GRATTAN Institute

Getting care into ‘GP deserts’

Submission to the Senate committee inquiry into rural healthcare

Peter Breadon and Molly Chapman, March 2026

Overview

This submission focuses on the biggest problem in rural primary healthcare: communities where there is far too little care to go around. ‘GP deserts’ are areas in the bottom 5 per cent for general practice services per person. They need more care than most areas, but get the least.

GP deserts have been struggling for years. Recent multibillion-dollar boosts to bulk billing have failed to solve the problem. In fact, GP deserts fell further behind.

Instead of relying on poorly targeted subsidies, governments should step in with tailored solutions to make sure these communities get enough care.

The National Health Reform Agreement commits to developing a range of reform options that could tackle ‘thin markets’. They will cover how governments choose where to intervene, plan solutions, and share funding, staff, and other resources. Health ministers will consider the approach by December this year.

But many commitments in the last national agreement were never realised. An independent review found that one thing helped get from agreement to action: money. Reforms with dedicated funding were much more likely to be carried out.

That’s why secure and long-term funding must be allocated to finally fix GP deserts. And governments must commit to target the worst first – not cherry-pick some locations, or restrict investment to some levels of remoteness over others.

With action on GP deserts so close after so long, the Senate inquiry should call on governments to follow-through with sufficient funding, and lock in a transparent and fair approach to spending it.

Box 1: Recommendations not covered in this submission

Previous Grattan Institute reports include recommendations relevant to rural Medicare and funding that are not covered in this submission.

Our 2022 report *A new Medicare* proposes a more flexible funding model for areas outside GP deserts.[a] That would unblock team-based care and increase funding for patients with more health risks, such as people who are sicker, older, poorer, or Aboriginal. It would also include a loading for rural patients, reflecting the extra care they need.

This new way of funding would promote team-based care, helping to overcome rural workforce shortages, and provide funding that matches the healthcare needs of rural communities, particularly those with older and sicker populations.

Our 2025 report *Special treatment* found that half of remote and very remote areas receive less than one medical specialist service per person per year, compared to no parts of major cities.[b] The report shows how to fill those gaps, including by expanding public specialist clinics.

a. Breadon and Romanes (2022).
b. Breadon et al (2025).

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1 Not all rural areas are GP deserts

People in rural and remote areas need more healthcare than people in cities, but get less. But effective policy needs to dig deeper to make sure every Australian can get the care they need.

Big towns aren’t all the same. Neither are small towns, or remote areas. Within each group, some communities get all the care they need, while others miss out. That’s why governments need to stop lumping rural communities together, and focus on the worst first.

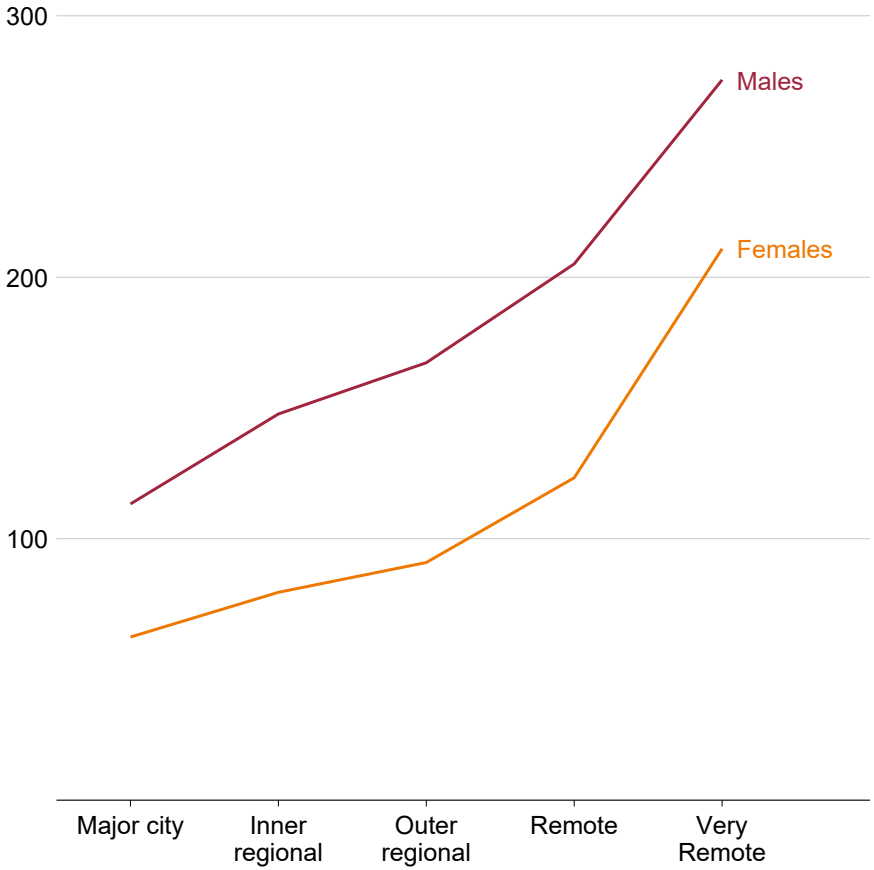
1.1 More sickness and less care

Australians living in rural and regional areas are sicker, and die sooner, than people who live in cities (Figure 1.1).[1]

That means rural and regional areas should get more general practice care. Instead, they get less. Compared to cities, regional centres get about 7 per cent fewer GP services per person, large towns get almost 9 per cent fewer, and remote areas get over 40 per cent fewer.[2]

Figure 1.1: Potentially avoidable deaths increase the further from a major city

Number of potentially avoidable deaths per 100,000 by remoteness (2021 to 2023)



Note: Areas are defined using the ASGS Remoteness Structure.

Source: Australian Institute of Health and Welfare (2025).

1. Compared to cities, the age-standardised burden of disease is about 1.2 times higher in inner and outer regional areas and 1.4 times higher in remote and very remote areas: Australian Institute of Health and Welfare (2021).
2. Throughout this submission, age-adjusted GP services per person have been calculated at an SA3 level using indirect age standardisation of service use data from 2024-25, which was the most recent data available at the time this analysis was completed: Australian Institute of Health and Welfare (2026a). SA3s are geographical areas typically covering a population of between 30,000 and 130,000 people: Australian Bureau of Statistics (2021). Each SA3 is assigned to the Modified Monash Model (MMM) category in which the largest share of its population lives. Percentage changes are calculated as the difference between population-weighted averages of SA3 values within each MMM category.

1.2 Not remotely similar

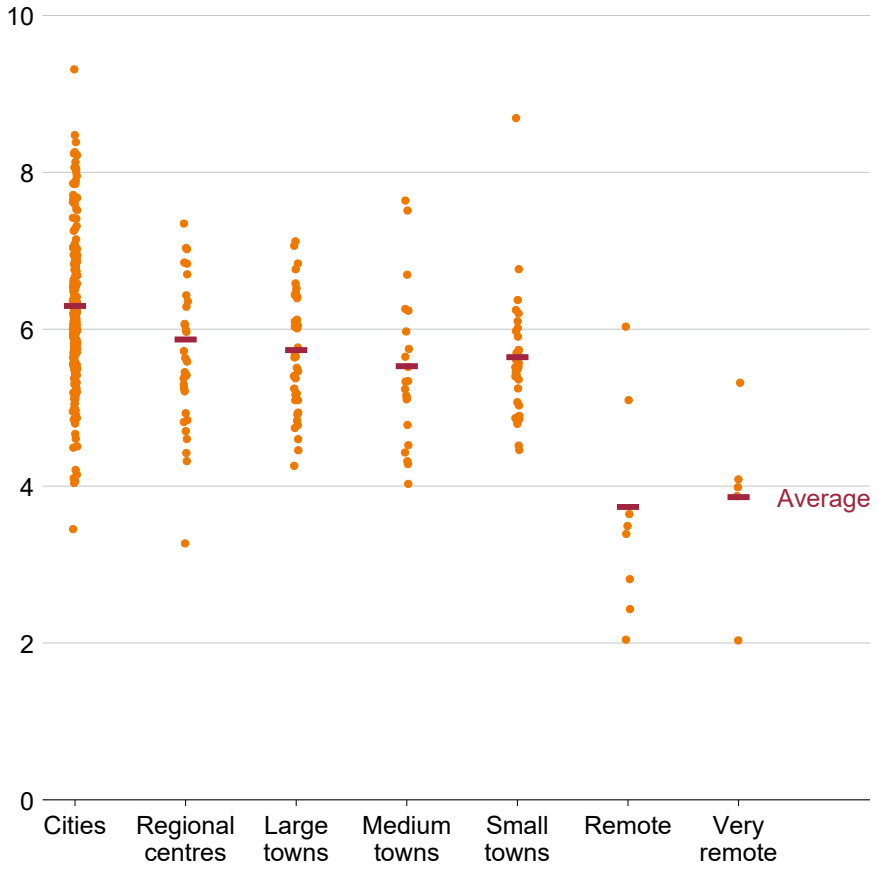
Although the average rural and remote area needs more GP care, averages can be misleading. Policies rely on categories that lump together areas with little in common in terms of wealth, health, or access to care:

- Cities
- Regional centres
- Large towns
- Medium towns
- Small towns
- Remote
- Very remote.[3]

For example, almost one in five areas classified as regional centres are in the top 25 per cent of the country for GP services per person.[4] That’s also true of 13 per cent of large towns, and 5 per cent of small towns (Figure 1.2).[5]

Figure 1.2: Access to GP services can vary significantly within remoteness categories

Age-adjusted GP services per person in each SA3 by remoteness (2024-25)



Notes: Remoteness classification uses the Modified Monash Model (MMM). The overall average for each MMM category is calculated as the average of the SA3s within that category, weighted by SA3 population. Some SA3s with small populations have been combined with nearby SA3s to allow for reporting of GP services per capita.

Sources: Australian Institute of Health and Welfare (2026a), Australian Government (2025), and Australian Bureau of Statistics (2025).

3. The classification is called the Modified Monash Model. The categories are defined by a combination of geographical remoteness and town population size. They were originally designed to help the government target health workforce incentives. See Department of Health (2019).
4. For this analysis, each SA3 has been assigned to the Modified Monash Model category in which the largest share of its population live.
5. While rural areas have a higher disease burden on average, suggesting they need above-average levels of care, the disease burden in rural areas also varies widely, as illustrated in Table 1.1.

Table 1.1: There are big differences between places that are in the same remoteness category
SA3 avoidable deaths, level of advantage, and GP services per person, by remoteness

	Higher need and lower services				Lower need and higher services			
Remoteness category	**SA3**	**Avoidable deaths**	**Advantage**	**GP services**	**SA3**	**Avoidable deaths**	**Advantage**	**GP services**
Cities	Mandurah, WA	Moderate	Low	Low	Hobsons Bay, Vic	Low	High	High
Regional centres	Brighton, Tas	Moderate	Low	Low	Hawkesbury, NSW	Low	High	High
Large towns	Broken Hill & Far West, NSW	Moderate	Low	Low	Macedon Ranges, Vic	High	High	High
Small towns	Burnett, Qld	Moderate	Low	Low	Creswick - Daylesford - Ballan, Vic	Low	Moderate	Moderate
Remote	Katherine, NT	High	Low	Low	Bourke - Cobar - Coonamble, NSW	Moderate	Low	Moderate

Notes: Each SA3 is assigned to the Modified Monash Model (MMM) category in which the largest share of its population lives. For each MMM category, two SA3s have been selected: one less sick, more advantaged and with higher service access and one more sick, more disadvantaged and with lower service access. GP services per capita from 2024-25 are age-adjusted at the SA3 level using indirect standardisation. Disadvantage is measured using the Index of Relative Socio-economic Advantage and Disadvantage (IRSAD) from 2023. Avoidable deaths are measured using the average annual age-adjusted rate of deaths from all avoidable causes per 100,000 people aged 0 to 74 in 2021. For avoidable deaths, advantage, and GP services, SA3s are characterised as ‘low’ (deciles 1-3), ‘moderate’ (4-7), and ‘high’ (8-10).

Source: Australian Institute of Health and Welfare (2026a), Australian Government (2025), Australian Bureau of Statistics (2025), Australian Bureau of Statistics (2023), and Torrens University Australia (n.d.).

1.3 Focus on the worst first

That’s why policy should focus less on crude categories such as remoteness, and more on how much care communities actually get.

We define ‘GP deserts’ as areas in the bottom 5 per cent of the country for GP services per person, adjusted for age.[6] This is a conservative statistical threshold to define a bare minimum level of care, not an estimate of the ideal level. It’s imperfect, because we haven’t adjusted for population health needs, and some communities may get primary care that isn’t captured in Medicare statistics.

The government should develop a better measure,[7] but our definition clearly shows that a new approach is needed for communities with far too little care.

On average, GP deserts get just under 3.5 Medicare-funded GP services per person a year, around 40 per cent below the national average.[8]

They also have much higher rates of potentially preventable hospital admissions. These hospital visits for potentially avoidable problems – such as amputations for diabetic patients, or conditions that could have been avoided by vaccinations – suggest people aren’t getting high-quality primary care.

GP deserts are a persistent policy failure: almost three quarters have had that status for at least 5 years.[9] A new approach is needed, and as the next chapter will show, it isn’t broad-based subsidies for each remoteness category.

6. This analysis is conducted at an SA3 level. Some very small SA3s do not have service data reported and thus cannot be included.
7. The National Health Reform Agenda commits governments to publishing local measures of unmet need: Department of Health, Disability, and Ageing (2026a). This should include risk-adjusted GP services per person, including relevant services that aren’t captured in Medicare data, which should be provided by Primary Health Networks.
8. This data is from 2024-25: Australian Institute of Health and Welfare (2026a). The average services per person for GP deserts is the weighted average of the values for each of the GP desert SA3s.
9. Out of the 15 GP deserts in 2024-25 for which we have consistent historical data, 11 (73 per cent) had been in the bottom 5 per cent of age adjusted services per capita in every year since 2020-21. All of them had been in the bottom decile for that entire time. Grattan analysis of Australian Institute of Health and Welfare (ibid).

2 Bulk-billing boosts haven’t helped GP deserts

The main way Medicare boosts payments for general practices in rural areas is through bulk-billing incentives, which increase with remoteness.

Recent increases to the incentive led to higher bulk-billing across the country. But rates went up the least in GP deserts. And despite starting with the lowest level of care in Australia, GP services per person in GP deserts fell further.

2.1 How the incentives have changed

GPs get a bonus payment from the government when they don’t charge patients a fee: the bulk-billing incentive. The incentive is bigger for clinics outside major cities, and recent changes have supercharged the difference.

The incentive was introduced in 2004. It gave clinics in cities $9.00 extra – in today’s dollars – for bulk-billing children and concession card holders. Clinics in rural and regional areas got $13.50.[10]

For more than a decade, the incentive was a fixed dollar amount, but in 2022 it was increased and indexed to inflation. The uniform payment outside cities was broken up into tiers, with payments rising with remoteness. In today’s dollars, the incentive was $7.60 in cities, $11.50 in regional centres, and $14.60 in the most remote areas.[11]

Table 2.1: Rural loadings for bulk-billing have surged

Location	2004	January 2022	November 2023
Major city	$9.00	$7.60	$21.90
Regional centre	$13.50	$11.50	$33.30
Large/Medium town	$13.50	$12.20	$35.40
Small town	$13.50	$13.00	$37.60
Remote	$13.50	$13.80	$39.70
Very remote	$13.50	$14.60	$42.10
Range	$4.50	$6.90	$20.20

Note: Nominal prices have been inflated to December 2025 prices using the all groups consumer price index.

Sources: Australian Bureau of Statistics (2026), Department of Health, Disability, and Ageing (2026b), and Parliament of Australia (2005).

10. Throughout this section, nominal prices have been inflated to December 2025 prices using the all groups consumer price index. See AustralianPolitics (2004) and Australian Bureau of Statistics (2026).
11. Department of Health (2022).

In 2023, the incentive was tripled for all but the shortest general face-to-face consultations.[12] Before the change it was $6.90 higher in the most remote areas, compared to cities. After the tripling, the difference jumped to $20.20 per consultation. The incentives over time are shown in Table 2.1 on the preceding page.

From November 2025, the incentive was expanded from children and concession card holders to apply to all patients. Clinics that bulk-bill all their services also get an extra 12.5 per cent of all their Medicare funding, compounding rural bulk-billing loadings.[13]

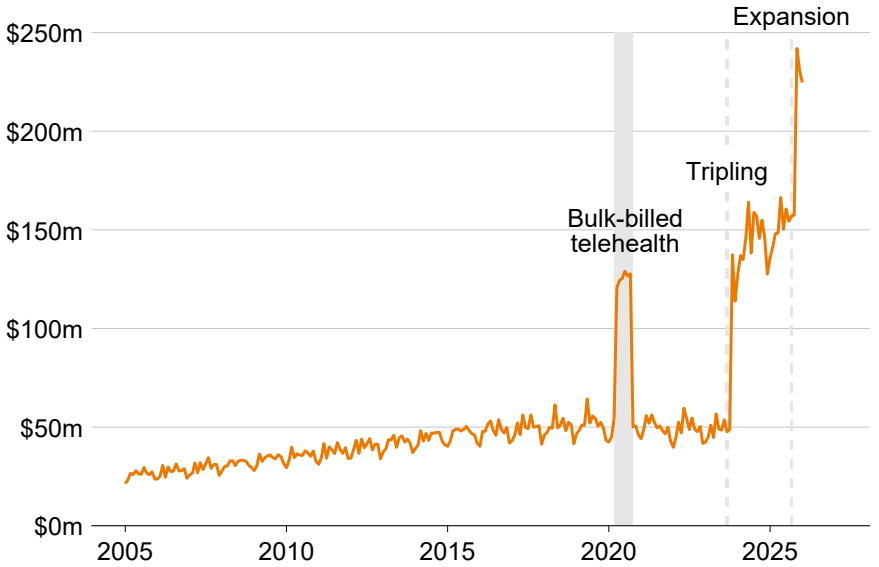
The cost of the incentive has surged, now costing the equivalent of $2.8 billion a year (see Figure 2.1).[14] Of this, about $1.5 billion represents new spending from the tripling of the incentive. This additional funding alone is equivalent to roughly 15 per cent of total GP Medicare benefits.[15]

It’s too early to tell what the ultimate impact of the most recent changes will be. But so far, the increase in spending seems to have pushed up bulk-billing by 4.3 percentage points nationally, and seen it increase in most parts of Australia.[16]

Bulk-billing in regional centres and towns increased the most. In 2022, they had the lowest bulk-billing rates, but now regional centres have caught up with cities, and towns are closing in on remote areas, which have the highest bulk-billing rate of all (Figure 2.2 on the following page).

But all the new spending hasn’t helped the areas with the least care.

Figure 2.1: Bulk-billing spending has surged
Monthly bulk-billing incentive spending



Notes: This data only includes bulk-billing incentive payments funded through Medicare, not the additional 12.5 per cent incentive payment. From 13 March 2020 to 1 October 2020, GPs were required to bulk-bill all telehealth appointments: Department of Health (2020).

Source: Australian Institute of Health and Welfare (2026b).

12. Incentives for some telehealth consultations were also tripled. See Department of Health and Aged Care (2023a).
13. Department of Health and Aged Care (2025).
14. In November and December 2025 – the two months following the expansion – about $470 million was spent on the GP bulk-billing incentive. When annualised this gives $2.8 billion. See Australian Institute of Health and Welfare (2026b).
15. Pre-reform expenditure is calculated from November 2022 to October 23 – the 12 months before the first tripling - then adjusted for inflation. Post-reform expenditure is calculated from February 2025 to January 2026 – the most recent 12 months of available data. The difference is then divided by total Medicare GP benefits from January to December 2025. See Australian Institute of Health and Welfare (2026b) and Australian Institute of Health and Welfare (2026c).
16. Department of Health, Disability, and Ageing (2026c).

2.2 Bulk-billing boosts haven’t helped GP deserts

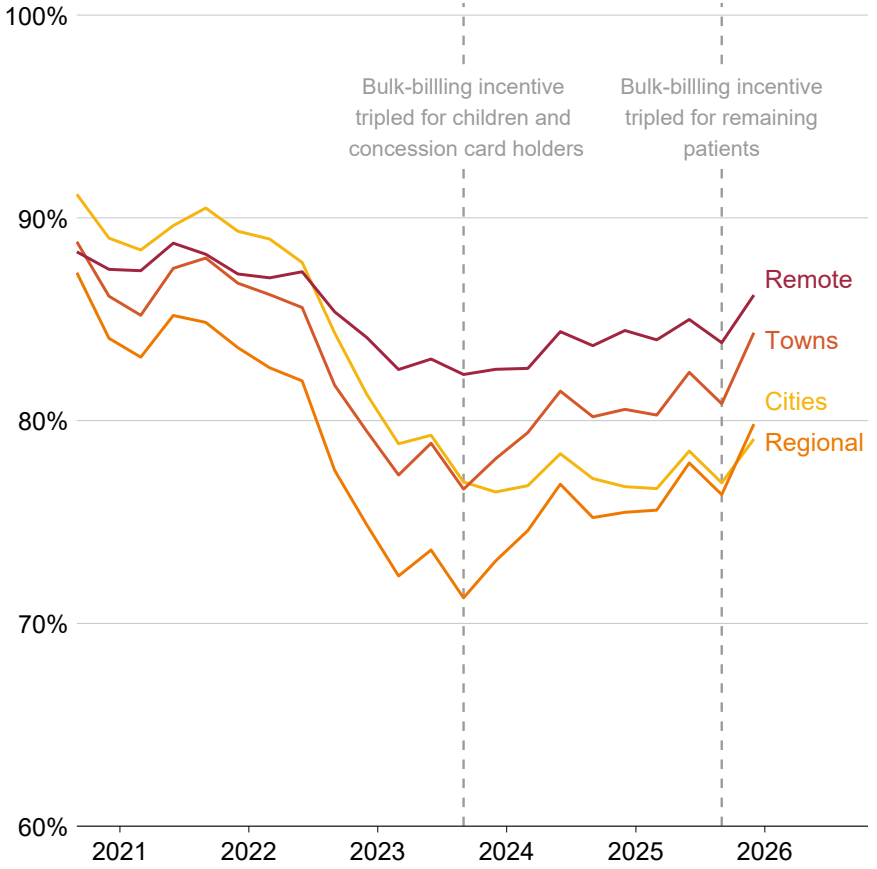
A year after the incentive was tripled in 2023, care in GP deserts actually fell, despite rising almost everywhere else (see the top panel of Figure 2.3).[17]

It’s too early to tell the ultimate impact of broadening the incentive, but the early signs aren’t good. In the first quarter including the change, services in GP deserts fell again.[18] This time, services per person fell in most of the country, but the fall in GP deserts was among the biggest (see the bottom panel of Figure 2.3).

Bulk-billing didn’t go up much in GP deserts either. After both changes, the increases were among the lowest in the country (Figure 2.4).[19]

Many things influence the amount of care and bulk-billing in local areas, but bulk-billing boosts don’t seem to have helped GP deserts at all. The changes weren’t aimed at them, but after committing billions of dollars, and seeing GP deserts fall even further behind, the case for targeting the worst first should be impossible to ignore.

Figure 2.2: Tripling the bulk-billing incentive has increased bulk-billing, especially in regional areas
GP bulk-billing rate by SA3 remoteness

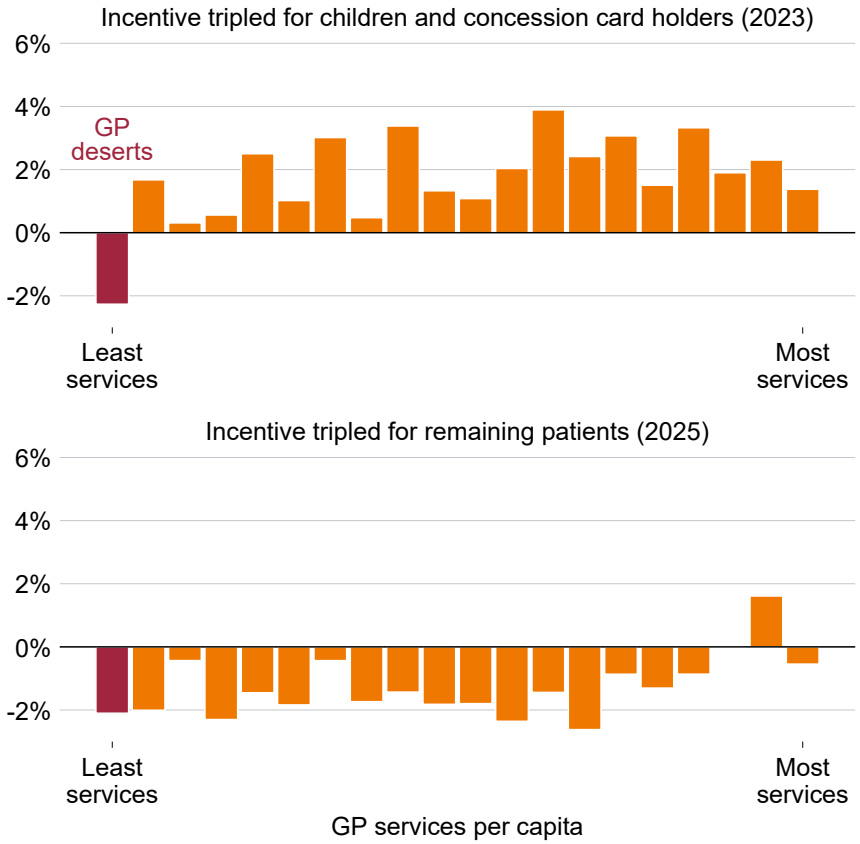


Notes: The Modified Monash Model (MMM) categories are collapsed into ‘Cities’ (major cities), ‘Regional centres’ (regional centres), ‘Towns’ (small, medium, and large towns), and ‘Remote’ (remote and very remote). Bulk-billing rates for each MMM group are calculated as the population-weighted average of the SA3 rates. Some SA3s with small populations are combined with nearby SA3s for reporting.

Sources: Department of Health, Disability, and Ageing (2026d), Australian Government (2025), and Australian Bureau of Statistics (2025).

17. When comparing areas by age-adjusted GP services per person.
18. Compared to a year earlier. The expanded incentive only applied in two of the three months in the December quarter.
19. When comparing areas by age-adjusted GP services per person.

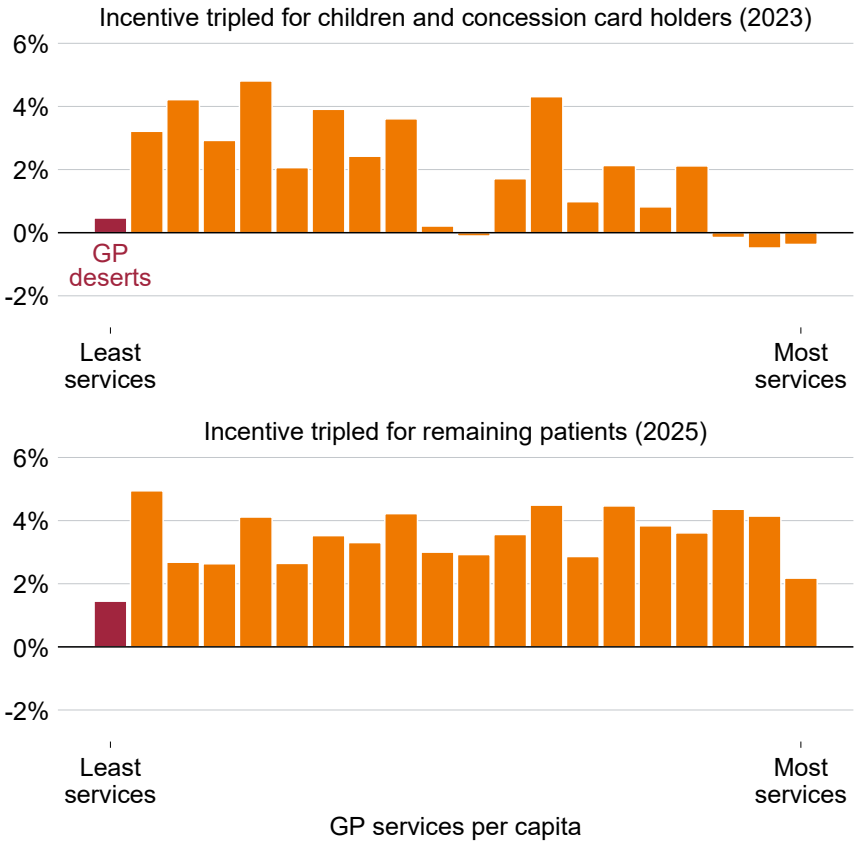
Figure 2.3: Service levels have been falling in GP deserts
Change in GP services per person by local age-adjusted service level



Notes: Crude GP services per capita are compared from September quarter 2023 to September quarter 2024 (2023 reform) and December quarter 2024 to December quarter 2025 (2025 reform). GP services per capita from 2024-25 are age-adjusted at the SA3 level using indirect standardisation and grouped into ventiles (5% bins). Includes Medicare-funded care only.

Sources: Department of Health, Disability, and Ageing (2026d), Australian Institute of Health and Welfare (2026a), Australian Government (2025), and Australian Bureau of Statistics (2025).

Figure 2.4: GP deserts have seen slower progress on bulk-billing
Change in GP bulk-billing rate by local age-adjusted service level



Notes: The bulk-billing rate is compared from September quarter 2023 to September quarter 2024 (2023 reform) and December quarter 2024 to December quarter 2025 (2025 reform). GP services per capita from 2024-25 are age-adjusted at the SA3 level using indirect standardisation and grouped into ventiles (5% bins). Includes Medicare-funded care only.

Sources: Department of Health, Disability, and Ageing (2026d), Australian Institute of Health and Welfare (2026a), Australian Government (2025), and Australian Bureau of Statistics (2025).

3 Target the worst first

GP deserts need local, tailored solutions. Those solutions should be developed and delivered by a partnership of Primary Health Networks, state governments, and local providers, including Aboriginal Community Controlled Health Organisations. Instead of the scattered trials we have today, this should be a standard response for all GP deserts.

The good news is that governments are already laying the groundwork. Now they need to follow through.

3.1 National collaboration is needed

It’s not surprising that broad-based subsidies haven’t worked in parts of the country that are, by definition, outliers.

GP deserts often have extreme difficulty attracting GPs and other clinicians. Some local councils have resorted to raising new levies on ratepayers and offering expensive salary and accommodation packages to attract staff.[20] Other areas might not have a big enough population to make a clinic financially viable with standard rebates.

For these areas, often referred to as ‘thin markets’, a different funding model is needed.

Our 2022 report, *A new Medicare*, recommended that governments step in to ensure people can get care in GP deserts. In fragile or missing markets, the federal government should fund Primary Health Networks to close gaps in care.[21]

Solutions should be tailored to local resources and needs (Table 3.1 on page 14). Primary Health Networks might provide block funding, salaries, or grants to guarantee a clinic’s financial viability. Or they might facilitate hub-and-spoke networks across a region, or telehealth or fly-in-fly-out care if needed.[22]

Primary Health Networks should work closely with state health departments to expand care so that local resources – such as rural hospital staff and facilities – are part of the plan wherever possible.

While flexibility is needed, a range of promising models should be documented and shared so that no Primary Health Network needs to start from scratch. There should also be strong accountability to improve access to care and get good value for money.

Instead of one-off pilots and programs, the federal government should make a ‘GP Guarantee’: a minimum level of care a community should expect. If an area stays below that level, it should automatically trigger funding for Primary Health Networks to step in and plug the gap.

3.2 Governments have agreed to lay the groundwork

Relief for GP deserts might be closer than it’s ever been. In March 2026, federal and state governments released the National Health Reform Agreement for 2026 to 2031. It could form the foundation for our proposed approach to GP deserts.

It commits to public reporting of local levels of unmet need. It commits to developing a clear and consistent way for Primary Health Networks, states, hospital networks, and Aboriginal Community Controlled Health Organisations to plan and jointly fund care. It says that this year, health ministers will consider options to improve access to care in rural areas,

20. Breadon and Hu (2025)
21. Breadon and Romanes (2022).
22. Primary Health Networks already get flexible funding of this kind, but it is not long-term, sufficient, and linked to thin markets, as we propose below.

which could include pooled funding, new payment models, and flexible employment arrangements for multidisciplinary teams (Figure 3.1).

That could add up to a new way to systematically tackle GP deserts.

3.3 Governments must follow through, and focus funding

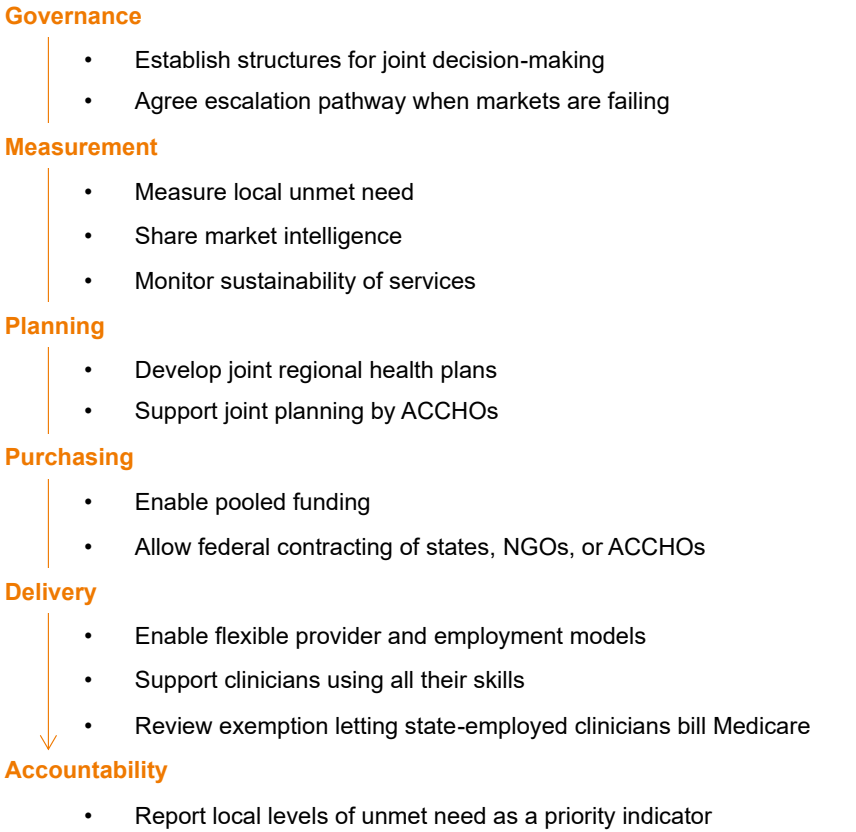
These commitments are real progress, but they don’t guarantee real action. An independent review of the last five-year agreement found that many commitments were never realised.[23] Importantly, it found that money often made the difference: initiatives that got funding were much more likely get off the ground.

Governments have agreed to design a system. Now they need to follow through by approving it, and by funding it. To avoid short-term fixes, that funding should be long term – at least five years – both for the overall program, and for funding for each GP desert.

It is also crucial to move away from a combination of crude, broad-based subsidies and scattered, cherry-picked trials. The agreement commits to measuring unmet need. It also commits to filling gaps in care. But it doesn’t link the two.[24] There is no requirement that investment be directed to areas with the most unmet need.

Governments should make an explicit commitment to focus on the worst first, so that Australia makes a genuine transition to targeting healthcare need. This GP guarantee would make sure funding goes where it is needed most, on a fair and transparent basis, removing the risk that any community is left behind.

Figure 3.1: Governments have committed to laying the groundwork
Aspects of rural care commissioning that governments have agreed to design or implement



Notes: ACCHO = Aboriginal Community Controlled Health Organisation. NGO = Non-governmental organisation.

Source: Grattan analysis of Department of Health, Disability, and Ageing (2026a).

23. Department of Health and Aged Care (2023b).
24. For pooled funding, it also suggests the approach ‘particularly’ for remote and very remote areas. Instead, it should be used where it is required to attract and retain the necessary workforce. See Department of Health, Disability, and Ageing (2026a).

Table 3.1: Solutions in thin markets should be tailored to local resources and needs

Supply problem	Primary Health Network response options
Small populations: town has a GP practice, but too few patients to cover costs	• Working with states, employ the GP part- or full-time in a RACCHO or rural hospital • Link the practice to others in the region that need support to meet excess demand
GP shortages: town has one GP who is overwhelmed with patient demand and is unable to recruit another GP	• Assist the practice to develop a business plan for employment of multidisciplinary staff (e.g. a nurse practitioner) • Link the practice with others to share staff
Viability risks: town has adequate demand and supply, but the clinic is struggling with high costs	• Commission a review of the practice to confirm viability risks cannot be resolved through business improvements • Underwrite the practice with a standing grant
No bulk-billing: town has one GP practice, which does not bulk-bill	• If there is sufficient patient demand, increase price competition by commissioning a GP or nurse practitioner / physician assistant to provide a regular low- or no-cost visiting session at the local hospital • If there is insufficient patient demand for the above, underwrite bulk-billed appointments for concession patients at the practice

Note: RACCHO = Rural Area Community Controlled Health Organisation.

Source: Breadon and Romanes 2022.

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