

Medical Services Housing Scheme Review

14 June 2024

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Dr Ceit Wilson
Manager Community Planning
City of Karratha

Medical Services Housing Scheme Review

Dear Ceit,

In accordance with our scope of works and engagement acceptance, dated 7 February 2024, Ernst & Young ("EY", "we" or "us") has prepared a Medical Services Housing Scheme (MSHS) Review Report.

Purpose of our report and restrictions on its use

This Report was prepared at the request of the City of Karratha ("the City" or "the client"), solely for the purpose to evaluate the effectiveness, impact and efficiency of the MSHS; provide clarity on the need and role of the City in supporting the provision of sustainable primary healthcare in the City; and provide conclusions and actionable recommendations with respect to the ongoing implementation of the MSHS. The City intends to incorporate the outcomes and recommendations from this Review into future implementation of the MSHS. It should not be used or relied on for any other purpose or distributed to any other party outside of City of Karratha without EY's prior written consent. A party other than the client accessing this Report should exercise its own skill and care with respect to use of this Report and obtain independent advice on any specific issues concerning it.

In carrying out our work and preparing this Report, we have worked solely on the instructions of the client and have not taken into account the interests of any other party. The Report has been constructed based on information current as of 18 April 2024, information which has been provided by the client and various stakeholders consulted as part of this Review. Since this date, material changes may have occurred which are not reflected in the analysis.

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Limitations

Our work in connection with this assignment is of a different nature to that of an audit of the MSHS or an audit of the Scheme participants receiving the subsidy. This Report is based on inquiries of, and discussions with, a range of stakeholders and MSHS participants. We have not sought to verify the accuracy of the data or the information and explanations provided by any stakeholders (outside appreciating the context in which the information was provided). If you would like to clarify any aspect of this analysis or discuss other related matters then please do not hesitate to contact me on 0422 150 526.

Yours sincerely,



Bill Scanlan
Partner

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Overview of the Scheme



Overview of the Medical Services Housing Scheme

The Medical Services Housing Scheme (MSHS or the Scheme) is designed to attract and retain General Practitioners (GPs) and Allied Health Professionals (AHPs) to work and live in the City of Karratha, by providing a rental subsidy that equalises the cost of the median rental prices between Perth and Karratha. The Scheme has a \$300 weekly rental ceiling.

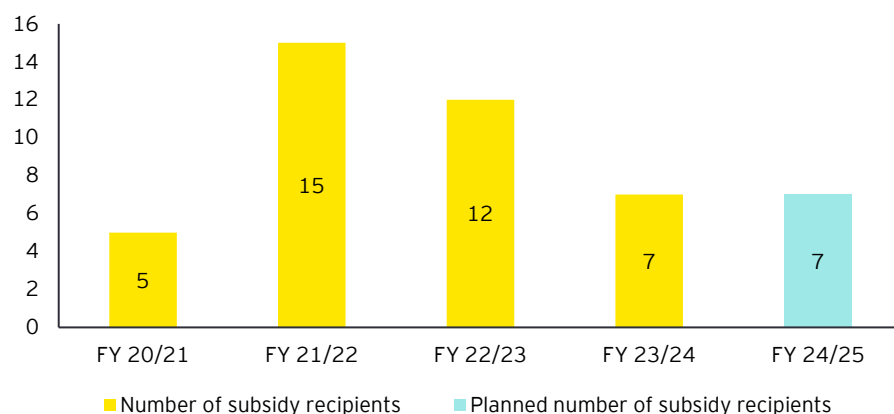
The main objectives of the MSHS include:

- ▶ To improve access and availability of GP and AHP appointments;
- ▶ To assist and offer continuity of care through the consistent presence of a GP and AHP; and
- ▶ To reduce the turnover of GPs and AHPs in the City of Karratha.

Previously, the then Shire of Roebourne established the Medical Services Equalisation Scheme (MSES) in 2008 and included subsidised GP housing, annual cash travel allowances and a cash loyalty payment for each year the GP completed service.

The MSHS was implemented in 2020 in partnership with industry partners after the cessation of the MSES. Since 2020, this new Scheme expanded to include both GPs and AHPs.

Figure 1: MSHS participants



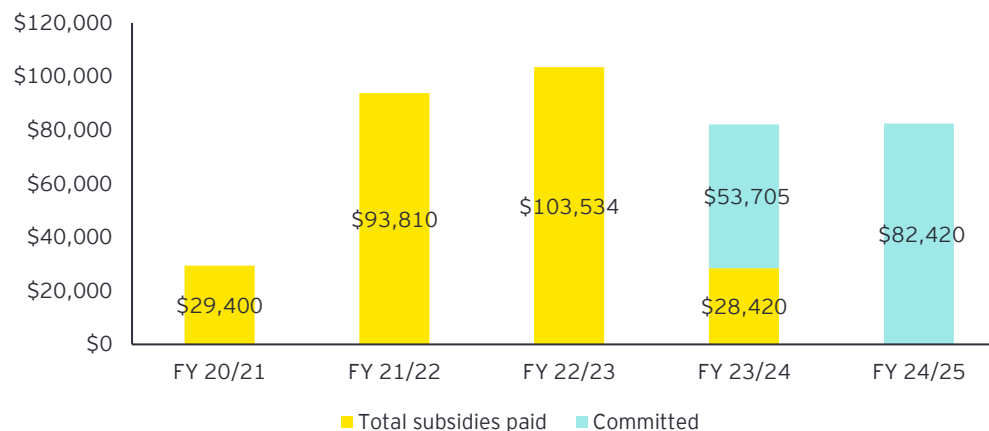
The current MSHS eligibility criteria requires:

- ▶ The GP or AHP to live in the bounds of the City of Karratha;
- ▶ The GP or AHP to work full time; and
- ▶ The residents in the household in which the GP or AHP reside do not receive another MSHS subsidy.

The MSHS can be characterised by the following observations:

- ▶ Since the change of the Scheme eligibility criteria, 47% of Scheme participants have been AHPs.
- ▶ There has been an average of nine participants per year who have been supported by the Scheme. Current trends illustrate a downward trajectory on the Scheme's uptake (per Figure 1), with only seven current participants.
- ▶ Between FY20/21 and FY23/24, seven people were deemed not eligible for the subsidy.
- ▶ The MSHS has an implementation budget of \$306,000 for the 2022/23 - 2023/24 period, with \$181,000 paid or committed (per Figure 2).

Figure 2: Total subsidies paid and committed



Utilisation of the Medical Services Housing Scheme

Analysis of the utilisation of the Scheme can help determine whether there are any trends as to the duration of participation of subsidy recipients and the subsidy amounts paid. Preliminary observations include:

- ▶ The average support provided to the 15 participants who have ceased engagement with MSHS was 48 weeks. The range was between 8 weeks and 117 weeks (see Figure 3 for more detail).
- ▶ Of the 15 participants who have ceased engagement with MSHS, 767 weeks of subsidy was paid averaging at \$213 per week (see Figure 4 for more detail).
- ▶ Over the past 12 months, Perth average rental prices have increased, effectively closing some of the gap between Karratha's and Perth's median rental prices (see Table 1 for more detail). This points towards the fall in average subsidy paid per quarter in Figure 4.

Table 1: Change in rental prices across Karratha and Perth

Type	Karratha			Perth			Difference between Perth and Karratha at March 2024
	(\$ Week ending 28 Mar 2024	12 month % change	3 year % (pa) change	(\$ Week ending 28 Mar 2024	12 month % change	3 year % (pa) change	
All houses	\$1,103	5%	15%	\$781	18%	15%	- \$322
3br houses	\$899	7%	14%	\$711	17%	15%	- \$188
All units	\$784	17%	18%	\$580	13%	14%	- \$205
2 br units	\$684	7%	2%	\$584	15%	15%	- \$100
Combined	\$1,032	7%	16%	\$697	16%	15%	- \$335

Source: SQM Research

Figure 3: Duration of subsidies paid per Scheme participant

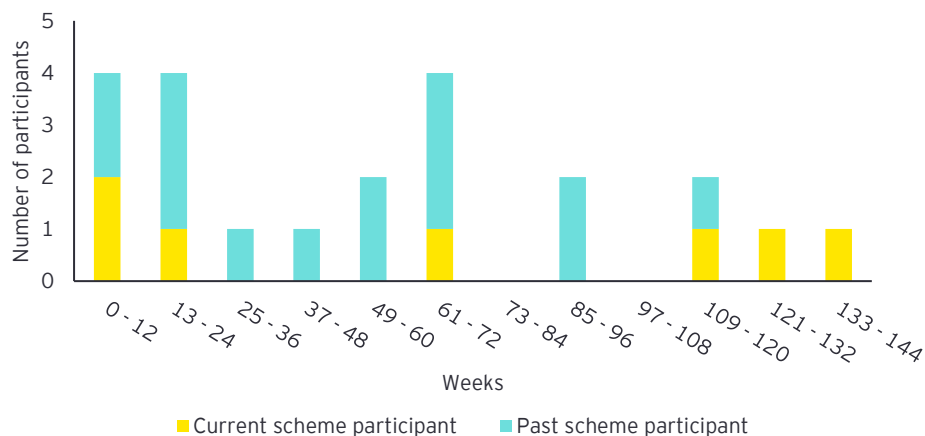
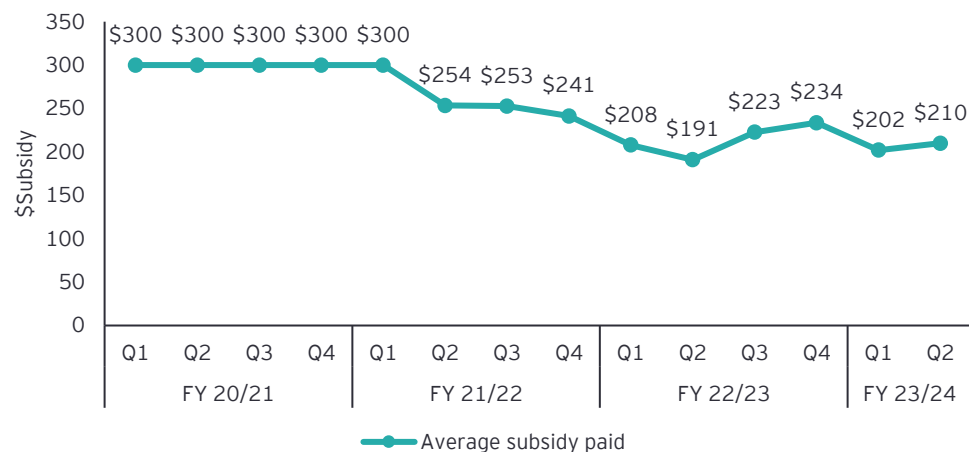


Figure 4: Average subsidy paid per quarter



Attraction and retention of Medical Services Housing Scheme participants

A deeper dive into the utilisation of the Scheme by GP and AHP cohort is presented below.

GP				AHP			
Attracted 12 Applicants	Eligible 10 Applicants <i>83% eligibility rate</i>	Retained 3 Applicants <i>30% retention rate</i> <i>Averaging 54 weeks</i>	Departed 7 Applicants <i>70% attrition rate</i> <i>Averaging 45 weeks</i>	Attracted 18 Applicants	Eligible 13 Applicants <i>72% eligibility rate</i>	Retained 5 Applicants <i>38% retention rate</i> <i>Averaging 71 weeks</i>	Departed 8 Applicants <i>62% attrition rate</i> <i>Averaging 52 weeks</i>
FY21 Eligible: 5 Retained: 1 <i>20% retention rate</i>	FY22 Eligible: 3 Retained: 0 <i>0% retention rate</i>	FY24 Eligible: 2 Retained: 2 <i>100% retention rate</i>	Average subsidy \$235 p/w Ranging from \$50p/w-\$300p/w	In FY22 Eligible: 9 Retained: 3 <i>33% retention rate</i>	In FY23 Eligible: 3 Retained: 1 <i>33% retention rate</i>	In FY24 Eligible: 1 Retained: 1 <i>100% retention rate</i>	Average subsidy \$169 p/w Ranging from \$30p/w-\$300p/w

Key observations include:

- ▶ The total GP workforce in City of Karratha was 11 in 2020 and 10 in 2024, which indicates on average, the MSHS attracted 15% of the local GP workforce.
- ▶ Approximately 20% of those GPs who commenced on the Scheme in FY21 remain on the Scheme today - outperforming the market retention rate of 13%.
- ▶ The Scheme did not retain any GPs in FY22 or attract any GPs in FY23.
- ▶ The average annual retention rate of the Scheme is 40%.
- ▶ Approximately 60% of GP participants claimed the maximum \$300 p/w.

Key observations include:

- ▶ As of 2024, the local AHP workforce in City of Karratha has grown to a total of 40, up from 21 in 2020.
- ▶ Nine new eligible AHPs commenced participation in the Scheme in FY22.
- ▶ Of these, approximately 33% remain operational in the City of Karratha, whilst the market retention rate experienced a 50% retention rate.
- ▶ Approximately 25% of the retained local AHP workforce since FY22 are participants of the Scheme.
- ▶ Approximately 23% of AHP participants claimed the maximum \$300 p/w.

NB: The reported figures and analysis above is reliant on information and date conveyed by stakeholders consulted as part of this Review. The data imparted may not be an exhaustive representation of the local GP and AHP workforce.

Key findings



Overview of findings

The following section outlines key findings of the Review of the MSHS. Findings have been primarily informed by stakeholder consultations and are supported by the desktop review and Scheme administrative data. The scope of the stakeholder consultation included discussions with current, former and enquiring practices and clinics that have or have a desire to participate in the Scheme. Perspectives as to the Scheme's effectiveness and impact were gathered. Government and non-government organisations were also consulted to ascertain contextual factors that may influence outcomes of the Scheme. In addition to stakeholder consultation a request for information was sent to stakeholders consulted to collect data which supplemented anecdotes made during consultations.

The six key findings are presented in alignment with the Review questions, as illustrated below. Overarching recommendations in relation to the key findings are contained in **Recommendations section**.

	Review questions	Key takeaways	Relevant key findings
Effectiveness	To what extent has the MSHS been effective in achieving its original objectives?	The Scheme has demonstrated it can act as an attraction and retention tool, but it could be more impactful.	1 2
	What factors (e.g. internal, external) have enabled or hindered achievement of the objectives?	Housing shortages, high rental prices, high expectations as to benefits, competition for labour and recent GP resignations have hindered Scheme objectives.	1 2 3
Impact	What impact has the MSHS had on the community and stakeholders (whether positive or negative, intended or unintended)?	There are some GPs and AHPs reliant on the Scheme for housing, such that they enable service delivery community. There is an unintentional high administration burden.	1 2
	Does the original problem still exist? What impact would cessation of the Scheme have on the community and other stakeholders?	The need to attract GPs and AHPs remain. Cessation would likely result in a need to attract even more GPs and AHPs.	1 2 3
Efficiency	Does the Scheme remain appropriate (e.g. the best use of resources) for addressing the original problem?	Yes, housing continues to be the largest barrier to attracting and retaining GPs and AHPs. However, changes are required to the Scheme to be more effective.	1 4 5 6
	What other local, state or federal programs, policies or initiatives exist to support and/or increase the rural GP workforce?	Relocation payments; housing subsidies; professional development allowances: education scholarships; retention benefits; vehicle assistance; and family support initiatives.	4 A1
	What alternative service delivery options by Council, if any, can be considered (e.g. to improve the use of resources)?	The Scheme should differentiate between GPs and AHPs as to the subsidy amount and consider additional flexibilities.	Recommendations and options

Key finding 1: Finding affordable and suitable accommodation continues to be the largest barrier to attracting and retaining GPs and AHPs in Karratha.

The sizeable housing shortage in the City of Karratha is well understood.

- ▶ As at February 2022, there was a rental vacancy rate of 1.5%. A vacancy rental rate between 2.5% and 3.5% typically represents a balanced market. (REIWA, 2024).
- ▶ In 2021, there was an average of 2.8 people per household across the City of Karratha (ABS Census 2021). Anecdotal evidence suggests this figure is currently 1.8 people per every 4-bedroom home (on average).
- ▶ For the six months to December 2023, 154 dwellings were listed for lease and 250 dwellings were leased (or re-leased) at a median weekly rent of \$956 per week (a 32% increase compared to the six-month period ending December 2022) (PDC, 2024).
- ▶ Rental prices are being driven by limited housing stock. Between March 2021 and March 2024, the average rental rose from \$674 to \$1,032 per week - a percentage increase of 15% (SQM Research).
- ▶ There is currently no large-scale housing development or land releases in the pipeline to address this future housing need.

The number of approved projects in the City of Karratha will put additional pressure on the existing housing shortfall.

- ▶ \$60bn in investment, across four major projects in City of Karratha will require approximately 5,700 jobs during construction and 1,010 jobs during production (City of Karratha, 2024).
- ▶ Anecdotal evidence suggest this will require approximately 1,200 dwellings in 3 to 5 years; 3,000 dwellings by 2030; with an additional 5,000 dwellings required FIFO workers by next decade.

All stakeholders consulted indicated that accessing affordable housing continues to be the largest barrier to attract and retain GPs and AHPs.

- ▶ A 2023 Pilbara Community Service Housing Subsidy survey produced by WACOSS outlined that 83% of respondents indicated they had staff leave due to housing affordability. With over half of survey respondents located in City of Karratha, it indicates that the housing availability and affordability is a deterrent for retaining staff in the City.
- ▶ Current scheme participants indicated that if it wasn't for the MSHS there would be a significant reduction in the capacity to provide general practice services.
- ▶ According to the 2023 WA Regional Price Index (which compares prices relative to Perth), housing in the Pilbara was indexed at 140.6 compared to Perth. The next highest region was the Kimberley at 113.0 (DPIRD, 2023).
- ▶ There are some medical practices that own houses to support employees with housing however the pool of employees that could occupy the stock housing is small (particularly if the house is not suitable for all household constructs) and rising interest rates act as constraints such that this strategy is not pervasive nor resolute.

Income levels of GPs and AHPs often breach other available subsidised affordable housing schemes offered within the City.

- ▶ Affordable housing available to service workers include Service Workers Accommodation (SWA) - provided by City of Karratha; and Warambie Estate and The Quarter Apartments - both provided by Development WA, are restricted to income levels that GPs and AHPs are likely to breach.

Key takeaway

The housing shortage continues to be the largest barrier in the City and is only expected to get worse, highlighting the need for housing assistance.

Key finding 2: Despite playing a positive role in workforce attraction and retention, there is the potential to enhance the effectiveness of the Scheme.

Wait times for general practice and allied health services in the City of Karratha remain high. There remains opportunity to improve access, enhance continuity of care, and reduce GP and AHP turnover rates.

Representatives of local practices indicated there was an insufficient workforce to cater to the existing demand which results in significant wait-times. Information shared as part of stakeholder consultation indicated that the local practices currently have 45% of the GP workforce and 79% of the AHP workforce required to meet current demand (at the time of reporting). The average wait-time for a GP appointment is reported to range from five days to six weeks depending on the practice. Wait-times for AHP services can range from one week to 12 months depending on service required.

Factors that contribute to wait times include:

- ▶ An recent decrease in the GP workforce with several long-standing GPs recently retiring or relocating.
- ▶ Closures of GP practices in surrounding areas. OneCentral closed its branch in City of Karratha, and Sonic Health Plus closed its branches in Port Hedland and Newman in recent years.
- ▶ Naturally high GP turnover rates. The Pilbara has one of the highest rates of all regions at 28% (RHW, 2023). Local practices report significantly higher rates of 80% in 2020 and 70% in 2022. AHP turnover rates were slightly better with a 75% in 2020 and improved to 50% in 2022.

A high turnover rate impacts the continuity of care for patients, resulting in knowledge loss, disruption in patient-provider relationships and inconsistency in provision of care.

Smaller waitlists would likely result in a decrease in lower urgency ED presentations, and subsequently improve community satisfaction.

- ▶ Community frustrations are said to stem from prolonged wait-times and care interruptions, prompting a rise in lower urgency ED presentations that GPs could adequately address. Representatives of local practices shared a reluctance to engage FIFO or temporary staff, prioritising the hiring of locals to maintain continuity of care. Although Telehealth could alleviate wait-times, there is a community inclination, particularly among Indigenous people, to decline this option in favour of the substantial benefits of personal consultations.

The local healthcare workforce, while currently stretched to meet existing service demands, will be likely required to grow to accommodate future demands.

- ▶ Participants noted that while the MSHS has contributed to the rise in GPs and AHPs, the numbers are still insufficient to meet the current demand, which perpetuates long waiting times.
- ▶ An influx of people to service the upcoming infrastructure projects in Karratha is expected, necessitating an expansion of the healthcare workforce.
- ▶ Throughout consultation local practices outlined an increase of 57% in AHPs and 120% increase in GPs is required to meet future demand and growth aspirations. This increase in GPs would allow City of Karratha to experience a GP to population ratio similar to that of metropolitan areas.

Key takeaway

Opportunities exist to modify the Scheme to better meet objectives and serve the City of Karratha's healthcare needs.

Key finding 3: The factors considered by GPs and AHPs before relocation differentiate, as do their expectations regarding any related financial incentives.

The characteristics of the local healthcare workforce across the Pilbara differentiate and should be understood.

- ▶ Approximately 84% of the health workforce in rural Western Australia are trained in Australia, with the majority trained in Western Australia (57%). This contrasts with GPs specifically, where approximately 52% are trained overseas. Anecdotal evidence suggests many GPs operating in the City of Karratha are established in their career with a family, and some are from overseas.
- ▶ GPs are said to be incentivised by significant housing benefits, government regional relocation schemes and a high earning potential. GPs in rural areas have an increase in income of around 18% compared with those working in urban areas (GPRA, 2018). In addition, international GPs are incentivised by a reduction of moratorium.
- ▶ The Pilbara healthcare workforce has a relatively young average age of 36 years, with 38% of the health workforce under the age of 30 (RHW, 2022). Anecdotal evidence suggests most AHPs that operate in the City of Karratha are younger professionals, and often without family.
- ▶ AHPs are said to have lower expectations regarding salary and housing supports. A significant portion of AHPs who relocate to Karratha are either graduates who have a higher propensity to live communally or are following their partner who has found employment in the resources industry.

The Scheme subsidy appears to have a greater potential to increase the disposable income for AHPs compared to GPs.

- ▶ The below table is a study to understand the impact the Scheme has on GPs and AHPs disposable income in a typical scenario for a GP and AHP respectively. Results indicate the Scheme has a greater impact (9%) of increasing an AHPs disposable income compared to GPs (4%). This indicates the subsidy impacts disposable incomes disproportionately between GPs and AHPs, favouring AHPs. Suggesting the subsidy level may need to increase for GPs to have the same level of impact on disposable incomes.

Table 2: Comparison of cost of living for an experienced GP renting a three-bedroom house and a Speech pathologist renting a two-bedroom unit.

	Karratha GP	Karratha AHP
Income	\$316,000	\$92,373
Rent paid per year	\$46,488	\$39,988
MSHS subsidy per year	\$12,220	\$8,788
Total disposable income per year without subsidy	\$269,512	\$52,385
% of disposable income compared to Total income	85%	57%
Total disposable income per year with Subsidy	\$281,732	\$61,173
% of disposable income compared to Total income	89%	66%
Total disposable income per year	4%	9%

Source: SQM Research, Pilbara Development Commission

Key takeaway

Tailored and targeted incentives within the Scheme may be required to address the different motivations that attract prospective GPs and AHPs to the City of Karratha.

Key finding 4: The current Scheme subsidy is considered modest in the context of the similar housing and liveability subsidies provided to local healthcare workers.

WA Country Health Service (WACHS) presents competition for healthcare workers within City of Karratha, given the housing benefits WACHS employees can access are more closely aligned to current GPs expectations.

- ▶ GPs and AHPs are offered a range of incentives to work in regional and remote areas. For an overview of programs and incentives please refer to Appendix A.
- ▶ WACHS employees can access heavily subsidised (around 50%) housing expenses, a vehicle, relocation payments and salary packaging opportunities. In 2018, 80% of GPs in the Pilbara were employed by WACHS (Department of Health, 2018).
- ▶ There is said to be a growing expectation among GPs that housing is either available or heavily subsidised when they take positions in regional and remote areas. Anecdotal evidence suggests many potential hires inquire about subsidised housing at the outset, suggesting it is a high priority.
- ▶ A substantial proportion of organisations (37% of respondents according to a WACOSS survey) do not offer housing subsidies to their employees. Perverse outcomes could occur if the utilisation of GP skillsets tend towards a hospital setting leaving an under-serviced GP skillset that operates in a community setting.

The role of the Scheme being an equaliser between Perth and Karratha rental prices may not be sufficient to bridge the gap in housing support expectations necessary to attract and retain GPs and AHPs.

- ▶ The median rental cost in Perth has increased by 15% in a year (a sharper rise than that experienced in Karratha at 7%) (SQM Research, 2024).
- ▶ The inability for GP and AHPs to maximise subsidy payments (given the faster rise in median rental costs in Perth compared to Karratha) further contribute to the gap in workforce expectations.
- ▶ The 2023 Regional Price Index reported the Pilbara was overall the most expensive region to live in WA at 115.0 compared to Perth. The next region is the Kimberley at 108.9.
- ▶ High rental prices in Perth (inherently limiting the subsidy amount provided to GPs and AHPs), coupled with significant workforce competition, high cost of living prices and high expectations as to housing support (predominately from GPs), does not provide a compelling incentive to relocate to the City of Karratha.
- ▶ The subsidy amount and eligibility criteria may need to go beyond the concept of equalisation if the Scheme is to be targeted and effective in achieving the objective of attracting and retaining GPs and AHPs to provide continuity of healthcare to community.

Key takeaway

A review of the objectives of the Scheme is required to ensure the eligibility criteria is conducive, and not restrictive in meeting the desired intent.

Key finding 5: The eligibility criteria imposed by the Scheme can be the difference between attracting a GP and losing the opportunity to an alternative practice elsewhere. AHPs do not seem to be as susceptible to this same risk.

Workforce patterns of GPs are shifting towards part-time and/or working across multiple organisations, requiring the need for the eligibility criteria to remain flexible.

- ▶ Local practices are adapting to a shift in GP employment patterns, with a trend towards either four-day full-time schedules, part-time hours, or full-time hours split across multiple organisations, which presents challenges in hiring. In the City of Karratha, per data provided by stakeholders an equal split exists where 50% of GPs work full time, and the other 50% work part-time. Consequently, only half of the practicing GPs qualify for the Scheme.

There is an opportunity to reduce additional financial stress on participants by covering employees when they are on annual leave.

- ▶ Currently, subsidy payments are momentarily paused for the period when annual leave is taken. This creates additional financial stress on participants during this period, especially considering the workforce is entitled to four week of annual leave per year. There is an opportunity to include up to four weeks of annual leave per year in the Scheme and reduce the additional financial burden placed on participants.

Many highlighted the opportunity to make other vital clinic employees eligible for the subsidy e.g. administration staff. This could enhance retention, improve accessibility and increase continuity of care.

- ▶ Housing shortages and attraction and retention issues do not just impact GPs and AHPs. Practices indicated other essential staff for the smooth operation of services are also impacted which include, Practice managers, nurses and administration staff. Majority of which, are unlikely to be eligible for other subsidised accommodations. Roles which are not adequately filled, just like GPs and AHPs, impact the continuity of the service.

Providing alternative permanent housing options may encourage participants to settle and think of Karratha as a long-term move.

- ▶ Feedback from stakeholders indicates that relying solely on rental subsidies might not be fully effective in cultivating long-term residency. To truly attract and retain new GPs and AHPs, a combination of rental assistance and home ownership incentives was suggested. This approach would aim to initially attract with subsidised rent and then encourage them to stay longer-term through the opportunity to own their own home.

Key takeaway

The eligibility criteria may require adjustment to broaden the pool of prospective GPs and AHPs that could be attracted and retained in the City of Karratha healthcare workforce.

Key finding 6: The Scheme does pose an unnecessary administrative load on participating practices and respective GPs and AHPs.

There is opportunity to clarify the criteria and increase the visibility of the Scheme.

- ▶ Local practices and clinics consulted as part of the Review indicated that ambiguity surrounding the eligibility criteria of the Scheme and its certainty to continue resulted in a reluctance to apply. In some circumstances it played a role in the healthcare professional choosing to depart the City of Karratha.
- ▶ Government and non-government stakeholders consulted indicated there was value in the Scheme being more visible to both Practices and wider community - both from improved subscription of the Scheme and community appreciation that action is being taken to address GP and AHP shortages.

Reducing the time lag of retrospective payments would lessen the financial burden imposed on Scheme participants.

- ▶ Quarterly retrospective payments under the Scheme currently create a financial strain for participants, as they must cover expenses while awaiting reimbursement. Aligning Scheme payments with monthly GP and AHP income schedules could alleviate financial stress.
- ▶ Additionally, the lengthy approval process for retrospective payments adds uncertainty, especially when participants are locked into annual leases. To mitigate these concerns, increasing the frequency of payments and maintaining consistent support would provide participants with financial stability and peace of mind.

Improving the efficiency of the administration, will support the impact and effectiveness of the Scheme.

The below quotes are views represented by Stakeholders. The views are quite stark; whether the below represents a perception or reality - action may be required to rectify.

- ▶ *"The process to receive the subsidy starts by collecting the receipt, submitting the receipts with the template. Then City of Karratha send a PO number which we have to writeup before sending it back. If there needs to be a correction, there is further emailing back and forth until it is then sent for approval. By the time the doctors receive the payment it is about four and a half months in retrospect."*
- ▶ *"It has taken two months for an assessment and then funding will come at a time much later period. There are cases where employees have gone five months out of pocket before receiving Scheme payments."*
- ▶ *"An employee applied to MSHS and was rejected. The employee's impression of the scheme was that it is currently at capacity."*
- ▶ *"An immediate concern was a person has recently been declined for the MSHS, but they were previously approved. There was no reason provided to why their application status was changed."*

Key takeaway

There is an identified need to revise the administration of the Scheme. This includes clarifying eligibility criteria and increasing visibility which will help reduce unnecessary administrative burdens.

Recommendations



Key recommendations

1. The City of Karratha should continue providing some form of housing assistance to attract and retain GPs and AHPs.

The Scheme has contributed to an uplift in the number of GPs and AHPs in the City of Karratha, however the uplift is not enough to meet current and anticipated future demand for primary health and allied health services.

2. Refinement of the Scheme approach and eligibility criteria should be undertaken.

The Scheme is currently subscribed to and is achieving the intended objectives to a degree. Pairing the fact that there is level of undersubscription with stakeholder feedback concerned with eligibility restrictions, it is believed that the Scheme could be better optimised to maximise impact.

The following considerations could be made to refine and maximise the impact of the Scheme:

- ▶ How can the City target an optimal balance between the number of GPs and AHPs supported, and level and longevity of this support? For example, would the City favour more GPs and AHPs at a lower average subsidy, or favour fewer GPs and AHPs at a higher average subsidy, noting that a higher subsidy may support a more sustainable cost of living environment and retain the GPs and AHPs for a longer period of time?
- ▶ How can the existing eligibility criteria be modified or removed to support the balance sought? For example, rather than deeming a 0.8FTE ineligible, can the participant obtain 80% of the subsidy available? It is noted in the case of the current local GP workforce, a 0.8FTE would be considered a 5-10% uplift and could make a material impact on wait times.

The following page has outlined several options that contemplate the above considerations.

Recommendation 2: Options for consideration

Four options are presented below, differentiated by underlying Scheme approach (i.e. equalisation or proactive tool), subsidy amounts and whether the subsidy amount is differentiated between GPs and AHPs. The options presented below are based on a funding pool of \$306,000 allocated over a two-year period. Estimated utilisation of the funding pool is based on the average weekly subsidies paid and the maximum number of participants to which this subsidy could be granted. Depending on the option, calculations assume that each participant receives either the average equalisation payment per week or the maximum flat rate per week. Yearly payments are based on 52 weeks.

Option 1	Option 2	Option 3	Option 4
The Scheme continues to be tool used to equalise rental price differentiation between Perth and Karratha, up to \$300 per week.	The Scheme provides a flat rate of \$300 per week to all eligible scheme participants.	The Scheme provides a flat rate of \$400 per week to all eligible scheme participants.	The Scheme subsidy differentiates between GPs and AHPs. A flat rate of \$400 per week is granted to GPs. The Scheme continues to be utilised as an equalisation tool of up to \$300 for AHPs.
Weekly subsidy: \$213 (current average across GPs and AHPs) Yearly payment: \$11,076 pp Participants supported: 14FTE (example scenario) Total participants supported across two years: 28 FTE	Weekly subsidy: \$300 (current maximum subsidy paid out by Scheme) Yearly payment: \$15,600 pp Participants supported: 10FTE Total participants supported across two years: 20 FTE	Weekly subsidy: \$400 (competitive rate reflective of sustained attraction difficulties) Yearly payment: \$20,800pp Participants supported: 7 FTE Total participants supported across two years: 14FTE	Average weekly subsidy: \$169 - \$400 (current average paid to AHPs; competitive rate reflective of sustained attraction difficulties) Yearly payment: \$8,788 - \$20,800pp Participants supported: 4FTE GPs and 7FTE AHPs (example scenario) Total participants supported across two years: 8FTE GPs and 14FTE AHPs
Conclusion: Despite its capacity to support the greatest number of participants, under-subscription of the current Scheme suggests the subsidy amount is insufficient.	Conclusion: Requires minimal administrative effort and allows a robust number of participants to be supported compared to alternative options.	Conclusion: Likely to have greater capacity to retain, however in the case of AHPs the amount may overcompensate. Constrained in number of participants supported.	Conclusion: Similar levels of administration required to present. Subsidy amounts believed to be better aligned to market expectations of GPs and AHPs based on current Scheme subscription levels and average subsidies paid to GP and AHP cohorts.

Recommendation 2: Preferred option

Option 4 is preferred and recommended to be endorsed.

The concept of the Scheme is valued, warranted and contributes to efforts to retain GPs. However there remains a GP shortage. The Scheme should support the proactive pursuit of GPs by offering a flat \$400 weekly subsidy to eligible participants.

- ▶ Three of an estimated total of 10 GPs operating in the City of Karratha are currently registered on the Scheme (30%).
- ▶ An additional three GPs (or 3 FTE) are required to meet regional ratios (at MM6) and an additional 11 (or 11 FTE) to meet metropolitan ratios in the City of Karratha, ensuring the community's healthcare needs are met effectively.
- ▶ There is a need to enhance the Scheme's attractiveness and meet the increasing expectations of the GP workforce as to housing supports:
 - ▶ Approximately 60% of GPs that have participated in the Scheme (in its current format) have claimed the maximum amount;
 - ▶ The state-wide pool of available GPs is likely to be ever-decreasing given macro factors (e.g. federal policies reducing GP earning capacity);
 - ▶ Greater housing supports are offered by WACHS (a competitor of sorts). Note perverse outcomes could occur if the utilisation of GP skillsets tend towards a hospital setting leaving an under-serviced GP skillset that operates in a community setting; and
 - ▶ Analysis indicates that the average Scheme subsidy of \$235 has a marginal impact (approximately 4%) on a GPs disposable income - which will be key to enable a sustainable cost of living in the City of Karratha.

The Scheme contributes to the attraction and retention of AHPs, but not as significantly when compared to GPs. There remains wait times for allied health services and as such support should continue to be made available. The Scheme should continue to be utilised as an equalisation strategy for AHPs and maintain the current subsidy of a Perth-Karratha delta, up to \$300 per week.

- ▶ It is estimated the number of AHPs participating in the Scheme represents approximately 12% of the local AHP workforce. This proportion is a notable percentage however it may also suggest that the Scheme is not a crucial factor influencing AHPs when deciding to pursue employment in the City of Karratha.
- ▶ The annual retention rate of AHPs who commenced work in 2022 across the local market was approximately 50% . The average annual retention rate of AHPs on the Scheme is approximately 33% suggesting the ability for local practices offering allied health services are not overly reliant on the Scheme.
- ▶ There is lacking evidence to warrant an increase in the subsidy offered to AHPs, particularly when at risk of overcompensation and resultant limitations in attracting a greater total number of GPs or AHPs as part of the Scheme (given funding is finite):
 - ▶ The average weekly subsidy paid to AHPs under the Scheme is \$169 (far from the maximum of \$300). Anecdotal evidence also indicated that the expectations of AHPs differ to that of GPs, partly owing to a demographic of AHPs often attracted to the City of Karratha (younger, early career professionals often willing to share a house given the lack of accompanying family).
 - ▶ Analysis indicates that the average Scheme subsidy of \$169 has a substantial impact (approximately 9%) of increasing a AHPs disposable income.

NB: The reported figures and analysis above is reliant on information and data conveyed by stakeholders consulted as part of this Review. The data imparted may not be an exhaustive representation of the local GP and AHP workforce. The notions communicated above stand.

Key recommendations (cont.)

3. The Scheme should include additional flexibilities (where capacity to administer allows) to ensure the Scheme maximises impact. Many of the below suggested inclusions are in line with underlying premise of Option 4. In sum, it is recommended that the Scheme go beyond the concept of equalisation and rather be utilised as a proactive attraction tool.
- ▶ Offering a readily available and vacant premises could remove an immediate barrier (i.e. finding a rental property) in efforts to attract and secure GPs and AHPs. The City of Karratha could consider utilising its own housing stock for Scheme participants when there is stock unoccupied.
 - ▶ There should be allowances for Scheme participants to take annual leave without being penalised. Assuming the recommended option is endorsed (i.e. \$400/w reserved for GPs and on average \$169/w paid to AHPs), \$11,132 per year would be required to cover 4 GP and 7 AHPs for four weeks of annual leave.
 - ▶ The City of Karratha should consider offering the equivalent of 52 weeks in rental subsidies as a lump sum to contribute to a home deposit to Scheme participants that demonstrate appetite to permanently relocate to the area. Having this option available may enhance retention efforts. As part of the contract underpinning the lump sum payment there should be a requirement for the participant to fulfil the relevant GP or AHP position for minimum stated period.
 - ▶ The Scheme should consider broadening eligibility to include part-time GPs and AHPs, whether they work at one health clinic or practice or across multiple. If the GP or AHP is employed on a 0.8 FTE to 1.0 FTE basis across multiple organisations, they should be eligible to a proportion of the full subsidy amount (the proportion being reflective of their employment status).
 - ▶ Where the Scheme is persistently under-subscribed and viability of local clinics and practices are under threat, there could be consideration to include other essential workers at healthcare practices and clinics. Practice Managers and Nurses also play a role to ensure there is adequate support to maintain continuity of care.
 - ▶ Assuming Option 4 is endorsed, or in the instance the status quo is maintained, the quarterly review of average rental prices should distinguish between the apartments and houses (or number of bedrooms) such that the level of comparability is enhanced.

Key recommendations (cont.)

4. The administration of the Scheme should be enhanced to ensure efficiency and maximum impact.

- ▶ The Scheme should collect data to ensure objectives are met and the desired balance is maintained. Data such as market and scheme attraction and retention rates for GPs and AHPs will help determine whether the Scheme should be lowered, uplifted, or nuanced to trigger the most effective incentive for the GP and AHP labour market. Key performance indicators could be built into the Scheme utilising this data to support the City of Karratha maintain its course. The program logic outlined in Appendix A could be utilised to support to discern appropriate objective measurement and key performance indicators.
- ▶ The City should uplift efforts to ensure clear communication as the Scheme's existence and the eligibility criteria to reduce uncertainty and maximise exposure.
- ▶ Where possible, the frequency of subsidy payments should increase to a monthly occurrence. This will reduce retrospective payments, reduce the financial burden on Scheme participants and encourage continued engagement on the Scheme.
- ▶ Efficiencies should be explored to streamline the request of proof of evidence in order to receive a Scheme subsidy payment. For example, the level of documentation to be provided by Scheme participants and subsequently reviewed by City of Karratha staff should be consistent each month.

OPTIONAL CONSIDERATION

The City of Karratha would require an additional 14FTE GPs and 20FTE AHPs in total to meet future demand and bridge the gap between the current workforce and the workforce said to be required. The 14FTE GP figure reflects the difference in the number of GPs required to meet the same GP to population ratio as metropolitan areas. The 20FTE AHP figure reflects the proxy number of AHPs local practice representatives stated they would require to meet future demand. The figures below outline the associated annual funding required under each option to service the additional workforce required plus the existing participants on the Scheme (3FTE GPs and 4FTE AHPs):

Option 1	Option 2	Option 3	Option 4
\$465,192	\$655,200	\$873,600	\$630,500

Appendix A – Research and data



Quantitative data collected from stakeholders

The following data was collected from Scheme Participants following consultations and is representative of the data received from the following organisations: [REDACTED].

Table 3: Employees who were working in 2020 and 2022 and are still currently employed.

Retention rates			
	2020	2022	2024
All	8	15	34
	24%	44%	100%
GP	2	3	10
	20%	30%	100%
AHP	6	12	24
	25%	50%	100%

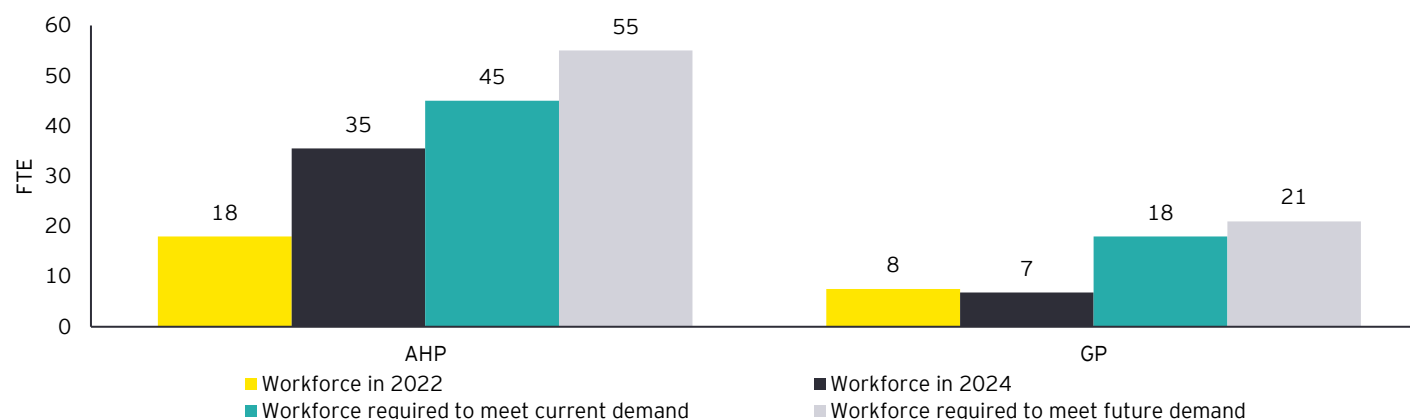
Table 4: The composition of AHP and GP workforce

Composition of Workforce	AHP		GP	
	Total	% of workforce	Total	% of workforce
Permanent	36.8	97%	7	88%
Locum	0	0%	1	13%
FIFO	1	3%	0	0%
Full Time	29	77%	5	50%
Part Time	8.8	23%	5	50%
Casual	0	0%	0	0%
Early Career	11	29%	0	0%
Established Professional	26.8	71%	5	100%

Table 5: Current wait times at each service

Waittimes	
Service 1 (AHP)	
Physiotherapy	Private 0-3 months NDIS 6-9 months
Continence Physiotherapy	Private 6-9 months NDIS 6-9 months
Dietician	No waitlist
Speech Pathology	Private 1-2 years NDIS 1-2 years
Service 2 (AHP)	
Speech Pathology	12 months
Occupational Therapy	9-12months
Physiotherapy (NDIS)	2 months
Physiotherapy (Private)	1 week
Service 3 (GP)	
General procedure	2-3 weeks
Waitlist for clinician	5-7 days
Waitlist for Clinic	5-7 days
Service 4 (GP)	
General practice	4 weeks to see your preferred Doctor
Service 5 (GP)	
General practice	6 - 8 weeks

Figure 5: FTE of AHPs and GPs required to meet past, current and future demand



GP and AHP Incentive Programs - Eligible for City of Karratha professionals

Agency	Incentive program	Participants eligible for the incentive	The purpose of the incentive	Monetary value of incentive
Federal Program - Department of Health and Age Care	Workforce Incentive Program Doctor Stream	Doctors must provide a minimum amount of eligible primary care services or undertake eligible or Rural Generalist training under an approved training pathway in MMM 3 to 7 locations.	The Workforce Incentives Programme (WIP) Doctor Stream aims to encourage doctors to practise in regional rural and remote communities. It promotes careers in rural medicine by providing financial incentives.	Incentive payments of between \$3,600 and \$60,000 per year. New participants providing services in MMM 3-5 will receive their first payment after achieving eight active quarters within a 16-quarter period and participants in MMM 6-7 will receive their first payment after achieving four active quarters within an eight-quarter period.
Rural Health West	WIP Rural Advanced Skills Payments	For doctor providing primary care services and advanced skills services in locations classified as Modified Monash MMM 3 to 7 locations	These grants aim to assist the health professionals by providing financial support to retain health professionals in difficult to staff locations. Under the two streams, the funding is distributed from Rural Health West, to the practices and then on to the GPs.	Stream 1 - Emergency Services and Workforce Incentive Program offers \$4,000 to \$10,500 per year to doctors offering emergency care after hours services in eligible locations. Stream 2 - Advanced Skills offers doctors with extra qualifications may be eligible for an additional \$4,000 to \$10,500 per year.
WA Health	WA Health Relocation Incentive (Belong Incentive)	For health professionals appointed to WA Health in Regional WA and working a permanent position or fixed term contract of 12 months	To help with relocation costs for doctors who are moving to regional Western Australia	The maximum incentive available is between \$8,000 to \$10,000 depending on the employee commencement date.
WA Country Health Service	Salary Packaging	All West Australian health workers.	Gives WA Health employees the opportunity to pay for expenses with pre-tax salary. Effectively, increasing disposable income	\$9,010 out of salary per year for mortgage, rent or living expenses. \$2,650 per year for meals and entertainment, and can salary package a vehicle.
WA Country Health Service	Country Nursing and Midwifery Incentive Program	New or existing Nurses and Midwives at endorsed sites around country Western Australia	The incentive program is designed to attract and retain new and existing nurses and midwives to work in the country for longer.	Endorsed sites receive between \$5,000 and \$17,000 paid over 12 months. \$10,000 relocation incentive, \$12,000 in HECS support, interprofessional education units and Special Care Nursery Course Level Training.
WA Country Health	Salary and Benefits	Health Care Professionals	To attract GPs to work in regional areas of Western Australia.	Provides Air Conditioning above the latitudinal line, home ownership subsidy scheme, subsidised rental accommodation, zone or special tax offset and district allowances

GP and AHP Incentive Programs - Incentives in other jurisdictions

Agency	Incentive program	Participants eligible for the incentive	The purpose of the incentive	Monetary value of incentive
Primary Health Tasmania	General Practice Incentive Fund	For General Practitioners	Primary Health Tasmania has received \$2 million in Australian Government funding to address GP recruitment and retention issues in north and north-west Tasmania.	Primary Health Tasmania has received \$2 million in Australian Government funding. This will be distributed accordingly amongst successful applicants.
South Australian Government	GP Rural Agreement	Regional and remote doctors across South Australia	The new GP agreement aims to provide greater recognition, remuneration and support for regional and remote doctors across South Australia.	<p>The rural attraction payment of up to \$50,000 for new GPs who are beginning practice and providing hospital services will be expanded, with a new payment of up to \$10,000 to a wider range of regional sites.</p> <p>A recognition payment of \$5,000 will be given to each current GP signing on to the new GPA to acknowledge their ongoing commitment to South Australian rural and regional communities.</p>
Primary Health Northern Territory	Workforce Incentive Program	Medical practitioners in accordance with the MMM	The scheme aims to encourage medical practitioners to practise in regional and remote communities.	\$4,500 up to \$60,000 is available through the WIP
NSW Health	Rural Health Workforce Incentive Scheme	The incentive scheme applies to all eligible health workers. Positions must be considered by the health agency Chief Executive and deemed to meet the definition of a hard to fill position.	The Rural Health Workforce Incentives Scheme (RHWIS) is a comprehensive incentive package that aims to attract, recruit, and retain key health workers in rural and regional locations employed in positions that are hard-to-fill or critically vacant.	Eligible healthcare workers can receive incentive packages up to \$20,000.
Queensland Health	Scheme 2 - Rural and remote healthcare workers	The payment is eligible to healthcare professionals that relocate from MMM 1 to 4 locations	The workforce attraction scheme will bring more frontline healthcare workers to communities across Queensland.	<p>Healthcare workers who commence working for Queensland Health in a rural or remote location will receive \$30,000 on commencement.</p> <p>Workers will receive another \$20,000 after completing a full 12 months of service in Queensland.</p>

Doctor Stream incentive payment amounts

Doctor Stream incentive payment amounts are financial incentives offered by the Australian Government aimed at encouraging doctors to practice in remote, rural, and regional areas of the country. The Modified Monash Model (MMM) is a geographical classification system used by the Australian Government to categorise regions in Australia based on their remoteness and population size. It was developed to support more effective distribution of resources, particularly for health workforce programs. The model divides the regions into seven categories - from MMM1, representing major cities, to MMM7, representing the most remote areas. The City of Karratha is located in the MMM6 area.

For vocationally registered doctors and non-vocationally registered doctors on an approved training pathway, the annual incentive payments amounts are below. Please note these amounts are per year, not per quarter.

Location (MMM)	Year Level 1	Year Level 2	Year Level 3	Year Level 4	Year Level 5 plus
MMM 3	\$0	\$4,500	\$7,500	\$7,500	\$12,000
MMM 4	\$0	\$8,000	\$13,000	\$13,000	\$18,000
MMM 5	\$0	\$12,000	\$17,000	\$17,000	\$23,000
MMM 6	\$16,000	\$16,000	\$25,000	\$25,000	\$35,000
MMM 7	\$25,000	\$25,000	\$35,000	\$35,000	\$60,000

For non-vocationally registered doctors who are not on an approved training pathway, the annual incentive payment amounts below apply from 1 January 2024. Please note these amounts are per year, not per quarter

Location (MMM)	Year 1	Year 2	Year 3	Year 4	Year 5 plus
MMM 3	\$0	\$3,600	\$6,000	\$6,000	\$9,600
MMM 4	\$0	\$6,400	\$10,400	\$10,400	\$14,400
MMM 5	\$0	\$9,600	\$13,600	\$13,600	\$18,400
MMM 6	\$12,800	\$12,800	\$20,000	\$20,000	\$28,000
MMM 7	\$20,000	\$20,000	\$28,000	\$28,000	\$48,000

1. <https://www.health.gov.au/our-work/workforce-incentive-program/doctor-stream/payment-amounts>

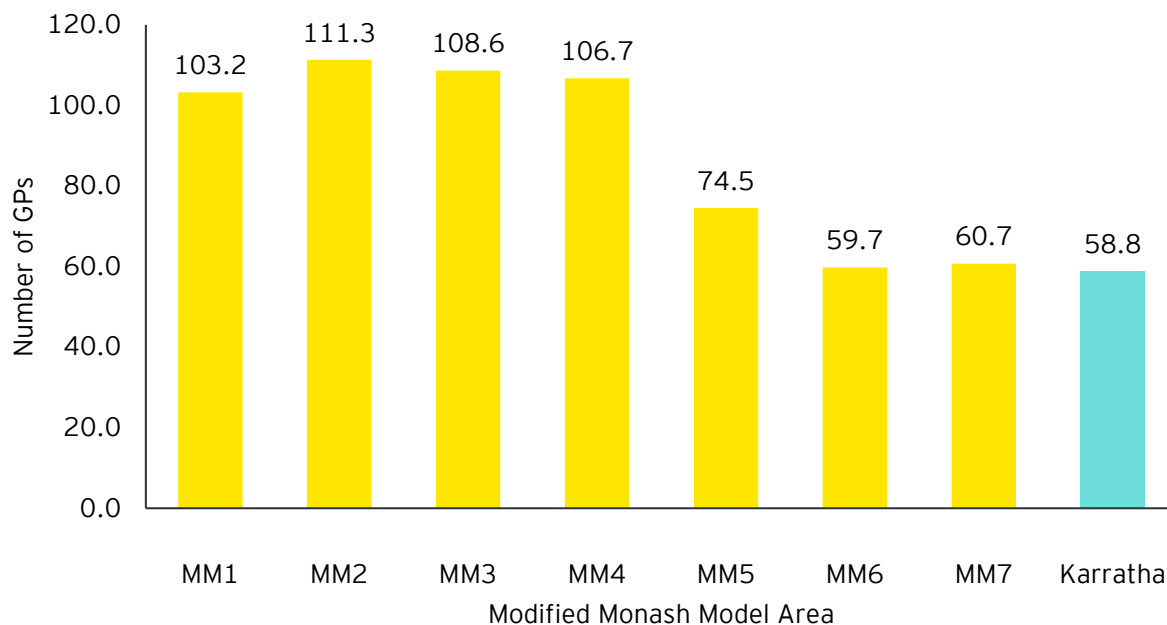
GP to population ratios

GP to population ratios are referenced within the body of this report. For further context:

- ▶ Figure 6 below compares the average FTE GP population ratio across Karratha and each Modified Monash Model (MMM) area in 2023-23. Karratha, which sits in the MM6, has the lowest GP to population ratio to any MMM Area.
- ▶ Figure 7 adjacent depicts a map of Modified Monash Model Areas across WA. Karratha is classified as a MM6 area.

The number of GPs and ratio of GPs per 100,000 people per Modified Monash Model Area, over time, is documented on the following page.

Figure 6: FTE GP per 100,000 population in WA



1. [Health Workforce Locator | Australian Government Department of Health and Aged Care](#)

Figure 7: Map of Modified Monash Model Areas across WA



GP to population ratios

Table 6: Number of GP per Modified Monash Model Area in WA

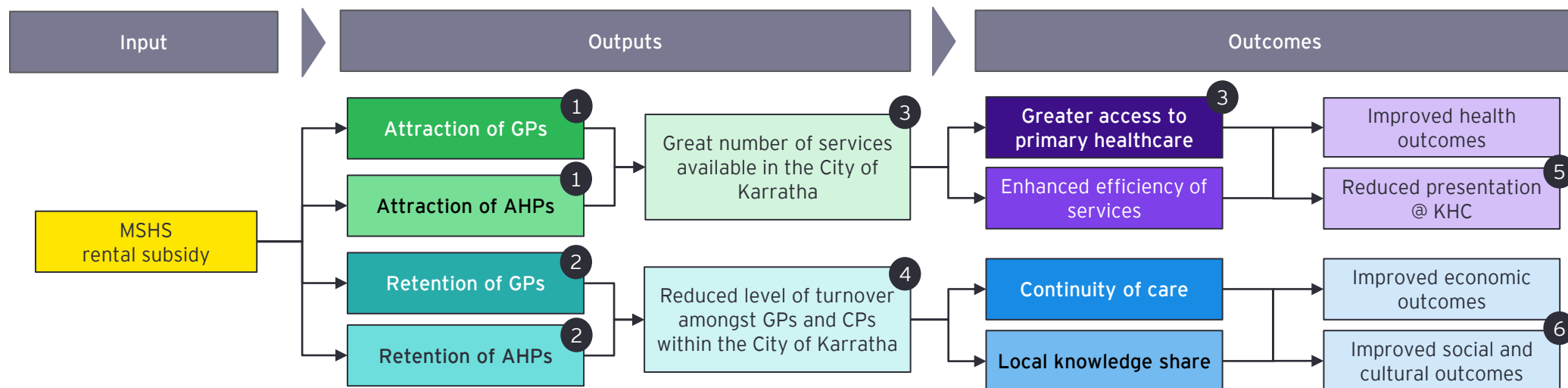
	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	Growth (CAGR) (last 5 periods)
MM1	2,171.2	2,267.2	2,300.1	2,376.4	2,443.3	2,266.0	0.9%
MM2	115.8	126.7	129.3	138.6	138.9	136.9	3.4%
MM3	160.7	161.3	164.4	167.3	174.3	163.6	0.4%
MM4	32.7	31.6	31.5	31.7	32.8	29.5	-2.0%
MM5	91.0	88.0	90.8	96.8	108.6	101.1	2.1%
MM6	63.1	63.2	59.0	56.6	58.4	54.7	-2.8%
MM7	43.7	41.8	39.5	37.4	37.3	40.1	-1.7%

Table 7: GPFTE per 100,000 population in WA

	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	Growth (CAGR) (last 5 periods)
MM1	107.6	110.7	110.3	111.5	113.0	103.2	-0.8%
MM2	101.8	109.7	110.3	116.1	114.4	111.3	1.8%
MM3	113.0	112.3	113.3	113.8	117.0	108.6	-0.8%
MM4	128.1	121.8	120.1	119.4	120.7	106.7	-3.6%
MM5	70.0	67.5	69.3	73.1	81.1	74.5	1.3%
MM6	72.8	72.4	66.9	63.2	64.4	59.7	-3.9%
MM7	63.1	61.5	59.0	56.5	56.7	60.7	-0.8%
Total	103.6	106.2	105.8	107.1	108.9	100.1	-0.7%

1. [General Practice Workforce providing Primary Care services in Australia \(health.gov.au\)](https://www.health.gov.au)

Possible program logic



Measurements

- | | |
|--|---|
| <p>1 ▶ Current GP : Population Ratio
▶ Current number of AHPs, by profession</p> <p>2 ▶ Long term average GP : Population Ratio
▶ Long term average number of AHPs, by profession</p> <p>3 ▶ Number of GP specialisations and service offerings
▶ Operating hours and days
▶ Appointment availability
▶ Average wait times at local clinics</p> | <p>4 ▶ Practice turnover rates, by profession
▶ Average length of stay, by profession</p> <p>5 ▶ Number of avoidable presentations at ED (KHC)
▶ Average wait times at ED (KHC)</p> <p>6 ▶ Average age of population (ability to age in community)</p> |
|--|---|

Appendix B – Stakeholder Consultations Summaries



Current Scheme participants

Stakeholders

Summary points of discussion

- ▶ It is a shared belief that there is currently a low level of GPs across practices operating within the City. In recent history there has been a greater number of GPs.
- ▶ There is hesitation to fill positions with FIFO personnel or locums given the lack of continuity it provides community, and the preference is to fill roles with locals.
- ▶ Both practices referred to partnerships with other primary health and allied health practices. Some partnerships exhibit the sharing of staff to provide services via other practices. In other cases, there partnership exhibits a strong referral pathway, in particular between GPs and AHPs.
- ▶ There are some services provided by practices in the City that extend to the Town of Port Hedland. There is a reliance of service provided within the City of Karratha to other regional townships.
- ▶ A prevailing view was that the Scheme is important and was often referred to as being responsible for the attraction of GPs and AHPs to the City.
- ▶ The Scheme was said to be particularly effective for graduates and early career AHPs. The size of subsidy payment is considered plentiful for graduates and early career professionals. The subsidy can potentially be maximised, considering graduates and early career professionals are more likely to be willing to share a house with a colleague.
- ▶ It should be noted that GPs often come from abroad and without their family. The rental subsidy can be considered a “softener” but may not be sufficient to attract the whole family, which may impact the longevity of the GPs stay.
- ▶ With respect to the current GPs and AHPs on the Scheme, it is circumstantial as to whether the subsidy amount makes a significant or little impact on the GPs or AHPs broader cost of living.
- ▶ By having a stable local primary healthcare workforce, many relationships can be built between healthcare professionals such that patients can obtain continuous, effective and informed care, and can find the right expertise depending on their needs. This is often critical for the Aboriginal community.
- ▶ Both Scheme participants suggested that the subsidy was passed on in full to the GP or AHP, with little merit thought to be gained from retaining whole or part of the subsidy for the practice itself.
- ▶ A concern was raised regarding the MSHS potentially being prioritised to not-for-profit organisations. It was suggested that private practices (albeit not bulk-billing community) do invest in community by reducing pressures on ED and providing a broader breadth of services or new equipment.
- ▶ Concerns were often raised that the MSHS would not be extended past the end of the financial year and there was a belief that all funding available has been exhausted.
- ▶ Suggestions concerning the administration of the Scheme included:
 - ▶ The belief that it was non-sensical to momentarily pause subsidies for the period of annual leave if the GP or AHP is out of town given the objective is to attract a GP or AHP (i.e. a person that is servicing the City of Karratha for an extended period, that also requires holidays).
 - ▶ The desire to increase the timeliness and frequency of MSHS payments. Quarterly subsidy payments have been problematic as they are often paid in retrospect of the rental payments made to the realtor. If the subsidy payment is denied, the GP or AHP loses out.
 - ▶ Experiences of inconsistency as to the level of evidence required or approval depending on the representative of City of Karratha.
 - ▶ Timeliness of eligibility for the Scheme and subsidy approvals thereafter, particularly given the requirements for GPs and AHP to often commit to year-long leases.
- ▶ Suggestions concerning the structure of the Scheme included:
 - ▶ Introducing a mix between rental subsidy and home ownership program. The combination potentially allowing the rental subsidy to attract, and the home ownership to retain.

Former Scheme participants

Stakeholders

Summary points of discussion

- ▶ If the number of GPs in the region decreased, then it is likely the follow-on impact will cause greater pressure in the emergency department. This would disincentivise people to go to hospital and could create situations where injuries/health worsen over the longer period of waiting for medical treatment. Chronic conditions could also worsen.
- ▶ The impact of the subsidy varies pending the circumstance of the healthcare professional and the rental obtained.
- ▶ WACHS presents competition for healthcare labour within City of Karratha given housing benefits WACHS employees are able to access.
- ▶ The eligibility requirements of full time presents challenges.
- ▶ Both practices were unaware of any other local government policies regarding housing and attracting GP/AHP workers in other regions of Western Australia. It was pointed out that GPs in the Wheatbelt are often provided accommodation and vehicles to incentives prospective employees.
- ▶ Suggestions concerning the administration of the Scheme included:
 - ▶ The reduction in retrospective payments. It creates uncertainty for the Scheme participant with the potential the application is denied.
 - ▶ The desire to provide accommodation before the GP or AHP arrives to simplify the relocation for both the employer and employee.
- ▶ Suggestions concerning the structure of the Scheme included:
 - ▶ The eligibility criteria being nuanced to consider subsidising GPs that may work across both ED and private practice within the City of Karratha.
 - ▶ The eligibility criteria being nuanced to consider healthcare workers that work a full week of hours in four days.
 - ▶ Inclusions of some incentivise for a Chief Medical Officer role to provide supervision and training to junior GPs. This role would help junior GPs obtain the required supervision to maintain practicing in the City of Karratha.
- ▶ There is a shared belief that the main issue persisting for local practices is the attraction and retention of doctors. The lack of availability of housing as the main problem related to staffing employees.
- ▶ There are large infrastructure projects incoming, which will bring an increase in people to the town and demand an increase of the healthcare workforce to match.
- ▶ Both practices have seen a shift in workforce patterns as GPs are starting to shift from the traditional five-day work weeks. It is now more common for GPs to work full time hours across four days or prefer to work part-time which creates additional recruitment challenges.
- ▶ It is difficult for practices to operate past baseline operations as high Medicare fees and operational costs make it difficult to earn a profit. In one practice 40% of the fees are required to carry overhead and will need two or three more doctors to break even.
- ▶ The Scheme is valued and deemed appropriate given suitable and affordable accommodation is the most difficult challenge for attracting potential candidates to Karratha. The first question candidates ask is if housing is available or subsidised. An important consideration for the area is the competition to attract international doctors - this extends interstate.
- ▶ By housing healthcare workers locally in Karratha, they can form relationships with patients and create connections within the community. They can sympathise with residents and develop a greater understanding of the issues that affect the region.
- ▶ From a community perspective, they are frustrated with waitlists and constrained services offerings. Practices seek to maintain a continuity of care that only permanent local employees can provide.

Enquiring Scheme participants

Stakeholders

Summary of discussion

- ▶ All practices have had little interaction with the MSHS and are interested to learn more about the scheme. There is a common theme that practices are unsure about the eligibility requirements of the MSHS. In one instance, they were unsure on the types of employees eligible for the Scheme.
- ▶ The rationale for healthcare professional departing the area is often circumstantial, notwithstanding the trend of an aging healthcare workforce resulting in numerous retirements over the past year. This brings into focus the need to focus on effective attraction and retention of employees to keep sufficient stock of healthcare workers.
- ▶ Some practices are adamant they can find employees who would work at the practice, but that the lack of housing creates significant barriers for prospective employees to relocate. For example, a mental healthcare worker that is currently providing services via telehealth would consider the move if there was affordable accommodation.
- ▶ There is a hesitancy to use, and a preference to avoid Telehealth as it does not provide effective health outcomes for most clients. It has been highlighted that the Indigenous community highly benefits from in person consultations.
- ▶ There is a prevalent view that ensuring continuity of care is one of the most important objectives of the practices. Having reliable services enables practices to ensure that practices are set up for a safe place that is culturally safe for some of the most at risk groups of the community.
- ▶ It should be noted that the practices consulted all provide some sort of housing support for employees, but each practice has insufficient funding or revenue to shoulder the entire housing cost.
- ▶ If the practices lost access to housing and were unable to attract new staff, then their service delivery outcomes would suffer. In a worst-case scenario, practices that are primarily grant funded would risk not hitting their objectives and jeopardise the chance to renew grant funding.
- ▶ There was a view shared that was supportive of the full-time criteria and a belief full-time workers should be prioritised for housing. This view was paired with the belief that finding interested employees was not difficult when adequate and affordable accommodation could be offered.
- ▶ If the number of GPs in the region decreased, then it is likely the impact will be felt through increased pressure in emergency. This would likely disincentivise people to go to hospital at all and would create the possibility that patient outcomes would worsen over the prolonged period of waiting for medical treatment.
- ▶ There is a great focus on finding suitable and affordable accommodation and is the most difficult challenge for attracting potential candidates to Karratha. The first question candidates ask is if housing is available or subsidised. An important consideration for the area is that the competition to attract international people - this extends interstate.
- ▶ Suggestions concerning the structure of the Scheme included:
 - ▶ The desire to pro rata the subsidy to reflect hours worked, rather than disqualifying part time healthcare professionals.
 - ▶ The request to include operational managers and nurses (that are essential to the running of services) be eligible for the Scheme, given they are also unlikely to be eligible for the Services Workers Accommodation.
 - ▶ Prioritisation of GPs and AHPS that work for not-for-profit practices that bulk bill. This belief comes from the idea that providing the most affordable care for patients should be of highest priority.

Government organisations

Stakeholders

Summary of discussion

- ▶ There is a relatively large rental market, however the resources industry and state government occupy most of these properties. This leaves a small proportion of rentals available which can be prohibitive for residents and smaller businesses.
- ▶ Building three-bedroom, two-bathroom housing in Karratha is not profitable as the CAPEX costs are significant. There are apartments available, but people are very reluctant to buy these properties as they favour larger sized blocks.
- ▶ Housing is considered underutilised with on average 1.8 people living in a four-bedroom, two-bathroom house.
- ▶ The City of Karratha is waiting on multiple Housing Australia Future Fund grant applications which if successful could allow to alleviate many housing pressures. If all grants are approved, then there would be an influx of up to 82 new affordable dwellings.
- ▶ Development WA holds much of the land release. It could be beneficial for Development WA to consolidate the Madigan blocks to make these areas more attractive for purchase.
- ▶ Currently, around a third of the healthcare workers occupy their own residential properties, with about 50-75% of staff needing assistance to find accommodation. The \$300 is largely seen as an appropriate amount for the most part, but it is circumstantial on an individual's housing preferences and family size.
- ▶ Greater choice of modern housing could support attract and retain healthcare workers. Most GPs have a preference on where they would like to live, and some take the socioeconomic issues of the area into consideration.
- ▶ Under WACHS, the housing benefit employees receive is dependent on contractual parameters. For example, permanent fixed contracts may receive bigger sized housing, while temporary locum staff would only get smaller apartments. There are situations where some short-term contract employees bring caravans and others where partners of those who work in mining have other housing schemes they can rely on.
- ▶ It is not very common for people to become permanent - there is a trend of employees who finish their contract and leave. Prevalent reasons for departure include the desire to relocate to larger towns with a greater number of resources (regional centres such as Bunbury, Albany or Broome).
- ▶ It was pointed out that regardless of the level of individual welfare needs in emergency, the hospital is still responsible for all patients after hours. This displays the importance of the existing partnerships with all healthcare providers to ensure Karratha can maintain a level of care for all individuals.
- ▶ Suggestions concerning the administration of the Scheme included:
 - ▶ Increased advertising of the Scheme through WAPHA, WACHS and other local, related avenues.
- ▶ Suggestions concerning the structure of the Scheme included:
 - ▶ Allocation of MSHS funds towards home ownership incentives. There have been mining companies that provide subsidies up to \$35,000 for employees to buy property.
 - ▶ To allow sublet of subsidised properties of MSHS participants to relieve pressure on the housing stock concern, and house more professionals (considered to be the ultimate objective).
 - ▶ Consideration for accommodation subsidies to be embedded within the GP or AHP employment contracts, which may allow practices to offer more long-term contracts and secure services for longer periods.
 - ▶ A focus on timeliness of approvals to facilitate preorganised housing, so as to improve security of relocation of GP and AHPs (and reduce stress that comes with relocation).
 - ▶ Quarantining a portion of the MSHS pool to fund introductory visits for GPs and AHPs to familiarise themselves with the town to convert GPs and AHPs that may be unsure with the relocation.

Non-government organisations

Stakeholders

Summary of discussion

- ▶ There is an issue with retention of GPs in Karratha which creates challenges for ensuring continuity of care especially when considering there is such a high turnover of staff. It is noted that there is also a high turnover of healthcare employees.
 - ▶ It is a shared belief that insufficient GPs can place pressure on and adversely impact the hospital.
 - ▶ Notwithstanding the constraints of the City of Karratha, to convert professionals in general to Karratha there is often a requirement to provide support for their families (i.e. supporting partners obtain employment, supporting children access favoured schools etc.). Subsidisation and support may need to extend beyond initial relocation given it can take a couple of years for a GP (and other professions) to build their client base. On boarding bonuses tend to help.
 - ▶ Further to the above, broader climactic and accessibility of infrastructure hinder the ability to attract GPs and AHPs, and other professionals. Recreational, community and family-friendly assets to distract from the fact the town is hot and arid, for example.
 - ▶ An anecdote was shared that there are 18 Wheatbelt towns that have one GP and for the Shires to attract these GPs they need to include a house and vehicle.
 - ▶ Subsidies need to reflect other incentives provided by the state and federal governments. Karratha is a MMM6 zone which results in a doctor's incentive payment to work there for a year to be between \$16,000 to \$35,000
- ▶ There is a relationship between AHPs and GPs. Attraction of GPs can support the viability of allied health practices given the referral requirements from GPs for some allied health services.
 - ▶ A major challenge conveyed by most NGOs is the ability for practices to find and attract graduate GPs to work in regional and remote areas. It has been described that this problem is a symptom of a larger state-wide issue that there are a falling number of students studying to become a GP.
 - ▶ There are now other medical professions in Perth that have higher earnings potential than a GP. There is consensus that substantial remuneration and benefit packages are needed to attract GPs to regional areas - to the point that there is a requirement for inclusion of housing benefits in contracts.
 - ▶ Although not prevalent, there was a perspective shared that regional primary healthcare service delivery is primarily the responsibility of the state government, rather than the local government. There was also a consideration as to the net benefit (or otherwise) contribution of the resources sector (given resources activity is a significant factor in the inflation of cost of living).
 - ▶ From a Pilbara wide social service worker survey, it was identified that 83% of respondents had staff leave due to housing affordability.
 - ▶ There is a firm view that the key drivers for GPs leaving are when they have completed their moratorium or when their children reach high school.
 - ▶ Suggestions concerning the structure of the Scheme included:
 - ▶ More attractive subsidies and flexible eligibility criteria to attract professionals that are willing to share housing.
 - ▶ Additional benefits outside of housing to acknowledge the broader cost of living (for example discounted gym memberships, discounted local events).
 - ▶ Allocation of MSHS funds towards home ownership incentives (reducing prohibitive insurance costs and bank approvals).

Appendix C: Stakeholder Engagement Plan



Stakeholder engagement approach

Current scheme participants

Objective

- ▶ Capture firsthand experiences, insights, and perspectives regarding the implementation, impact, and effectiveness of the MSHS.

Approach:

- ▶ 1 hour discussion with each GP/AHP Clinic via Teams

Organisations:

- ▶ [Redacted]
- ▶ [Redacted]

Former scheme participants

Objective

- ▶ Capture firsthand experiences, insights, and perspectives regarding the implementation, impact, and effectiveness of the MSHS.

Approach:

- ▶ 1 hour discussion with each GP/AHP Clinic via Teams

Organisations:

- ▶ [Redacted]
- ▶ [Redacted]
- ▶ [Redacted]
- ▶ [Redacted]

Enquiring about the scheme

Objective

Capture current challenges, understand specific needs for assistance and whether the absence of such a scheme could threaten operational sustainability.

Approach:

- ▶ 1 hour discussion with each GP/AHP Clinic via Teams

Organisations:

- ▶ [Redacted]
- ▶ [Redacted]
- ▶ [Redacted]

Government

Objective

- ▶ Capture an understanding and perception of the scheme and understand other programs, policies or initiatives available to GPs and AHPs.

Approach:

- ▶ A 30 min discussion with each Government agency via Teams

Organisations:

- ▶ [Redacted]
- ▶ [Redacted]
- ▶ [Redacted]

Non-Government Organisations/Education

Objective

- ▶ Capture an understanding and perception of the scheme, the community impact and unintended consequences of reduced healthcare in the regions and understanding of other programs, policies or initiatives available to GPs and AHPs.

Approach:

- ▶ A 30 min discussion with each Agency via Teams

Organisations:

- ▶ [Redacted]
- ▶ [Redacted]
- ▶ [Redacted]

Key evaluation questions

Further information on how key evaluation questions will be tailored to each stakeholder is detailed in the following section. An example discussion guide is also provided.

Effectiveness

- ▶ To what extent has the MSHS been effective in achieving its original objectives?
- ▶ What factors (e.g. internal, external) have enabled or hindered achievement of the objectives?

Impact

- ▶ What impact has the MSHS had on the community and stakeholders (whether positive or negative, intended or unintended)?
- ▶ Does the original problem still exist? What impact would cessation of the scheme have on the community and other stakeholders?

Efficiency

- ▶ Does the scheme remain appropriate (e.g. the best use of resources) for addressing the original problem?
- ▶ What other local, state or federal programs, policies or initiatives exist to support and/or increase the rural GP workforce?
- ▶ What alternative service delivery options by Council, if any, can be considered (e.g. to improve the use of resources)?

Additional evaluation questions posed by EY

- ▶ Are like for like comparisons in properties between Perth and Karratha possible? How do you measure the disparity in available properties?
- ▶ Is the policy inadvertently encouraging people to rent short term rather than buy and settle in the town for the long term?

Current scheme participants

Objective

Our primary objective in consulting with current Scheme participants is to capture their firsthand experiences, insights, and perspectives regarding the implementation, impact, and effectiveness of the Medical Services Housing Scheme.

Approach

An hour discussion with each Clinic via Teams

Organisations



Further analysis the stakeholder could support

- ▶ Data analysis on occupancy rates of roles compared to the desired level of roles required to meet demand; and
- ▶ Desktop research into housing/rental availability, incentives by other council/governments.

Key line of questioning

Contextual

- ▶ Understanding the participants level of engagement with, and utilisation and perception of the MSHS.

Effectiveness

- ▶ To what extent has the MSHS been effective in achieving its original objectives?
 - ▶ *Ability to service local demand? Demand for appts? Demonstrated ability to provide continuity of care? Reduction in turnover? Ability to extend clinic hours? Less reliance on locum or FIFO staff?*
- ▶ What factors (e.g. internal, external) have enabled or hindered achievement of the objectives?
 - ▶ *\$300 sufficient? Does your practice offer further subsidies? Same challenges in attraction vs. retention? Broader liveability factors at play? Competition with other regional townships?*

Impact

- ▶ What impact has the MSHS had on the community and stakeholders (whether positive or negative, intended or unintended)?
 - ▶ *Increased referrals to specialists? Reduction in presentations to ED/Karratha Health Campus? Is there an administrative burden? Perspectives on eligibility criteria?*
- ▶ Does the original problem still exist? What impact would cessation of the scheme have on the community and other stakeholders?
 - ▶ *What change has occurred since the scheme? Is the GP/AHP labour force constrained irrespective of scheme?*

Efficiency

- ▶ Does the scheme remain appropriate (e.g. the best use of resources) for addressing the original problem?
 - ▶ *Rental assistance the largest barrier to the attraction and retention of GPs and AHPs? How suitable is the scheme to addressing the root cause of the problem, or symptoms of the problem?*
- ▶ What other local, state or federal programs, policies or initiatives exist to support and/or increase the rural GP workforce?
 - ▶ *Aware of comparable schemes that act as competition?*
- ▶ What alternative service delivery options by Council, if any, can be considered (e.g. to improve the use of resources)?
 - ▶ *Quarantined housing for health professionals? Subsidies to support home ownership? Travel vouchers to visit family and friends from previous location of residence? Direct subsidy to GP or AHP?*

Former scheme participants

Objective

Our primary objective in consulting with former Scheme participants is to capture their firsthand experiences, insights, and perspectives regarding the implementation, impact, and effectiveness of the Medical Services Housing Scheme.

Approach

An hour discussion with each Clinic via Teams

Organisations

- ▶
- ▶
- ▶
- ▶

Further analysis the stakeholder could support

- ▶ Data analysis on occupancy rates of roles compared to the desired level of roles required to meet demand; and
- ▶ Desktop research into housing/rental availability, incentives by other councils/governments.

Key line of questioning

Contextual

- ▶ Understanding the participants previous level of engagement with, and utilisation and perception of the MSHS.

Effectiveness

- ▶ To what extent has the MSHS been effective in achieving its original objectives?
 - ▶ *Previous ability to service local demand? Previous demonstrated ability to provide continuity of care? Recorded reduction in turnover? Previous ability to extend clinic hours? Less reliance on locum or FIFO staff?*
- ▶ What factors (e.g. internal, external) have enabled or hindered achievement of the objectives?
 - ▶ *Rationale for no longer being a participant in the Scheme? \$300 sufficient? Did your practice offer further subsidies? Same challenges in attraction vs. retention? Broader liveability factors at play? Competition with other regional townships?*

Impact

- ▶ What impact has the MSHS had on the community and stakeholders (whether positive or negative, intended or unintended)?
 - ▶ *Previous increase in referrals to specialists? Any recorded reduction in presentations to ED/Karratha Health Campus? Was there an administrative burden? Perspectives on eligibility criteria?*
- ▶ Does the original problem still exist? What impact would cessation of the scheme have on the community and other stakeholders?
 - ▶ *Demonstrated change since cessation of participation in the Scheme? Is the GP/AHP labour force constrained irrespective of scheme?*

Efficiency

- ▶ Does the scheme remain appropriate (e.g. the best use of resources) for addressing the original problem?
 - ▶ *Rental assistance the largest barrier to the attraction and retention of GPs and AHPs? How suitable is the scheme to addressing the root cause of the problem, or symptoms of the problem?*
- ▶ What other local, state or federal programs, policies or initiatives exist to support and/or increase the rural GP workforce?
 - ▶ *Aware of comparable schemes that acted as competition?*
- ▶ What alternative service delivery options by Council, if any, can be considered (e.g. to improve the use of resources)?
 - ▶ *Quarantined housing for health professionals? Subsidies to support home ownership? Travel vouchers to visit family and friends from previous location of residence? Direct subsidy to GP or AHP?*

Enquiring about the scheme

Objective

Our primary objective in consulting with organisations who have enquired about the scheme is to capture their current challenges, understand their specific needs for assistance and whether the absence of such a scheme could threaten their operational sustainability.

Approach

An hour discussion with each Clinic via Teams

Organisations



Further analysis the stakeholder could support

- ▶ Data analysis on occupancy rates of roles compared to the desired level of roles required to meet demand; and
- ▶ Desktop research into housing/rental availability, incentives by other council/governments.

Key line of questioning

Contextual

- ▶ Understanding the potential participants level of engagement with, and utilisation and perception of the MSHS.

Effectiveness

- ▶ To what extent has the MSHS been effective in achieving its original objectives?
 - ▶ *What has attracted you to enquire about the scheme? Ability to extend clinic hours? Less reliance on locum or FIFO staff? What is your current ability to service local demand?*
- ▶ What factors (e.g. internal, external) have enabled or hindered achievement of the objectives?
 - ▶ *Do you believe \$300 will be sufficient? Would your practice offer further subsidies? What are your current challenges in attraction and retention? Broader liveability factors at play? Competition with other regional townships?*

Impact

- ▶ What impact has the MSHS had on the community and stakeholders (whether positive or negative, intended or unintended)?
 - ▶ *How do you think the Scheme will impact on the broader health continuum of GP and AHP availability? Increased referrals to specialists? Reduction in presentations to ED/Karratha Health Campus? Perspectives on eligibility criteria and potential administrative burden?*
- ▶ Does the original problem still exist? What impact would cessation of the scheme have on the community and other stakeholders?
 - ▶ *Is the GP/AHP labour force constrained irrespective of any incentive?*

Efficiency

- ▶ Does the scheme remain appropriate (e.g. the best use of resources) for addressing the original problem?
 - ▶ *Rental assistance the largest barrier to the attraction and retention of GPs and AHPs? How suitable do you think the scheme will be in addressing the root cause of the problem, or symptoms of the problem?*
- ▶ What other local, state or federal programs, policies or initiatives exist to support and/or increase the rural GP workforce?
 - ▶ *Aware of comparable schemes that acted as competition?*
- ▶ What alternative service delivery options by Council, if any, can be considered (e.g. to improve the use of resources)?
 - ▶ *Quarantined housing for health professionals? Subsidies to support home ownership? Travel vouchers to visit family and friends from previous location of residence? Direct subsidy to GP or AHP?*

Government

Objective

Our primary objective in consulting with Government stakeholders capture their understanding and perception of the scheme and understand other programs, policies or initiatives available to GPs and AHPs.

Approach

A 30 min discussion with each Government department via Teams

Organisations

- ▶ [Redacted]
- ▶ [Redacted]

Further analysis the stakeholder could support

- ▶ Desktop research into housing/rental availability, incentives by other councils/governments; and
- ▶ Desktop research to understand variance between i) labour force availability, ii) local service requirements, and iii) fulfilment of service requirements by scheme participants.

Key line of questioning

Contextual

- ▶ Understanding the Scheme participants previous level of engagement with and perception of the MSHS.

Effectiveness

- ▶ To what extent has the MSHS been effective in achieving its original objectives?
 - ▶ *What do you believe is the level of influence of similar schemes? Level of accessibility of the Scheme?*
- ▶ What factors (e.g. internal, external) have enabled or hindered achievement of the objectives?
 - ▶ *Do you believe \$300 is sufficient? Known challenges in attraction and retention? Broader liveability factors at play? Competition with other regional townships?*

Impact

- ▶ What impact has the MSHS had on the community and stakeholders (whether positive or negative, intended or unintended)?
 - ▶ *What are the reported impacts on the broader health continuum of poor GP and AHP availability? Effect on specialist referrals? Effect on ED presentations? Effect on the broader health ecosystem?*
- ▶ Does the original problem still exist? What impact would cessation of the scheme have on the community and other stakeholders?
 - ▶ *Is the GP/AHP labour force constrained irrespective of scheme?*

Efficiency

- ▶ Does the scheme remain appropriate (e.g. the best use of resources) for addressing the original problem?
 - ▶ *Rental assistance the largest barrier to the attraction and retention of GPs and AHPs? How suitable do you think the such a scheme is in addressing the root cause of the problem, or symptoms of the problem?*
- ▶ What other local, state or federal programs, policies or initiatives exist to support and/or increase the rural GP workforce?
 - ▶ *Aware of comparable schemes that acted as competition?*
- ▶ What alternative service delivery options by Council, if any, can be considered (e.g. to improve the use of resources)?
 - ▶ *Quarantined housing for health professionals? Subsidies to support home ownership? Travel vouchers to visit family and friends from previous location of residence?*

Non-Government Organisations

Objective

Capture an understanding and perception of the scheme, the community impact and unintended consequences of reduced healthcare in the regions and understanding of other programs, policies or initiatives available to GPs and AHPs.

Approach

A 30 min discussion with each Agency via Teams

Organisations

- ▶
- ▶
- ▶

Further analysis the stakeholder could support

Support consultation with:

- ▶ Desktop research into housing/rental availability, incentives by other council/governments.

Key line of questioning

Contextual

- ▶ Understanding the Scheme participants previous level of engagement with and perception of the MSHS.

Effectiveness

- ▶ To what extent has the MSHS been effective in achieving its original objectives?
 - ▶ *What do you believe is the level of influence of similar schemes? Level of accessibility of the Scheme?*
- ▶ What factors (e.g. internal, external) have enabled or hindered achievement of the objectives?
 - ▶ *Do you believe \$300 is sufficient? Known challenges in attraction and retention? Broader liveability factors at play? Competition with other regional townships?*

Impact

- ▶ What impact has the MSHS had on the community and stakeholders (whether positive or negative, intended or unintended)?
 - ▶ *What are the reported impacts on the broader health continuum of poor GP and AHP availability? Effect on specialist referrals? Effect on ED presentations? Effect on the broader health ecosystem?*
- ▶ Does the original problem still exist? What impact would cessation of the scheme have on the community and other stakeholders?
 - ▶ *Is the GP/AHP labour force constrained irrespective of scheme?*

Efficiency

- ▶ Does the scheme remain appropriate (e.g. the best use of resources) for addressing the original problem?
 - ▶ *Rental assistance the largest barrier to the attraction and retention of GPs and AHPs? How suitable do you think the such a scheme is in addressing the root cause of the problem, or symptoms of the problem?*
- ▶ What other local, state or federal programs, policies or initiatives exist to support and/or increase the rural GP workforce?
 - ▶ *Aware of comparable schemes that acted as competition?*
- ▶ What alternative service delivery options by Council, if any, can be considered (e.g. to improve the use of resources)?
 - ▶ *Quarantined housing for health professionals? Subsidies to support home ownership? Travel vouchers to visit family and friends from previous location of residence?*

Example discussion guide – Current Scheme participants (1/3)

The table below provides a comprehensive list of potential questions that may be asked during stakeholder consultations, pending the flow of conversation. The final report will not draw findings on each of the questions detailed and will be more reflective of the themes that result from consultation.

Per the detailed approach section, there may also be data that could be provided by stakeholders that would support analysis that forms part of the Review.

Key evaluation questions	Potential consultations questions to be asked	Supplementary sources
Contextual		
	<ul style="list-style-type: none"> ▶ Can you please outline the interaction that you and your entity has had with the MSHS? Has this interaction been consistent year to year? ▶ What is your understanding of the MSHS? ▶ Do you pass the subsidy onto the GP and AHP directly? How do you utilise the Scheme to attract GP and/or AHPs? 	<ul style="list-style-type: none"> ▶ Past evaluations
Effectiveness		
What factors (e.g. internal, external) have enabled or hindered achievement of the objectives?	<ul style="list-style-type: none"> ▶ What have been some of the key factors, from your experience, that have either helped or hindered the access and availability of GP and AHP presence? <ul style="list-style-type: none"> ▶ Is a cap of \$300 a week a sufficient level of support to sway a GP or AHP to live in the City of Karratha, to enjoy living in City of Karratha and to stay living in the City of Karratha? Is the eligibility criteria appropriate? ▶ To what extent are other regional development factors at play? (i.e. education for children of GPs and AHPs, access to specialist care, general climate and liveability, cost of living, standard of housing etc.) ▶ What have been some of the key factors, from your experience, that have either helped or hindered the continuity of care? <ul style="list-style-type: none"> ▶ Does the practice rely less on locum or FIFO GP and AHP staff? ▶ Is the practice able to provide GP and AHP services to reflect changes in population and demographics of community? ▶ What have been some of the key factors, from your experience, that have either helped or hindered turnover of GPs and AHPs in the City of Karratha? <ul style="list-style-type: none"> ▶ Does the City of Karratha compete with other regional centres or the metropolitan to attract GPs and AHPs? ▶ What are the competitive factors that differentiate City of Karratha favourably and unfavourably? 	<ul style="list-style-type: none"> ▶ Research into housing prices, housing/rental availability ▶ Identification into other incentives by other local councils/ governments

Example discussion guide - Current Scheme participants (2/3)

Key evaluation questions	Potential consultations questions to be asked	Supplementary sources
Effectiveness		
To what extent has the MSHS been effective in achieving its original objectives?	<ul style="list-style-type: none"> ▶ How has the MSHS impacted your ability to provide GP and Allied Health Professionals (AHPs) services in Karratha? <ul style="list-style-type: none"> ▶ How many GPs or AHPs have been supported via the MSHS in your practice? ▶ Has it improved your access to service demand for GP and AH appointments? ▶ Has the MSHS afforded a level of consistency in GP and AHP presence since the implementation of the MSHS? If yes, how has this impacted the level of continuity of care for patients? What are some other favourable impacts? ▶ Since the practice's participation in the MSHS, has there been a reduction in the turnover of GPs and AHPs within your practice? Or within the City of Karratha if you can comment? 	<ul style="list-style-type: none"> ▶ Data analysis on occupancy rates of roles, and the percentage of availability
Impact		
What impact has the MSHS had on the community and stakeholders (whether positive or negative, intended or unintended)?	<ul style="list-style-type: none"> ▶ How has your involvement in the MSHS impacted the practice and practice clients? Please provide any points of both positive or negative, and intended or unintended impacts. ▶ Has there been a demonstrable impact on the broader continuum of care (e.g. increased access to GPs have reduced level of ED presentations, or increase number of specialist referrals)? ▶ Describe the favourable or unfavourable change (e.g. increase in practice opening hours, access to evening and weekend sessions, greater number of appointments available in general). 	<ul style="list-style-type: none"> ▶ Researching into the liveability scale of the local government area
Does the original problem still exist? What impact would cessation of the scheme have on the community and other stakeholders?	<ul style="list-style-type: none"> ▶ How would you describe the current state of supply of GP and AHP services? What are the major issues with the current state? ▶ How has the current state changed with the introduction and/or maintenance of the MSHS? <ul style="list-style-type: none"> ▶ In your opinion, does the initial problem the MSHS was trying to address still exist? ▶ In case of a cessation of the MSHS, what do you imagine would be the impact on the practice, practice clients, and the wider community? 	<ul style="list-style-type: none"> ▶ Research into the impacts in other areas, with no GP or medical healthcare professionals

Example discussion guide - Current Scheme participants (3/3)

Key evaluation questions	Potential consultations questions to be asked	Supplementary sources
Efficiency		
Does the scheme remain appropriate (e.g. the best use of resources) for addressing the original problem?	<ul style="list-style-type: none"> ▶ How would you describe the ongoing suitability of the MSHS in addressing the original issues it was designed to resolve? 	<ul style="list-style-type: none"> ▶ Research into other areas of what is provided. ▶ Acquiring homes/vs supporting in subsidising rentals
What other local, state or federal programs, policies or initiatives exist to support and/or increase the rural GP workforce?	<ul style="list-style-type: none"> ▶ Are you aware of any other local, state, or federal programs, policies, or initiatives that support or could potentially increase the rural GP workforce? 	<ul style="list-style-type: none"> ▶ Research to support or confirm policies/programs identified
What alternative service delivery options by Council, if any, can be considered (e.g. to improve the use of resources)?	<ul style="list-style-type: none"> ▶ Can you suggest any alternative service delivery options that might improve the use of resources or benefit the City of Karratha's healthcare system? Think about when the subsidy is provided, who it is provided to and what the subsidy is expected to be directed to. 	<ul style="list-style-type: none"> ▶ Research into other areas of what else is provided. ▶ Acquiring homes/vs supporting in subsidising rentals

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