

HEALTH WORKFORCE NEEDS ASSESSMENT 2026



phn NORTHERN TERRITORY

An Australian Government Initiative

RURAL Workforce AGENCY NT



ACKNOWLEDGEMENT OF COUNTRY

Northern Territory PHN acknowledges the Traditional Owners of the Country on which we work and live, and recognises their continuing connection to land, waters and community. We pay our respects to Elders past, present and emerging, and to their cultures.

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CEO MESSAGE

I am very pleased to introduce Northern Territory PHN's 2026 Health Workforce Needs Assessment (HWNA).

The Northern Territory's (NT) primary health care workforce is diverse, highly skilled and deeply committed to the communities it serves. This year's HWNA brings together the needs of general practitioners, nurses and midwives, allied health professionals and Aboriginal Health Practitioners across every region of the NT - from Greater Darwin to our most remote communities - into a single, connected assessment of workforce need.

This whole-of-workforce approach gives us a clearer view of the pressures shared across professions and regions, while recognising that workforce experiences and needs are not the same everywhere. What affects a clinician in Greater Darwin can look very different from what affects someone working in a regional town or remote community, and effective workforce planning must reflect that.

What this year's assessment makes clear is that no single intervention will resolve the challenges our workforce faces. Housing, access to leave, professional development, supervision, service capacity and the broader realities of living and working in the Territory all shape whether a clinician stays or leaves, as much as the work itself does. The temptation is always to reach for one lever, more graduates, more incentives, more locums, but the evidence in this report shows that lasting change will come from a coordinated suite of responses, pursued together and matched to the needs of each community and each part of our workforce.

The HWNA 2026 sets out 4 priorities: strengthening access to primary health care; building workforce capability and quality of care; supporting workforce sustainability and future planning; and strengthening Aboriginal and Torres Strait Islander workforce development. Each depends on the others, and none can be delivered by any one organisation alone. Progress will require the active involvement of our health services, education and training partners, communities and governments, working together rather than in parallel.

The report also speaks to the considerable strengths of working in the NT. Health professionals consistently point to the diversity of clinical work, broad scope of practice, professional autonomy, supportive colleagues and the opportunity to build meaningful relationships with patients, communities and cultures. These strengths are a strong foundation, but they need to be matched by practical action on the pressures that affect people's ability to stay and thrive.

What gives me confidence is the dedication of the people across our sector, those already doing the hard work in clinics and communities across the Territory, and those ready to collaborate in new ways to build something more sustainable. This HWNA is not just a picture of where we are. It is a shared foundation for the decisions ahead of us, and for the work of building a stronger, more connected primary health care workforce for the whole of the NT.

I want to thank every individual, service and partner who contributed to this year's assessment. Your honesty, and your willingness to share what is working and what is not, is what makes this report a genuine foundation for action.



Paul Connolly
Chief Executive Officer



EXECUTIVE SUMMARY

The NT Health Workforce Needs Assessment (HWNA) 2026 provides a comprehensive, evidence-informed analysis of current and future primary health care workforce needs across the Territory. Drawing on national datasets, local workforce intelligence, stakeholder consultation, and targeted surveys of both health professionals and services, the assessment identifies key challenges and priority actions required to strengthen the NT health workforce.

The NT presents a uniquely complex workforce environment, where challenges are experienced right across the Territory rather than confined to rural or remote locations. With all the population living in areas classified as regional, rural or remote (MMM 2–7)*, workforce demand is shaped not only by population size but by geographic dispersion, a high burden of chronic and complex disease, and the need to deliver culturally responsive care across diverse communities. These pressures are often compounded by broader rural health funding inequities. Findings from the National Rural Health Alliance estimate an annual healthcare spending shortfall of approximately $1,090 per rural Australian, increasing to around $4,701 per person in MMM 5–7 areas compared with metropolitan regions[1]. These funding gaps contribute to reduced access to preventive and primary care, increased service demand and poorer health outcomes, including higher rates of chronic disease, hospitalisation and premature death. These factors result in significantly higher service and workforce requirements that are not fully captured in national datasets. In particular, data limitations relating to outreach, locum, visiting and grant-funded service delivery models mean that workforce activity in the NT is often underrepresented, highlighting the need for locally informed workforce planning.

Persistent workforce shortages and maldistribution continue to limit access to primary health care services across the NT. Services use a mix of delivery models, including General Practitioner (GP)-led, nurse-led, multidisciplinary, outreach and telehealth approaches. However, ongoing workforce constraints mean services are not consistently able to meet community needs. Access remains impacted by limited after-hours availability, affordability barriers, and critical infrastructure challenges such as workforce housing and digital connectivity. In many regions, reliance on locum and fly-in fly-out workforce models remains necessary but contributes to reduced continuity of care, ongoing service instability and significant cost.

Workforce capability and quality of care are closely linked to the availability of appropriate support structures, particularly in remote settings where clinicians are required to operate across extended scopes of practice. Challenges include limited access to supervision, mentoring, clinical governance, and structured orientation, as well as gaps in culturally safe training. Strengthening multidisciplinary models of care and supporting expanded and flexible scopes of practice are essential to improving both service quality and responsiveness to community need.

Sustainability of the health workforce remains a high priority. High turnover, workforce fatigue, and an ageing workforce contribute to ongoing instability, particularly in rural and remote communities. Recruitment alone is insufficient to address these challenges without a parallel focus on retention, workforce wellbeing, leadership development, and succession planning. These issues are further heightened by thin labour markets, service challenges, and complex funding arrangements that limit the ability of services to maintain a stable workforce.

* MMM: Modified Monash Model assists in distribution of the health workforce in rural and remote areas

Strengthening the Aboriginal and Torres Strait Islander health workforce is central to improving health outcomes and delivering culturally safe and appropriate care. While there is strong recognition of its importance, significant gaps remain in workforce pathways, retention, and career progression. Addressing these challenges requires continued investment in locally led workforce development, culturally safe supervision and education models, and the embedding of Aboriginal leadership and governance across workforce planning and service delivery.

Sustained workforce improvements depend on stronger data and planning, including:

- an NT-specific minimum data set
- improved housing and digital connectivity
- expanded local education and training pathways
- innovative and multidisciplinary models of care
- better coordination across Commonwealth and Territory programs.

Building a stable, skilled and local workforce requires a coordinated, long-term approach that extends beyond recruitment to strengthen retention and workforce development.



ABOUT US

The Northern Territory Primary Health Network (NT PHN) incorporating Rural Workforce Agency NT (RWA NT), plays a central role in supporting, strengthening and sustaining the rural and remote primary health care workforce across the Territory.

As the designated Rural Workforce Agency, NT PHN incorporating RWA NT works to address workforce shortages, maldistribution and capability gaps in some of Australia's most remote and diverse regions.

NT PHN delivers the Primary Care Workforce Support Program (PCWSP) alongside a broader suite of workforce development, planning and support programs. These programs are designed to support the workforce across the full lifecycle, including attraction and recruitment, professional development, supervision, retention and long-term workforce sustainability. Together, they provide a coordinated, place-based approach to workforce support that responds to both immediate service pressures and longer-term challenges.

In addition to program delivery, NT PHN incorporating RWA NT plays an important role in workforce policy, strategy and advocacy. This includes working with primary health service providers, professional bodies and government partners to identify systemic barriers and advocate for workforce solutions that reflect the unique operating environment of the NT.

BACKGROUND

Primary health care plays a critical role in improving health outcomes in the NT, particularly given the Territory's high rates of chronic disease, geographic remoteness and dispersed population.

The availability, stability and capability of the primary health care workforce directly determine whether communities can access timely, continuous and culturally safe care. A commitment to strengthening the workforce is central to improving access, quality and sustainability across the NT health system.

The NT Health Workforce Needs Assessment (HWNA) 2026 has been developed to support workforce planning, investment decisions and policy advocacy by providing a shared, evidence-informed understanding of workforce need across the Territory. It recognises that workforce challenges in the NT are shaped by many factors that differ to other parts of Australia and cannot be fully understood through national data alone.

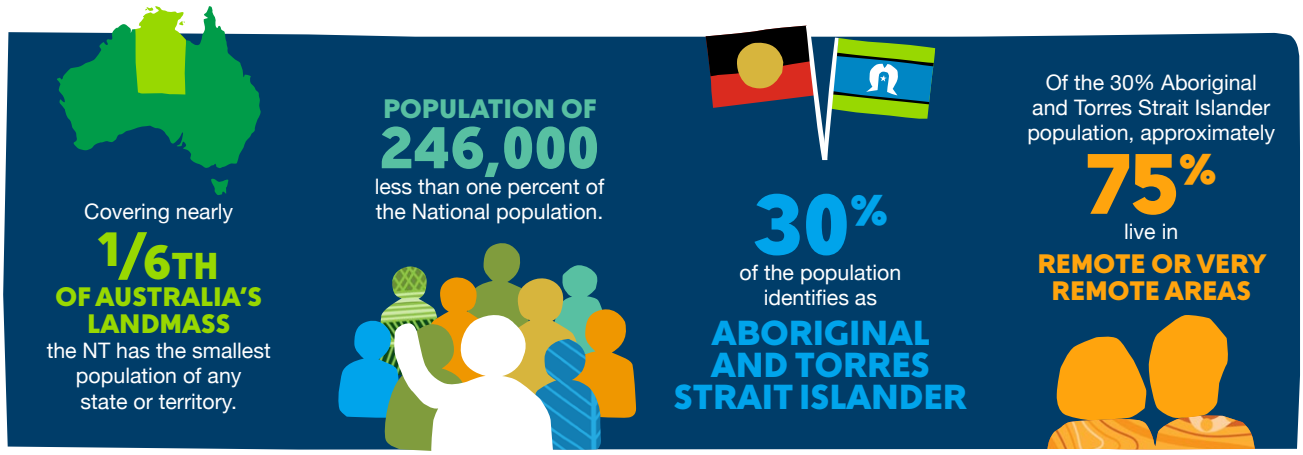
The NT experiences some of the most significant health challenges in Australia. Life expectancy remains the lowest nationally and, while outcomes have improved over time, substantial disparities persist, particularly for Aboriginal and Torres Strait Islander people[2]. Higher rates of chronic disease, multimorbidity and potentially preventable hospitalisations reinforce the importance of strong, accessible and culturally responsive primary health care, especially in rural and remote settings[3,4,5].

Despite covering nearly one-sixth of Australia's landmass, the NT has the smallest population of any state or territory (n= 246,000), accounting for less than one percent of the National population. Around 30 percent of the population identifies as Aboriginal and Torres Strait Islander, with approximately 75 percent living in remote or very remote areas[6]. While most Territorians live in the Greater Darwin Region, around 40 percent reside in locations classified as MMM 6 and 7.[6,7] This highly dispersed population presents ongoing challenges for workforce distribution, service viability and continuity of care.

Geography and isolation further compound workforce pressures. Large distances, limited road access and seasonal disruption mean that many communities are accessible only by air or unsealed roads for parts of the year. Health professionals working in these environments frequently experience professional isolation, limited infrastructure and high workload demands, contributing to high turnover and reliance on short-term workforce arrangements.

Taken together, these factors mean that workforce requirements in the NT are greater than national population-based ratios alone would suggest. Understanding workforce need requires a place-based approach that considers service models, community infrastructure and readiness, workforce stability, supervision capability and long-term sustainability of care.

This report focuses on the NT primary health care workforce, including GPs, nurses and midwives, allied health professionals and Aboriginal Health Practitioners and Aboriginal Health Workers. It examines workforce needs across regional, rural and remote settings and across different service delivery models. To capture the complexity of workforce delivery in the NT, the HWNA adopts a mixed-methods approach that integrates national workforce data with NT-specific survey findings, service-level intelligence and stakeholder consultation.



WHY A PLACE-BASED APPROACH IS NEEDED

National population-based workforce ratios underestimate workforce need in the NT and do not capture service fragility, turnover, or reliance on visiting and short-term workforce models.

Research methods

The assessment has used quantitative and qualitative data sources to provide a comprehensive and contextualised understanding of workforce supply, distribution, capability and emerging pressures. Targeted data collection and analysis were undertaken between September 2025 to February 2026 and informed by ongoing engagement with the NT primary health care sector.

Data sources

The HWNA draws on 4 primary sources of evidence:

National workforce data

National datasets were used to provide high-level information on workforce supply, distribution and trends over time. These datasets support broad comparisons and contextual analysis but are limited in their ability to capture workforce turnover, service viability, supervision capacity and reliance on short-term workforce models in the NT context. These limitations are outlined further in the workforce data section.

NT-specific workforce data and intelligence

Where available, NT-specific datasets and service-level information were used to supplement national data and provide more granular insight into regional workforce pressures, service delivery models and workforce stability.

HWNA workforce surveys

Targeted surveys were conducted with primary health care professionals and health service providers across the NT. The surveys collected information on workforce capacity, recruitment and retention challenges, workload and wellbeing, supervision and professional development, and service sustainability. Survey responses were analysed thematically and quantitatively to identify cross-cutting issues and profession-specific pressures.

Stakeholder consultation and governance

Qualitative input was gathered through consultations with health services, professional groups and sector stakeholders, including the Health Workforce Stakeholder and Advisory Group (HWSAG). These discussions were used to validate findings, provide local context and identify emerging issues not captured through quantitative data alone.

Our approach

Analysis focused on identifying workforce pressures and risks across 3 key dimensions:

- access to care
- quality of care
- sustainability of services.

Findings were examined by profession, region and service delivery model to reflect the diversity of operating contexts across the NT.

Rather than relying on workforce numbers alone, the assessment considers factors such as workforce stability, turnover risk, supervision capacity, training pipelines, service viability and broader workforce enablers, including housing availability, family and community supports, and local infrastructure. This approach enables the HWNA to identify priority areas for action that are both evidence-informed and responsive to the realities of workforce delivery in the NT.

Governance and validation

The HWNA was developed with oversight of NT PHN incorporating RWA NT with guidance from sector stakeholders. Draft findings were reviewed and validated through established governance and advisory processes to ensure accuracy, relevance and alignment with sector experience.

WORKFORCE DATA: TERRITORY SNAPSHOT

The following section presents an overview of workforce supply and distribution using the most recent National Health Workforce Dataset (2024). It provides a high-level picture of workforce patterns across the NT, rather than a definitive measure of workforce adequacy or service capacity.

Table 1. Health workforce in the NT, by profession and Modified Monash Model location

Professions	Year	MMM 2	MMM 5	MMM 6	MMM 7	Total
Aboriginal and Torres Strait Islander Health Practitioners	2024	52	0	50	43	**145**
Chiropractors	2024	20	0	5	0	**25**
Chinese medicine practitioners	2024	6	0	5	0	**11**
Dental practitioners	2024	103	0	27	0	**132**
Medical practitioners	2024	915	0	298	98	**1,312**
Medical radiation practitioners	2024	98	0	26	4	**128**
Nurses and midwives	2024	2,750	10	1,070	387	**4,217**
Occupational therapists	2024	170	0	42	5	**217**
Optometrists	2024	29	0	9	0	**38**
Osteopaths	2024	5	0	0	0	**5**
Pharmacists	2024	156	0	35	7	**199**
Physiotherapists	2024	181	0	51	12	**244**
Podiatrists	2024	20	0	8	0	**28**
Paramedicine practitioners	2024	146	0	60	13	**219**
Psychologists	2024	158	3	34	6	**199**
Total	**2024**	**4,809**	**14**	**1,720**	**576**	**7,119**

Source: National Health Workforce Dataset (NHWDS).

Data considerations

Having accurate workforce data is essential for health service planning in the NT. National workforce datasets provide important information on workforce supply, distribution and broad trends over time; however, their application in the NT context requires careful interpretation.

In rural and remote NT settings, national datasets do not consistently capture the full range of workforce models used to deliver primary health care. Locums, agency staff, fly-in fly-out (FIFO) and visiting health professionals play a significant role in service delivery across the Territory, yet their contribution is not always reflected in workforce collections. Similarly, Medicare data, commonly used to assess GP workforce supply, has limited applicability in communities where services are funded primarily through grant-based arrangements rather than fee-for-service models.

Workforce data challenges are more common in remote and Aboriginal health services, where funding models, service configuration and workforce availability vary across locations. High levels of workforce mobility and turnover also affect the reliability of point-in-time datasets and limit their usefulness for forecasting future workforce needs in isolation.

Allied health workforce data presents additional challenges. Access to timely and comprehensive information remains limited, constraining visibility of workforce distribution, capability and emerging shortages across disciplines. Delays in the release of national workforce datasets and the absence of regulatory data for some allied health professions further affect workforce planning. In the absence of a standard definition for what professions are grouped under the allied health umbrella in national or international literature, NT PHN has reviewed and localised a list of priority professions (refer to appendix A).

Aboriginal data sovereignty underpins NT PHN's approach to workforce and health data collection and use. Data practices are guided by Indigenous knowledge systems and Indigenous data sovereignty principles, ensuring strengths-based interpretation and appropriate governance, use and sharing of information relating to the Aboriginal and Torres Strait Islander workforce. Ongoing work to strengthen data sharing frameworks will further enhance the accuracy, relevance and cultural integrity of workforce planning across the Territory.

For these reasons, this HWNA uses a needs-based lens that considers disease burden, service demand, cultural and geographic context, and the social and infrastructure conditions required to support a stable workforce, rather than relying on population-based workforce ratios alone.





SURVEY RESPONDENTS BY CATCHMENT



HWNA SURVEY RESULTS

To complement the national workforce data and address the limitations outlined above, the following section presents findings from the HWNA workforce surveys. These results provide NT-specific insights.

Survey findings should be interpreted in the context of respondent coverage. While the surveys provide valuable insight into workforce experiences and pressures, they represent a subset of the NT primary health care workforce and may not fully reflect the views or circumstances of all health professionals. Survey results were informed and validated through qualitative input where possible. In total, the HWNA received just under 300 health professional responses and close to 60 service providers participated in the survey and/or consultation.

At a glance

GENERAL PRACTITIONER (GP)

Workforce demographics

Gender

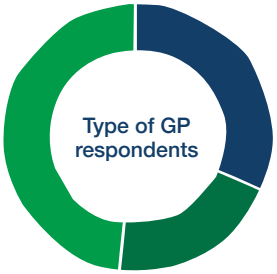
- Female **66.6%**
- Male **31.6%**
- Prefer not to say **1.8%**

Identify as Aboriginal and Torres Strait Islander

- No **96.4%**
- Both Aboriginal and Torres Strait Islander **1.8%**
- Prefer not to say **1.8%**

Age group

- < 25 **0%**
- 25–34 **19.3%**
- 35–44 **28.1%**
- 45–54 **14.0%**
- 55–64 **24.6%**
- > 65 **14.0%**



- GP registrar 31.6%
  (44.4% IMG; 44.4% ATD and 11.1% unspecified)
- GP supervisor 21%
  (Note: all also VR GPs)
- VR-GP 47.4%



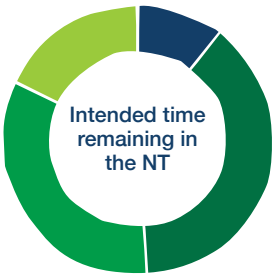
- < 1 year 15.8%
- 1–3 years 22.8%
- 3–5 years 5.3%
- 5–10 years 15.8%
- > 10 years 40.4%

ATD - Australian Trained Doctor
IMG - International Medical Graduate
VR GP - Vocationally Registered
Non-VR GP - Non -Vocationally Registered General Practitioner

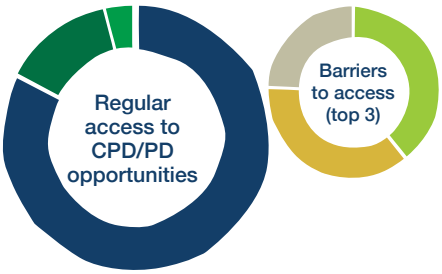
Workforce experience, development and retention



- < 6 months 7%
- 6–12 months 7%
- 1–2 years 28.1%
- 3–5 years 15.8%
- > 5 years 26.3%
- Undecided 15.8%



- For the next 12 months 11%
- For the next 2-5 years 38.6%
- Longer term 33.3%
- Unsure 17.5%



- Yes 82.5%
- No 14%
- Unsure 3.5%
- Lack of time 40.4%
- Travel distance 36.8%
- Cost 24.6%



- Yes, and it is provided 80.7%
- Yes, but not provided 3.5%
- No 10.5%
- Unsure 5.3%



- Very confident or confident on cultural awareness 75%
- Working to full scope (Yes) 73.7%
- Receive adequate supervision 81.1%
- Satisfied with supervision (very or somewhat satisfied) 80%
- Dissatisfied with supervision 8%

NURSING AND MIDWIFERY

Workforce demographics

Gender

Female **92.5%**

Male **6.25%**

Prefer not to say **1.25%**

Identify as Aboriginal and Torres Strait Islander

No **92.4%**

Aboriginal only **5.1%**

Prefer not to say **2.5%**

Age group

< 25 **1.3%**

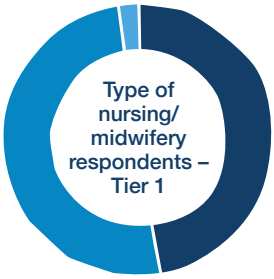
25–34 **23.8%**

35–44 **27.5%**

45–54 **25.0%**

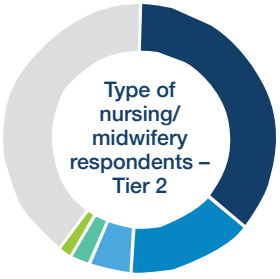
55–64 **13.7%**

> 65 **8.7%**



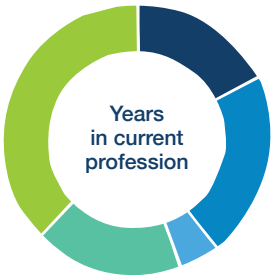
Tier 1 – Base qualification

- Registersed Nurse (RN) 47.5%
- Registered Nurse (RN) with additional scope 50%
- Enrolled Nurse (EN) 2.5%



Tier 2 – Extended scope/ specialised endorsement (held on top of RN qualification)

- Remote Area Nurse 35.0%
- Midwife 15.0%
- Child Health Nurse 5.0%
- Nurse Practitioner 2.5%
- Diabetes Educator 1.3%

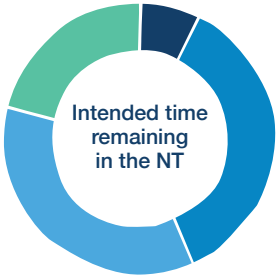


- < 1 year 17.5%
- 1–3 years 22.5%
- 3–5 years 5.0%
- 5–10 years 17.5%
- > 10 years 37.5%

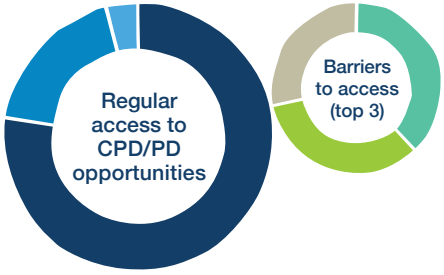
Workforce experience, development and retention



- < 6 months 12.5%
- 6–12 months 10%
- 1–2 years 25%
- 3–5 years 18.8%
- > 5 years 16.2%
- Undecided 17.5%



- For the next 12 months 7.5%
- For the next 2-5 years 36.3%
- Longer term 35%
- Unsure 21.2%



- Yes 77.5%
- Unsure 3.7%
- No 18.8%
- Lack of time and backfill staff not available 43.8%
- Limited availability of relevant training 38.8%
- Travel distance 32.5%



- Yes, and it is provided 86.3%
- Yes, but not provided 11.2%
- No 2.5%
- Unsure 0%



- Very confident or confident on cultural awareness 74.4%
- Working to full scope (Yes) 60%
- Receive adequate supervision 50.7%
- Satisfied with supervision (very or somewhat satisfied) 78.1%
- Dissatisfied with supervision 9.4%

ALLIED HEALTH

Workforce demographics

Gender

Female **82%**

Male **16.6%**

Non-Binary **1.4%**

Identify as Aboriginal and Torres Strait Islander

No **95.7%**

Aboriginal only **3.6%**

Prefer not to say **0.7%**

Age group

< 25 **4.3%**

25–34 **41.7%**

35–44 **29.5%**

45–54 **11.5%**

55–64 **12.3%**

> 65 **0.7%**



- Occupational therapist 18.0%
- Physiotherapist 16.6%
- Social worker 11.5%
- Speech pathologist 9.4%
- Pharmacist 7.9%
- Psychologist 7.9%
- Podiatrist 5.8%
- Counsellor 5.0%
- Exercise physiologist 4.3%
- Dietitian 1.5%
- Oral health (dental assistant, oral health therapist) 1.4%
- Chiropractor 0.7%
- Allied health assistant 0.7%
- Optometrist 0.7%
- Other 8.6%

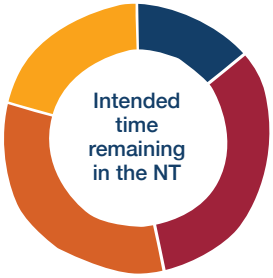


- < 1 year 10.8%
- 1–3 years 23.7%
- 3–5 years 18%
- 5–10 years 14.4%
- > 10 years 33.1%

Workforce experience, development and retention

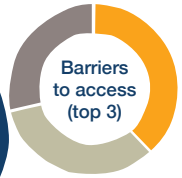


- < 6 months 7.2%
- 6–12 months 17.3%
- 1–2 years 23%
- 3–5 years 18.7%
- > 5 years 21.6%
- Undecided 12.2%



- For the next 12 months 14.4%
- For the next 2–5 years 31.7%
- Longer term 33.8%
- Unsure 20.1%





- Yes 74.1%
- No 15.8%
- Unsure 10.1%
- Cost 54.7%
- Travel distance 48.2%
- Lack of time 41.7%



- Yes, and it is provided 85.6%
- Yes, but not provided 7.2%
- No 4.3%
- Unsure 2.9%



- Very confident or confident on cultural awareness 73.6%
- Working to full scope (Yes) 62.6%
- Receive adequate supervision (Yes answer + remove responses for N/A to supervision) 77%
- Satisfied with supervision (very or somewhat satisfied) 90.2%
- Dissatisfied with supervision 3.3%



ABORIGINAL HEALTH PRACTITIONER AND ABORIGINAL HEALTH WORKER

Workforce demographics

Gender

Female **87.5%**

Male **12.5%**

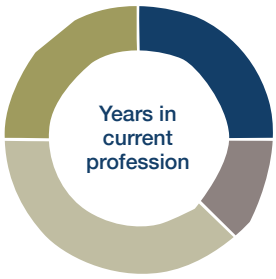
Identify as Aboriginal and Torres Strait Islander

Both Aboriginal and Torres Strait Islander **25%**

Aboriginal only **75%**

Age group

< 25 **0%**	25–34 **12.5%**
35–44 **50%**	45–54 **25%**
55–64 **12.5%**	> 65 **0%**



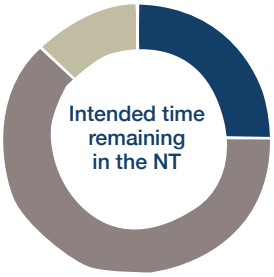
- < 1 year 0%
- 1–3 years 25%
- 3–5 years 12.5%
- 5–10 years 37.5%
- > 10 years 25%



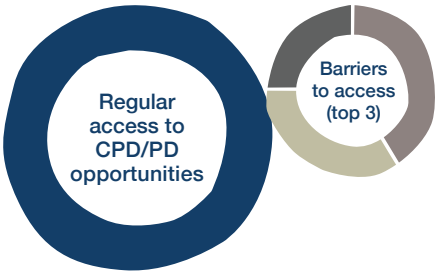
Workforce experience, development and retention



- < 6 months 12.5%
- 6–12 months 25.0%
- 1–2 years 0.0%
- 3–5 years 12.5%
- > 5 years 25.0%
- Undecided 25.0%



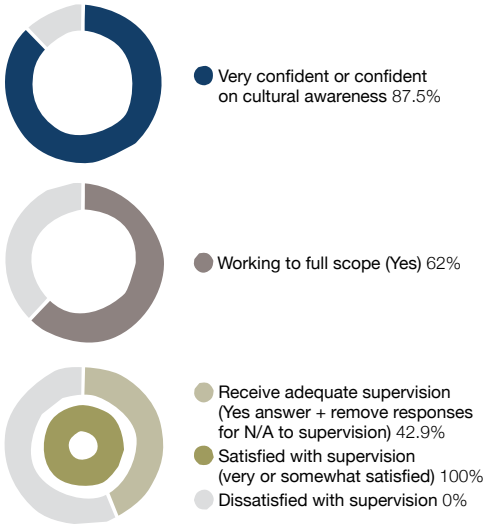
- For the next 12 months 0.0%
- For the next 2–5 years 25.0%
- Longer term 62.5%
- Unsure 12.5%



- Yes 100%
- No 0%
- Unsure 0%
- Lack of time 62.5%
- Backfill of staff not available 50%
- Travel distance 37.5%



- Yes, and it is provided 87.5%
- Yes, but not provided 12.5%
- No 0%
- Unsure 0%



- Very confident or confident on cultural awareness 87.5%
- Working to full scope (Yes) 62%
- Receive adequate supervision (Yes answer + remove responses for N/A to supervision) 42.9%
- Satisfied with supervision (very or somewhat satisfied) 100%
- Dissatisfied with supervision 0%

TOTAL WORKFORCE OVERVIEW

Current health workforce professional development needs according to survey respondents.

Most health professionals reported positive experiences across cultural awareness, supervision and working to their full scope of practice.

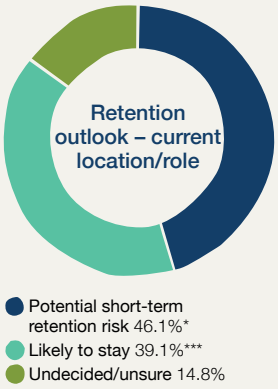
74.5%
confident or very confident in their cultural awareness

65.8%
working to their full scope

69.1%
receiving adequate supervision

66.4%
satisfied with supervision among respondents receiving it





* Planning to remain in their current location for two years or less. ** Planning to remain in the NT for the next 12 months. *** Planning to remain in their current location for three years or more. **** Planning to remain in the NT for 2–5 years or longer term.



46.1%
plan to remain in their current location for two years or less,
indicating potential short-term retention challenges for local services.



69.0%
plan to remain in the NT for two years or longer,
suggesting stronger retention intentions across the Territory overall.

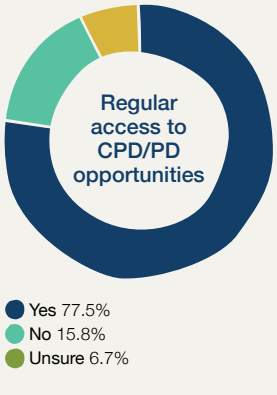
Access to regular professional development opportunities

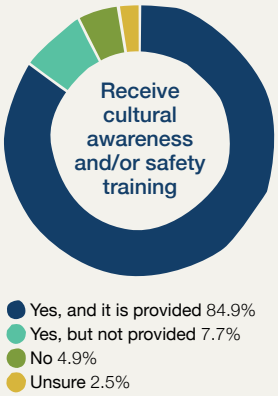
Most respondents (77.5%) reported having regular opportunities to access continuing professional development.

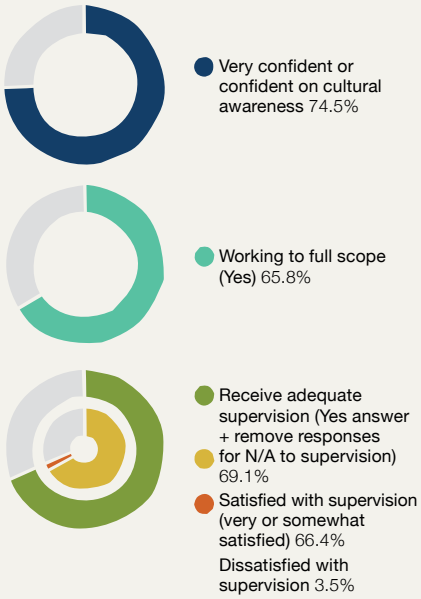
Receives cultural awareness and/or safety training

Most respondents (84.9%) reported that cultural awareness or safety training was available and provided.

Most respondents reported positive experiences of supervision and working to their full scope of practice.







Personal wellbeing and work-life balance

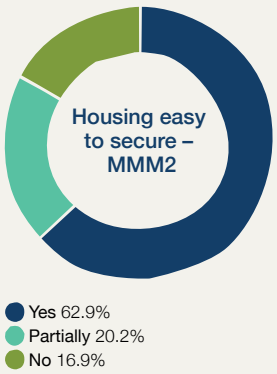
This section explores respondents' personal wellbeing and living conditions, including experiences of burnout, access to leave, wellbeing supports and housing. These factors can influence quality of life and the ability to remain working in the NT.

Metric	GP	Nurse/ midwives	Allied health	AHP and AHW	Total workforce
Housing easy to secure (yes)	64.9%	63.8%	57.6%	50%	60.6%
Observed colleagues leave (over last 2 years)	80.7%	92.5%	92.8%	87.5%	90.1%
Burnout (occasional + frequent)	70.2%	75%	75.6%	100%	75%

Across the total health workforce survey sample, 75% of respondents reported experiencing burnout or high levels of stress either occasionally or frequently in their current role, underscoring workload and wellbeing as significant workforce sustainability risks.

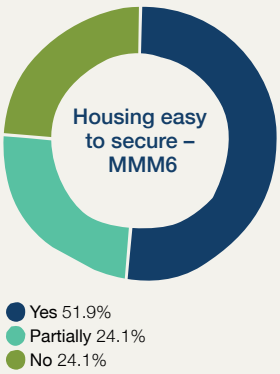
Housing access by remoteness (MMM 2-7)

Housing access was most difficult in MMM 6, where 48.2% reported that housing was only partially easy or not easy to secure. While MMM 7 respondents reported the highest level of access, qualitative feedback indicated this often relied on employer or partner-provided accommodation, masking limited private housing options in remote areas.



Reason:

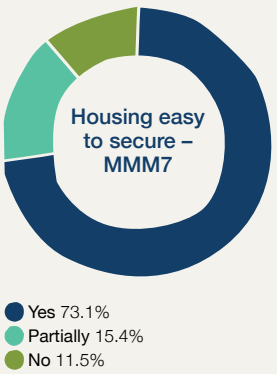
Housing access in MMM 2 was mainly affected by high costs, limited rental availability and strong competition. Respondents also reported difficulty finding suitable short-term, pet-friendly or family housing, with some relying on shared or temporary accommodation



Reason:

Housing access in MMM 6 was affected by high rental costs, limited availability and strong competition.

Respondents also raised concerns about safety and housing quality, with some relying on employer support, personal connections or temporary accommodation to secure housing.



Reason:

Housing access in MMM 7 often depended on accommodation provided through an employer or partner.

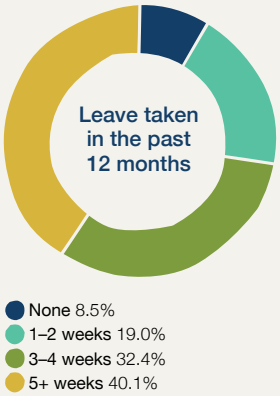
Limited staff housing, variable quality, high costs and unsuitable accommodation for families or pets remained key concerns.

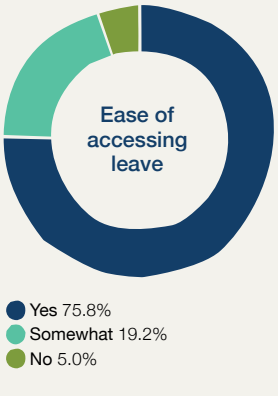
75% of respondents reported experiencing burnout or high levels of stress either occasionally or frequently in their current role, underscoring workload and wellbeing as significant workforce sustainability risks

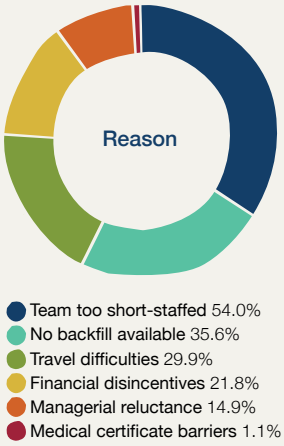
Leave taken and ease of access - whole workforce

Most respondents (72.5%) had taken 3 or more weeks of leave during the previous 12 months, while 8.5% reported taking no leave. Among respondents who took leave, 75.8% reported that it was easy to access.

For respondents who took no leave or reported that leave was only somewhat easy or not easy to access, staffing pressures were the main barriers:







*Respondents could select more than one reason

Wellbeing supports

Respondents were asked what mental health or wellbeing supports would be most helpful to them:

Theme	Examples raised by respondents
Flexible work and time away	Mental health days, registered days off, easier access to leave, time off in lieu, flexible hours and working from home.
Professional mental health support	Affordable counselling and psychology, expanded employee assistance program sessions, face-to-face services and after-hours access.
Peer and professional connection	Peer networks, clinical supervision, mentoring and regular debriefing.
Workforce capacity and manageable workloads	Additional staff, backfill, reduced caseloads and less on-call work.
Physical health and wellbeing initiatives	Subsidised gym access, exercise, yoga, mindfulness and wellbeing allowances.
Supportive leadership and management	Regular check-ins, recognition, communication and action on staff concerns.

*Respondents highlighted the need for practical and preventative wellbeing supports, including flexible work and time away, accessible professional mental health care, peer support and supervision, and adequate staffing to manage workloads.

Drivers of workforce satisfaction and retention

Respondents were asked to identify what they liked most and least about their current role and location, and what factors would most influence a decision to stay or leave. In addition, respondents were asked to identify the main reasons they had observed colleagues leaving their workplace over the past two years. Respondents could select multiple reasons.

The most frequent observed reasons for colleagues leaving were:



54.9%
Relocation for lifestyle or personal goals



46.8%
Burnout or mental health



38.0%
Poor management or leadership



34.2%
Better pay or conditions elsewhere



28.2%
Family or partner employment changes



25.4%
Career advancement



23.2%
Lack of support or supervision

These findings suggest that workforce attrition reflects both organisational pressures and personal or family considerations. Addressing burnout, leadership quality and employment conditions must occur alongside strategies that support family stability and community integration to strengthen long-term retention.

Positive drivers

Survey respondents were asked what aspects of their roles contribute most to a positive workforce experience in the NT. Several consistent drivers emerged across all professions.

Positive driver	% of respondents
Diverse and interesting clinical work	60.6%
Scope of practice (ability to use a wide range of skills)	55.6%
Team environment and supportive colleagues	54.2%
Opportunities to build meaningful relationships with patients/clients	53.2%
Cultural learning and working with Aboriginal and Torres Strait Islander communities	48.9%
Professional autonomy and responsibility	47.9%
Lifestyle benefits (nature, outdoors, slower pace and cultural richness)	42.6%
Strong sense of community	39.1%

Retention risks and workforce pressures

The most commonly reported challenges related to workforce shortages, geographic distance from family and support networks, and the structural realities of delivering health services across remote and regional settings.

Workforce pressure	% of respondents
Staff shortages and high turnover	55.6%
Distance from family and friends	47.2%
Burnout risk and work–life balance challenges	44.4%
Long waitlists and high service demand	34.9%
Lack of resources, equipment or infrastructure	26.8%
Cost of living and housing availability	26.4%
Safety and security concerns	25.0%
Professional isolation or lack of peer support	20.4%
Limited access to training, supervision or career development	19.4%
Limited schooling or education options for children	8.8%
Travel requirements: fly-in fly-out (FIFO), drive-in drive-out (DIDO) or other long-distance travel	7.4%

Workforce support needs identified through the HWNA survey

Rank	GP	Nursing/midwifery	Allied health	AHP
1	CPD 40.4%	CPD 52.5%	CPD 51.8%	Recognition of remote skillsets 75.0%
2	Clinical supervision 36.8%	Clinical supervision 36.2%	Management/ leadership training 38.8%	CPD 62.5%
3	Peer networks 36.8%	Management/ leadership training 35.0%	Recognition of remote skillsets 33.8%	Clinical supervision 50.0%
4	Access to locums/relief 31.6%	Recognition of remote skillsets 30.0%	Peer networks 33.1%	Management/ leadership training 37.5%
5	Management/ leadership training 26.3%	Peer networks 30.0%	Support with housing/ accommodation 26.6%	Peer networks, housing support and access to locums (each) 25.0%

Top 5 support needs - total workforce

Rank	Support need	%	Evidence from survey responses
1	Continuing professional development	50.0%	Top-ranked need overall. Demand for accessible, role-relevant CPD aligned to rural and remote practice
2	Management or leadership training	35.2%	Increasingly important for clinicians in small teams where leadership and coordination responsibilities are often implicit.
3	Peer networks	32.7%	Important for reducing isolation and supporting complex clinical decision-making.
4	Recognition of remote skillsets	32.0%	Reflects the complexity of NT roles and the need for career recognition and progression pathways.
5	Clinical supervision or mentoring	31.7%	Particularly important for remote practice, early-career clinicians and sole practitioner roles.

Workforce satisfaction drivers and retention risk by profession

Profession	Top satisfaction driver	Key retention risk	Top support need
General Practitioners	Diverse and interesting clinical work (73.7%)	Staff shortages and high turnover (57.9%)	Continuing professional development (40.4%)
Nursing and Midwifery	Scope of practice (58.8%)	Staff shortages and high turnover (55.0%)	Continuing professional development (52.5%)
Allied Health	Team environment and supportive colleagues (64.0%)	Staff shortages and high turnover (54.0%)	Continuing professional development (51.8%)
Aboriginal Health Practitioners	Scope of practice (62.5%)	Staff shortages and high turnover (75.0%)	Recognition of remote skillsets (75.0%)

Key insight

Professional satisfaction is shaped by clinical scope, autonomy and meaningful patient relationships, but retention risks are driven by system-level pressures. Across all professions, staff shortages and workforce instability were the most significant challenges, felt most acutely by Aboriginal Health Practitioners.

Support needs also diverge from the norm: while CPD leads overall, Aboriginal Health Practitioners are the only profession ranking recognition of remote skillsets above CPD.

This points to a need for coordinated, cross-profession strategies on staffing and workload, alongside profession-specific responses where the evidence shows a distinct pattern.

Health workforce experience in the NT

Across professions, many highlighted the breadth and complexity of clinical practice, opportunities for professional autonomy and the ability to deliver meaningful care to communities with high levels of need. Health professionals frequently described strong professional satisfaction derived from practising across an expanded scope, building long-term relationships with patients and contributing to improved health outcomes for Aboriginal and Torres Strait Islander communities.

At the same time, respondents identified several structural pressures affecting workforce sustainability. Workforce shortages, limited access to locum relief and reliance on small teams were reported to contribute to heavy workloads and reduced leave capacity. Professional isolation, particularly in regional and remote settings, was also frequently identified alongside administrative burden, fragmented referral pathways and system coordination challenges.

Housing availability, travel requirements and distance from family were also noted as factors influencing both workforce attraction and longer-term retention.

Overall, survey findings found that while many clinicians value the professional opportunities offered in the NT, workforce sustainability depends on strengthening supervision structures, workforce depth and system-level support.

Key workforce experience themes

Health professionals working in the Northern Territory reported:

- broad scope of practice and professional autonomy
- meaningful relationships with patients and communities
- opportunities for cultural learning and engagement
- high workload and workforce shortages
- professional isolation in remote settings
- limited access to locum relief and supervision.

These themes were consistent across the whole primary health care workforce.



Workforce experience by profession



Attractions to NT practice:

- Broad scope of clinical practice and professional autonomy.
- Opportunity to deliver comprehensive, community-based care.
- Meaningful long-term relationships with patients and communities.

Key workforce pressures:

- Fragility of small practice teams.
- Limited locum availability and workforce relief.
- Administrative burden and coordination challenges across the health system.

Supports identified:

- Reliable access to locum relief.
- Peer support and clinical supervision networks.
- Recognition of advanced rural and remote practice skillsets.



Attractions to NT practice:

- Community-focused care and strong patient relationships.
- Opportunities to practise across a broad clinical scope.
- Meaningful work supporting Aboriginal and Torres Strait Islander health.

Key workforce pressures:

- Workforce shortages and high turnover.
- Professional isolation in remote settings.
- Limited access to structured supervision and training.

Supports identified:

- Clinical supervision and mentoring.
- Continuing professional development aligned to remote practice.
- Structured onboarding and transition support.



Attractions to NT practice:

- Opportunities to practise across expanded scopes.
- Diverse and complex caseloads.
- Multidisciplinary collaboration and professional growth.

Key workforce pressures:

- High demand and extended waiting lists.
- Sole practitioner roles and small teams.
- Administrative and funding complexity.

Supports identified:

- Discipline-specific CPD and supervision.
- Peer networks and mentoring opportunities.
- Increased workforce depth and administrative support.



Attractions to NT practice:

- Strong connection to community and culturally grounded care.
- Opportunity to improve health outcomes for Aboriginal communities.
- Central role within multidisciplinary primary health care teams.

Key workforce pressures include:

- Limited access to structured supervision and mentoring.
- Workforce shortages and workload pressures in small teams.
- Housing and accommodation challenges in some communities.

Supports identified:

- Clinical supervision and culturally appropriate mentoring.
- Professional development and career progression opportunities.
- Recognition of advanced remote practice skillsets.

Variation within the allied health workforce

While several common themes emerged across allied health responses, survey findings showed important differences in how workforce pressures are experienced between professional groups.

Rehabilitation and therapy disciplines

(Occupational therapy, physiotherapy, exercise physiology, speech pathology, podiatry, chiropractic)

Therapy and rehabilitation-focused disciplines consistently described demand-driven pressures associated with chronic disease, disability and ageing populations.

Key challenges reported include:

- high caseload volumes and extended waiting lists
- increasing NDIS-related demand and reporting requirements paired with decreasing funding
- travel requirements and outreach models reducing available clinical time
- administrative complexity associated with funding and compliance requirements
- working as sole practitioners or within very small teams.

Respondents emphasised the need for increased staffing levels, clearer referral pathways, improved administrative support and recognition of advanced rural generalist skillsets.

Mental health and psychosocial disciplines

(Psychologists, counsellors, social workers, alcohol and other drug workers)

Mental health professionals described a different profile of workforce pressure. While demand was also high, the dominant pressures related to clinical complexity and emotional workload.

Key issues identified include:

- high acuity presentations and trauma-informed care requirements
- cumulative emotional burden and increased burnout risk
- fragmented referral pathways across health, housing, justice and social services
- limited specialist escalation pathways in regional and remote areas.

Respondents emphasised the importance of structured clinical supervision, regular peer debriefing and access to cultural safety training.

Oral health and dentistry

(Dentists, oral health therapists)

Oral health professionals described persistent unmet need, particularly in regional and remote communities where workforce distribution remains uneven.

Key pressures reported include:

- long waiting periods for public dental services
- workforce shortages outside Darwin
- travel requirements associated with outreach service delivery
- infrastructure and equipment constraints in smaller clinics.

Respondents highlighted the importance of stable staffing models and improved regional workforce distribution.

Pharmacy

Key workforce pressures include:

- expanding scope of practice expectations
- increasing complexity of medication management for ageing and multimorbid populations
- workforce shortages in rural and remote communities
- growing regulatory and administrative requirements.

Community pharmacists in smaller towns also highlighted challenges related to business sustainability and workforce recruitment.

Cross-discipline insight

Across professions, workforce sustainability is shaped by both shared infrastructure challenges and discipline-specific pressures.

Key highlights include:

- general practice and nursing respondents emphasised workforce shortages and workload pressures
- Aboriginal Health Practitioners highlighted the importance of culturally safe workplaces and recognition of advanced remote practice roles
- rehabilitation disciplines primarily reported capacity and logistics pressures
- mental health disciplines emphasised emotional sustainability and supervision needs
- oral health and pharmacy highlighted workforce distribution and service viability challenges.

These findings reinforce the need for workforce strategies that strengthen shared professional infrastructure, including supervision, workforce depth, service coordination and workforce relief, while also addressing discipline-specific pressures across different parts of the primary health care system.

SECTOR-BASED WORKFORCE INSIGHTS

Survey findings indicate that workforce shortages are affecting service delivery across all primary health care sectors in the NT. While many workforce challenges are shared, differences emerge between community-controlled/ not-for-profit services and private practice in relation to service impacts, recruitment barriers and retention pressures.

The HWNA 2026 health service survey received 53 responses across the Territory, representing private general practice, allied health services and ACCHOs. These responses reflect only the services that participated, not the full-service profile of NT primary health care services but provides a useful baseline for understanding recruitment and retention barriers across sectors

This section presents findings through 3 lenses: service type, remoteness (MMM classification), and PHN region.

Service type

Private GP

Recruitment challenges: financial limitations, competition with other employers, lack of professional development options, visa or registration issues for international medical graduates.

Retention challenges: burnout and stress, family or schooling challenges, high workload, limited career progression.

Most effective supports: flexible work arrangements, team-based workplace culture, relocation assistance.

Service impact: 54.2% of practices reduced services or hours due to workforce shortages in the past 12 months. Wait times were shortest of the 3 sectors overall, though this largely reflects the concentration of Private GP services in Greater Darwin. Practices in remote and very remote locations can face wait times of 1-2 months, well beyond the same-day to 2-4 week waits reported across Darwin-based respondents.

Vacancies: 50% reported at least one current vacancy. Of those, the average was 2.0 FTE vacancies per service, with some services reporting up to 6.0 FTE vacant. Registered nurses were the most frequently cited vacant role, followed by GPs.

Private allied health services

Recruitment challenges: remoteness and isolation, competition with other employers, lack of professional development options.

Retention challenges: burnout and stress, social isolation, community safety or unrest.

Most effective supports: relocation assistance, CPD/training support, team-based workplace culture.

Service impact: 47.1% of allied health providers reduced services or hours. This sector reported the longest wait times of the 3 sectors, with 41.2% reporting waits of a month or longer.

Vacancies: 76.5% reported at least one current vacancy, with an average of 2.8 vacancy per service reported. The highest single service reported 7 vacancies, all pharmacist roles. Physiotherapists and Occupational Therapists were the most frequently cited vacant roles.

Aboriginal Community-Controlled Health Organisations (ACCHOs)

Recruitment challenges: inadequate housing, remoteness and isolation, difficulty attracting families or partners, competition with other employers.

Retention challenges: social isolation, community safety or unrest, burnout and stress, poor housing or living conditions.

Most effective supports: salary packaging, relocation assistance, housing provision, CPD/training support.

Service impact: 44.4% reduced services or hours. 55.6% of ACCHOs had already implemented an alternative workforce model.

Funded, filled and vacant FTE for participating ACCHOs*:

Role	Funded FTE	Filled permanently	Gap if locum coverage excluded	Covered by locum/ agency	Unfilled after locum coverage
GP	80.0	46.2 (57.8%)	**42.2%**	25.1 (31.4%)	8.7 (10.9%)
Nurse/midwife	280.5	231.9 (82.7%)	**17.3%**	46.5 (16.6%)	2.1 (0.7%)
Aboriginal Health Practitioner	65.7	52.9 (80.5%)	**19.5%**	0.0 (0.0%)	12.8 (19.5%)

Sector comparison

Indicator	ACCHO	Private general practice	Private allied health
Services reduced due to work force shortages	44.4%	54.2%	47.1%
Typical wait time	Same day to 7 days	Same day to 2 days; up to 2 months remotely	Usually 1–2 weeks; sometimes over 2 months
Recruitment barriers	Housing, remoteness, family relocation and competition	Funding, competition, CPD and IMG requirements	Remoteness, competition and CPD
Retention pressures	Isolation, safety, burnout and housing	Burnout, workload, family needs and career progression	Burnout, isolation and safety concerns
Key feature	Remote delivery and reliance on locum/agency workers	Concentrated in Greater Darwin, with limited service availability in remote areas	Highly variable wait times and vacancies

By remoteness (MMM classification)

MMM2

Recruitment challenges: competition with other employers, financial limitations, distance from family and friends.

Retention challenges: burnout and stress, high workload, uncertainty of contracts/funding.

Most effective supports: flexible work arrangements, team-based workplace culture, CPD/training support.

Service impact: **48.6%** reduced services or hours. Wait times were shortest here, with 57.1% offering same-day or 1-2-day appointments.

MMM6

Recruitment challenges: difficulty attracting families or partners, remoteness and isolation, competition with other employers.

Retention challenges: community safety or unrest, burnout and stress, social isolation.

Most effective supports: relocation assistance, team-based workplace culture, flexible work arrangements, CPD/training support.

Service impact: **66.7%** reduced services or hours, the highest rate of the three classifications.

MMM7

Recruitment challenges: inadequate housing, remoteness and isolation, competition with other employers.

Retention challenges: social isolation, poor housing or living conditions, community safety or unrest.

Most effective supports: housing provision, salary packaging, relocation assistance.

Service impact: **16.7%** reduced services or hours, the lowest rate of the three classifications, despite MMM7 facing the most severe workforce pressures on almost every other measure. This is not a sign of lower difficulty. **83.3%** had already implemented or were actively exploring an alternative workforce model, the highest rate of any classification, suggesting these services have already restructured how they operate rather than having further capacity left to cut.

* ACCHO workforce data reflect participating services only and should not be interpreted as representative of all ACCHOs. Allied health is excluded due to differences in service provision and role definitions across participating services.

MMM classification insight

Factor	MMM2	MMM6	MMM7
Housing as a recruitment barrier	17.1%	50.0%	83.3%
Housing as a retention risk	5.7%	33.3%	66.7%
Community safety/unrest as a retention risk	11.4%	83.3%	66.7%
Top support identified	Flexible work	Relocation assistance	Housing provision

NT PHN regional comparison

Factor	Top End	Central Australia	Big Rivers	East Arnhem	Barkly
Leading retention concern	Burnout and stress	Community safety/unrest	Community safety/unrest	Housing conditions	Housing conditions
Housing as a retention concern	Minor → Less commonly reported	Emerging → Reported by some respondents	Emerging → Reported by some respondents	Dominant → Leading concern	Dominant → Leading concern
Top support identified	Flexible work	Relocation assistance	Relocation assistance	Relocation assistance / housing provision	Relocation assistance / housing provision



HWNA 2026 PRIORITY AREAS



PRIORITY 1:

STRENGTHEN ACCESS TO PRIMARY HEALTH CARE

Access to primary health care (PHC) is foundational to improving health outcomes and reducing inequities across the NT.

In a jurisdiction characterised by vast geography, dispersed populations and a high proportion of Aboriginal and Torres Strait Islander communities, equitable access to timely, culturally safe and affordable first-contact care remains a persistent challenge. While primary health care is often defined broadly to include prevention, health promotion and the social determinants of health, in the Australian context 'primary care' more specifically refers to the community-based services that people access first when they need health care[8]. In the NT, primary care is delivered through general practice, ACCHOs, NT Government community health services, allied health (including mental health and AOD services), pharmacy and oral health services. Together, these services form the front door of the health system and play a critical role in early intervention, chronic disease management and coordination of care across specialist and hospital services[9]. When access to primary care is limited, communities experience delayed treatment, increased reliance on emergency departments and poorer long-term outcomes[10,11].

Survey insights: observed service gaps

Health professionals were asked to identify the primary health service gaps they observe within their community or service. Across disciplines, the most frequently identified gaps were:

- allied health services (including physiotherapy, occupational therapy and speech pathology)
- homelessness health services
- mental health and psychosocial support, including AOD services
- after-hours or urgent care
- Aboriginal and Torres Strait Islander health services
- aged care and disability services.

Health service representatives were also asked which services are most in demand within their region. General practice, mental health, allied health, nursing and aged care were consistently identified as areas of highest demand. When considering health conditions driving service utilisation, AOD issues, mental health conditions and chronic disease were most frequently cited.

Key issues impacting access to PHC in the NT

1. Maldistribution and shortage of the health workforce

Access in the NT is shaped by a combination of workforce maldistribution, infrastructure constraints and structural barriers that limit the availability, affordability and cultural safety of care. Despite national growth in overall health workforce numbers, clinicians remain concentrated in urban centres, leaving many regional, rural and remote communities with limited on-site access to the primary health care workforce[12,13]. These shortages are compounded by high turnover, reliance on locum models and declining full-time equivalent capacity, reducing continuity of care and service stability[14]. Further, workforce fragility limits appointment availability, reduces after-hours capacity and increases pressure on remaining staff.

In this context, service gaps frequently reflect workforce supply limitations rather than reduced community demand.

NOTE ON INTERPRETATION:

Survey findings reflect the lived experience and professional perspectives of respondents. While responses may vary by discipline, service setting and geographic location, the consistency of themes across professions and regions strengthens confidence in the identified access gaps.

2. Lack of appropriate infrastructure

Infrastructure limitations directly constrain access to primary health care in the NT. Without reliable ICT capability, fit-for-purpose clinical facilities and adequate social infrastructure, services cannot operate at full capacity or deliver timely, continuous care. These constraints restrict outreach, telehealth, after-hours provision and service coordination. They also reduce the Territory's ability to attract and retain the workforce required to sustain local services. When infrastructure is inadequate, both service availability and workforce stability are compromised, limiting equitable access for communities.

Information, Communication and Technology (ICT)

- Inconsistent digital connectivity limits telehealth, remote supervision and specialist consultation.
- System interoperability challenges affect coordination across services.

These constraints restrict the scope and timeliness of care, particularly in remote settings.

Physical infrastructure

- Limited clinic space and consulting rooms.
- Variable quality and condition of facilities and equipment.
- Transport constraints affecting outreach and patient access.

Inadequate facilities can limit the range of services delivered locally and affect clinicians' ability to practise safely and efficiently.

Social infrastructure

- Availability and quality of staff housing.
- Access to schooling and community services.
- Competition for limited housing and childcare resources.

While primarily influencing workforce attraction and retention, these factors also directly affect service continuity and stability, thereby shaping community access.

3. Barriers to accessing services

Even where services are present, barriers may limit equitable utilisation.

Cost of services

- Higher out-of-pocket costs and declining bulkbilling reported during survey period (2025).
- Financial fragility of small rural practices.
- Funding inequities for rural Australians despite higher burden of disease[15,16].
- Travel costs for outreach and specialist access.

After-hours services

- Limited extended-hours general practice.
- Restricted urgent care availability in some regional centres.
- Increased reliance on emergency departments for primary care-type presentations.

Culturally appropriate health services

- Limited Aboriginal workforce representation in some professions and locations.
- Variability in cultural safety capability.
- Services are not always designed in partnership with local community leadership and governance structures, limiting responsiveness to their needs.

Service understanding and awareness

- Health literacy barriers.
- Fragmented service information.
- Limited care navigation support in remote communities to help patients access and coordinate care across primary, allied health, specialist and tertiary services.



4. Service gaps often reflect health workforce gaps

Across the NT, gaps in primary health care services are closely linked to workforce availability. Demand for health professionals is largely determined by demand for health care, which in the NT is shaped by a high burden of chronic disease, multimorbidity, mental health conditions and preventable hospitalisations[3,17].

In many cases, the absence or limited availability of services reflects workforce supply constraints rather than reduced community need. Persistent challenges in attracting and retaining health professionals in regional and remote areas mean that some services operate with limited staffing, visiting outreach models or periodic service delivery.

These constraints are most evident across mental health and psychosocial support, allied health, disability services, aged care and primary care. Workforce shortages in these areas contribute to longer wait times, reduced continuity of care and increased reliance on hospital-based services for conditions that could otherwise be managed within primary care.

Addressing service gaps in the NT therefore requires coordinated action to strengthen workforce supply, distribution and sustainability alongside broader service planning.

Mental health and psychosocial support

Demand for mental health, suicide prevention and AOD services continues to exceed workforce capacity, particularly outside major centres.

Allied health services

Demand for physiotherapy, occupational therapy, speech pathology and other allied health services related to chronic disease, disability and rehabilitation is not consistently matched by workforce availability across the Territory.

Disability services (NDIS)

Expansion of the NDIS has increased demand for allied health assessments and therapy, while workforce shortages and service viability challenges limit provider availability in remote areas.

Aged care and palliative care

Increasing longevity and complex health needs are driving demand for culturally appropriate aged care, community nursing and palliative care services in many communities.

Primary care access

GP shortages and turnover among nurses and Aboriginal Health Practitioners continue to affect service capacity, contributing to longer wait times and increased reliance on hospital emergency departments for primary care-type presentations.



PRIORITY 2:

BUILD WORKFORCE CAPABILITY AND QUALITY OF CARE

A strong and sustainable health system requires not only an adequate supply of health professionals, but a workforce equipped with the skills, competencies and cultural capability needed to meet the needs of diverse communities.

The quality of primary health care is closely linked to the availability of clinicians who are both clinically capable and responsive to local context.

Health professionals working in the NT frequently deliver care across broader scopes of practice than their metropolitan counterparts. In many remote communities, primary health care is delivered predominantly by Remote Area Nurses (RANs) and Aboriginal Health Practitioners (AHPs), supported intermittently by visiting general practitioners and allied health professionals[18,19]. In many locations there is no resident GP, placing significant responsibility on RANs and AHPs to manage acute presentations, chronic disease, maternal and child health, mental health, health promotion and public health activities. This care is often delivered in cross-cultural contexts and under substantial resource constraints[26].

Evidence suggests that approximately 80% of a RAN's workload consists of non-emergency consultations, highlighting the breadth and complexity of skills required for remote practice[20]. Many of these competencies are not comprehensively addressed in undergraduate training, reinforcing the need for specialised education, mentoring and ongoing professional support to ensure safe and effective care[20].

AHPs play a vital role in bridging Indigenous communities and the health system, strengthening communication, cultural safety and trust. Their involvement contributes to improved engagement with services and better health outcomes[21]. However, the Aboriginal and Torres Strait Islander health workforce remains under pressure, with declining numbers and ongoing retention challenges.

Strengthening workforce capability through targeted training, supervision, professional support and culturally responsive workforce development is therefore essential to improving the quality, continuity and effectiveness of primary health care across the NT.

Key issues impacting capability and quality of PHC in the NT

1. Workforce capability and skills gaps

Delivering safe and effective care in rural and remote contexts requires additional competencies in chronic disease management, cross-cultural communication, mental health care, emergency response and population health.

However, workforce shortages, professional isolation and high turnover can limit opportunities for clinicians to maintain and develop these skills.

Continuing Professional Development (CPD) is critical for maintaining workforce capability, particularly in remote settings where clinicians may have limited access to peer networks and supervision.

Evidence from the HWNA survey

Health professionals identified several priority training needs that reflect the realities of NT practice, including:

- Aboriginal and Torres Strait Islander health and cultural safety
- child and youth health
- chronic disease management
- family, domestic and sexual violence (FDSV) response
- mental health care
- remote and rural health practice
- women's health.

Leadership and management skills were also identified as increasingly important, particularly for clinicians working in small teams where supervision and service coordination responsibilities are often implicit.

Despite strong demand, access to CPD remains constrained. Respondents reported that lack of time, travel distance, cost, limited local training availability and the absence of workforce backfill were the main barriers to participation. These challenges disproportionately affect clinicians in rural and remote communities, where workforce shortages and geographic isolation make it difficult to leave service delivery to attend training.

2. Episodic service delivery and limited continuity of care

While primary health care services exist across many NT communities, the presence of services does not always equate to comprehensive and continuous care.

Comprehensive primary health care includes preventative, promotive, curative, rehabilitative and palliative services delivered in a coordinated and person-centred manner[22]. However, workforce shortages and geographic isolation mean that many NT communities rely on episodic models of care delivered through visiting clinicians, outreach services, telehealth or fly-in fly-out workforce arrangements.

These models play an important role in maintaining service access, but they can also limit continuity of care, reduce opportunities for long-term patient-provider relationships and fragment care coordination across services. Sustained and continuous care is often further constrained by high workforce turnover and funding models that do not support long-term service continuity.

Multidisciplinary models, such as GP-led practices supported by nurses and AHPs, provide examples of more comprehensive and person-centred care. However, these models remain unevenly distributed across the Territory.

Evidence suggests that gaps in comprehensive care contribute to potentially avoidable hospitalisations, reduced patient confidence in services and poorer chronic disease outcomes[23]. For Aboriginal and Torres Strait Islander communities, culturally safe, continuous and locally embedded services are particularly important for improving engagement with care, treatment adherence and overall health outcomes[24, 25].

Evidence from the HWNA survey

Health services reported relying on a mix of service delivery models to maintain access, including:

- GP-led primary care services
- nurse-led primary care services
- multidisciplinary team care
- shared care models
- telehealth and virtual care
- outreach, mobile service delivery and visiting clinician services
- private fee-for-service arrangements.

While these approaches help sustain service access, fully integrated multidisciplinary models involving GPs, nurses, Aboriginal Health Practitioners and allied health professionals were reported less consistently across regions.

This gap between community health needs and available service model capacity is particularly evident in areas requiring coordinated, long-term care, including:

- chronic disease management
- mental health services
- alcohol and other drug treatment.

These findings highlight the importance of strengthening sustainable multidisciplinary models of care to support continuity, coordination and long-term engagement in primary health care.

3. Cultural capability and culturally safe care

Culturally safe care is a fundamental component of quality primary health care in the NT. Aboriginal and Torres Strait Islander peoples represent around 30% of the NT population, and most clinicians work across linguistic and cultural boundaries.

Delivering effective care therefore requires not only clinical capability but also cultural capability. Health professionals must navigate different languages, kinship systems, cultural obligations and health beliefs while supporting communities with complex health needs[26].

Aboriginal Health Practitioners play a critical role in bridging communities and the health system, strengthening communication, trust and engagement with services. Evidence shows that culturally safe care improves treatment adherence, reduces hospital discharge against medical advice and supports better long-term health outcomes[21, 27].

Evidence from consultations and survey feedback

Stakeholders consistently emphasised that improving cultural safety requires:

- locally developed and community-led cultural safety training
- stronger Aboriginal and Torres Strait Islander workforce pathways
- cultural capability embedded within organisational governance and supervision
- greater involvement of communities in service design and delivery.

Growing the Aboriginal health workforce in under-served communities was identified as a critical strategy for strengthening culturally safe care while improving service continuity.

PRIORITY 3:

SUPPORT WORKFORCE SUSTAINABILITY AND FUTURE PLANNING

Sustaining the NT health workforce requires long-term investment in workforce pipelines, service viability and strategies to attract and retain health professionals.

Despite national growth in the number of registered health professionals, the NT continues to experience persistent shortages across most primary health care professions, particularly in rural and remote communities where access to care is most limited.

Workforce sustainability in the NT is shaped by a combination of structural challenges including workforce maldistribution, limited local training capacity, high turnover, and the financial fragility of some service models. These factors contribute to heavy reliance on short-term locums, fly-in fly-out workforce arrangements and visiting services, which can limit continuity of care and increase system costs.

Strengthening workforce sustainability requires coordinated action across education providers, health services, professional bodies and governments to build local training pathways, improve workforce attraction and retention, and develop service models that are financially and operationally sustainable over the long term.

Key issues impacting PHC sustainability

1. Growing the health workforce pipeline

Developing a sustainable NT workforce requires a connected pipeline that supports people to train, live and work in the Territory. This includes early engagement with students, local training opportunities, and clearer pathways between education, training and employment.

Stakeholders emphasised that workforce pipelines must extend beyond medicine to include nursing, midwifery, allied health and Aboriginal Health Practitioners. Key priorities include:

- strengthen local clinical placements and training opportunities in remote communities
- promote health careers to NT secondary students and support school-based traineeships
- expand Aboriginal Health Practitioner and Aboriginal Health Worker career pathways, embedding leadership and mentorship roles
- improve support for international recruits and interstate graduates relocating to the NT
- strengthen coordination between education providers, NT PHN, ACCHOs and NT Health to ensure clear and supported transition points from training to employment.

Evidence consistently shows that local or rurally trained professionals are more likely to remain in or return to the NT workforce, highlighting the importance of regional education pathways as a long-term workforce strategy[28].

A. GP and medical workforce pathways

Ongoing shortages of GPs and rural generalists remain among the most significant workforce challenges in the NT. The pipeline of locally trained GPs has declined in recent years, while the NT continues to receive a relatively small proportion of newly registered international doctors compared with larger jurisdictions[29].

Between 2016 and 2023, enrolments in Australian General Practice Training (AGPT) programs in the NT declined substantially. Although registrar numbers have begun to recover, training capacity remains below the level required to meet long-term workforce needs[30]. Stakeholders emphasised the critical role of GP registrars as both service providers and the foundation of future supervision capacity within primary care.

Exposure to rural and remote practice during medical school remains one of the strongest predictors of future rural practice. The NT Medical Program, delivered through a partnership between the NT Government and Flinders University, continues to play an important role in developing a locally trained medical workforce through placements across hospital and community settings.

In March 2026, Charles Darwin University commenced its new medical program in partnership with Menzies School of Health Research. The program represents a significant milestone in expanding locally delivered medical education and strengthening the Territory's long-term workforce pipeline. Continued investment in training capacity, supervision and postgraduate pathways will be essential to make sure these programs provide strong workforce outcomes across the NT.

Despite recent national reforms intended to strengthen international medical recruitment, the NT continues to attract relatively low numbers of overseas-trained GPs. Following the Kruk Review, the expedited specialist pathway was introduced nationally in October 2024 to streamline registration for specialist international medical graduates from comparable health systems. However, Medical Board of Australia data for 2025 showed that the NT received only one GP through this pathway, the lowest number nationally, compared with approximately 70-94 expedited pathway GP registrations across several larger jurisdictions[31]. These findings suggest that registration reform alone is unlikely to resolve NT GP workforce shortages without broader strategies addressing workforce attraction, housing, supervision capacity, relocation support and long-term retention.

B. Nursing and midwifery workforce pathways

Nurses represent the largest component of the NT health workforce and are essential to maintaining access and continuity of care across the Territory, particularly in remote and Aboriginal community settings. Despite this critical role, the NT continues to experience shortages of registered and enrolled nurses across both hospital and primary health care services[32,33,34].

Stakeholders highlighted that current education pathways remain strongly hospital-focused and do not always align with the needs of community and primary health care services. Undergraduate nursing programs vary in the extent to which primary care is embedded in curricula, and many students report limited exposure to community and preventive health practice. Expanding clinical placements in primary health care and remote community settings was identified as an important strategy for improving workforce readiness and encouraging community-based nursing careers[28,31].

Strengthening the Aboriginal and Torres Strait Islander nursing workforce is widely recognised as critical to improving culturally safe care and health outcomes. Expanding Aboriginal student entry pathways, scholarships, mentoring and culturally safe supervision models will be essential to growing this workforce. Aboriginal nurses and midwives play a vital role within multidisciplinary teams by strengthening cultural understanding, supporting effective communication and helping ensure services are responsive to community needs[34,25].

Retention remains a significant challenge, mainly in remote settings where professional isolation, limited supervision and workload pressures can affect workforce sustainability. Supporting early-career nurses through structured mentoring, flexible supervision models and improved workplace support was identified as important for strengthening retention and building a stable nursing workforce[32,33].

C. Allied health workforce pathways

Allied health professionals play a vital role in supporting prevention, chronic disease management, rehabilitation and disability care, particularly in remote and Aboriginal community settings. However, workforce shortages persist across many allied health professions, with limited availability in rural and very remote regions[34]. Recruitment and retention challenges are compounded by professional isolation, high turnover, limited housing and workforce fatigue, reducing continuity of care and service responsiveness[32].

As a result, many remote ACCHOs rely on visiting allied health professionals funded through outreach programs such as Medical Outreach Indigenous Chronic Diseases (MOICD) Program, the Rural Health Outreach Fund (RHOF) and the NDIS. While these models help maintain access, they can limit continuity of care and focus on local community needs.

Strengthening the allied health workforce pipeline requires a coordinated approach to education, training and career development. Expanding locally accessible training pathways and ensuring students can undertake placements within NT health services are important strategies for encouraging graduates to enter and remain in the Territory workforce. Exposure to primary health care and remote practice during training is also a key factor influencing future workforce distribution.

Stakeholders also highlighted the importance of strengthening Allied health assistant (AHA) pathways through the vocational education and training sector. AHAs can extend the reach of allied health services in remote settings while providing local employment opportunities and creating pathways into higher-level allied health qualifications.

D. Aboriginal and Torres Strait Islander workforce pathways

Aboriginal and Torres Strait Islander people make up more than 30% of the NT population yet remain significantly under-represented across many health professions[35]. Strengthening supported and culturally responsive pathways for Aboriginal and Torres Strait Islander people across health careers is essential to building a sustainable workforce and improving culturally safe care across the NT.

Local education and training pathways play an important role in supporting this goal. Evidence shows that students who train locally or in regional settings are more likely to remain in, or return to, rural and remote areas to practise.[28] Programs such as the Northern Territory Medical Program have contributed to growing a locally trained medical workforce, and initiatives that prioritise Aboriginal and Torres Strait Islander student entry are important for strengthening Indigenous representation within the profession.

However, stakeholders consistently emphasised that stronger pathways are required across all health careers, not only medicine. Barriers to entry remain significant for many Aboriginal students, particularly those living in remote communities where access to secondary education, vocational training and tertiary programs may require relocation away from family, culture and Country. These challenges can affect participation and completion rates, while limiting the pool of potential trainees entering health careers.

The Aboriginal Health Practitioner workforce remains foundational to culturally safe primary health care in remote communities. Strengthening this pipeline requires accessible and culturally appropriate training models, including community-based education, flexible delivery approaches and structured mentoring and support for trainees.

System priorities for strengthening Aboriginal workforce pathways

Stakeholders emphasised that strengthening Aboriginal and Torres Strait Islander workforce pathways will require coordinated action across education, training and health service systems. Key areas identified include:

- culturally informed and supported training models
- regionally delivered vocational education and university health programs
- housing and financial support for students undertaking placements away from home
- paid cadetships, traineeships and scholarships for Aboriginal students across health disciplines
- increased availability of local clinical placements supported by culturally appropriate supervision
- strong partnerships between ACCHSs, schools, VET providers, NT Health, universities and NT PHN
- long-term investment in rebuilding the Aboriginal Health Practitioner workforce.

2. Service provider collaboration and system integration

Stakeholder consultations highlighted challenges in coordination between general practices, ACCHOs, NT Health services and community-based programs. Limited integration can result in duplicated effort, unclear referral pathways and inconsistent patient experiences.

Survey feedback reinforced the need for stronger collaboration across providers. In many cases, coordination relies on informal relationships rather than structured processes, limiting continuity of care and proactive service planning. Limited visibility of available services and referral pathways was also identified as a barrier for clinicians and patients navigating the system.

Key challenges include:

- limited coordination between primary health care, hospital and community services
- unclear or inconsistent referral pathways
- limited visibility of available services and outreach programs
- reliance on informal relationships rather than structured collaboration mechanisms.

Strengthening collaboration across the NT health system will support better use of limited workforce resources and improve continuity of care for communities.

3. Achieving sustainable workforce models

Many primary health care services in the NT operate within thin markets, where small populations, geographic isolation and workforce shortages make it difficult to sustain traditional service models. Stakeholders consistently highlighted that flexible workforce arrangements and multidisciplinary models are essential to maintaining service access across remote and regional communities.

Services have adapted through a range of approaches including telehealth, outreach services, visiting clinicians and shared workforce arrangements. These models help maintain access where a permanent workforce cannot always be sustained.

However, many primary health care providers, particularly small private practices and community-based services, operate close to the edge of financial viability. High operating costs, workforce shortages and limited economies of scale create ongoing challenges in balancing patient-centred care with the financial sustainability of services, particularly where communities have high health needs but limited capacity to support private service models.

Key challenges identified include:

- small and dispersed populations limiting economies of scale
- high costs associated with travel, accommodation and remote service delivery
- reliance on locum, outreach and fly-in fly-out workforce models
- financial fragility of small primary care practices and community providers.

Addressing these challenges will require flexible workforce models and funding arrangements that better reflect the realities of delivering care in remote and sparsely populated communities.

4. Attracting the health workforce

Stakeholders emphasised that successful attraction strategies must address both the professional motivations that draw clinicians to practice and the practical considerations that influence relocation and longer-term retention.

From a professional perspective, clinicians are often drawn to the NT by opportunities to practise across a broader scope of care, manage diverse and complex presentations, and develop strong relationships with patients and communities. Working within multidisciplinary teams and contributing to improving health outcomes in remote communities were also identified as important aspects of rewarding practice.

Data collected through RWA NT recruitment activities highlight several factors that commonly attract health professionals to rural and remote practice in the NT. These include:

- opportunities for rural and remote clinical experience
- career progression and expanded scope of practice
- lifestyle change and a different pace of life
- working in Aboriginal and Torres Strait Islander health
- the sense of adventure associated with practising in remote environments.

Consultations and survey findings suggest that workforce attraction in the NT should prioritise quality of workforce fit, focusing on clinicians whose professional interests, values and expectations align with community-based practice. Health professionals with a strong interest in multidisciplinary care, remote Aboriginal and Torres Strait Islander health, and community engagement are more likely to remain in the Territory over time. Recruitment approaches that emphasise short-term remote experiences without realistic preparation for NT practice can contribute to mismatch and early attrition.

Many clinicians reported being attracted to NT practice by opportunities for professional autonomy, diverse clinical work and meaningful relationships with patients and communities. Cultural learning and engagement with Aboriginal and Torres Strait Islander communities were also described as professionally enriching aspects of practice.

Attraction is also shaped by broader lifestyle and structural factors. Access to suitable housing, employment opportunities for partners, schooling and childcare, and the ability to maintain work–life balance all influence relocation decisions. Competitive remuneration, professional development, supportive supervision and flexible workforce models, including locum, outreach and rotational roles, can further support attraction by enabling clinicians to gain remote practice experience while maintaining employment stability.

These findings highlight that effective attraction strategies must balance professional opportunity, realistic expectations of remote practice and the practical supports required to live and work in the NT.

5. Retaining the health workforce

The NT continues to experience high levels of workforce turnover, particularly in rural and remote communities. Frequent movement of staff between locations, jurisdictions and employers affects service stability, continuity of care and community trust. Stakeholders consistently highlighted that regular staff turnover disrupts patient–provider relationships, increases training and orientation costs and places additional pressure on remaining staff.

Evidence indicates that turnover in remote primary health care services is significantly higher than in urban settings. Remote Aboriginal Community Controlled Health Services report annual clinic-level turnover rates exceeding 150% across all staff, with even higher rates in the most remote clinics[32]. These patterns contribute to reliance on locum, outreach and fly-in fly-out workforce models which, while necessary to maintain service access, can reinforce workforce transience and limit continuity of care.

Drivers of workforce turnover

HWNA survey

Health professionals reported that decisions to stay or leave a role are most strongly influenced by:

- job satisfaction
- salary and remuneration
- workload and burnout
- career development and progression opportunities
- workplace culture
- access to leave and flexible work arrangements.

Health services identified the following as the most common contributors to retention challenges:

- burnout and stress
- community safety concerns
- social isolation
- family or schooling challenges
- high workload.

Additional factors included limited career progression, poor housing or living conditions and uncertainty associated with short-term contracts or funding.

Early workforce experience

Data from RWA NT provides insight into the experiences of health professionals recruited during their first 3 months of practice in the NT:

The most common challenges identified include:

- managing complex workloads and caseloads
- partner or family adjustment to relocation
- unfamiliarity with community and cultural contexts
- housing and accommodation issues
- social isolation.

Despite these challenges:

73.1% of respondents reported completing or currently undertaking cultural training

86.3% of clinicians reported feeling supported by their employer

Health professionals also identified several positive aspects of early NT practice, including:

- working with diverse and complex caseloads
- making a meaningful impact in communities
- greater professional autonomy and expanded scope of practice
- exposure to unique clinical experiences
- strong team cultures and community engagement
- access to outdoor lifestyle and environment.

These findings indicate that workforce turnover in the NT is shaped by a combination of workplace conditions, living environments and career opportunities. Addressing turnover will require strategies that strengthen workplace support, improve living conditions and support long-term career pathways for clinicians working across the NT.

PRIORITY 4:

STRENGTHEN ABORIGINAL AND TORRES STRAIT ISLANDER WORKFORCE DEVELOPMENT

Strengthening the Aboriginal and Torres Strait Islander workforce will support improved access to culturally safe care, strengthens community trust in health services and contributes to long-term workforce sustainability.

Across this report, Aboriginal workforce development is reflected through the following priorities:

Priority 1 – Access to care

Grow the Aboriginal and Torres Strait Islander health workforce in communities to strengthen continuity of care and culturally safe access to services.

Priority 2 – Workforce capability and quality of care

Embed cultural capability as a core competency across all workforce development and training initiatives.

Priority 3 – Workforce sustainability and future planning

Prioritise retention of Aboriginal and Torres Strait Islander health professionals as a key strategy for workforce stability and long-term service sustainability.

While Aboriginal and Torres Strait Islander workforce development is embedded across these priorities, it remains important to explicitly recognise and support this workforce. Aboriginal and Torres Strait Islander health professionals often work within unique cultural, professional and community contexts, and may experience additional responsibilities and expectations in their roles. These factors influence workforce participation, retention and career progression and require targeted and culturally responsive workforce strategies.

Aboriginal and Torres Strait Islander health professionals play an essential role in delivering holistic, culturally grounded care across the NT. Their contribution extends beyond clinical tasks to strengthening cultural understanding, supporting communication between services and communities, and improving continuity of care. These roles are critical to improving health outcomes and ensuring health services are responsive to community needs.

Evidence indicates that Aboriginal and Torres Strait Islander health professionals continue to experience systemic barriers within the health workforce. Interpersonal and structural racism, alongside workplace cultures that do not consistently support cultural safety and limited access to career progression opportunities, can undermine workforce wellbeing, retention, and professional advancement[36]. Cultural safety challenges have also been identified within health education and training pathways, influencing participation and completion of specialist and professional training programs across medicine, nursing and allied health professions[37].

Addressing these challenges requires sustained investment across the entire career pathway, from entry into health careers through to leadership and advanced practice roles. This includes culturally secure education pathways, access to mentoring and peer support, culturally responsive supervision, and leadership opportunities that support Aboriginal and Torres Strait Islander health professionals to progress within the health system.

System-level enablers are also required to support workforce development. These include flexible funding arrangements that enable community-based workforce models, culturally safe supervision and governance structures, and stronger Aboriginal leadership within health service organisations.

Strengthening the Aboriginal and Torres Strait Islander health workforce is critical to delivering culturally safe, community-informed primary health care and improving health outcomes across the NT.

KEY ISSUES AND STRATEGIES

Access

Improving the access and continuity of access to essential primary healthcare

Key issues	• Shortages of primary health care workforce across GPs, nurses and midwives, allied health professionals and Aboriginal Health Practitioners. • Inequitable workforce distribution, particularly in remote areas. • Lack of appropriate infrastructure, including ICT, clinical facilities and staff housing. • Barriers to access including cost, limited after-hours availability and cultural safety gaps. • Difficulty attracting a primary health care workforce.
Strategies	• Targeted recruitment support across local, interstate and international pathways. • Coordinated marketing and attraction campaigns. • Continued delivery of locum, outreach and flexible workforce support, including the GP Locum Program. • Investment in fit-for-purpose infrastructure, including staff housing and digital connectivity. • Continued development of an NT-specific minimum data set to inform planning.
Desired outcomes	• Increased supply of primary health care workforce to priority areas. • Core GP, nursing, allied health and Aboriginal Health Practitioner roles filled. • Increased availability of suitable housing for health professionals. • Reduced reliance on episodic and locum-only service delivery models.

Quality

Building workforce capacity

Key issues	• Limited access to supervision, mentoring and structured orientation, particularly in remote settings. • Workforce shortages and professional isolation limiting opportunities to maintain and develop skills. • Gaps in culturally safe training and cultural capability across the workforce. • Under-representation of Aboriginal and Torres Strait Islander people delivering care. • Barriers to CPD participation, including cost, travel distance and lack of workforce backfill.
Strategies	• Expand access to CPD aligned to rural and remote practice needs. • Strengthen clinical supervision and mentoring, particularly for early-career clinicians and sole practitioners. • Embed cultural safety training and locally developed, community-led cultural safety models. • Strengthen Aboriginal and Torres Strait Islander workforce pathways and leadership. • Support multidisciplinary models of care to improve continuity and coordination.
Desired outcomes	• A workforce with the skills and confidence to practise safely across an expanded scope. • Improved access to supervision and structured professional development. • Increased cultural safety capability across the primary health care workforce. • Stronger representation of Aboriginal and Torres Strait Islander health professionals.

Sustainability

Growing the long-term sustainability of the health workforce

Key issues	• High turnover and workforce instability, particularly in rural and remote communities. • Reliance on locum, outreach and fly-in fly-out workforce models. • Financial fragility of small primary care practices and community providers. • Limited local training pipelines and constrained supervision capacity. • Housing, cost of living and family/lifestyle factors influencing retention decisions.
Strategies	• Strengthen local and regional training pathways across all primary health care professions. • Support flexible workforce and employment models suited to thin markets. • Continue to build the NT-specific evidence base needed to plan and fund workforce sustainability initiatives. • Strengthen service provider collaboration and system integration. • Advocate for sustained investment in housing and social infrastructure as a workforce enabler, not a secondary consideration.
Desired outcomes	• Improved retention rates across all professions. • A locally trained, more stable primary health care workforce. • Reduced reliance on short-term and episodic workforce arrangements. • Financially viable primary care services across the Territory, including in thin markets.



ACRONYMS

Acronym	Definition
ACCHO	Aboriginal Community Controlled Health Organisation
AHP	Aboriginal Health Practitioner
AIHW	Australian Institute of Health and Welfare
AHW	Aboriginal Health Worker
AHPRA	Australian Health Practitioner Regulation Agency
AGPT	Australian General Practice Training Program
AMS	Aboriginal Medical Service
AOD	Alcohol and Other Drugs
CPD	Continuing Professional Development
DHDA	Department of Health, Disability and Ageing (Australian Government)
DIDO	Drive-in-drive-out
FIFO	Fly-in fly-out
FDSV	Family, domestic and sexual violence
FTE	Full-time equivalent
GP	General Practitioner
HWNA	Health Workforce Needs Assessment
HWSAG	Health Workforce Stakeholder Advisory Group
ICT	Information, Communication and Technology
IMG	International Medical Graduate
MBS	Medicare Benefits Schedule
MDT	Multidisciplinary team
MOICD	Medical Outreach Indigenous Chronic Disease Program
MMM	Modified Monash Model
NDIS	National Disability Insurance Scheme
NHDS	National Health Data Set
NT	Northern Territory
NTG	Northern Territory Government

NT Health	Northern Territory Department of Health
NT PHN	Northern Territory Primary Health Network
PHC	Primary health care
RAN	Remote area nurse
RHOF	Rural Health Outreach Fund
RWA NT	Rural Workforce Agency Northern Territory
VET	Vocational education and training

Key terms

Thin market	A context in which population size, workforce supply, and service demand are insufficient to sustain stable and viable health services. In health care, thin markets are characterised by limited provider availability, service fragility, and increased risk of service disruption, particularly in rural and remote settings.



APPENDIX A

NT PHN defines the following as priority allied health professions for primary health care in the Northern Territory:

Audiology	Physiotherapy
Diabetes Education	Podiatry
Dietetics	Pharmacy
Exercise physiology	Prosthetics and orthotics
Medical imaging (Radiography, Sonography)	Psychology
Occupational Therapy	Social Work
Optometry and Orthoptics	Speech Pathology

NT PHN acknowledges that this is not a comprehensive list of allied health professions involved in the delivery of quality health care. A broad range of allied health professions play an important role in supporting the health, wellbeing and quality of life of Territorians

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