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Short-Term Fixes, Long-Term Gaps: Addressing Rural Health Workforce Challenges in Queensland

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ABSTRACT

Purpose: To assess the scope and distribution of rural health workforce policies at both national and state (Queensland) levels through a systematic analysis of their status and characteristics.

Methods: A mapping review was adopted, with rural health workforce policy documents identified and extracted from websites of the national Department of Health and Aged Care, Queensland Health, and Queensland's Rural Workforce Agency. Documents were coded for demographic data, policy type, health profession, and overarching strategic focus on health workforce supply, distribution, and performance.

Findings: From the total of 12 921 rural health workforce policy documents identified in national and state repositories, 118 documents (67 national and 51 Queensland state) were included for synthesis. Analysis showed that the national rural health workforce policy is dominated by short-term mixed policy instruments—grants, programs, and sub-programs. After 2018, national policy showed a more balanced coverage of supply, distribution, and performance, compared with the stronger supply emphasis evident among policies issued before 2018. Queensland-specific policy places greater emphasis on retention, primarily through incentives embedded in employment policies, including financial allowances, leave, development opportunities, and workload management provision. However, these policies give limited attention to broader drivers of retention that are well established in the literature, including social, cultural, and work environment factors. Policy attention to performance is relatively narrow, focusing more on individual or professional outcomes than on system-level workforce outcomes.

Conclusion: Findings highlight the complexity and underlying fragmentation of Australia's rural health workforce policy. The layering of multiple nationally driven programs alongside state-level employment policy makes it difficult to assess the individual scope, overall coherence, interaction, and impact of health workforce policy in rural and remote regions.

1 | Introduction

Persistent shortages and maldistribution of the health workforce in rural and remote regions remain one of the most intractable challenges in health systems worldwide [1]. Despite decades of policy attention, efforts to ensure that "the right health workers, with the right skills, in the right place, at the right time" have yielded uneven progress [2]. Global initiatives, including the World Health Organisation's Global Strategy on Human Resources for Health [3], have sought to establish guiding frameworks, yet implementation has often been hampered by competing policy priorities [4], short-term funding cycles [5], and the difficulty of sustaining workers in remote areas [6]. While political attention devoted to rural health workforce issues continues

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Summary

What Is Known About the Topic

- Despite considerable investment in increasing rural health workforce policy numbers and activities, challenges in health workforce availability, recruitment, and retention remain across Australia's rural and remote regions.
- Rural health workforce governance remains underdeveloped at both national and state levels, with fragmented responsibilities, weak coordination, and limited mechanisms for strategic alignment.
- A clearer understanding of the rural health workforce policy landscape is needed to support more systematic alignment between national and state initiatives, yet such analyses remain limited.

What Does This Paper Add

- This paper provides a systematic analysis of current rural health workforce policies across national and Queensland jurisdictions.
- It demonstrates a fragmented policy landscape, characterised by national short-term programmatic initiatives alongside Queensland employment-based retention policies, with uneven attention to professions and strategic workforce domains.
- It shows that improving rural workforce policy will require more coherent long-term planning, stronger governance, and better alignment between national and state policy settings.

to wax and wane, the fundamental challenges—recruiting, retaining, and supporting fit-for-purpose workers in geographically dispersed settings—remain unresolved [7].

In Australia, the rural health workforce challenge plays out within a complex national governance landscape. The national government holds responsibility for national policy, regulatory frameworks, health professionals' training pathways, and primary care funding, as well as the workforce related to aged care and Aboriginal and Torres Strait Islander health [8]. State and territory governments are responsible for public hospitals and public health services, the majority of workforce employment and management, and performance monitoring [9]. They also share responsibility for public hospital funding, some health professional accreditation, and collaboration with statutory bodies such as Primary Health Networks, Australian Health Practitioner Regulation Agency (AHPRA), and Aboriginal Community Controlled Health Organisations [10]. While such arrangements allow for multiple levers of influence, they complicate efforts to pursue a coherent long-term workforce strategy [11].

Between 2009 and 2014, Health Workforce Australia (HWA) served as a national coordinating body, leading data collection, policy development, and workforce planning [12]. Its disbandment left a major coordination gap, including for rural and remote workforce planning, which has since depended on a patchwork of national initiatives and state-based rural workforce agencies [13]. In Queensland, for example, two principal mechanisms support rural workforce development. **Health Workforce Queensland** is a nationally funded, non-government Rural Workforce Agency and member of the Rural Workforce Agencies Network (RWAN), which collectively administers national government incentive and scholarship programs, recruitment and retention initiatives, and undertakes workforce needs assessments [14]. In parallel, the **Office of Rural and Remote Health (ORRH)** is situated within the Queensland Department of Health and provides strategic policy direction, program oversight, and clinical governance support for rural and remote service delivery [15]. However, no central mechanism exists to ensure systematic alignment between these state-based functions and national initiatives, including the Primary Health Networks (PHN), nor to facilitate coordination across jurisdictions.

In this context, the national government launched the 10-year Stronger Rural Health Strategy in 2018 [16]. Structured around four themes—teach, train, recruit, and retain—the Stronger Rural Health Strategy consolidated existing initiatives and introduced new measures to expand training pipelines, support recruitment into rural practice, and improve retention. Despite this renewed commitment, chronic challenges remain, including workforce shortages, reliance on short-term programmatic funding, and persistent difficulties with retention and burnout [17].

This paper contributes to drawing attention to the abovementioned challenges by mapping and analysing rural health workforce policies at national and Queensland state levels. A systematic review of policy documents provides an empirical account of the current landscape—identifying what kinds of policies exist, which professions they target, and how they are distributed across the important health workforce domains of supply, distribution, and performance. Such a review does not assess implementation or impact per se, nor does it seek to attribute policy development to any single strategy. Rather, it aims to reveal patterns of emphasis, omission, layering, and potential fragmentation across the policy environment in which workforce challenges are being addressed. By surfacing these policy features, the study seeks to provide a clearer evidence base for deliberation about health workforce governance and alignment—considering where national and state responsibilities intersect, where duplication or gaps arise, and where mechanisms for coordination could be strengthened. In this way, this descriptive policy mapping provides a necessary starting point for informed debate and more strategic long-term planning in this critical domain.

2 | Methods

2.1 | Design

Mapping reviews are designed to enable bodies of literature or policy documents to be systematically and visually summarised according to criteria of interest [18, 19]. This policy review adopted a mapping approach to identify the key characteristics of national and (Queensland) state-level rural health workforce policies by policy type, targeted health professions, and strategic health workforce policy domains, namely—supply, distribution, and performance. The searching, policy identification, and extraction were conducted and reported according to the Preferred

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Reporting Items for Systematic Reviews and Meta-Analyses extension for Scoping Reviews [20].

2.2 | Definition of Health Workforce

A broad definition of health workforce, often termed “human resources for health” in the literature, includes “all people primarily engaged in actions with the primary intent of enhancing health” [21]. This broad World Health Organisation (WHO) definition encompasses a wide range of health cadres, including workers without professional training or outside formal regulatory systems, such as traditional healers, patient transporters, and community health volunteers [22]. However, because this study focuses on mapping the scope and distribution of rural and remote health workforce policy, we adopted a narrower definition. Consistent with WHO guidance, this narrower definition was operationalised using categories derived from the International Standard Classification of Occupations (ISCO, 2008 revision) and focused on three workforce groups—health professionals, health-associated professionals, and personal care workers [23]. Health management and support personnel, and other service providers were excluded. This profession-specific approach to the health workforce was applied throughout the data collection and analysis of this study.

2.3 | Search Strategy

For national policies, we searched for health workforce policy documents from the website of the Australian Government Department of Health and Aged Care. For Queensland policies, we searched the websites of Queensland Health and Health Workforce Queensland, as these are the main publicly accessible repositories of current health workforce strategy and human resources (employment) policy documents. Because the architecture of the three websites differed, the search strategy was adapted for each source. On the Department of Health and Aged Care website, keyword filtering was available, so seventeen search terms were applied across three website tabs. On the Queensland Health and Health Workforce Queensland websites, equivalent filtering functions were not available across tabs, meaning the same search-term approach could not be applied systematically. Instead, we undertook a structured manual search by navigating each relevant tab sequentially and screening all pages within those tabs until no further eligible documents remained. This approach allowed the search to remain systematic and comprehensive despite differences in website design. The search terms for national policies and the total number of documents identified in each tab of the three websites are shown in File 1A and File 1B.

2.4 | Data Selection and Analysis

2.4.1 | Data Selection

Because the aim of the study was to map the current rural health workforce policy landscape, policy documents were included on the basis of their currency and operational relevance at the time of data collection, regardless of whether they were issued before or after the introduction of the Stronger Rural Health Strategy in 2018. All policy documents were screened based on title and summary; only policy documents that met the inclusion criteria underwent a full text screen. The study included health workforce policy documents that meet the following criteria: (1) focused on the planning, governance, and management (including human resource and employment aspects) of rural health workforce; (2) were current and effective until at least until October 2024 (national policy documents) or January 2025 (Queensland's policy documents); and (3) were publicly accessible. Exclusion criteria were: (1) inappropriate document types (including meeting agendas, books, brochures, campaign certification statements, case definitions, case studies, datasets, digital images, fact sheets, forms, government responses to inquiries, infographics, letters, meeting minutes, posters, presentations, procedures, policy reviews, public interest certificates, reports, statements, terms of reference); (2) government policy focused on clinical practice; (3) not current and effective after October 2024 (national policy documents) or January 2025 (Queensland's policy documents); (4) unavailable in full-text.

2.4.2 | Data Charting and Coding

Among the included documents, a first phase focused on extracting demographic data into an Excel spreadsheet using the following fields: Title, issuing entities, implementing entities, source, and year of publication. A second phase of data extraction identified the focus and scope of each policy document. Each document was coded according to: (i) its alignment with one of the health workforce strategic domains—supply, distribution, and performance; and (ii) and relevance to different types of health professionals. Given the definitional variation of health professions mentioned in Queensland's employment policy (e.g., “health employees”, “health practitioners”, “health workers”), we developed standardised labels for all professions before applying health professional-specific codes to each document (File 2). Each document could be coded to more than one strategic domain and more than one health professional grouping.

To further understand the different types of incentives among Queensland's performance-focused policies for health professionals, we developed codes guided by the Guidelines: Incentives for Health Professionals [24], including: (i) allowance; (ii) leave; (iii) professional development; (iv) workload management; (v) flexible working hours; (vi) positive working environment; (vii) service access. For service access, we included policies that facilitated access to social supports such as accommodation, children's education, and employment opportunities for partners, as well as policies intended to support social and cultural integration into local rural communities. Each policy could be coded to more than one type of incentive. It should also be noted that the content of incentives is a component in any given performance-related policies, rather than a separate policy instrument.

To provide greater temporal clarity, national and Queensland policy documents were also descriptively grouped as pre-2018 and 2018 onwards. This temporal grouping was used to compare the composition of the policy portfolio before and after the introduction of the Stronger Rural Health Strategy, not to infer causal effects of the Strategy on subsequent policy development.

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The third phase enabled a consistent categorisation of (i) levels of policy outcomes and (ii) document types. Each document was coded to one of three levels of policy outcomes. Documents coded to 'system-level health workforce policy' targeted actual health workforce outcomes (e.g., Medical Practitioner Workforce Plan for Queensland, Rural and Remote Relief Nursing and Midwifery Program). Documents coded to 'individual-level health workforce policy' targeted career or professional development outcomes (e.g., Allied Health Rural Generalist Education Framework, Queensland Rural Generalist Pathway Prevocational Training Program Framework). In cases where policies could benefit both levels simultaneously, documents were coded 'system-level health workforce policy' (e.g., Go Rural North program, GROW Rural program). Documents coded to 'employment policy' (for state-level policies only) focused on human resource aspects (e.g., remuneration, classification levels, condition of employment) to meet industrial or other administrative requirements. The exclusive coding of 'employment policy' for Queensland policies was used because Queensland Health is directly responsible for recruiting health workers, and the recognition of employment and professional rights for health workers through 'employment policy' directly impacts the retention and sustainability of the health workforce.

We additionally defined document types based on Howlett and Ramesh's spectrum of substantive policy instruments (File 3), which range from policy instruments that give the government the highest control in their implementation to those that invite other non-governmental stakeholders and have minimal government involvement [25, 26]. We developed an adapted glossary of document types in which mandatory policies e.g., laws, agreements, strategies, plans, frameworks, standards, guidelines (national policy); laws (including labour laws), industrial instruments, directives, human resources policies (state-level and employment policy) are at the top hierarchy, while mixed policies (e.g., schemes, programs, sub-programs, incentives, grants (national policy), human resource standards, and human resource guidelines (state-level and employment policy)) are at the bottom. File 4 outlines all the document types for national and state policy documents. To ensure coding consistency, all policies were examined and coded based on content, rather than the policy/document title. In all phases of the data extraction, the first author initially coded the data, and the second author reviewed the selected documents. Any disagreement was discussed until an agreement was reached.

2.4.3 | Data Analysis

The analysis aimed to produce a structured descriptive mapping of rural health workforce policy using a pre-defined coding framework. As outlined above, the framework classified each policy by document type, level of policy outcome, strategic domain, targeted profession, and year of publication. Analysis then involved counting frequencies within these categories and identifying recurring patterns across the dataset, such as the predominance of particular policy types, strategic domains, or professional groupings. Because many policy documents addressed more than one issue, interpretive judgement was sometimes required to assign a primary category. This judgement was applied systematically across all documents and guided by the pre-defined coding framework and consistent decision rules to ensure coherence and reliability.

2.5 | Ethics Statement

This review relied on primary policy documents and, as such, received a formal exemption from ethics review by the James Cook University Human Research Ethics Committee.

3 | Results

Our search identified 12 921 policy documents (3 380 national policies, 9 541 state policies). Following screening and review, a total of 118 eligible policy documents (67 national and 51 Queensland state documents) were retained for synthesis (File 5). Because inclusion was based on current/effective status rather than date of issue, the final dataset comprised both policies that predated the 2018 Stronger Rural Health Strategy and policies issued subsequently. Files 6 and 7 contain the charting of all national and Queensland policies, respectively.

Of the 67 national policy documents included, 32 were issued before the introduction of the Stronger Rural Health Strategy in 2018, and 35 were issued in 2018 or later. Among the pre-2018 documents, supply was the most frequently represented strategic domain ($n=20$), compared with distribution ($n=11$) and performance ($n=8$). In contrast, national documents issued from 2018 onwards showed more even distribution across the three domains, with 18 addressing supply, 17 addressing distribution, and 16 addressing performance (Figure 1). Across both periods, however, the national portfolio is dominated by mixed instrument-type policies, such as programs, sub-programs, and grants.

When comparing Queensland and national policy portfolios, different emphases on strategic domains are evident. National policy documents issued from 2018 onwards are more evenly distributed across supply, distribution, and performance (Figure 1). However, as shown in Figure 2 (Queensland pre- and post-2018) and Figure 3 (Queensland all current policies), Queensland's rural and remote health workforce policy remains more strongly oriented towards performance ($n=34$), as compared to distribution ($n=17$) or supply ($n=12$). In the performance domain, and compared to the national portfolio, Queensland policy has a greater focus on health workforce retention (Figure 3), via multiple types of incentives such as allowances, leave, financial incentives, professional development, workload management, flexible working hours, positive working environment, and service access (Figure 4). However, these incentives are predominantly focused on individual and professional outcomes rather than system-level outcomes. Additionally, we found a few references in Queensland policy to drivers of retention linked to broader social, cultural, and work environment factors.

When examining health professional groups, medical doctors and specialists, and nurses and midwives were the most frequently mentioned in current national rural health workforce policies (Figure 5). We identified no national rural health workforce documents mentioning medical laboratory

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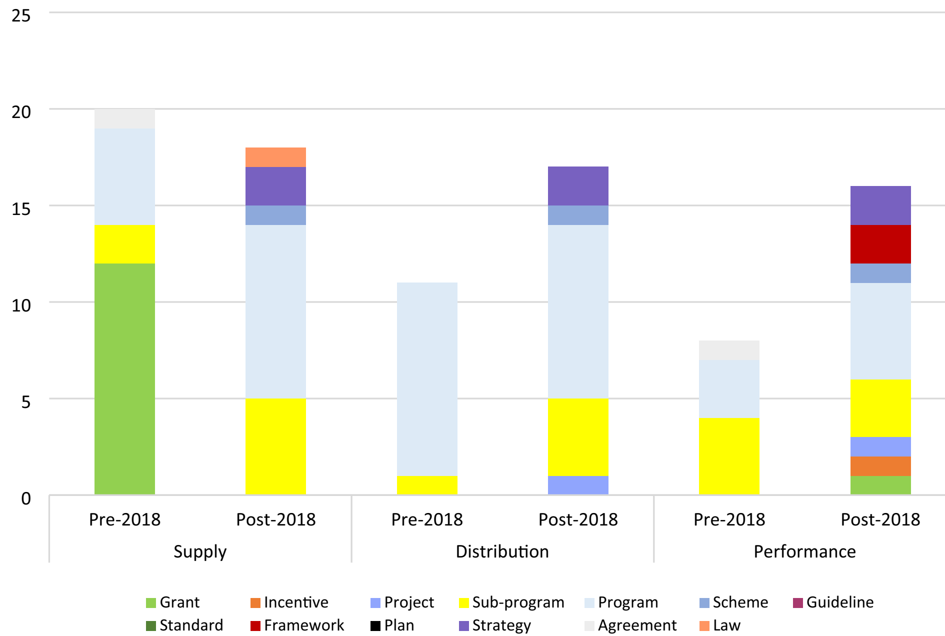


FIGURE 1 | Strategic policy domains addressed in national rural health workforce policy documents by document types, before and after 2018.

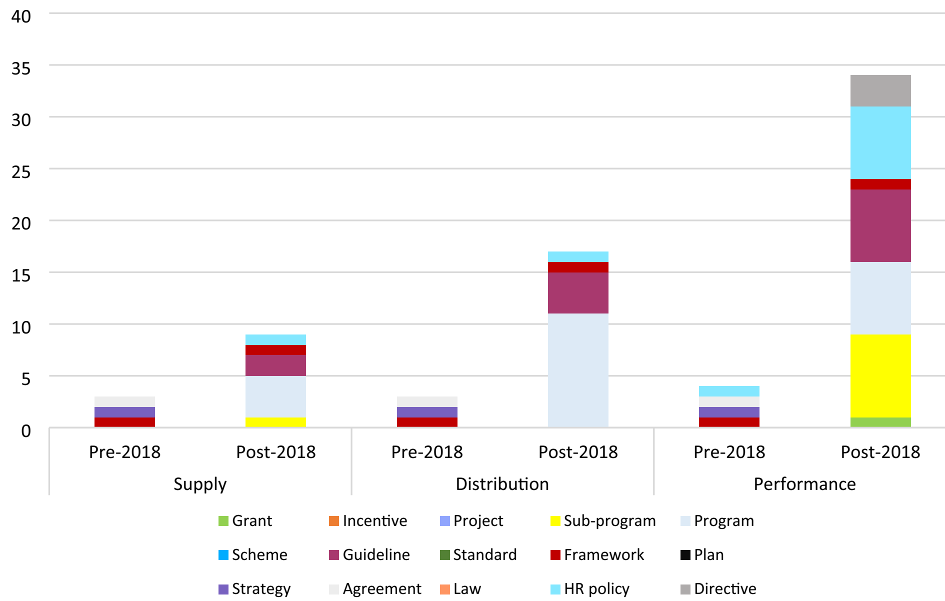
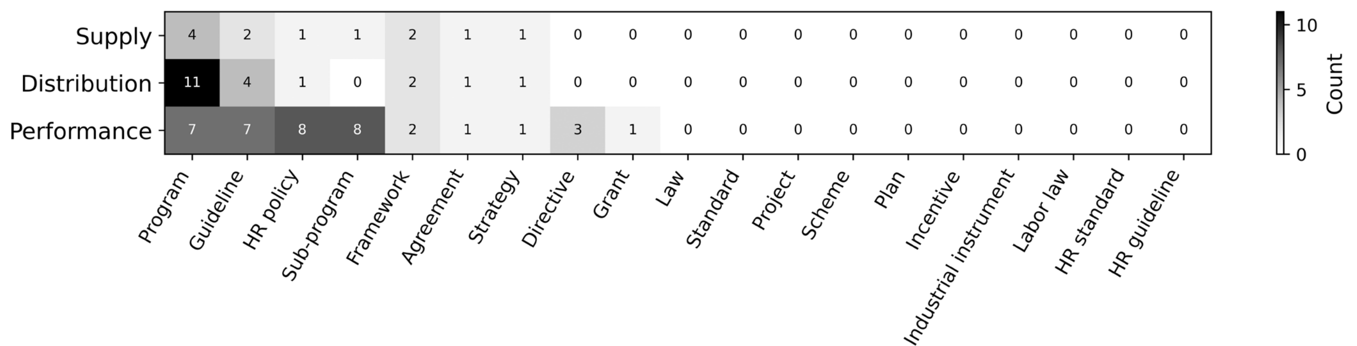


FIGURE 2 | Strategic domains addressed in Queensland rural health workforce policy by document types, before and after 2018.



	Program	Guideline	HR policy	Sub-program	Framework	Agreement	Strategy	Directive	Grant	Law	Standard	Project	Scheme	Plan	Incentive	Industrial instrument	Labor law	HR standard	HR guideline
Supply	4	2	1	1	2	1	1	0	0	0	0	0	0	0	0	0	0	0	0
Distribution	11	4	1	0	2	1	1	0	0	0	0	0	0	0	0	0	0	0	0
Performance	7	7	8	8	2	1	1	3	1	0	0	0	0	0	0	0	0	0	0

FIGURE 3 | Strategic domains addressed across all current Queensland rural health workforce policy documents by document types.

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scientists, paramedics, or physician assistants. Relatively few national rural and remote workforce policies mention dentists or dental practitioners (6), or aged care workers (6), while Aboriginal and Torres Strait Islander Health Workers and/or Practitioners and pharmacists, were each mentioned in 11 documents, respectively. Most professional groups were mentioned in a spread of policy across the supply, distribution, and performance domains. However, we found no mention of pharmacists, dentists, or dental practitioners in any national policies in the performance domain.

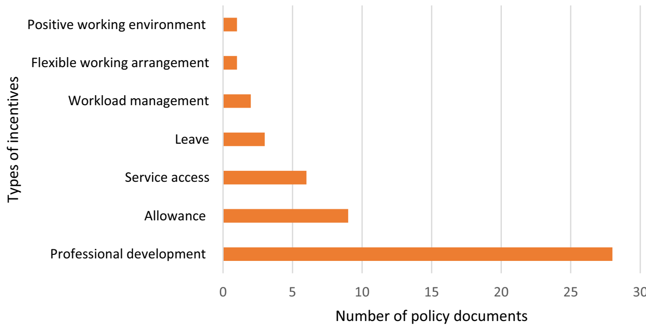

FIGURE 4 | Number of all current Queensland rural health workforce policy documents by types of incentives mentioned.

A similar pattern relating to health professionals can be observed among current Queensland policy documents (Figure 6), with relatively more documents mentioning medical doctors and specialists (38), allied health professionals (18), and nurses and midwives (12), while others, including paramedics and physician assistants, are sparsely mentioned. Within five health professional groups (Medical Practitioners; Allied Health professionals; Nurses and midwives; Dentists and dental practitioners; Aboriginal and Torres Strait Islander Health Professionals), policies with a focus on individual-level outcomes (e.g., career development or progression) make up the largest proportion. Policies targeting individual-level outcomes also dominate the Queensland policy data set as a whole, comprising 49 documents, as compared with 26

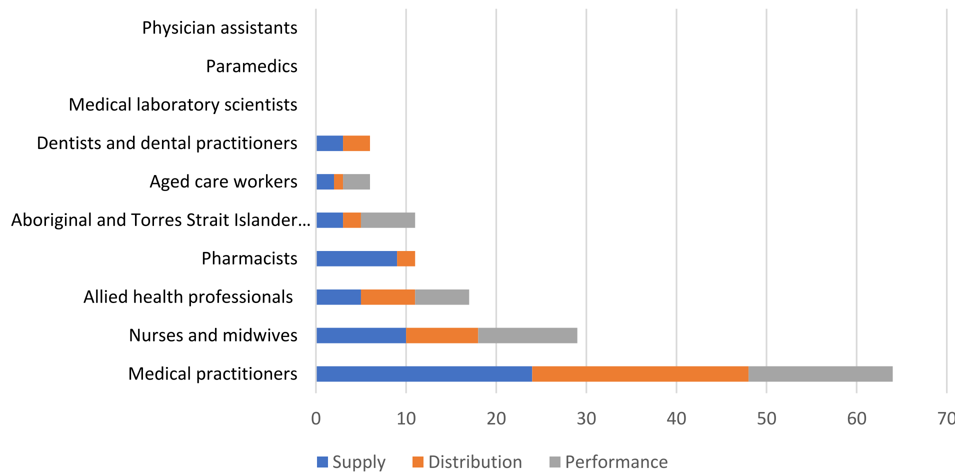

FIGURE 5 | Number of national rural health workforce policy documents by mention of health professional type and strategic workforce domain (supply, distribution, performance).

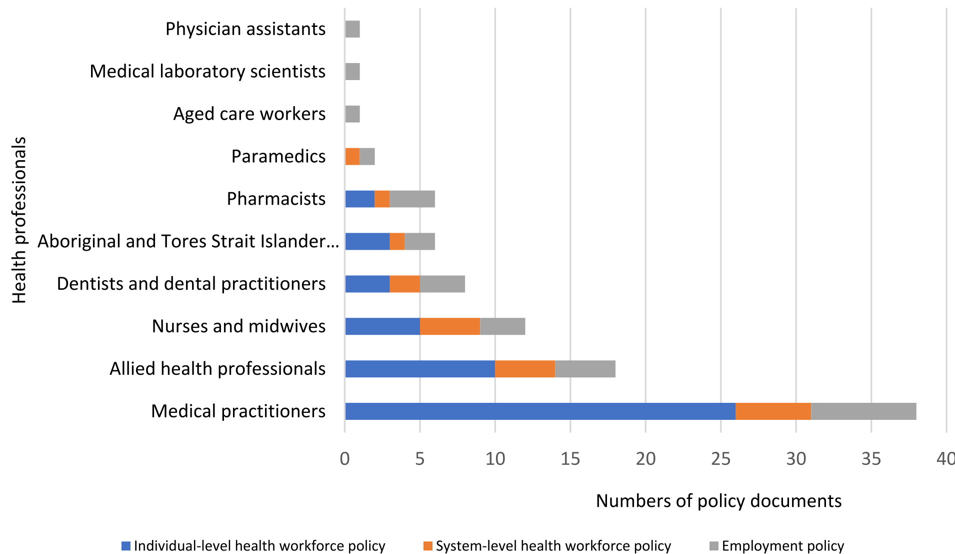

FIGURE 6 | Number of Queensland rural health workforce policy documents by mention of health professional types and focus of policy outcome (individual, system-level, employment).

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addressing employment-related outcomes and 18 addressing system-level strategic workforce outcomes.

4 | Discussion

This review provides the first systematic mapping of rural health workforce policies in the state of Queensland, identifying 118 policy documents across national and state repositories. By examining the current policy portfolio, including both still-current policies that predate the Stronger Rural Health Strategy and those issued subsequently, the study highlights the complexity and fragmentation of the rural health workforce policy. Three key issues were identified: (1) short-term orientation, (2) uneven distribution across professions, and (3) limited reference to the broader drivers of retention; all of which are compounded by weak health workforce governance within and across state and national jurisdictions. Each issue holds considerable implications for policy, practice, and, by extension, health outcomes for Queensland's rural and remote communities.

4.1 | Short-Term Orientation

Short-term funding cycles for health and social services outside the Medicare and public hospital funding systems are widely recognised as long-standing systemic issues in Australian health policy [27–30]. Our findings show that rural health workforce policy at both national and Queensland state levels is dominated by short-term measures, comprising a succession of discrete programs and sub-programs. Short-term measures can offer advantages, including fostering collaboration between public and private stakeholders and delivering rapid, visible results. However, these benefits are often counterbalanced by higher coordination and accountability costs and the difficulty of evaluating long-term impact [31]. At the state level, these limitations are compounded by a high volume of policies that prioritise immediate employment outcomes (e.g., human resources policy) and define workforce performance primarily in terms of individual professional development, as reflected in industrial agreements. This individual focus sidelines system-level priorities such as equitable workforce distribution.

Reducing the dominance of short-termism will require not only reorienting policies towards integrated, system-level goals—a complex task within Australia's fragmented governance architecture—but also introducing workforce performance metrics that track and evaluate progress towards those goals. Relevant indicators might include transparent reporting of retention rates in both metropolitan and rural or remote areas, vacancy rates by professional category, and service coverage in underserved communities. System-level metrics could play a complementary role by making progress more visible and supporting stronger accountability.

At present, workforce targets are not part of the Service Level Agreements (contracts) signed annually by each Queensland Hospital and Health Service. Nor are workforce metrics consistently reported at the broad organisational level or by rural and remote settings in annual reports or on the Queensland Health Performance website [32–34], limiting the capacity to track or compare regional shortages or evaluate policies that target retention. Establishing or more routinely reporting these system-wide metrics would provide a more robust foundation for evidence-based workforce planning and accountability [35]. However, achieving this reorientation demands cross-jurisdictional negotiation across professions and institutional interests.

4.2 | Uneven Distribution and Professional Focus

Study findings additionally show that national and state workforce policies give uneven attention to different health professions. As expected, medical doctors, nurses and midwives, and allied health professionals dominate the policy agenda, while other groups—such as paramedics, dentists, pharmacists, and Aboriginal and Torres Strait Islander Health Workers and/or Practitioners—receive far less policy focus. This imbalance reflects entrenched professional hierarchies in Australian health policy [11], yet it is particularly problematic in rural and remote areas. In these settings, where specialist availability is limited, practitioners are often required to work across broader scopes of practice, demonstrate higher levels of cultural Safety, and deliver services spanning prevention, primary healthcare, emergency care, and rehabilitation [36].

The skewed professional focus of current rural and remote policy makes the development of multi-disciplinary, team-based models of care more difficult and risks widening the gap between the capabilities of health professionals and the health needs of rural populations. When policy attention is concentrated around a few professions, opportunities to support alternative cadres and more flexible models of care are lost, further entrenching inequities in access and service quality. For example, a failure to holistically support Aboriginal and Torres Strait Islander health workers weakens culturally safe care delivery, while under-investment in paramedics or pharmacists can constrain innovation in task-sharing and role substitution at the intersection of public and private care delivery.

Addressing these imbalances requires renewed attention on policy coordination (not just content), alongside deliberate investment in data and monitoring systems capable of tracking overall supply, distribution, scope of practice, and contribution of different health professionals to team-based care. Strengthening infrastructure to monitor policy content and outcomes would enable systematic evaluation of the skill mix in each service area, rather than narrowly tracking doctor numbers. When combined with population health needs assessments, service gap mapping could support more effective workload analysis, task delegation, help reduce professional burnout, and improve care quality [37]. Without such deliberate investment in systemic monitoring and planning, health workforce policy will likely remain fragmented and profession-specific, reinforcing the short-term orientation identified above and limiting the capacity to build a sustainable, needs-based rural workforce.

4.3 | Limited Reference to Broad Drivers of Retention

Over more than 25 years, Australian rural health workforce research has generated consistent recommendations on retention

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[38, 39]. A central message across this literature is that retention is not determined by any single factor. Rather, it reflects the interaction of professional, social, cultural, and material conditions that shape whether health workers and their families can build sustainable lives in rural communities. Yet the findings of this study suggest that this multidimensional understanding of retention is only weakly reflected in current national and Queensland policy portfolios.

Within the 10-year Stronger Rural Health Strategy, incentives are used across a range of programs, including the Workforce Incentive Program and the Bonded Medical Program, to encourage movement into rural practice. However, these mechanisms are framed as tools of recruitment and redistribution, directed towards attracting practitioners to rural locations rather than supporting the longer-term conditions that influence whether they remain.

In Queensland, performance-oriented policy additionally focuses on strengthening the professional experience of health workers, particularly through professional development, leave provisions, allowances, and aspects of work autonomy. While these are important supports, they capture only part of the retention challenge. Decisions about whether to remain in rural practice are rarely made on professional grounds alone, being shaped by wider considerations including housing, partner employment, children's education, community connection, and the broader social and cultural experience of living in rural and remote areas [40, 41]. The relative absence of policy responses to these factors in current national or Queensland policy suggests that retention continues to be approached through discrete incentive mechanisms rather than as a broader question of how to create socially and professionally sustainable conditions for long-term rural practice.

Such findings flag a continuing gap between what the rural workforce literature identifies as necessary for retention and what is currently emphasised in policy design. Despite longstanding evidence that retention requires holistic and place-based support, such an approach remains only weakly institutionalised in both national and Queensland rural health workforce policy.

4.4 | Lack of Policy Coherence

Underpinning the above issues, we see the persistent challenge of policy coherence arising from limited or absent health workforce governance across national and state policy settings, including since the Stronger Rural Health Strategy was published. The coexistence of multiple still-current policy instruments from different periods, alongside newer initiatives introduced during the Strategy era, creates a layered policy environment in which alignment cannot be assumed.

For example, the John Flynn Prevocational Doctor Program (JFPDP) is a Commonwealth-funded program administered by state and territorial governments to deliver rural and remote rotations for junior doctors [42]. From January 2026, the JFPDP will be incorporated into the Australian Primary Care Prevocational Program (APCPP), which also seeks to expand training rotations in metropolitan areas. Yet introducing the APCPP midway through the JFPDP's implementation risks disrupting the latter's delivery. Likely changes in funding allocations to states and territories will affect annual work plans and add to coordination challenges among multiple consortium partners, including GP clinics, Aboriginal Community Controlled Health Organisation (ACCHO) facilities, and other primary care services. Updated details on how the new APCPP's funding will be distributed across jurisdictions remain limited [42]. However, by shifting the focus from rural and remote to metropolitan rotations, the APCPP could well incentivise junior doctors to train in cities, undermining service delivery in areas where workforce shortages are most severe (Box 1, Tables 1 and 2).

TABLE 1 | The Commonwealth's estimated funding delivery to states and the Northern Territory of the John Flynn Prevocational Doctor Program up to and including the 2026 calendar year.

($)	2022–2023	2023–2024	2024–2025	2025–2026	*6 months 2026–2027	Total
Estimated total	12546667.67	27680473.33	35338860.00	43908000.00	26777500.00	146251501.00
Less estimated National Partnership Payments	12546667.67	27680473.33	35338860.00	43908000.00	26777500.00	146251501.00
– NSW	2266666.67	5422633.33	7978200.00	9103678.77	5551921.25	30323100.02
– VIC	1017142.86	2607817.14	3785040.00	4305617.34	2625800.96	14341418.30
– QLD	3075000.00	6264720.00	7832280.00	9977875.98	6085054.52	33234930.50
– WA	682142.86	1840457.14	2378400.00	2847750.42	1736713.97	9485464.38
– SA	2763809.52	5825830.48	6874360.00	8985434.08	5479809.17	29929243.26
– TAS	954285.71	1931474.29	2124240.00	2911085.41	1775339.11	9696424.52
– NT	1787619.05	3787540.95	4366340.00	5776558.00	3522861.03	19240919.03

Source: John Flynn Prevocational Doctor Program: Federation Funding Agreement—Health: (Schedule), available at: https://federalfinancialrelations.gov.au/sites/federalfinancialrelations.gov.au/files/2024-11/QLD%20Schedule%20-%20John%20Flynn%20Prevocational%20Doctor%20Program.PDF.

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TABLE 2 | The commonwealth's allocation of primary care rotations under the new Australian Primary Care Prevocational Program.

	2023 Target	2023 Delivered	2024 Target	2024 Delivered	2025 Target	2026 Target	2027 Target	2028 Target
APCPP – Rural (Current JFPDP)	500	433	600	508	800	1 000	N/A	N/A
APCPP – Metro	N/A	N/A	N/A	N/A	N/A	200	300	400

Source: Data compiled from the Australian Department of Health and Aged Care, available at: https://www.health.gov.au/our-work/john-flynn-prevocational-doctor-program.

BOX 1 | John Flynn Prevocational Doctor Program: Lack of Policy Alignment in Delivering Primary Care Training Placements in Regional, Rural, and Remote Areas.

Launched on 1 January 2023, the JFPDP aimed to expand primary care rotations for hospital-based and junior doctors in Australia's Modified Monash Model (MMM) 2–7 regions, with funding of $146 251 501 through to 2027, see Table 1 [42].

However, on 23 February 2025, the Australian Government announced the Strengthening Medicare package, incorporating the JFPDP into the new APCPP from January 2026. The APCPP has two streams—APCPP–Rural (continuing the JFPDP) and APCPP–Metro [42]. This change reduces policy alignment with the original goal of expanding rural and remote rotations. Although the Rural Doctors Association of Australia has called for 1 600 rural rotations per year under the APCPP [44], only 1 000 rotations (250 FTE) are planned in MMM 2–7 areas, while 200 metropolitan rotations (50 FTE) will begin in 2026 and rise to 400 (100 FTE) by 2028, see Table 2. This reallocation risks further diluting rural training capacity.

A second example - the Single Employer Model (SEM) highlights the lack of coherent national workforce policy helping to align jurisdictional policies and implementation environments in ways that undermine effective evaluation. The SEM trial, designed to improve retention of rural generalist trainees by guaranteeing stable employment and continuity of entitlements, is nationally funded and evaluated, but designed and operated by state health services [42]. Local variation of SEM trials, while necessary, hampers national efforts to establish standardised metrics or parameters for cross-jurisdictional evaluation before any national rollout (Box 2).

BOX 2 | Single Employer Model: Lack of Alignment on GP Retention Policy.

Unlike hospital-based trainees who are employed by state health systems, GP trainees in private practice are contracted by GP clinics and do not receive full employment benefits such as leave, salary packaging, and stable working conditions. The SEM trial enables rural generalist trainees to remain employed by a single employer (state or territory health service or community organisation) for up to four years, supported by a section 19(2) exemption of the Health Insurance Act 1973, allowing them to bill Medicare Australia during training [42]. However, policy alignment issues occur both within and beyond the scheme.

Within the scheme, although the Australian Government funds and evaluates the SEM, states control trial design, site selection, administration, and reporting, producing a wide variation in implementation. Queensland is running a four-year pilot from February 2025, supporting 60 FTE GP and rural generalist trainees across three health service regions [45], while South Australia has expanded its earlier trial to 60 trainees statewide [46]. Victoria has opted for a smaller pilot of 15 positions across three services, citing the need for caution and local consultation [47]. The variance across states means trainees in different locations may receive greater or fewer entitlements than others, complicating the incentive structures and development of consistent evaluation metrics. This variability makes it difficult to identify effective models before any national rollout.

Beyond the scheme: New Commonwealth-funded university fee (HECS-HELP) debt relief schemes for GPs working rurally at least 25 h per week further complicate the picture. SEM registrars who split their time between private general practice and their public hospital employment do not qualify for that university fee debt relief, despite working in the same communities and roles. At the same time, medical interns and junior doctors who enter the workforce through state employment arrangements carry their own entitlements, conditions, and progression pathways. These state-based employment structures sit alongside Commonwealth incentives that are tied to Medicare billing and private practice participation. Because the two systems are designed around different logics—state systems prioritising employment stability and service continuity, and Commonwealth systems incentivising activity and billing—trainees moving between hospital and community settings face overlapping, inconsistent, and sometimes mutually exclusive incentives.

4.5 | Strengths and Limitations

This review provides the first systematic synthesis and mapping of national and state rural health workforce policies, analysing their types, targeted professions, and alignment with strategic workforce domains of supply, distribution, and performance. Its dual focus on national and state levels is a key strength, offering a clearer view of the fragmented policy environment in which decisions are made and where reform is needed. At a time of persistent global and domestic workforce challenges, developing a shared understanding of this landscape is critical to building coherent and sustainable policy responses. Notably, the Mid term Review of the

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National Health Reform Agreement Addendum 2020 - 2025 [43] contained workforce related recommendations that included the need for 'a shared plan of action' and a workforce planning body, which are consistent with the above findings.

This study is limited by its focus on policy scope and content rather than policy impact or operationalisation. In analysing policy scope and content, interpretative judgement in policy document classification was unavoidable. However, the application of a structured, pre-defined coding framework across all documents and the consistent decision rules enabled a standardised procedure and reduced the likelihood that variations in individual coding decisions could impact the overall findings. Moreover, policy documents tend to reflect institutional priorities at the time they were issued; the findings in this study should be understood as an analysis of how health workforce issues are represented in policy portfolios, rather than a direct measure of workforce outcomes.

To maintain its focus on policies issued by the Department of Health and Aged Care (national policies) and the Department of Health (state policies), tertiary education policies issued by the Department of Education and profession-specific health workforce policies issued by or negotiated by other statutory bodies or service agencies outside of Queensland Health and Health Workforce Queensland, such as Queensland Ambulance Service and Queensland Mental Health Commission, were not investigated. Future research should examine how political and economic interests, governance arrangements, and institutional barriers shape policy implementation. Complementary mapping of other jurisdictions will also be essential to provide a national picture of rural health workforce policy and its coherence. Finally, because the review was designed to map the current policy portfolio, it included still-operative policies issued across different time periods. Accordingly, comparisons between pre-2018 and post-2018 documents are descriptive and should not be interpreted as evidence of the causal effects of the Stronger Rural Health Strategy on subsequent policy production or implementation.

5 | Conclusion

Queensland continues to face entrenched rural and remote health workforce shortages within a policy environment that is layered across time, fragmented across jurisdictions, and uneven in strategic emphasis. The coexistence of still-current legacy policies with newer strategy-era initiatives complicates coordination, obscures policy effects, and constrains long-term workforce planning. Meeting these challenges requires a strategic shift: From piecemeal initiatives to coherent, long-term systemic policy planning; from health professional-oriented incentives to place-based retention mechanisms; and from profession-specific priorities to system-wide performance goals underpinned by cross-jurisdictional coordination.

To address the full scope and impact of health workforce policies in rural and remote areas, regular national–state dialogue and governance mechanisms are urgently needed to improve coordination and coherence across jurisdictions. Institutionalising these interactions—through mechanisms that ensure they are ongoing, structured, and substantive rather than transactional—could, over time, enable joint planning, clarify roles and responsibilities, and strengthen accountability, laying the groundwork for more effective policy implementation with sustained rural and remote health workforce outcomes.

Author Contributions

Karen Johnston: investigation, writing – review and editing, formal analysis, validation. **Stephanie M. Topp:** conceptualization, investigation, funding acquisition, methodology, validation, visualization, writing – review and editing, formal analysis, data curation, supervision, project administration, resources. **Thu Nguyen:** conceptualization, investigation, writing – original draft, methodology, validation, visualization, writing – review and editing, formal analysis, project administration, data curation, software. **Lana M. Elliott:** investigation, writing – review and editing, formal analysis, validation.

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Conflicts of Interest

The authors declare no conflicts of interest.

Data Availability Statement

The data that support the findings of this study are available in File 1A of this article.

References

1. World Health Organisation, "World Health Statistics 2023: Monitoring Health for the SDGs, Sustainable Development Goals," accessed September 9, 2025, https://www.who.int/publications/i/item/9789240074323.

2. K. Johnston, M. Guingona, S. Elsanousi, et al., "Training a Fit-For-Purpose Rural Health Workforce for Low- and Middle-Income Countries (LMICs): How Do Drivers and Enablers of Rural Practice Intention Differ Between Learners From LMICs and High Income Countries?," *Frontiers in Public Health* 8 (2020): 582464, https://doi.org/10.3389/fpubh.2020.582464.

3. World Health Organisation, "Global Strategy on Human Resources for Health: Workforce 2030," accessed September 9, 2025, https://www.who.int/publications/i/item/9789241511131.

4. C. A. Figueroa, R. Harrison, A. Chauhan, and L. Meyer, "Priorities and Challenges for Health Leadership and Workforce Management Globally: A Rapid Review," *BMC Health Services Research* 19, no. 1 (2019): 239, https://doi.org/10.1186/s12913-019-4080-7.

5. A. Endalamaw, R. B. Khatri, D. Erku, et al., "Barriers and Strategies for Primary Health Care Workforce Development: Synthesis of Evidence," *BMC Primary Care* 25, no. 1 (2024): 99, https://doi.org/10.1186/s12875-024-02336-1.

14401584, 2026, 3, Downloaded from https://onlinelibrary.wiley.com/doi/10.1111/ajr.70214 by National Health And Medical Research Council, Wiley Online Library on [27/05/2026]. See the Terms and Conditions (https://onlinelibrary.wiley.com/terms-and-conditions) on Wiley Online Library for rules of use; OA articles are governed by the applicable Creative Commons License

6. World Health Organisation, “WHO Guideline on Health Workforce Development, Attraction, Recruitment and Retention in Rural and Remote Areas,” accessed September 9, 2025, https://www.who.int/publications/i/item/9789240024229.

7. C. Dolea, D. Shaw, P. Zurn, and J. M. Braichet, “Increasing Access to Health Workers in Remote and Rural Areas Through Improved Retention,” accessed September 9, 2025, https://www.ncbi.nlm.nih.gov/books/NBK138618/.

8. Australian Institute of Health and Welfare, *Health System Overview* (Australian Institute of Health and Welfare, 2024), accessed 9 September, 2025, https://www.aihw.gov.au/reports/australias-health/health-system-overview.

9. Australian Department of Health and Aged Care, *The Australian Health System* (Commonwealth of Australia, 2024), accessed 9 September, 2025, https://www.aihw.gov.au/reports/australias-health/health-system-overview.

10. Australian Department of Health and Aged Care, *Health Peak and Advisory Bodies Program* (Commonwealth of Australia, 2025), accessed 9 September, 2025, https://www.health.gov.au/our-work/health-peak-and-advisory-bodies-program.

11. S. M. Topp, T. Nguyen, and L. M. Elliott, “Federal Health Workforce Policy in Australia and Its Implications: A Descriptive Policy Document Review,” *Medical Journal of Australia* 223 (2025): 459–466, https://doi.org/10.5694/mja2.70021.

12. M. V. McCarty and B. J. Fenech, “Towards Best Practice in National Health Workforce Planning,” *Medical Journal of Australia* 199, no. 5 Suppl (2013): S10–S13, https://doi.org/10.5694/mja12.10309.

13. Australian Department of Health and Aged Care, *Portfolio Budget Statements 2014–15* (Commonweath of Australia, 2014) accessed 9 September, 2025.

14. “Australian Department of Health and Aged Care. Rural Workforce Agencies Network,” accessed September 9, 2025, Rural Workforce Agencies Network.

15. “Queensland Government. Office of Rural and Remote Health,” accessed October 8, 2025, Office of Rural and Remote Health.

16. Australian Department of Health and Aged Care, “Stronger rural health strategy,” accessed September 9, 2025, Stronger Rural Health Strategy.

17. D. Russell, S. Mathew, M. Fitts, et al., “Interventions for Health Workforce Retention in Rural and Remote Areas: A Systematic Review,” *Human Resources for Health* 19, no. 1 (2021): 103, https://doi.org/10.1186/s12960-021-00643-7.

18. F. Campbell, A. C. Tricco, Z. Munn, et al., “Mapping Reviews, Scoping Reviews, and Evidence and Gap Maps (EGMs): The Same but Different— The “Big Picture” Review Family,” *Systematic Reviews* 12, no. 1 (2023): 45, https://doi.org/10.1186/s13643-023-02178-5.

19. M. J. Grant and A. Booth, “A Typology of Reviews: An Analysis of 14 Review Types and Associated Methodologies,” *Health Information and Libraries Journal* 26, no. 2 (2009): 91–108, https://doi.org/10.1111/j.1471-1842.2009.00848.x.

20. D. Moher, A. Liberati, J. Tetzlaff, and D. G. Altman, “Preferred Reporting Items for Systematic Reviews and Meta-Analyses: The PRISMA Statement,” *PLoS Medicine* 6, no. 7 (2009): e1000097, https://doi.org/10.1371/journal.pmed.1000097.

21. World Health Organization, *Working Together for Health: The World Health Report 2006: Policy Briefs* (World Health Organization, 2006).

22. A. S. George and V. Govender, *A Health Policy and Systems Research Reader on Human Resources for Health* (Alliance for Health Policy and Systems Research, World Health Organization, 2017).

23. *International Standard Classification of Occupations: Introduction to Occupational Classifications (ISCO-08) Companion Guide* (International Labour Office, 2023).

24. Guidelines: Incentives for health professionals. “Geneva: International Council of Nurses, International Pharmaceutical Federation, World Dental Federation, World Medical Association, International Hospital Federation, World Confederation for Physical Therapy,” accessed September 9, 2025, WHPA Positive Practice Environments Guidelines.

25. M. Howlett, “Managing the “Hollow State”: Procedural Policy Instruments and Modern Governance,” *Canadian Public Administration* 43, no. 4 (2000): 412–431, https://doi.org/10.1111/j.1754-7121.2000.tb01152.x.

26. M. Howlett and A. Perl, *Studying Public Policy, Policy Cycles and Policy Subsystems* (Oxford University Press, 2003).

27. S. K. Dixit and M. Sambasivan, “A Review of the Australian Healthcare System: A Policy Perspective,” *Sage Open Medicine* 6 (2018): 2050312118769211, https://doi.org/10.1177/2050312118769211.

28. S. Wanni Arachchige Dona, J. Ananthapavan, C. van Kemenade, et al., “Funding and resourcing mechanisms for long-term strategies: An Accelerated Evidence Snapshot prepared by The Australian Prevention Partnership Centre, a centre of the Sax Institute, for the Tasmanian Government”.

29. A. Harris and D. Mortimer, “Funding Illness Prevention and Health Promotion in Australia: A Way Forward,” *Australia and New Zealand Health Policy* 6, no. 1 (2009): 25, https://doi.org/10.1186/1743-8462-6-25.

30. A. Shiell, K. Garvey, S. Kavanagh, V. Loblay, and P. Hawe, “How Do We Fund Public Health in Australia? How Should We?,” *Australian and New Zealand Journal of Public Health* 48, no. 5 (2024): 100187, https://doi.org/10.1016/j.anzjph.2024.100187.

31. Queensland Government, “Townsville Hospital and Health Service Annual Report 2023–2024,” accessed September 9, 2025, Townsville Hospital and Health Service Annual Report Archive.

32. Queensland Government, “Townsville Hospital and Health Service annual report 2023–2024,” accessed September 9, 2025, Townsville Hospital and Health Service Annual Report Archive.

33. Queensland Government, “Central West Hospital and Health Service annual report 2023–2024,” accessed September 9, 2025, Central West Hospital and Health Service Annual Reports.

34. Queensland Government, “Our performance,” accessed September 9, 2025, Queensland Health Performance Portal.

35. Queensland Government, “Strategic workforce planning framework,” accessed September 9, 2025, Strategic Workforce Planning.

36. J. Konkin, L. Grave, E. Cockburn, et al., “Exploration of Rural Physicians' Lived Experience of Practising Outside Their Usual Scope of Practice to Provide Access to Essential Medical Care (Clinical Courage): An International Phenomenological Study,” *BMJ Open* 10, no. 8 (2020): e037705, https://doi.org/10.1136/bmjopen-2020-037705.

37. Queensland Government, “Health service and system planning,” accessed September 9, 2025, Health Service and System Planning.

38. R. B. Hays, P. C. Veitch, B. Cheers, and L. Crossland, “Why Doctors Leave Rural Practice,” *Australian Journal of Rural Health* 5, no. 4 (1997): 198–203, https://doi.org/10.1111/j.1440-1584.1997.tb00267.x.

39. L. K. Walters, M. R. McGrail, D. B. Carson, et al., “Where to Next for Rural General Practice Policy and Research in Australia?,” *Medical Journal of Australia* 207, no. 2 (2017): 56–58, https://doi.org/10.5694/mja17.00216.

40. C. Cosgrave, “The Whole-Of-Person Retention Improvement Framework: A Guide for Addressing Health Workforce Challenges in the Rural Context,” *International Journal of Environmental Research and Public Health* 17, no. 8 (2020): 2698.

41. J. S. Humphreys, *Retention Strategies and Incentives for Health Workers in Rural and Remote Areas: What Works?* (Australian Primary Health Care Research Institute & The Australian National University, 2009).

14401584, 2026, 3, Downloaded from https://onlinelibrary.wiley.com/doi/10.1111/ajr.70214 by National Health And Medical Research Council, Wiley Online Library on [27/05/2026]. See the Terms and Conditions (https://onlinelibrary.wiley.com/terms-and-conditions) on Wiley Online Library for rules of use; OA articles are governed by the applicable Creative Commons License

42. Australian Department of Health and Aged Care, "Single Employer Model (SEM) Trials," accessed September 9, 2025, Single Employer Model (SEM) Trials.

43. H. Ruxtable, *Mid-Term Review of the National Health Reform Agreement Addendum 2020–2025 - Final Report* (Australia Department of Health and Aged Care, 2023).

44. Rural Doctors Association of Australia, "Need more rural doctors? Train more rural doctors," accessed September 9, 2025. RDAA media release (PDF).

45. Australian Department of Health and Aged Care, "Attracting More Doctors to Rural Queensland," accessed September 9, 2025, Attracting More Doctors to Rural Queensland.

46. Government of South Australia, "Three-Year High of Trainee Doctors in Regional South Australia," accessed September 9, 2025, Three-Year High of Trainee Doctors in Regional South Australia.

47. M. Liotta, "RACGP Cautiously Accepts Victorian Single Employer Model," accessed September 10, 2025, RACGP NewsGP article.

Supporting Information

Additional supporting information can be found online in the Supporting Information section. **File 1A** Search strategies, results, and inclusion criteria for health workforce policy documents from the website of the Australian Department of Health and Aged Care. File 1B Search strategies, results, and inclusion criteria for health workforce policy documents from the website of the Queensland Health and Health Workforce Queensland. File 2 Standardised labels for coding health professionals. File 3 Adapted spectrum of policy instruments*. File 4 Adapted glossary of policy sub-types with definitions*. File 5 Policy document search and selection. File 6 Federal rural health workforce policies coded for policy types, document types, profession(s), strategic domains, issuing entity (ies), and years of publication. File 7 Queensland's rural health workforce policies coded for policy types, document types, profession(s), strategic domains, incentive types, issuing entity (ies), and years of publication.

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