

Multidisciplinary workforce planning: Best and emerging practice analysis report

Kruk Review Recommendation 19

HEALTH WORKFORCE TASKFORCE

The Health Workforce Taskforce provides advice and recommendations to Australian Health Ministers on priority workforce matters.





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A note on terminology used in this report

The Victorian Department of Health (the Department) acknowledges that certain terms are used interchangeably to describe similar concepts and professions across the sector. For example, terms such as “skills”, “capabilities” and “competencies” may have different meanings depending on the audience. To ensure we accurately reflect insights shared during consultation, we have adopted the terminology used by stakeholders in their respective contexts.

In addition, we acknowledge that there may be variation in how jurisdictions refer to different professions. For example, the term “para-professional workforce” is used in this report to refer to workers such as health assistants, technicians, care workers and peer support workers. This is in alignment with the definition and scope outlined in the Scope of Practice Review.

1 Background

This section outlines the context and purpose of this report. It provides a summary of the rationale for its development, an overview of system level challenges impeding multidisciplinary workforce planning, and the purpose of this paper within the broader context of the Kruk Review. The intended audience for the Technical Guide, which will be informed by this report, is also outlined in this section.

1.1 Context and rationale

The Department is leading the development of a best and emerging practice analysis report, which will inform the subsequent Technical Guide on multidisciplinary workforce planning to deliver on Recommendation 19 of [*the Independent Review of Australia's Regulatory Settings Relating to Overseas Health Practitioners*](#) (the Kruk Review). This work is being progressed on behalf of the National Health Workforce Taskforce, in collaboration with Australian health jurisdictions. Recommendation 19 seeks a nationally coordinated approach to multidisciplinary workforce planning. Its intent is to:

- Identify system-wide themes that influence workforce availability and distribution.
- Outline mechanisms for effective multidisciplinary planning.
- Support the development of integrated models of care, including methods to identify and measure workforce and skills gaps.

The aim of the project is to develop a practical Technical Guide document that can be used at the service level within organisations across Australia to support workforce planning for multidisciplinary care delivery.

1.1.1 System challenges in workforce planning

The Kruk Review highlighted several long-standing and structural challenges across Australia's health system that underpin the need for improved, multidisciplinary workforce planning. This included significant and persistent workforce pressures across medical, nursing, midwifery, allied health practitioners, and rising demand driven by an ageing population, a growing burden of chronic disease and increased service complexity. These pressures were noted to affect all jurisdictions and limit the system's capacity to meet current and future care needs. There are several recommendations within the Kruk Review that seek to address these long-standing challenges.

Regarding multidisciplinary workforce planning, the Kruk Review specifically identified¹:

- Existing workforce planning approaches are fragmented, siloed and highly 'profession specific'.
- There is no consistent national method for multidisciplinary planning.
- Workforce data is incomplete, particularly for self-regulated professions, and national modelling for many professions was either outdated or not yet developed.
- Integrated workforce plans, instead of separate plans for each profession, were required to ensure high-quality care delivery.

¹ Australian Government Regulatory Reform Division. (2025). *Health Practitioner Regulatory Settings Review* [Archived webpage]. National Library of Australia Web Archive. <https://webarchive.nla.gov.au/awa/20250623081358/https://www.regulatoryreform.gov.au/priorities/health-practitioner-regulatory-settings-review>

In addition, the Kruk Review noted that improving workforce planning requires addressing the maldistribution of the workforce alongside broader planning reforms, particularly because rural and remote communities continue to experience some of the most significant shortages of doctors, nurses and allied health professionals. The Kruk Review also highlighted that workforce planning should keep pace with contemporary models of care, which increasingly span aged care, disability and social care sectors and therefore rely on multidisciplinary, team-based responses.

1.2 Purpose of this report

The purpose of this report is to present emerging evidence, early insights from stakeholder engagement, and initial analysis of current and better practice to:

- Build a shared understanding of the multidisciplinary workforce planning challenges, including the respective roles, levers and limitations that exist at different levels of the health system and how these shape multidisciplinary workforce planning.
- Clarify the key issues and opportunities that influence multidisciplinary workforce planning, particularly at the service and organisational level (see the *Intended audience for the e* section below).
- Test and refine the proposed focus areas for the Technical Guide, including practical approaches, data needs, planning steps, and capability requirements for multidisciplinary teams.
- Seek targeted feedback from jurisdictions and sector stakeholders to ensure the Technical Guide is usable, scalable and grounded in the realities of multidisciplinary workforce planning, while remaining consistent with national objectives.

Insights gathered through this report will directly shape the structure, content and practical orientation of the Technical Guide.

1.2.1 Intended audience for the Technical Guide

Multidisciplinary workforce planning occurs across the different layers of the health system, each with different levers, constraints and responsibilities. To ensure the Technical Guide developed through this project is practical and usable, it is important to clearly define the level of the system the Technical Guide will target.

The Technical Guide is intended to support ‘service’ or ‘organisation’ level workforce planning, rather than systemwide strategic planning or unit level operational rostering. The table below summarises the different workforce planning considerations at each level and defines the intended audience for the Technical Guide.

Table 1 Key workforce planning activities by system level

System level	Definition
Macro level: National / Jurisdictional stakeholders <i>Includes</i> • Commonwealth, state and territory health departments (including central workforce policy and strategy teams) • Regulatory and accreditation bodies	Workforce planning at the macro level focuses on determining the overall size, composition, distribution and future supply of the health workforce needed to meet population level health needs at a ‘whole-of- system’ or jurisdiction level. Some of the key functions and focus areas at this level include: • Funding models and investment settings • Regulation, legislation and industrial arrangements • Professional accreditation and national standards

System level	Definition
- Industrial relations agencies and workforce unions - Peak bodies and health workforce agencies - Primary Health Network (PHN) workforce planning and commissioning leads	- High level workforce supply, demand and distribution modelling - Assessment of population level need These activities shape the environment in which services and organisations operate but sit outside the direct scope of the Technical Guide to be developed. However, they provide important context for understanding the constraints and opportunities faced by service level planners.
Meso level: Service / Organisational stakeholders <i>Includes</i> - Service level workforce planners - Health service executives - Clinical service directors / discipline leaders - Organisational planning and HR leads	Workforce planning at the meso level focuses on translating population need and service priorities into a practical workforce model, including the required mix of roles, capabilities and team configurations needed to deliver models of care within an organisation or service. Clinicians are explicitly recognised as joint owners of workforce design, ensuring it directly relates to quality and safety. Key functions and focus areas at this level include: - Service level workforce planning - Care pathway and model of care design - Planning for multidisciplinary capability and skill mix - Partnerships with health and care providers and local networks - Local responses to service demand and patient need This is the level at which the Technical Guide must be directly usable, enabling the intended audience of service level planners to understand and apply multidisciplinary workforce planning in their local service context.
Micro level: Operational level / Individual teams and organisational units <i>Includes</i> - Unit / ward managers - Team leaders - Practice managers - Shift coordinators / duty managers - Service coordinators / program managers	Workforce planning at the micro level focuses on day-to-day and short-term deployment of the workforce, including how staff are allocated, supervised and coordinated within individual teams or service units. Key functions and focus areas at this level include: - Regular rostering - Daily staffing decisions - Delegation, supervision and task allocation - FTE allocation within teams While this level is not the intended primary audience of the Technical Guide, the document may still inform and provide useful support for planning at this level.

2 Approach

This section outlines the approach undertaken to develop this report. It provides a summary of the key activities and sources of evidence that informed the content of this paper. These activities were designed to ensure the paper reflects existing knowledge, insights and practical experience concerning multidisciplinary workforce planning while balancing academic and applied knowledge.

2.1 Desktop review

A comprehensive desktop review was conducted to identify key findings, emerging evidence and existing practices related to multidisciplinary workforce planning.

The desktop review considered:

- All regulated, self-regulated and paraprofessional health professions involved in service delivery across public, private and aged care sectors.
- Australian jurisdictions and key international comparators (New Zealand, United Kingdom, Canada, United States).
- Literature from 2010–2026 across both published (peer-reviewed) literature and grey literature sources including government policies, organisational frameworks, planning tools, and previous national reviews (e.g., *Unleashing the Potential of our Health Workforce Scope of Practice Review (SOP Review)*²).

2.1.1 Method for desktop review

The desktop review adopted a rapid realist approach, examining how multidisciplinary workforce planning methods operate in different contexts and what mechanisms lead to particular outcomes. Key considerations included:

- Aligning with the Kruk Review's focus areas and relevant factors identified in subsequent health workforce reviews (for example: education, employment, leadership, regulation, funding, technology).
- Identifying examples where multidisciplinary workforce planning responds to both team-based models of care and population health needs.
- Building on evidence from previous national reviews to identify key knowledge gaps and cross-cutting themes in multidisciplinary workforce planning.
- Ensuring the desktop research was relevant to informing the development of Technical Guide that is practical, useable and transferable across jurisdictions to support service level planners.

2.2 Stakeholder consultations

Targeted consultations were conducted with key stakeholders involved in the workforce planning and healthcare delivery system to provide real world perspectives and pragmatic evidence. Table 2 below summarises the stakeholders consulted and focus areas explored. A complete list of stakeholders consulted is available in the Appendices.

² Australian Government Department of Health and Aged Care. (2024). *Unleashing the potential of our health workforce: Scope of practice review – Final report*. https://www.health.gov.au/sites/default/files/2024-11/unleashing-the-potential-of-our-health-workforce-scope-of-practice-review-final-report_0.pdf

Table 2 List of stakeholders consulted and focus areas

Stakeholder	Focus area for consultations
Jurisdictional stakeholders including health department representatives from each state and territory and the Commonwealth. These representatives are jurisdictional workforce strategy leaders (macro level) and jurisdictional service level workforce planners (meso level).	• Current practices, tools and approaches to multidisciplinary workforce planning • Examples of emerging and innovative practices and tools • Barriers, enablers and contextual constraints • Practical needs of organisational level users • Opportunities for improvement in multidisciplinary workforce planning approaches in Australia • Professions, skills and roles that could be better integrated into multidisciplinary workforce models
Peak and industrial body representatives, including representatives from different peak and industry groups, to contribute system-wide insights related to workforce pressures, scope of practice, training pathways and other settings that shape multidisciplinary practice for the professions or communities they represent.	

Insights from these targeted consultations have informed the analysis in this paper, alongside consideration of findings from broader sector wide consultation processes undertaken in parallel with, and following, the Kruk Review. This includes consideration of insights into multidisciplinary workforce planning from the SOP Review and other priority reform areas under the Strengthening Medicare Taskforce, to ensure alignment with emerging national policy directions and systemwide evidence.

2.3 Case studies

Case studies were incorporated into the methodology to illustrate practical applications of multidisciplinary workforce planning and highlight transferable lessons from Australia and international comparators. All jurisdictional stakeholders and peak body and industrial body stakeholders consulted were asked to provide relevant case examples for consideration and contemporary case examples were sought from published and grey literature sources.

A consistent rapid realist structure³ was applied so that each case study developed includes:

- **Context:** system setting, workforce or service challenge
- **Mechanism:** planning approach, tool, framework or model used
- **Outcome:** insights relevant to multidisciplinary workforce planning (e.g., what worked well, were benefits/improvements realised)

The selection of case studies included in this report prioritise relevance to Australian multidisciplinary workforce planning challenges while incorporating international examples where they offered clear transferable insights.

The findings from the desktop review were triangulated with insights from stakeholder consultations and case studies provided by jurisdictions, to support the development of this report.

³ The University of Melbourne (2025). [Which Review is that? A guide to review types](#).

3 Key findings

This section outlines key findings on:

- Current state of multidisciplinary workforce planning
- Best practice principles/themes of multidisciplinary workforce planning
- Key barriers and enablers for multidisciplinary workforce planning.

Case studies are included to illustrate practical examples, and discussion questions are posed to support stakeholder feedback.

3.1 Current state

The key findings show that the current state of workforce planning is:

- Largely profession based, despite widespread recognition of the need for multidisciplinary approaches
- Based on approaches that replace FTE
- Reactive and constrained by short term funding

Further insights from the literature and stakeholders are presented below:

3.1.1 Workforce planning is still largely profession based, despite widespread recognition of the need for multidisciplinary approaches

What stakeholders told us

In consultations, stakeholders consistently noted that workforce planning remains dominated by profession specific structures and hierarchies, with nursing, medical and allied health streams still planning almost entirely within their own professional boundaries. Some stakeholders emphasised that, even when multidisciplinary intent exists, the practical planning work is still undertaken profession by profession and is often shaped by past practices rather than current or future service needs.

Some stakeholders also emphasised that a lack of understanding of capabilities and scopes of practice across professions remains a persistent challenge in multidisciplinary workforce planning (this is explored further in Section 3.2). In particular, both jurisdictional and peak and industrial body stakeholders noted that self-regulated professions and para-professional workforces are often misunderstood or overlooked, and their contributions to multidisciplinary teams are not adequately recognised. This limited understanding restricts efforts to fully integrate these professions into workforce planning.

Several jurisdictional stakeholders raised the challenge of current funding and planning cycles unintentionally reinforcing ‘siloes’ or profession-based thinking. Examples of this included how current service funding, capital planning and Full Time Equivalent (FTE) allocations remain disconnected, encouraging workforce planners to focus on filling existing positions rather than designing (or prioritising) integrated teams. Stakeholders generally agreed that the most meaningful multidisciplinary planning approaches emerged during operational crises such as in response to COVID-19. In these examples, normal hierarchies and barriers broke down out of necessity, however many stakeholders noted that positive changes to multidisciplinary planning during these periods have not been sustained.

What the literature indicates

Across healthcare systems both in Australia and internationally, published literature suggests that workforce planning is still commonly undertaken on a profession specific basis and is often not integrated with broader health service planning or population health needs.^{4,5} While multidisciplinary models are broadly acknowledged as better suited to complex and evolving healthcare needs, these approaches have yet to be embedded as standard practice in most planning processes.^{6 7}

3.1.2 Current approaches remain based on replacing existing FTE

What stakeholders told us

Jurisdictional and peak and industrial body stakeholders consistently noted that FTE-replacement approaches are often the current 'default method' of workforce planning, while acknowledging the limitations of this approach in considering future service requirements or changing models of care. In particular, jurisdictional stakeholders noted that FTE based approaches are often used because they align with existing data systems, funding models and industrial arrangements and are therefore easier to implement. Some stakeholders noted that there is an ongoing reliance on staff-per-bed or nursing ratios when workforce planning for acute care settings, because these ratios are familiar and easily translated into budget-requests, or may also be required by law.

Stakeholders also noted that the continued reliance on traditional FTE-based workforce frameworks is driven not only by historical staffing ratios, but also the absence of standardised workforce data sets for self-regulated professions and para-professional workforces. The absence of standardised datasets limits the planner's ability to account for evolving skill mix needs or roles beyond those of regulated professionals. Several jurisdictional stakeholders also highlighted that current workforce data largely supports planning for the workforce that exists today, rather than the workforce required in the future.

Stakeholders frequently described workforce planning in Australia as reactive to service and infrastructure decisions, with multidisciplinary workforce considerations introduced late in the planning process. This reinforces reliance on historical staffing profiles and limits the ability to proactively plan for different skill mixes, multidisciplinary teams or emerging roles required to meet future population needs.

Some stakeholders noted the variable capability across the system to move away from legacy service models for workforce planning. Jurisdictional stakeholders noted that planners in local health services have limitations in their access to reliable establishment data and analytical capabilities, which makes it difficult to move away from FTE-based approaches and undertake more complex needs-based or skills-based modelling. Stakeholders also observed the current lack of

⁴ Murphy, G. T., Birch, S., Mackenzie, A., Rigby, J., & Langley, J. (2017). An Integrated Needs-Based Approach to Health Service and Health Workforce Planning: Applications for Pandemic Influenza. *Démarche axée sur les besoins intégrés pour les services de santé et la planification de la main-d'œuvre en santé : application à une pandémie d'influenza. Healthcare policy = Politiques de sante*, 13(1), 28–42. <https://doi.org/10.12927/hcpol.2017.25193>

⁵ MacKenzie, A., Tomblin Murphy, G. & Audas, R. (2019). A dynamic, multi-professional, needs-based simulation model to inform human resources for health planning. *Hum Resour Health* 17, 42 <https://doi.org/10.1186/s12960-019-0376-2>

⁶ MacKenzie, A., Tomblin Murphy, G. & Audas, R. (2019). A dynamic, multi-professional, needs-based simulation model to inform human resources for health planning. *Hum Resour Health* 17, 42 <https://doi.org/10.1186/s12960-019-0376-2>

⁷ Asamani, J. A., Christmals, C. D., & Reitsma, G. M. (2021). The needs-based health workforce planning method: a systematic scoping review of analytical applications. *Health policy and planning*, 36(8), 1325–1343. <https://doi.org/10.1093/heapol/czab022>

nationally consistent methods or approaches for multidisciplinary workforce planning in Australia, noting that it often feels like many jurisdictions are working on the same problem but there is not adequate documentation or sharing of key learnings.

“We should have resources that are designed to support people who are doing planning. These should talk about models of care, the workforce required, and the FTE associated with the level of activity ... and then it can be a local resource with the ability to be adapted. Designing it yourself every single time doesn't make sense when there's a lot of evidence-based practise out there.”

– Jurisdiction stakeholder

What the literature indicates

The literature supports stakeholder views that health workforce planning continues to default to static FTE based models and historical staffing ratios, despite recognition that these approaches are poorly aligned with evolving population health needs and models of care.^{8,9} While needs-based workforce planning frameworks are conceptually well developed, their uptake in national and system level planning remains limited, with many jurisdictions continuing to rely on supply-side or utilisation based approaches derived from existing service patterns rather than future need.¹⁰

Consistent with stakeholder feedback, literature notes that historical FTE based approaches persist largely because they are administratively simpler to apply. They rely on readily available workforce data, align with existing funding, budgeting and industrial frameworks and avoid the need to make explicit assumptions about models of care, productivity or skill mix.¹¹

3.1.3 Approaches are often reactive and constrained by short-term funding settings

What stakeholders told us

Several jurisdictional stakeholders described a pattern where capital builds or service redesigns progress first, with workforce planning conducted as a secondary, reactive step once the scope is already fixed. This approach illustrates the broader issue of relying on separate static documents for planning, rather than pursuing a more integrated and dynamic approach to service and workforce

⁸ Asamani, J. A., Christmals, C. D., & Reitsma, G. M. (2021). The needs-based health workforce planning method: a systematic scoping review of analytical applications. *Health policy and planning*, 36(8), 1325–1343. <https://doi.org/10.1093/heapol/czab022>

⁹ Murphy, G. T., Birch, S., Mackenzie, A., Rigby, J., & Langley, J. (2017). An Integrated Needs-Based Approach to Health Service and Health Workforce Planning: Applications for Pandemic Influenza. *Démarche axée sur les besoins intégrés pour les services de santé et la planification de la main-d'œuvre en santé : application à une pandémie d'influenza. Healthcare policy = Politiques de sante*, 13(1), 28–42. <https://doi.org/10.12927/hcpol.2017.25193> & Asamani, J. A., Christmals, C. D., & Reitsma, G. M. (2021). The needs-based health workforce planning method: a systematic scoping review of analytical applications. *Health policy and planning*, 36(8), 1325–1343. <https://doi.org/10.1093/heapol/czab022>

¹⁰ Asamani, J. A., Christmals, C. D., & Reitsma, G. M. (2021). The needs-based health workforce planning method: a systematic scoping review of analytical applications. *Health policy and planning*, 36(8), 1325–1343. <https://doi.org/10.1093/heapol/czab022>

¹¹ Asamani, J. A., Christmals, C. D., & Reitsma, G. M. (2021). The needs-based health workforce planning method: a systematic scoping review of analytical applications. *Health policy and planning*, 36(8), 1325–1343. <https://doi.org/10.1093/heapol/czab022>

planning, as highlighted by many stakeholders. They explained that this often limits options for multidisciplinary team design because major service decisions have already been locked in.

“Our service planning and infrastructure planning come together; however, workforce planning is at the end of the process for our service plans. It's not an afterthought, but it's a reaction to the service planning. Instead, we could potentially look at our workforce shortages from a multidisciplinary perspective to progress a workforce planning approach.”

– Jurisdiction stakeholder

Some stakeholders described the challenge of funding being tied to election cycles, leading to ‘boom-or-bust’ type funding models which are reactive to short-term workforce needs but do not support longer-term planning approaches. Stakeholders noted that when funding is short term, uncertain, or dependent on political cycles, services cannot commit to the stable roles, capability development or team structures required for multidisciplinary models, leaving service level workforce planners unable to consider the use of multidisciplinary teams beyond the life of a grant or short-term initiative.

Peak and industrial body stakeholders reinforced that current approaches to workforce planning remain program-led, and that planning is typically structured around existing fundings streams (for example, the Workforce Incentive Programs for general practice and Medicare Benefits Scheme (MBS) item numbers) that are geared towards discrete professional roles rather than truly supporting multidisciplinary teams. Many of these stakeholders also highlighted that some examples of multidisciplinary teams in primary care or Primary Health Network (PHN) commissioned environments exist only because a specific grant requires it, and when grant funding ceases the multidisciplinary team structure usually cannot be sustained. It was noted that this makes it difficult to plan for multidisciplinary teams, as traditional funding sources, which are often tied to specific professional roles, cannot flexibly support multidisciplinary team models once grant funding ends.

Some stakeholders also noted that innovative approaches often emerge from committed local leaders who create workarounds to sustain multidisciplinary teams in the absence of systemically aligned support. An example of a locally led initiative given by a jurisdiction is the Geriatric Flying Squad, which is a rapid response outreach service into Residential Aged Care Facilities in the Sutherland Shire in New South Wales. It was established to address gaps in providing rapid, on-site medical care to prevent unnecessary hospitalisations, improve end of life care and enhance healthcare system efficiency.¹² This team consists of a geriatrician, nurse practitioners/nurse practitioner candidates and a clinical nurse consultant.¹³ This service provides care to aged care residents who are acutely unwell with conditions including pneumonia and heart failure, as well as outbreak management, and palliative care. This approach is seen as highly effective but is difficult to replicate or scale beyond its immediate context. The difficulty in scaling the approach was attributed to constraints related to activity-based funding models and a lack of enabling conditions

¹² NSW Agency for Clinical Innovation. (2014). *Specialist geriatric outreach to residential care* (ACI Clinical Innovation Program) https://aci.health.nsw.gov.au/_data/assets/pdf_file/0004/262804/Specialist-Geriatric-Outreach-model-ACI-Clinical-Innovation-Program.pdf

¹³ Jain, S., Gonski, P. N., Jarick, J., Frese, S., & Gerrard, S. (2018). Southcare Geriatric Flying Squad: an innovative Australian model providing acute care in residential aged care facilities. *Internal Medicine Journal*, 48(1), 88–91. <https://doi.org/10.1111/imj.13672>

for innovation, including strong leadership, autonomy and institutional support to test and implement new approaches.

Both jurisdictional and peak and industrial body stakeholders frequently cited Aboriginal Community Controlled Health Organisations (ACCHOs) as strong examples of multidisciplinary team-based care in practice. The Indigenous Australians' Health Programme is the key source of funding for ACCHOs, which provides a longer term, sustainable and flexible source of funding. This reflects a point of difference from fee-for-service and activity-based funding models, which can constrain long term workforce planning, workforce retention and the ability to scale proven approaches beyond local settings.

What the literature indicates

The literature supports stakeholder views that short-term, program-based workforce funding discourages long term workforce redesign and reinforces reliance on existing service and staffing models. Asmani et al. note that, in the absence of stable, system level planning framework, workforce innovations are more likely to remain confined to pilots or crisis responses with limited translation into routine, scalable workforce planning.¹⁴

3.2 Towards better practice: needs-based, capability based and integrated workforce planning

Drawing on insights from the literature and stakeholder engagement. The following best practice principles for multidisciplinary workforce planning have been identified:

- Workforce planning should be needs-based, to ensure workforce design is grounded in population health profiles, service gaps and patterns of demand rather than historical staffing ratios or existing FTE structures.
- Planning should leverage capabilities and skill-mix approaches by designing flexible teams built around skills and competencies rather than being limited by profession specific boundaries. This supports flexible use of the workforce and enables health professionals to work to their full scope of practice.
- Effective planning requires starts with the design of the model of care, adopting a structured and co-designed approach to first determine the service requirements and goals before multidisciplinary workforce planning begins
- Place-based approaches are essential to ensure models of care and workforce plans reflect the unique needs, contexts, and cultural considerations of different communities, particularly in rural, remote and culturally diverse settings.

The subsections that follow explore these principles in detail, drawing on stakeholder perspectives, case studies and the supporting literature to illustrate how they are applied in practice.

3.2.1 Needs-based planning provides a stronger foundation for aligning workforce with population health need

What stakeholders told us

¹⁴ Asamani, J. A., Christmals, C. D., & Reitsma, G. M. (2021). The needs-based health workforce planning method: a systematic scoping review of analytical applications. *Health policy and planning*, 36(8), 1325–1343. <https://doi.org/10.1093/heapol/czab022>

Jurisdictional stakeholders generally agreed that needs-based approaches offer a better evidence base for multidisciplinary team planning than relying on historic FTE patterns. Needs-based workforce planning focuses on aligning workforce composition with the unique health needs of the population.

Several jurisdictions described efforts to better align workforce design with population health profiles, community demand and service utilisation data, noting that this would provide a clearer basis for determining both the mix and capability requirements of future teams. Stakeholders emphasised that such planning requires the integration of workforce needs and with service delivery and infrastructure considerations to ensure flexibility and responsiveness to changing population needs. In rural and remote settings, stakeholders stressed that needs-based approaches are essential because traditional single profession models are not always viable. Some stakeholders noted that for rural and remote workforce planning there must be consideration of factors such as service scarcity, travel distances, cultural expectations and the realities of working with smaller, more generalist workforces.

Peak and industrial body stakeholders also supported the idea of needs-based planning approaches, particularly across primary care. Some stakeholders noted that commissioning bodies such as PHNs are increasingly shifting towards multidisciplinary models informed by disease burden, local service gaps and community participation. Oral health stakeholders, for example, described approaches that begin with mapping population health needs and then determining cost effective skill mixes (including emerging and assistant workforces) to meet those needs.

A range of peak and jurisdictional stakeholders highlighted the Ontario Family Health Teams model as an example of better practice. Stakeholders commented that this model is an international benchmark for multidisciplinary workforce planning, underpinned by funding reform and practical population-based data.

Case study: Ontario Family Health Teams (Canada)¹⁵

Ontario Family Health Teams provide an international benchmark for multidisciplinary primary care enabled by funding reform. The multidisciplinary teams include practitioners from health care services and community care who work together to deliver population-specific care across Ontario. Teams include GPs, nurses, pharmacists, and allied health professionals, designed around population health needs. Importantly, under the model, these healthcare providers are supported and enabled to deliver a full continuum of care even if the multidisciplinary teams are not in the same organization or the same physical location. The Family Health Teams model incorporates engagement with patients, family members, and caregivers to ensure the communities' needs shape planning and implementation decisions. The framework is underpinned by criteria spanning readiness at establishment, implementation expectations at 1-year, and at maturity level¹⁶. The criteria include considerations around:

- Patient care and experience
- Patient partnership and community engagement
- Defined patient population
- In-scope services

¹⁵ Ontario Ministry of Health. (2014). *Family Health Teams*. Ontario.ca. <https://www.ontario.ca/page/family-health-teams>

¹⁶ Ontario Ministry of Health. (2024). *Ontario Health Teams: Guidance for Health Care Providers and Organizations*. Ontario.ca. <https://www.ontario.ca/files/2024-01/moh-oht-hcp-guidance-doc-en-2024-01-22.pdf>

- Leadership, accountability and governance
- Performance measurement, quality improvement, and continuous learning
- Funding and incentive structure
- Digital health

The model also uses blended capitation and salary funding with clear scope definitions across professions. It seeks to transition health teams from individual funding envelopes to integrated funding envelopes based on the care needs of their specific population. Additionally, this model demonstrates how funding reform enables multidisciplinary teams more effectively than isolated scope changes.

What the literature indicates

Unlike traditional workforce planning, which often rely on workforce supply levels, existing ratios of professionals or historic FTE data, needs-based approaches adopt a population driven and demand sensitive perspective. This enables planners to address unmet needs and prepare for unexpected surges in demands, such as those caused by pandemics or natural disasters.^{17,18}

At its core, needs-based planning seeks to identify population health profiles, understand service requirements and workforce capacity, and tailor models of care, accordingly, ensuring that workforce strategies directly address the health demands of individuals and communities. This approach moves away from predefined headcounts, static ratios or professional silos, focusing instead on accurate and equitable responses to evolving needs.^{19,20}

For example, dynamic and multi-professional simulation models have proven useful in estimating health workforce needs in complex and evolving healthcare scenarios. This includes accounting for workforce availability, division of labour and service specific competencies which are important for achieving effective coverage and efficiency.²¹

A well-developed framework would begin by assessing a population's age distribution, the burden of disease and environmental factors that influence health. These factors are then translated into the types of services, interventions and workforce resources required to address health disparities.

¹⁷ Murphy, G. T., Birch, S., Mackenzie, A., Rigby, J., & Langley, J. (2017). An Integrated Needs-Based Approach to Health Service and Health Workforce Planning: Applications for Pandemic Influenza. *Démarche axée sur les besoins intégrés pour les services de santé et la planification de la main-d'œuvre en santé : application à une pandémie d'influenza. Healthcare policy = Politiques de sante*, 13(1), 28–42. <https://doi.org/10.12927/hcpol.2017.25193>

¹⁸ Asamani, J. A., Christmals, C. D., & Reitsma, G. M. (2021). The needs-based health workforce planning method: a systematic scoping review of analytical applications. *Health policy and planning*, 36(8), 1325–1343. <https://doi.org/10.1093/heapol/czab022>

¹⁹ Asamani, J. A., Christmals, C. D., & Reitsma, G. M. (2021). The needs-based health workforce planning method: a systematic scoping review of analytical applications. *Health policy and planning*, 36(8), 1325–1343. <https://doi.org/10.1093/heapol/czab022>

²⁰ Murphy, G. T., Birch, S., Mackenzie, A., Rigby, J., & Langley, J. (2017). An Integrated Needs-Based Approach to Health Service and Health Workforce Planning: Applications for Pandemic Influenza. *Démarche axée sur les besoins intégrés pour les services de santé et la planification de la main-d'œuvre en santé : application à une pandémie d'influenza. Healthcare policy = Politiques de sante*, 13(1), 28–42. <https://doi.org/10.12927/hcpol.2017.25193>

²¹ MacKenzie, A., Tomblin Murphy, G., & Audas, R. (2019). A dynamic, multi-professional, needs-based simulation model to inform human resources for health planning. *Human resources for health*, 17(1), 42. <https://doi.org/10.1186/s12960-019-0376-2>

Such needs-based frameworks are seen as integral to achieving Universal Health Coverage and improving equitable access to care.²²

Case study: Segal and Leach’s needs-based tool for primary and community care multidisciplinary planning (Australia)²³

Context

Traditional approaches to workforce planning are limited in that they do not always account for the complexity and variation in patient needs. This case study details the development and application of a Workforce Evidence-Based (WEB) model in diabetes care in primary and community care settings in Australia. This model was developed by scholars Segal and Leach. A key feature of the model is the classification of subpopulations, and the consideration of threats to self-care capacity, which provides greater nuance when determining the needs of the population. The model also highlights how needs-based health workforce planning facilitates skilled, multidisciplinary teams with the right occupational and skill mix required to deliver care across complex population needs.

Mechanism

The model seeks to address challenges associated with the complexity of reflecting the diverse community and clinical population needs and translates those needs into clinical care requirements. It does so through the following framework:

- A four-step competency and skill-based needs assessment:
 - Identifying the health status of the selected population.
 - Estimating population levels and attributes for different subpopulation groups based on existing data.
 - Collating and integrating evidence-based findings on better practice care for each subpopulation.
 - Translating best-practise care into care protocols, which account for different competencies and skills.
- An estimate of regional service requirements, using care protocols and population-level estimates.
- Policy implications, providing data to optimise workforce composition and health service delivery.

The model was applied to diabetes care in primary and community settings and used a mix of expert panels, clinical guidelines, and data from national surveys to estimate regional demand for tailored health workforce planning. The model allows for customisation of population attributes, care protocols, cost parameters, and changes in the understanding of disease and threats to successful treatment, enabling the modelling of different scenarios.

Outcome

The theoretical application of this model highlights its role in promoting equity, particularly for patients from disadvantaged subpopulations. The model’s customisable features better enable

²² Asamani, J. A., Christmals, C. D., & Reitsma, G. M. (2021). The needs-based health workforce planning method: a systematic scoping review of analytical applications. *Health policy and planning*, 36(8), 1325–1343. <https://doi.org/10.1093/heapol/czab022>

²³ Segal, L., & Leach, M. J. (2011). *An evidence-based health workforce model for primary and community care*. *Implementation Science*, 6(93). <https://doi.org/10.1186/1748-5908-6-93>

consideration of factors such as psychological and functional limitations, which feeds into more responsive workforce planning. In turn, it improves the quality of multidisciplinary approaches, promoting a more comprehensive view of the patient and their needs. The model has also been used in practice by the South Australian Department of Health to inform state-wide paediatric speech pathology services as well as the state's palliative care workforce.

Despite growing awareness of its value, needs-based workforce planning is underutilised in practice due to several challenges. These include lack of standardisation in methodological frameworks, inconsistent application of key concepts across countries, and limited adoption of comprehensive, open access models that can guide practical implementation.²⁴

3.2.2 Capability- and skill-mix approaches enable more flexible and sustainable teams

What stakeholders told us

Jurisdictional stakeholders noted that capability based and skill mix approaches present an important opportunity to use Australia's limited health workforce more flexibly. Stakeholders from both jurisdictions and peak and industrial bodies generally described the significant challenges faced in understanding the scopes of practice for different regulated and self-regulated professions and the lack of practical resources that explain the capabilities of these individual professions. While stakeholders did not explicitly reference the recent SOP Review, they described challenges that mirror its findings. This specifically relates to the existing regulated and self-regulated professions not being adequately enabled to work to their full scope in multidisciplinary teams and how this presents a barrier to employing capability-based multidisciplinary workforce planning in practice.

In the context of employing capability-based approaches to multidisciplinary workforce planning, some jurisdictional stakeholders also raised the issue of delegation to para-professional workforces (e.g. assistant workforces, physician assistants) and students. This was described as an effective way to create capacity so that regulated and self-regulated workforces could focus on working to the top of their scope, particularly when supported by strong senior clinical buy in and clear agreements on task boundaries. Other stakeholders noted, however, that use of these para-professional workforces is not a 'magical solution', emphasising that, while assistant use is important, there does need to be balanced approaches that consider the specialisations within professions and underutilisation of the capabilities across the regulated and self-regulated health professional workforce.

"There is no shortage of innovative ideas from clinical staff. They are boldly thinking from multidisciplinary and transdisciplinary perspectives and considering different roles that are needed. The models that our clinicians ... are saying that they want to move towards are not just bricks and mortar. They are dynamic, cross-disciplinary workforce models. But ... we don't have mechanisms as a system to properly plan for these models ... they aren't one-off costs; they involve ongoing costs."

– Jurisdiction stakeholder

²⁴ Asamani, J. A., Christmals, C. D., & Reitsma, G. M. (2021). The needs-based health workforce planning method: a systematic scoping review of analytical applications. *Health policy and planning*, 36(8), 1325–1343. <https://doi.org/10.1093/heapol/czab022>

Several jurisdictions highlighted successful local models that demonstrate a capability-based approach to team construction, such as transitional care wards led by nurse practitioners or transdisciplinary rapid response teams. It was noted that these models operate most effectively when supported by structured training, clarity of scope and strong leadership.

Peak and industrial body stakeholders similarly acknowledged the need for workforce models built around capabilities, with many highlighting emerging national training and capability projects designed to support role evolution and career pathways for regulated, self-regulated and para-professional health workforces. They also noted that while many professions are willing to expand practice and participate more fully in multidisciplinary models, regulatory constraints, funding mechanisms and cross jurisdictional inconsistencies often prevent this. Stakeholders highlighted that without addressing these structural barriers, skill mix redesign will remain limited to isolated pilots rather than embedded in everyday practice.

What the literature indicates

Capability-based approaches focus on the tasks, skills and competencies required to deliver healthcare rather than job titles or professional categories. According to the literature, skill mix frameworks highlight gaps in the existing workforce while identifying opportunities to reconfigure care delivery. They emphasise tasks that can be performed by various professional groups, allowing a more flexible and efficient allocation along the care pathway.²⁵ Such approaches ensure better alignment between the available skill mix and population needs while improving transparency in forward workforce planning. By enabling task redistribution across multidisciplinary teams, they allow professionals to practice at the top of their scope and optimise limited resources.²⁶

For instance, the transition from ‘staff mix’ to ‘skill mix’ equips healthcare systems to adapt to emerging challenges, helping address workforce shortages and streamline task allocation. Rather than relying solely on traditional population to provider ratios or static professional roles, skill mix approaches allow health workforce planning to incorporate pay, productivity and practice style differences between professional groups.²⁷ This kind of task redistribution promotes sustainability and ensures that non-medical and para-professional roles can fully contribute to improving system-level outcomes, provided they have consistent regulatory and structure support.^{28; 29}

Literature sources suggest that the success of capability-based workforce planning also relies on addressing systemic inefficiencies, including the lack of integration between workforce planning,

²⁵ Birch, S., Gibson, J. & McBride, A. (2020). Opportunities for, and implications of, skill mix changes in healthcare pathways: Pay, productivity and practice variations in a needs-based planning framework *Social Science & Medicine*, (250) 112863, <https://doi.org/10.1016/j.socscimed.2020.112863>.

²⁶ Meadows, D., Maclaren, J., Morton, A., & Ross, D. (2025). Determining skill mix and optimal multidisciplinary team composition: A scoping review. *Healthcare management forum*, 38(3), 278–285. <https://doi.org/10.1177/08404704241293095>

²⁷ Birch, S., Gibson, J. & McBride, A. (2020). Opportunities for, and implications of, skill mix changes in healthcare pathways: Pay, productivity and practice variations in a needs-based planning framework *Social Science & Medicine*, (250) 112863, <https://doi.org/10.1016/j.socscimed.2020.112863>.

²⁸ Meadows, D., Maclaren, J., Morton, A., & Ross, D. (2025). Determining skill mix and optimal multidisciplinary team composition: A scoping review. *Healthcare management forum*, 38(3), 278–285. <https://doi.org/10.1177/08404704241293095>

²⁹ Dubois, C. A., & Singh, D. (2009). From staff-mix to skill-mix and beyond: towards a systemic approach to health workforce management. *Human resources for health*, 7, 87. <https://doi.org/10.1186/1478-4491-7-87>

health service delivery models and healthcare funding systems.³⁰ Further, effective planning necessitates moving beyond simplistic population to provider ratios and incorporating productivity differences in how professional groups provide similar services, as well as the mix of tasks required for efficient care delivery.³¹

The SOP Review identified limited national visibility of workforce skills and capabilities as a critical barrier to workforce reform, noting that this gap undermines workforce planning, funding decisions and the effective design of multidisciplinary teams around capability³². Further, the SOP Review highlighted that both regulated and self-regulated health professionals are often not enabled to work to their full scope of practice within multidisciplinary teams. However, the SOP Review also identified a series of better practice examples of effective multidisciplinary workforce team models, many of which were also raised by stakeholders throughout consultation for this report. A selection of these case studies is presented in the table below, spanning both Australian and international contexts.

Table 3 Case studies examples identified in the SOP Review³³

Case study	Description
Aboriginal Community Controlled Health Services (ACCHSs)	ACCHSs provide an established Australian example of place based multidisciplinary teams operating effectively with expanded scopes of practice. Teams include GPs, nurses, nurse practitioners, Aboriginal Health Practitioners and Workers, allied health professionals, and social and community support roles. Clear role delineation, strong governance, and trust enable non-medical practitioners to work to full clinical and cultural scope. This results in improved access and strong chronic disease outcomes for priority populations. The SOP Review identified ACCHSs as evidence that multidisciplinary teams can function safely when funding and governance are aligned.
GP Led Multidisciplinary Primary Care Teams	GP led multidisciplinary primary care teams in Australia show how scope of practice can be optimised within general practice. Teams typically include GPs, practice nurses, embedded or linked pharmacists, and allied health professionals. Nurses and allied health professionals deliver care without unnecessary GP gatekeeping, supported by shared care planning based on capability. This enables better use of GP time for complex presentations. The SOP Review uses these models to show many scope restrictions are structural rather than clinical.
Pharmacist Integrated Care Models	Pharmacist integrated care models draw on Australian pilots and international comparators to demonstrate safe scope expansion within multidisciplinary teams. Models include pharmacists

³⁰ Meadows, D., Maclaren, J., Morton, A., & Ross, D. (2025). Determining skill mix and optimal multidisciplinary team composition: A scoping review. *Healthcare management forum*, 38(3), 278–285. <https://doi.org/10.1177/08404704241293095>

³¹ Birch, S., Gibson, J. & McBride, A. (2020). Opportunities for, and implications of, skill mix changes in healthcare pathways: Pay, productivity and practice variations in a needs-based planning framework *Social Science & Medicine*, (250) 112863, <https://doi.org/10.1016/j.socscimed.2020.112863>.

³² Australian Government Department of Health and Aged Care. (2024). *Unleashing the potential of our health workforce: Scope of practice review – Final report*. https://www.health.gov.au/sites/default/files/2024-11/unleashing-the-potential-of-our-health-workforce-scope-of-practice-review-final-report_0.pdf

³³ Australian Government Department of Health and Aged Care. (2024). *Unleashing the potential of our health workforce: Scope of practice review – Final report*. https://www.health.gov.au/sites/default/files/2024-11/unleashing-the-potential-of-our-health-workforce-scope-of-practice-review-final-report_0.pdf

	embedded in general practice, pharmacist prescribing with additional training, and pharmacist led chronic disease medication management. The SOP Review highlights that expanded scope is safe with appropriate training, governance, and team-based care arrangements. Reported benefits include reduced GP workload and improved medication safety and quality use of medicines. These examples support workforce redesign and funding reform, rather than isolated profession specific expansion.
Nurse Led and Nurse Practitioner Models	Nurse led and nurse practitioner models across Australia and internationally demonstrate safe and effective expanded nursing scope in primary care. Models include nurse led clinics, chronic disease management, and preventive care and follow up for defined cohorts. Evidence shows outcomes comparable to doctor led care and high patient satisfaction. These models are most effective when funding and regulatory arrangements support clinical autonomy. The SOP Review shows nursing scope is limited more by payment systems than competence.

3.2.3 Model of care design underpins effective multidisciplinary workforce planning

What stakeholders told us

Jurisdictional stakeholders consistently emphasised the importance of designing multidisciplinary models of care *first* before engaging in workforce planning when planning for new facilities or redesigning care and service pathways. As noted earlier, many stakeholders described their current workforce planning process as reactive and disconnected, stemming from the sequencing of workforce planning before multidisciplinary service or model of care design has been considered. Some stakeholders observed that when the model of care is established first and then refined through an iterative two-way discussion with workforce planning, it becomes far easier to identify the multidisciplinary team structure, skill mix and capability requirements needed to deliver the service. Several jurisdictions described positive experiences in greenfield (hospital site) developments, where service design, model of care work and workforce planning were aligned from the outset, resulting in clearer workforce requirements and more effective multidisciplinary collaboration. Conversely, jurisdictions noted that, when models of care are not well-defined, workforce planning is more likely to default to historical FTE structures.

Some jurisdictional stakeholders emphasised the importance of taking a deliberate, genuine co-design approach involving service designers, clinicians, planners and communities to help shape the model of care and the multidisciplinary workforces that will deliver on the model of care. They noted that this requires explicit guidance for workforce planners, including how to run multidisciplinary and community led design workshops, how to build roles and interactions collaboratively and guidance on ways to set aside ‘traditional practice’ to design new, integrated ways of working.

“For new workforces, for new sites and services, the best way is to land on the model of care first and then build the workforce around it.”

– Jurisdictional stakeholder

Peak and industrial body stakeholders generally agreed the importance of designing models of care that support multidisciplinary teams as a key need for effective workforce planning. Stakeholders

noted that many proposed models of care assume full scope, new roles or enhanced supervision arrangements, but these assumptions are often undermined by existing funding structures, training pathways or regulatory constraints. Some stakeholders explained that, unless these enabling conditions are addressed upfront, model driven workforce planning may not be realistic in practice.

As noted earlier, stakeholders from both jurisdictions and peak and industrial bodies described how there is a lack of clarity on scopes of practice for different professions, and they highlighted how this is also a significant barrier to designing and implementing effective models of care. Some stakeholders specifically noted that the ambiguity in role definitions across professions complicates model of care development, workforce arrangements and, therefore has a direct impact on the ability to effectively plan for multidisciplinary workforces.

Clinician engagement was also flagged as important in effective multidisciplinary workforce planning approaches. Participants noted that clinicians, particularly those who are involved in multidisciplinary teams, hold valuable insights into designing and structuring teams for better outcomes. Collaborative planning processes that involve senior clinicians during the early stages of models of care development, and as champions of change throughout the process, were flagged as important to achieve ‘buy-in’ from leaders, and acceptance of multidisciplinary team-based approaches. The case study below highlights some work undertaken in Queensland to employ co-design processes to develop models of care that better embed the role of Aboriginal and Torres Strait Islander Health Practitioners (A&TSIHPs) and consider the delivery of culturally and clinically safer care.

Case Study: Strengthening Culturally and Clinically Safe Models of Care – Role of Aboriginal and Torres Strait Islander Health Practitioners (Australia)³⁴

Context

The Queensland Government committed to redesigning workforce models to enhance cultural safety, clinical safety, and service accessibility for First Nations people. This approach was co-designed in 2023 through work with the Better Health North Queensland Alliance and is intended to promote better access to quality care and better health outcomes for First Nations patients.

Mechanism

This process developed a culturally and clinically safe model of care that embeds A&TSIHPs into multidisciplinary teams to improve outcomes for First Nations peoples across Queensland. It details the importance of the A&TSIHP profession and roles, a framework for culturally and clinically safe care, models of care for six priority clinical areas (diabetes, kidney care, sexual and reproductive health, antenatal Care, mental health, and rheumatic heart disease), and implementation enablers for use by health services. The A&TSIHP role is embedded across each clinical service model. Across each stage of care, the framework demonstrates that multidisciplinary teams are responsible for delivering tasks to:

- Maximise clinical safety and quality of care for Aboriginal and Torres Strait Islander peoples, including:
 - Enabling patient access

³⁴ Queensland Health. (2023). *Strengthening culturally and clinically safe models of care*. https://www.health.qld.gov.au/_data/assets/pdf_file/0029/1345961/strengthening-culturally-and-clinically-safe-models-of-care.pdf

- Supporting patient engagement, informed consent and shared decision-making
- Maintaining patient confidentiality and privacy
- Coordinating and supporting the navigation of care
- Providing referrals
- Embed culturally safe practices that enable optimal health and wellbeing outcomes for Aboriginal and Torres Strait Islander peoples, by:
 - Ensuring cultural respect and empowering self-determination
 - Applying a strengths-based approach to the provision of holistic care
 - Engaging community and family Incorporating cultural practices, traditions and beliefs into the delivery of care
 - Using traditional languages, interpreters and culturally appropriate resources

The framework is designed at a high-level to support application and adaptation across specific service areas and patient needs. It is represented in a linear approach but recognises that patients may move in and out of different stages of care over time. In doing so, it highlights how multidisciplinary teams therefore need to deliver responsive and person-centred care that is coordinated across sectorial, organisational and geographic boundaries.

Outcome

The models of care developed provide practical templates and examples which health services can use and adapt. These are applicable to the services considered during development, as well as other services and health conditions.

3.2.4 Place-based approaches to multidisciplinary planning are effective in reflecting and meeting specific community needs

What stakeholders told us

Stakeholders described 'place-based' approaches as complementary to needs-based and capability-based planning, but distinct in that they explicitly account for the realities of 'place'. This theme is included in this paper because it emerged repeatedly during consultations, particularly in discussions about planning for rural and remote service delivery and culturally safe care.

Jurisdictional stakeholders emphasised that place-based planning approaches are crucial in rural, remote and culturally diverse communities, where models of care must reflect local needs, local workforce availability and community expectations. Stakeholders highlighted the importance of designing networked, regionwide models in small or remote areas, recognising that single site models are often unsustainable because they are unable to offer an adequate FTE allocation to attract health professionals to the role at a single site alone, and do not reflect the reality of service providers working together across organisational boundaries to meet need. Examples shared by stakeholders, such as the Torres and Cape health worker led model and 'grow-your-own' regional workforce initiatives, reflected the importance of building local pipelines, ensuring cultural alignment and designing workforce models that reflect community realities. These insights were reinforced through examples from jurisdictions participating in community led 'thin markets' projects, where service design began with identifying local needs and then determining a feasible workforce model to meet them.

"The Support at Home Thin Markets Program that the Commonwealth is running ... has a high level of community engagement and a real population health approach. Because it is based in a

rural community, it considers employment models, the design of a facility and who would be in the facility ... It goes beyond workforce roles and FTE capabilities into how it will operate ... especially when you get to the small rural locations. That's important because the models we would use for large sites don't translate to small locations. It is quite heavily focused on design, but the point of difference is that it has been crowdsourced from the community with a very high level of engagement. It has resulted in a sustainable and innovative design.”

– Jurisdiction stakeholder

Several participants also described place-based models that are designed to deliver ‘in place care’, rather than defaulting to hospital-based care. Stakeholders described these approaches as helping keep people well and supported at home or in their usual setting, while reducing avoidable emergency department presentations.

Peak and industrial body stakeholders reinforced the view that place-based approaches promote proactive communication and collaboration with local stakeholders, including community members, healthcare organisations and service providers. A peak body stakeholder gave an example of facilitating roundtable discussions as a means to design solutions tailored to community needs. Another stakeholder gave an example of effective workforce planning approaches involving the identification of hot spots where care / service solutions are required through consultation with local communities to determine urgency and need, rather than assuming previous workforce distribution models were correct. Stakeholders highlighted that practical factors such as housing availability, supervision capacity and childcare access can be decisive in attracting and retaining rural health professionals. They also noted the critical role of community-controlled organisations and local commissioning in tailoring multidisciplinary models to each community's circumstances.

What the literature indicates

Population-specific needs are often not accounted for in health service and health workforce planning³⁵. This contributes to unmet needs across populations and inaccurate projections of workforce demand³⁶. Some research has highlighted the value of place-based approaches in multidisciplinary workforce planning. Place-based approaches, particularly those that are co-designed or developed with input from communities, are effective in meeting the needs and values of the population it serves. By understanding the needs of a community, as well as the gaps it faces in service provision, health services are better able to develop and implement comprehensive workforce planning models³⁷. Place-based approaches are also useful in empowering communities to take an active role in, and the ability to, make informed decisions about their healthcare. The case study below is an example of a mature multidisciplinary care model that incorporates place-based approaches such as understanding unique community needs and designing teams that meet those needs. This approach has seen improvements in health outcomes and access to services across its community.

³⁵ Tomblin Murphy, G., Gilbert, J. H., & Rigby, J. (2019). Integrating interprofessional education with needs-based health workforce planning to strengthen health systems. *Journal of Interprofessional Care*, 33(4), 343–346. <https://doi.org/10.1080/13561820.2019.1638758>

³⁶ Asamani, J. A., Christmals, C. D., & Reitsma, G. M. (2021). The needs-based health workforce planning method: a systematic scoping review of analytical applications. *Health policy and planning*, 36(8), 1325–1343. <https://doi.org/10.1093/heapol/czab022>

³⁷ Gottlieb, K. (2013). The Nuka System of Care: improving health through ownership and relationships. *International Journal of Circumpolar Health*, 72(1), 21118. <https://doi.org/10.3402/ijch.v72i0.21118>

Case study – Nuka System of Care (Canada)³⁸**Context**

Southcentral Foundation's *Nuka System of Care* is a system designed, managed and owned by Alaska Native people which provides a variety of behaviour, dental, medical, and community-based health services. The Nuka System is a result of a complete redesign of the tribal healthcare system based on the values and needs of the Alaska Native people, who have a key role in the design, implementation, and control of the health programs provided. This approach to multidisciplinary care delivery represents a mature, place-based approach which includes understanding the needs of the local community and working with them to meet these needs. It is underpinned by three key principles:

- Shared responsibility: working with patients as customer-owners to identify and respond to their needs, and forming relationship-based partnerships across local, regional, national service partners to collaborate and identify service gaps.
- Commitment to quality: structured organisational planning to optimise the skills and contributions of staff, and dedicated staff training days led by the president/CEO to model the organisation's relationship-building behaviours.
- Family wellness: multidimensional and cross-generational health and wellness is the benchmark for success, reflecting a focus on both current and future needs.

Mechanism

The model uses integrated care teams and promotes the integration of behavioural health and traditional healing into primary care. It also supports its community members living in rural areas through distance delivery of healthcare, and the provision of telehealth-style services. Clinical teams within the Nuka model regularly travel to villages to provide family medicine, behavioural health, dental and optometry services, with some locations only accessible only by air or boat. Some of the model's key implementation principles underpinning this workforce approach include:

- Relationships between the customer-owner, the family, and provider must be fostered and supported
- Locations that are convenient for the customer owner and create minimal stops for the customer owner
- Intentional whole system design to maximise coordination and minimise duplication
- Interests of the customer-owner drive the system to determine what we do and how we do it
- Population-based systems and services
- Services and systems build on the strengths of Alaska Native cultures

The Nuka System offers a strong example of a place-based approach to multidisciplinary workforce planning, with the design of services and multidisciplinary teams grounded entirely in local relationships, community ownership and culturally specific needs. Alaska Native people also play a central role in governance and day to day operations, occupying clinical, nonclinical and leadership positions across the organisation. Nuka's operational principles shape key workforce planning decisions, including hiring practices, facility design, job progressions, and organisational structures. The Nuka System also engages with customer-owners across Alaska, working in partnership with different cultural groups to capture feedback. This is done via informal methods

³⁸ Gottlieb, K. (2013). The Nuka System of Care: improving health through ownership and relationships. *International Journal of Circumpolar Health*, 72(1), 21118. <https://doi.org/10.3402/ijch.v72i0.21118>

such as personal interactions with staff and comment cards, as well as more structured methods such as surveys, a 24-hour telephone hotline, online forms, focus groups and advisory committees.

Outcome

The Nuka System has improved health outcomes and increased access to services for its customer-owners across Alaska. These improvements are evident in the increase in access to a primary care provider from 35% in 1996 to more than 95% in 2013, and the 36% reduction in hospital days, 42% reduction in emergency and urgent care usage, and a 58% reduction in specialty clinic visits over ten years.

3.3 Existing models shifting towards better practice: a review of grey literature

This section reviews examples of existing and previous workforce planning models from consultations and grey literature, highlighting common features and lessons that support the shift towards multidisciplinary, needs-based approaches.

3.3.1 Overview of current and previous examples

What stakeholders told us

During consultation, stakeholders shared examples of standalone tools developed in different contexts to support multidisciplinary workforce planning efforts. These include Health Workforce Australia (HWA)³⁹ from 2014, informed by the World Health Organisation's systems thinking framework, Gold Coast Health⁴⁰ (GCH), prepared in 2025, and the Toronto Region Primary Care Workforce Planning Toolkit⁴¹, developed in 2022. Many stakeholders highlighted these examples due to their clear processes and steps, sharing that they can be applied across contexts.

What the literature indicates

While each model was designed for a specific population, a review of the available grey literature indicates that there are commonalities across the processes which can be translated into different contexts. The common features across models highlight the need to:

- Conduct a needs assessment.
- Identify the population and its relevant stakeholders.
- Conduct a gap analysis on existing capabilities and skillsets.
- Assess the skillset required to meet the needs of the population.
- Develop and discuss implications of the changes with clinical reference groups and the workforce.

Health Workforce Australia

³⁹ Health Workforce Australia. (2014). Regional health workforce planning in north Queensland: starting with the end in mind.

⁴⁰ Gold Coast Health, Queensland Government. (2025). Strategic Workforce Planning Framework Workforce Strategy. <https://www.goldcoast.health.qld.gov.au/>

⁴¹ Ontario Health Toronto and Canadian Health Workforce Network. (2025). Toronto Region Primary Care Workforce Planning Toolkit. <https://www.ontariohealthprofiles.ca/ontariohealthtoronto/index.php>

The HWA model incorporates the use of clinical reference groups as a key stakeholder at each stage of design and development. This is intended to provide opportunities for health services to participate in the process. The approach also seeks to ensure that all communities and health services are represented in decision-making, spanning public and private providers, as well as community-controlled organisations. The steps in this model include:

- **Establishing clinical reference groups and conducting a needs assessment:** identifying stakeholders and convening clinical reference groups, needs assessment, agreeing on an essential collective of services and gap analysis.
- **Remodelling and designing health service model:** develop a current and future state model which meets the needs of the community, discuss impacts of change with clinical reference group, and prioritise service delivery areas for action.
- **Assessing skillsets required and configuring the workforce:** design workforce model in priority areas, discuss existing and required skillsets, present findings to clinical reference group, and refine workforce requirement projections.
- **Developing a workforce and training plan:** identify additional sources of revenue and options for workforce configuration, identify existing and required training pathways, discuss with clinical reference group, and implement and evaluate approach.

Gold Coast Health

The GCH Strategic Workforce Planning Framework also reinforces the sentiment shared by many stakeholders that the model of care should be defined prior to workforce planning. It is accompanied by a series of practical toolkits, checklists, and questions to guide discussion, implementation, monitoring and evaluation. The GCH framework involves the following steps:

- **Getting ready:** determining the health service's strategic workforce planning readiness.
- **Align:** scanning and understanding the health service's strategic direction, business drivers, and environmental factors, to anticipate future service needs and critical capability requirements.
- **Analyse:** conducting a detailed analysis into relevant workforce profiles to identify the gap between capability, demand, supply and conceptualised scenarios.
- **Profile:** consolidating findings and projections into clearly defined and agreed actions, targets and measures to achieve the strategic workforce vision.
- **Implement and monitor:** ensuring actions owners are aware of their responsibilities, monitoring and reporting progress of the plan, and evaluating success against defined actions.

In addition to FTE replacement processes, the GCH framework outlines approaches for conducting environmental scans with relevant stakeholders and undertaking guided scenario planning- workshops led by Workforce Strategy and Capability specialists. These tools are designed to support exploration of a range of possible service scenarios (such as changes to capital build programs, networked service models, ward closures or new models of care) to identify the workforce capabilities and adjustments that may be required. The framework also describes the data available through the organisation's workforce planning dashboard, which enable a better understanding of the current workforce profile and consider future workforce needs.⁴²

Toronto Region Primary Care Workforce Planning Toolkit

The Toronto Region Primary Care Workforce Planning Toolkit includes a collection of interactive resources to support integrated primary care workforce planning. This approach defines population needs and workforce capacity at the neighbourhood, sub-region, and whole city levels, and factors

⁴² Gold Coast Health. (2025). Strategic Workforce Planning Framework.

in challenges specific to Toronto, including patient mobility, population growth, and workforce retirement. The key steps in this interactive model include:

- **Understanding community characteristics:** identifying key attributes such as population size, health status, age, hospitalisation data, amongst other demographic characteristics.
- **Understanding service requirements:** modelling how many times a patient will visit the service over a defined period to help determine workforce needs.
- **Understanding workforce service capacity:** identifying which health professionals currently provide services in the defined population area and developing future workforce projections based on needs of population.
- **Assessing alignment:** determining whether service capacity aligns with service requirements into the future.
- **Explore factors at play:** adjust projections based on factors such as population growth, mobility, and retirement levels.

The Toolkit is accompanied by a playbook⁴³ designed to guide health workforce planners in practice. It provides practical tools and questions to assist workforce planners to identify gaps and understand which types of data to draw on.

The toolkit adopts a cyclical health workforce planning process. This includes horizon scanning, scenario generation and quantitative workforce analysis activities, which inform policy analysis and decision-making. Engagement is at the core of this process and is embedded across all stages. The tools identified to assist workforce planners in identifying gaps include:

- A Systems Framework
- Social Technological, Economic, Environmental, Political, Legal, Education and Demographic (STEEPLED) analysis
- Strengths, Weaknesses, Opportunities, and Threat (SWOT) analysis
- Causal loop diagrams

The playbook identifies potential sources of data workforce planners can draw on to guide their planning. It identifies different subsets of population data, including the data elements, geographic parameters, and the data source. These are tailored to communities across Ontario, including population-based datasets, administrative health records, neighbourhood-level primary care data, and qualitative insights from stakeholder engagement.

3.4 Enablers and barriers to implementing better practice

Drawing on stakeholder insights and the literature, this section identifies a set of interrelated enablers that underpin the effective implementation of multidisciplinary workforce planning. Specifically, the evidence highlights that:

- Leadership and governance are foundational to initiating, legitimising and sustaining multidisciplinary workforce planning. Strong executive and senior clinical leadership are required to set expectations, support change across professional boundaries and align ‘top down’ direction with ‘bottom up’ innovation at the service level.

⁴³ Canadian Health Workforce Network & Ontario Health Toronto. (2024). *How-to playbook for health workforce planning*. Ontario Community Health Profiles Partnership.
https://ontariohealthprofiles.ca/ontariohealthtoronto/doc/Planning%20How-to%20Playbook_Final_September%202024.pdf

- Consistent, high quality workforce data is essential to enable forward-looking, multidisciplinary planning. Accessible and trusted data supports informed decision making, reduces reliance on static FTE replacement approaches and enables consideration of alternative team configurations and skill mixes.
- Technology and information sharing play an enabling role in coordinating multidisciplinary teams and supporting new planning approaches. Digital tools, including telehealth platforms and emerging AI enabled analytics, have the potential to strengthen collaboration, support virtual models of care and enhance workforce planning capabilities.
- Funding and payment models materially influence the feasibility and durability of multidisciplinary workforce models. Sustainable funding arrangements are critical to moving beyond short-term pilots and enabling services to plan, invest in and retain multidisciplinary teams over time.
- Collaboration across professions, organisations and communities is central to breaking down silos in workforce planning. Structural supports for cross disciplinary engagement, shared planning processes and coordination across sectors are required to embed multidisciplinary workforce planning approaches.
- Education, training and supervision systems must enable capability-based and multidisciplinary models of care. Consistent, interprofessional education and training pathways support shared understanding of roles and scopes of practice, build confidence in team-based care and enable workforce flexibility.

3.4.1 Leadership and governance enable multidisciplinary planning to be initiated, sustained and scaled

What stakeholders told us

Jurisdictional stakeholders consistently identified that strong cross-professional leadership, particularly from senior clinical leaders, is an important factor determining whether multidisciplinary workforce models and workforce planning approaches can be established and sustained. Across jurisdictions, some stakeholders described that, often, innovations are highly dependent on committed senior clinicians, especially medical and nursing leaders, who can legitimise new approaches and help override professional resistance. They also noted that, when these leaders move on, successful models often lose momentum or collapse, indicating the fragility of multidisciplinary team efforts without ongoing stewardship. Stakeholders generally agreed that this places a challenge on effective multidisciplinary workforce planning and there was consensus that a 'top-down' approach is a key enabler to support workforce planners within organisations.

"We have had some success with delegation ... and that has worked best when we've gone through a fairly comprehensive process of task analysis and buy-in from senior clinical staff around what's possible to be delegated."

– Jurisdiction stakeholder

"These models, because they're innovative, require constant gardening. It needs someone who understands this different way of working, who brings someone new in, who gives them that training, who really sticks to that model of care. Because it can float away to individual professions very quickly"

– Jurisdictional stakeholder

Nonetheless, stakeholders also observed that multidisciplinary team structures often emerge from ‘bottom up’ efforts at the practice or local level. These efforts were described as driven by individual leadership and localised needs rather than systemic design. These arrangements are common in regional or rural areas where resource constraints have demanded innovations out of necessity. Many stakeholders observed that strong leadership at a local level works in tandem with the broader ‘top-down’ support, suggesting both are important for successful and sustainable multidisciplinary planning.

Peak and industrial stakeholders reinforced these observations, emphasising that the absence of national leadership around scopes of practice, training expectations and regulatory permissions limits the ability of multidisciplinary workforce models to take hold more broadly. Some stakeholders described that many promising or innovative multidisciplinary team models occur despite the system, rather than because of it, highlighting the need for national leadership to set expectations and create a supportive environment for multidisciplinary care models.

Case Study: St Arnaud and District (Australia)⁴⁴

Context

In December 2025, leaders from health services in St Arnaud, Victoria, and surrounding areas held a collaborative, co-design workshop, bringing together community members, health professionals, service providers and local organisations to talk about healthcare in St Arnaud and surrounding district.

Mechanism

The workshop intended to understand what the needs are of community members, identify areas which are working well and areas for improvement, and to jointly design, practical, locally based solutions that works for people in the area. Leaders spoke with more than 50 participants who shared insights relating to their lived experience, professional insights, and community priorities. In doing so, the workshop identified priority populations within the community, as well as guiding themes to shape the direction of care moving forward. One of the key themes that emerged related to the need for team-based care, with collaboration across health professionals including GPs, nurses, nurse practitioners, allied health staff, and mental health service providers working together.

Outcome

The codesign approach created a shared community vision for healthcare in St Arnaud and surrounding areas that promotes better access, and enhanced coordination and sustainability. Moreover, the ideas and priorities identified by participants were included in a funding proposal by Murray Primary Health Network and its partners, which is currently being considered by the Australian Government Department of Health, Disability and Ageing.

What the literature indicates

Strong leadership plays a pivotal role in initiating, sustaining and scaling multidisciplinary workforce planning by building trust and creating an environment to support shared decision making. The

⁴⁴ Rural Workforce Agency Victoria. (2025). Co-design workshop summary – community.

literature suggests that effective multidisciplinary teams are underpinned by inclusive leadership approaches that prioritise accountability, trust building and collective problem solving.⁴⁵

Leaders are critical in moving away from traditional workforce planning approaches that focus on “adding more” staff toward strategies that optimise current resources, “adding right” instead.⁴⁶ This involves aligning workforce composition with care needs, redistributing tasks where appropriate, and ensuring staff work to their top scope of practise. The need for strong executive leadership and sponsorship is vital to engaging teams and creating the cultural and operational shifts required to move toward better-aligned care models.⁴⁷

3.4.2 Consistent workforce data is required to support multidisciplinary workforce planning methods

What stakeholders told us

Jurisdictional stakeholders consistently described workforce data as fragmented, inconsistent and often not trusted. They noted that planners struggle to access reliable establishment data within their own services, and that national datasets frequently do not match local experience, making it difficult to use data confidently for forward looking modelling. Several jurisdictions (alongside peak and industrial body stakeholders) highlighted that the self-regulated professions and the para-professional workforces are often invisible in national datasets, which reinforces reliance on FTE based planning and limits the ability to undertake genuine multidisciplinary workforce planning and modelling. Jurisdictional stakeholders also noted that local analytical capability is variable across organisations, and without better foundational data and clearer guidance, services default to historic patterns rather than more sophisticated approaches.

“Hopefully we can shift from our current approach to workforce planning, where our information primarily helps us plan for the workforce we have now, rather than the workforce that we want into the future. We need to start to grapple with how we look at what we need for the future and work backward to align with the workforce we currently have. The key is determining how to make the best use of today’s workforce while also considering how we better integrate those two processes more effectively.”

– Jurisdiction stakeholder

“Where business areas might be self-servicing and doing planning by themselves, there might be different approaches taken. We wanted to put forward a consistent way, so we’ve created the workforce planning framework. Now, other organisations can know that this is how this jurisdiction

⁴⁵ Meadows, D., Maclaren, J., Morton, A., & Ross, D. (2025). Determining skill mix and optimal multidisciplinary team composition: A scoping review. *Healthcare management forum*, 38(3), 278–285.

<https://doi.org/10.1177/08404704241293095>

⁴⁶ Meadows, D., Maclaren, J., Morton, A., & Ross, D. (2023). A novel and practical care process framework to inform model of care development. *Healthcare management forum*, 36(4), 249–255. <https://doi.org/10.1177/08404704231157215>

⁴⁷ Meadows, D., Maclaren, J., Morton, A., & Ross, D. (2023). A novel and practical care process framework to inform model of care development. *Healthcare management forum*, 36(4), 249–255. <https://doi.org/10.1177/08404704231157215>

recommends approaching workforce planning, and that these are the things to consider, the touch points, and the data sets.”

– Jurisdiction stakeholder

Peak and industrial stakeholders echoed these concerns, noting that national workforce data is spread across multiple inconsistent datasets, which often produce contradictory figures. They highlighted that accurate workforce intelligence is increasingly essential for commissioning decisions, professional advocacy and pipeline planning, but the current system does not provide this consistently across professions.

“There's a lack of access to consistent workforce data. There are a lot of sources like the Australian Bureau of Statistics, Jobs and Skills Australia, and the Jobs and Skills Council, but they need to be consistent. Sometimes they say different things, which makes it harder for us to advocate on behalf of the profession and makes it harder for us to deliver reports.”

– Peak/industrial body stakeholder

What the literature indicates

Consistent and reliable workforce data is a critical enabler of effective multidisciplinary workforce planning. International evidence demonstrates that workforce planning methods which integrate population need, service demand and workforce capability depend on high-quality, standardised data across professions.^{48;49}

In the absence of such data, planning tends to default to profession specific headcounts and historical FTE ratios, reinforcing siloed approaches and limiting the ability to model alternative team configurations.⁵⁰

3.4.3 Technology and information sharing enable coordination across multidisciplinary teams

What stakeholders told us

Jurisdictional stakeholders generally observed that technology is a key future workforce requirement rather than a current enabler for multidisciplinary teams. Stakeholders noted that, although technology has potential to support new multidisciplinary workforce planning approaches by improving data, modelling capacities and enabling ‘virtual workforce’ integration, this is not yet ‘well-translated’ into current approaches. They also noted there is interest in how tools like telehealth and

⁴⁸ Murphy, G. T., Birch, S., Mackenzie, A., Rigby, J., & Langley, J. (2017). An Integrated Needs-Based Approach to Health Service and Health Workforce Planning: Applications for Pandemic Influenza. *Démarche axée sur les besoins intégrés pour les services de santé et la planification de la main-d'œuvre en santé : application à une pandémie d'influenza. Healthcare policy = Politiques de sante*, 13(1), 28–42. <https://doi.org/10.12927/hcpol.2017.25193>

⁴⁹ MacKenzie, A., Tomblin Murphy, G. & Audas, R. (2019). A dynamic, multi-professional, needs-based simulation model to inform human resources for health planning. *Hum Resour Health* 17, 42 <https://doi.org/10.1186/s12960-019-0376-2>

⁵⁰ MacKenzie, A., Tomblin Murphy, G. & Audas, R. (2019). A dynamic, multi-professional, needs-based simulation model to inform human resources for health planning. *Hum Resour Health* 17, 42 <https://doi.org/10.1186/s12960-019-0376-2>

Artificial Intelligence (AI) could enhance multidisciplinary care delivery by streamlining team collaboration and enabling remote models of care, particularly in rural and remote areas. Stakeholders highlighted the importance of preparing for the transformative impact of AI and other emerging technologies on workforce planning. Both jurisdictional and peak and industrial body stakeholders consistently raised varied constraint related to technology in multidisciplinary workforce planning, including the need for better forecasting tools, automation of planning tasks (such as FTE calculators) and AI enabled modelling support.

“There's the emerging role of technology and AI, and we are in this rapidly transforming state. We don't know how technology and AI are going to transform our workforce, but we need to be prepared legislatively and from a change management point of view to take on the scale of transformation.”

– Jurisdiction stakeholder

Some peak and industrial body stakeholders also highlighted that issues relating to interoperability of technology platforms can be a barrier to multidisciplinary teams being able to share information and work effectively together. While this issue was not related directly to multidisciplinary workforce planning, it was noted to impact the coordination, service delivery and ultimately, the success of multidisciplinary team-based approaches to care delivery.

What the literature indicates

Technology and effective information sharing tools form an important part of multidisciplinary team coordination and integrated care delivery. Literature indicates that digital tools may assist multidisciplinary coordination by making team structures, task distribution and cross-professional interactions more explicit which is required for planning around roles, capabilities and skill mix rather than professions alone.⁵¹ However, reviews of needs-based and multidisciplinary workforce planning methods consistently observe that existing tools and systems are not typically designed to support these planning functions, with limited capacity to model team-based work, shared tasks or changes in coordination requirements over time.⁵² As a result, technology has not yet been systematically leveraged to inform multidisciplinary workforce planning, reinforcing reliance on profession based planning approaches.⁵³

Telemedicine and virtual services are also emerging as essential components of technology-enabled multidisciplinary workforce planning, particularly in addressing gaps in healthcare access. By integrating telemedicine into workforce planning processes, health systems can account for how virtual care delivery might affect workforce distribution, skill mix requirements and role definition

⁵¹ Asamani, J. A., Christmals, C. D., & Reitsma, G. M. (2021). The needs-based health workforce planning method: a systematic scoping review of analytical applications. *Health policy and planning*, 36(8), 1325–1343. <https://doi.org/10.1093/heapol/czab022>

⁵² Asamani, J. A., Christmals, C. D., & Reitsma, G. M. (2021). The needs-based health workforce planning method: a systematic scoping review of analytical applications. *Health policy and planning*, 36(8), 1325–1343. <https://doi.org/10.1093/heapol/czab022>

⁵³ Asamani, J. A., Christmals, C. D., & Reitsma, G. M. (2021). The needs-based health workforce planning method: a systematic scoping review of analytical applications. *Health policy and planning*, 36(8), 1325–1343. <https://doi.org/10.1093/heapol/czab022>

across different regions.⁵⁴ Incorporating telemedicine into workforce planning also requires consideration of workforce capabilities in using virtual platforms and engagement strategies to ensure multidisciplinary team members are trained and prepared for digitally enabled health service delivery.⁵⁵

3.4.4 Funding and payment models impact the feasibility and sustainability of multidisciplinary workforce models

What stakeholders told us

Jurisdictional stakeholders consistently identified funding approaches as one of the most significant barriers to establishing and sustaining multidisciplinary workforce models. As noted through earlier sections of this paper, stakeholders generally observed that capital and operational funding streams are poorly aligned, particularly during new hospital / facility builds, limiting the ability to invest in the workforce needed to operate newly designed models of care. Election cycle funding was also cited as a major constraint, creating short-term, reactive funding models that make it difficult to plan or invest in long-term multidisciplinary workforce approaches.

Peak and industrial body stakeholders noted that pilots and innovative models often collapse once time limited funding ends, preventing scaling and reinforcing short-term workforce patterns. A stakeholder described this as ‘cobbled together’ arrangements where services pool multiple inadequate funding streams to sustain operations, often leading healthcare professionals struggling with limited resources and administrative burden associated with managing these ‘thin’ funding sources.

Additionally, some stakeholders highlighted that funding models often fail to support ‘coordinator’ capability within multidisciplinary teams. This is the role responsible for bringing the team together and aligning their activities. This gap was noted as a barrier to building collaboration and maintaining the functionality of multidisciplinary teams over the long term.

“There is a need to consider different funding models to support successful approaches. The current fee-for-service model doesn’t work well in rural areas. There is an opportunity to consider how multidisciplinary teams are funded and how we incentivise professionals to stay in communities.”

– Peak/industrial body stakeholder

What the literature indicates

Funding and payment models are a critical determinant of whether multidisciplinary workforce models can be implemented and sustained at scale.⁵⁶ International evidence shows that funding

⁵⁴ Meadows, D., Maclaren, J., Morton, A., & Ross, D. (2025). Determining skill mix and optimal multidisciplinary team composition: A scoping review. *Healthcare management forum*, 38(3), 278–285. <https://doi.org/10.1177/08404704241293095>

⁵⁵ Meadows, D., Maclaren, J., Morton, A., & Ross, D. (2025). Determining skill mix and optimal multidisciplinary team composition: A scoping review. *Healthcare management forum*, 38(3), 278–285. <https://doi.org/10.1177/08404704241293095>

⁵⁶ Archer, J., Robinson, L., & Brown, T. (2022). The Impact of Healthcare Funding on Interprofessional Collaboration and Integrated Service Delivery in Primary and Allied Care: Protocol for a Scoping Review. *JMIR research protocols*, 11(5), e36448. <https://doi.org/10.2196/36448>

arrangements that align payment with population need and team-based care enable more effective multidisciplinary planning than fee-for-service or profession specific models.^{57,58} Tools like the Toronto Region Primary Care Workforce Planning Toolkit stand as a benchmark example.

3.4.5 Collaboration across professions, organisations and communities is critical for breaking down silos in workforce planning

What stakeholders told us

Both jurisdictional and peak and industrial body stakeholders described collaboration as essential to multidisciplinary planning but emphasised that it was structurally difficult to achieve. They noted that professional protectionism, entrenched role boundaries and siloed organisational structures continue to inhibit collaboration across disciplines. Stakeholders also pointed to the lack of structured cross-disciplinary forums, shared planning workshops and coordination between local services and central departments, which makes it difficult to scale successful models or embed consistent multidisciplinary practices across systems.

Peak and industrial body stakeholders also highlighted adversarial dynamics between professions which can act as a barrier to multidisciplinary team-based care. Stakeholders observed that collaboration requires harmonised scope of practice across jurisdictions, interoperable systems and shared supervision models, but these enabling conditions are not the current reality in practice.

What the literature indicates

Effective multidisciplinary workforce planning depends on collaboration across professions, organisations and communities rather than planning within single professional or institutional boundaries. Collaborative planning approaches support better alignment between workforce capability, models of care and population need and can reduce duplication across services.⁵⁹

3.4.6 Education and training systems enable capability-based and multidisciplinary models of care

What stakeholders told us

Both jurisdictional and peak and industrial body stakeholders highlighted that education and training systems are not keeping pace with the capability needs of multidisciplinary models. They noted wide inconsistency in advanced practice training frameworks across jurisdictions, which limits the scalability of roles such as advanced allied health practitioners or physiotherapists in extended-scope emergency roles. Peak and industrial body stakeholders also noted the need for better education and training to adequately prepare health professionals for working in multidisciplinary teams, because current approaches are often ‘profession-led’ and don’t support clinicians’ understanding of integrated team roles and dynamics. Some stakeholders also suggested there is a

⁵⁷ Asamani, J. A., Christmals, C. D., & Reitsma, G. M. (2021). The needs-based health workforce planning method: a systematic scoping review of analytical applications. *Health policy and planning*, 36(8), 1325–1343. <https://doi.org/10.1093/heapol/czab022>

⁵⁸ Meadows, D., Maclaren, J., Morton, A., & Ross, D. (2025). Determining skill mix and optimal multidisciplinary team composition: A scoping review. *Healthcare management forum*, 38(3), 278–285. <https://doi.org/10.1177/08404704241293095>

⁵⁹ Hamdi, Sultan. (2025). The Role of Multidisciplinary Health Teams in Enhancing Patient Care in Emergency Departments: A Comprehensive Review. *The Review of Diabetic Studies*. 669-683. 10.70082/q2mx1k18.

current challenge in clinical supervision models for health professions, causing a ‘bottleneck’ and capacity constraints in being able to develop and grow multidisciplinary teams. This was noted to be particularly evident in rural and regional communities.

“A barrier to capability development that is beyond your entry level professional capabilities is education and training. Every jurisdiction has their own education and training frameworks. We don't have scalability for things like that. Why not have one education and training framework so that we know the training is consistent across the country.”

– Jurisdiction stakeholder

“There are a number of versions of the Quick Access Response Team (QuART) Model of Care, in New South Wales Health currently being trialled. In one instance, there was a cross between a transdisciplinary and interdisciplinary team supporting elderly patients in rural areas. Some team members had concerns around other team members performing at the top of their scope of practice. This was managed through training modules which covered all professions involved in the team. As a result, each practitioner had a greater understanding of what skillsets the team members had and the services each team member could provide.”

– Jurisdiction stakeholder

What the literature indicates

Education and training systems play a critical role in enabling capability based and multidisciplinary models of care. Interprofessional education aligned with needs-based workforce planning supports role flexibility, shared understanding of scope and more effective team-based practice.⁶⁰ However, fragmented and profession specific training frameworks can limit scalability and reinforce siloed workforce development.⁶¹

To address workforce gaps and align education with new care delivery models, the literature highlights the need for workforce planners and interprofessional educators to collaborate, ensuring that training prepares both students and existing healthcare workers for roles within new care systems.⁶² Focusing on how workforce planners and interprofessional education educators co-design education and training models can enable flexible, team-based approaches and more effectively address population health needs.⁶³

⁶⁰ Tomblin Murphy, G., Gilbert, J. H., & Rigby, J. (2019). Integrating interprofessional education with needs-based health workforce planning to strengthen health systems. *Journal of Interprofessional Care*, 33(4), 343–346. <https://doi.org/10.1080/13561820.2019.1638758>

⁶¹ Tomblin Murphy, G., Gilbert, J. H., & Rigby, J. (2019). Integrating interprofessional education with needs-based health workforce planning to strengthen health systems. *Journal of Interprofessional Care*, 33(4), 343–346. <https://doi.org/10.1080/13561820.2019.1638758>

⁶² Fraher, E., & Brandt, B. (2019). Toward a system where workforce planning and interprofessional practice and education are designed around patients and populations not professions. *Journal of interprofessional care*, 33(4), 389–397. <https://doi.org/10.1080/13561820.2018.1564252>

⁶³ Fraher, E., & Brandt, B. (2019). Toward a system where workforce planning and interprofessional practice and education are designed around patients and populations not professions. *Journal of interprofessional care*, 33(4), 389–397. <https://doi.org/10.1080/13561820.2018.1564252>

Appendix A: Glossary and acronyms

Glossary

Table 4 Glossary⁶⁴

Term	Definition
Aboriginal and Torres Strait Islander Health Workforce	For the purposes of this report, the Aboriginal and Torres Strait Islander Health Workforce refers to health workers who identify as Aboriginal and/or Torres Strait Islander, across a broad range of roles including Aboriginal and Torres Strait Islander Health Practitioners, Health Workers, Hospital Liaison Officers, doctors, nurses, and allied health professionals, and those who provide other care and support roles.
Allied health	Governments and allied health peak bodies generally recognise allied health professions that meet the following criteria: a university qualification (AQF 7 level or higher) accredited by a recognised national accreditation body; a national professional organisation with clearly defined membership criteria; clear national entry-level competency standards and assessment processes; autonomy of practice; and a clearly defined scope of practice.
Fee-for-service	The main payment model for primary care in Australia, in which healthcare providers are paid per episode of care delivered by a specific type of health professional.
General practice	General practice means a practice or health service that provides comprehensive, patient-centred, whole-person and continuous care, and where services are predominantly of a general practice nature.
General practitioner	A registered specialist medical practitioner who is qualified and competent to provide general practice anywhere in Australia; has the skills and experience to provide patient-centred, continuing, comprehensive, coordinated primary care to individuals, families and communities; and maintains professional competence in general practice.
Health professionals	For the purposes of this document, this term includes regulated and, self-regulated health professionals and the para-professional workforce, e.g., health assistants, technicians, care workers, peer support workers.
Multidisciplinary team	Multidisciplinary team care in healthcare refers to collaborative care, which occurs when multiple health professionals from different professional backgrounds provide comprehensive services by working together in a team, and with patients, their families, carers and communities to deliver care across settings.

⁶⁴ The terms listed in this glossary table have been adapted from the definitions outlined in *Unleashing the Potential of our Health Workforce* (2024).

Term	Definition
Primary care	Primary care is a model of care that supports first-contact, accessible, continuous, comprehensive and coordinated person-focused care. It aims to optimise population health and reduce disparities across the population by ensuring that subgroups have equal access to services.
Primary healthcare	A whole-of-society approach to effectively organise and strengthen national health systems to bring services for health and wellbeing closer to communities. It includes integrated health services to meet people's health needs across the life course; addressing the broader determinants of health through multisectoral policy and action; and empowering individuals, families and communities to take charge of their own health.
Professional capabilities	Professional capabilities identify the knowledge, skills and professional attributes needed to safely and competently practise as a health professional in Australia, i.e. the threshold level of professional capability required for both initial and continuing registration.
Strategic workforce planning	Strategic workforce planning supports long-term decision-making to ensure health services have the right people, skills, and roles to meet future needs and deliver on strategic priorities. Unlike operational or detailed workforce planning, which typically looks at the next 3 to 24 months and responds to immediate business needs, strategic workforce planning focuses on a longer-term view, typically over 2 to 5 years. It considers future scenarios, forecasts workforce supply and demand, and prepares for changes such as shifts in technology, service models, and labour market trends. ⁶⁵

Acronyms and abbreviations

Table 5 Acronyms and abbreviations

Acronym/abbreviation	Definition
ACCHO	Aboriginal Community Controlled Health Organisation
ACCHS	Aboriginal Community Controlled Health Service
AI	Artificial Intelligence
A&TSIHP	Aboriginal and Torres Strait Islander Health Practitioner
FTE	Full-Time Equivalent
GCH	Gold Coast Health
GP	General Practitioner
HR	Human Resources
HWA	Health Workforce Australia

⁶⁵ Adapted from Queensland Health's Gold Coast Health Strategic Workforce Planning Framework.

Acronym/abbreviation	Definition
MBS	Medicare Benefits Scheme
PHN	Primary Health Network
QuART	Quick Access Response Team
SOP Review	Unleashing the Potential of our Health Workforce Scope of Practice Review
The Department	The Department of Health, Victoria
The Kruk Review	The Independent Review of Australia's Regulatory Settings Relating to Overseas Health Practitioners
WEB	Workforce Evidence-Based Model

Appendix B: Stakeholders consulted

Stakeholder group/jurisdiction	Stakeholder type
Jurisdictional health departments*	• Workforce strategy and planning leaders • Workforce planners
Peak bodies and industrial bodies	• Public Health Association Australia • Rural Workforce Agency Network • Australian College of Nursing • The Royal Australian College of General Practitioners • Pharmacy Guild of Australia • Pharmaceutical Society of Australia

**All state and territory health departments were invited to participate in consultation via the Health Workforce Taskforce. To support this process, a request for written input was sent to stakeholders who were unable to attend formal consultation.*