JANUARY 2025

POSITION PAPER

# PROVISION OF REMOTE GP SERVICES


**ALLIANCE OF RM 6 and RM 7 COUNCILS**

Shire of Gnowangerup | Shire of Jerramungup | Shire of Kojonup
Shire of Narembeen | Shire of Lake Grace | Shire of Ravensthorpe

This position paper is prepared by the alliance of Councils including Gnowangerup, Jerramungup, Kojonup, Lake Grace, Narembeen and Ravensthorpe.

Version: 1

Adopted: February 2025

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# DEFINITIONS

**Remote**: The Australian Statistical Geographical Standard (ASGS) system has been used to categorise rural and remote communities in Australia. The ASGS is a geographical classification system which ranks areas rurality or remoteness by the Australian Bureau of Statistics (ABS) gathered from federal census data. In the ASGS areas are ranked from RA1 to RA5, with RA1 being major cities and RA5 for very remote locations.

| | Classification | Ranking |
|---|---|---|
| Shire of Gnowangerup | Remote Australia | RA4 |
| Shire of Jerramungup | Remote Australia | RA4 |
| Shire of Kojonup | Outer Regional Australia | RA3 |
| Shire of Lake Grace | Remote Australia | RA4 |
| Shire of Narembeen | Remote Australia | RA4 |
| Shire of Ravensthorpe | Very Remote Australia | RA5 |

# EXECUTIVE SUMMARY

Many countries face the problem of shortages of health workers in rural and remote areas. Health workers generally prefer to be located close to major hospitals and health facilities where they trained and with good professional support and resources, and in areas with family and social support and access to schools for their children. According to the World Health Organisation, rural health workforce shortages are one of the major impediments to well-functioning health systems with a lack of General Practitioners (GPs) in rural communities associated with reduced access and inferior health outcomes.[1]

Factors contributing to rural medical workforce shortages include training pathways with little rural exposure, demanding working conditions, inadequate remuneration and professional development opportunities in rural practice, and social isolation. Financial incentives are widely used by Commonwealth and State policy makers as well as local governments to improve recruitment and retention of GPs to rural and remote communities.

There are minimum floor costs that exist to maintain basic medical services in any location. These include GPs, nursing and administration staff, premises, equipment and ongoing overheads. In remote communities, Medicare billing alone cannot cover these floor costs for a variety of reasons.

The alliance of councils comprising the Shires of Gnowangerup, Jerramungup, Kojonup, Lake Grace, Narembeen, and Ravensthorpe have prepared this position paper to raise awareness and suggest a solution to attract and retain GPs in their rural and remote communities, where current Commonwealth and State government policy settings are inadequate.

The six local governments collectively contribute over $1.475 million cash annually to attract and retain resident GP services, plus housing, vehicles, and surgeries. These financial contributions are sourced through rates and are unsustainable. They are essential for community health but place a significant financial strain on local government resources, diverting funds from other vital services that are well within the remit of local government.

The six remote local governments (RM6 and RM7 under the Modified Monash Model) are using a substantial portion of their ratepayer funds to attract and retain GPs (some up to 16% of their rates). The financial incentives to attract a GP are currently heavily influenced by the local government tender process where providers have the ability to set and negotiate the market rate. This is unsustainable.

Local governments are required to step into the space of primary health care because the per capita expenditure by the Commonwealth and States on health is lower in the regions, the viability of practices is challenged due to remote geography, increased business costs and less patients.

The current Medical Facilities Cost Adjustor within the Financial Assistance Grants paid to local governments is insufficient. Higher income incentives are currently required by local governments and practice operators to attract GPs to remote areas, and existing programs do not meet these needs.

The alliance is though raising awareness to the fact that market rates to attract a GP in a RM 6 and RM 7 community are significantly rising, with Commonwealth and State Government programs needed to match these market rates. The alliance is also raising awareness that

[1] Impact of rural workforce incentives on access to GP services in underserved areas: Evidence from a natural experiment, Swami and Scott, 2021

telehealth is not the answer to shortages of GPs in remote communities and a rural generalist model, which is currently provided across the Shires is well received and delivering immense benefits.

They are seeking sustainability payments from Commonwealth and State Governments to local governments to reduce ratepayer funding towards primary health care.

# 1. BACKGROUND

In Australia, shortages and the inequitable distribution of general practitioners (GPs) remain a significant policy issue despite the fact that since the 1990s the Commonwealth Government has been implementing a range of initiatives to address rural workforce shortages.

A 2023 Rural Health West study found that 53% of non-metropolitan local governments in WA were spending money to provide GP services, costing just under $7.8million annually (Note this was from the 2021/22 Financial Year and has substantially increased not only through inflation but market rates). Communities across the country are also experiencing a GP shortage, and according to the Commonwealth's Department of Health report (August 2024), the shortage is most pronounced in rural areas.

At the Australian Local Government Association national meeting in September 2024, the Shire of Dundas put forward the following motion (113), which was carried:

*This National General Assembly calls upon the Australian Government and the Commonwealth Minister for Health and Aged Care, Hon Mark Butler MP, to plan and fund the provision of medical services (in consultation with relevant local governments) to regional, rural and remote communities.*

On Friday November 11, 2024 the WA Local Government Association (WALGA) convened a meeting of band 4 local governments. The purpose of the meeting was to identify the strategic priorities of the members, to help inform WALGA policies on a variety of issues. It was agreed at the meeting that *"Local Governments allocating ratepayer funds towards delivering medical services or contracting medical service providers to have a presence in their community"* was the second highest priority to all band 4 local governments in WA.

In response to both the ALGA and WALGA meetings, the Shire of Lake Grace called a meeting of six local governments (band 3 and band 4) and key stakeholders to meet at the Lake Grace Sportsmans Club on Friday 29 November 2024. The purpose of the meeting was to discuss the financial and in-kind contributions made by local governments to secure consistent and accessible medical service providers in their communities.

This position paper is in response to the meeting outcomes from the Lake Grace meeting.

Participating local governments in this position paper include:

Figure 1: Classification of local governments by the Modified Monash Model

| | Modified Monash Model classification (RM) | Number of doctor surgeries within and provided by the Local Government |
|---|---|---|
| Shire of Gnowangerup | 7 | 1 |
| Shire of Jerramungup | 7 | 2 |
| Shire of Kojonup | 6 | 1 |
| Shire of Lake Grace | 7 | 2 |
| Shire of Narembeen | 7 | 1 |
| Shire of Ravensthorpe | 7 | 2 |

# 2. CURRENT SITUATION

The six local governments annually contribute $1.475m of ratepayer funds towards the provision of resident GP services in their communities plus the provision of houses, vehicles, surgeries and carry the maintenance and depreciation of these assets.

The expenditure by the six local governments is crucial for maintaining the health and well-being of their communities who otherwise face barriers to accessing primary health care. This significant financial strain on rural local governments reduces resources available for other vital community services and infrastructure that is within the legislated role of local government (roads, community infrastructure, waste services etc) highlighting the significant need for more sustainable solutions to primary health care access, particularly in RM 6 and 7 communities.

Understanding the community profile, economy, health services, health condition and health needs of those living in the six local governments is the first step in improving service provision and access.

## 2.1 Community Profile

The six local governments are located within the Wheatbelt and Great Southern regions of Western Australia. They are classified as either RM6 or RM7 by the MMM and are similar in population size, demographics and economy.

The communities of the six local governments are:

- Median age is increasing across all local governments and there is an ageing population (see appendice)
- The Socio-Economic Indexes for Areas (SEIFA) ranks areas in Australia according to relative socio-economic advantage and disadvantage. Four of the six local governments are considered disadvantaged.
- Major industries include: agriculture, mining, education, tourism and professional services.

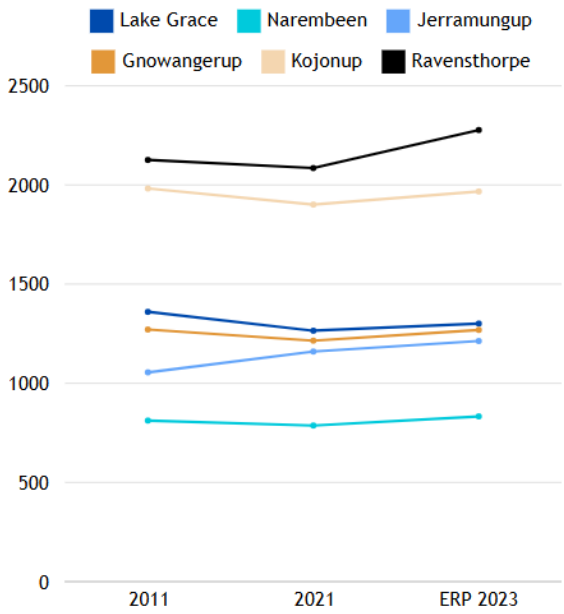
Figure: Population, Ratepayers and SEIFA score by Local Government

| | Service Towns | LGA Population[2] | SEIFA score[3] |
|---|---|---|---|
| Shire of Gnowangerup | Gnowangerup | 1,215 | 996 |
| Shire of Jerramungup | Bremer Bay<br>Jerramungup | 1,160 | 996 |
| Shire of Kojonup | Kojonup | 1,901 | 997 |
| Shire of Lake Grace | Lake Grace<br>Newdegate | 1,265 | 1051 |
| Shire of Narembeen | Narembeen | 787 | 1028 |
| Shire of Ravensthorpe | Hopetoun<br>Ravensthorpe | 2,085 | 1002 |

Figure: Population by local government in 2011, 2021 and future estimate (2023)

[2] Census, 2021

[3] Socio-Economic Indexes for Areas (SEIFA), Australia, 2021




## 2.2 Health Profile

The National Rural Health Alliance 2023 report *Evidence base for additional investment in rural health in Australia* demonstrates a clear healthcare disparity between rural and urban Australia: rural Australians have a poorer health status, and even before accounting for the increased cost of health service, receive significantly less funding per capita than their urban counterparts.

Compared with major cities, the life expectancy in regional areas is one to three years lower, and in remote areas it is up to seven years lower. According to the Australian Institute of Health and Welfare, the burden of disease and life expectancy disparities are even more pronounced for rural, regional and remote Aboriginal and Torres Strait Islander peoples and communities.[4]

Examining the social determinants of health and related risk factors across the six local governments highlights the necessity for accessible primary health care services, such as nearby GPs. As remoteness increases, many essential quality of life factors decline, leading to poorer health outcomes.

The education levels, collective scope of job opportunities and limitations in income potential in remote communities, all influence health outcomes for people living in the communities.

[4] AMA plan for improving access to rural general practice, AMA, 2023

Figure: Country of birth, language, education and employment by Local Government[5]

| | Population | Born overseas | Households who don't speak English at home | Attained Yr 10 as highest level of education | Median weekly personal income | Unemployment rate[6] |
|---|---|---|---|---|---|---|
| WA Average | | | 21.2% | 11.3% | $848 | 4.2% |
| Shire of Gnowangerup | 1215 | 293 | 30 / 6.9% | 18% | $911 | 4.3% |
| Shire of Jerramungup | 1,160 | 250 | 23 / 5.4% | 15.5% | $870 | 1.5% |
| Shire of Kojonup | 1,901 | 423 | 50 / 6.8% | 16.3% | $882 | 1.5% |
| Shire of Lake Grace | 1,265 | 278 | 30 / 6.4% | 16.4% | $1,001 | 1.3% |
| Shire of Narembeen | 787 | 199 | 22 / 8.4% | 16.1% | $923 | 3.8% |
| Shire of Ravensthorpe | 2,085 | 616 | 56 / 7.1% | 15.3% | $926 | 2.5% |

The WA Country Health Service (WACHS) Health Profiles (2022) identifies the health behaviours and risk factors prevalent in the three WACHS regions. The majority of health behaviours and risk factors in the communities are above state averages.

| **Wheatbelt (Inclusive of the local governments of Narembeen, Lake Grace)** | **Central Great Southern (Inclusive of the local governments of Gnowangerup, Kojonup)** | **Lower Great Southern (Inclusive of the local governments of Jerramungup, Ravensthorpe)** |
|---|---|---|
| ▪ 88.1% did not eat the daily recommended serves of vegetables<br>▪ 51.8% did not eat the daily recommended serve of fruit<br>▪ 21.7% had high blood pressure (WA 16.5%)<br>▪ 13.5% had self-reported a current mental health problem<br>▪ 36.6% are overweight (WA 38.9%)<br>▪ 38.8% are obese (WA 29.7%)<br>▪ 45.8% did less than 150mins of physical activity in a week (WA 38.3%) | ▪ 85% did not eat the daily recommended serves of vegetables<br>▪ 53% did not eat the daily recommended serve of fruit<br>▪ 17.8% had high blood pressure (WA 16.5%)<br>▪ 11.9% had self-reported a current mental health problem<br>▪ 35.5% are overweight (WA 38.9%)<br>▪ 38.9% are obese (WA 29.7%) | ▪ 87.7% did not eat the daily recommended serves of vegetables<br>▪ 48.7% did not eat the daily recommended serve of fruit<br>▪ 20% had high blood pressure (WA 16.5%)<br>▪ 14.3% had self-reported a current mental health problem<br>▪ 39% are overweight (WA 38.9%)<br>▪ 34.5% are obese (WA 29.7%) |

[5] Census, 2021
[6] WA Treasury 2025

The Australian Health Tracker data breaks the risk factors down by local governments and supports the WACHS profiles and the ABS' National Health Survey conclusions that remote people are at greater risk of poorer health outcomes. All the estimates below are above average when compared to metropolitan communities.

Figure: Health Risk Factors by Local Government

| | Risk Factor (estimate) 2-17yrs who are obese / per 100 | Risk Factor (estimate) adults who are overweight or obese / per 100 | Alcohol consumption considered at risky levels / per 100 | No or low physical activity / per 100[7] |
|---|---|---|---|---|
| Shire of Gnowangerup | 10.9 | 72.3 | 30 | 71.2 |
| Shire of Jerramungup | Greater than 10.9 | 72.3 | Unknown | Unknown |
| Shire of Kojonup | 10.9 | 72.3 | 30 | 71.2 |
| Shire of Lake Grace | 10.8 | 70.9 | 28.2 | 71.3 |
| Shire of Narembeen | 10.8 | 70.9 | 28.2 | 71.3 |
| Shire of Ravensthorpe | Greater than 10.9 | Unknown | Unknown | Unknown |

There are a number of social determinants for children in the six local governments that support the evidence and need for local access to primary health services. It is well recognised that vulnerable children and their families may require more assistance, support and intervention than families with no identified vulnerabilities. Assistance, support and intervention also needs to be in close proximity of residences for children and their families to access.

Figure[8]: Child and Youth Wellbeing by Local Government

| | Children living in household earning less than $1000 per week | Learning – developmentally vulnerable on one or more domains (AEDC) | Primary health care access (GP attendance 0-24yrs/100) | Primary health care access (GP Medicare benefits 0-24yrs / 100) $ |
|---|---|---|---|---|
| Shire of Gnowangerup | 37% | 29.63% | 268.24 | 11,364 |
| Shire of Jerramungup | 44% | 14.71% | 164.77 | 7054 |
| Shire of Kojonup | 41% | 26.67% | 268.24 | 11,364 |
| Shire of Lake Grace | 33% | 29.41% | 264.19 | 11,095 |
| Shire of Narembeen | 33% | 29.41% | 264.19 | 11,095 |
| Shire of Ravensthorpe | 44% | 14.71% | 164.77 | 7054 |

[7] Australia's Health Tracker by Area, Australian Health Policy Collaboration, 2020
[8] Australian Child and Youth Wellbeing Atlas, 2021

## 2.3 General Practitioners

A declining number of GPs in remote communities of Western Australia creates significant gaps in healthcare access. The lack of GP services contributes to people living in country areas utilising hospital emergency departments as a substitute for GPs, more than their metropolitan counterparts. WACHS reports that over half of emergency department presentations are non-urgent presentations related to the lack of access to local GPs.[9]

The investment made by the six local governments to attract and retain resident GPs is necessary for the following reasons:

1. **Critical Role of Primary Care**: Primary care is the most significant contributor to positive health outcomes. With the number of general practitioners in Australia declining, especially in rural areas, ensuring access to primary care is crucial.[10] Additionally, reducing emergency department presentations in rural communities with the provision of a local GP reduces the financial burden on State Governments and pressure on the hospital workforce.

2. **Acute Shortages in Rural Areas**: The reduction in the primary care workforce is felt most keenly in rural communities, where dependence on primary health care is more pronounced. For example, Western Australia (WA) has just 77.1 full-time equivalent (FTE) GPs per 100,000 people in outer regional, remote, and very remote areas, compared to the national average of 88.9 FTE GPs.[11]

3. **Comparative Disadvantage**: WA's overall GP per capita is 101.8 FTE GPs per 100,000 people, which is lower than the national average of 115.2 FTE GPs. This disparity highlights the need for targeted measures to attract and retain doctors in these underserved areas.

By offering financial programs, local governments can attract more doctors to rural areas, thereby improving access to primary care and overall health outcomes for these communities.

## 2.4 Travel Distances

The six local governments seek to ensure that residents in their communities have access to a doctor, within a reasonable driving distance.

According to the National Rural Health Alliance the number of doctors providing care per capita drops with increasing remoteness: for the year 2021-22 125/100,000 people in metropolitan areas compared to 84.9 in small rural towns and 66.8 in very remote communities.

In 2022, 57,899 living in Australia did not have access to general practitioner services within a 60-minute drive from their place of residence. The following table demonstrates the furthest distance a rural resident (outside of the townsite) must travel in each Shire to access the doctor; and if the doctor was not provided, the alternative.

[9] Support and service improvement for people in country areas, Department of Health, 2019
[10] Decline in new medical graduates registered as general practitioners, Denese Playford, Jennifer A May, Hanh Ngo, Ian B Puddey, 2020
[11] Australian Government Productivity Commission Report on Government Services 2024

Figure: GP travel distances (average)

| | Surgery and doctor (provided by local government) | Furthest travel distance WITHIN the local government to provided doctor (estimate) | Closest alternative doctor and if NO doctor is provided by any of the six local governments | Furthest travel distance to alternative (estimate) |
|---|---|---|---|---|
| Shire of Gnowangerup | Gnowangerup | 77km | Katanning (western residents) Albany (eastern and southern residents) | Between 108km – 172km |
| Shire of Jerramungup | Jerramungup | 96km (south) | Albany | 234km (from Fitzgerald) |
| | Bremer Bay | 65km (west) | Albany | 180km (from Bremer Bay) |
| Shire of Kojonup | Kojonup | 49km (south) | Katanning | 89km (from Mobrup) |
| Shire of Lake Grace | Lake Grace | 115kms (east) | Kondinin (Shire of Kondinin supported) | 184kms (from Lake King) |
| | Newdegate | 62kms (east) | Kondinin (Shire of Kondinin supported) | 184kms (from Lake King) |
| Shire of Narembeen | Narembeen | 85kms (east) | Bruce Rock (Shire of Bruce Rock supported) | 120kms (from West Holleton / Woolocutty) |
| Shire of Ravensthorpe | Ravensthorpe | 80km (east) | Esperance | 107km (from Munglinup) |
| | Hopetoun | 80km (east) | Esperance | 191km (from Hopetoun) |

It should be noted that people do not stick to local government boundaries. For example, the furthest eastern residents amongst the six local governments, in Holt Rock, Varley and Lake King travel to practices in either Jerramungup and Lake Grace / Newdegate – regardless of which local government delivers the service. The six local governments in this paperwork together informally to ensure there are reasonable distances between GPs.

## 2.5 Rural Generalist

The six local governments are currently served under a rural generalist model. A rural generalist is a medical practitioner who is trained to meet the specific current and future healthcare needs of Australian rural and remote communities, in a cost-effective way, by providing both comprehensive general practice and emergency care and required components of other medical specialty care in a hospital and community settings as part of a rural healthcare team.

Under this model there are 10 practices across the six Shires with services including emergency care, palliative care, aboriginal health clinics and skin cancer clinics, with additional team members who are Geriatricians, Psychiatrists and Optometrists. The model is multi-site with multiple purposes and through a shared system and use of technology delivers a timely service with reduced latency and downtime.

The local governments are observing under this model, reduced hospital transfers and emergency retrieval costs as well as a comprehensive suite of services delivered locally by a well-connected team.

# 3. THE PROBLEM

## 3.1 Local Government Rates Expended on Primary Health

The National Rural Health Alliance 2023 report *Evidence base for additional investment in rural health in Australia* clearly demonstrates, using publicly available data, that there is disparity in health expenditure between metropolitan and rural, regional, and remote Australia, with more expenditure per capita in the metropolitan areas by State and Commonwealth Government.

*Who picks up this gap in per capita health expenditure to ensure accessible health services?*

The Sustainable Health Review (SHR) by the WA State Government heard that health service delivery in rural and remote areas presents considerable challenges and due to remoteness, it is generally considered more costly to deliver 'small scale' services in the country than in the metropolitan area. Due to scale, management issues arise such as rostering, increased reliance on staff being on-call (to hospitals) and services being vulnerable if a staff member is away sick or on leave. It is very difficult to attract health practitioners to work in many country locations and staff turnover rates are high.[12]

The smaller populations, high demand for health professionals, complex health needs, and higher cost of delivering services in the regions means that many communities don't have access to adequate primary healthcare services.[13]

It is evident through the local government tender / recruitment process that:

- The current State and Commonwealth Government incentives to reside and work in a remote community as a GP are inadequate.
- There are higher costs to operate in remote communities; and
- Smaller patient bases.

These all contribute to less profitability for practices, declining confidence by GPs to operate their own practice and the need for practice owners to provide higher incentives (sometimes up to 85% of billing hours) to attract GPs.

The majority of general practice services in Australia are funded through a combination of the Medicare system, direct patient billing and delivery of occupational medicine and other forms of non-Medicare medical service provision. Many general practices throughout rural Western Australia, particularly smaller, rural practices are only marginally viable under the existing funding models, such as the Medicare Benefits Scheme, Practice Incentive Payment and others.

In major cities and inner regional areas, health services are mainly supported through activity-based funding and fee-for-service funding, while block funding is common in remote areas such as what is occurring in the six local governments[14].

How doctors in private practice manage their billing and workload is a key issue in the problem as well. Doctors are continuing to increase their bulk-billing rates, especially for non-GP specialists, to help maintain volume, whilst fees for non-bulk billed services increase. Whilst

[12] Support and service improvement for people in country areas

[13] Local Government Primary Healthcare Services Survey Report

[14] Evidence base for additional investment in rural health in Australia, National Rural Health Alliance, 2023

discretion on setting fees has provided some flexibility, there is only so much that can be done if there are fewer patients to go around[15] - particularly in rural and remote areas.

Local government funds are increasingly being used to address funding shortfalls in practices (in some cases up to 16% of rates income). This means that a significant portion of local rates is allocated to ensure a GP is firstly attracted to the community and then retained, so that residents have access to essential healthcare.

The six local governments annually contribute in excess of $5m towards the provision of resident GP services in their communities (cash, houses, vehicles, surgeries, depreciation of assets).

The expenditure by rural WA local governments is crucial for maintaining the health and well-being of rural populations, who otherwise face significant barriers to accessing health care. This significant financial strain on rural local governments reduces resources available for other vital community services and infrastructure.

To attract and retain a resident GP, the following contributions are made by each local government in this alliance:

Figure: Cash and other contributions to attract and retain a doctor in each local government.

| Local Government | Number of GPs | Annual cash | Additional contributions | 23/24 Rates | % of rates income 23/24 |
|---|---|---|---|---|---|
| Shire of Gnowangerup (1 surgery) | 1 | $250K | ✓ Provision of surgery<br>✓ Executive House<br>✓ Vehicle | $4.9m | **7%** |
| Shire of Jerramungup (2 surgeries) | 1 | $220K | ✓ Executive House in Bremer Bay<br>✓ Vehicle and servicing<br>✓ costs<br>✓ Contribution to vehicle running costs<br>✓ WACHS owns the medical centre, arrangement between them and the Shire | $3.8m | **5.7%** |
| Shire of Kojonup (1 surgery) | 1 | $250K | ✓ House<br>✓ Vehicle<br>✓ Plus servicing of the loan for the construction of the medical centre | $5.4m | **4.6%** |
| Shire of Lake Grace (2 surgeries) | 1 | $250K | ✓ Provision of surgeries<br>✓ Executive House<br>✓ Vehicle and fuel | $5.1m | **7.3%** |

[15] The evolution of the medical workforce

| | | | | | |
|---|---|---|---|---|---|
| Shire of Narembeen (1 surgery) | 1 | $305K | ✓ Provision of surgery<br>✓ Vehicle<br>✓ New Executive House | $2.6m | **16%** |
| Shire of Ravensthorpe (2 surgeries) | 2 | $200K | ✓ Provision of surgeries<br>✓ House provided by FQM | $5.7m | **5%** |
| **TOTAL** | **$1,475,000 pa** | | | | |

# 4. THE CONTRIBUTING FACTORS

There are systemic challenges in the current health system for rural Australians.

This position paper is advocating for a solution to reduce the financial burden faced by remote local governments to attract and retain resident GPs, either through the expansion of existing programs or new initiatives.

## 4.1 Procurement Process

The six local governments are reluctant to take on the provision of primary health services. However, when they did so, they were mandated by the WA Local Government Act to tender medical service practices due to exceeding the procurement threshold of $250,000 (when the service goes to market on the first occasion a tender needs to be conducted however not if the same providers contract is extended). Example responses below:

| | Tender Close Date | Number of responses received | Applicant requests |
|---|---|---|---|
| Shire of Gnowangerup | 31st May 2024 | 3 | Applicant 1 $250,000 cash per annum Executive house, car (including maintenance) medical practice. Provider to pay utilities, cleaners, supports staff (reception, nurse, practice manager), IT expenses, medical equipment.<br>Submission 2 $90,000 cash per annum. Deemed high risk due to shortfall between their projected operating costs ($790k pa) versus requested contribution. Also requested house, car and practice. Submission 3 $200,000 cash per annum Predominantly telehealth service with occasional face to face with a visiting doctor maximum service 4 days per week. No hospital cover and dependant on suitable internet speed (to allow for telehealth). Provide medical practice. |
| Shire of Jerramungup | August 2021 | 1 | Applicant 1<br>$200,000<br>House, car and running expenses of the practice |
| Shire of Lake Grace | August 2023 | 2 | Applicant 1<br>$250,000pa<br>House, car and medical practice premises and equipment to be supplied<br>Provider to pay utilities, cleaners, IT upgrades, upgrades to medical equipment et al.<br>Applicant 2<br>$100,000pa no further details<br>House, car and medical practice premises and equipment to be supplied<br>No experience in running a rural practice. |

| | | | |
|---|---|---|---|
| Shire of Narembeen | 3 July 2023 | 1 | Applicant 1<br>$280,000 - $300,000 per annum<br>Additional provision of house, car and commercial space. Applicant to pay all running costs and replace medical equipment at their own cost, which is to remain the property of the Shire. |

The WA State Government has since removed the requirement of local governments to go to tender to extend an existing GP contract or attract a new one. Regardless, this has not solved the problem of recruiting and attracting GPs for a reasonable and sustainable amount. In the above table, it demonstrates the limited number of applications in the process and highlights why the local governments are paying significant ratepayer funds to attract a GP.

Providing significant funds to attract and retain resident GPs through an open process also creates competition amongst rural Western Australian local governments. They are competing for limited human resources. GPs are also leveraging local governments against each other to match cash payments and supporting incentives. This is evident through the tender process, but it should be remembered, that local governments should not be required to undertake a tender process for GP services, if current incentives and programs were enhanced to reflect the true cost of service delivery in remote communities.

## 4.2 Inadequate Financial Assistance Grants

Local Government Financial Assistance Grants are funded by the Commonwealth Government and distributed among 137 local governments in Western Australia each year.

The Financial Assistance Grants are the State's entitlement for financial assistance from the Commonwealth Government, paid upfront for a financial year, under the Local Government (Financial Assistance) Act 1995.

The WA Grants Commission recommends allocations to the WA Minister for Local Government. In 2024/25 the WA Grants Commission allocated $2,189,431 for the Medical Facilities cost adjustor to acknowledge the costs that some regional local governments must contribute to employ a doctor.

In 2024/25 there were 11 local governments who received the maximum allowance of $100,000. Only 5 of the 6 local governments party to this paper received the Medical Facilities cost adjustor. The Shire of Kojonup did not receive the Medical Facilities cost adjustor as they work with a local not-for-profit to engage a GP.

The Shires of Narembeen, Lake Grace, Kojonup did not receive the maximum amount.

Included in the Medical Facilities cost adjustor eligible expenditure is; GP salaries / retainer, car, housing, LG related administration costs, GP surgery (rent or forgone rent), GP surgery administrative costs, surgical and medical equipment, communication expenses, stationery, loan costs and depreciation.

| | Financial Assistance Grants – Medical Facilities Cost Assessment | 3yr Average Medical Expenditure (reported to WA Grants Commission) | GAP between MFCA and 24/25 actuals |
|---|---|---|---|
| Shire of Gnowangerup | $100,000 | $165,178 | $150,000 |
| Shire of Jerramungup | $100,000 | $207,083 | $100,000 |
| Shire of Kojonup | 0 | 0 | $250,000 |

| | | | |
|---|---|---|---|
| Shire of Lake Grace | $36,392 | $44,380 | $213,608 |
| Shire of Narembeen | $54,008 | $44,287 | $250,992 |
| Shire of Ravensthorpe | $100,000 | $184,096 | $100,000 |

## 4.3 Attracting GPs

Using data from the *Medicine in Australia: Balancing Employment and Life (MABEL)* survey, research has shown that to move a GP from the city to a rural area would take an increase in income of between 18% and 130%, depending on the rural area.[16]

For an average GP who reported their annual income in the MABEL survey as $222,535, this means they would need to be paid between $261,700 and $511,830 to go rural[17]. This is coincidentally in line with the current cash component that six local governments are paying in RM6 and RM7 communities to attract and retain local doctors – essentially covering their operating costs and setting a baseline income for them – in addition to the Commonwealth and State government rural incentive programs.

There are a range of Commonwealth Government policies, programs and incentives for GPs, including financial incentives under the Practice Incentive Program and the Workforce Incentive Scheme for GPs - **but these are not specific to remote communities**.

The Commonwealth Government's Strengthening Medicare Reforms does not include programs or incentives for rural practices; MyMedicare is for telephone consultations for registered users, the General Practice Grants Program does not specifically support rural or remote GPs because it can be accessed by RM 2 practices in metropolitan areas.

In Western Australia there are incentives such as the Country Health Innovation (CHI) financial incentive obtained through the Department of Primary Industries and Regional Development (DPIRD) Royalties for Regions (RfR) Program. The program within regional catchment areas provides for Emergency Department incentives, procedural incentives, additional Procedural incentives, a location incentive, Small Town GP incentive and an Aboriginal Health Community incentive. However, the majority of these incentives are only available to fellows and again, offered to the same communities closer to the metropolitan area.

The challenge faced by the six rural WA local governments included in this position paper is certainly not unique. The Shire of Bogan in Queensland is currently paying $500,000 towards the operational costs of its medical centre.[18] It is very rare that a rural local government in Western Australia (and indeed within other states) is not contributing to payments that attract and retain resident GPs.

So, why despite current Commonwealth and State Government policies and programs to attract and retain resident GPs in remote communities, are the six local governments still paying significant retainers to ensure their local medical centres remain open?

There are some policies and programs that are specifically for rural and remote communities, however they are not reflective of the true cost of providing a GP service or encourage GPs to go and live in the community.

[16] Medicine in Australia: Balancing Employment and Life Australia's national longitudinal survey of doctors; University of Melbourne

[17] Professor Anthony Scott, University of Melbourne, It's more than the money: Getting GPs to go to rural areas, 2021

[18] Local council running medical centre at $500k shortfall | Health Services Daily

All six local governments have tried various providers and models of service delivery, they have provided different incentives, equipment and resources plus lifestyle amenities to secure the services of a GP. The local governments have tried to work with the Commonwealth Government on fly in fly out services in partnership with the Royal Flying Doctor, hub and spoke models, a pool of locums, recruiting overseas doctors, accessing Commonwealth and State incentives, operating the medical centres themselves to alleviate the challenges of operating a compliant practice, but the same challenges present;

- Smaller populations in the communities and therefore revenue generation;
- Perceived lower status of general practice (and particularly being based in remote areas);
- The generally lower income provided by Medicare fees;
- The burden of practice accreditation;
- Geographical distances;
- Work–life balance in rural communities[19];
- GPs requiring a locum to cover periods of leave e.g. annual leave (in some cases this is extremely costly at $10K per week);
- WA Country Health policies are not fit for purpose;
- Commonwealth and State Government incentives see RM 6 and RM 7 communities compete against RM 2 communities; and
- Fluctuations in patronage due to local economic conditions e.g. agriculture and mining.

Regardless of the current provider arrangements with each local government, the six local governments are contributing a total of $1.435m cash to provide their communities with access to resident GPs across 9 towns (and indeed additional communities that neighbour them). Collectively this is 5.1% of the rate base across six local governments.

The local governments are also contributing to surgery infrastructure, GP vehicles and residences and depreciation cost of assets accounting for an estimated $4.5m/pa.

The geographic spread of people in the six local governments creates both issues with logistics of access and efficiency of utilisation of resources. This impacts upon the costs, both of delivering services and for patients attending care, often requiring a greater time commitment and transportation costs to physically access services. The larger geographic footprint involved with creating a patient pool sufficient to sustain a clinic or service on a fee for-service basis results can result in lower utilisation. This is typically reflected in lowered utilisation of staff and services in these regions, and a greater reliance on grant and block funding to address shortfalls. Paying for these ‘gaps’ in remote and very remote communities through grants or block funding, is 3.46 times more per capita than that of metropolitan settings.[20]

Additionally, fluctuations in patronage for medical centres due to local economic conditions that are beyond the control of GPs, impact the break even point of rural medical centres. One such example of a fluctuating local economy has been in the Shire of Ravensthorpe. In April 2024 First Quantum Minerals confirmed the Ravensthorpe nickel mine would be placed into care and maintenance, with 330 jobs to be lost. [21]First Quantum Minerals is a financial contributor to the Ravensthorpe and Hopetoun surgeries, ultimately a service that supports

[19] Decline in new medical graduates registered as general practitioners, Denese Playford, Jennifer A May, Hanh Ngo, Ian B Puddey, 2020

[20] Evidence base for additional investment in rural health in Australia, National Rural Health Alliance, 2023

[21] First Quantum Minerals to close Ravensthorpe nickel project with loss of 330 jobs - ABC News

their workforce. The closure of the nickel mine places significant pressure on local businesses and service providers, such as the medical centre, as patronage declines.

When providing cash payments to GPs, the RM 6 and RM 7 local governments may be asked why they don't just implement gap fees, which potentially could be much lower than what they are currently paying.

In the 2021 Commonwealth Budget the GP revenue for a Standard Level B consultation rose from $48.55 to $50.45 for remote communities. This increase only applies to under 16yr olds and concession card holders. Consultations for other patients continue to receive the basic $38.75.

The number of under 16yrs and concession card holder consultations is not significant enough to attract additional income under Medicare for the doctors in the six local governments (the majority of the communities only have primary and secondary schools to yr 10, many young people attend high school in the metropolitan and regional centres) and hence implementing gap fees is not advantageous (see below).

| | Under 16yrs of age | Aboriginal and Torres Strait Islanders | Under 16yrs of age as a percentage of the total population | Commonwealth Seniors Health Card | Health Care Card | Low Income Card | Pension Concession Card[22] |
|---|---|---|---|---|---|---|---|
| Shire of Gnowangerup | 260 | 93 | / 1215 | 10 | 60 | 5 | 195 |
| Shire of Kojonup | 371 | 99 | / 1901 | 65 | 85 | 5 | 310 |
| Shire of Narembeen | 154 | 25 | / 787 | 20 | 30 | 5 | 95 |
| Shire of Ravensthorpe | 389 | 88 | / 2085 | 35 | 80 | 5 | 345 |
| Shire of Jerramungup | 250 | 39 | / 1160 | 15 | 50 | 10 | 145 |
| Shire of Lake Grace | 250 | 29 | / 1265 | 20 | 45 | 5 | 105 |

[22] DSS Payments by 2022 LGA - June 2023 to September 2024, Department of Social Services

## 4.4 Why Does this Problem Need to be Solved?

### Limited Ratepayer Funds

Over the past ten years the six local governments collectively have paid in excess of $6m of ratepayer funds to retain resident GPs.

Not only is this a significant opportunity cost for local governments and their communities but it diverts their limited funds towards a service that should be funded by State and/or Commonwealth Government. It means core local government services and infrastructure are underfunded, not pursued or not maintained to an adequate level (impacting Councils ability to adequately manage their asset maintenance and preservation programs).

In WA, local governments are also now required to prepare public health plans. These are essentially primary health plans and whilst community socio and economic health is an outcome in the provision of local government services and facilities, they are not responsible for primary health services and facilities which is included in the plans.

### Access to Healthcare is linked to Economic Health

Providing quality healthcare in a rural community goes beyond immediate healthcare services; it also has a positive impact on the economic health of a community – its productivity, absenteeism rates, workforce participation and more.

Rural health and rural community and economic development are also inextricably connected—neither field can be successful without the other. Thriving economies and communities require healthy people, and people need strong economic and health systems to thrive.

### Unintended consequences of the reliance on telehealth in rural Australia[23]

Studies and experience have identified that telehealth — the use of electronic means such as video or telephone to deliver health care remotely — has many benefits for patients, health care providers and health systems, including reduced costs, improved health care access, productivity gains, and increased satisfaction, convenience and efficiency. Beyond direct benefits, there is a widely held view that telehealth may potentially mitigate the negative impact of health workforce shortages in rural areas and achieve early intervention in health problems.

Telehealth can help enhance the health status of rural and remote communities by improving accessibility. By cutting travel costs such as fuel, accommodation, and lost wages due to work disruption, telehealth contributes positively to socio-economic wellbeing and helps relieve some of the financial burden rural communities face to access services.

While providing tangible support to rural clinicians on the ground, dependency on telehealth can [however] mask the need to invest long term to improve rural health, such as direct investment in infrastructure and the rural health workforce. By relying on metropolitan centres to provide care to rural Australians, telehealth essentially redirects rural resources to these centres, reducing future rural health care funding. This deflection of resources could threaten the viability and existence of rural practice altogether, eroding health services in rural areas and exacerbating the situation in a vicious cycle of overdependency and inaccessibility. Reliance on metropolitan doctors reduces opportunities for training in rural health, potentially

[23] Beyond the planned and expected: the unintended consequences of telehealth in rural and remote Australia through a complexity lens, Medical Journal of Australia, Osman et al, 2024

deskilling clinicians, especially those early in their career, thereby undermining the quality of health care rural patients receive over time. Intermittent metropolitan telehealth service providers do not participate in local call rosters nor have an understanding of the complex and chronic conditions of local, and especially Indigenous, patients needing personalised care. And predatory providers seeking to expand their business model might not be in the best interest of local communities due to this lack of local and contextual knowledge.

All in all, inherent limitations of telehealth, such as the inability to examine patients physically, may leave staff in rural primary care and emergency settings less skilled, and hence more vulnerable to medicolegal liabilities and overstretched as telehealth adds to their workload by transferring examining patients on behalf of the consulting physician or performing other clinical tasks outside their scope of work. Other concerns include that medicolegal consequences may arise due to miscommunication, lack of local context by the physician providing care via telehealth, and the hesitation of nurses and junior doctors to raise any concerns to a remote clinician. This may make work environments less attractive, further increasing the challenge of recruiting and retaining junior clinicians to rural practice.

Anecdotally reports within remote communities that support staff such as nurses feel pressure when there is no doctor in the room, particularly during emergency situations and the absence of collegiately is missed.

The continuity of care is also essential for every patient and the continuity of doctors through the telehealth service is clearly lacking and not avoidable.

There may also be social and economic consequences on rural communities due to the missed opportunity of having clinicians relocate to rural areas, contribute to the rural economy, bring investments, and attract more businesses to rural areas. And if the converse occurs, and telehealth fuels migration of rural Australians to metropolitan centres seeking specialist care or clinicians to work in cities, this can exacerbate the metropolitan housing crisis and the economy.

These actual and potential effects are largely unintended consequences of the implementation or telehealth in rural Australia and have not to date been subject to overt planning. They nonetheless can have considerable impact on rural and remote communities.

# 5. SOLUTION

Countries with a strong primary health care system experience better population health and lower rates of unnecessary hospital admissions. General practice is the bedrock of healthcare in rural areas. Ongoing access relies on being able to recruit and retain enough properly distributed GPs in all parts of the country.[24] The six local governments have tried various business models and incentives over the past decade and worked with organisations that are funded to support primary health care in the regions to attract GPs. They have resisted at every opportunity to part with ratepayer funds to attract and retain a GP, knowing firsthand that they have limited income but increasing needs for infrastructure and services across their communities that are required for current residents but also necessary for communities and industry to grow.

The Australian and Western Australian health systems are complex. However, despite complexities it is well evidenced that the third tier of government, local government, is not responsible for the delivery of primary health care, specifically the provision of GPs.

While local governments supporting GPs are rightly proud of securing and/or retaining these essential services for their communities, this should not distract from the fact that such support is a financial impost and takes away from other essential local government services and functions.[25]

Local government support for primary healthcare services is grounded in their pursuit of creating thriving communities. Local governments are stepping in to provide support for these services due to Commonwealth and State Governments failing in their responsibilities to ensure the adequate provision of essential services.[26]

The Local Government Primary Healthcare Services Survey Report by Rural Health West in 2024 identified a number of recommendations, one being the WA State Government establish a Local Government Primary Healthcare funding program. Based on the survey findings an initial annual fund of $5 million per annum is recommended across the State. However, this amount will likely be inadequate. Potentially such a fund should only be applied to RM6 and RM7 local governments.

Policy makers may say, set a gap fee payment or raise rates in each local government, to cover the cost of the provision of GP services, but the local conditions (population, demographics and local economy) are not favourable or sustainable to see these solutions last.

Investing in the general practice workforce in remote WA communities requires additional and distinct solutions to overcome unique workforce issues such as professional isolation, uncompetitive remuneration compared to metropolitan practices, state hospital salaries and locum rates and the viability challenges of running a rural general practice. It is critical State Governments and the Commonwealth Government work together to resolve GP workforce issues.[27]

Some policies have been introduced recently, such as rural generalist training pathways and will not yet show an effect, but other policies such as financial incentives have been in place

[24] AMA plan for improving access to rural general practice, AMA, 2023
[25] Local Government Primary Healthcare Services Survey Report, Rural Health West, 2024
[26] Local Government Primary Healthcare Services Survey Report, Rural Health West, 2024
[27] AMA plan for improving access to rural general practice, AMA, 2023

for a long time. Evidence shows that financial incentives may not be effective (Scott et al., 2013), or if they are it is only for GP Registrars who are the most mobile (Yong et al., 2018).

Due to the complexity of the health care system, there are many levers that could be used to help resolve the issues experienced by remote communities to attract and retain a GP. This position paper is not advocating to amend Medicare. The local governments are also not advocating to directly fund private enterprise or amend training and workforce policies. There are also WA Country Health policies for hospitals, locums and close availability GPs to service hospitals that influence the position the six local governments are faced with – the alliance will advocate on these separately.

The alliance is though raising awareness to the fact that market rates to attract a GP in a RM 6 and RM 7 community are significantly rising, with Commonwealth and State Government programs needed to match these market rates. The alliance is also raising awareness that telehealth is not the answer to shortages of GPs in remote communities.

The six local governments agree to continue to support GPs through the provision of a space for a practice under peppercorn leases, a house and vehicle, however the ongoing cash payment towards operations is unsustainable.

The six local governments need the Commonwealth and State Government's to consider a sustainability payment to assist in attracting and retaining resident GPs. This would reduce the cash component provided by local governments to GPs. The Tasmanian and Queensland Government provide similar programs.

Such a program for local governments would also reduce health inequalities experienced in the remote communities.[28]

A custom-made variation in the allocation of resources is required. Resourcing for such a solution can still be funded centrally, flexibility at the regional decision-making level uses local information better and is more adaptable.

Primary healthcare funding is a Commonwealth responsibility. In remote communities there are significant funding gaps.

The State Government has primary health care responsibilities as well, more than that of local governments.

**The Alliance is requesting the Commonwealth include a sustainability payment in the Federal Budget 25/26; directly to the six RM6 and RM7 local governments as a pilot program over a 3yr period; to the value of $4,425,000 plus CPI.**

**This could be distributed through the Medical Facilities cost adjustor (Financial Assistance Grants additional contribution).**

[28] Regional health inequalities in Australia and social determinants of health: analysis of trends and distribution by remoteness, Flavel et all, 2023

# APPENDICE

Figure: Location of hospitals neighbouring the alliance of Councils.

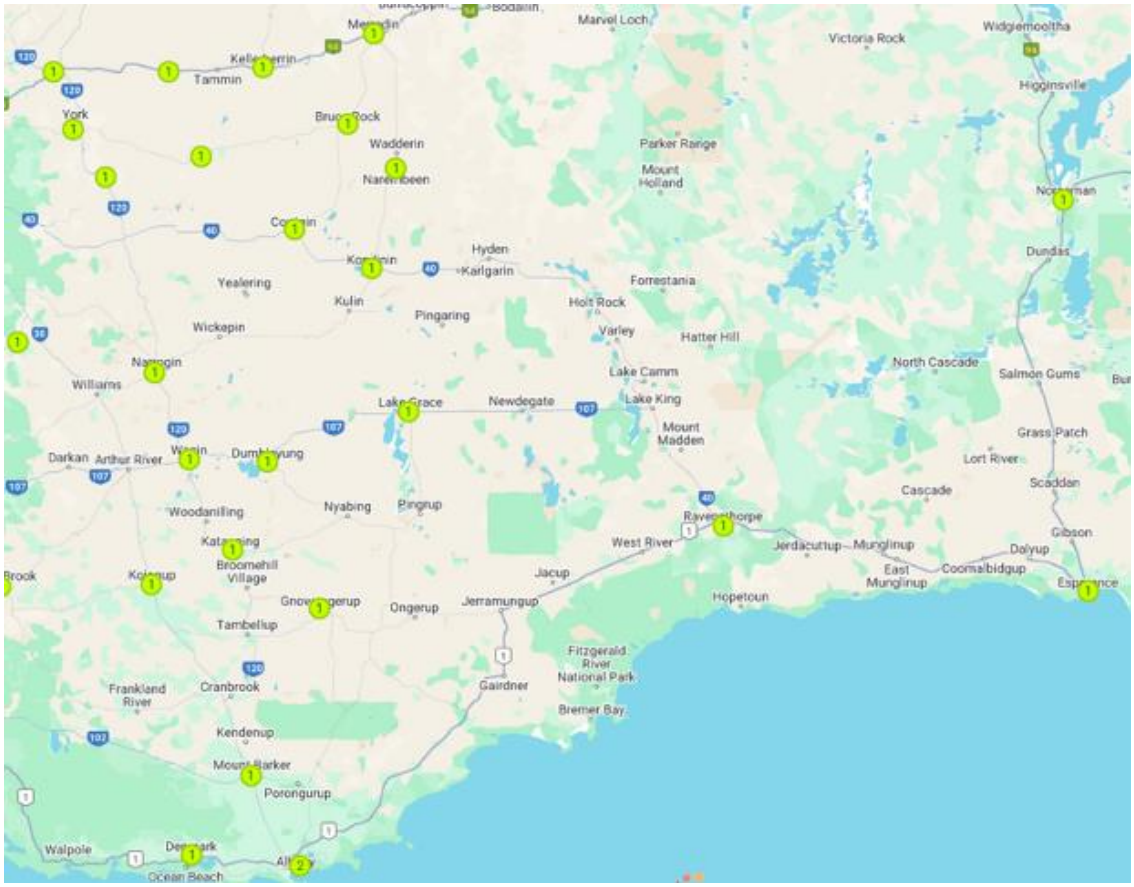


Figure: Location of GPs neighbouring the alliance of Councils.

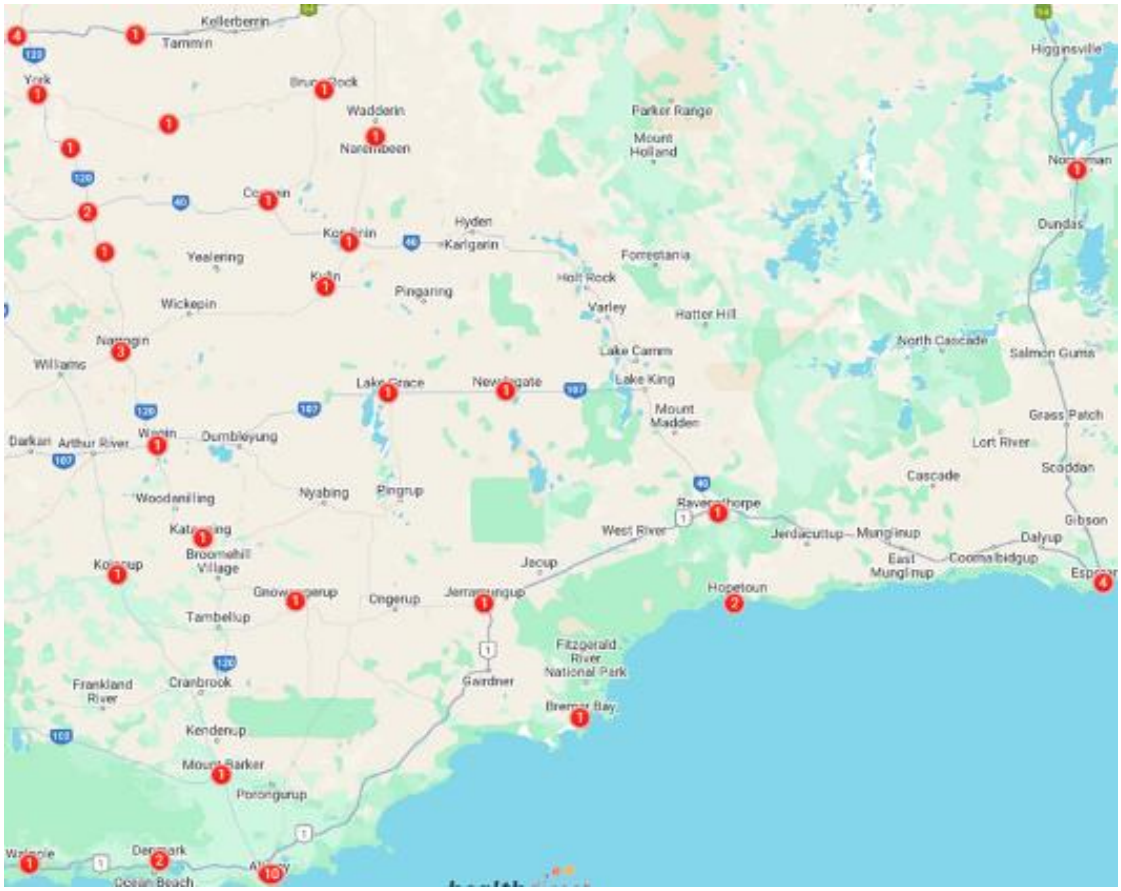
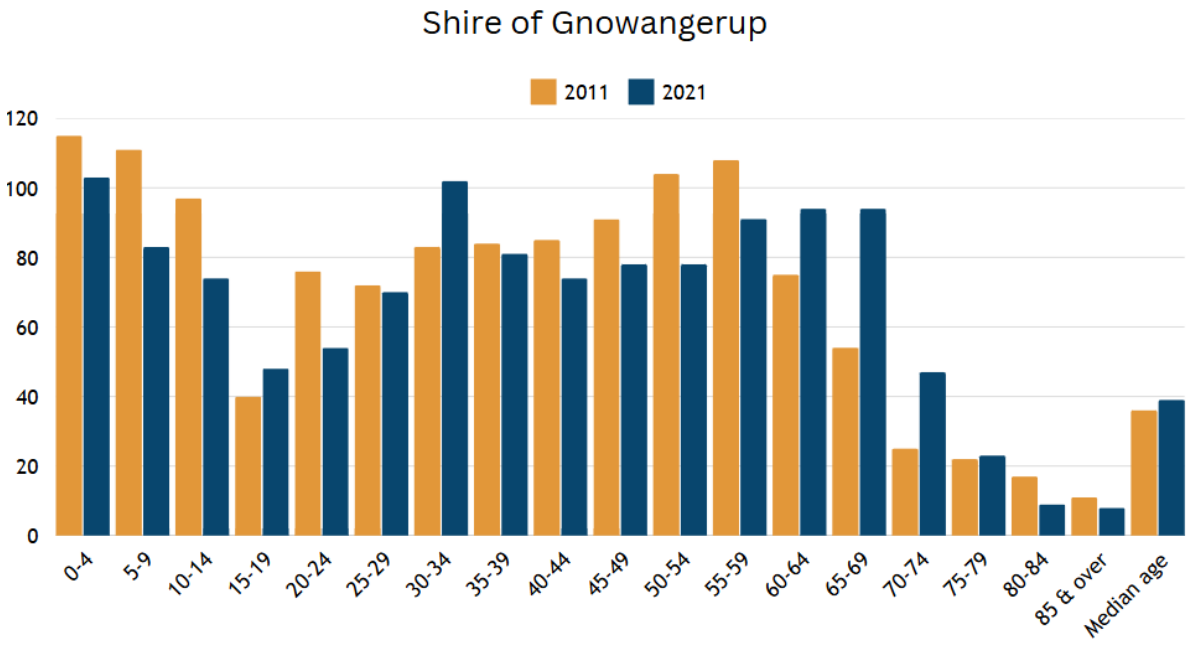
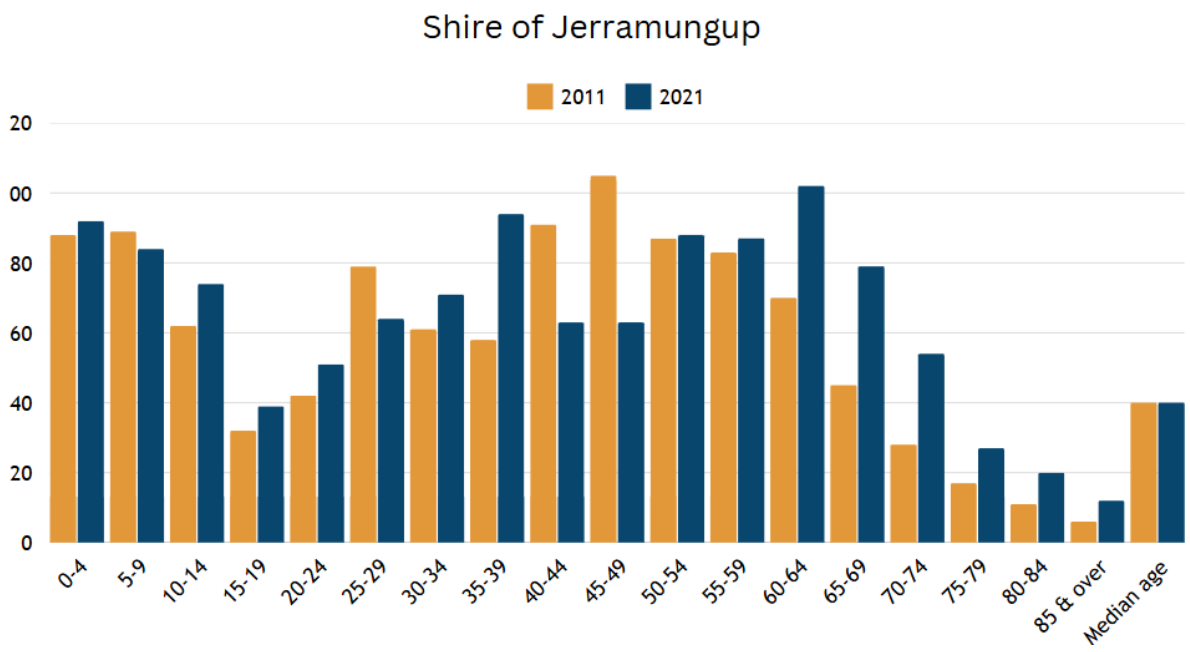



Figure: Age Profiles

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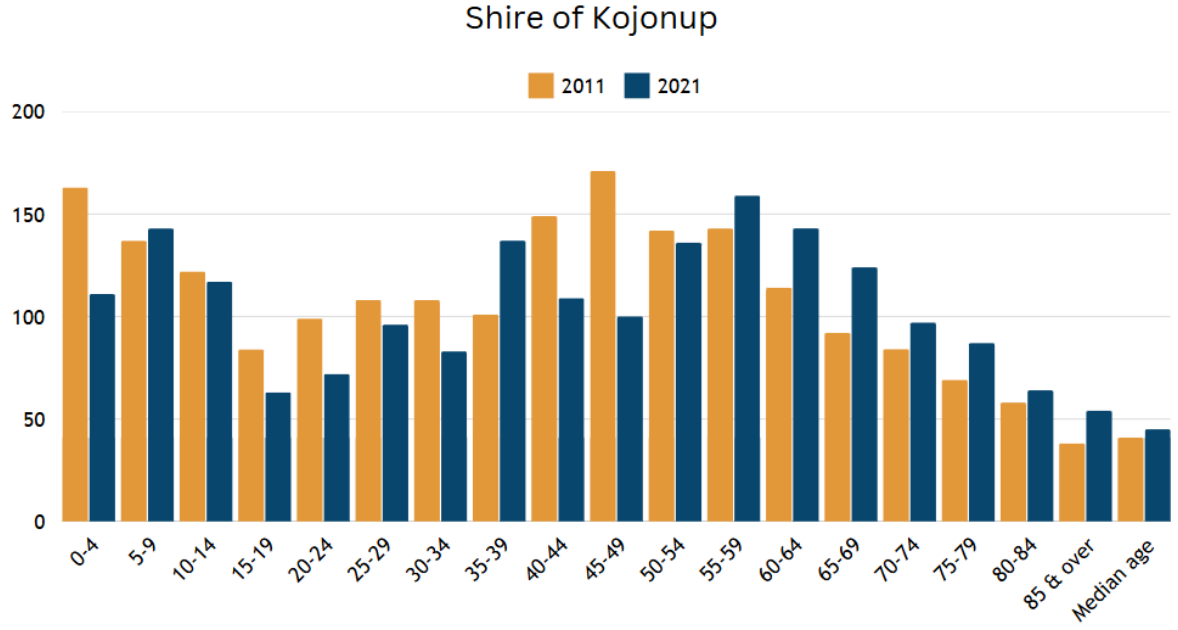
85 & over
Median age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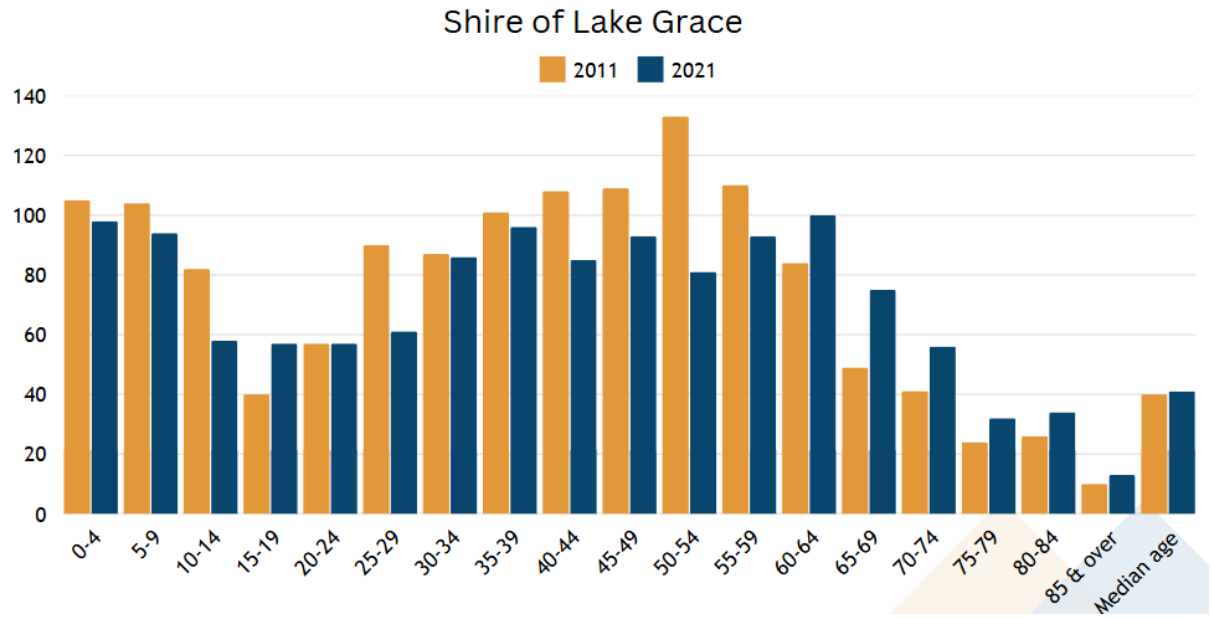
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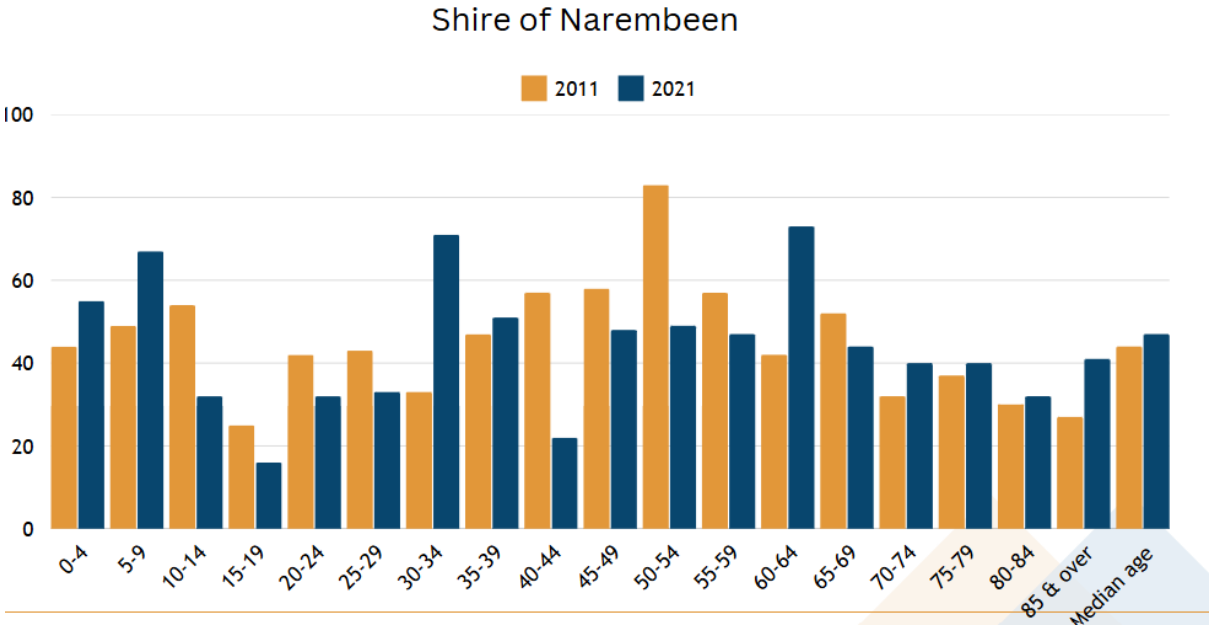
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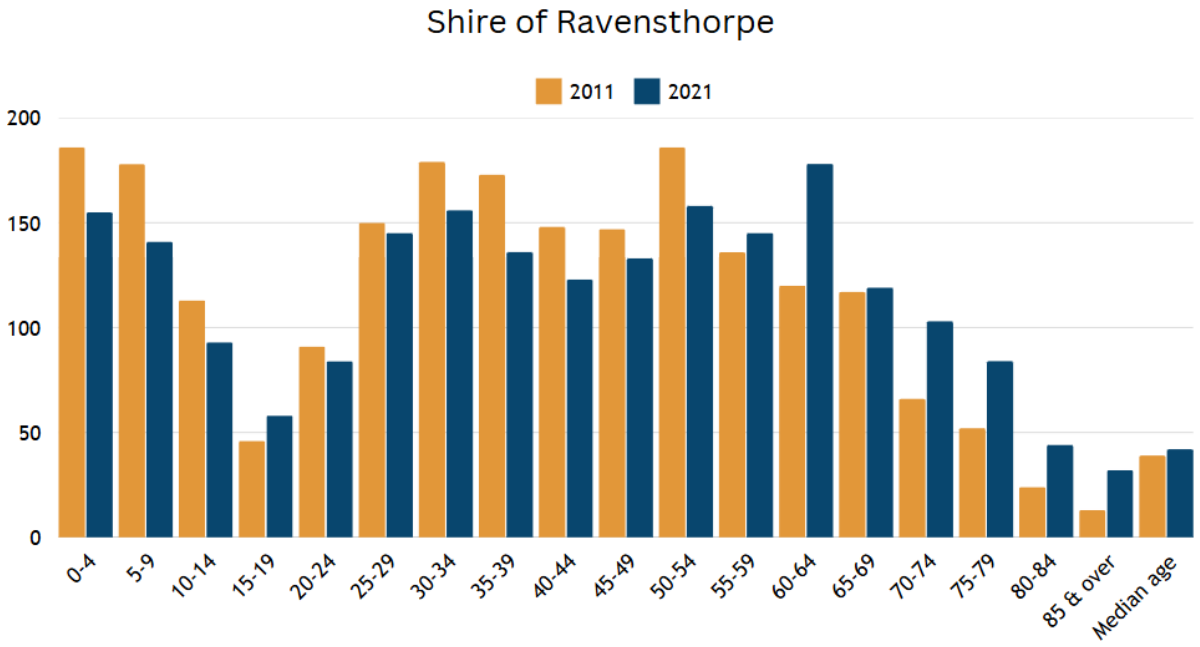
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Median age