (6)**	**62.61 (5)**
Diabetes Education	**62.07 (8)**	58.85 (9)	**71.87 (6)**	**68.87 (8)**	54.75 (11)
Nutrition/Dietetic	59.64 (9)	58.32 (10)	**66.80 (8)**	56.29 (15)	54.80 (10)
Dentistry	59.18 (10)	**61.56 (8)**	59.38 (11)	**76.63 (4)**	49.17 (13)
Podiatry	56.59 (11)	56.36 (11)	**60.53 (10)**	**60.43 (14)**	51.88 (12)
Audiology	54.02 (12)	51.91 (13)	54.46 (13)	54.40 (16)	56.63 (9)
Exercise Physiology	52.99 (13)	51.67 (14)	56.19 (12)	**79.38 (2)**	44.76 (15)
Radiography/Sonography	52.96 (14)	49.48 (15)	50.35 (16)	**66.53 (9)**	57.66 (7)
Physiotherapy	52.70 (15)	56.13 (12)	51.00 (15)	**62.13 (12)**	46.73 (14)
Optometry	45.09 (16)	42.99 (16)	47.82 (16)	**73.13 (7)**	36.11 (16)
Pharmacy	34.78 (17)	36.97 (17)	38.02 (17)	54.21 (17)	20.86 (17)

In the **NQ region** there were eight workforce gap rating means of 60 or more. The highest were for the psychology, general practice, and speech pathology workforces. The only means lower than 50 were for the optometry and pharmacy workforces.

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

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

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

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

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

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