Senate Standing Committee Rural and Regional Affairs and Transport References Committee Inquiry into Rural, Regional and Remote Medicare Access and Funding

WALGA Submission

April 2026

Table of Contents

About WALGA

The Western Australian Local Government Association (WALGA) is an independent, member-based, not for profit organisation representing and supporting the Western Australian (WA) Local Government sector.

Our membership includes all 139 Local Governments in the State. WALGA uses its influence, support and expertise to deliver better outcomes for WA Local Governments and their communities.

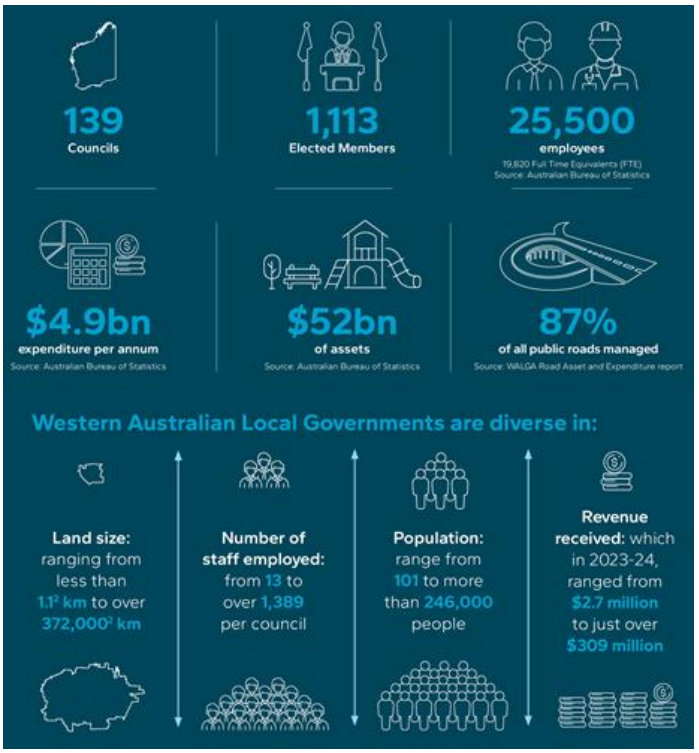
We do this through effective advocacy to all levels of Government on behalf of our Members, and by the provision of expert advice, services and support to Local Governments.

WALGA's vision is for agile and inclusive Local Governments, enhancing community wellbeing and enabling economic prosperity.

Local Government in WA

Local Government undertakes functions most appropriately implemented at the local level in the best interests of local communities.

The Local Government sector in WA is diverse. There are 139 Local Governments; 30 metropolitan and 109 regional, varying in geographical size and population. As a result, there is a significant diversity in the range of functions and services that are provided by Local Government.



Context

WALGA's Submission considers the Inquiry Terms of Reference as they relate to West Australian Local Governments. This Submission has been informed by WALGA's:

- 2021-22 Local Government Primary Healthcare Services Survey Report
- 2025 General Practice Support Survey Report
- 2026-27 Federal Budget Submission, and
- ongoing collaboration with health sector partners, including Rural Health West.

This Submission aligns to WALGA advocacy position:
3.2.2 Rural and Remote Healthcare Services:

> *The Western Australian and Australian Governments are responsible for ensuring that all West Australians have equitable access to primary healthcare services, regardless of their location. Local Governments should not have to step in to support the provision of these services for their communities.*

1. *WALGA calls on the Western Australian and Australian Governments to address the systemic failures in the provision of rural and remote primary healthcare services, including through:*
    a. *the development and implementation of adequate, appropriate and sustainable funding models*
    b. *incentivising rural and remote healthcare workforce recruitment and retention.*
2. *Local Governments should be reimbursed for costs incurred to support the provision of primary healthcare services until sustainable funding and workforce models are in place.*

September 2025

Introduction

WALGA welcomes the opportunity to provide a submission to the Senate Standing Committee on Rural and Regional Affairs and Transport Inquiry into the Australian Government's changes to rural, regional and remote Medicare access and funding (the Inquiry) on behalf of the WA Local Government sector.

The provision of healthcare services in Australia is both an Australian and State/Territory Government responsibility. All Australians deserve equitable access to primary healthcare services. For many of the seven million Australians, and more than half a million Western Australians, living in rural, regional and remote areas, the Medicare system remains inadequate.

Relatively smaller populations, complex health needs and higher cost of delivering services means that general practice (GP) services throughout rural WA are not, or only marginally, viable. The current Medicare funding model does not sufficiently account for these additional costs or market limitations. This is resulting in Local Governments intervening to ensure access to essential health services for their communities. In 2024-25 in WA alone, Local Governments spent over $9.5 million supporting GP services. This pattern of unrecognised financial support is mirrored across Australia and unintentionally masks the urgent need for Medicare reform for rural, regional and remote Australia.

While Local Governments that support primary healthcare services are justifiably proud of securing or retaining these essential services for their communities, this should not distract from the fact that such support diverts resources from other core responsibilities and is unsustainable. These responsibilities are where Local Governments are best placed to enable healthy communities and reduce pressures on the health system, such as investing in public health planning and sports and recreational facilities.

The investment in Medicare funding for rural and remote areas to date is welcomed. However, significant funding and service model reform is still required to create a healthcare system that is sustainable across rural, regional and remote areas and removes the need for additional support from Local Governments to ensure access for all Australians.

Local Government Support for Primary Healthcare

Local Governments provide critical infrastructure and services that are essential to the wellbeing, productivity and liveability of local communities. This community focused driver, and increasing community expectations, is resulting in a growing level of support for primary healthcare services outside of core Local Government responsibilities.

Increasing numbers of Local Governments are providing significant financial and in-kind support to primary healthcare services, especially GP services. Without Local Government intervention many WA rural and remote communities would not have access to essential primary healthcare services. This need for financial support persists despite bulk-billing incentives in recent years.

It is widely understood that Local Governments undertake these actions as a last resort, responding to their community's needs and their place-making expertise.

In 2023, WALGA commissioned a Local Government Primary Healthcare Services Survey (2023 Survey) of WA Local Governments to better understand the extent to which the sector was providing financial or in-kind support to secure primary healthcare services.

The 2023 Survey key findings include:

- In 2021-22, $6.8 million was contributed by 69 Local Governments (67 per cent of respondents) towards primary healthcare services,
- Of that expenditure, $5.2 million was focused on supporting GP services by 48 Local Governments (47 per cent of respondents), and
- 92 per cent of the total respondent expenditure on GP services was committed by Local Governments with populations under 5,000 residents.

A similar survey of WA Local Governments was undertaken in 2025 and demonstrated the cost the sector is bearing is increasing:

- In 2024-25, $9.5 million was contributed by 41 Local Governments (69% of respondents) for GP services.
- Of that expenditure, $8.6m (91%) was committed by Local Governments with populations under 5,000.

The survey results also highlight that the burden of support is disproportionately carried by smaller Local Governments with populations under 5,000 heavily concentrated in the Wheatbelt and Goldfields regions. Within limited ratepayer revenue, these Local Governments are contributing hundreds of thousands of dollars annually to secure GP services, as illustrated by the Local Government Rural Health Funding Alliance. WALGA understands that comparable levels of support are being provided by Local Governments across other states and territories.

Local Government expenditure to support GP services varies across WA but most commonly provide a combination of supports that can include:

- Income guarantees and incentive payments
- Provision of practice facilities
- Provision of accommodation or rental assistance
- Provision of vehicle and fuel
- Practice management and administrative services
- Direct contracting of GPs
- Locum subsidies to enable leave and service continuity.

The growing reliance on Local Governments to supplement Medicare rebates and incentives should be viewed as a symptom of structural gaps in the primary care funding model. The deficit in primary healthcare provision is well-documented as is the costly impact it has on the public hospital system. Without system-level reform that better accounts for rural market failure, these communities will remain dependent on ad hoc local subsidies, creating ongoing inequity and instability in rural GP service provision.

Impact of the 1 November 2025 Medicare changes

The 2025-26 Federal Budget included a $7.9 billion investment aiming to increase the rate of bulk billed GP consultations to 90 per cent by 2030. The investment was implemented through two programs; extending the Medicare Benefits Scheme (MBS) bulk billing incentive items to all Australians and offering an additional incentive for GP practices that agree to bulk bill all eligible patient consultations, 'universal bulk billing'. The programs built on the 2023-24 Federal Budget investment of $3.5 billion to triple the bulk bill rebate rates for children and concession card holders.

Australian Institute of Health and Welfare data shows that as of January 2026 the bulk billing rate for WA was 73% and has remained almost constantly at that level over the last three years. This compares to the national bulk billing rate of 81%. Both bulk billing rates fall short of the required trajectory to reach the 90% rate by 2030.

These investments focus on reducing out of pocket costs of a GP consultation but do not resolve the structural limitations embedded in the existing funding model for rural and remote practices. The changes also have limited impact in lower socio-economic areas with existing high proportions of bulk billing eligible patients.

Delivering GP services in rural and remote locations often cannot generate the level of Medicare revenue required to cover practice overheads. As a result, these locations are less attractive to providers and require additional incentives to secure and retain GP services.

Discussions with health sector stakeholders and WA GPs indicate that the additional incentives implemented on 1 November 2025 are not delivering the level of impact needed to make the current model sustainable as they do not offset the higher costs and complexities of providing care in rural and remote areas.

Financial sustainability of independently owned rural general practices

The fragile financial stability of small independent GPs in WA is clearly demonstrated by the level of support being provided by Local Governments. This is particularly acute in towns with populations under 5,000 and those classified as Modified Monash Model Categories 5–7. In these locations, GPs frequently operate as solo practitioners or in very small practices without the economies of scale available in larger medical practices or organisations. Fixed costs such as practice administration, nursing, practice facilities, software and equipment remain high, regardless of patient volume. Patients in these communities rightly expect equitable access to healthcare, yet the current system does not make service provision economically viable without external support.

Further to this, professional isolation and shortages in critical enablers such as housing and childcare create additional challenges to recruiting and sustaining independent or solo operator practices.

Local Government support for these GPs, while grounded in pursuit of creating thriving communities and essential healthcare services, is upholding a funding model that is inadequate for current and future service demands for rural Australians.

Extent to which current Medicare settings contribute to avoidable emergency presentations and preventable hospital admissions

The data on health outcomes and healthcare spending for Australians living in rural and remote Australia is stark. Australian Institute of Health and Welfare data shows that people living in rural and remote areas have higher rates of hospitalisations, deaths and injury and have poorer access to, and use of, primary health care services than people living in major cities. In addition, the burden of disease from many preventable, chronic illnesses is higher in regional areas as is the prevalence of people living with two or more long-term health conditions. [1]

Despite the clear need for quality primary care to prevent and manage chronic conditions and reduce hospital presentations and admissions, there is an ongoing maldistribution of GPs across Australia. In outer regional, remote, and very remote areas in WA there are 77.2 full-time equivalent (FTE) GPs per 100,000 people, compared to the national average for major cities of 111.3 FTE GPs per 100,000.[2] The National Rural Health Alliance's The Forgotten Spend Report states a health-spend shortfall between urban and rural citizens of $8.35 billion in 2023-24.

Primary healthcare can provide a cost-effective means of delivering preventive healthcare that reduces pressures on the hospital system and can deliver better outcomes for communities. According to the Health of the Nation Report 2025, seventy-two per cent of GPs are already managing patient conditions that would typically be expected to be treated in a hospital emergency department or urgent care clinics. To sustain this role and reduce the burden on the hospital system requires investment, commitment and leadership by the Australian State/Territory Governments to innovate and implement flexible funding models that enables placed-based primary health care solutions tailored to community need.

Adequacy of Medicare support for the mixed-team models of care

Mixed-team models provide a combination of medical practitioners to meet patient and community need. Typically, these models combine the services of a GP, nurse and other allied health professions. By maximising practitioner scopes of practice, accessing multiple funding streams and combining administration costs, mixed-team models can provide sustainable primary care in rural and remote areas in which the current Medicare system is not adequate. Mixed-team models hold particular potential in areas with complex service demand and limited workforce supply.

Under the current Medicare funding model, examples of mixed-team models are limited to viability investigations and pilots that utilise short term incentive payments and grant funding such as the General Practice Incentive Fund (GPIF) program. Under the current Medicare funding model there is limited scope to enable seed funding or long term flexible funding options to implement and embed innovative models of primary care such as mixed- teams.

WALGA, in partnership with Rural Health West and other key WA health sector stakeholders, is undertaking work to examine a range of alternative service and funding models for primary health

[1] Rural and remote health - Australian Institute of Health and Welfare
[2] 10 Primary and community health - Report on Government Services 2026 | Productivity Commission

care in rural and remote Western Australia. This work will identify and propose a set of models that have the potential to enable more sustainable, flexible, and locally responsive primary care arrangements in WA rural and remote settings and remove the need for Local Government financial support. Initial discussions have highlighted the benefits and flexibility of mixed-team models.

Reforms needed to ensure Medicare is fair, workable and sustainably funded

The current Medicare funding model, built on a standardised fee-for-service and rebate system, is not providing a sustainable or appropriate level of primary healthcare across Australia. Increasing the level of Medicare rebates or GP incentives will not address the structural challenges of small populations and higher operational costs for rural and remote primary healthcare. System-level reforms are required.

The work that WALGA is progressing with WA health sector stakeholders is investigating the viability of alternative service and funding models to address these service challenges for rural and remote communities. This work draws on evidence from existing investigations and pilots across Australia and is expected to have relevance beyond WA. The work will support policy discussions with the Australian and WA State Government on viable directions for reform. The group welcomes further discussion on this work with the Committee.

Initial discussions have highlighted the benefits of models that can respond to local need, enable community engagement and embraces a realistic and sustainable primary healthcare service response.

The group's investigations to date have noted three key issues:

1. It is highly unlikely that a single model would be effective across the full range of rural and remote contexts. Adaptation of models, or model elements, will be required to support equitable outcomes across rural and remote communities.
2. Further work on detailed modelling, contextual nuancing and real-world testing to assess feasibility and impacts will be required before implementation.
3. Work to develop alternative service models across Australian jurisdictions to date have not progressed beyond scoping or heavily funded pilots, suggesting the need for additional seed funding and increased eligibility that enables collective approaches.

Leadership, strategic direction and collaboration from the Australian and state and territory governments will be central to successfully investigating and establishing alternative service and funding models.

Conclusion

WALGA thanks the Senate Standing Rural and Regional Affairs and Transport References Committee for undertaking an inquiry into this important issue and the opportunity to provide a submission.

The growing expectation that Local Governments underwrite the financial viability of GP services is neither sustainable nor appropriate. Western Australia Local Governments are facing a significant cost impost in providing in-kind and financial support for vital primary healthcare services for their rural and remote communities. This pattern of unrecognised financial support is mirrored across Australia and unintentionally masks the urgent need for Medicare reform for rural, regional and remote Australia.

Incremental adjustments to Medicare rebates including the bulk-billing incentive changes introduced on 1 November 2025, are unlikely to resolve the issue raised by this Inquiry. This will require reforms that embrace innovation to service and funding models that are place-based and adaptable across the diversity of rural communities.

Without reform, Local Governments will continue to bear the cost of maintaining GP services in areas where the Medicare system is failing — a role they are neither designed or resourced to undertake and that significantly impact their other responsibilities to community. Local Governments have an important role in placemaking and are a key stakeholder in discussions on what a fair, workable and sustainable primary healthcare system looks like for rural and remote Australia.

Collaboration between all levels of Government, healthcare providers, and community stakeholders will be essential to develop and implement reforms that can achieve meaningful change in rural healthcare that could have positive impacts on the whole healthcare system.

For enquiries on this Submission please contact Hannah Godsave, Manager Community Policy, at hgodsave@walga.asn.au or (08) 9213 2074.