ALGA
Australian Local Government Association

ALGA Submission

Senate Rural and Regional Affairs and Transport References Committee

Inquiry into Rural, Regional and Remote Medicare Access and Funding

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Building Better Communities.

Introduction

The Australian Local Government Association (ALGA) is the voice of local government in Australia, representing 538 councils across the nation. ALGA was established in 1947 and throughout its history has been actively involved in issues of national significance affecting local government and local communities.

In structure, ALGA is a federation of state and territory local government associations. This submission should be read in conjunction with any separate submissions received from state and territory associations as well as individual councils.

ALGA welcomes the opportunity to make a submission to the Senate Rural and Regional Affairs and Transport References Committee inquiry into rural, regional and remote Medicare access and funding. Across Australia, local governments are increasingly acting as the **de facto safety net for primary and community healthcare**, stepping in where existing market based and government funded service provision has failed to meet community need. This puts a direct cost-shifting burden onto local government.

Evidence provided by ALGA's members demonstrates that current Medicare funding, aged care and disability funding, and workforce incentive settings are **not sustaining viable services** in many rural, regional and remote communities. This has resulted in **significant cost shifting to local government**, worsening health inequities and growing pressure on councils' capacity to deliver core local services. This submission draws on evidence to outline the impacts of current settings and identify reforms required to ensure Medicare and related health funding arrangements are fair, workable and sustainable.

Reforms Needed to Ensure Medicare is Fair, Workable and Sustainable

Based on evidence from local governments across all jurisdictions, ALGA supports the following reforms:

- Mandatory rural and remote stress-testing of all Medicare, aged-care and primary care reforms prior to implementation.
- Reform of workforce distribution and Medicare Provider Number methodologies to reflect service catchments rather than postcode-based assessments.
- Clear acknowledgement of local government in health system planning to meet associated funding pressures where local government is the only service provider in thin markets.
- Mechanisms to address ongoing cost shifting, including reimbursement for council expenditure incurred to sustain essential health, aged care and disability services.
- Funding models that recognise the role of infrastructure and housing in service viability and cover true operating costs, including overheads and capital.
- Flexible, locally led pilot programs and block-funding models tailored to community need.
- Telehealth settings that complement, rather than replace, place-based primary and community care.

Sincerely,

Mayor Matthew Burnett
President

Impact of the 1 November 2025 Medicare Changes on Access to Primary Care

Local governments report that the 1 November 2025 Medicare bulk-billing changes have not delivered meaningful improvements in access to primary care in many rural and remote communities. In areas characterised by small population bases and socioeconomic disadvantage, most patients were already eligible for bulk billing prior to the changes. As a result, increases to rebate rates have had limited impact on service viability.

Evidence presented through ALGA's Rural Health Advocacy forum reinforced that Medicare rebates do not reflect the true cost of delivering primary healthcare in thin or failed markets. Councils reported that, even where clinics continue to bill Medicare, the gap between revenue and operating costs must be met through local subsidies, infrastructure provision or workforce incentives. Incremental changes to rebate rates are therefore insufficient to address the structural challenges associated with delivering primary care in rural, regional and remote communities.

Financial Sustainability of Independently Owned Rural General Practices

Across jurisdictions, evidence shows that a growing number of independently owned rural general practices are **not commercially viable** under current Medicare funding and incentive arrangements. Local governments are increasingly providing direct and indirect financial support to retain GP services, including practice subsidies, accommodation assistance, infrastructure provision and incentive packages.

Data from Western Australia demonstrates the scale of this issue, with local governments contributing $9.5 million in 2024–25 to support GP services alone, up from $7.8 million in 2021–22. Ninety-one per cent of this expenditure was incurred by councils serving populations under 5,000 people, and more than two-thirds of councils are now providing support packages for GP services.

This trend was echoed by councils in South Australia, New South Wales, Victoria, Queensland and the Northern Territory. Councils consistently reported that these costs are met through retained earnings, increased rates, or the reallocation of funding from core services. While councils intervene to protect community wellbeing, sustaining primary healthcare sits outside the traditional role and funding base of local government and represents ongoing, systemic cost-shifting.

This pressure is occurring in the context of broader and well-documented challenges to the financial sustainability of local government. ALGA has previously advised Parliament that councils are experiencing declining real revenue, increasing infrastructure backlogs and expanding service delivery responsibilities, driven in part by persistent cost-shifting from other levels of government. These systemic pressures significantly constrain councils' ability to absorb additional functions, including the ongoing subsidisation of primary healthcare services. ALGA outlined these challenges in its initial and subsequent submissions to the House of Representatives Standing Committee on Regional Development, Infrastructure and Transport inquiry into local government sustainability.

Aged Care and Disability Services as Related Matters

Evidence from councils highlights that local governments play a **critical "last resort" role** in delivering aged care and disability services in regional, rural and remote communities. In many small and isolated communities, councils are the only providers of home support programs, aged-care centres and disability services, due to the absence of alternative NGOs or private providers.

This role is particularly evident in New South Wales, where councils are directly involved in aged care delivery beyond remote locations. Nine regional and rural councils currently provide residential aged care services, and more than 30 councils deliver the Commonwealth Home Support Program (CHSP). CHSP services are non-clinical, in-home supports, such as meals, transport, social support and basic home maintenance, that are essential to enabling older people to remain living independently. These services

have not yet transitioned into the Support at Home program and remain a core area of council service delivery.

Evidence from councils in other jurisdictions indicates that the cumulative impact of aged care reforms is also driving councils to withdraw from aged care service delivery altogether. Submissions from ALGA and local government associations in Queensland, South Australia and Victoria to recent Commonwealth consultations and Senate inquiries highlighted that increased governance and compliance obligations under the Support at Home reforms, including the introduction of expanded Responsible Person provisions, are creating significant legal, administrative and risk exposure for councils[1].

Councils also raised concern about the loss of block funding arrangements and the move toward more transactional, individualised funding models, which undermine service viability in thin markets and remove the certainty required to sustain workforce, infrastructure and regional service coverage. For some councils, these combined pressures are prompting decisions to exit aged care programs, further reducing local service availability and shifting pressure onto hospitals, families and already stretched state systems.

Without councils delivering daily meals, personal care, transport to clinics and shops, social activities and basic home support **across many regional, rural and remote communities**, older people and people with disabilities in many remote communities would have limited or no access to local services. These services form an essential part of the primary and community care continuum and are directly relevant to the inquiry's consideration of Medicare access and funding.

Despite this essential role, funding models are insufficient to support sustainable service delivery. Federal, State and Territory program grants typically fund only direct service delivery costs and fail to cover corporate overheads and capital expenses, including management, administration, IT, insurance, vehicles and staff housing. As a result, many councils incur ongoing operating losses on aged-care and disability programs and are forced to cross-subsidise Commonwealth services with limited local revenue, placing small councils under acute financial strain.

Interaction with Aged Care Reforms and Cost-Shifting

The introduction of the **Support at Home** aged-care reforms from 1 November 2025 has exacerbated existing funding pressures in remote communities. Under the new arrangements, clients are required to contribute up to 17.5 per cent of the cost of "everyday living" services, with only clinical care fully funded by government.

In remote NT communities, many clients are unable to afford these co-payments. Councils reported that they are unwilling to pursue debt recovery against elderly and vulnerable residents and instead absorb the funding shortfall to maintain essential services such as regular showers, meals and home support. Councils are therefore forced to choose between withdrawing basic care or continuing services at their own expense—an untenable position that further entrenches cost-shifting and undermines service sustainability.

Avoidable Emergency Presentations and Preventable Hospital Admissions

Local governments consistently reported that inadequate access to sustainable primary, aged-care and disability services contributes to avoidable emergency department presentations and preventable hospital admissions. Councils described situations where service instability or withdrawal led to earlier health

[1] https://www.aph.gov.au/DocumentStore.ashx?id=b2e458fe-25ef-4a6b-90b6-32bd268aa695&subId=786307

deterioration, increased reliance on hospitals, and greater strain on already stretched regional and remote health systems.

In the Northern Territory in particular, hospitals often function as default care providers in the absence of adequately funded community-based services. Evidence from councils indicates that it is more effective and equitable to fully fund local services upfront, rather than incurring higher downstream costs through hospital admissions and residential aged-care placements resulting from inadequate home-based care.

Adequacy of Medicare Support for Mixed-Team Models of Care

Local governments are supporting a range of mixed-team and place-based models of care involving general practitioners, nurses, allied health professionals, visiting specialists and Rural Generalists. While these models can improve access and continuity, current Medicare and health funding settings do not adequately support their implementation or long-term sustainability.

Councils emphasised that no single model is suitable for all communities, given the diversity of geography, population size and health needs across rural Australia. Evidence supports the need for flexible funding arrangements, including block-funding and pilot programs, that reflect population health needs, service catchments, workforce realities and distance. ALGA supports appropriately funded reforms that enable locally driven, collaborative models co-designed with communities and local governments.

Infrastructure, Housing and the Viability of Medicare-Funded Services

Councils consistently identified infrastructure and housing as critical enablers of healthcare access. Evidence from across jurisdictions shows that local governments routinely fund or deliver GP clinics, health centres and housing for medical, aged-care and disability workers, often where state-owned facilities are unavailable, inadequate or poorly maintained.

Housing shortages were repeatedly identified as a decisive barrier to workforce attraction and retention, particularly in very small and remote communities. Despite this, councils reported that access to infrastructure funding is inconsistent, highly competitive and often excludes local government, even where councils are the primary delivery agent. These costs are not recognised in Medicare or aged-care funding models, despite being essential to sustaining services.

This local perspective aligns with the Australian Government's increased focus on housing for essential workers, including health professionals, as part of its broader housing reform agenda. Through mechanisms such as the Housing Australia Future Fund, the National Housing Accord and targeted health worker accommodation programs, the Commonwealth has acknowledged the link between housing affordability and workforce stability, particularly in regional, rural and remote areas. However, councils note that while national programs are expanding supply at scale, there remains a structural gap in recognising and directly supporting the role of local government as a delivery partner in small and thin-market communities where health service viability is most fragile.

Impacts of Medicare Rules on Small Community Clinics Compared with Corporate Providers

Smaller, community-embedded clinics in rural and regional areas face disproportionate challenges under current Medicare rules and incentive arrangements. ALGA's members highlighted that workforce distribution policies and Medicare Provider Number settings, often based on postcode-level assessments, do not adequately reflect the large catchment areas serviced by regional centres.

As a result, communities can be disadvantaged in attracting and retaining practitioners despite clear demand. Councils reported that this often leaves them as the only entity capable of intervening to maintain services, reinforcing inequities between communities and further entrenching cost-shifting.

Case Studies from Local Government

Case study 1: Remote NT councils delivering last-resort aged care

Remote Northern Territory councils reported acting as last-resort providers of aged care and disability services, delivering daily meals, personal care, transport and home support in communities where no alternative providers operate. Program grants cover only direct service delivery costs, leaving councils to fund administration, vehicles, staff housing and insurance. Following the introduction of aged-care co-payments under Support at Home, councils absorbed unpaid client contributions to avoid withdrawing essential services from financially vulnerable residents.

Case study 2: Small remote SA council sustaining GP services

A small remote council in South Australia serving approximately 1,100 residents reported funding the construction of a health centre, providing housing for medical practitioners and meeting ongoing recruitment and incentive costs to retain GP services. The council estimated annual health-related expenditure of approximately $160,000–$180,000, funded through general revenue. The community is located more than two hours from the nearest major hospital, making local primary care essential.

Case study 3: Regional NSW council funding health services under rate capping

A regional council in New South Wales operating under rate-capping arrangements reported spending approximately four per cent of its total rate income on health services. This expenditure was primarily directed toward providing medical centre facilities, housing for doctors, and transport and logistical support to enable practitioner access, rather than delivering clinical services directly.

This expenditure displaced funding that would otherwise support core services such as roads, libraries and emergency management. The council noted that providing health services reduced pressure on other levels of government to intervene, despite the arrangement being financially unsustainable.

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- Funding models that recognise the role of infrastructure and housing in service viability and cover true operating costs, including overheads and capital.
- Flexible, locally led pilot programs and block-funding models tailored to community need.
- Telehealth settings that complement, rather than replace, place-based primary and community care.
- Recognition that telehealth must complement, not replace, place-based primary care services.

Conclusion

Local governments are already playing a critical role in sustaining access to primary healthcare, aged care and disability services in rural, regional and remote Australia. Without substantive reform to Medicare and related funding arrangements, this role will continue to expand in an unsustainable and inequitable manner, masking system failure and placing increasing pressure on councils and local communities.

ALGA urges the Committee to recommend reforms that deliver sustainable, community-appropriate services without further cost-shifting to local government. Addressing these issues is essential to improving health outcomes, strengthening regional communities and ensuring the long-term viability of Australia's healthcare system.

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