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Regional Development Australia

GOLDFIELDS ESPERANCE

RESPONSE TO QUESTION ON NOTICE

Modified Monash Model
Doctor Attraction and Retention

Goldfields Esperance Region, Western Australia

Submitted by	Regional Development Australia Goldfields Esperance
Author	Sharon Henderson, Director
Committee	Senate Select Committee on the Australian Government's Productivity Agenda
Hearing date	24 April 2026, Kalgoorlie-Boulder
Question on Notice from	Senator the Hon Dr Michelle Ananda-Rajah
Subject	Whether the Modified Monash Model is helping or hampering doctor attraction and retention in the Goldfields Esperance region
Response date	8 May 2026

1. Direct response

The Modified Monash Model both helps and hampers doctor attraction and retention in the Goldfields Esperance region. It helps by providing a national framework that recognises remoteness and channels workforce incentives towards rural, remote and very remote areas. It hampers by attaching incentive structures to those classifications that are not, in their current form, sufficient to overcome the practical barriers to recruiting and retaining doctors in MM6 and MM7 communities, and by classifying the regional service hub of Kalgoorlie-Boulder at MM3, the same tier as Busselton.

On balance, the framework is necessary but not sufficient. It identifies the problem but does not yet provide the level of targeted investment required to solve it.

2. Regional context

The Goldfields Esperance region covers approximately 771,276 square kilometres, an area larger than the State of Victoria, and is home to approximately 58,000 residents across ten local government areas. Approximately half of the region's population lives in Kalgoorlie-Boulder, which is also the regional service hub: it is where the majority of the region's GP workforce is necessarily located, where specialist visiting services concentrate, and where the regional hospital sits. Under MMM 2023, Kalgoorlie-Boulder is classified MM3, the Shire of Esperance is MM6, and the remaining eight local government areas are MM7.

3. How the Modified Monash Model helps attraction and retention

The Modified Monash Model provides a structured, nationally consistent framework for recognising the geography of rural and remote Australia and for directing health workforce policy towards the areas where recruitment is hardest. In the Goldfields Esperance region, the framework helps in the following ways.

3.1 It recognises that remoteness matters

By classifying nine of the ten local government areas in the region as MM6 or MM7, the model formally acknowledges what residents have long experienced: that the Goldfields Esperance region is one of the most remote populated parts of Australia. That recognition is the precondition for any targeted workforce policy and is welcomed.

3.2 It enables financial incentives that would not otherwise be available

The classification activates a range of Commonwealth and State workforce supports for our MM6 and MM7 communities, including the Workforce Incentive Program - Doctor Stream, the Rural Bulk Billing Incentive at higher tiers for MM6 and MM7 services, HELP debt relief settings for doctors who practise in eligible rural and remote areas, and access to the rural generalist training pathway. In Western Australia, the classification also intersects with State programs delivered through the Department of Primary Industries and Regional Development under the Royalties for Regions Country Health Innovation incentive, including emergency department incentives, procedural incentives, location incentives and small-town GP incentives.

3.3 It provides finer differentiation than the previous classification system

Compared with the Australian Statistical Geography Standard remoteness classifications used in earlier policy settings, the MMM allows for finer differentiation between an inner regional town and a very remote community. For Goldfields Esperance, this means that the Ngaanyatjarra Lands, the Northern Goldfields, and the more remote parts of the Esperance hinterland are not lumped in with regional centres closer to Perth, and the workforce incentives accordingly carry greater weight in those communities.

3.4 It enables access to a broader recruitment pool through Distribution Priority Area linkage

The MMM is closely linked to the Distribution Priority Area system, which determines where doctors with Medicare provider number restrictions can practise. MM2 to MM7 locations are generally eligible for DPA status. This linkage is critical because International Medical Graduates must work in DPA areas to access Medicare, and DPA classification also underpins return-of-service obligations for bonded doctors. For the Goldfields Esperance region, this architecture is fundamental to recruitment: a substantial proportion of the doctors practising in Kalgoorlie-Boulder, Esperance, and the Northern Goldfields communities are recruited through pathways that depend on MMM-derived DPA eligibility. Without the MMM and DPA framework operating together, these recruitment pathways would not be available at the scale required to sustain GP services in the region.

3.5 Examples in the region

Examples in the region include the use of MM7 status to access higher-tier WIP-DS payments for doctors recruited to towns including Laverton, Leonora, Norseman and Ravensthorpe; the use of MM6 status by Esperance to support locum cover and procedural incentives; and the use of the rural generalist training pathway to attract early-career doctors into Goldfields Esperance hospitals via WA Country Health Service. Without the MMM framework, these supports would not be available at the level they are.

4. How the Modified Monash Model hampers attraction and retention

The same framework that recognises remoteness also produces three structural problems for doctor attraction and retention in the Goldfields Esperance region.

4.1 Incentives are not calibrated to the cost of practice in MM6 and MM7 thin markets

MM6 and MM7 communities in Goldfields Esperance are very small, very dispersed, and have limited patient pools. Medicare fee-for-service revenue alone does not cover the floor cost of running a sustainable general practice in these contexts. Existing WIP-DS, RBBI and HELP settings narrow the gap but do not close it, particularly when housing, locum relief, professional development and on-call expectations are factored in. The result is that even with MM6 or MM7 classification, recruitment is heavily reliant on local government, resource sector and not-for-profit contributions to make a position viable.

The same structural pattern is documented across other very remote Western Australian communities. The Local Government Rural Health Funding Alliance, comprising six MM6 and MM7 shires in the Wheatbelt and Great Southern, has shown that local governments are diverting up to 16 per cent of total rates revenue to attract and retain resident doctors. An independent economic assessment by Econisis (January 2026) calculated a benefit-cost ratio of 3.08 on this local government investment, while concluding that it is unsustainable and should be funded from Commonwealth or State sources rather than local rates.

This pattern is now documented in the Goldfields Esperance region directly. The WALGA 2025 General Practice Support Survey, with responses from 74 of 108 mainland non-metropolitan Western Australian local governments covering FY2024-25, recorded $1,339,149 in gross local government expenditure on GP services within the Goldfields Esperance Country Zone, an increase of 103 per cent from $659,678 in 2021-22. Three local governments in the zone provided this support. After partial offset by the Financial Assistance Grant Medical Facilities Cost Adjustor, the net financial impost on those local governments was $998,344. The survey also confirmed that 91 per cent of total local government GP support expenditure across regional Western Australia, $8.6 million of $9.5 million, came from 38 local governments with populations under 5,000, the cohort that corresponds most closely to MM6 and MM7 communities. Statewide expenditure rose from $7.8 million in 2021-22 to $9.5 million in 2024-25, indicating a worsening rather than stabilising pattern of cross-subsidy.

4.2 The classification of the regional service hub does not reflect its workforce role

Kalgoorlie-Boulder is classified MM3 under MMM 2023. The Department of Health, Disability and Ageing's MMM 2023 Fact Sheet identifies Busselton, 223 kilometres from Perth, as a canonical MM3 example. Kalgoorlie-Boulder, 595 kilometres of road from the nearest tertiary referral centre, sits at the same workforce incentive tier despite being the regional service hub for an area larger than Victoria, the location of the majority of the region's residents, and the anchor for the visiting-specialist, locum-relief and referral networks that sustain primary care across the surrounding MM6 and MM7 communities. This reflects a broader limitation in how MMM is applied: it is based on the population and remoteness of a single geographic location, not the functional service catchment that the location supports, and the gap between classification and function is most pronounced where a regional hub anchors a much larger surrounding catchment.

The Department's own Review of the remoteness classification system for aged care (final report, 2026) identified Kalgoorlie among the locations where stakeholders advised that the MM3 rating did not properly reflect their remoteness and significant workforce and service delivery challenges. The same observation applies in the doctor workforce setting. When recruitment to Kalgoorlie-Boulder is constrained by incentives calibrated to substantially less remote contexts, the workforce architecture on which the MM6 and MM7 communities of Goldfields Esperance depend is weakened.

4.3 Incentives do not adequately support the full attraction and retention package

In very remote contexts, attraction and retention is not delivered by Medicare fees and incentive payments alone. It requires housing, family relocation support, locum relief to enable leave and continuing professional development, supervision arrangements for early-career doctors, and viable practice infrastructure. In Goldfields Esperance, these costs are typically being carried by local governments, by resource sector partners, by Aboriginal Community Controlled Health Organisations such as Bega Garnbirringu, and by individual practices, often at the expense of other core local government responsibilities. The MMM-tied incentive architecture does not currently treat these supports as integral with the result that classification translates into a partial rather than a complete attraction and retention package.

4.4 The MMM-linked Distribution Priority Area architecture does not always reflect on-ground workforce reality

While the MMM and DPA framework enables recruitment, the review and update processes are slow to respond to on-ground workforce shifts. Classification changes are tied to Census cycles and Departmental review timelines that can lag the operational reality faced by practices and communities. In thin markets such as those across the Goldfields Esperance region, the loss of a single doctor can rapidly shift a community from manageable workforce stress to crisis, but the MMM and DPA classifications under which it recruits do not adjust at that pace. There is also a related "cliff edge" risk: a future MMM update that reclassifies a community downwards, for example reclassifying Esperance from MM6 to MM5, could remove incentives, workforce program eligibility and DPA-linked recruitment access suddenly, with no transitional protection for affected practices, local governments, and patients. Communities operating with very thin margins of GP coverage cannot absorb that kind of step change.

4.5 Evidence of the resulting workforce constraint

The WA Primary Health Alliance has reported that GP full-time-equivalent supply in the region sits below the State rate, with the Goldfields SA3 at 0.9 FTE per 1,000 residents and the Esperance SA3 at 0.8 FTE per 1,000 residents, compared with 1.1 FTE per 1,000 across Western Australia. WAPHA has also identified Esperance, Esperance Region, and Kambalda, Coolgardie and Norseman among the lowest decile areas in Western Australia for access to bulk-billing GPs relative to need. On-the-ground consequences include reliance on locums and the cost premium that creates, renal patients relocated to Perth for ongoing dialysis, six inpatient mental health beds for the entire region with none for under-18s, and very long travel distances for residents in the Northern Goldfields and the Ngaanyatjarra Lands to access primary and specialist care.

5. Overall assessment

The Modified Monash Model is a useful and necessary framework. It has provided national recognition of remoteness, has enabled a tiered workforce incentive architecture, and has channelled meaningful supports into the Goldfields Esperance region that would not otherwise be available. To that extent, it is helping.

However, the framework is not sufficient on its own to attract and retain doctors at the levels the region's residents need. The incentives attached to MM6 and MM7 classifications are not calibrated to the cost of sustainable practice in thin markets; the classification of Kalgoorlie-Boulder at MM3 does not reflect its role as the workforce anchor for an area larger than Victoria; and the incentive architecture does not yet treat housing, locum relief, family relocation and practice viability as integral. To that extent, in its current form, the model is hampering.

The model identifies the problem. It does not yet solve it.

6. Suggested improvements

RDA Goldfields Esperance recommends that the Committee consider the following improvements to translate Modified Monash Model classification into effective doctor attraction and retention in the Goldfields Esperance region and in comparable very remote contexts.

- A targeted MM6 and MM7 primary care sustainability payment for thin-market communities where fee-for-service models are not viable, complementing rather than duplicating existing State and Commonwealth incentives. The Local Government Rural Health Funding Alliance's 2026-27 Pre-Budget Submission proposes a three-year pilot in this form and provides an existing model for design.
- Greater weighting for very remote communities within existing workforce incentive programs, recognising distance, isolation, housing shortages, professional development barriers and on-call expectations.
- Recognition of the workforce role of regional service hubs such as Kalgoorlie-Boulder, on which surrounding very remote communities depend, at a level that reflects their actual function rather than only their geographic classification. This may take the form of an exception classification, a hub-specific weighting within existing programs, or a methodological review of how road distance to the nearest tertiary referral centre is treated within the MMM framework.
- Funding that supports the full attraction and retention package, including housing, family relocation, locum relief, supervision, training pathways and practice viability.
- Support for rural generalist models, including integration with WA Country Health Service hospital rosters and emergency cover, to stabilise workforce supply across very remote catchments.
- A review of how MMM classifications translate into actual workforce incentives, to ensure MM6 and MM7 communities are not competing on the same settings as larger or more accessible regional centres.
- Transitional protections when MMM classifications change, so that communities reclassified to a lower MMM tier do not experience sudden loss of incentives, eligibility for workforce programs, or DPA-linked recruitment access. Phased step-down arrangements would allow practices, local governments and communities to plan for change rather than absorb cliff-edge impacts on GP supply.

RDA Goldfields Esperance thanks the Committee for the opportunity to respond and remains available to provide further information.

Sharon Henderson

Director, Regional Development Australia Goldfields Esperance

director@rdage.org.au 0417 959 458

6/171 Piccadilly Street (PO Box 10331), Kalgoorlie WA 6430 rdage.org.au