SHIRE OF
WESTONIA
A vibrant community lifestyle

Councillor Information Bulletin

For the Ordinary Council Meeting
held on Thursday 26 March 2026

INDEX

SHIRE OF WESTONIA

March/April 26

Date & Time	What	Where	Who
Monday 9 March	WALGA Great Eastern Zone Training at Westonia	Old Hall	Cr Crees & Cr Crews
Thursday 11 March	WEROC Medical Students Thank You Dinner	Stadium	Crs and staff
Tuesday 17 March	Department of Local Government, Industry Regulation and Safety	East Perth offices	ACEO & Heather Lockyer
Monday 23 March	Water Corp - CW04322 Goldfields Pipeline catch up	Shire Office	President & ACEO
Tuesday 24 March	Audit Entrance Meeting	Chambers	Councillors, Senior Staff
Thursday 26 March	Council Meeting	Chambers	Councillors, Senior Staff
Wednesday 29 April	WEROC CEO Meeting	Zoom	ACEO

ACTING CEO'S REPORT

- **GENERAL MATTERS**
- The WEROC Medical Immersion group visited the community from Tuesday 10 to Friday 13. The purpose of the visit was to provide participants with exposure to rural health services and community life while strengthening connections with the region. During their stay, the group took part in a range of activities, including a town tour and farm tour to gain insight into local industries and lifestyle. Community engagement activities included lawn bowls and a bingo session with senior residents. The group also delivered a Teddy Bear Hospital program at Moorine Rock Primary School and toured Southern Cross Hospital to better understand local healthcare services. A Community Thank You Dinner was held on Thursday evening to acknowledge the group's visit and provide an opportunity for informal interaction with community members.

- The Raffle for Progress has now been finalised following the successful completion and submission of the Bank Guarantee to the Department of Local Government, Industry Regulation and Safety. The raffle is scheduled to go live on 21/03/2026, offering participants the opportunity to enter for a chance to win a 2026 Toyota Hilux. We look forward to the community's support as the raffle goes ahead.
- Due to the current fuel situation, Bill and I have decided that the 24-hour fuel depot will be closed to the general public and will now be available exclusively for community members.
- Heather and myself attend a meeting on Tuesday 17 March Department of Local Government, Industry Regulation and Safety in Ref_179-2526 - Industrial relations system.

- **DELEGATED AUTHORITY ACTIONS**

  Nil

- **ROADCREW**
- Bituminous sealing works were completed on floodways along Six Mile Gate Road and Four Mile Gate Road.
- Bituminous sealing was also carried out on a 1.3 km section of Carrabin South Road from the railway line.
- Diorite Street and Mica Street received bituminous surfacing.
- Tree slashing was undertaken along Clothier and Henderson Roads.
- Maintenance grading was carried out on roads south of the Shire.
- The construction crew has now moved on to a 4.3 km section of the Warralakin Road reconstruction project.

- **TOWN**
- After Chris Clarks resignation, Bill was able to interview Juan Petroni and employee him as our new Horticulturalist
- Bob has been setting up for the Ball event happening on Saturday Night.

- **PLANT HOURS**
  The following is a list of plant and vehicle kilometre and hour readings for the period ending 31.03.26.

Item		28.02.26	31.03.26
P1	*CAT 140 GRADER*	4,414hrs	4,459hrs
P2	*CAT 12M GRADER*	10,826hrs	10,921hrs
P3	*PRIME MOVER (KENWORTH)*	81,343kms	82,831kms
P4	*ROAD TRAIN (NEW FREIGHTLINER)*	178,582kms	180,333kms
P5	*JOHN DEERE LOADER*	12hrs	23hrs
P6	CAT ROLLER (SKIP)	3,079hrs	3,110hrs
P7	*MINI-EXCAVATOR*	1,463hrs	1,472hrs
P8	*TELEHANDLER JCB*	635hrs	658hrs
P9	*TOYOTA (GRADER UTE)*	85,179ms	86,145ms
P10	*MITSUBISHI CANTER*	38,664ms	39,619ms
P11	*TOYOTA HILUX (HCS) WT 35*	114,915kms	115,092kms
P12	*JOHN DEERE (5100)*	2,821hrs	2,821hrs
P14	*TOYOTA LANDCRUISER GXL (CEO)*	32,523kms	32,523ms
P15	*TOYOTA HILUX D/CAB (W/SUPER)*	77,677kms	77,677ms
P16	*TOYOTA RAV4 (Community)*	21,431kms	21,kms
P17	*TOYOTA HILUX DUAL CAB*	82,345kms	84,732ms
P19	*FAST ATTACK*	22,729kms	22,893ms
P20	*FIRE TRUCK*	7,564kms	7,635kms
P18	*WESSY BUS*	155,567kms	155,992kms
P22	*KUBOTA RIDE ON MOWER (OVAL)*	2,203hrs	2,204hrs
P23	*TOYOTA MINI-BUS (WT COM V)*	51,249kms	51,249kms
P24	CAT ROLLER (LOLA)	3,464hrs	3,520hrs
P25	*MICK's BEAUT UTE*	188,103kms	188,815kms
P27	*TOYOTA PRADO GXL (DCEO)*	44,870kms	46,683kms
P28	*TOYOTA HILUX UTILITY (TOWN)*	12,800kms	13,306kms
P29	*MOWER*	156hrs	17hrs

COMMUNITY DEVELOPMENT AND WELLBEING REPORT

COMMUNITY DEVELOPMENT REPORT

Working group meetings held every 3rd Wednesday of the month:
Event planning – Back to our Roots, Bring your Boots Ball, Community fitness, active Farmers and move it or Loose it and Westonia Swimming Pool, Laps for Life
Westonia Workers WhatsApp group
CRC – Jasmine and Stacey attended the Co-design Workshop held by the DPIRD WACRN team. This workshop was designed to glean feedback from CRC leaders in how to shape the new look contract in 2027. With the changes to the Contract DPIRD are hoping to make meeting deliverables realistic and relevant to our CRC's now and into the future.
DPIRD Sheep and goat eID implementation project – Stacey Met with Julie Mercer Project Officer, NLIS Sheep & Goat eID Animal Product Integrity & Traceability Animal Biosecurity and Welfare. Regarding using the new eID reading Wand and rollout which will be enforced by July 2026. They are running eID information sessions on a variety of subjects in the coming months and we have offered to host one here. They have given us some new brochures to put on display.
Westonia's BRBB Ball went really well being the first time we have run something to this scale out of the hall in a very long time it was great to have the support of Shire and community to pull this all together. We tried to keep cost's low by sourcing donations and upcycling where ever possible. Bob, Jonsey, Mick & Pete have done and amazing job getting the Hall whipped in to shape. The new ramp & steps were a godsend and the rustic decorations, lighting under the tree's to make an outdoor room, the new/old bar (thanks to Heather and Bob) really made the place pop. The Tickets were very slow to sell but we got there in the end. We had a really good mix of locals and visitors. Music was fantastic thanks to Sophie Jane and her band, the Westonia Playground Fundraising group ran the Bar with Daimo Geier who put his hand up early and helpers to serve refreshments. games and Mikayla D. was our fabulous MC for the evening. A huge thank you again needs to go out to our volunteers who help plan, set up, cook, make sure people didn't go thirsty and help with the pack down they tirelessly show up when we need them.

Grant applications & award nominations submitted:

Succsessful application with the Collgar Community Fund grant $6000 to go towards the 21st March 2026 "Back to our roots, Bring your Boots" Ball.
Future grant opportunities & award nominations:
Signed up with Easy Grants and am on the hunt for grants for Wessy on the Green 2027. Quantas regional grants are open now and close at the end of May, Bendigo Bank will be another avenue, we will also send out Sponsorship letters to companies asking for corporate sponsorship with naming rights to our event.

WELLBEING REPORT

Weekly Activities ongoing Bingo, Sewing room sessions, Scrabble/Mahjong
Bus trips NIL so far
Active Farmers with Emilie Menze Every Wednesday (2x General Fitness classes and seniors' session) getting real traction with over 20 people showing up each day and some unexpected faces in attendance, which is so fantastic.

Age Care

Westonia Home Care Services
We are continuing to provide community Wellbeing activities
We continue to provide Meals on wheels, Lite N Easy Equipment and Aids for our clients Westonia Home Care Services Clients: 23
New clients about to join service: 2
Staff delivering services: 5
Services: Administration and Package management, Cleaning and Household tasks, Medical, Personal Care, Social Support, Support work, Gardening & Maintenance, Meals, Allied health, Medicine management, Equipment and Home modifications.

Monthly and annual reporting – Quarterly and annual financial reports to Department of health, disability and ageing. SaHCC annual reporting (Support @ Home cost collection). Various SaH rollout training sessions (online) ongoing.

Community activities and resources
2026 Activities/ Events:
Bingo every Thursday 9-12 Pax
Scrabble every Tuesday 5 Pax

WESTONIA TOURIST PARK

The Park farewelled Jae in January, we wish Jae all the best with the next venture and want to thank her for her time and dedication to the park and keeping it in pristine condition. There was a lot of interest in this role, the park would like to welcome Barry our new caretaker, Barry has managed multiple parks throughout his career and brings a wealth of knowledge.

REPAIRS & MAINTENANCE

Various minor repairs and maintenance are ongoing. Focal area being bathroom maintenance (fixtures and disabled bathroom upgrade)

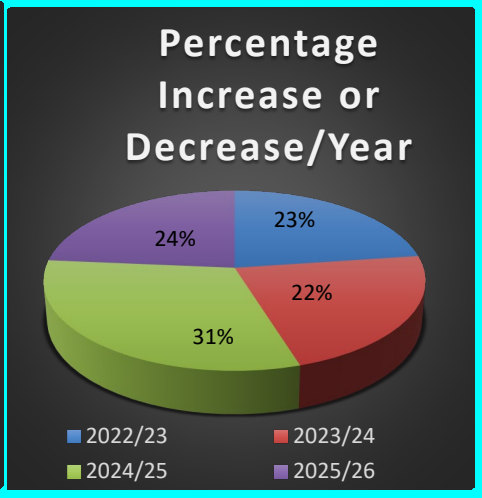
Disabled toilet drainage will need some major work as tree roots have made their way into the pipes.

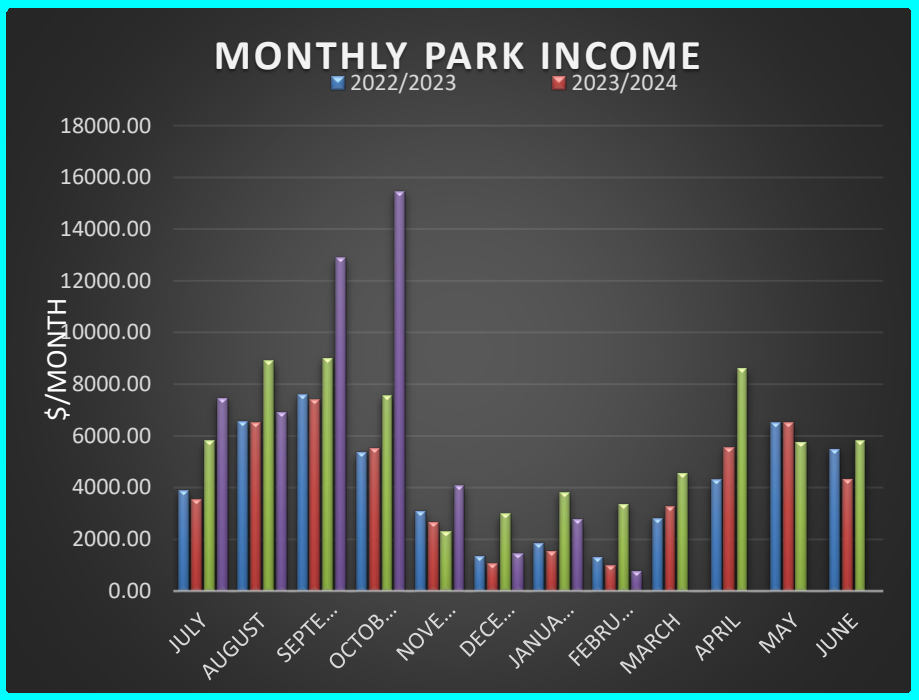
FUTURE PROJECTS

Permanent signage required to say "If office is unattended, please ring the caretakers phone or Shire office alternatively you can visit the Shire office during business hours Monday to Friday to complete your booking".

Overflow – new signs needed for sites and information sign needed to describe who to ring or see to book in and outline that you must un-hook. Defined bays might be a good idea for this area.

STATISTICS





HOOD-PENN MUSEUM and COOPERS GARAGE MUSEUM

Ramelius Resources gave an extremely generous donation from the sale of household items no longer needed since the closure of the mine. The museums are now open for the weekend visitors

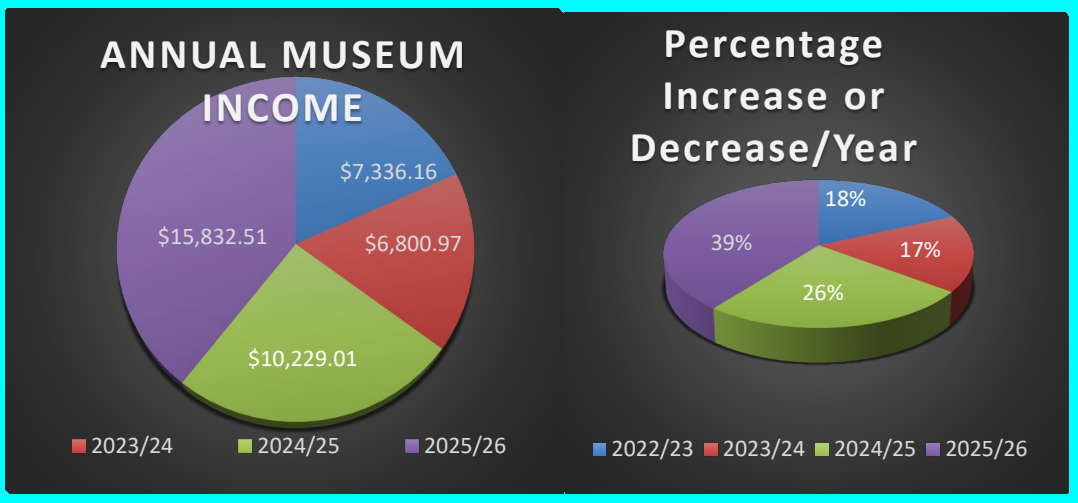
REPAIRS & MAINTENANCE

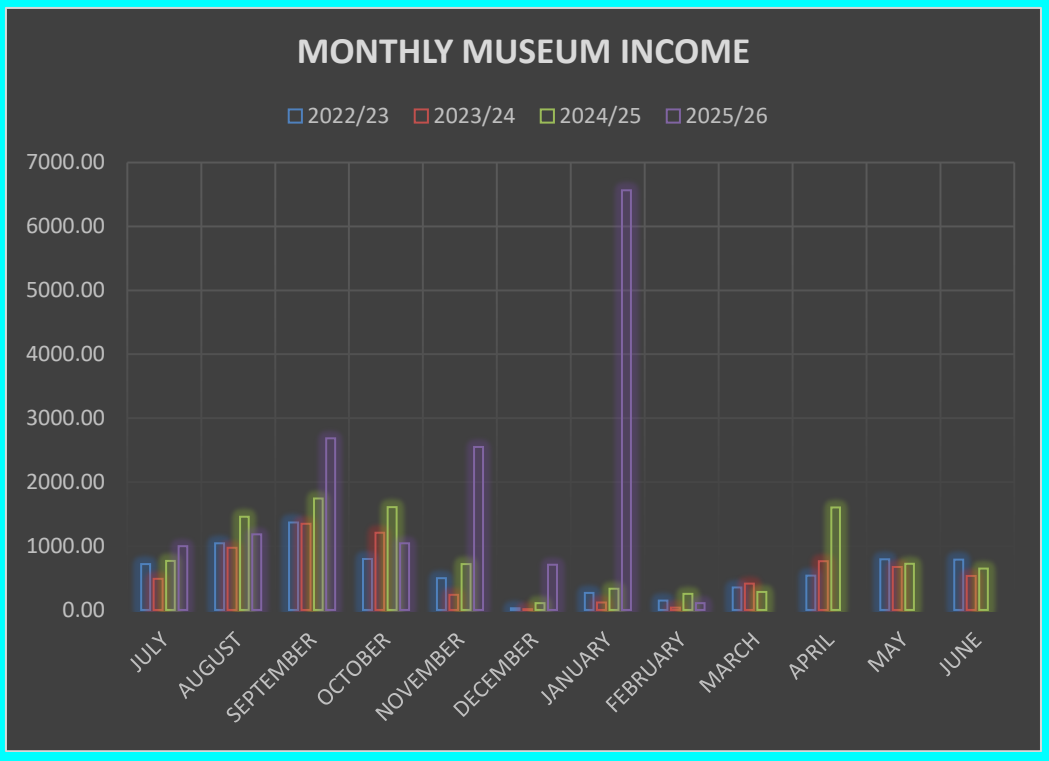
Various minor repairs and maintenance ongoing RECENT PROJECTS
War Memorial moved from OM Hall and photo signs now installed.
Model War Planes hung in War Memorial scene

FUTURE PROJECTS

New scenes to be created in the existing space of the old storage room to tell the stories of our primary industries of which Westonia was founded on.

STATISTICS





Legislative Assembly

Thursday 26 February 2026

Wheatbelt Secondary Freight Network

93. **Mr Lachlan Hunter to the Minister for Transport:**

I refer to the Wheatbelt Secondary Freight Network, a longstanding partnership between the state government, local governments and the Commonwealth government, which has now been removed from the state government's infrastructure priority list, despite the Wheatbelt recording some of the worst road safety outcomes in Western Australia.

Can the minister confirm that the Wheatbelt Secondary Freight Network is no longer treated as a funding priority by her government?

Ms Rita Saffioti replied:

There is nothing like the Nationals asking about road spending that gets me excited! When in government—

Mr Shane Love interjected.

The Speaker: Member! The minister has not even started her response.

Ms Rita Saffioti: Like I said, there is nothing like a discussion about road funding in regional WA, where WA Labor is spending a record amount. I know the "MetroNats" do not get out very often; they live on the CAT bus route, so they do not get out there. They bring in their four-wheel drives and put fake dirt on the side with those little spray bottles to pretend—

Several members interjected.

The Speaker: Minister!

Ms Rita Saffioti: They are big supporters of—

Several members interjected.

The Speaker: Minister for Planning and Lands!

Ms Rita Saffioti: —the CAT bus extensions because they use them every day.

Mr Lachlan Hunter interjected.

The Speaker: Member for Central Wheatbelt, please stop interjecting, and you will get a supplementary question.

Ms Rita Saffioti: We are rolling out a record amount on regional roads through our Regional Road Safety Program. We are rolling out a record amount of funding in—

Point of order

Mr Lachlan Hunter: Point of order, Mr Speaker!

The Speaker: Member for Central Wheatbelt, this would have to be a pretty good point of order or—

Mr Lachlan Hunter: I asked a very specific question about the infrastructure priority list and the Wheatbelt Secondary Freight Network, and the minister has gone nowhere near it.

The Speaker: Member, there is no point of order. Misuse of points of order or standing orders is against standing orders. The minister is a minute into her response. She can build the background to answering your question, and she is getting there.

Questions without notice resumed

Ms Rita Saffioti: I know it is very hard for the member for Central Wheatbelt to respect anybody in this house. We have seen his performance, in particular last week in his disrespect—

Withdrawal of remark

Mr Shane Love: I ask that the minister withdraw that unfounded comment about the member for Central Wheatbelt.

Several members interjected.

The Speaker: Members! Minister, can you please withdraw that.

Ms Rita Saffioti: Sorry, what did I say?

The Speaker: Just withdraw it, please.

Ms Rita Saffioti: I actually do not remember what was offensive.

The Speaker: Then just say withdraw.

Ms Rita Saffioti: Honestly, I cannot actually remember what I said. What did I say that was—

Several members interjected.

The Speaker: No; this is not open for discussion. Please just say you withdraw.

Ms Rita Saffioti: I withdraw.

The Speaker: Thank you.

Ms Sabine Winton: Rephrase it.

The Speaker: No. Minister for Education, I am calling you for the first time.

Questions without notice resumed

Ms Rita Saffioti: In relation to Wheatbelt spending, we have invested a record amount in black spot funding, a record amount in regional road spending and a record amount to local governments. We continue to roll out spending on the Wheatbelt Secondary Freight Network. Of course, we have invested more in regional road spending not only for state roads, but we have started a program to fund local government roads. We have spent more on Wheatbelt roads than the opposition ever did. The then Leader of the National Party said Royalties for Regions was not for roads. The Leader of the National Party said that. It sold off the freight—

Mr Lachlan Hunter interjected.

The Speaker: Member for Central Wheatbelt!

Several members interjected.

The Speaker: Member for Mid-West!

Mr Shane Love: The federal Leader of the National Party funded it.

Ms Rita Saffioti: The Leader of the National Party is right; it was a partnership between this Labor government and the then federal Liberal–National government. Where were you the previous eight years? It was us who started the program. It was a state Labor Party that started the program. As I said, we have invested across all measures—the Regional Road Safety Program, grants to local governments for regional road safety programs and through the Western Australian Local Government Association agreement, black spot funding and the regional supply chain program. About 10 programs is a record amount.

Mr Shane Love interjected.

The Speaker: Member for Mid-West, I am calling you for the first time. Please stop interjecting.

Ms Rita Saffioti: That program continues just like the Regional Road Safety Program. Over 10,000 kilometres of regional roads in WA have been upgraded because the opposition left them in a shambles after eight and a half years. We have had so much

catch-up to do. We are supporting local governments in widening its roads as part of our regional road program grants to local governments. That is on top of a record increase in funding to WALGA and all local governments for regional roads. Across all measures, we are spending a record amount. We are going through a process of buying back the freight network that you sold off.

Several members interjected.

The Speaker: Members! Minister!

Mr Shane Love interjected.

The Speaker: Member for Mid-West! Minister, if could complete your comments, please.

Ms Rita Saffioti: The National Party is out there trying to set a price, trying to impact the value-for-money negotiations. Not only did the National Party sell it off, I think, for about $385 million, it is now saying we should buy it back for $5 billion. It is a 49-year lease. It has gone 25 years. I think the National Party sold it for $385 million, and now it is saying it is worth $5 billion. The National Party is trying to jeopardise negotiations because of some petty, pathetic political stunt. That is what the National Party is doing. The Liberal Party tickled its tummy to sell that off.

Point of order

Mr Liam Staltari: Already this week! The minister should direct her comments through the Chair.

The Speaker: Yes, if the minister could conclude her comments, please.

Questions without notice resumed

Ms Rita Saffioti: The Nationals sold the regional rail freight network. They were bought off on this couple of hundred million dollars from the Liberal Party for some regional roads. As a result, they impacted regional Western Australia, regional jobs and regional roads for decades.

94. **Mr Lachlan Hunter to the Minister for Transport:**

I have a supplementary question. Will the minister commit to meeting with representatives from the Wheatbelt Secondary Freight Network to discuss funding and safety upgrades for these critical freight routes in Western Australia?

Ms Rita Saffioti replied:

We have $24 million allocated in 2026–27. That is how much we have for the regional freight network, on top of everything else. That is what we do. We allocate to regional roads. Like I said, the "MetroNats" are lecturing us about regional roads.

Mr Lachlan Hunter interjected.

The Speaker: Member for Central Wheatbelt!

Ms Rita Saffioti: You know—

Mr Lachlan Hunter interjected.

The Speaker: Member for Central Wheatbelt!

Ms Rita Saffioti: —you are never here for proper debates. You hit the cocktail circuit. You are not here for vital—

Mr Lachlan Hunter: Cocktail circuit?

Ms Rita Saffioti: Yes, that is what you do, member.

Point of order

Mr Liam Staltari: I ask that the Treasurer withdraw that comment.

Several members interjected.

The Speaker: Members!

Mr Liam Staltari: I ask the Treasurer to withdraw that comment because the member is often here engaging in debate.

Several members interjected.

The Speaker: Members! Planning minister! I appreciate that it is Thursday. It has been a long week. I am not upholding that point of order, member for Carine, but if the minister can conclude her remarks. It is a supplementary question.

Questions without notice resumed

Ms Rita Saffioti: Yes, it is.

Mr Lachlan Hunter interjected.

The Speaker: Member for Central Wheatbelt, I am calling you for the—

Several members interjected.

The Speaker: Members! Member for Pilbara, I write this down, so I do not need your help, thank you very much.

Ms Rita Saffioti: The "MetroNats" are too busy hitting the cocktail circuit to be in here for vital votes. We are spending a record amount, and we will continue to focus on

improving road safety throughout WA because we are passionate about it. The Leader of the National Party at the time, who had $8.5 billion of royalties for regions money said, "Roads are not our priority." They are the exact words he said. As a result, there is enormous catch-up. The Nationals sold the freight routes. They did nothing, and the regional freight network program was started by this government, not yours.

Wheatbelt Secondary Freight Network

Grievance

Mr Lachlan Hunter (Central Wheatbelt) (9:05 am): Today, I rise to grieve to the Minister for Transport. I believe that the Minister for Wheatbelt is representing the Minister for Transport this morning. My grievance is about the state government's awful decision not to continue funding the Wheatbelt Secondary Freight Network. It is good that the minister is representing the Minister for Transport because she is also the Minister for Wheatbelt and it should greatly concern her that her government is not funding this network beyond the 2025–26 financial year. When the Minister for Wheatbelt comes out to the Wheatbelt, she will be hearing from very, very disgruntled local governments about her government's decision. This decision will have serious consequences for the condition and safety of regional roads right across the Wheatbelt and beyond. I urge her government to reconsider this decision.

The Wheatbelt Secondary Freight Network involves 42 local governments that come together to establish a program to upgrade key freight routes across the region through coordinated planning, joint investment and strategic project delivery. This network includes approximately 4,400 kilometres of local government roads across 53 priority freight routes, connecting state and national highways. Since the program first began in 2019, approximately $187 million has been invested to upgrade around 450 kilometres of freight routes across 18 key corridors. These upgrades have delivered and strengthened pavements, improved sealing standards and delivered roads better suited to modern freight vehicles. The program has improved freight reliability, strengthened road safety and built road construction capability. Importantly, minister, it operates through a cooperative funding model with around 80% of from the Commonwealth government, thanks to the former Liberal–National government that actually implemented it; 13% from the state government, a very humble request; and 7% from participating local governments. Mr Speaker, I seek leave to place on the table for the remainder of the day a number of documents.

(The papers were tabled for the information of members.)

Mr Lachlan Hunter: Today I am tabling every single one of those letters that participating local governments have written to the Minister for Transport requesting to meet with her about this horrendous decision. I will forward them to the Minister for Wheatbelt who is representing the Minister for Transport. But guess what, Mr Speaker? They have received zero responses from the Cook Labor government and Minister Saffioti.

This decision is particularly concerning given the scale of the freight task across the Wheatbelt. Western Australia recorded a grain harvest of the highest order that we have ever seen in the state of Western Australia—27 million tonnes—and guess what, Mr Speaker? When you grow that much grain in the state of Western Australia, you have to somehow cart that to port. I know that the Labor Party does not like to say it, but that is done by diesel-fuelled trucks that drive on a little thing called a road. To add to this fact, the freight is increasingly being carried by larger and heavier vehicles. Whilst these

vehicles improve freight productivity, they also place significant pressure on road infrastructure that was never designed to carry these massive loads.

This is where the fundamental issue lies. Local governments, as my good friend the member for Geraldton and the shadow minister knows, are responsible for the care, control and management of these roads, yet they do not control the policy decisions that determine how these roads are used. The state government determines heavy vehicle access policy, restricted access vehicle classifications and freight productivity settings across the network. Over recent years, the expansion of the number of larger restricted access vehicles (RAVs) and concessional loading arrangements have significantly increased wear on our regional roads. Local governments are frequently reminded that they do not control these access arrangements, yet the infrastructure consequences of those decisions fall largely on them.

The Wheatbelt Secondary Freight Network was designed to help address this challenge, recognising that many local government roads now perform a regional freight function far beyond their original design. Road safety must be front of mind. The Wheatbelt region consistently records the highest number of deaths and serious road injuries of any region in Western Australia. In fact, the Western Australian Road Fatalities and Serious Injuries 2024 report recorded the most notable rise in fatalities with a 60% increase relative to the five-year average. Upgrades delivered through the Wheatbelt Secondary Freight Network have already improved safety and reliability across key freight routes. Without continued funding, the level of service on the local road network will continue to decline, which will only increase the likelihood of serious and fatal accidents in the region.

The state government spends just over $4 million a year for the Wheatbelt Secondary Freight Network. It is great to see the member for Mandurah here who was at the Eastern Wheatbelt Forum. The Minister for Wheatbelt was invited but failed to turn up. The Wheatbelt Secondary Freight Network roads are a great collaboration between the Commonwealth government, the state government and local government. When the Minister for Wheatbelt comes out to our regions I will send her each and every one of those letters that are tabled here today in case she does not have time to read them. My plea to the minister is to come out, listen to those local governments, assure the communities of the Wheatbelt that Commonwealth government funding will not be withdrawn because of the failure of the Cook Labor government to fund the Wheatbelt Secondary Freight Network beyond 2027.

This is the real question, minister: Are there assurances for the communities that the National Party represents that beyond 2027 the minister will be out there backing them for greater road safety and for greater improvement on our transport routes to get our product to market? A mere $4-something million is very, very small in comparison to all the other wasteful spending that this government seems to think is a priority. Thank you.

Ms Sabine Winton (Wanneroo—Minister for Wheatbelt) (9:12 am): I thank the member for Central Wheatbelt for his grievance today. I am happy to represent the Minister for

Transport in response. Of course, as the Minister for Wheatbelt, I have heard directly from locals on the importance of this issue.

The Wheatbelt Secondary Freight Network, as the member mentioned, is a jointly funded program involving the Commonwealth, state government and 42 Wheatbelt local governments. As we know, it is a practical cooperative program focused on improving 53 regional freight routes. As the member said, it is a significant amount of road—4,400 kilometres of road that supports, importantly, the region's major industries. I recognise that the Wheatbelt in particular was the main contributor to what has been a record grain harvest this year.

This freight network is about keeping freight moving, improving productivity, supporting local jobs, and making sure that the road network can meet the needs of our modern industries across agriculture, mining, advanced industry and renewable energy. Let us be clear about why this work matters. It does matter and it is important to have it on the record because regional WA was badly let down by the decision of the former Liberal–National government to privatise the freight rail network. That decision did not happen by accident. It was a choice made by the former Liberal–National government. It was a choice to wash its hands of a strategic asset of the state. It was a choice to leave the freight logistics to the private market and hope for the best. We see what happens when you do that. It was a choice to abandon the long-term planning in favour of a short-term budget fix.

The results are plain to see for regional Western Australians. More freight has shifted onto roads, more pressure has been placed on local infrastructure and, as a result of that, more wear and tear. Taxpayers have been left to foot the bill for decisions made by the Liberal–National government and that is the fact of the matter. It is the legacy of its economic management.

As demand for a freight network grows, this Labor government is doing the hard work to bring the network back to public hands, because public control matters. Public control would mean targeted, strategic and accountable government investment in freight rail. It would also allow the state to plan for the long term rather than continue tolerating the consequences of privatisation. That is the difference between a government prepared to govern and an opposition still pretending that its sale of the freight rail network was a clever idea.

I turn to the funding of the Wheatbelt Secondary Freight Network. It has been and continues to be funded through to mid next year. The claim that the state government has decided not to continue funding the Wheatbelt Secondary Freight Network in 2026–27 and beyond is incorrect. The Wheatbelt Secondary Freight Network has $24.5 million allocated in the 2026–27 financial year and the Australian Government, with the support of the Cook Labor government, has allocated $175 million towards the program with an additional $12.5 million from local governments. The total funding therefore is some $187.5 million.

It is a genuine partnership across the three levels of government to deliver practical

freight upgrades where they are needed most. It is already delivering real benefits. There are practical gains for farmers, freight operators, local businesses and communities right across the region and I understand that work is ongoing in planning for future works. I have also been advised that Main Roads has been supporting the Wheatbelt Secondary Freight Network for more than 18 months.

This government is getting on with the job. We know that many of the roads in the Wheatbelt were never designed to accommodate the size and mass of the vehicles now required by industry. We understand that reality and we are responding to it. We continue to improve road reliability right across the area, including $250 million for the Great Eastern Highway upgrade, $80 million for Toodjay Road and $25 million for the Northam–Pithara Road upgrades.

Additionally, we are also constructing new overtaking lanes and building and upgrading heavy vehicle resting areas and sealed road shoulders. Since 2017, our government has spent more than $2.2 billion on Wheatbelt roads alone. I compare that to the former Liberal government. In its dying days, a total of $162 million was spent across the Wheatbelt. Fast forward to 2024–25 and it is nearly $300 million. That is almost double the investment in the Wheatbelt compared to the dying days of the Liberal–National government.

Since 2017, our government has remained committed to delivering significant improvements to the freight network. We know how critically important it is. We know the contributions the Wheatbelt makes to our state's economy. We value that contribution and we will continue to invest important infrastructure to support industries in the Wheatbelt. It is always interesting to hear those opposite feigning concern about regional freight and wheatbelt infrastructure, because when it came time to make the big decisions, the Liberals and the Nationals did exactly the opposite of what the regions needed. Now they feign concern. Thank you.

Several members interjected.

The Speaker: Members of the opposition, this is grievances. Grievances are heard in silence. A grievance was raised by member for Central Wheatbelt and the minister responded. Whether members opposite like that or not, I do not care, and we do not near to hear that. Please do not break out into little conversations in the middle of grievances.

WHEATBELT SECONDARY FREIGHT NETWORK

WSFN
WHEATBELT SECONDARY FREIGHT NETWORK

01 Committment

The Australian Government committed **$150m** towards the $187.5m project.

The remainder of the funding has been provided by the State Government and 42 Local Governments.

02 Collaboration

The WSFN is the largest collaboration of local governments in Australia, with 42 Shires committed to upgrading 53 strategic routes across the Wheatbelt that are state and nationally relevant.

03 Funded

Since inception in 2019 the program has received Federal, State and Local government funding amounting to **$185m**.

04 Strategic

500km of strategic routes have been fully constructed, improving freight efficiency, productivity, market competitiveness for the agriculture and mining industries, as well as improved road safety.

05 Contribution

In the 2024-25 financial year, the Wheatbelt region generated **$9.1 billion** in gross regional product, with agricultural output alone exceeding **$5.3 billion**.

06 Inclusion

The WSFN has included Aboriginal participation in the road workforce of **14% of all hours** spent on the program and **2% of procurement**.

07 Opportunity

The WSFN is a vital part of Western Australia's economic success, contributing to increased employment opportunities and generating economic benefits throughout our regional communities.

08 Supported

"In particular for the Shire of Moora, projects have greatly contributed to road safety, possibly one of the most significant outcomes of the WSFN program and should certainly be assessed and the results presented with other major Road Safety Programs."

$150m
Australian Government committed

42
Shires committed to upgrading 53 strategic routes

500km
Of strategic routes have been fully constructed

$30m
Spent annually on construction works along with a further $2.5m in development

4,400km
of Local Government managed roads that connect with State and national highways

14%
of all workforce hours was Aboriginal participation

$9.1b
2024/25 Wheatbelt gross regional product

LOCAL GOVERNMENT RURAL HEALTH FUNDING ALLIANCE

Third Communique

FEBRUARY 2026 | www.ruralhealthfundingalliance.au

We are pleased to share the *third* update of activities of the Local Government Rural Health Funding Alliance, a collaboration of six local governments in rural WA—Lake Grace, Kojonup, Gnowangerup, Jerramungup, Narembeen, and Ravensthorpe—working together to address the challenge of attracting and retaining general practitioners in remote and very remote communities.

Announcement

WA Wheatbelt & Great Southern undertake economic impact assessment on primary health care expenditure to secure local GP services and ease ratepayer contributions.

The Alliance has commissioned an independent economic impact assessment to quantify the costs and benefits of local government investment in GP services, supporting its 2026–27 Federal Budget submission for a targeted Commonwealth program to sustain resident GP access in rural, remote and thin-market communities.

The Local Government Rural Health Funding Alliance says it has been necessary to step in where current Commonwealth and State funding and GP incentive settings do not meet the thin market realities of geographically dispersed and low population rural communities.

The six councils currently contribute more than $1.475 million in cash every year, plus substantial in-kind support including housing, vehicles, surgeries and facilities, to attract and retain doctors. In some shires, GP support spending equates to up to 16% of annual rates revenue, making it one of the largest non-core budget items.

“Ratepayers in our towns already contribute through their Medicare levy and pay consultation fees—and now they pay a third time because their rates contribute to primary care costs to keep a doctor in town. It’s not sustainable for the community, local government or indeed the system” said Cr O’Keefe, Shire President of Gnowangerup.

An independent economic assessment by Econisis (January 2026) examined the costs, benefits and opportunity costs of local government financial support to assist in the provision of GP services. It concluded that there is a strong economic return, but councils are carrying the cost of a service that is not the responsibility of the third sphere of government.

For every $1 invested in maintaining local GP access it generates about $3 in quantified economic and social benefits, but local government is shouldering an outsized share of the funding[1].

The biggest benefits of the local government support has been improved GP accessibility and travel savings for patients; improved health outcomes; local key health worker productivity and positive health sector supply chain impacts.

The report also found around 55% of benefits relate to community health outcomes, with the remainder linked to broader economic and social outcomes.

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[1] Over a three-year period, the data determined there was a present value of costs between $4.03m–$4.26m (depending on discount rate) and a present value of benefits between $12.35m–$13.19m.

The report also assessed what councils forgo by diverting local revenue to GP subsidies. It concluded that it was in residents' and governments' interests for higher-tier funding to support GP sustainability so councils can redirect funds to core local responsibilities.

The Alliance undertook the economic impact assessment and made its Federal Budget submission because:

- Access to primary care is critical in communities experiencing longstanding GP shortages, higher chronic disease risk factors and significant travel distances to care.
- Over half of emergency department presentations in the region are reported as non-urgent, linked to limited local GP access and reduced early intervention/prevention.
- Local residents can currently travel 49–115 km to reach their closest GP, and if services were lost, alternative travel distances could rise to 89–234 km depending on the LGA.
- Councils are diverting scarce local revenue away from core responsibilities—roads, community infrastructure and essential services—creating a major opportunity cost for small rate bases.

The Alliance's submission seeks a three-year Commonwealth program commencing FY2026–27 to relieve and reduce the cash burden on small rural councils while maintaining local access to resident GPs in thin markets.

"This is a practical, measurable proposal: back a short, targeted pilot, collect the data, and prove what works in the hardest places to staff—so the model can be replicated nationally" said Cr Armstrong, Shire President of Lake Grace.

2026 Submissions

- Inquiry into Local Government Funding and Fiscal Sustainability 2026 (Commonwealth)
- Federal Budget 2026/27 Submission

Further information available:

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All reports available at www.ruralhealthfundingalliance.au

SUSTAINING PRIMARY CARE IN MM6–MM7 RURAL COMMUNITIES

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Local Government Rural Health Funding Alliance
Pre-Budget Submission

Federal Budget 2026–27

Prepared in accordance with Australian Treasury submission guidelines.

Executive Summary

Six local governments in WA's Wheatbelt and Great Southern regions (local governments classified as Modified Monash Model 6 and 7) have faced acute shortages of resident GPs for decades.

Not only is life expectancy up to seven years lower in these communities than metro areas [1]; **over half of emergency department presentations in the region are non-urgent due to lack of local GP access** [2]. Four Shires out of the six are socio-economically disadvantaged (SEIFA ≤ 1,002), coupled with high chronic disease, obesity (up to 38.9%) and mental health prevalence (up to 14.3%)[3] as well as lengthy travel distances to access primary health.

To meet community needs but more importantly ensure equitable access to primary health care, the six local governments divert up to 16% of their annual rate income —collectively $1.45m in cash plus housing, vehicles and surgeries—to attract and retain doctors – **with total benefits from the support estimated between $12.35 million and $13.19 million, yielding a net present value of $8.32 million to $8.94 million**[4].

An opportunity cost analysis completed in January 2026 by an independent economist indicates that the cash contribution by the local governments diverts funds from other potentially higher-return initiatives and is a significant financial burden on local governments, impacting their ability to fund core responsibilities. This is unsustainable and undermines role of local government.

The six local governments are members of the Local Government Rural Health Funding Alliance and are requesting a three-year pilot commencing FY2026–27, providing $6m annually to reduce local government contributions for doctor attraction and retention in their thin markets. The six local governments will continue to fund surgeries, vehicles and housing and are not seeking for this to be included in the pilot. **Currently the benefit-cost ratio (BCR) of the support provided by local governments is approximately 3.08**, indicating a strong return on investment for the Federal Government pilot.

The pilot will collect data on doctor workforce sustainability specifically in MM6 and 7 communities, emergency department impact, continuity of care and rural generalist models. The rationale for this investment is because current State and Commonwealth policies, programs and incentives do not differentiate between metropolitan, outer metropolitan, rural, remote and very remote communities. Traditionally MM6 and 7

[1] National Rural Health Alliance Rural Health in Australia Snapshot 2025
[2] WA Country Health Service 2025
[3] WA Country Health Service (WACHS) Health Profiles (2022)
[4] Regional Generalist Hub GP Subsidy Assessment, Econisis (2026)

communities are thin markets and required a tailored and specific level of support or incentives.

We expect to complete annual reports to the Australian Government with:

- Improved access and uptake of local primary care
- Improved continuity of care for patients
- Improved health outcomes as preventative care is accessible
- Reduced emergency department workforce pressure on regional and outer metropolitan hospitals
- Lower financial burden on ratepayers of local governments who already pay their Shire rates, Medicare levy and a doctor consultation fee
- Enhanced health equity and outcomes for vulnerable populations including seniors, Indigenous and at risk individuals.

1. Background and Need

The National Rural Health Alliance 2023 report *Evidence base for additional investment in rural health in Australia* demonstrates a clear healthcare disparity between rural and urban Australia: rural Australians have a poorer health status, and even before accounting for the increased cost of health service, receive significantly less funding per capita than their urban counterparts.

The National Rural Health Alliance report details the comparative Government health spend between major city residents and rural and remote Australia. It showed a gap of $8billion, which is a health spend shortfall of $1090.47 per person in rural and remote Australia.

The Local Government Rural Health Funding Alliance comprises the Shires of Gnowangerup (MM7), Jerramungup (MM7), Kojonup (MM6), Lake Grace (MM7), Narembeen (MM7) and Ravensthorpe (MM7) and was formed in 2024 following a common challenge in attracting and retaining doctors in socio-economically disadvantaged communities with small populations but large geographical service areas (populations range from ~787 (Narembeen) to ~2,085 (Ravensthorpe) and residents in some areas travel 49 to 115 kilometers to reach their nearest GP, with potential distances increasing to 89 to 234 kilometers if local services are lost).

Collectively, the Shires contribute $1,475,000 cash per annum to attract and retain resident doctors, plus houses, vehicles, clinics and asset depreciation. Individual cash contributions and share of **rates annually** include: Gnowangerup $250k (7% of total rate income), Jerramungup $220k (5.7%), Kojonup $250k (4.6%), Lake Grace $250k (7.3%), Narembeen $305k (16%) and Ravensthorpe $200k (5%). Total annual support (cash + in-kind) exceeds $5m.

Residents in the communities have risk factors above WA averages e.g., obesity up to 38.9%; high blood pressure up to 21.7%; low physical activity up to 45.8%. The WA Country Health Service also reports over half of emergency department presentations are non-urgent and linked to lack of local GPs and lack of early intervention and prevention.

Recognising the importance of being able to see a doctor, Local Governments are reluctantly stepping in to try and secure healthcare services for their communities. In 2024-25, over half of non-metropolitan Councils were actively supporting primary healthcare services – an investment totalling over $9.5 million, according to WALGA's 2025 Local Government GP Support Survey. This is not sustainable. Funding medical care is placing enormous pressure on already stretched Local Government budgets – diverting resources from other essential services and infrastructure. Local Governments should not, and cannot, continue to bear this cost.[5]

This is not just a West Australian issue. Interstate, the Shire of Bogan in Queensland is currently paying $500,000 towards the operational costs of its medical centre.[6] It is very rare that a remote or very remote local government in Western Australia (and indeed within other states) is not contributing to payments that attract and retain resident GPs in some form.

The Alliance seeks to increase Financial Assistance Grants and recalibrate their distribution to better support rural councils funding GP services, via a motion at the ALGA National General Assembly in June 2025. The motion was carried unanimously. A similar motion was also passed at the WALGA AGM in 2025.

The Alliance's proposal also aligns strongly with the Australian Medical Associations Easy Entry, Gracious Exit Model which is designed to address chronic GP shortages in small rural and remote towns by removing barriers to recruitment and retention.

2. Rationale For Investment

The resident and business communities of the Alliance seek leadership from their local governments to address the inequity of access to essential primary health care, **because they are closest to the problem and can respond in a timely manner,** hence the investment made to attract and retain resident GPs is necessary.

The Sustainable Health Review (SHR) by the WA State Government heard that health service delivery in rural and remote areas presents considerable challenges and due to remoteness, it is generally considered more costly to deliver 'small scale' services in the country than in the metropolitan area.[7]

The WA Grants Commission has acknowledged this challenge and the thin market for GPs and as such includes a Medical Facilitator Adjustor within the Financial Assistance Grant to local governments. It is however clearly inadequate and does not cover even a

[5] 2026-27-WALGA-State-Budget-Submission-(WEB).pdf
[6] Local council running medical centre at $500k shortfall | Health Services Daily
[7] Sustainable Health Review, Department of Health WA (2019)

third of the costs incurred by local governments currently (maximum amount of the Adjuster is $100,000).

It has been necessary for local governments to step into the provision of medical services in MM6 and MM7 communities for the following reasons:

1. **Critical Role of Primary Care**: Primary care is the most significant contributor to positive health outcomes. With the number of general practitioners in Australia tight, especially in rural areas, ensuring access to primary care is crucial.[8] The population across the six local governments is stable, with an average age above the national average, indicating a need for more healthcare services. Additionally, reducing emergency department presentations in rural communities with the provision of a local GP reduces the financial burden on State Governments and pressure on the hospital workforce.

2. **Acute Shortages in Rural Areas**: The reduction in the primary care workforce is felt most keenly in rural communities, where dependence on primary health care is more pronounced. For example, Western Australia (WA) has just 75.9 full-time equivalent (FTE) GPs per 100,000 people in outer regional, remote, and very remote areas, compared to the national average of 87.3 FTE GPs.[9]

3. **Comparative Disadvantage**: Access to GPs decreases with remoteness; rural residents see a GP about 6.2 times per year on average[10]. WA's overall GP per capita is 101.8 FTE GPs per 100,000 people, which is lower than the national average of 115.2 FTE GPs. This shortage has real consequences for people in regional and rural areas, as they face higher healthcare costs, reduced access to timely care, and poorer health outcomes compared to those in metropolitan centres. Rural WA is clearly disadvantaged but it occurs nationally as well and the disparity highlights the need for targeted measures to attract and retain doctors in these underserved, think market communities.

4. **Costly Delivery to Large Geographical Areas**: The Sustainable Health Review (SHR) by the WA State Government heard that health service delivery in rural and remote areas presents considerable challenges and due to remoteness, it is generally considered more costly to deliver 'small scale' services in the country than in the metropolitan area. Due to scale, management issues arise such as rostering, increased reliance on staff being on-call (to hospitals) and services being vulnerable if a staff member is away sick or on leave. It is very difficult to attract health practitioners to work in many country locations and staff turnover rates are high.[11] The larger geographic footprint involved with creating a patient pool sufficient to sustain a clinic or service on a fee for-service basis results can result in lower utilisation. This is typically reflected in lowered utilisation of staff and

[8] Decline in new medical graduates registered as general practitioners, Denese Playford, Jennifer A May, Hanh Ngo, Ian B Puddey, 2020
[9] Australian Government Productivity Commission Report on Government Services 2024
[10] AIHW (2025) Primary care Services, accessed at https://www.aihw.gov.au/reports/primary-health-care/general-practice-allied-health-primary-care
[11] Support and service improvement for people in country areas

services in these regions, and a greater reliance on grant and block funding to address shortfalls. Paying for these 'gaps' in remote and very remote communities through grants or block funding, is 3.46 times more per capita than that of metropolitan settings. [12] The smaller populations, high demand for health professionals, complex health needs, and higher cost of delivering services in the regions means that many communities don't have access to adequate primary healthcare services[13] and block funding by local governments is necessary.

5. **Inadequate GP Incentives for MM6-7 Communities:** The Commonwealth Government's Strengthening Medicare Reforms do not include programs or incentives for rural practices; MyMedicare is for telephone consultations for registered users, the General Practice Grants Program do not specifically support rural or remote GPs because it can be accessed by MM2 practices in metropolitan areas. In Western Australia there are incentives such as the Country Health Innovation (CHI) financial incentive obtained through the Department of Primary Industries and Regional Development (DPIRD) Royalties for Regions (RfR) Program. The program within regional catchment areas provides for Emergency Department incentives, procedural incentives, additional Procedural incentives, a location incentive, Small Town GP incentive and an Aboriginal Health Community incentive. The majority of these incentives are only available to fellows and again, offered to the same communities closer to the metropolitan area indirectly creating competition for GPs and the workforce seeking closer proximity to professional development networks and essential services that the city offers.

6. **Thin Markets as a result of reasons 2,4 and 5**: The majority of general practice services in Australia are funded through a combination of the Medicare system, direct patient billing and delivery of occupational medicine and other forms of non-Medicare medical service provision. Many general practices throughout rural Western Australia, particularly smaller, rural practices are only marginally viable under the existing funding models, such as the Medicare Benefits Scheme, Practice Incentive Payment and others. In major cities and inner regional areas, health services are mainly supported through activity-based funding and fee-for-service funding, while block funding is common in remote areas such as what is occurring in the six local governments because of the thin market and small patient base[14]. How doctors in private practice manage their billing and workload is a key issue in the problem as well. Doctors are continuing to increase their bulk-billing rates, especially for non-GP specialists, to help maintain volume, whilst fees for non-bulk billed services increase. Whilst discretion on setting fees has provided some flexibility, there is only so much that can be done if there are fewer patients to go around[15] - particularly in rural and remote areas. Local government funds are increasingly being used to address funding shortfalls in practices because there

[12] Evidence base for additional investment in rural health in Australia, National Rural Health Alliance, 2023
[13] Local Government Primary Healthcare Services Survey Report

[14] Evidence base for additional investment in rural health in Australia, National Rural Health Alliance, 2023
[15] The evolution of the medical workforce, Melbourne Institute (2021)

exists a thin market and no tailored programs to MM6-7 communities. This means that a significant portion of local rates is allocated to ensure a GP is firstly attracted to the community and then retained, so that residents have access to essential healthcare.

7. **Procurement**: Recruiting and attracting GPs for a reasonable and sustainable amount is difficult when going to an open market. Providing significant funds to attract and retain resident GPs through an open process also creates competition amongst rural Western Australian local governments. They are competing for limited human resources. GPs are also leveraging local governments against each other to match cash payments and supporting incentives. This is evident through the tender process, but it should be remembered, that local governments should not be required to undertake a tender process for GP services, if current incentives and programs were enhanced to reflect the true cost of service delivery in remote communities.

3. Proposal Details

Access to medical professionals has been getting more challenging over time because of national GP shortages, rising costs and the difficulties of attracting and retaining doctors in small towns. To keep services running (and not disadvantage regional and remote residents), the Alliance Councils have taken on a large share of the financial responsibility for GP attraction and retention.

While this has helped to retain essential health services, the fiscal outlay has also impinged on the capacity of the local governments to effectively invest into the delivery core responsibilities. The contribution of funds toward the attraction and retention of GPs represents a strong return on investment with a BCR of 3.08. However, in assuming responsibility for attraction and retention of this essential service, the Alliance has been forced to shift budgeted funding away from other responsibilities – areas of focus that have the potential deliver a greater return to the community and local residents.

The Alliance seeks support for a program to attract and retain doctors in thin markets (MM6-7) and relieve local government cash contributions for a pilot of three years while improving access and continuity of care for remote and very remote residents using a rural generalist model.

Scope: Six local governments (Gnowangerup, Jerramungup, Kojonup, Lake Grace, Narembeen, Ravensthorpe); resident doctor services are already operating under a rural generalist model across 10 practices; integration with WA Country Health Service hospital rosters and emergency cover (WACHS provides hospitals however only on call doctors in the communities).

Design: Commonwealth sustainability payment disbursed as a pilot program at $6m p.a; eligibility limited to the MM6–MM7 LGAs in the Alliance and weighted using the current %

of rates expended; with funding complementing existing State incentives and local in-kind support. Participating local governments continue to contribute to doctor surgeries, vehicles and housing across 10 practices (excluded from the pilot funding). Final distribution to be agreed with Treasury.

Duration: Three-years (FY2026–27 to FY2028–29) with assessment conducted by an independent external party, annual reviews, preferred governance model and end-of-pilot evaluation. To deliver the expected outcomes the Alliance will work closely with WA Country Health Service.

Administration: Disbursement through the WA Grants Commission as a targeted enhancement or through the WA Primary Health Network; quarterly acquittals and annual performance reporting.

Governance: Alliance Committee (Chaired by the Shire of Lake Grace President and Vice Chair the Shire President of Gnowangerup) with four member Presidents and CEOs'; Commonwealth liaison (Treasury/Finance); WA Country Health Service Rural Executive Director and WALGA advisory inputs; as well as an independent evaluation partner.

Targets to be assessed: emergency department presentations (triage categories 4–5) in local and regional hospitals; patient continuity index (same-provider ratio); service coverage (clinic days per site); travel distance/time saved by patients at each practice; preventative care assessments.

4. Health, Social and Economic Impact

Econisis modelled the health, economic and social impacts and benefits of the pilot based on the current funding (restricted to 3yrs) and found the local government funding delivers a robust return on investment with a BCR at 3.08. Local community health outcomes and access, long-term economic and social participation impacts and key health worker productivity were all also identified as major benefits.

We expect with the Federal funding pilot:

- Increased GP availability reduces non-urgent presentations to regional and metropolitan hospitals, improves continuity of care for the patient and early and preventative chronic disease management, palliative care as well as Aboriginal health clinics can be delivered locally.
- Reduced travel (often >200 km) for residents in remote and very remote communities lowers household costs and productivity losses; it stabilises local services and supports workforce participation and regional business confidence.
- Attracting and retaining clinicians enhances community amenity and resilience; rural generalist hub-and-spoke service model reduces hospital transfers and emergency retrieval costs.

5. Alignment with Government Priorities

1. Strengthening Medicare and making healthcare more accessible

Direct impact on primary care access: The pilot supports local governments to attract and retain resident GPs in MM6–MM7 communities, creating a point of differentiation for remote and very remote communities and a targeted approach for GPs in thin markets that can be replicated elsewhere. This pilot program addresses the gap in Medicare's reach for remote areas, ensuring continuity of care, complemented by the WA Country Health Service telehealth.

By restoring local GP access, the pilot program reduces non-urgent emergency department presentations (currently >50% of visits in these regions), which aligns with Medicare's goal of improving primary care and reducing hospital strain.

2. Closing rural health gaps

Life expectancy in Alliance communities is up to seven years lower than metro areas, and chronic disease risk factors exceed WA averages. The pilot directly targets these disparities by funding sustainable primary health care services in the most remote classifications (MM6–MM7).

Elderly, children, and Indigenous Australians are disproportionately affected by GP shortages and long travel distances (>200 km). The pilot improves access for these cohorts, supporting national Closing the Gap objectives.

3. Fiscal discipline and measurable outcomes

Funding flows through the Financial Assistance Grants, avoiding new administrative structures. The Alliance has engaged with the WA Primary Health Alliance regarding support through their Innovation Fund however they have a high number of competing priorities.

Conclusion

Rural and remote communities in Western Australia face a structural health inequity that cannot be resolved through existing Medicare settings or current incentive programs. The evidence is clear: thin markets in MM6–MM7 regions make traditional fee-for-service models unsustainable, forcing local governments to divert significant ratepayer funds away from core services to maintain basic medical access. Without targeted intervention in these markets, these communities will continue to experience poorer health outcomes, higher emergency department demand, and escalating financial pressure on local councils.

The proposed three-year pilot offers a practical, cost-effective solution that complements existing State and Commonwealth initiatives while addressing a critical gap in rural health policy in thin markets. By introducing a sustainability payment, the pilot stabilises GP services, reduces non-urgent hospital presentations, and improves continuity of care for vulnerable populations—including seniors, Indigenous Australians, and those living with chronic disease. It aligns with national priorities to strengthen Medicare, close rural health gaps, and deliver measurable outcomes without creating new administrative burdens.

This is not a discretionary investment; it is a necessary step to ensure health equity for Australians living in the most remote communities. The Alliance's model leverages proven rural generalist frameworks, local infrastructure support, and collaborative governance to deliver enduring benefits for patients, clinicians, and governments alike. Without this intervention, the viability of rural practices will continue to erode, forcing councils to raise rates or cut essential infrastructure—an outcome that undermines both community wellbeing and regional economic resilience.

This submission may be published by Treasury following the 2026–27 Budget.

6. Attachments

A. Economic Impact Assessment of Local Government Provision of GP Services
B. Case study inclusion in the Regional Australia Institute's Ambition Report. The Ambition is a 10 year plan for regional Australia. It is a set of 25 targets for regional Australia across six pillars – Population, Jobs & Skills, Liveability, Productivity & Innovation, Sustainability and Resilience and now Health. Health is a new pillar for 2025 and includes targets and measures for medical practitioners, allied health professionals, Medicare service access, potential years of life lost and accessing NDIS. The Alliance featured in the Ambition Report.
C. Provision of Medical Services Position Paper

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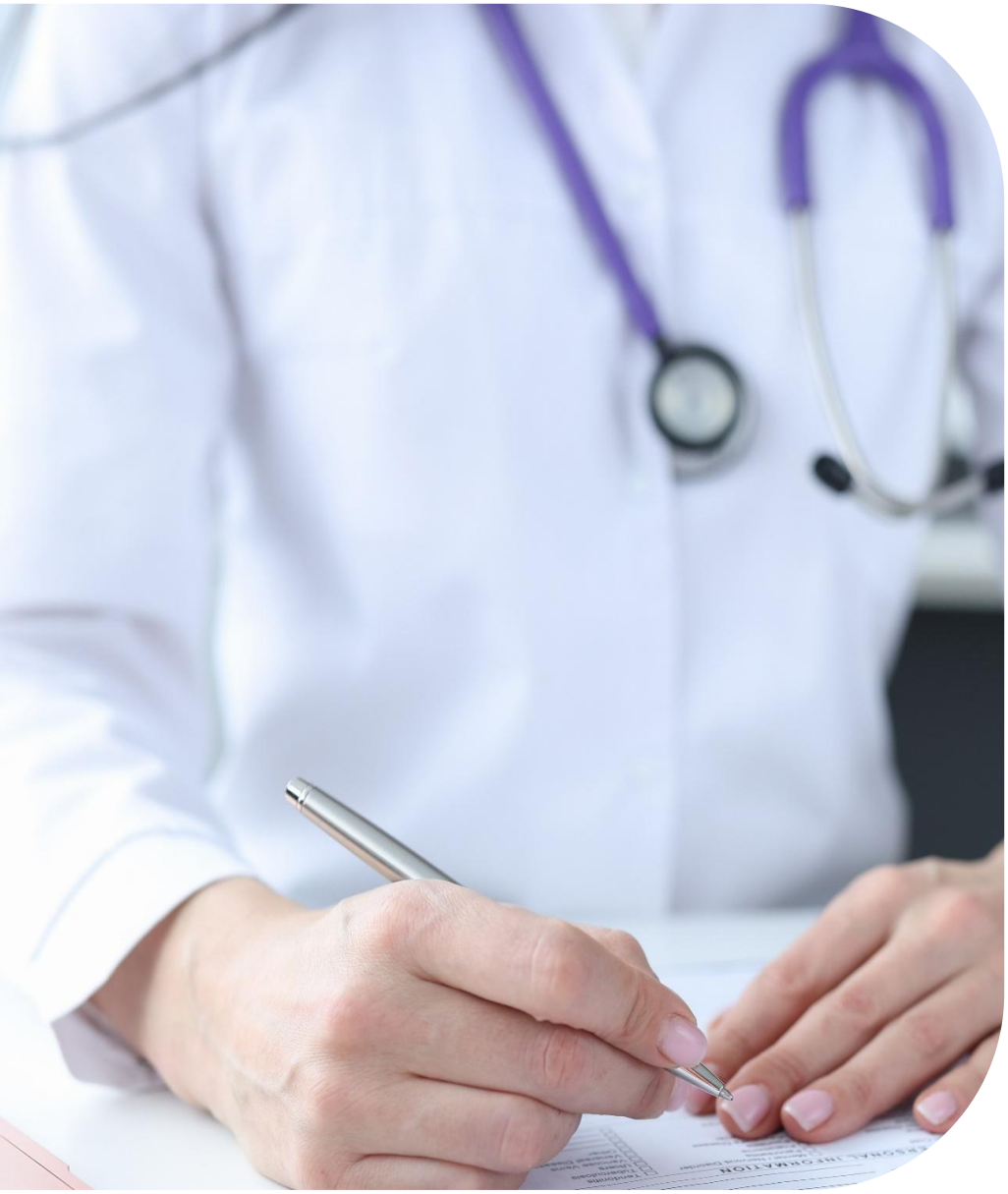

REGIONAL GENERALIST HUB GP SUBSIDY ASSESSMENT

LOCAL GOVERNMENT RURAL HEALTH FUNDING ALLIANCE

Client: LOCAL GOVERNMENT RURAL HEALTH FUNDING ALLIANCE

Title: REGIONAL GENERALIST HUB GP SUBSIDY ASSESSMENT

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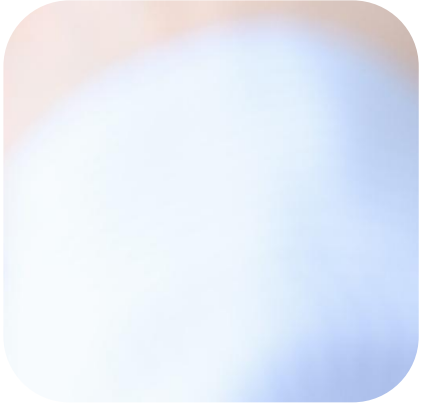

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DISCLAIMER

VERSION CONTROL

VERSION	PURPOSE	AUTHOR	REVIEWER	APPROVER	APPROVAL DATE
DraftA	Draft for internal review	LP	MW	MW	19/12/2025
DraftB	Draft for client review	MW/LP	EW	MW	06/01/2026
Final	Final with client feedback	JB/LP	EW	MW	22/01/2026

APPROVAL FOR ISSUE

APPROVER	CONTACT	SIGNATURE	DATE
Mark Wallace PRINCIPAL	**T**: 0431 676 254 **E**: mark.wallace@econisis.com.au		22/01/2026

CONTENTS

FIGURES AND TABLES

EXECUTIVE SUMMARY

Introduction

- A group of six local governments in the Great Southern and Wheatbelt regions are working together to address a growing issue around access to primary health care.
- To keep services running, the councils have taken on a large share of the financial responsibility for GP attraction and retention.
- Econisis was engaged by the Shire of Lake Grace on behalf of the six Western Australian Shires comprising the Local Government Rural Health Funding Alliance to develop a cost benefit analysis that valued the economic and social value for money return of subsidising GP access.
- Furthermore, Econisis was tasked with assessing the opportunity cost to the Shires of using the local Council revenues to subsidise GP accessibility and the benefits foregone from it not being spent toward other Shire responsibility expenditure areas.

Health Service Context

- National data shows that people in rural and remote areas have poorer health outcomes than those in major cities.
- Access to primary care, and particularly GPs, is central to this disadvantage. Across Australia, people now see a GP about 6.2 times per year on average, but the number of GPs per head of population falls as remoteness increases[1].
- Census health data for the six regions shows a clear concentration of long-term conditions that drive strong and ongoing GP demand.
- Residents in some parts of each shire already travel between 49 and 115 kilometres to reach their closest GP. If local services were lost, the alternative distances to the next available GP would range from 89 to 234 kilometres, depending on the LGA.
- For some shires the GP Subsidy funding commitments equate to up to 16% of their total rates revenue, making it one of the largest non-core expenditure items in their budget.

Socio-Economic Attributes

- Across the six Alliance LGAs, population has been mostly stable over the long term with older age profiles and below average incomes reflecting rural/remote, agricultural-based nature of the region's population.
- There are approximately 1,800 registered businesses, highlighting an active economic base for a small and dispersed population.
- Unemployment across the six LGAs has been consistently low, generally sitting between 1 and 3%, well below the WA average of around 4 to 7% over the same period.

GP Subsidy Cost Benefit Analysis

- A CBA is the most commonly used, and most comprehensive, of the economic evaluation techniques.
- The annual cost of the subsidy program has been estimated to cost $1.48m per annum. For the purposes of this modelling Econisis has modelled this over a 3-year period to reflect spending commitments sought by the Alliance. Discounted over the next 3-years the present value of costs ranges from $4.26m at the 4% discount rate to $4.03m at the 10% discount rate.

[1] AIHW (2025) Primary care Services, accessed at https://www.aihw.gov.au/reports/primary-health-care/general-practice-allied-health-primary-care

- A range of direct economic and social benefits of the Subsidy have been identified. These benefits can be broken into 2 broad categories, those being Community Health Outcomes and Economic and Social Outcomes.

Figure 1 Regional Generalist Hub GP Subsidy Benefits

- The result of the CBA is seen in the below table.

Table 1 Summary of GP Subsidy Cost Benefit Analysis

Summary	4%	7%	10%
Total Costs ($m)	***$4.26***	***$4.14***	***$4.03***
Funding Cost	$4.26	$4.14	$4.03
Total Benefits ($m)	***$13.19***	***$12.75***	***$12.35***
Community Health Outcomes			
Improved GP Accessibility Benefit	$5.21	$5.07	$4.94
Improved Population Health Outcomes	$2.01	$1.96	$1.91
Economic and Social Outcomes			
Local Key Health Worker Productivity Benefits	$2.52	$2.46	$2.39
Health Sector Supply Chain Impacts	$0.73	$0.71	$0.69
Long-Term Economic and Social Participation Benefits	$2.72	$2.56	$2.43
Net Present Value ($m)	***$8.94***	***$8.61***	***$8.32***
Benefit-Cost Ratio (BCR)	***3.10***	***3.08***	***3.06***

Opportunity Cost Impact Analysis

- An Opportunity Cost Impact Analysis has been undertaken by Econisis to assess the forgone benefits as the result of members of the Alliance spending their revenue on GP subsidies as opposed to regular spending responsibilities.
- With an annual GP Subsidy spending cost of $1.48m Econisis has modelled the opportunity cost of a series of substitute spending programs for the local councils.
- Note that the opportunity cost scenarios are indicative only and are designed to provide context for the value for money proposition of the GP Subsidy.

- The results of the Opportunity Cost Impact Analysis (at the 7% discount rate) reveal that the Local Infrastructure Efficiency and Safety program returned the highest BCR of 4.56 at the 7% discount rate.

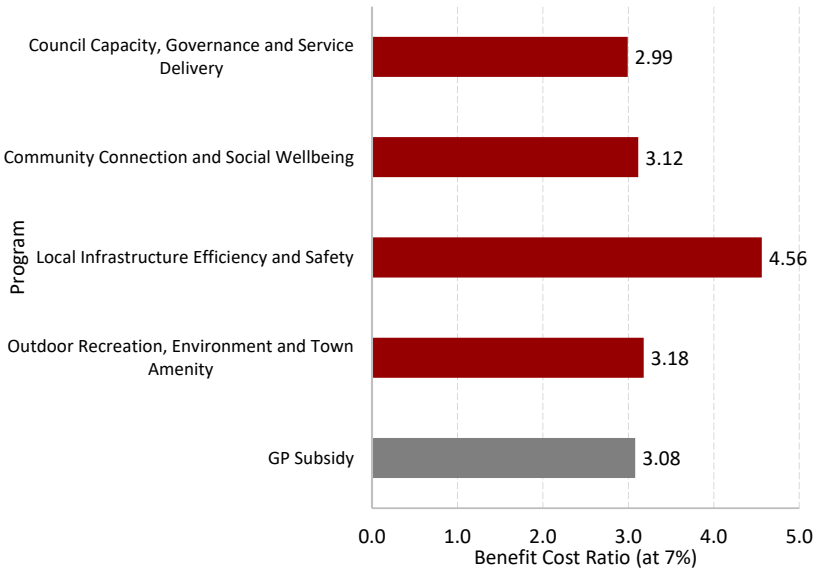

Figure 2 Benefit Cost Ratio of Substitute Spending Programs

- It is in Government's and the local resident's best interest that the $1.48m of annual spend be diverted toward the Local Infrastructure Efficiency and Safety spending program initiative or other initiatives modelled that yield a higher BCR that 3.08.

Findings and Conclusions

- The GP Subsidy Program currently represents a substantial financial burden on the six local governments across the Great Southern and Wheatbelt that are part of the Local Government Rural Health Funding Alliance.
- Access to medical professionals has been getting more challenging over time because of national GP shortages, rising costs and the difficulties of attracting and retaining doctors in small towns. To keep services running (and not disadvantage regional and remote residents), the Alliance Councils have taken on a large share of the financial responsibility for GP attraction and retention.
- While this has helped to retain essential health services, the fiscal outlay has also impinged on the capacity of the Alliance Councils to effectively investment into the delivery core responsibilities.
- The contribution of funds toward the GP Subsidy Program represents a strong return on investment with a BCR of 3.08. However, in assuming responsibility for attraction and retention of this essential service, the Alliance Council have been forced to shift budgeted funding away from other responsibilities – areas of focus that have the potential deliver a greater return to the community and local residents.
- It is therefore recommended that:

The six Shires of the Local Government Rural Health Funding Alliance seek funding support from State and/or National Governments to resource the GP Subsidy Program and to redirect current funding other expenditure programs within the core responsibility of Local Government.

1 INTRODUCTION

This section provides an overview of the background and context, scope and structure of the report.

1.1 Background and Context

A group of six local governments in the Great Southern and Wheatbelt regions are working together to address a growing issue around access to primary health care. These communities rely on a small number of GPs to provide day to day medical services, emergency support and continuity of care. Access has been getting harder over time because of national shortages, rising costs and the challenges of attracting and keeping doctors in small towns.

To keep services running, the councils have taken on a large share of the financial responsibility for GP attraction and retention. This includes direct funding, housing, vehicles and maintaining practice facilities. These contributions are now absorbing a significant share of local rates revenue. While they help keep essential health services available, they also reduce how much councils can spend on their core responsibilities.

The purpose of this report is to assess the value of the current GP subsidy model and provide an evidence base that can guide future funding arrangements. The report will look at health and GP service trends in regional Australia, outline the characteristics of the six participating LGAs, and examine the economic and social impacts of limited access to primary health care. It will also apply a cost benefit framework to estimate the benefits of maintaining local GP services and compare these outcomes to the alternative uses of council funds.

This work aims to support discussions between local governments and state and Commonwealth agencies about long term, sustainable solutions. Ensuring reliable access to primary health care is vital for community wellbeing, workforce participation and the functioning of local health systems. At the same time, it is important that the funding burden does not sit disproportionately with small regional councils.

1.2 Report Scope and Structure

Econisis was engaged by the Shire of Lake Grace on behalf of the six Western Australian Shires comprising the Local Government Rural Health Funding Alliance to develop a cost benefit analysis that valued the economic and social value for money return of subsidising GP access.

Furthermore, Econisis was tasked with assessing the opportunity cost to the Shires of using the local Council revenues to subsidise GP accessibility and benefits foregone from it not being spent toward other Shire responsibility expenditure areas.

This report is comprised of the following key sections:

- **INTRODUCTION** – This section provides a summary of the background, context and structure of the report.
- **HEALTH SERVICE CONTEXT** – This section provides wider context for the current state of health services in rural regions as well as a more specific analysis of the state of health services in the assessment area and funding costs for each Shire.
- **SOCIO-ECONOMIC ATTRIBUTES** – This section provides an overview of economic and socioeconomic indicators of the assessment area, providing an overall context to the program.
- **GP SUBSIDY COST BENEFIT ANALYSIS** – This section outlines the methodology, assumptions, and results of the GP Subsidy Cost Benefit Analysis.
- **OPPORTUNITY COST IMPACT ANALYSIS** – This section assesses the forgone benefits as the result of members of the Alliance spending their revenue on GP subsidies as opposed to regular spending responsibilities.
- **FINDINGS AND CONCLUSIONS** – This section summarises the findings and conclusions of the analysis as well as makes a concluding recommendation for action into the future.

1.3 Alliance Area

The Local Government Rural Health Funding Alliance is a collaboration of six local governments in rural WA working together to address the challenge of attracting and retaining general practitioners in remote and very remote communities. These local governments include:

- Lake Grace,
- Kojonup,
- Gnowangerup,
- Jerramungup,
- Narembeen, and
- Ravensthorpe.

Figure 3 Founding Local Government Alliance members

1.4 Glossary and Abbreviations

The following terms and abbreviations are referenced in this report.

Table 2 Glossary and Abbreviations

Term/Abbreviation	Definition
ABS	Australian Bureau of Statistics
BCR	Benefit Cost Ratio
CBA	Cost Benefit Assessment
EIA	Economic Impact Assessment
Externalities	External Costs or Benefits not captured in market prices
GVA	Gross Value Added
LGA	Local Government Area
NPV	Net Present Value
SA2	Statistical Area 2
YTD	Year to date
FTE	Full time equivalent
IO	Input-output
OBPR	Office of Best Practice Regulation

2 HEALTH SERVICE CONTEXT

This section provides wider context for the current state of health services in rural regions as well as a more specific analysis of the state of health services in the assessment area and funding costs for each Shire.

2.1 Health Services in Rural Regions

Around one quarter of Australians live in rural and remote areas, spread across small towns and very large distances[2]. The health system uses the Modified Monash Model to classify these places from MM1 (major city) to MM7 (very remote) and to guide how doctors and funding are distributed. In practice, the higher MM categories have smaller populations, longer travel times, thinner service markets and more difficulty attracting and keeping health workers[3]. These structural factors make it harder to run traditional fee-for-service general practices and to provide the same range of services that people in cities use every day.

National data show that people in rural and remote areas have poorer health outcomes than those in major cities. The Australian Institute of Health and Welfare reports higher rates of hospitalisation, injury and death outside the cities, and a higher burden of chronic disease. Age-standardised death rates rise with remoteness and are around 1.6 times higher in very remote areas than in major cities[4]. Life expectancy falls as remoteness increases, with regional areas one to three years lower than cities and remote areas up to seven years lower. These gaps are even larger for Aboriginal and Torres Strait Islander communities[5]. The National Rural Health Alliance and related work for the Alliance estimate that rural Australians receive over $8 billion less per year in health funding than urban populations, a shortfall of around $1,090 per person, with the largest per capita gaps in MM5 to MM7 locations[6].

Access to primary care, and particularly GPs, is central to this disadvantage. Across Australia, people now see a GP about 6.2 times per year on average, but the number of GPs per head of population falls as remoteness increases[7]. AIHW modelling on access relative to need shows that many rural communities have lower GP access than their health needs would suggest, even after accounting for age and illness profiles[8]. For Western Australia, Alliance material draws on national sources to show that outer regional, remote and very remote areas have about 77.1 full-time equivalent GPs per 100,000 people, compared with 88.9 nationally, and that WA's overall GP rate is below the Australian average.

Several trends will influence how GP access changes in rural Australia over the next decade. Rural communities have older populations than major cities, and ageing will continue to increase demand for GP care as chronic disease rates rise with age[9]. At the same time, the national GP workforce is also ageing, with many rural doctors nearing retirement and fewer young graduates choosing remote practice, which is expected to worsen existing shortages[10]. Improvements in medical technology may support access, including better telehealth services, remote monitoring and digital consultations, which expanded sharply during the pandemic and continue to benefit rural patients[11]. Advances in AI-driven diagnostics and robotic assistance in imaging and

[2] AIHW (2025) Rural and Remote Australians, accessed at https://www.aihw.gov.au/reports-data/population-groups/rural-remote-australians/overview
[3] DHSA (2025) Modified Monash Model, accessed at https://www.health.gov.au/topics/rural-health-workforce/classifications/mmm
[4] AIHW (2025) Rural and Remote Australians, accessed at https://www.aihw.gov.au/reports-data/population-groups/rural-remote-australians/overview
[5] AMA (2023) Plan for improving access to rural general practice, accessed at https://www.ama.com.au/improving-access-to-rural-general-practice
[6] The National Rural Health Alliance (2025) The Forgotten health Spend, accessed at https://www.ruralhealth.org.au/wp-content/uploads/2025/08/The_Forgotten_Health_Spend_Report_08_2025.pdf
[7] AIHW (2025) Primary care Services, accessed at https://www.aihw.gov.au/reports/primary-health-care/general-practice-allied-health-primary-care
[8] AIHW (2024) Modelling Access to GPs, accessed at https://www.aihw.gov.au/getmedia/5b76fba0-5a33-43ba-a687-b77fa61e42e8/aihw-ihw-293-access-to-gps.pdf?inline=true&v=20240724164815
[9] AIHW (2025) Rural and Remote Australians, accessed at https://www.aihw.gov.au/reports-data/population-groups/rural-remote-australians/overview
[10] University of Wollongong (2024) Small rural towns are suffering critical shortages of healthcare workers, accessed at https://www.uow.edu.au/media/2024/small-rural-towns-are-suffering-critical-shortages-of-health-care-workers.php
[11] The Medical Journal of Australia (2024) … telehealth in rural and remote Australia …, accessed at https://www.mja.com.au/journal/2024/220/10/beyond-planned-and-expected-unintended-consequences-telehealth-rural-and-remote

triage may also help reduce the reliance on in-person GP supply in the long term[12]. However, the benefit of these technologies depends on reliable infrastructure. Many rural areas still face weaker internet coverage, slower mobile data speeds and more service interruptions than urban centres[13]. Poor road conditions, long travel distances, unstable electricity supply and supply chain delays can also limit the reach of health technology and emergency response[14]. Together, these factors show a future where demand pressure grows, technology can ease some of the burden, but structural access barriers may continue to hold rural communities back unless broader systems are strengthened.

These patterns have clear social and economic implications. Limited access to timely primary care leads to higher rates of preventable illness, avoidable hospital admissions and emergency presentations, which in turn increase costs for state health systems. It also affects people's ability to work, care for family members and remain in smaller towns, reducing labour force participation and weakening local economies over time. For local governments in thin rural markets, the national funding gap often shows up as a direct cost on rates, because councils feel compelled to subsidise GP services, housing and clinics to prevent service collapse. As a result, health delivery in rural Australia is both a health equity issue and a productivity issue, with primary care access acting as a key driver of community wellbeing, workforce stability and the long-term viability of small regional towns.

2.2 Health Service in Assessment Area

The six LGAs in the Local Government Rural Health Funding Alliance share a set of structural health and demographic challenges that shape their need for reliable primary care. These communities are small, dispersed and ageing, with limited local health infrastructure and long travel distances to alternative services. Alliance documents note that health behaviours and outcomes in the Wheatbelt, Central Great Southern and Lower Great Southern regions are consistently poorer than Western Australia overall, with higher rates of physical inactivity, obesity, high blood pressure and mental health concerns. These patterns are similar across all six LGAs and reflect the broader disadvantage seen in many MM5–MM7 communities.

Local age structures amplify these pressures. Between 15% and 24.7% of residents in the Alliance LGAs are aged over 65, compared with a national rate of around 17.2 percent[15]. Older populations typically require more frequent GP contact and ongoing management of chronic and complex conditions. The Alliance also highlights that four of the six LGAs fall into lower SEIFA brackets, indicating socio-economic disadvantage that is linked with poorer health outcomes and higher demand for accessible, affordable primary care.

Census health data for the six regions shows a clear concentration of long-term conditions that drive strong and ongoing GP demand. Prevalence rates for many chronic illnesses including arthritis, asthma, diabetes, heart disease, lung disease and mental health conditions are equal to or higher than the Western Australian and national averages across most LGAs. When the six shires are considered together, residents report more than 4,700 long-term health conditions, including 780 cases of arthritis, 623 asthma, 374 diabetes, 315 heart disease, 151 lung conditions and 628 mental health conditions. These levels underscore a population that is older, has higher health needs, and is more exposed to the negative consequences of delayed or inconsistent access to primary care[16].

[12] CSIRO (2025) Trends shaping the future of digital health, accessed at https://www.csiro.au/en/news/all/articles/2025/march/aehrc-trends-digital-healthcare
[13] Telecommunications Industry Ombudsman (2024) Telco problems significantly impacting regional, rural and remote Australians, accessed at https://www.tio.com.au/news/telco-problems-significantly-impacting-regional-rural-and-remote-australians
[14] Infrastructure Australia (2022) Regional Strengths and Infrastructure Gaps, accessed at https://www.infrastructureaustralia.gov.au/publications/2022-regional-strengths-and-infrastructure-gaps
[15] ABS (2021) Census QuickStats, accessed at https://www.abs.gov.au/census/find-census-data/quickstats/2021
[16] As Above.

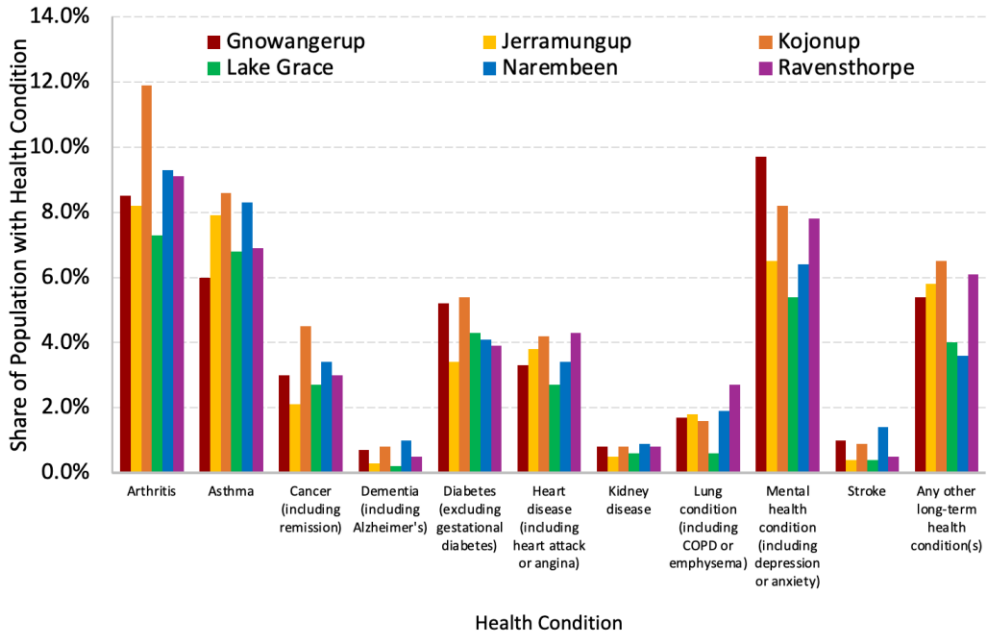

Figure 4 Share of Population with a Health Condition, Assessment Area LGAs, 2021

Access risk is heightened by the geography of the region. Even with local GP surgeries operating, residents in some parts of each shire already travel between 49 and 115 kilometres to reach their closest GP. If local services were lost, the alternative distances to the next available GP would range from 89 to 234 kilometres, depending on the LGA. For many residents, especially older people, families with young children, people with limited transport and Aboriginal community members, these distances translate to missed appointments, delayed treatment, increased avoidable hospitalisations and heavier reliance on overstretched emergency departments.

2.3 Current Rural Generalist Hub Service Subsidy

Current GP access across the six LGAs relies on the Rural Generalist hub model, underpinned by substantial financial contributions from councils. Together, the Alliance LGAs contribute around $1.475 million in cash annually, along with housing, vehicles, surgeries and administrative support. For some shires this equates to up to 16% of their total rates revenue, making it one of the largest non-core expenditure items in their budgets. The Alliance's preferred model is designed to stabilise service provision, but its continuation is heavily dependent on local government funding because workforce shortages, small patient bases and high operating costs make traditional, fully private GP practice unviable in towns of this size.

Table 3 Local Government Subsidy Spending Contributions

Local Government	Annual cash	Additional contributions	2023/24 Rates	Proportion of 2023/24 Rates Income
Shire of Gnowangerup	$250K	Provision of surgery, executive house, vehicle	$4.9m	7%
Shire of Jerramungup	$220K	Executive House in Bremer Bay, vehicle and servicing costs, contribution to vehicle running costs, WACHS owns the medical centre, arrangement between them and the Shire	$3.8m	5.7%
Shire of Kojonup	$250K	House, Vehicle, Plus servicing of the loan for the	$5.4m	4.6%

Local Government	Annual cash	Additional contributions	2023/24 Rates	Proportion of 2023/24 Rates Income
		construction of the medical centre		
Shire of Lake Grace	$250K	Provision of surgeries, executive house, vehicle and fuel	$5.1m	7.3%
Shire of Narembeen	$305K	Provision of surgery, vehicle, new executive house	$2.6m	16%
Shire of Ravensthorpe	$200K	Provision of surgeries, house provided by FQM	$5.7m	5%

The combined effect of high chronic-disease prevalence, older demographics, socio-economic disadvantage and long travel distances means that the six LGAs face a structurally higher need for GP access than many parts of Western Australia. Without sustained local GP availability, the region would likely see higher avoidable hospitalisations, more retrievals and transfers, reduced health outcomes, and broader social and economic costs. The current model mitigates many of these risks, but it does so by shifting a significant share of primary-care funding onto local governments that have limited fiscal capacity.

3 SOCIO-ECONOMIC ATTRIBUTES

This section provides an overview of economic and socioeconomic indicators of the assessment area, providing an overall context to the program.

3.1 Population

Across the six Alliance LGAs, population has been mostly stable over the long term. The combined population shifted from 9,230 in 2001 to around 8,900 in 2024, with only gradual year-to-year changes. Ravensthorpe, the largest LGA, shows the most movement linked to economic activity, while Kojonup has held steady just under 2,000 residents. Narembeen remains the smallest community and has been consistently close to 820–850 residents over the past two decades[17].

WA Tomorrow projections point to a generally stable outlook with signs of gradual growth across the region. The population is expected to rise from about 8,936 in 2025 to around 9,044 in 2041, an increase of 1.2 percent. While growth is modest, it indicates that the region is expected to remain steady and avoid the sharper declines seen in some remote areas, with Ravensthorpe projected to grow more strongly due to its broader economic base[18].

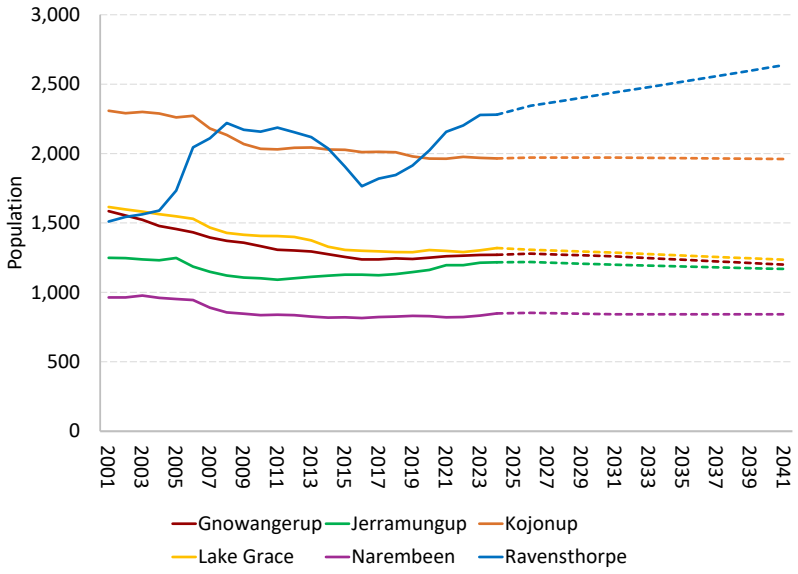

Figure 5 Population Projections, Alliance LGAs, 2001 to 2041

Overall, the projections show a population that is stable and resilient, with gradual growth supporting continued demand for essential services. Combined with an ageing demographic profile, this points to a sustained need for reliable local GP services, even in the absence of large population shifts

3.2 Socio-Economic Profile

A summary of key attributes of the “project location” from the 2021 Census of Population and Housing is provided in the table below.

[17] ABS (2024) Regional Population, accessed at https://www.abs.gov.au/statistics/people/population/regional-population/latest-release#data-downloads

[18] WA.gov.au (2025) Population Forecasts, accessed at https://www.wa.gov.au/government/document-collections/wa-tomorrow-12-population-forecast-data-tables

Table 4 Census Socio-Economic Profile, Assessment Area LGAs & WA, 2021

Indicators	Gnowangerup	Jerramungup	Kojonup	Lake Grace	Narembeen	Ravensthorpe	WA
Headline							
Population	1215	1160	1901	1265	787	2085	2,660,026
Median Age	39	40	45	41	47	42	38
Average Household Size	2.5	2.4	2.3	2.4	2.3	2.2	2.5
Share of Population 0-14 (%)	21.5%	21.4%	19.6%	19.7%	19.3%	18.7%	19.0%
Share of Population 65+ (%)	15%	16.4%	22.4%	16.5%	24.7%	18.2%	16.1%
Born in Australia	75.9%	78.4%	77.7%	78.0%	74.7%	70.5%	62.0%
Share of People Attending Educational Institutions							
Pre-School	**19**	**24**	**40**	**27**	**19**	**43**	**45,452**
Primary	**100**	**100**	**185**	**111**	**62**	**168**	**222,555**
Primary - Government	27.9%	32.2%	24.9%	27.9%	24.5%	29.5%	19.3%
Primary - Catholic	0.0%	0.0%	11.2%	0.0%	0.0%	0.0%	4.5%
Primary - other non-Government	3.5%	1.3%	0.00%	0.00%	1.30%	0.00%	3.6%
Secondary	**50**	**43**	**70**	**44**	**21**	**65.00**	**175,841**
Secondary - Government	8.7%	10.0%	10.4%	10.1%	4.2%	10.4%	12.7%
Secondary - Catholic	0.0%	1.3%	0.0%	0.0%	0.0%	0.0%	4.5%
Secondary - other non-Government	7.7%	2.9%	3.5%	5.7%	1.3%	0.0%	4.6%
Tertiary	**28**	**25**	**50**	**26**	**11**	**59**	**172,239**
Tertiary - Vocational education (including TAFE and private training providers)	5.1%	4.5%	4.3%	2.7%	3.0%	6.3%	7.4%
Tertiary - University of other higher education	4.5%	2.6%	5.1%	4.7%	3.0%	5.0%	13.9%
Weekly Incomes							
Personal	$911	$870	$882	$1,001	$923	$926	$848
Family	$2,034	$1,798	$2,004	$2,100	$1,875	$2,019	$2,214
Household	$1,482	$1,421	$1,446	$1,715	$1,483	$1,655	$1,815
Share of Household							
Couple family without children	31.6%	20.3%	29.8%	34.0%	37.5%	33.1%	27.2%
Couple family with children	33.5%	17.7%	27.8%	31.3%	28.0%	23.1%	32.1%
One parent family	5.8%	2.9%	6.3%	3.9%	6.5%	7.8%	11.4%
Other family	0.7%	0.0%	0.0%	0.6%	0.0%	0.4%	1.1%
Lone Person Households	26.6%	57.9%	33.8%	28.5%	26.4%	33.9%	24.4%
Group Households	1.8%	1.2%	2.3%	1.7%	1.5%	1.7%	3.8%
Dwelling Occupancy							
Occupied	71.4%	51.5%	77.3%	69.8%	77.1%	62.0%	89.1%
Unoccupied	29.2%	48.3%	23.1%	30.4%	21.2%	38.2%	10.9%
Dwelling Type							

Indicators	Gnowangerup	Jerramungup	Kojonup	Lake Grace	Narembeen	Ravensthorpe	WA
Separate house	97.3%	92.2%	94.4%	93.4%	94.3%	94.1%	79.7%
Semi-detached, row or terrace house, townhouse etc	0.9%	3.3%	4.1%	3.8%	6.9%	0.5%	13.0%
Flat or apartment	0.0%	0.0%	0.0%	0.6%	0.0%	1.7%	6.5%
Other dwelling	0.0%	4.5%	0.7%	0.9%	0.0%	3.2%	0.6%
Tenure							
Owned outright	42.6%	38.7%	41.4%	45.2%	56.1%	35.8%	29.2%
Owned with a mortgage	21.1%	23.3%	21.2%	19.6%	18.3%	16.4%	40.0%
Rented	22.2%	25.0%	26.1%	20.7%	18.7%	28.0%	27.3%
Other tenure type	12.1%	12.5%	7.7%	11.9%	7.3%	18.1%	2.1%
Tenure type not stated	2.1%	0.0%	3.7%	3.2%	0.0%	2.3%	1.4%

Key findings from the socio-economic profile include:

Population size and structure:

- The six LGAs range from very small communities like Narembeen (787 residents) to larger centres such as Ravensthorpe (2,085), showing a dispersed settlement pattern that increases the cost of delivering services. The total population base is small compared to WA's 2.66 million, which limits economies of scale for health and community services.
- Median ages are higher than the WA average (38), with several LGAs such as Kojonup (45) and Narembeen (47) showing older populations. An older demographic increases demand for GP services, chronic disease management and home-based care.

Household structure:

- Average household sizes are smaller (2.2–2.5) compared to WA (2.5), and all LGAs have high shares of lone-person households, especially Jerramungup and Ravensthorpe. Smaller households and more people living alone tend to increase reliance on local health services due to weaker informal support networks.
- Couple families without children are more common in LGAs like Lake Grace and Narembeen, consistent with ageing populations. This reinforces long-term demand for primary care and reduces the labour force base that local councils rely on.

Age distribution:

- Most LGAs have lower shares of children aged 0–14 than WA, indicating slower generational turnover.
- All LGAs have higher shares of residents aged 65+ than the WA average (16.1%), with Narembeen (24.7%) and Kojonup (22.4%) standing out. Older communities increase the need for regular GP access, drive up chronic disease prevalence and raise costs for both councils and state health services.

Education participation:

- School enrolments are small across the region, reflecting population size and creating thin education markets.
- University attendance is significantly lower than the WA average (13.9%), with most LGAs between 2.6 and 5.1%. Lower tertiary participation tends to correlate with lower long-term incomes and less diverse local labour markets, limiting the ability to attract skilled workers, including health professionals.

Income levels:

- Personal, family and household incomes are generally below the WA average, except for small pockets such as Lake Grace. Lower incomes reduce private spending capacity and increase dependence on public services, including subsidised GP provision.

Housing, tenure and occupancy:

- The region is dominated by separate houses (over 90%), much higher than the WA average (79.7%).
- Unoccupied dwellings are high in several LGAs, especially Jerramungup and Ravensthorpe. High vacancy can reflect seasonal work, farm properties or housing stock misaligned with demand. Economically, this suggests weaker housing markets and difficulty attracting permanent workers, including GPs.
- A much higher share of dwellings are owned outright, particularly in Narembeen and Lake Grace. This matches the age profile but also signals limited population growth and fewer new entrants to the region.

Tenure patterns:

- Mortgage rates are well below the WA average (40%), again reflecting ageing populations and limited new housing development.
- Higher rental shares in Ravensthorpe and Kojonup can indicate greater labour mobility, often tied to mining or agriculture. However, rental availability in small markets can still be thin, which affects GP attraction when councils cannot supply housing.

3.3 Number of Registered Businesses

Across the six LGAs, there are approximately 1,800 registered businesses, highlighting a surprisingly active economic base for a small and dispersed population. Business counts range from fewer than 150 in the smallest LGA to over 500 in the largest, showing the mix of small farm enterprises, contractors, logistics operators and service businesses that support the regional economy.

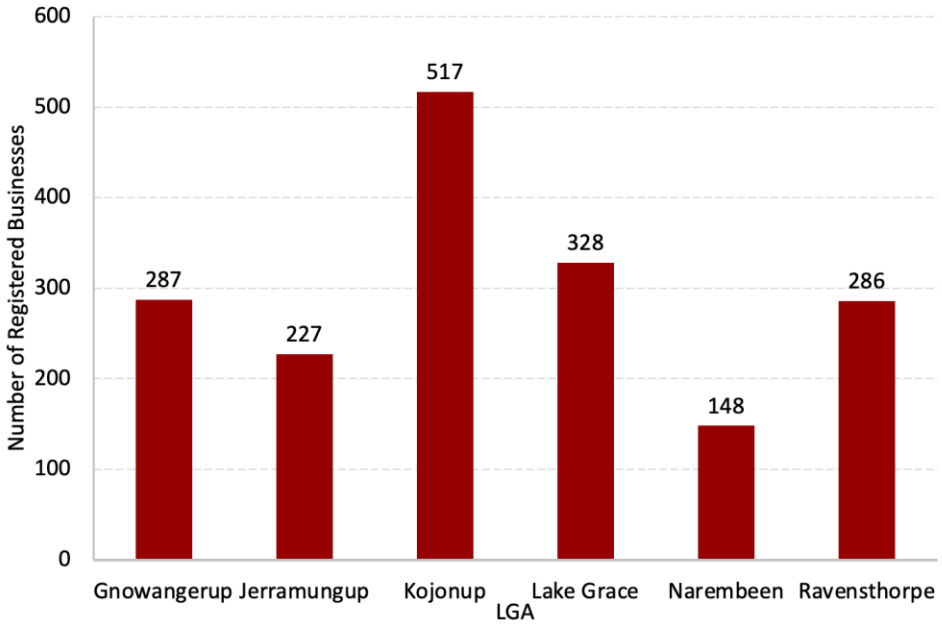

Figure 6 Business Registrations, Assessment Area LGAs, 2024[19]

The business base across the six LGAs is strongly shaped by agriculture, with 986 agricultural businesses, making it by far the dominant sector. Together with rental and real estate services (259 businesses) and

[19]ABS (2024) Count of Businesses accessed at abs.gov.au

construction (107), the top three industries account for about 75% of all registered businesses, demonstrating the concentration of the local economy. Most other sectors, including retail, accommodation, transport, professional services and manufacturing, operate at small scales consistent with low population density and dispersed markets. Health care and social assistance is also limited (27 businesses), which aligns with the region's reliance on council-supported GP services rather than a strong private health sector.

3.4 Unemployment Rate

Unemployment across the six LGAs has been consistently low, generally sitting between 1 and 3 percent, well below the WA average of around 4 to 7 percent over the same period. Within this range, Narembeen has recorded the highest unemployment at times (around 3 to 4 percent), while Gnowangerup and Ravensthorpe have often had the lowest rates, falling to below 2 percent in recent years. This tight labour market leaves very little spare workforce capacity, meaning illness or delays in accessing medical care can more directly affect business continuity and productivity.

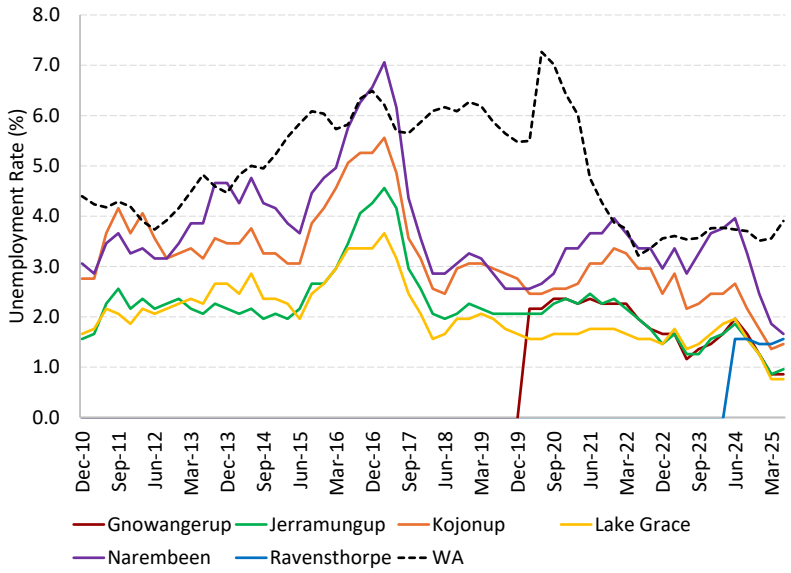

Figure 7 Unemployment Rate, Assessment Area LGAs, Dec 2010 – Jun 2025[20]

[20] National Skills Commission (2025) Small Area Labour Markets, accessed at https://www.nationalskillscommission.gov.au/topics/small-area-labour-markets

4 GP SUBSIDY COST BENEFIT ANALYSIS

This section outlines the methodology, assumptions, and results of the GP Subsidy Cost Benefit Analysis.

4.1 Methodology

A CBA is the most commonly used, and most comprehensive, of the economic evaluation techniques. Essentially, a CBA compares the monetised benefits and costs of a project to evaluate the desirability of a project. This approach is the most appropriate to assess the net economic benefits that accrue from the two development options.

The CBA steps include:

1. Identify the quantifiable benefits that can be monetised;
2. Calculate the value (in monetary terms) of the quantified incremental benefits and costs in net present value (NPV) terms using the discount rates;
3. Calculate the benefit cost ratio (BCR) – the total present value of all net benefits divided by the present value of costs to determine the ratio to which incremental net benefits exceed (or undershoot) incremental costs related with the upgrade; and
4. Undertake a sensitivity assessment.

4.1.1 Discount Rates

Discounting is the reverse of adding (or compounding) interest. It reduces the monetary value of future costs and benefits back to a common time dimension – the base date. Discounting satisfies the view that people prefer immediate benefits over future benefits (social time preference), and it also enables the opportunity cost to be reflected (opportunity cost of money). Recognising the potential for multiple audiences for the business cases, real discount rates of 3, 7 and 10% have been applied. This complies with recommendations set by the Office of Impact Analysis (OIA) at the Federal Government level and Western Australian Treasury Business Case Template and Program Evaluation guidelines.

Modelling of quantifiable benefits and costs are developed over a 20-year timeframe (post initial year or Year 0).

4.1.2 Cost of Capital Approach

The cost benefit assessment undertaken in this report represents a “cost of capital” assessment. This approach focuses primarily on the up-front fiscal costs of the project with reduced consideration of ongoing or opportunity costs. The primary reason for this is that the results of the assessment are to be used as evidence of the value for money of the subsidy and its notional economic and social return on investment.

Opportunity costs – the cost of forgoing the next best alternative – is considered as part of the analysis within section 5.0 of this assessment.

4.2 Benefits Statement

A range of direct economic and social benefits of the Subsidy have been identified. These benefits can be broken into 2 broad categories:

1. **Community Health Outcomes**
    a. Improved GP Accessibility Benefit
    b. Improved Population Health Outcomes
2. **Economic and Social Outcomes**
    a. Local Key Health Worker Productivity Benefits
    b. Health Sector Supply Chain Impacts

c. Long-Term Economic & Social Participation Benefits

Figure 8 Regional Generalist Hub GP Subsidy Benefits

Those benefits which are capable of being monetised for inclusion in the CBA are detailed accordingly.

Table 5 Benefits Statement

Benefit	Description	Method of Calculation
Community Health Outcomes		
Improved GP Accessibility Benefit	The Improved GP Accessibility benefit represents the reduced travel time and travel costs for the local catchment population as the result of subsidies localising GPs for the area.	Catchment population is multiplied by the rate of GP visits per year and total time spent travelling to GPs for the catchment to calculate the travel time and distance. For time costs, this is multiplied by the non-economic value of time per hour. For travel costs this is multiplied by the ATO mileage reimbursement of $0.88 per Km. This is subject to an attribution rate of 50% to reflect rule of half.
Improved Population Health Outcomes	The Improved Population Health Outcomes benefit reflects the reduction in adverse health outcomes as the result of patient delays for GP appointments.	Per patient value of improved health outcomes multiplied by the catchment population multiplied by the historical GP patient delay rate for inaccessible GP appointments. This is subject to an attribution rate of 50% to reflect other factors influencing the achievement of local health outcomes.
Economic and Social Outcomes		
Local Key Health Worker Productivity Benefits	The Local Key Health Worker Productivity Benefit reflects the increased catchment area worker GVA as the result of inducing health industry expenditure through the local GP subsidy program.	Total health care workers required for catchment population represented by GP per 100,000 per person rate of 112 along with additional one supporting healthcare worker per GP. This is applied by Regional WA Health Care and Social Assistance Worker Productivity value for 2024. An attribution rate of 50% is applied to reflect the contribution of other factors in local GP worker productivity.

Benefit	Description	Method of Calculation
Health Sector Supply Chain Impacts	The Health Sector Supply Chain Impacts capture the positive uplift in supply chain expenditure as the result of the first-round industry support GVA multiplier.	Total health worker productivity induced by GP subsidy program is converted to turnover and then multiplied by the First Round and Industry Support GVA multiplier rate. This is a proxy for health care expenditure supply chain.
Long-Term Economic and Social Participation Benefits	The Long-Term Economic and Social Participation Benefits model the long term increase in resident productivity and output as well as economic participation as the result of improved health outcomes.	The labour force count for the local catchment multiplied by the employment rate and the worker productivity to estimate the total economic output and value added of population. This is multiplied by the long term economic participation uplift rate of 0.5% per year and applied for 2 years post improved health.

4.3 Assumptions

The assumptions used in the modelling of CBA benefits are outlined below in the List of Assumptions.

Table 6 List of Assumptions

Benefit	Value
Non-Economic Value of Time (per hour)[21]	$20.4
Rate of GP Attendances per Person per Annum[22]	6.13
Average Travel Speed to GP out of Catchment	80km/h
Rural Distance Premium for Medical Travel[23]	80km
Australian Tax Office Mileage Reimbursement per Km Driven[24]	$0.88
GP Patient Delays based on Cost and Availability[25]	7%
Specialist Patient Delays based on Cost and Availability[26]	10.5%
Value of a Statistical Life Year[27]	$245,000
Average Annual Specialist Hours per Resident[28]	4.0
Average Annual GP/NP Hours per Resident[29]	5.3
Rate of GPs for an Area per 100,000 Residents[30]	112
Regional WA Health Care and Social Assistance Annual Worker Productivity Value[31]	$87,743
First Round and Industry Support Health Care GVA Multiplier[32]	7.2%
Long Term Economic Participation Uplift Rate	0.5%

[21] ATAP (2025) Parameter Values accessed at https://www.atap.gov.au/parameter-values/index and adjusted to $2024/25 by CPI
[22] Australian Institute of Health and Welfare (2025), General practice, allied health and other primary care services, accessed at https://www.aihw.gov.au/reports/primary-health-care/general-practice-allied-health-primary-care
[23] Estimates by the Alliance indicate travel times of more than 200km. A single leg trip of 80km was selected as representative of the travel distances involved, based on the population centres and distances involved.
[24] ABS (2025) Patient Experiences accessed at https://www.abs.gov.au/statistics/health/health-services/patient-experiences
[25] As above
[26] OIA (2025) Value of statistical life accessed at https://oia.pmc.gov.au/resources/guidance-assessing-impacts/value-statistical-life
[27] Australian Government Department of the Prime Minister and Cabinet Office of Impact Analysis (2024), Value of statistical life, accessed at https://oia.pmc.gov.au/sites/default/files/2024-11/value-statistical-life-guidance-note.pdf
[28] ABS (2025) Patient Experiences accessed at https://www.abs.gov.au/statistics/health/health-services/patient-experiences
[29] As above
[30] ABS (2025) Patient Experiences accessed at https://www.abs.gov.au/statistics/health/health-services/patient-experiences
[31] Economy ID (2025) Western Australia Economy Profile accessed at https://economy.id.com.au
[32] Derived from regional transaction tables for Western Australia using National Accounts to develop regional Input-Output based GVA multipliers. Applies the first round and industry supply GVA multipliers only to notional GP service turnover value as a proxy for operational expenditure supply chain impacts.

4.4 Results

4.4.1 Costs

The annual cost of the subsidy program has been estimated to cost $1.48m per annum. For the purposes of this modelling Econisis has modelled this over a 3-year period to reflect spending commitments sought by the Alliance. Discounted over the next 3-years the present value of costs ranges from $4.26m at the 4% discount rate to $4.03m at the 10% discount rate.

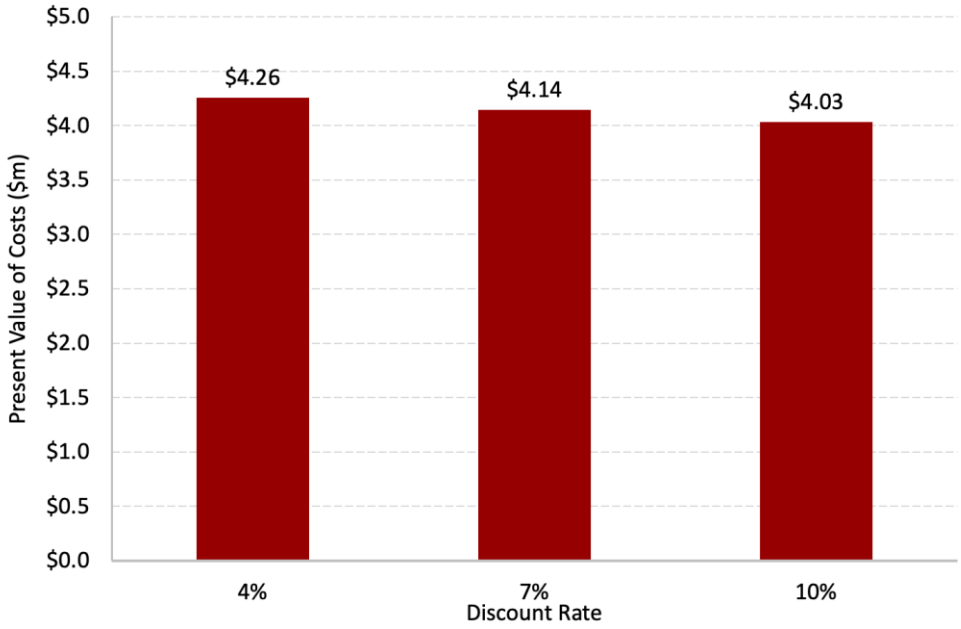

Figure 9 Present Value of Costs ($m)

4.4.2 Benefits

The total benefits for the GP subsidy program over the 3-year assessment period ranges from $13.19m at the 4% discount rate to $12.35m at the 10% discount rate.

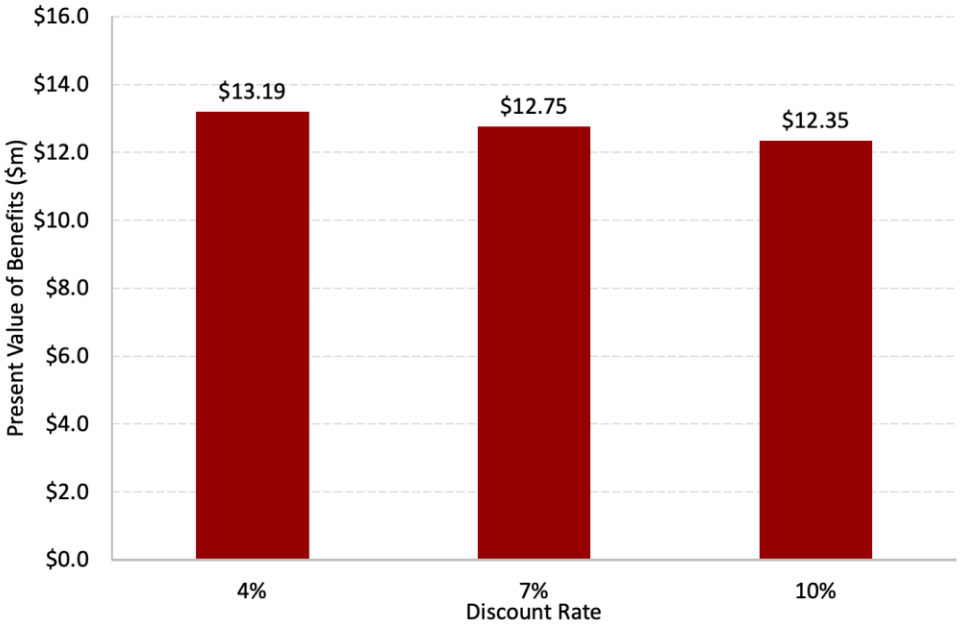

Figure 10 Present Value of Benefits ($m)

Analysing these benefits individually at the 7% discount rate, it is revealed that the largest contributing benefit is the Improved GP Accessibility Benefit with a value of $5.07m. The second largest contributing benefit is Long-Term Economic and Social Participation Benefits with a value of $2.56m followed closely by Local Key Health Worker Productivity at $2.46m.

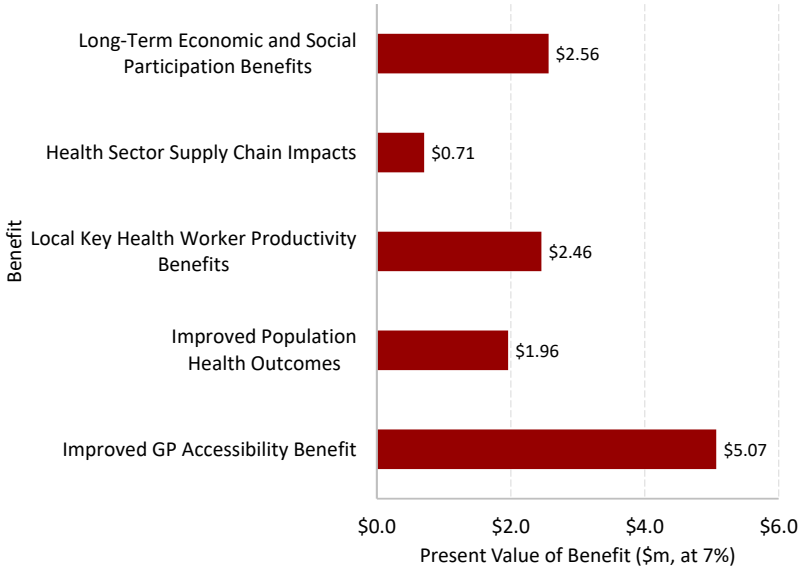

Figure 11 Present Value of Benefits by Type ($m)

When examined based on the benefit categories, approximately 55% of benefits relate to Community Health Outcomes with the remainder represents wider Economic and Social Outcomes.

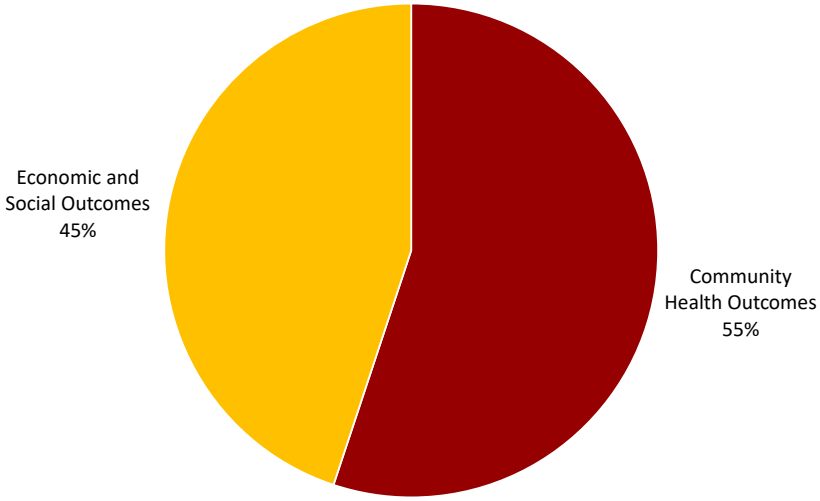

Figure 12 Share of Benefits, by Category, 7% Discount Rate

4.4.3 Net Present Value

The net present value (NPV) of the program ranges from a total of $8.94m at the 4% discount rate to $8.32m at the 10% discount rate. With a positive NPV at all discount rates this program provides a positive social and economic return on investment.

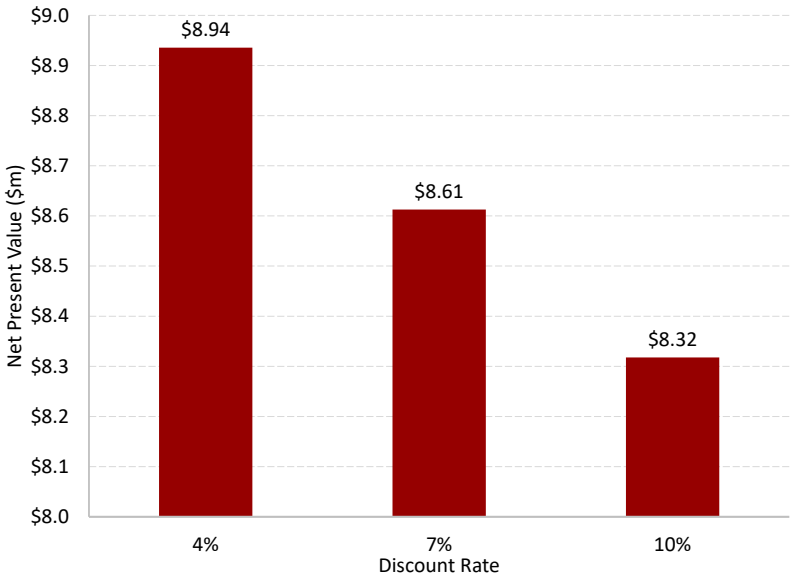

Figure 13 Net Present Value ($m)

Overall, with a benefit cost ratio ranging from of 3.06 to 3.10 across the discount rates applied, the GP Subsidy CBA represents a strong value for money proposition. Any result with a BCR above 1.0 means that the present value of benefits exceeds cost. With a BCR in excess of 3.0, the GP Subsidy provides a robust economic and social return on investment and supports the realisation of critical health outcomes for the collective communities.

Table 7 Summary of GP Subsidy Cost Benefit Analysis

Summary	4%	7%	10%
Total Costs ($m)	***$4.26***	***$4.14***	***$4.03***
Funding Cost	$4.26	$4.14	$4.03
Total Benefits ($m)	***$13.19***	***$12.75***	***$12.35***
Community Health Outcomes			
Improved GP Accessibility Benefit	$5.21	$5.07	$4.94
Improved Population Health Outcomes	$2.01	$1.96	$1.91
Economic and Social Outcomes			
Local Key Health Worker Productivity Benefits	$2.52	$2.46	$2.39
Health Sector Supply Chain Impacts	$0.73	$0.71	$0.69
Long-Term Economic and Social Participation Benefits	$2.72	$2.56	$2.43
Net Present Value ($m)	***$8.94***	***$8.61***	***$8.32***
Benefit-Cost Ratio (BCR)	***3.10***	***3.08***	***3.06***

5 OPPORTUNITY COST IMPACT ANALYSIS

An Opportunity Cost Impact Analysis has been undertaken by Econisis to assess the forgone benefits as the result of members of the Alliance spending their revenue on GP subsidies as opposed to regular spending responsibilities.

5.1 What are Opportunity Costs?

An opportunity cost is the value of the next best alternative forgone when a choice is made. In economics, resources are scarce, so committing funds to one activity results in other opportunities missing out. For governments, this trade-off is critical because public revenue allocation must strike a balance between providing healthcare, education, infrastructure investment, and public safety initiatives.

The opportunity cost for the six local governments and shires in the case of the GP Subsidy Program is particularly important to analyse and understand due to the substantially large proportion of total revenue that current subsidy funding consumes. In some cases, the current requirement of annual subsidy funding consumes up to 16% of a shire's annual revenue base. The resulting effect of this is that the opportunity cost of funding the GP Subsidy Program is quite substantial as large spending commitments that are typical of local governments are neglected in place of funding the subsidy program.

5.2 Approach to Assessing Opportunity Costs

The approach to assessing opportunity costs taken in the Opportunity Cost Impact Analysis involves utilising a similar CBA method as outlined in section 4.0. This entails forecasting the benefits profiles of each Opportunity Cost Scenario (see below) which represent substitute spending program for the notion $1.48m per year that each Council could embark on. These profiles are discounting back to the present day at the 7% discount rate to enable comparison of the benefit cost ratios for each Scenario with that of the GP Subsidy Program to ascertain comparable value for money on the funding.

5.2.1 Opportunity Cost Scenarios

With an annual GP Subsidy spending cost of $1.48m, Econisis has modelled the opportunity cost of a series of substitute spending programs for the local councils. These substitute spending programs scenarios include:

- **Council Capacity, Governance and Service Delivery:** This scenario models the annual cost of $1.48m being spent on initiatives that increase council worker output and the corresponding productivity uplifts and decreased regulatory turnaround times/duration.
- **Community Connection and Social Wellbeing:** This scenario represents resources being directed towards programs that increase youth and senior engagement in the community though community events as well as greater volunteering participation throughout the year as the result of this increased community engagement.
- **Local Infrastructure Efficiency and Safety:** This scenario models the increases in commercial activity, safety improvements, and time savings benefits for local residents as the result of transport infrastructure spending by Councils.
- **Outdoor Recreation, Environment and Town Amenity:** This scenario reflects the benefit of spending being redirected to programs that enhance community sporting participation, uplift outdoor community space use, improve urban amenity and environment and increase volunteer and social cohesion.

5.2.2 Limitations

Note that the opportunity cost scenarios are indicative only and are designed to provide context for the value for money proposition of the GP Subsidy. There are no specific programs, expenditure items or projects that have been tested for each of the opportunity cost scenarios.

Instead, the scale of the expenditure and the size of the service population have been used as proportional constraining factors in determining the size and extent of benefits that could be yielded from investments in each of the substitute spending programs.

5.3 Results

The results of the Opportunity Cost Impact Analysis (at the 7% discount rate) reveal that the Local Infrastructure Efficiency and Safety program returned the highest BCR of 4.56 at the 7% discount rate. The lowest return, and the only program that returned a BCR below the comparison GP Subsidy spending program was the Council Capacity, Governance and Service Delivery program with a BCR of 2.99.

Figure 14 Benefit Cost Ratio of Substitute Spending Programs

The conclusion formed from the Opportunity Cost Impact Analysis is that while the annual $1.48m spend on the GP Subsidy program does present a strong value for money proposition with a BCR of 3.08, it is less than other substitute spending programs.

As the result, it is in the interest of local resident that the $1.48m of annual spend be diverted toward the Local Infrastructure Efficiency and Safety spending program initiative or other initiatives modelled that yield a higher BCR that 3.08.

The results of the main scenario and the opportunity cost scenarios are outlined here.

Table 8 Opportunity Cost Impact Scenarios, CBA Results, by Discount Rates

Summary	4%	7%	10%
Total Costs ($m)	***$4.26***	***$4.14***	***$4.03***
Current Contribution (3 Years)	$4.26	$4.14	$4.03
Total Benefits ($m)	***$13.08***	***$12.39***	***$11.78***
Council Capacity, Governance and Service Delivery	$13.08	$12.39	$11.78
NPV ($m)	***$8.82***	***$8.25***	***$7.74***
BCR	***3.07***	***2.99***	***2.92***

Summary	4%	7%	10%
Total Costs ($m)	***$4.26***	***$4.14***	***$4.03***
Current Contribution (3 Years)	$4.26	$4.14	$4.03
Total Benefits ($m)	***$13.27***	***$12.91***	***$12.57***
Community Connection and Social Wellbeing	$13.27	$12.91	$12.57
NPV ($m)	***$9.02***	***$8.76***	***$8.53***
BCR	***3.12***	***3.12***	***3.11***

Summary	4%	7%	10%
Total Costs ($m)	***$4.26***	***$4.14***	***$4.03***
Current Contribution (3 Years)	$4.26	$4.14	$4.03
Total Benefits ($m)	***$19.42***	***$18.89***	***$18.40***
Local Infrastructure Efficiency and Safety	$19.42	$18.89	$18.40
NPV ($m)	***$15.16***	***$14.75***	***$14.37***
BCR	***4.56***	***4.56***	***4.56***

Summary	4%	7%	10%
Total Costs ($m)	***$4.26***	***$4.14***	***$4.03***
Current Contribution (3 Years)	$4.26	$4.14	$4.03
Total Benefits ($m)	***$13.90***	***$13.17***	***$12.51***
Outdoor Recreation, Health and Wellness Benefit	$8.65	$8.20	$7.79
Environmental Quality and Town Amenity	$5.24	$4.97	$4.72
NPV ($m)	***$9.64***	***$9.02***	***$8.48***
BCR	***3.26***	***3.18***	***3.10***

6 FINDINGS AND CONCLUSIONS

This section summarises the findings and conclusions of the analysis as well as makes a concluding recommendation for action into the future.

6.1 Summary of Findings

The GP Subsidy Program currently represents a substantial financial burden on the six local governments across the Great Southern and Wheatbelt that are part of the Local Government Rural Health Funding Alliance.

Access to medical professionals has been getting more challenging over time because of national GP shortages, rising costs and the difficulties of attracting and retaining doctors in small towns. To keep services running (and not disadvantage regional and remote residents), the Alliance Councils have taken on a large share of the financial responsibility for GP attraction and retention. This includes direct funding, housing, vehicles and maintaining practice facilities. These contributions are now absorbing a significant share of local revenues. While this has helped to retain essential health services, the fiscal outlay has also impinged on the capacity of the Alliance Councils to effectively investment into the delivery core responsibilities.

Econisis modelled the health, economic and social impacts and benefits of the Program based on a 3 year funding period and found the program delivers a robust return on investment with a BCR at 3.08. Local community health outcomes and access, long-term economic and social participation impacts and key health worker productivity were all identified as major benefits.

While the expenditure of funding by the Alliance Councils on the Program represents a strong value for money position, the Opportunity Cost Impact Analysis revealed that the expenditure could be more effectively allocated to areas of Local Government responsibility. This includes on local roads to facility community and freight transport, community facilities, open space and environment and other economic and social programs.

This would yield a comparable or even larger return on investment for rate payers.

6.2 Recommendation Statement

Overall, the contribution of funds toward the GP Subsidy Program represents a strong return on investment with a BCR of 3.08. However, in assuming responsibility for attraction and retention of this essential service, the Alliance Council have been forced to shift budgeted funding away form other responsibilities – areas of focus that have the potential deliver a greater return to the community and local residents.

It is therefore recommended that:

The six Shires of the Local Government Rural Health Funding Alliance seek funding support from State and/or National Governments to resource the GP Subsidy Program and to redirect current funding other expenditure programs within the core responsibility of Local Government.

ECONISIS

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Supporting regional workforce growth

- The **Federal Government** is adding 100 new **Commonwealth Supported Positions** per year in medicine, targeted at universities that demonstrate evidence-based strategies to encourage students to pursue general practice careers and focus on regional, rural, and remote Australia.

State and Territories

Supporting regional workforce growth

- **Queensland** has announced it will establish a new **Health Sciences Academy in Rockhampton** to train the next generation of regional health workers. The Academy will fast-track years 10-12 students into careers as doctors, nurses, paramedics and allied health professionals in regional Queensland.
- The **Victorian Governmen**t is funding the construction of 15 self-contained apartments at **Shepparton Hospital** to **support healthcare workers** through the Regional Worker Accommodation Fund. These energy-efficient units will help address housing shortages for frontline staff and improve retention in regional Victoria. More than 20 projects, including 12 healthcare housing initiatives, are underway statewide to attract and retain essential workers and strengthen regional communities.

Innovation

- **NSW's** *Health Research and Innovation Strategy 2025–2030* includes several initiatives specifically targeting regional, rural, and remote communities to improve health outcomes and equity. It emphasises place-based research and innovation, supporting **regional health precincts** – collaborations between local health districts, universities and community organisations. These precincts enable clinical trials and translational research in rural and remote areas, along with strategic investment in areas of strength such as agriculture, environmental health, and Indigenous health. Additional investment in digital health tools and data systems will allow regional services to participate fully in statewide research and innovation efforts.
- In **Victoria**, La Trobe Clinical Trials Platform launched in May, to **expand clinical research opportunities in regional Australia**. It supports trials in allied health, nursing, psychology, and public health, with a focus on non-pharmaceutical interventions. Tailored for startups and SMEs, the platform offers modular services including trial design, ethics approval, and data analysis. By leveraging La Trobe's Rural Health School and regional partnerships, it aims to improve healthcare access and innovation in underserved communities. This initiative helps bridge the gap between research and delivery, enabling regional areas to participate in and benefit from cutting-edge clinical studies.

The GP challenge in remote and very remote communities

Six remote and rural local governments in Western Australia - Gnowangerup, Jerramungup, Kojonup, Lake Grace, Narembeen, and Ravensthorpe - are facing a critical challenge in sustaining access to primary healthcare. These communities, classified as RM 6 and RM 7 under the Modified Monash Model, suffer from chronic shortages of General Practitioners (GPs), leading to poorer health outcomes, increased emergency department use, and significant travel burdens for residents. To address this, the councils collectively contribute over $1.475 million annually in cash, plus housing, vehicles, and medical facilities, to attract and retain GPs. These contributions represent up to 16% of their ratepayer income - an unsustainable financial burden that diverts funds from core local government responsibilities like infrastructure and community services.

Despite various Commonwealth and State programs, current incentives do not reflect the true cost of delivering health care in remote areas. The councils argue that telehealth, while helpful, cannot replace the need for resident GPs due to limitations in continuity of care, emergency response, and community integration.

The councils have formed an alliance to call for help with a sustainability payment from the Commonwealth and State Governments to reduce the financial burden on local governments. The alliance is seeking Federal block funding of $300,000 per MM5–7 local government to support integrated rural generalist services.

JANUARY 2025

POSITION PAPER

PROVISION OF REMOTE GP SERVICES

ALLIANCE OF RM 6 and RM 7 COUNCILS

Shire of Gnowangerup | Shire of Jerramungup | Shire of Kojonup
Shire of Narembeen | Shire of Lake Grace | Shire of Ravensthorpe

This position paper is prepared by the alliance of Councils including Gnowangerup, Jerramungup, Kojonup, Lake Grace, Narembeen and Ravensthorpe.

Version: 1

Adopted: February 2025

CONTENTS

DEFINITIONS

Remote: The Australian Statistical Geographical Standard (ASGS) system has been used to categorise rural and remote communities in Australia. The ASGS is a geographical classification system which ranks areas rurality or remoteness by the Australian Bureau of Statistics (ABS) gathered from federal census data. In the ASGS areas are ranked from RA1 to RA5, with RA1 being major cities and RA5 for very remote locations.

	Classification	Ranking
Shire of Gnowangerup	Remote Australia	RA4
Shire of Jerramungup	Remote Australia	RA4
Shire of Kojonup	Outer Regional Australia	RA3
Shire of Lake Grace	Remote Australia	RA4
Shire of Narembeen	Remote Australia	RA4
Shire of Ravensthorpe	Very Remote Australia	RA5

EXECUTIVE SUMMARY

Many countries face the problem of shortages of health workers in rural and remote areas. Health workers generally prefer to be located close to major hospitals and health facilities where they trained and with good professional support and resources, and in areas with family and social support and access to schools for their children. According to the World Health Organisation, rural health workforce shortages are one of the major impediments to well-functioning health systems with a lack of General Practitioners (GPs) in rural communities associated with reduced access and inferior health outcomes.[1]

Factors contributing to rural medical workforce shortages include training pathways with little rural exposure, demanding working conditions, inadequate remuneration and professional development opportunities in rural practice, and social isolation. Financial incentives are widely used by Commonwealth and State policy makers as well as local governments to improve recruitment and retention of GPs to rural and remote communities.

There are minimum floor costs that exist to maintain basic medical services in any location. These include GPs, nursing and administration staff, premises, equipment and ongoing overheads. In remote communities, Medicare billing alone cannot cover these floor costs for a variety of reasons.

The alliance of councils comprising the Shires of Gnowangerup, Jerramungup, Kojonup, Lake Grace, Narembeen, and Ravensthorpe have prepared this position paper to raise awareness and suggest a solution to attract and retain GPs in their rural and remote communities, where current Commonwealth and State government policy settings are inadequate.

The six local governments collectively contribute over $1.475 million cash annually to attract and retain resident GP services, plus housing, vehicles, and surgeries. These financial contributions are sourced through rates and are unsustainable. They are essential for community health but place a significant financial strain on local government resources, diverting funds from other vital services that are well within the remit of local government.

The six remote local governments (RM6 and RM7 under the Modified Monash Model) are using a substantial portion of their ratepayer funds to attract and retain GPs (some up to 16% of their rates). The financial incentives to attract a GP are currently heavily influenced by the local government tender process where providers have the ability to set and negotiate the market rate. This is unsustainable.

Local governments are required to step into the space of primary health care because the per capita expenditure by the Commonwealth and States on health is lower in the regions, the viability of practices is challenged due to remote geography, increased business costs and less patients.

The current Medical Facilities Cost Adjustor within the Financial Assistance Grants paid to local governments is insufficient. Higher income incentives are currently required by local governments and practice operators to attract GPs to remote areas, and existing programs do not meet these needs.

The alliance is though raising awareness to the fact that market rates to attract a GP in a RM 6 and RM 7 community are significantly rising, with Commonwealth and State Government programs needed to match these market rates. The alliance is also raising awareness that

[1] Impact of rural workforce incentives on access to GP services in underserved areas: Evidence from a natural experiment, Swami and Scott, 2021

telehealth is not the answer to shortages of GPs in remote communities and a rural generalist model, which is currently provided across the Shires is well received and delivering immense benefits.

They are seeking sustainability payments from Commonwealth and State Governments to local governments to reduce ratepayer funding towards primary health care.

1. BACKGROUND

In Australia, shortages and the inequitable distribution of general practitioners (GPs) remain a significant policy issue despite the fact that since the 1990s the Commonwealth Government has been implementing a range of initiatives to address rural workforce shortages.

A 2023 WALGA commissioned Rural Health West study found that 53% of non-metropolitan local governments in WA were spending money to provide GP services, costing just under $7.8million annually (Note this was from the 2021/22 Financial Year and has substantially increased not only through inflation but market rates). Communities across the country are also experiencing a GP shortage, and according to the Commonwealth's Department of Health report (August 2024), the shortage is most pronounced in rural areas.

At the Australian Local Government Association national meeting in September 2024, the Shire of Dundas put forward the following motion (113), which was carried:

This National General Assembly calls upon the Australian Government and the Commonwealth Minister for Health and Aged Care, Hon Mark Butler MP, to plan and fund the provision of medical services (in consultation with relevant local governments) to regional, rural and remote communities.

On Friday November 11, 2024 the WA Local Government Association (WALGA) convened a meeting of band 4 local governments. The purpose of the meeting was to identify the strategic priorities of the members, to help inform WALGA policies on a variety of issues. It was agreed at the meeting that *"Local Governments allocating ratepayer funds towards delivering medical services or contracting medical service providers to have a presence in their community"* was the second highest priority to all band 4 local governments in WA.

In response to both the ALGA and WALGA meetings, the Shire of Lake Grace called a meeting of six local governments (band 3 and band 4) and key stakeholders to meet at the Lake Grace Sportsmans Club on Friday 29 November 2024. The purpose of the meeting was to discuss the financial and in-kind contributions made by local governments to secure consistent and accessible medical service providers in their communities.

This position paper is in response to the meeting outcomes from the Lake Grace meeting.

Participating local governments in this position paper include:

Figure 1: Classification of local governments by the Modified Monash Model

	Modified Monash Model classification (RM)	Number of doctor surgeries within and provided by the Local Government
Shire of Gnowangerup	7	1
Shire of Jerramungup	7	2
Shire of Kojonup	6	1
Shire of Lake Grace	7	2
Shire of Narembeen	7	1
Shire of Ravensthorpe	7	2

2. CURRENT SITUATION

The six local governments annually contribute $1.475m of ratepayer funds towards the provision of resident GP services in their communities plus the provision of houses, vehicles, surgeries and carry the maintenance and depreciation of these assets.

The expenditure by the six local governments is crucial for maintaining the health and well-being of their communities who otherwise face barriers to accessing primary health care. This significant financial strain on rural local governments reduces resources available for other vital community services and infrastructure that is within the legislated role of local government (roads, community infrastructure, waste services etc) highlighting the significant need for more sustainable solutions to primary health care access, particularly in RM 6 and 7 communities.

Understanding the community profile, economy, health services, health condition and health needs of those living in the six local governments is the first step in improving service provision and access.

2.1 Community Profile

The six local governments are located within the Wheatbelt and Great Southern regions of Western Australia. They are classified as either RM6 or RM7 by the MMM and are similar in population size, demographics and economy.

The communities of the six local governments are:

- Median age is increasing across all local governments and there is an ageing population (see appendice)
- The Socio-Economic Indexes for Areas (SEIFA) ranks areas in Australia according to relative socio-economic advantage and disadvantage. Four of the six local governments are considered disadvantaged.
- Major industries include: agriculture, mining, education, tourism and professional services.

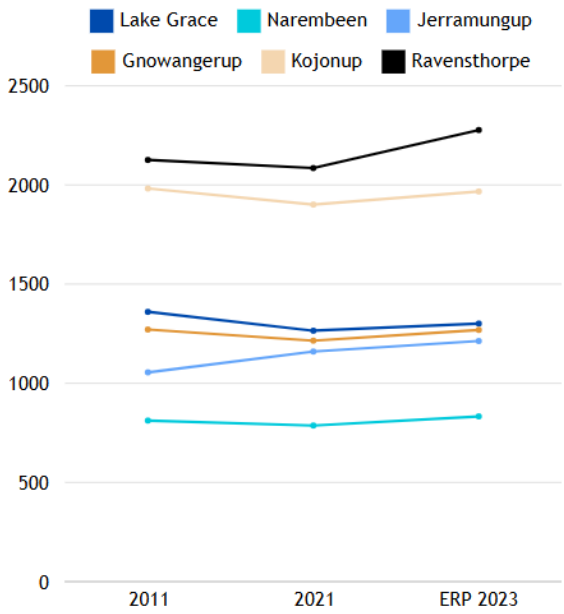
Figure: Population, Ratepayers and SEIFA score by Local Government

	Service Towns	LGA Population[2]	SEIFA score[3]
Shire of Gnowangerup	Gnowangerup	1,215	996
Shire of Jerramungup	Bremer Bay Jerramungup	1,160	996
Shire of Kojonup	Kojonup	1,901	997
Shire of Lake Grace	Lake Grace Newdegate	1,265	1051
Shire of Narembeen	Narembeen	787	1028
Shire of Ravensthorpe	Hopetoun Ravensthorpe	2,085	1002

Figure: Population by local government in 2011, 2021 and future estimate (2023)

[2] Census, 2021

[3] Socio-Economic Indexes for Areas (SEIFA), Australia, 2021



2.2 Health Profile

The National Rural Health Alliance 2023 report *Evidence base for additional investment in rural health in Australia* demonstrates a clear healthcare disparity between rural and urban Australia: rural Australians have a poorer health status, and even before accounting for the increased cost of health service, receive significantly less funding per capita than their urban counterparts.

Compared with major cities, the life expectancy in regional areas is one to three years lower, and in remote areas it is up to seven years lower. According to the Australian Institute of Health and Welfare, the burden of disease and life expectancy disparities are even more pronounced for rural, regional and remote Aboriginal and Torres Strait Islander peoples and communities.[4]

Examining the social determinants of health and related risk factors across the six local governments highlights the necessity for accessible primary health care services, such as nearby GPs. As remoteness increases, many essential quality of life factors decline, leading to poorer health outcomes.

The education levels, collective scope of job opportunities and limitations in income potential in remote communities, all influence health outcomes for people living in the communities.

[4] AMA plan for improving access to rural general practice, AMA, 2023

Figure: Country of birth, language, education and employment by Local Government[5]

	Population	Born overseas	Households who don't speak English at home	Attained Yr 10 as highest level of education	Median weekly personal income	Unemployment rate[6]
WA Average			21.2%	11.3%	$848	4.2%
Shire of Gnowangerup	1215	293	30 / 6.9%	18%	$911	4.3%
Shire of Jerramungup	1,160	250	23 / 5.4%	15.5%	$870	1.5%
Shire of Kojonup	1,901	423	50 / 6.8%	16.3%	$882	1.5%
Shire of Lake Grace	1,265	278	30 / 6.4%	16.4%	$1,001	1.3%
Shire of Narembeen	787	199	22 / 8.4%	16.1%	$923	3.8%
Shire of Ravensthorpe	2,085	616	56 / 7.1%	15.3%	$926	2.5%

The WA Country Health Service (WACHS) Health Profiles (2022) identifies the health behaviours and risk factors prevalent in the three WACHS regions. The majority of health behaviours and risk factors in the communities are above state averages.

Wheatbelt (Inclusive of the local governments of Narembeen, Lake Grace)	**Central Great Southern (Inclusive of the local governments of Gnowangerup, Kojonup)**	**Lower Great Southern (Inclusive of the local governments of Jerramungup, Ravensthorpe)**
▪ 88.1% did not eat the daily recommended serves of vegetables ▪ 51.8% did not eat the daily recommended serve of fruit ▪ 21.7% had high blood pressure (WA 16.5%) ▪ 13.5% had self-reported a current mental health problem ▪ 36.6% are overweight (WA 38.9%) ▪ 38.8% are obese (WA 29.7%) ▪ 45.8% did less than 150mins of physical activity in a week (WA 38.3%)	▪ 85% did not eat the daily recommended serves of vegetables ▪ 53% did not eat the daily recommended serve of fruit ▪ 17.8% had high blood pressure (WA 16.5%) ▪ 11.9% had self-reported a current mental health problem ▪ 35.5% are overweight (WA 38.9%) ▪ 38.9% are obese (WA 29.7%)	▪ 87.7% did not eat the daily recommended serves of vegetables ▪ 48.7% did not eat the daily recommended serve of fruit ▪ 20% had high blood pressure (WA 16.5%) ▪ 14.3% had self-reported a current mental health problem ▪ 39% are overweight (WA 38.9%) ▪ 34.5% are obese (WA 29.7%)

[5] Census, 2021
[6] WA Treasury 2025

The Australian Health Tracker data breaks the risk factors down by local governments and supports the WACHS profiles and the ABS' National Health Survey conclusions that remote people are at greater risk of poorer health outcomes. All the estimates below are above average when compared to metropolitan communities.

Figure: Health Risk Factors by Local Government

	Risk Factor (estimate) 2-17yrs who are obese / per 100	Risk Factor (estimate) adults who are overweight or obese / per 100	Alcohol consumption considered at risky levels / per 100	No or low physical activity / per 100[7]
Shire of Gnowangerup	10.9	72.3	30	71.2
Shire of Jerramungup	Greater than 10.9	72.3	Unknown	Unknown
Shire of Kojonup	10.9	72.3	30	71.2
Shire of Lake Grace	10.8	70.9	28.2	71.3
Shire of Narembeen	10.8	70.9	28.2	71.3
Shire of Ravensthorpe	Greater than 10.9	Unknown	Unknown	Unknown

There are a number of social determinants for children in the six local governments that support the evidence and need for local access to primary health services. It is well recognised that vulnerable children and their families may require more assistance, support and intervention than families with no identified vulnerabilities. Assistance, support and intervention also needs to be in close proximity of residences for children and their families to access.

Figure[8]: Child and Youth Wellbeing by Local Government

	Children living in household earning less than $1000 per week	Learning – developmentally vulnerable on one or more domains (AEDC)	Primary health care access (GP attendance 0-24yrs/100)	Primary health care access (GP Medicare benefits 0-24yrs / 100) $
Shire of Gnowangerup	37%	29.63%	268.24	11,364
Shire of Jerramungup	44%	14.71%	164.77	7054
Shire of Kojonup	41%	26.67%	268.24	11,364
Shire of Lake Grace	33%	29.41%	264.19	11,095
Shire of Narembeen	33%	29.41%	264.19	11,095
Shire of Ravensthorpe	44%	14.71%	164.77	7054

[7] Australia's Health Tracker by Area, Australian Health Policy Collaboration, 2020
[8] Australian Child and Youth Wellbeing Atlas, 2021

2.3 General Practitioners

A declining number of GPs in remote communities of Western Australia creates significant gaps in healthcare access. The lack of GP services contributes to people living in country areas utilising hospital emergency departments as a substitute for GPs, more than their metropolitan counterparts. WACHS reports that over half of emergency department presentations are non-urgent presentations related to the lack of access to local GPs.[9]

The investment made by the six local governments to attract and retain resident GPs is necessary for the following reasons:

1. **Critical Role of Primary Care**: Primary care is the most significant contributor to positive health outcomes. With the number of general practitioners in Australia declining, especially in rural areas, ensuring access to primary care is crucial.[10] Additionally, reducing emergency department presentations in rural communities with the provision of a local GP reduces the financial burden on State Governments and pressure on the hospital workforce.

2. **Acute Shortages in Rural Areas**: The reduction in the primary care workforce is felt most keenly in rural communities, where dependence on primary health care is more pronounced. For example, Western Australia (WA) has just 77.1 full-time equivalent (FTE) GPs per 100,000 people in outer regional, remote, and very remote areas, compared to the national average of 88.9 FTE GPs.[11]

3. **Comparative Disadvantage**: WA's overall GP per capita is 101.8 FTE GPs per 100,000 people, which is lower than the national average of 115.2 FTE GPs. This disparity highlights the need for targeted measures to attract and retain doctors in these underserved areas.

By offering financial programs, local governments can attract more doctors to rural areas, thereby improving access to primary care and overall health outcomes for these communities.

2.4 Travel Distances

The six local governments seek to ensure that residents in their communities have access to a doctor, within a reasonable driving distance.

According to the National Rural Health Alliance the number of doctors providing care per capita drops with increasing remoteness: for the year 2021-22 125/100,000 people in metropolitan areas compared to 84.9 in small rural towns and 66.8 in very remote communities.

In 2022, 57,899 living in Australia did not have access to general practitioner services within a 60-minute drive from their place of residence. The following table demonstrates the furthest distance a rural resident (outside of the townsite) must travel in each Shire to access the doctor; and if the doctor was not provided, the alternative.

[9] Support and service improvement for people in country areas, Department of Health, 2019
[10] Decline in new medical graduates registered as general practitioners, Denese Playford, Jennifer A May, Hanh Ngo, Ian B Puddey, 2020
[11] Australian Government Productivity Commission Report on Government Services 2024

Figure: GP travel distances (average)

	Surgery and doctor (provided by local government)	Furthest travel distance WITHIN the local government to provided doctor (estimate)	Closest alternative doctor and if NO doctor is provided by any of the six local governments	Furthest travel distance to alternative (estimate)
Shire of Gnowangerup	Gnowangerup	77km	Katanning (western residents) Albany (eastern and southern residents)	Between 108km – 172km
Shire of Jerramungup	Jerramungup	96km (south)	Albany	234km (from Fitzgerald)
	Bremer Bay	65km (west)	Albany	180km (from Bremer Bay)
Shire of Kojonup	Kojonup	49km (south)	Katanning	89km (from Mobrup)
Shire of Lake Grace	Lake Grace	115kms (east)	Kondinin (Shire of Kondinin supported)	184kms (from Lake King)
	Newdegate	62kms (east)	Kondinin (Shire of Kondinin supported)	184kms (from Lake King)
Shire of Narembeen	Narembeen	85kms (east)	Bruce Rock (Shire of Bruce Rock supported)	120kms (from West Holleton / Woolocutty)
Shire of Ravensthorpe	Ravensthorpe	80km (east)	Esperance	107km (from Munglinup)
	Hopetoun	80km (east)	Esperance	191km (from Hopetoun)

It should be noted that people do not stick to local government boundaries. For example, the furthest eastern residents amongst the six local governments, in Holt Rock, Varley and Lake King travel to practices in either Jerramungup and Lake Grace / Newdegate – regardless of which local government delivers the service. The six local governments in this paperwork together informally to ensure there are reasonable distances between GPs.

2.5 Rural Generalist

The six local governments are currently served under a rural generalist model. A rural generalist is a medical practitioner who is trained to meet the specific current and future healthcare needs of Australian rural and remote communities, in a cost-effective way, by providing both comprehensive general practice and emergency care and required components of other medical specialty care in a hospital and community settings as part of a rural healthcare team.

Under this model there are 10 practices across the six Shires with services including emergency care, palliative care, aboriginal health clinics and skin cancer clinics, with additional team members who are Geriatricians, Psychiatrists and Optometrists. The model is multi-site with multiple purposes and through a shared system and use of technology delivers a timely service with reduced latency and downtime.

The local governments are observing under this model, reduced hospital transfers and emergency retrieval costs as well as a comprehensive suite of services delivered locally by a well-connected team.

3. THE PROBLEM

3.1 Local Government Rates Expended on Primary Health

The National Rural Health Alliance 2023 report *Evidence base for additional investment in rural health in Australia* clearly demonstrates, using publicly available data, that there is disparity in health expenditure between metropolitan and rural, regional, and remote Australia, with more expenditure per capita in the metropolitan areas by State and Commonwealth Government.

Who picks up this gap in per capita health expenditure to ensure accessible health services?

The Sustainable Health Review (SHR) by the WA State Government heard that health service delivery in rural and remote areas presents considerable challenges and due to remoteness, it is generally considered more costly to deliver 'small scale' services in the country than in the metropolitan area. Due to scale, management issues arise such as rostering, increased reliance on staff being on-call (to hospitals) and services being vulnerable if a staff member is away sick or on leave. It is very difficult to attract health practitioners to work in many country locations and staff turnover rates are high.[12]

The smaller populations, high demand for health professionals, complex health needs, and higher cost of delivering services in the regions means that many communities don't have access to adequate primary healthcare services.[13]

It is evident through the local government tender / recruitment process that:

- The current State and Commonwealth Government incentives to reside and work in a remote community as a GP are inadequate.
- There are higher costs to operate in remote communities; and
- Smaller patient bases.

These all contribute to less profitability for practices, declining confidence by GPs to operate their own practice and the need for practice owners to provide higher incentives (sometimes up to 85% of billing hours) to attract GPs.

The majority of general practice services in Australia are funded through a combination of the Medicare system, direct patient billing and delivery of occupational medicine and other forms of non-Medicare medical service provision. Many general practices throughout rural Western Australia, particularly smaller, rural practices are only marginally viable under the existing funding models, such as the Medicare Benefits Scheme, Practice Incentive Payment and others.

In major cities and inner regional areas, health services are mainly supported through activity-based funding and fee-for-service funding, while block funding is common in remote areas such as what is occurring in the six local governments[14].

How doctors in private practice manage their billing and workload is a key issue in the problem as well. Doctors are continuing to increase their bulk-billing rates, especially for non-GP specialists, to help maintain volume, whilst fees for non-bulk billed services increase. Whilst

[12] Support and service improvement for people in country areas

[13] Local Government Primary Healthcare Services Survey Report

[14] Evidence base for additional investment in rural health in Australia, National Rural Health Alliance, 2023

discretion on setting fees has provided some flexibility, there is only so much that can be done if there are fewer patients to go around[15] - particularly in rural and remote areas.

Local government funds are increasingly being used to address funding shortfalls in practices (in some cases up to 16% of rates income). This means that a significant portion of local rates is allocated to ensure a GP is firstly attracted to the community and then retained, so that residents have access to essential healthcare.

The six local governments annually contribute in excess of $5m towards the provision of resident GP services in their communities (cash, houses, vehicles, surgeries, depreciation of assets).

The expenditure by rural WA local governments is crucial for maintaining the health and well-being of rural populations, who otherwise face significant barriers to accessing health care. This significant financial strain on rural local governments reduces resources available for other vital community services and infrastructure.

To attract and retain a resident GP, the following contributions are made by each local government in this alliance:

Figure: Cash and other contributions to attract and retain a doctor in each local government.

Local Government	Number of GPs	Annual cash	Additional contributions	23/24 Rates	% of rates income 23/24
Shire of Gnowangerup (1 surgery)	1	$250K	✓ Provision of surgery ✓ Executive House ✓ Vehicle	$4.9m	**7%**
Shire of Jerramungup (2 surgeries)	1	$220K	✓ Executive House in Bremer Bay ✓ Vehicle and servicing ✓ costs ✓ Contribution to vehicle running costs ✓ WACHS owns the medical centre, arrangement between them and the Shire	$3.8m	**5.7%**
Shire of Kojonup (1 surgery)	1	$250K	✓ House ✓ Vehicle ✓ Plus servicing of the loan for the construction of the medical centre	$5.4m	**4.6%**
Shire of Lake Grace (2 surgeries)	1	$250K	✓ Provision of surgeries ✓ Executive House ✓ Vehicle and fuel	$5.1m	**7.3%**

[15] The evolution of the medical workforce

Shire of Narembeen (1 surgery)	1	$305K	✓ Provision of surgery ✓ Vehicle ✓ New Executive House	$2.6m	**16%**
Shire of Ravensthorpe (2 surgeries)	2	$200K	✓ Provision of surgeries ✓ House provided by FQM	$5.7m	**5%**
TOTAL	**$1,475,000 pa**				

4. THE CONTRIBUTING FACTORS

There are systemic challenges in the current health system for rural Australians.

This position paper is advocating for a solution to reduce the financial burden faced by remote local governments to attract and retain resident GPs, either through the expansion of existing programs or new initiatives.

4.1 Procurement Process

The six local governments are reluctant to take on the provision of primary health services. However, when they did so, they were mandated by the WA Local Government Act to tender medical service practices due to exceeding the procurement threshold of $250,000 (when the service goes to market on the first occasion a tender needs to be conducted however not if the same providers contract is extended). Example responses below:

	Tender Close Date	Number of responses received	Applicant requests
Shire of Gnowangerup	31st May 2024	3	Applicant 1 $250,000 cash per annum Executive house, car (including maintenance) medical practice. Provider to pay utilities, cleaners, supports staff (reception, nurse, practice manager), IT expenses, medical equipment. Submission 2 $90,000 cash per annum. Deemed high risk due to shortfall between their projected operating costs ($790k pa) versus requested contribution. Also requested house, car and practice. Submission 3 $200,000 cash per annum Predominantly telehealth service with occasional face to face with a visiting doctor maximum service 4 days per week. No hospital cover and dependant on suitable internet speed (to allow for telehealth). Provide medical practice.
Shire of Jerramungup	August 2021	1	Applicant 1 $200,000 House, car and running expenses of the practice
Shire of Lake Grace	August 2023	2	Applicant 1 $250,000pa House, car and medical practice premises and equipment to be supplied Provider to pay utilities, cleaners, IT upgrades, upgrades to medical equipment et al. Applicant 2 $100,000pa no further details House, car and medical practice premises and equipment to be supplied No experience in running a rural practice.

Shire of Narembeen	3 July 2023	1	Applicant 1 $280,000 - $300,000 per annum Additional provision of house, car and commercial space. Applicant to pay all running costs and replace medical equipment at their own cost, which is to remain the property of the Shire.

The WA State Government has since removed the requirement of local governments to go to tender to extend an existing GP contract or attract a new one. Regardless, this has not solved the problem of recruiting and attracting GPs for a reasonable and sustainable amount. In the above table, it demonstrates the limited number of applications in the process and highlights why the local governments are paying significant ratepayer funds to attract a GP.

Providing significant funds to attract and retain resident GPs through an open process also creates competition amongst rural Western Australian local governments. They are competing for limited human resources. GPs are also leveraging local governments against each other to match cash payments and supporting incentives. This is evident through the tender process, but it should be remembered, that local governments should not be required to undertake a tender process for GP services, if current incentives and programs were enhanced to reflect the true cost of service delivery in remote communities.

4.2 Inadequate Financial Assistance Grants

Local Government Financial Assistance Grants are funded by the Commonwealth Government and distributed among 137 local governments in Western Australia each year.

The Financial Assistance Grants are the State's entitlement for financial assistance from the Commonwealth Government, paid upfront for a financial year, under the Local Government (Financial Assistance) Act 1995.

The WA Grants Commission recommends allocations to the WA Minister for Local Government. In 2024/25 the WA Grants Commission allocated $2,189,431 for the Medical Facilities cost adjustor to acknowledge the costs that some regional local governments must contribute to employ a doctor.

In 2024/25 there were 11 local governments who received the maximum allowance of $100,000. Only 5 of the 6 local governments party to this paper received the Medical Facilities cost adjustor. The Shire of Kojonup did not receive the Medical Facilities cost adjustor as they work with a local not-for-profit to engage a GP.

The Shires of Narembeen, Lake Grace, Kojonup did not receive the maximum amount.

Included in the Medical Facilities cost adjustor eligible expenditure is; GP salaries / retainer, car, housing, LG related administration costs, GP surgery (rent or forgone rent), GP surgery administrative costs, surgical and medical equipment, communication expenses, stationery, loan costs and depreciation.

	Financial Assistance Grants – Medical Facilities Cost Assessment	3yr Average Medical Expenditure (reported to WA Grants Commission)	GAP between MFCA and 24/25 actuals
Shire of Gnowangerup	$100,000	$165,178	$150,000
Shire of Jerramungup	$100,000	$207,083	$100,000
Shire of Kojonup	0	0	$250,000

Shire of Lake Grace	$36,392	$44,380	$213,608
Shire of Narembeen	$54,008	$44,287	$250,992
Shire of Ravensthorpe	$100,000	$184,096	$100,000

4.3 Attracting GPs

Using data from the *Medicine in Australia: Balancing Employment and Life (MABEL)* survey, research has shown that to move a GP from the city to a rural area would take an increase in income of between 18% and 130%, depending on the rural area.[16]

For an average GP who reported their annual income in the MABEL survey as $222,535, this means they would need to be paid between $261,700 and $511,830 to go rural[17]. This is coincidentally in line with the current cash component that six local governments are paying in RM6 and RM7 communities to attract and retain local doctors – essentially covering their operating costs and setting a baseline income for them – in addition to the Commonwealth and State government rural incentive programs.

There are a range of Commonwealth Government policies, programs and incentives for GPs, including financial incentives under the Practice Incentive Program and the Workforce Incentive Scheme for GPs - **but these are not specific to remote communities**.

The Commonwealth Government's Strengthening Medicare Reforms does not include programs or incentives for rural practices; MyMedicare is for telephone consultations for registered users, the General Practice Grants Program does not specifically support rural or remote GPs because it can be accessed by RM 2 practices in metropolitan areas.

In Western Australia there are incentives such as the Country Health Innovation (CHI) financial incentive obtained through the Department of Primary Industries and Regional Development (DPIRD) Royalties for Regions (RfR) Program. The program within regional catchment areas provides for Emergency Department incentives, procedural incentives, additional Procedural incentives, a location incentive, Small Town GP incentive and an Aboriginal Health Community incentive. However, the majority of these incentives are only available to fellows and again, offered to the same communities closer to the metropolitan area.

The challenge faced by the six rural WA local governments included in this position paper is certainly not unique. The Shire of Bogan in Queensland is currently paying $500,000 towards the operational costs of its medical centre.[18] It is very rare that a rural local government in Western Australia (and indeed within other states) is not contributing to payments that attract and retain resident GPs.

So, why despite current Commonwealth and State Government policies and programs to attract and retain resident GPs in remote communities, are the six local governments still paying significant retainers to ensure their local medical centres remain open?

There are some policies and programs that are specifically for rural and remote communities, however they are not reflective of the true cost of providing a GP service or encourage GPs to go and live in the community.

[16] Medicine in Australia: Balancing Employment and Life Australia's national longitudinal survey of doctors; University of Melbourne

[17] Professor Anthony Scott, University of Melbourne, It's more than the money: Getting GPs to go to rural areas, 2021

[18] Local council running medical centre at $500k shortfall | Health Services Daily

All six local governments have tried various providers and models of service delivery, they have provided different incentives, equipment and resources plus lifestyle amenities to secure the services of a GP. The local governments have tried to work with the Commonwealth Government on fly in fly out services in partnership with the Royal Flying Doctor, hub and spoke models, a pool of locums, recruiting overseas doctors, accessing Commonwealth and State incentives, operating the medical centres themselves to alleviate the challenges of operating a compliant practice, but the same challenges present;

- Smaller populations in the communities and therefore revenue generation;
- Perceived lower status of general practice (and particularly being based in remote areas);
- The generally lower income provided by Medicare fees;
- The burden of practice accreditation;
- Geographical distances;
- Work–life balance in rural communities[19];
- GPs requiring a locum to cover periods of leave e.g. annual leave (in some cases this is extremely costly at $10K per week);
- WA Country Health policies are not fit for purpose;
- Commonwealth and State Government incentives see RM 6 and RM 7 communities compete against RM 2 communities; and
- Fluctuations in patronage due to local economic conditions e.g. agriculture and mining.

Regardless of the current provider arrangements with each local government, the six local governments are contributing a total of $1.435m cash to provide their communities with access to resident GPs across 9 towns (and indeed additional communities that neighbour them). Collectively this is 5.1% of the rate base across six local governments.

The local governments are also contributing to surgery infrastructure, GP vehicles and residences and depreciation cost of assets accounting for an estimated $4.5m/pa.

The geographic spread of people in the six local governments creates both issues with logistics of access and efficiency of utilisation of resources. This impacts upon the costs, both of delivering services and for patients attending care, often requiring a greater time commitment and transportation costs to physically access services. The larger geographic footprint involved with creating a patient pool sufficient to sustain a clinic or service on a fee for-service basis results can result in lower utilisation. This is typically reflected in lowered utilisation of staff and services in these regions, and a greater reliance on grant and block funding to address shortfalls. Paying for these ‘gaps’ in remote and very remote communities through grants or block funding, is 3.46 times more per capita than that of metropolitan settings.[20]

Additionally, fluctuations in patronage for medical centres due to local economic conditions that are beyond the control of GPs, impact the break even point of rural medical centres. One such example of a fluctuating local economy has been in the Shire of Ravensthorpe. In April 2024 First Quantum Minerals confirmed the Ravensthorpe nickel mine would be placed into care and maintenance, with 330 jobs to be lost. [21]First Quantum Minerals is a financial contributor to the Ravensthorpe and Hopetoun surgeries, ultimately a service that supports

[19] Decline in new medical graduates registered as general practitioners, Denese Playford, Jennifer A May, Hanh Ngo, Ian B Puddey, 2020

[20] Evidence base for additional investment in rural health in Australia, National Rural Health Alliance, 2023

[21] First Quantum Minerals to close Ravensthorpe nickel project with loss of 330 jobs - ABC News

their workforce. The closure of the nickel mine places significant pressure on local businesses and service providers, such as the medical centre, as patronage declines.

When providing cash payments to GPs, the RM 6 and RM 7 local governments may be asked why they don't just implement gap fees, which potentially could be much lower than what they are currently paying.

In the 2021 Commonwealth Budget the GP revenue for a Standard Level B consultation rose from $48.55 to $50.45 for remote communities. This increase only applies to under 16yr olds and concession card holders. Consultations for other patients continue to receive the basic $38.75.

The number of under 16yrs and concession card holder consultations is not significant enough to attract additional income under Medicare for the doctors in the six local governments (the majority of the communities only have primary and secondary schools to yr 10, many young people attend high school in the metropolitan and regional centres) and hence implementing gap fees is not advantageous (see below).

	Under 16yrs of age	Aboriginal and Torres Strait Islanders	Under 16yrs of age as a percentage of the total population	Commonwealth Seniors Health Card	Health Care Card	Low Income Card	Pension Concession Card[22]
Shire of Gnowangerup	260	93	/ 1215	10	60	5	195
Shire of Kojonup	371	99	/ 1901	65	85	5	310
Shire of Narembeen	154	25	/ 787	20	30	5	95
Shire of Ravensthorpe	389	88	/ 2085	35	80	5	345
Shire of Jerramungup	250	39	/ 1160	15	50	10	145
Shire of Lake Grace	250	29	/ 1265	20	45	5	105

[22] DSS Payments by 2022 LGA - June 2023 to September 2024, Department of Social Services

4.4 Why Does this Problem Need to be Solved?

Limited Ratepayer Funds

Over the past ten years the six local governments collectively have paid in excess of $6m of ratepayer funds to retain resident GPs.

Not only is this a significant opportunity cost for local governments and their communities but it diverts their limited funds towards a service that should be funded by State and/or Commonwealth Government. It means core local government services and infrastructure are underfunded, not pursued or not maintained to an adequate level (impacting Councils ability to adequately manage their asset maintenance and preservation programs).

In WA, local governments are also now required to prepare public health plans. These are essentially primary health plans and whilst community socio and economic health is an outcome in the provision of local government services and facilities, they are not responsible for primary health services and facilities which is included in the plans.

Access to Healthcare is linked to Economic Health

Providing quality healthcare in a rural community goes beyond immediate healthcare services; it also has a positive impact on the economic health of a community – its productivity, absenteeism rates, workforce participation and more.

Rural health and rural community and economic development are also inextricably connected—neither field can be successful without the other. Thriving economies and communities require healthy people, and people need strong economic and health systems to thrive.

Unintended consequences of the reliance on telehealth in rural Australia[23]

Studies and experience have identified that telehealth — the use of electronic means such as video or telephone to deliver health care remotely — has many benefits for patients, health care providers and health systems, including reduced costs, improved health care access, productivity gains, and increased satisfaction, convenience and efficiency. Beyond direct benefits, there is a widely held view that telehealth may potentially mitigate the negative impact of health workforce shortages in rural areas and achieve early intervention in health problems.

Telehealth can help enhance the health status of rural and remote communities by improving accessibility. By cutting travel costs such as fuel, accommodation, and lost wages due to work disruption, telehealth contributes positively to socio-economic wellbeing and helps relieve some of the financial burden rural communities face to access services.

While providing tangible support to rural clinicians on the ground, dependency on telehealth can [however] mask the need to invest long term to improve rural health, such as direct investment in infrastructure and the rural health workforce. By relying on metropolitan centres to provide care to rural Australians, telehealth essentially redirects rural resources to these centres, reducing future rural health care funding. This deflection of resources could threaten the viability and existence of rural practice altogether, eroding health services in rural areas and exacerbating the situation in a vicious cycle of overdependency and inaccessibility. Reliance on metropolitan doctors reduces opportunities for training in rural health, potentially

[23] Beyond the planned and expected: the unintended consequences of telehealth in rural and remote Australia through a complexity lens, Medical Journal of Australia, Osman et al, 2024

deskilling clinicians, especially those early in their career, thereby undermining the quality of health care rural patients receive over time. Intermittent metropolitan telehealth service providers do not participate in local call rosters nor have an understanding of the complex and chronic conditions of local, and especially Indigenous, patients needing personalised care. And predatory providers seeking to expand their business model might not be in the best interest of local communities due to this lack of local and contextual knowledge.

All in all, inherent limitations of telehealth, such as the inability to examine patients physically, may leave staff in rural primary care and emergency settings less skilled, and hence more vulnerable to medicolegal liabilities and overstretched as telehealth adds to their workload by transferring examining patients on behalf of the consulting physician or performing other clinical tasks outside their scope of work. Other concerns include that medicolegal consequences may arise due to miscommunication, lack of local context by the physician providing care via telehealth, and the hesitation of nurses and junior doctors to raise any concerns to a remote clinician. This may make work environments less attractive, further increasing the challenge of recruiting and retaining junior clinicians to rural practice.

Anecdotally reports within remote communities that support staff such as nurses feel pressure when there is no doctor in the room, particularly during emergency situations and the absence of collegiately is missed.

The continuity of care is also essential for every patient and the continuity of doctors through the telehealth service is clearly lacking and not avoidable.

There may also be social and economic consequences on rural communities due to the missed opportunity of having clinicians relocate to rural areas, contribute to the rural economy, bring investments, and attract more businesses to rural areas. And if the converse occurs, and telehealth fuels migration of rural Australians to metropolitan centres seeking specialist care or clinicians to work in cities, this can exacerbate the metropolitan housing crisis and the economy.

These actual and potential effects are largely unintended consequences of the implementation or telehealth in rural Australia and have not to date been subject to overt planning. They nonetheless can have considerable impact on rural and remote communities.

5. SOLUTION

Countries with a strong primary health care system experience better population health and lower rates of unnecessary hospital admissions. General practice is the bedrock of healthcare in rural areas. Ongoing access relies on being able to recruit and retain enough properly distributed GPs in all parts of the country.[24] The six local governments have tried various business models and incentives over the past decade and worked with organisations that are funded to support primary health care in the regions to attract GPs. They have resisted at every opportunity to part with ratepayer funds to attract and retain a GP, knowing firsthand that they have limited income but increasing needs for infrastructure and services across their communities that are required for current residents but also necessary for communities and industry to grow.

The Australian and Western Australian health systems are complex. However, despite complexities it is well evidenced that the third tier of government, local government, is not responsible for the delivery of primary health care, specifically the provision of GPs.

While local governments supporting GPs are rightly proud of securing and/or retaining these essential services for their communities, this should not distract from the fact that such support is a financial impost and takes away from other essential local government services and functions.[25]

Local government support for primary healthcare services is grounded in their pursuit of creating thriving communities. Local governments are stepping in to provide support for these services due to Commonwealth and State Governments failing in their responsibilities to ensure the adequate provision of essential services.[26]

The Local Government Primary Healthcare Services Survey Report by Rural Health West in 2024 identified a number of recommendations, one being the WA State Government establish a Local Government Primary Healthcare funding program. Based on the survey findings an initial annual fund of $5 million per annum is recommended across the State. However, this amount will likely be inadequate. Potentially such a fund should only be applied to RM6 and RM7 local governments.

Policy makers may say, set a gap fee payment or raise rates in each local government, to cover the cost of the provision of GP services, but the local conditions (population, demographics and local economy) are not favourable or sustainable to see these solutions last.

Investing in the general practice workforce in remote WA communities requires additional and distinct solutions to overcome unique workforce issues such as professional isolation, uncompetitive remuneration compared to metropolitan practices, state hospital salaries and locum rates and the viability challenges of running a rural general practice. It is critical State Governments and the Commonwealth Government work together to resolve GP workforce issues.[27]

Some policies have been introduced recently, such as rural generalist training pathways and will not yet show an effect, but other policies such as financial incentives have been in place

[24] AMA plan for improving access to rural general practice, AMA, 2023
[25] Local Government Primary Healthcare Services Survey Report, Rural Health West, 2024
[26] Local Government Primary Healthcare Services Survey Report, Rural Health West, 2024
[27] AMA plan for improving access to rural general practice, AMA, 2023

for a long time. Evidence shows that financial incentives may not be effective (Scott et al., 2013), or if they are it is only for GP Registrars who are the most mobile (Yong et al., 2018).

Due to the complexity of the health care system, there are many levers that could be used to help resolve the issues experienced by remote communities to attract and retain a GP. This position paper is not advocating to amend Medicare. The local governments are also not advocating to directly fund private enterprise or amend training and workforce policies. There are also WA Country Health policies for hospitals, locums and close availability GPs to service hospitals that influence the position the six local governments are faced with – the alliance will advocate on these separately.

The alliance is though raising awareness to the fact that market rates to attract a GP in a RM 6 and RM 7 community are significantly rising, with Commonwealth and State Government programs needed to match these market rates. The alliance is also raising awareness that telehealth is not the answer to shortages of GPs in remote communities.

The six local governments agree to continue to support GPs through the provision of a space for a practice under peppercorn leases, a house and vehicle, however the ongoing cash payment towards operations is unsustainable.

The six local governments need the Commonwealth and State Government's to consider a sustainability payment to assist in attracting and retaining resident GPs. This would reduce the cash component provided by local governments to GPs. The Tasmanian and Queensland Government provide similar programs.

Such a program for local governments would also reduce health inequalities experienced in the remote communities.[28]

A custom-made variation in the allocation of resources is required. Resourcing for such a solution can still be funded centrally, flexibility at the regional decision-making level uses local information better and is more adaptable.

Primary healthcare funding is a Commonwealth responsibility. In remote communities there are significant funding gaps.

The State Government has primary health care responsibilities as well, more than that of local governments.

The Alliance is requesting the Commonwealth include a sustainability payment in the Federal Budget 25/26; directly to the six RM6 and RM7 local governments as a pilot program over a 3yr period; to the value of $4,425,000 plus CPI.

This could be distributed through the Medical Facilities cost adjustor (Financial Assistance Grants additional contribution).

[28] Regional health inequalities in Australia and social determinants of health: analysis of trends and distribution by remoteness, Flavel et all, 2023

APPENDICE

Figure: Location of hospitals neighbouring the alliance of Councils.

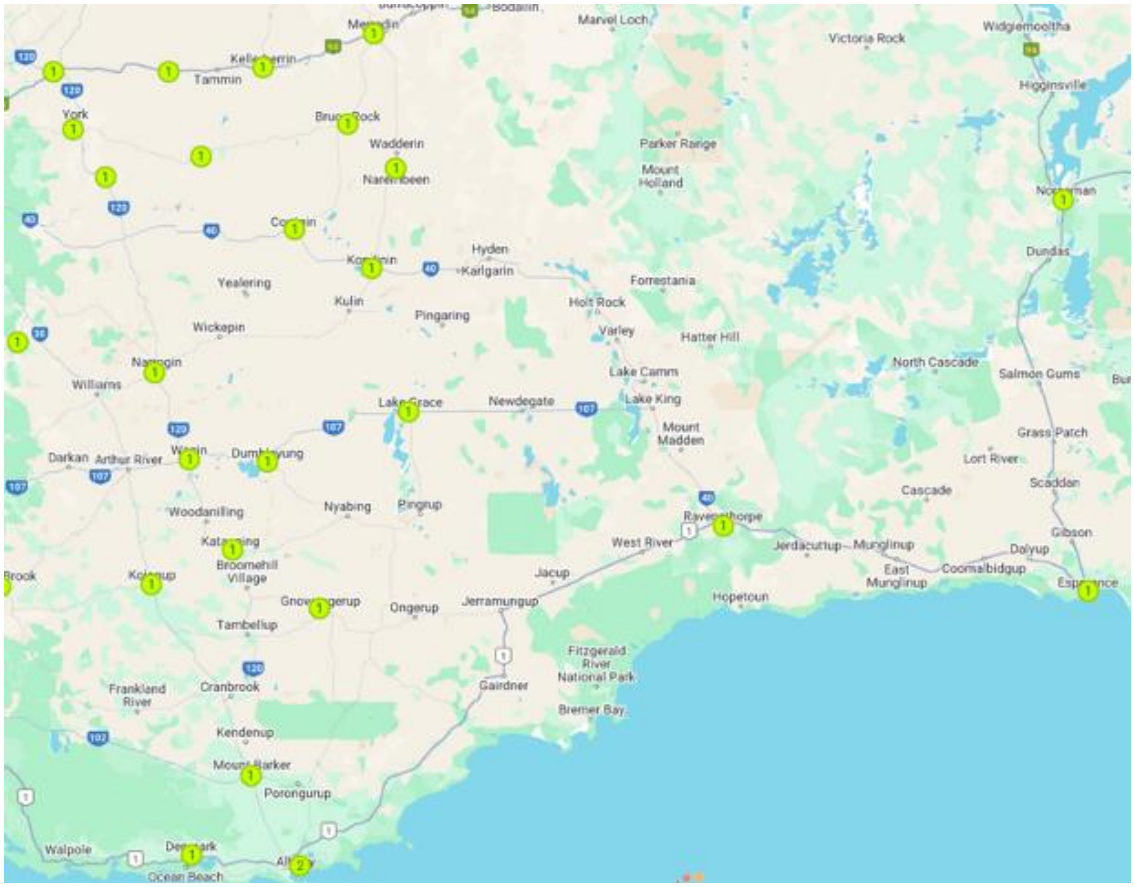


Figure: Location of GPs neighbouring the alliance of Councils.

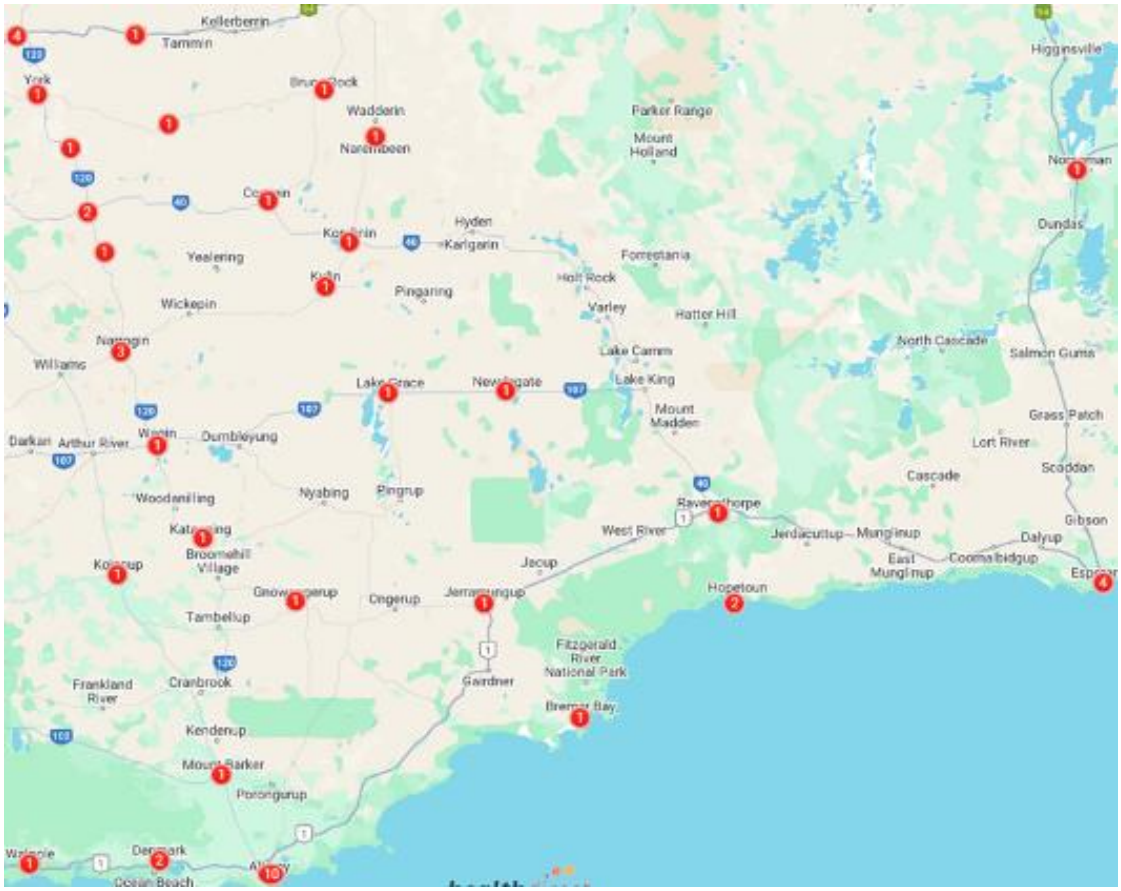
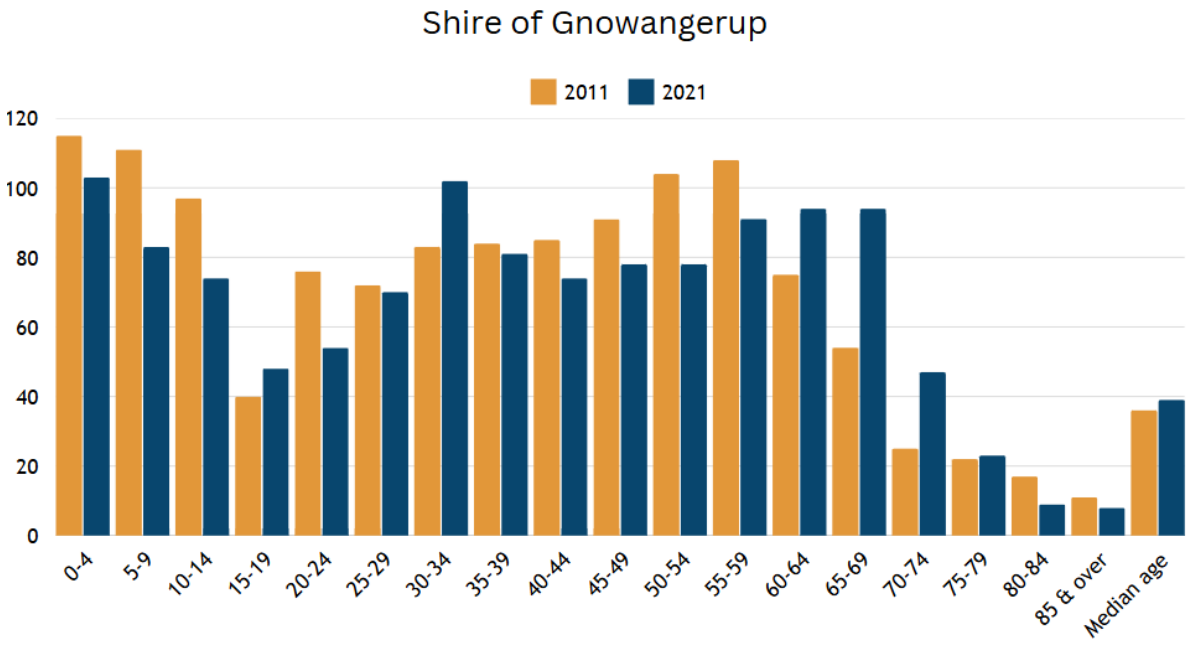
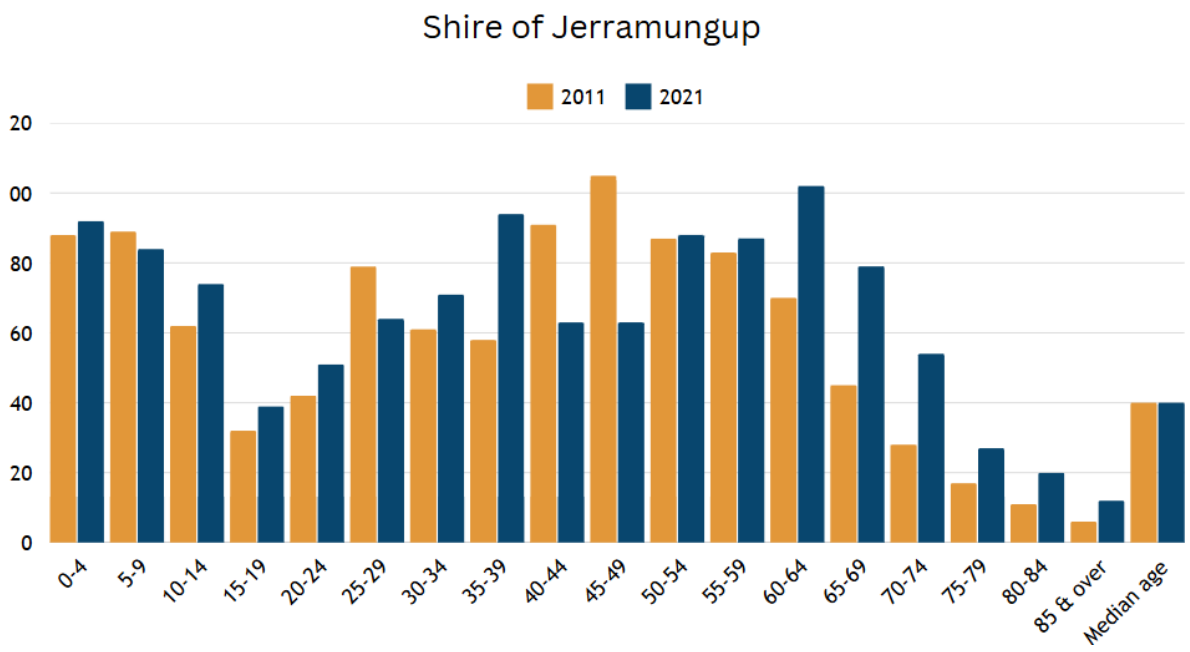


Figure: Age Profiles

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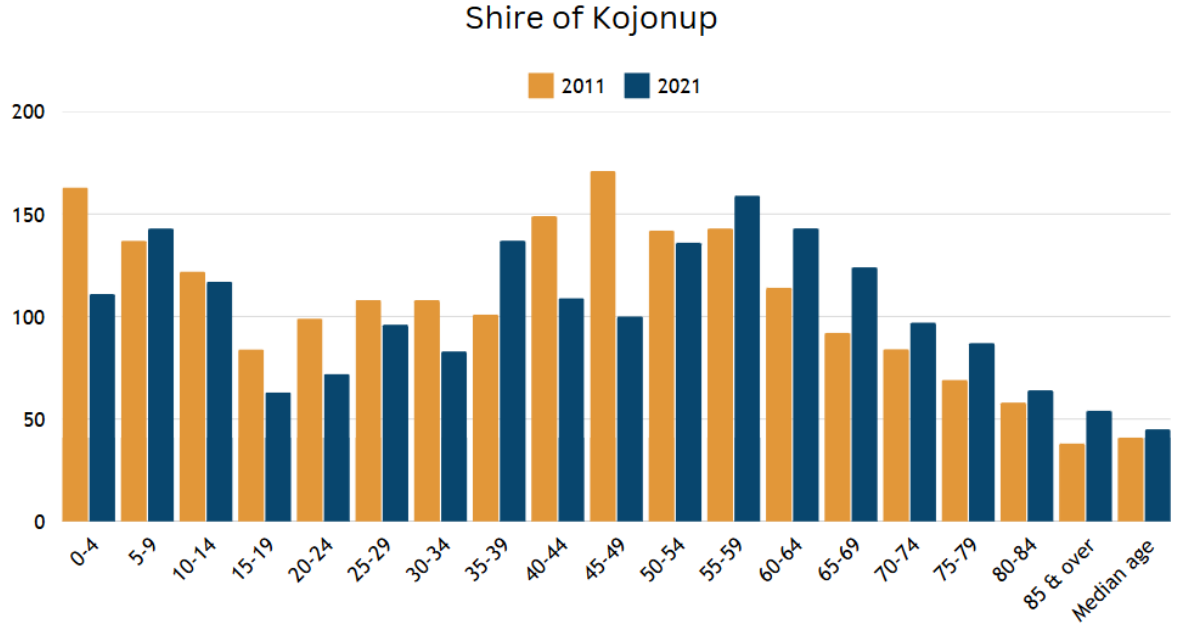
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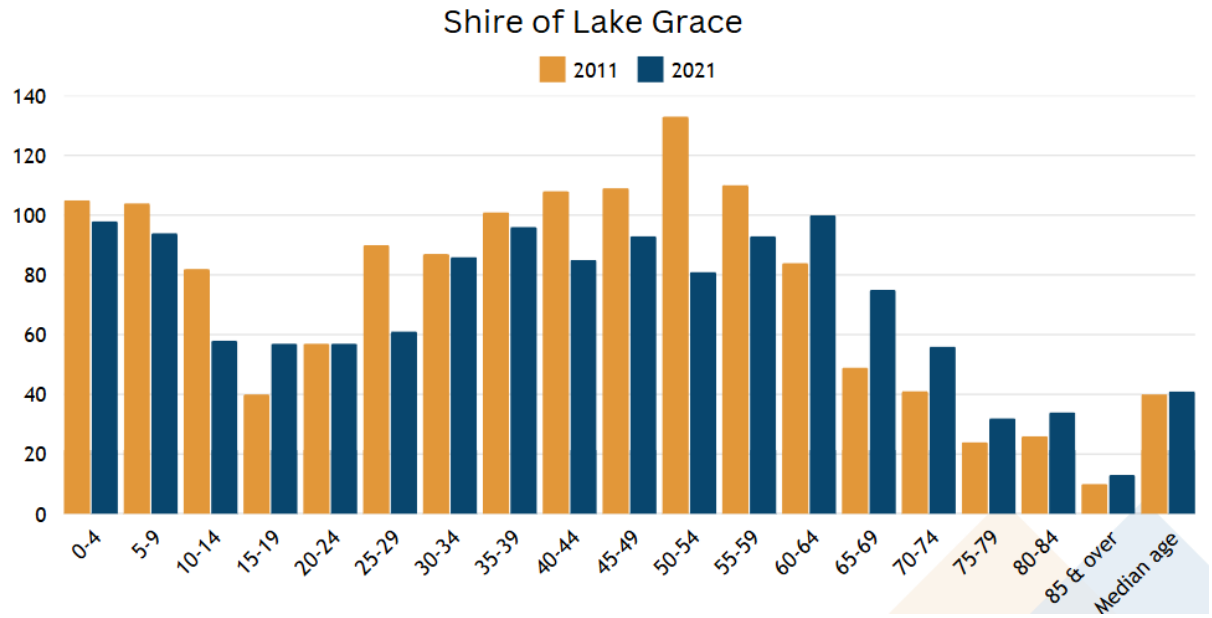
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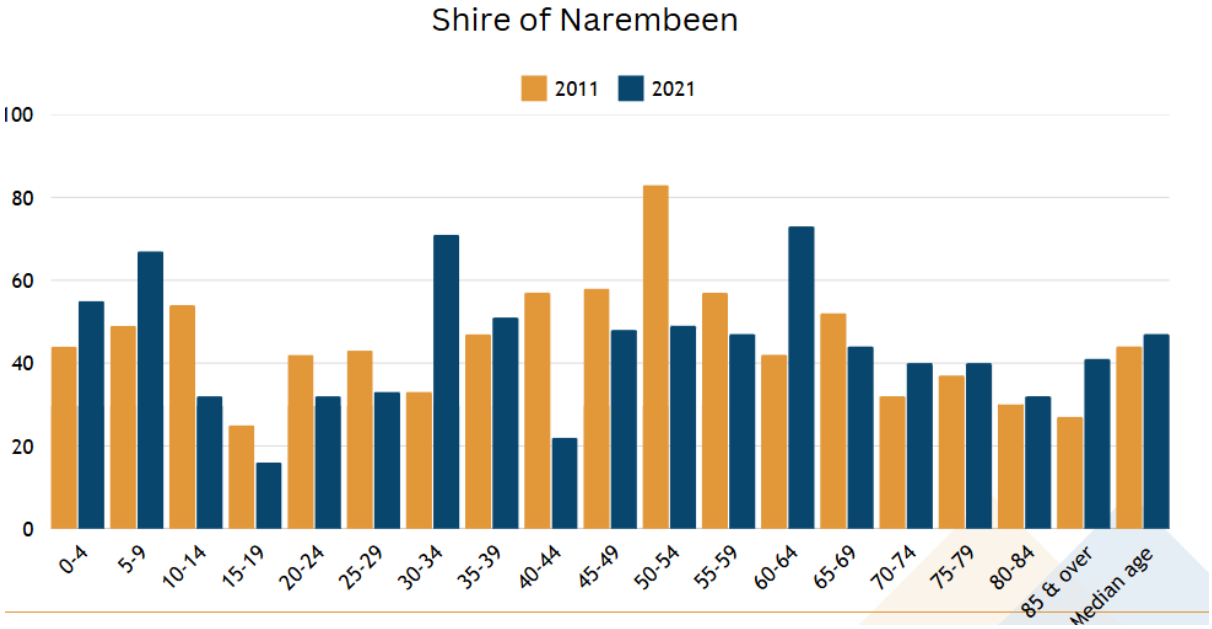
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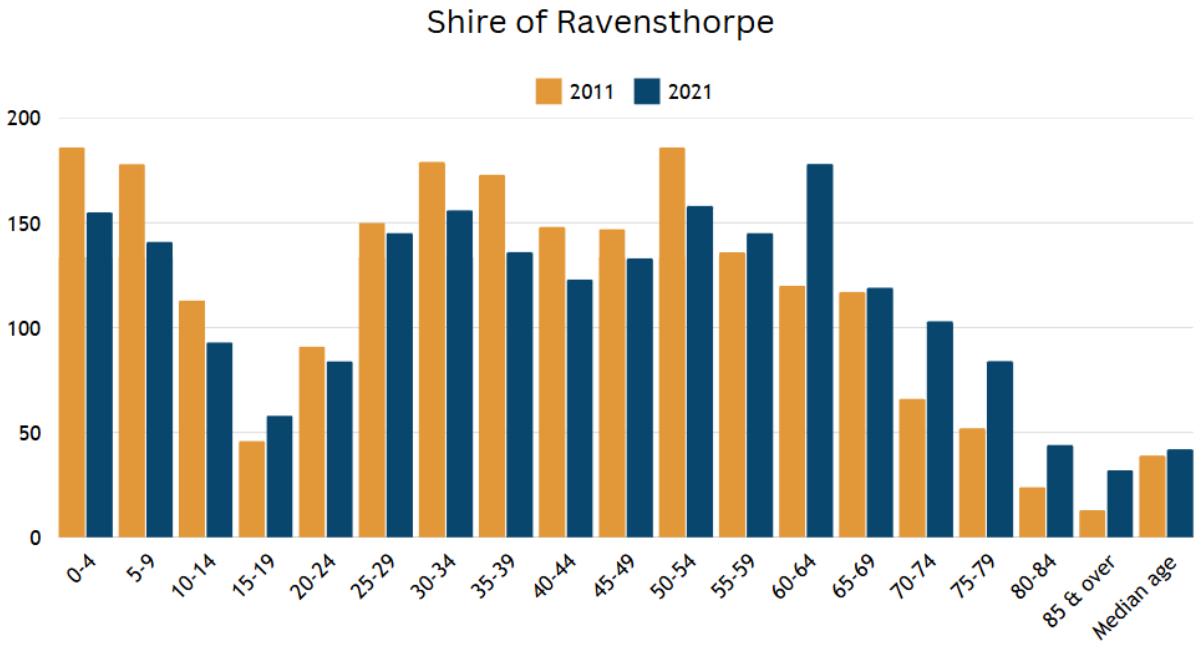
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Electoral Reform Discussion Paper

1. Background

1.1. Purpose

The purpose of this discussion paper is to request Council-endorsed Local Government feedback to inform WALGA's advocacy on Local Government electoral reforms expected to be proposed by the State Government, specifically:

- full spill elections every 4 years; and
- compulsory voting at Local Government elections

These options have been raised in statements by the Minister for Local Government, Hon Hannah Beazley MLA, but no formal proposals have yet been provided for consultation. While WALGA has relevant advocacy positions (discussed further below), the purpose of this discussion paper is to undertake early sector engagement to ensure WALGA's positions reflect the sector's current views and enable timely, well-informed and effective engagement with the anticipated State Government reform proposals.

1.2. WALGA existing advocacy positions

1.2.1. Elections

WALGA has established advocacy positions reflecting the sector's support of voluntary voting and elections of half the offices on Council every two years. These advocacy positions are provided in Appendix 1.

In late 2024 WALGA conducted a review of its Elections Advocacy Positions to ensure they reflected the sector's contemporary view.

Local Government responses at that time indicated strong (98%) support for half spills every two years, which was reflected in the adopted Advocacy Position 2.5.16 Elections.

While voluntary voting was supported by an overall majority of responses (74%), compulsory voting was supported by a majority (64%) of metropolitan respondents and a majority (61%) of Class 1 and 2 respondents.

State Council requested that the WALGA secretariat undertake further investigation of the implications of compulsory and voluntary participation in Local Government elections before reporting back to State Council.

In the interim, Advocacy Position 2.5.15 Participation in Local Government Elections was retained, expressing support for voluntary voting with a note that further work was being undertaken.

This investigation was ongoing when the Minister for Local Government raised the prospect of further Local Government election reform.

A State by State comparison of electoral statistics is provided in Appendix 2.

1.2.2. Election costs

In 2024, WALGA conducted a review of five Local Government biennial election cycles up to and including the 2023 Local Government elections. The review demonstrated significant cost increases and concerns about the lack of transparency in costings provided by the Western Australian Electoral Commission (WAEC).

In September 2024, State Council adopted Advocacy Position 2.5.18 Local Government Elections Analysis 2015-2023, calling for an independent audit of the WAEC's cost allocation methods and the introduction of Service Level Agreements to ensure transparency of costing methodology.

Cost implications are a relevant consideration in assessing the appropriateness of any proposed electoral reform. However, the current lack of transparency in costing methodology makes it impossible to confidently forecast cost impacts.

This discussion paper seeks to identify the factors associated with each reform proposal that may affect election costs. This is further complicated by the interaction of possible reform options and external economic factors.

WALGA has requested that the Department of Local Government, Regulation and Industry Safety (LGIRS) and the Western Australian Electoral Commission, undertake modelling to identify the cost implications of any proposed reforms.

A comparison of available electoral costs data, State by State, is included as Table 4 in Appendix 2.

WALGA has contacted other Local Government associations to ask if they have experienced changes in costs associated with compulsory four-year, all-in all-out, local government elections. As this has been the approach in most jurisdictions for some time, responses were largely unable to address changes in cost.

2. Election Frequency

Current situation

Western Australia holds biennial elections, with half of the offices on Council elected every two years for four-year terms. All other Australian jurisdictions hold full spill elections every four years (four-year terms).

Considerations

Considerations include:

- Voter participation and fatigue
- Continuity, knowledge retention and mentorship for new Council Members
- Stable whole-of-Council mandate and collective accountability
- Capacity for candidate recruitment
- Administrative requirements
- Extraordinary vacancies and backfilling
- Timing and transitional arrangements

Re-election rates

WALGA has analysed the composition of Councils following the last two Local Government elections in other Australian jurisdictions, all of which have full spill elections. A comparison of available data on re-election rates is included as Table 2 in Appendix 2.

This data suggests that on average, re-elected Council Members make up between 47% and 57% of Council following full spill elections.

By comparing over 700 consecutive ordinary election results, the review identified nine occasions when the membership of Council following an ordinary election was 100% different from the Council following the previous ordinary election. However, four of these local governments held mid-term extraordinary elections, meaning the changes in membership occurred over two or more elections within a four-year period.

Costs

In one respect, a change to a four-year cycle would reduce costs by reducing the number of elections. However, the cost of each election may increase. The WAEC uses the number of vacancies to inform quotations for the conduct of elections. Full spill elections would double the number of vacancies, with possible increased costs associated with printing and postage and increased staffing for the count.

WALGA cannot definitively determine an overall cost impact to Local Government without the requisite cost-modelling from the WAEC. WALGA has requested that the WAEC provide this modelling to LGIRS. The cost impact of a change in election frequency may also vary between Local Governments.

Questions

1. Does your Local Government support half spill elections every two years or full spill elections every four years?
2. What are the key considerations informing this view?
3. If full spill elections every four years were introduced, what transitional arrangements and consequential amendments may be required?
4. Any other comments?

3. Compulsory or Voluntary Voting

Current situation

Voting in Local Government elections is voluntary in Western Australia and South Australia. All other Australian jurisdictions have compulsory voting.

Considerations

Considerations include:

- Voter participation and democratic legitimacy
- Voter engagement, awareness and/or fatigue
- Administrative and enforcement requirements
- Application to owner and occupier rolls

Participation rates

A comparison of available participation data is included as Table 3 in Appendix 1.

Costs

The WAEC uses expected participation rates to inform quotations for the conduct of elections. It is likely that an increased participation rate would increase election costs through higher reply-paid charges and increased staffing for the count. However, in-person elections become more cost effective than postal elections at higher participation rates.

WALGA cannot definitively determine an overall cost impact to Local Government without the requisite cost-modelling from the WAEC. WALGA has requested that the WAEC provide this modelling to LGIRS. The cost impact of compulsory voting may also be different for each Local Government depending on their current participation rates and methods for holding elections, and whether these would change significantly.

Tasmania implemented compulsory voting in Local Government elections in 2022. Local Government Association Tasmania (LGAT) advised that this resulted in reasonably significant cost increases. The Tasmanian Electoral Commission reported a $9.32 per elector cost for the first compulsory Local Government elections in 2022, a 35% increase from $6.92 in 2018. An analysis of the factors contributing to this increase is not available and it may be challenging to draw direct comparisons between Tasmania and WA.

It is likely that the cost impact of compulsory voting would be moderated if elections also transition to a 4 yearly cycle.

Questions

5. Does your Local Government support compulsory voting or voluntary voting in Local Government elections?
6. If the frequency of Local Government elections were changed to every 4 years, would your Local Government support compulsory or voluntary voting?
7. What are the key considerations informing this view?
8. Any other comments?

Appendix 1- WALGA Elections Advocacy Positions

2.5.15 Participation in Local Government Elections

Position Statement	The Local Government sector supports voluntary participation in Local Government elections. *Noting that State Council at its 6 December 2024 State Council meeting resolved that the WALGA Secretariat further investigate implications of compulsory and voluntary participation in Local Government elections and report back to State Council.*
Background	Voluntary participation in Local Government elections is a long-established position of the Local Government sector, and was confirmed as a result of sector feedback received during the Local Government reform process.
State Council Resolution	December 2024 - 090.5/2024 February 2022 – 312.1/2022 December 2020 – 142.6/2020 March 2019 – 06.3/2019 December 2017 – 121.6/2017 October 2008 – 427.5/2008
Supporting Documents	Advocacy Positions for a New Local Government Act WALGA submission: Local Government Reform Proposal (February 2022)

2.5.16 Elections

Position Statement	The Local Government sector supports: 1. Councillors serve four-year terms with elections every two years and half of the Council positions spilled at each election. 2. First-Past-The-Post (FPTP) voting system for Local Government elections. If Optional Preferential Voting (OPV) remains as the primary method of voting, the sector supports the removal of the 'proportional' part of the voting method for general elections. 3. First-Past-The-Post (FPTP) voting system for internal Council elections.

4. Councils holding elections by means of in-person, postal and/or electronic voting.
5. Current legislative provisions of Mayor/President of Class 1 and Class 2 Local Governments being directly elected by the community and Class 3 and Class 4 Local Governments determining whether its Mayor or President is elected by the Council or by the community.

Background

The sector positions on Local Government elections have been long-established. This was confirmed as a result of sector feedback received during the Local Government reform process.

Following the 2023 Local Government Elections where legislative reforms to Local Government elections processes were first implemented, sector wide consultation was conducted on key elements of the elections advocacy positions to determine if they accurately reflected the sector's contemporary view.

State Council Resolution

December 2024 - 091.5/2024

February 2022 – 312.1/2022

December 2020 – 142.6/2020

March 2019 – 06.3/2019

December 2017 – 121.6/2017

October 2008 – 427.5/2008

2.5.18 Local Government Elections Analysis 2015-2023

Position Statement

That WALGA advocate to the State Government:

1. For an independent Local Government election audit, focusing on the Western Australia Electoral Commission's (WAEC) service delivery and cost allocation methods and costing applications used, to confirm that marginal cost recovery principles are applied and that the costing program is being effectively managed.
2. For the requirement for the WAEC to develop and implement Service Level Agreements with Local Governments, similar to those agreements currently used in New South Wales and Victorian Local Government elections and that includes:
   a. transparency of costing methodology,
   b. direct engagement with Local Governments pre and post elections, and
   c. the roles and responsibilities of the WAEC and Local Governments in the conduct of elections.

3. For a review of the legislative framework that would allow for more than one election services provider to conduct Local Government elections.
4. For a mandated WAEC Report to Parliament specific to Local Government elections post each election cycle, outlining costs, results, voter turnout and matters for improvement both in the conduct of elections and the legislation, if relevant.

Background	A comprehensive review and analysis of five election cycles up to and including the 2023 Local Government election against the backdrop of legislative reforms to the Local Government electoral process in Western Australia was carried out by WALGA. With a focus on postal elections conducted exclusively by the Western Australian Electoral Commission (WAEC), the analysis has found evidence of the rising cost and reduced service level of conducting Local Government elections in Western Australia. Elected Member feedback, costs vs service comparisons and engagement by the sector with WALGA's governance services over the 2023 Local Government election period, are the basis for the position outlined above.
State Council Resolution	September 2024 - 065.4/2024

Appendix 2 - Election Statistics

The data in the following tables is derived from publicly available reports issued by the respective State Electoral Commissions for the elections they conducted. The different content and format of reporting in each jurisdiction can make direct comparisons challenging.

Table 1: Comparative overview

Jurisdiction	Compulsory/optional voting	Frequency	Postal/In Person
Western Australia	Optional	Half spill every 2 years	Postal or in person
South Australia	Optional	Full spill every 4 years.	Postal.
Northern Territory	Compulsory	Full spill every 4 years	Postal or in person.
Queensland	Compulsory	Full spill every 4 years.	Postal or in person.
New South Wales	Compulsory	Full spill every 4 years.	In person.
Victoria	Compulsory	Full spill every 4 years.	Postal
Tasmania	Compulsory	Full spill every 4 years.	Postal

Table 2: Average percentage of returning Council Members (at individual Council level)

States with full spills only. Calculated using publicly reported ordinary election results including elections conducted by private providers.

State	Most recent election year Average % of Council Members who were Council Members the previous term	Previous election year Average % of Council Members who were Council Members the previous term
Queensland	2024 47%	2021 49%
New South Wales	2024 54%	2021 49%
Victoria	2024 46%	2020 47%
South Australia	2022 57%	2018 48%
Tasmania	2022 53%	2018 54%

Table 3: Percentage of all elected candidates who were returning Council Members (at State level)

States with full spills only. Official state level percentage reported by electoral commissions for elections they conducted.

State	Most recent election year % of returning Council Members	Previous election year % of returning Council Members
Queensland	2024 43.2%	2021 46.0%
New South Wales	2021 56.8%	2016/17 (amalgamations) 60.6%
Victoria	2024 43.0%	2020 51.9%
South Australia	2022 50.0%	2018 55.3%
Tasmania	2022 46.0%	2018 48.0%

Table 4: Election participation rates

State	Election Year	Election Year	Election Year
WA	2023 31.2%	2021 30.2%	2019 29.1%
NSW	2024 84.54%	2021 *(2020 postponed)* 83.56%	2016/2017 (*amalgamations)* 2017: 79.58% 2016: 79.27%
NT	2025 *Official report not yet available.*	2021 61.3%	2017 58.5%
QLD	2024 82.31%	2020 *(COVID impacted)* 77.71%	2016 83.04%
SA	2022 32.9%	2018 31.6%	2014 31.99%
TAS	2022 *(First election with compulsory voting)* 84.79%	2018 58.72%	2014 54.58%
VIC	2024 81.46%	2020 81.47%	2016 72.15%

Table 5: Election costs

Election costs invoiced to Local Governments.

State	Election Year	Election Year	Election Year
WA	2023 *postal elections only* $5.17 per elector 1,763,392 electors (115 districts)	2021 *postal elections only* $4.06 per elector 1,727,712 electors (92 districts)	2019 *postal elections only* $3.70 per elector 1,619,431 electors (86 districts)
NSW	2024 $55.67million 5,242,086 electors (125 councils)	2021 $46million *(budgeted)* 4,838,137 electors (122 councils)	2016/2017 2017 $19.17 million 2.73 million electors (45 councils) 2016 $14.11 million 1.97million electors (76 councils)
NT	2025 NA	2021 $1,864,193 142,546 electors	2017 $1,593,775 133,927 electors
SA	2022 $8.93million (ex GST) $6.93 per elector (ex GST)	2018 $6.57million (ex GST) $5.41 per elector (ex GST)	2014 $4.36million (ex GST) $3.77 per elector (ex GST)
TAS	2022 *voting became compulsory* $9.32 per elector 410,975 electors	2018 $6.92 per elector 356,810 electors	2014 *first all-in all-out* $5.59 per elector 375,355 electors

Note: Data in this table is taken from reports published by the relevant Electoral Commissions. Due to differences in the ways electoral costs are apportioned, a per elector cost is only provided if it was reported. Data for QLD and VIC is not clearly discernible in Election Reports, and therefore not presented in this table.

Government of **Western Australia**
Department of **Housing and Works**

Dear Community Housing Providers

Updates to Community Housing Policies and Increase to Social Housing Income Eligibility Limits

I am writing to advise the Minister for Housing and Works has also approved a $11 per week increase to **Social Housing (Band A)** Income Eligibility Limits for single income households and a $16 per week income limit for dual income households. **The new income limits will take effect from Monday, 16 March 2026**. This increase is in response to the upcoming Commonwealth Pension Indexation effective 20 March 2026.

The new weekly Social Housing Income Eligibility Limits, which applies to Social Housing (Band A) provided by the Community Housing Sector as required by the Community Housing Agreement (if applicable to your organisation), the Community Housing Eligibility Policy, and/or the contract for specific properties/projects leased or in joint venture with you, are provided in **Attachment 1.** The equivalent annual income has been provided in the table for general information purposes only.

The Community Housing Eligibility Policy will be updated to reflect the changes and will be published on the Department of Housing and Works website shortly.

If you have any queries about these changes, please contact Tilly Chaney, A/Manager Social Housing Policy and Reform at CHPolicy@dohw.wa.gov.au.

Yours sincerely

M. Donnelly.

Mark Donnelly
A/Executive Director
Strategic Housing and Asset Policy, Planning and Business Development

17 March 2026

Government of **Western Australia**
Department of **Housing and Works**

Attachment 1 - Social Housing Income Eligibility Limits (March 2026)

Metro / South-West								
Number of People in Household	**Income Limit**				**Disability Income Limit**			
	Single Income		**Dual Income**		**Single Income**		**Dual Income**	
	Weekly	**Annual**	**Weekly**	**Annual**	**Weekly**	**Annual**	**Weekly**	**Annual**
1	$551	$28,744			$689	$35,943		
2	$701	$36,569	$830	$43,298	$877	$45,750	$1,038	$54,149
3	$816	$42,568	$950	$49,558	$1,020	$53,210	$1,188	$61,974
4	$936	$48,828	$1,090	$56,862	$1,170	$61,035	$1,363	$71,103
North-West / Remote								
Number of People in Household	**Income Limit**				**Disability Income Limit**			
	Single Income		**Dual Income**		**Single Income**		**Dual Income**	
	Weekly	**Annual**	**Weekly**	**Annual**	**Weekly**	**Annual**	**Weekly**	**Annual**
1	$772	$40,273			$965	$50,341		
2	$982	$51,228	$1,1620	$60,618	$1,227	$64,009	$1,453	$75,798
3	$1,143	$59,627	$1,330	$69,382	$1,428	$74,494	$1,663	$86,753
4	$1,311	$68,391	$1,526	$79,606	$1,638	$85,449	$1,908	$99,534
Additional Limits Per Person								
Additional Household Member	**Income Limit**				**Disability Income Limit**			
	Weekly		**Annual**		**Weekly**		**Annual**	
	$115		$6,000		$145		$7,565	

Band A income limits are based on weekly assessable income. Annualised figures (using a 313/6 multiplier) are provided for general information purposes only.

DRAFT - Small Towns Reinvention Conference

6–11 September 2026

Day 0 – Sunday 6 September 2026

Arrival – Longreach

- Delegates arrive in Longreach throughout the day
- Airport transfers and hotel check-in
- Evening at leisure
- Optional informal networking at local accommodation venues

4.30pm WELCOME DINNER TBC

Outback Pioneers

Tour of the Pride of the Murray

Dinner

*this may be swapped for Sunday night depending on Outback Pioneers availability for the Welcome Dinner

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Day 1 – Monday 7 September 2026

Conference Workshops – Longreach

Venue: Longreach (Conference venue TBA)

8:00am – 8:30am

- Registration & light breakfast

8:30am – 4:00pm

- Full-day workshops
- Morning tea & lunch provided on site

4:00pm – 5:30pm

- Free time / refresh

6:30pm – 9:00pm

Qantas Founders Museum sound and light Show TBC

Dinner

Community Catering:

- Rotary Club **or** Lions Club **or** Scouts (select one)

*This may be swapped for Sunday night depending on Outback Pioneers availability for the Welcome Dinner

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Day 2 – Tuesday 8 September 2026

Longreach to Winton via Age of Dinosaurs

7:00am – 7:30am

- Breakfast at **Qantas Park**
- *Community group catering TBC*

7:30am

- Depart Longreach by coach

9:30am – 11:30am
Age of Dinosaurs – Winton

- Welcome and site experience
- Morning tea / light refreshments

11:30am – 12:00pm

- **Guest Speaker:** David Elliott and Naomi Miles

12:00pm

- Depart Age of Dinosaurs

12:30pm – 2:00pm

- Arrive Winton
- Lunch (venue TBA)
- Guest Speaker – Winton Shire Council about Signage Strategy

2:00pm – 3:00pm

- Touring Waltzing Matilda Centre

3:00pm

- Depart Winton by Coach

5:00pm

- Arrive Darr River Downs
- Guest Speaker Fiona Tindall
- Sunset nibbles on Boot Hill

6:00PM

- Depart for Longreach

7.30pm

- Dinner TBC

Day 3 – Wednesday 9 September 2026

Longreach to Aramac via Ilfracombe

7:00am

- Depart Longreach by coach

7:30am – 8:00am

- Breakfast at **Wellshot Hotel**, Ilfracombe

8:00am

- Depart Ilfracombe for Aramac

9:00am

- Arrive Aramac
- **Venue:** Harry Redford Community & Sporting Centre

10:00am – 12:30pm

- Morning tea
- Workshops and community-led discussions
- **Guest Speaker:** Milynda Rogers – *Sculpture* Trail
- **Guest Speaker:** Adorabulls

12:30pm – 1:30pm

- Lunch (venue / community catering TBC)

2:00pm

- Depart Aramac for Sculpture Trail route TBC

Late Afternoon / Evening – Longreach
Dinner Options (select one): TBC

- **Silver Tails Rail Sunset**
    - Departs 4:30pm from Longreach Railway Station
    - Includes *Smithy's Outback Dinner & Show*
- **Drovers Sunset Cruise**
    - Pick-up from accommodation at 4:30pm
    - Includes *Smithy's Outback Dinner & Show*

Day 4 – Thursday 10 September 2026

Longreach to Blackall via Isisford

7:00am

- Breakfast at accommodation

7:30am

- Depart Longreach by coach

9:30am

- Arrive Blackall
- Tour
- Morning tea

10:30am – 12:30pm

- Workshops and presentations
- **Guest Speaker:** Lisa Alexander – *The Blackall Sign*
- **Guest Speaker:** Alison Shaw – *Tambo Teddies*

12:30pm – 1:30pm

- Lunch

1:30pm – 3:30pm

- Workshop sessions

4:00pm

- Depart Blackall for Isisford

5:00pm

- Arrive Isisford

5:30pm – 6:00pm

- Drinks at **Golden West Hotel**

6:30pm – 8:30pm

- Dinner at **Outer Barcoo Interpretion Centre (OBIC)**
- **Guest Speaker:** Cocky Bignell – *Big Yellowbelly*
- **Guest Speaker:** Yellowbelly Fishing Competition

8:30pm

- Depart Isisford for Longreach accommodation

Day 5 – Friday 11 September 2026

Conference – Longreach

7:00am

- Breakfast

8:00am – 10:00am

- Workshops – Longreach (venue TBA)

10:00am – 10:30am

- Morning tea

10:30am – 12:00pm

- Final workshop sessions

12:00pm

- Lunch to go
- Departure form Longreach or stay and explore