

# Submission

## Rural, regional and remote Medicare access and funding

March 2026



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## **1.0 About Rural Health West**

Rural Health West is a not-for-profit organisation committed to ensuring people living in country communities have access to medical and health services. With 30 years in the rural health sector, we are known as the 'go to' people for rural health workforce.

As the designated health workforce agency in Western Australia, we work hard behind the scenes to provide a range of support to rural health professionals to keep country people healthy.

We are funded by the Australian Government Department of Health and the Government of Western Australia WA Country Health Service to deliver programs designed to attract, recruit and support medical and health professionals to rural Western Australia.

We have been improving access to healthcare services for country communities for over 30 years. We are able to identify and implement solutions to health workforce issues through our collaborative work with government agencies, private organisations and other non-government organisations at local, state and national levels.

## **2.0 Executive Summary**

This submission responds to the inquiry into the Government's changes to rural, regional and remote Medicare access and funding, with particular emphasis on the financial sustainability of independently owned community-embedded rural general practices and the growing reliance of small inland communities on Local Governments to subsidise primary care.

A survey of Western Australian local governments undertaken by Rural Health West and WA Local Government Association in 2023 demonstrated a clear and persistent market failure in many small, rural and remote (MMM 5-7) communities, particularly those with populations under 5,000 (Local Government Primary Healthcare Services Survey Report, 2024).

These communities are typically small, geographically isolated towns with ageing populations and limited local services, often located more than 100 kilometres from larger regional centres. Many were established as agricultural and service towns and now face declining populations and increasing health service needs, making access to local primary healthcare critical to community sustainability.

In these locations, Medicare-funded, fee-for-service general practice is frequently unable to generate sufficient revenue to meet the threshold of financial viability to make them attractive to general practitioners.

As a result and at the behest of their communities, local governments are increasingly intervening to secure and retain GP services through direct financial subsidies or income guarantees, provision of housing, facilities and vehicles, practice management support and locum coverage.

This local government intervention is not occurring in a policy vacuum. In many small rural communities, access to a GP is seen as essential community infrastructure, underpinning not only health outcomes but also community viability, workforce attraction and the ability for older residents to age in place. Research by the Rural, Regional and Remote Women's Network found healthcare was the top priority issue for rural women, with 48% identifying it as a priority, and GP services identified as the most difficult service to access.

Communities therefore hold a strong expectation that access to primary healthcare should be available locally, and when this is not achieved through market-based Medicare funding, local governments often step in to meet this community expectation and maintain the sustainability of their towns.

This growing reliance on Local Governments is neither sustainable nor appropriate. It reflects structural shortcomings in current Medicare funding and incentive arrangements, rather than local inefficiency or lack of effort. Without reform, inequity will continue to widen between metropolitan and rural Australians, with these small country communities bearing a disproportionate financial burden to maintain access to essential primary healthcare.

This submission recommends that government adequately resource structured, place-based investigations into sustainable service and funding models for small rural and remote communities throughout Western Australia experiencing market failure.

While general practitioners may not always be the most appropriate or sole solution, any transition to alternative multidisciplinary models requires investment in health needs assessment, service planning, system coordination and community engagement. Without this groundwork, reform efforts risk failure due to community resistance, service fragmentation and unintended impacts on local hospitals and aged care services, who often rely upon the local GP workforce.

### **3.0 Rural primary healthcare and structural market failure**

Primary healthcare is a shared responsibility across governments, with the Australian Government primarily responsible for funding general practice through Medicare, and State Governments responsible for public hospitals and many community health services.

In practice, this division creates a significant gap in small rural and remote communities where neither system is designed to address thin workforce markets and the market failure associated with delivering general practice services in small and isolated communities.

In metropolitan and larger regional centres, Medicare functions reasonably well. Population density, patient throughput and economies of scale allow practices to absorb overhead costs and remain viable.

In contrast, small inland communities across rural Western Australia face a combination of:

- Low and dispersed populations
- Higher fixed practice costs
- Lower patient tolerance for private billing or paying co-contributions
- Enduring workforce shortages
- An ageing health workforce
- Reliance on International Medical Graduates
- Older populations with complex health needs.

In these settings, Medicare revenue alone is often insufficient to sustain a general practice. This results in market failure – where there is demand for services, but the private market cannot viably supply them under existing funding arrangements.

The consequences of this failure are visible across inland Western Australia. Communities experience repeated cycles of essential health worker loss or relocation, fueled by growing competition between communities for a limited pool of GPs. These cycles undermine continuity of care, increase preventable hospital presentations and erode community confidence in the health system.

The ongoing and systemic failure of funding for rural and remote primary healthcare is not new. It was highlighted by the Senate Standing Community Affairs Reference Committee 2022 report into the *Provision of general practice and related primary health services to outer metropolitan, rural and regional Australians – Interim Report*.

The Committee received 218 submissions, reflecting the depth and breadth of community and professional concern for rural and remote health and services. The Standing Committee made nine (9) recommendations to the Federal Government and also identified areas of ‘concern and dissatisfaction’.

These included the issue of maldistribution of rural and remote primary health professionals and identified the lack of multi-jurisdictional collaboration as a leading cause in failing to meet the primary healthcare needs of local communities.

The committee said, *‘It is clear to the committee that the current division between federal, state and territory governments is failing to recognise the needs of communities...neither the federal or the state governments have taken proper responsibility for the provision of GPs and other primary health professionals.’*

And, *“The committee is gravely concerned that local councils have been left to fill the gaps caused by a lack of federal and state responsibility to provide primary health services. Local councils should not have to fundraise or impose rate increases to support these services.”\**

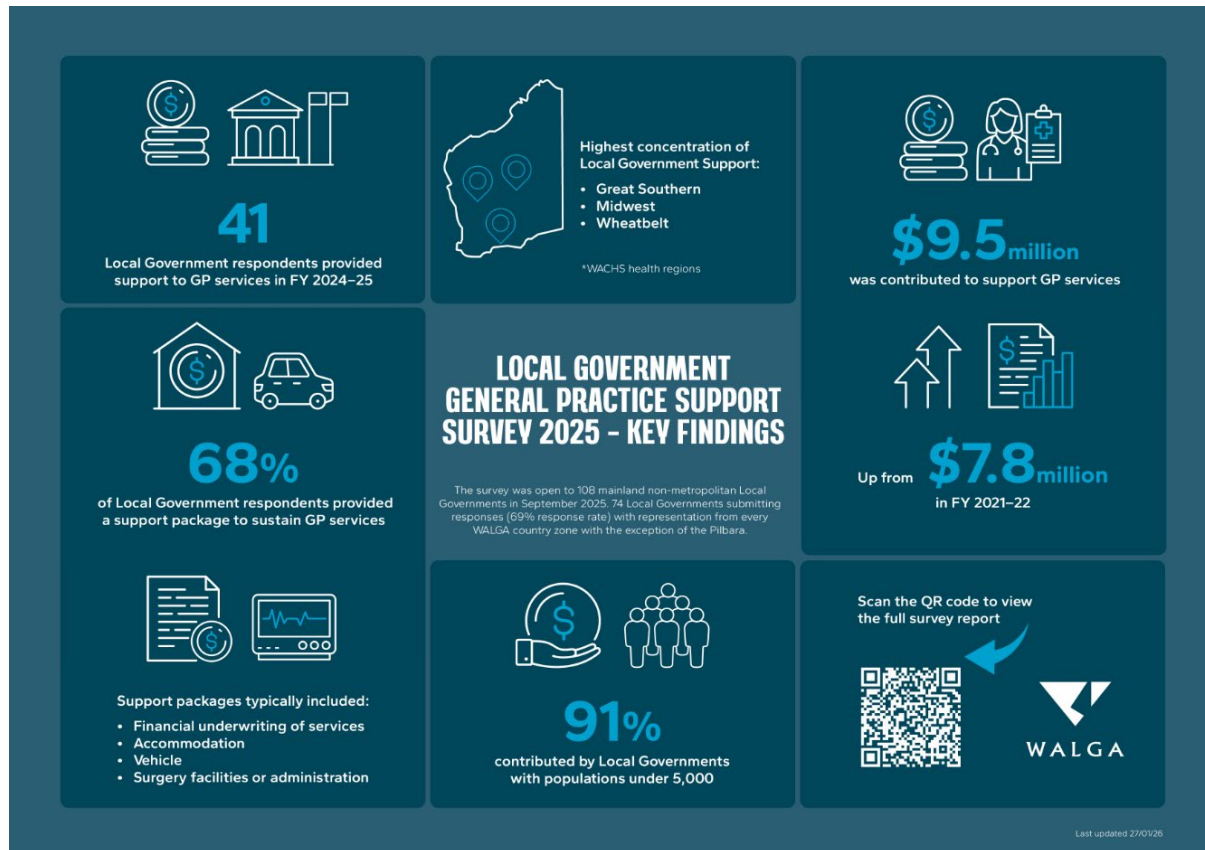
The Committee’s conclusion of shared jurisdictional responsibility for the current systemic failure in aspects of rural and remote primary healthcare requires State and Territory Governments to become more accountable and active in fulfilling their obligations under The *National Health Reform Agreement – Addendum 2020-25*, which emphasises the need for cooperation and shared responsibility in *‘identifying rural and remote areas where there is limited access to health and related services with a view to developing new models of care to address equity of access and improve outcomes.’\**

There does not yet appear to be significant progress made on this issue in the intervening period given that the scale of local government intervention to retain general practice services for their communities has been escalating in recent years.

## 4.0 Local government intervention in the primary healthcare market

Evidence from Western Australia shows that small, inland Local Governments are increasingly stepping in to fill the gaps left by Medicare funding arrangements. In 2023, the [Local Government Primary Healthcare Services Survey](#) undertaken by Rural Health West in collaboration with WA Local Government Association showed that Local Governments collectively contributed \$6.8 million (net) toward primary healthcare services, with \$5.2 million directed specifically to general practice.

By 2024-25, this contribution had grown to \$9.5 million for GP services alone, despite fewer Local Governments responding to the [WALGA 2025 General Practice Support Survey](#) than the 2023 survey undertaken by Rural Health West. A snapshot of results from the latest survey is captured below. Graphic provided courtesy of WA Local Government Association.



Critically, over 90 per cent of this expenditure is borne by Local Governments with populations under 5,000; largely located in inland communities with Modified Monash Model (MMM) designations 5-7. These Local Governments often have the smallest ratepayer bases, yet are contributing hundreds of thousands of dollars per year to sustain GP services.

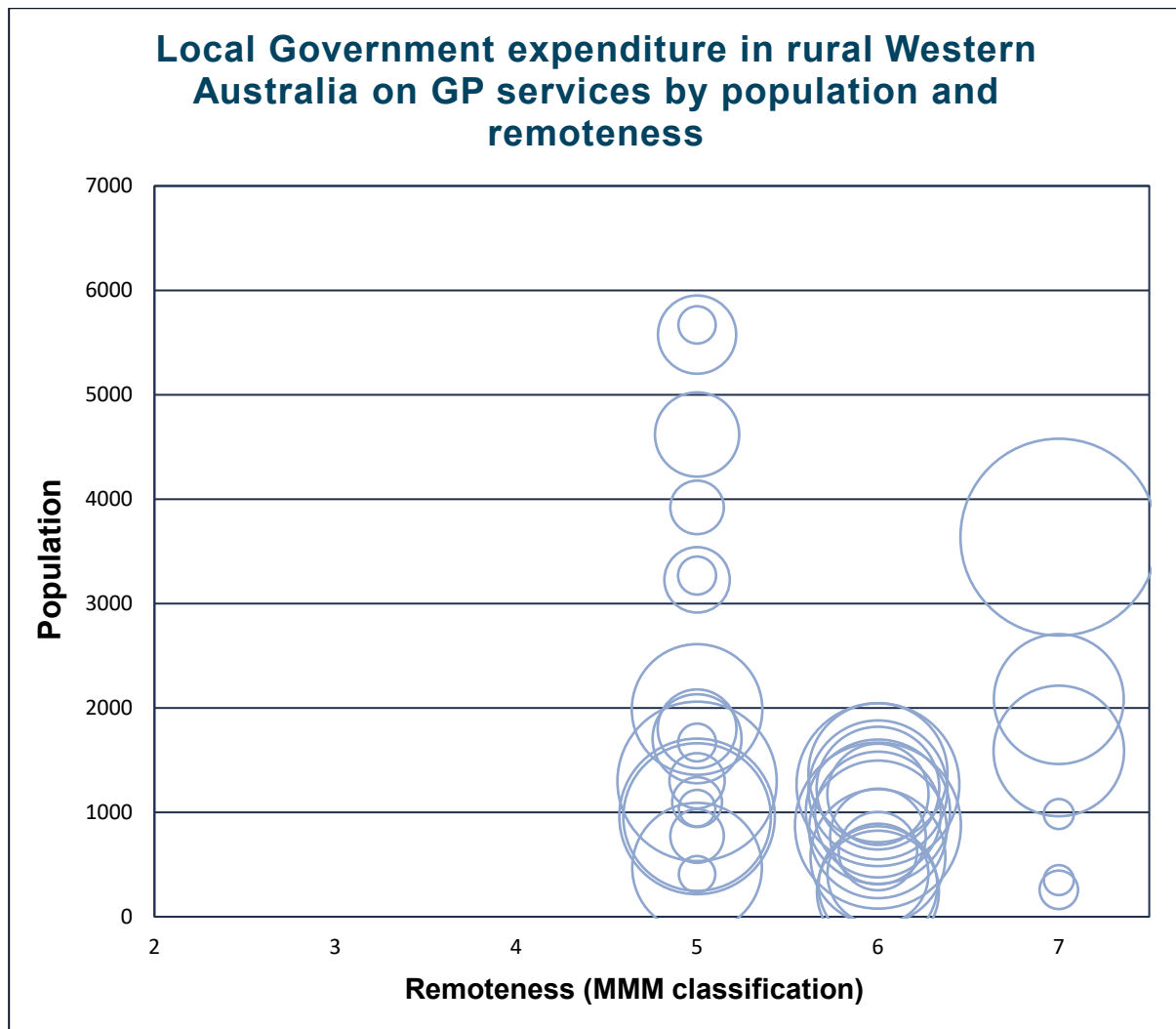
The smaller Local Governments shouldering this impost are mostly concentrated in the Wheatbelt and Midwest regions of Western Australia. People living in these regions are geographically and demographically challenged in accessing public and private health care services, which are concentrated in larger regional centres and the metropolitan area.

This means that some medical services are operating in locations where the viability of the fee-for-service practice model is difficult and, in some cases, unworkable under current financial arrangements. However, the service is needed and is considered to be vital for the future for these communities.

At the behest of their communities, who have deemed the attraction and retention of doctors as 'non-negotiable,' Local Governments are actively competing in the open market for doctors, nurses, and allied health professionals. This has led to a situation where communities hoping to gain a recruitment advantage are prepared to offer very significant financial and in-kind incentives.

The graph below highlights the relationship between remoteness, small population size and elevated Local Government spending on general practice services for their communities.





Local Government administrators describe the community demand for a country doctor, the financial imposts on their budgets and the day-to-day management of specialist medical practices as a constant source of worry and pressure. The common refrain from CEOs is: “If we haven’t got a doctor, we haven’t got a community.’

While all the CEOs interviewed as part of the [Local Government Primary Healthcare Services Survey](#) in 2023 said that communities were ‘extremely proud’ of what they have achieved in lowering the barriers of entry in establishing a GP practice, they all agreed that this ‘is not the job of local government’.

Forms of Local Government support being offered across rural Western Australia include:

- Income guarantees and incentive payments
- Provision of practice facilities and equipment
- Subsidised or free housing and vehicles
- Practice management and administrative support
- Direct contracting of GPs
- Locum subsidies to enable leave and service continuity.

The table below outlines expenditure across rural Western Australia by Local Governments towards general practitioner services as reported by Local Governments in the 2024-25 financial year. This information was captured by WA Local Government Association through the [WALGA 2025 General Practice Support Survey](#).

Nature of Support	
Subsidised power	\$73,629
Incentive payment/income guarantee	\$3,334,950
Travel vouchers	\$0
Provision of GP facilities	\$1,394,611
Locum subsidy/incentive	\$38,000
Provision of accommodation or rental assistance	\$751,203
Local Government employment of GP directly	\$85,000
Provision of vehicle and/or fuel	\$515,870
GP contracted by Local Government	\$1,436,220
Provision of practice management/administrative services	\$840,415
In kind	\$174,455
Other	\$839,809
<b>Total Gross Expenditure in 2024-25</b>	<b>\$9,484,162</b>
Financial Assistance Grant - Medical Facilities Cost Adjustor*	-\$1,699,191
<b>Total Net Expenditure in 2024-25</b>	<b>\$7,784,971</b>
Additional costs in the three financial years since 2021-22 in relation to general practice recruitment processes	\$70,383

\* The Medical Facilities Cost Adjustor is applied to Financial Assistance Grants (FAG) by the WA Grants Commission to recognise costs that are out of a Local Governments control or do not equally impact Local Governments. The Cost Adjustor is based on indicator data rather than actual spend with the maximum allowance capped at \$100,000 per Local Government recipient from 2024-25.

Some Local Governments provided GP service support without receiving the cost adjustor while others are receiving the Cost Adjustor but have not identified any GP service support in their survey response.

While these interventions are driven by community need and place-making responsibilities, they sit outside Local Government's intended role and financial capacity. Local Governments report redirecting funds away from core services such as infrastructure, recreation and community development to maintain access to healthcare.

As one Chief Executive Officer from an MMM6 location stated during qualitative interviews, "We'll always sacrifice a kilometre of road to keep the doctor. If we lose the doctor, we lose the town."

This growing financial burden should be understood as a system-level failure, not a local one. Without this Local Government intervention, many communities would have no resident or visiting GP at all.



## 4.1 Characteristics of small inland communities across Western Australia

Small inland communities across Western Australia's Wheatbelt, inland Midwest and Upper Great Southern regions are characterised by large geographic areas, small and dispersed populations, and significant distances between towns and services.

The Wheatbelt covers approximately 154,000 square kilometres and the Midwest approximately 472,000 square kilometres, yet the population is spread across many small towns, most with fewer than 5,000 residents and often located more than 100 kilometres apart. These distances and small population bases make service delivery more expensive and reduce the patient volumes that support fee-for-service general practice.

These regions are largely agriculture-based and have experienced long-term population decline due to farm consolidation, mechanisation and reduced labour requirements. At the same time, many communities have ageing populations and increasing rates of chronic disease, resulting in higher health service needs despite smaller populations.

Together, these factors create "thin markets" for healthcare, where there is sufficient need for services but insufficient population volume to support a fully private, Medicare-funded general practice model. In these communities, general practice also supports local hospitals, aged care services and emergency response, meaning the loss of a GP has impacts beyond primary care alone.

## 4.2 Community expectations

In many small rural communities, access to a local GP is understood not as an optional service, but as essential community infrastructure. Communities strongly associate the presence of a GP with safety for families, the ability for older residents to age in place, access to urgent and after-hours care, and continuity of care across hospital, aged care and community settings. In this context, the loss of a GP is often seen as a turning point for a town's future, affecting not only health outcomes but also population retention, workforce attraction and broader community sustainability.

Research consistently shows that rural residents place a very high value on access to healthcare. The [Rural, Regional and Remote Women's Network Survey Report 2024-2025](#) found that healthcare was the top priority issue for rural women, with 48% identifying it as a priority, and GP services identified as the most difficult service to access, with 60% of respondents reporting difficulty accessing a GP.

Local Governments are responding to these community expectations and service gaps. The [Provision of Medical Services in MMM6 and MMM7 Communities](#) position paper published by an alliance of six rural Western Australian councils concluded that access to healthcare contributes not only to health outcomes, but also to productivity, workforce participation and broader economic sustainability, reinforcing the view that healthcare functions as essential infrastructure in small communities.

This expectation is reinforced by the health profile of many inland communities, which often have older populations, higher rates of chronic disease and long travel distances to alternative services. Rural WA's government health service provider, WA Country Health Service, reporting has shown that a significant proportion of emergency department presentations in some inland

regions are non-urgent and linked to lack of local GP access and limited early intervention and prevention services, demonstrating the system-wide impact when primary care is not locally available.

Reporting in [The Australian](#) newspaper in February 2026 described the loss of medical services as contributing to the “hollowing out” of small towns throughout inland Western Australia, as residents relocate to larger regional centres with better access to healthcare and services.

In the same article WALGA President Karen Chappel stated, “We’re reluctantly stepping into this to fill the gap and provide these services,” reinforcing the view that access to healthcare is seen by communities as essential infrastructure rather than a discretionary service.

The practical reality is that without Local Government support to retain local primary care, these communities face declining health outcomes, increased hospital demand, reduced workforce attraction and long-term risks to community sustainability.

## **5.0 Impacts of Medicare settings on general practices servicing small rural communities**

Current Medicare rules and incentive structures disproportionately advantage large corporate providers and group practices operating in high-volume markets. These providers benefit from:

- Economies of scale across multiple sites
- Centralised administration
- Expertise and capacity to maximise Practice Incentive Payments (PIPs)
- Expertise and capacity to model and maximise Medical billings and clinic revenue
- Greater capacity to cross-subsidise services
- Higher patient throughput.

In contrast, small, independently-owned rural practices – often solo or two-GP clinics – face significantly higher per-GP overheads. Fixed costs such as staffing, IT systems, accreditation, insurance and facilities do not reduce proportionally with patient numbers. Small practices also have less capacity to investigate and introduce processes and practices required to be eligible for PIPs or to consider alternate revenue streams, such as occupational health or after-hours services.

Smaller patient numbers also reduces the viability of these practices taking on GP registrars, or practising with a partner, which can be highly desirable for GPs throughout their careers, but particularly as they near retirement.

While recent Medicare incentive changes, including bulk-billing incentives introduced in November 2025, may improve margins in some settings, early feedback indicates they do not materially improve viability in small rural communities. In many cases, these incentives fail to offset the lower consultation volumes and longer consultation times needed in rural practice due to patient complexity and visit infrequency.

As a result, corporate providers are more likely to avoid or withdraw from these small rural markets, while community-embedded practices rely on Local Government subsidies to survive.

These new incentives also fail to recognise that many small, inland communities lack the lifestyle and amenity on offer in larger, coastal communities. It is an unavoidable reality, that

additional incentives must be on offer to attract GPs, who have a high degree of career portability, to some communities.

## 6.0 Need for investment

It is acknowledged that in some of these communities, a traditional GP-led model may not be the most appropriate or sustainable solution. Multidisciplinary, team-based models involving nurse practitioners, nurses, allied health professionals, visiting specialists and telehealth may offer improved and more cost-effective access to care.

However, transitioning to these models is complex and resource-intensive. It requires:

- Detailed local health needs assessments
- Clear definition of service scope and roles
- Integration with hospitals and aged care services
- Identifying and accessing appropriate sustained funding
- Community consultation and education
- Change management to build trust and acceptance

Without this groundwork, communities resist alternative models, particularly where there is fear that services will be downgraded or fragmented.

Crucially, Medicare currently provides limited support for the planning, coordination and non-face-to-face activities required to establish and sustain multidisciplinary care in thin markets. While there is innovation funding available through the Primary Health Networks, accessing this funding is somewhat opaque and can be overly prescriptive.

## 7.0 Recommendations

To address the issues outlined above, this submission recommends that government:

### 7.1 Fund a structured investigation into sustainable rural primary care models

The Australian Government, potentially in partnership with States and Local Governments, should adequately resource a comprehensive investigation into service and funding models for small rural and remote communities experiencing market failure and/or those reliant upon Local Government investment for primary care services.

This should include:

- Identification of minimum viable service thresholds
- Assessment of alternative GP and non-GP-led models
- Analysis of Medicare, State and place-based funding options

## **7.2 Increase support place-based pilots and trials**

Governments should fund place-based pilots in selected communities, in the Western Australian Wheatbelt and locations facing similar issues across rural Australia, to trial alternative models, with built-in evaluation and scalability considerations. Funding should cover not only service delivery, but planning, coordination and evaluation – and also consider long-term funding structures.

Dedicated funding should also be provided for community consultation, evaluation, education and change management to support transitions away from GP-only models where appropriate.

Any reform must also explicitly account for the role of GPs in local hospitals and aged care settings, ensuring continuity of medical coverage and clinical governance in the broader health ecosystem.

## **7.3 Reduce reliance on Local Government subsidisation**

Future funding models should aim to remove the expectation that Local Governments underwrite the financial viability of primary care services, recognising this as a symptom of system failure rather than a sustainable solution.

## **8.0 Conclusion**

The growing reliance of small rural and remote communities on Local Governments to sustain GP services is clear evidence that current Medicare funding and incentive structures are not fit for purpose in thin markets and areas of market failure. Without reform, inequity will deepen, and communities will continue to face instability and uncertainty in access to care.

Addressing this challenge requires more than incremental Medicare changes. It demands deliberate investment in place-based planning, community engagement and system coordination to develop sustainable, community-supported models of care. With appropriate resourcing and collaboration, governments have an opportunity to deliver fairer, more resilient primary healthcare for rural and remote Australians.

### **Contact details**

Professor Catherine Elliott, Chief Executive Officer  
Kerida Hodge, General Manager, Communications and Business Analytics

### **Rural Health West**

Address: Level 2, 10 Stirling Highway, Nedlands WA 6009

Ph: 08 6389 4500

Email: [REDACTED]