The *Review of cohealth general practice and related services, Final Report,* was provided to the Department of Health, Disability and Ageing, and the Victorian Department of Health, on 17 March 2026.

This version of document includes redacted and removed material*:

1. protected by secrecy provisions in the *Health Insurance Act 1973*, and personal information as defined by the *Privacy Act 1988.*

2. provided by cohealth to the reviewer containing commercial financial data.

*Includes appendices

Review of cohealth general practice and related services

Final Report

March 2026

The cohealth review, what it was, what it found

The announcement in September 2025 that the cohealth Board had decided to close three of its general practice clinics provoked widespread community outrage. cohealth blamed the closure of its Collingwood, Fitzroy, and Kensington clinics on the inadequacies of Medicare funding.

As a result, the Commonwealth and Victorian Governments jointly commissioned this Review into the reasons behind cohealth's closure decision, and the governance processes associated with that. The Review team consisted of Stephen Duckett, John Furler, and Jane Seeber. The Review's Terms of Reference were wide-ranging, looking at the financial viability of the clinics and the governance of cohealth. Importantly, the Terms of Reference also required the Review team to identify 'options to support the continuation of (GP) services to the community'.

We met with about 100 people – patients, staff, community members, and leaders of cohealth (Board and management). Our call for submissions generated 326 submissions.

We heard clearly from patients that the decision had caused them distress and anxiety. They were concerned for their neighbours and their communities, as well as for their own health.

cohealth GPs look after about 7,000 patients across its four clinics, almost 5,000 in the three sites slated for closure.

We were assisted in our financial analysis by McGrathNicol. In addition to our meetings with staff and stakeholders, our approach involved a careful review of documents – especially Board and committee papers and minutes – as well as a detailed scrutiny of accounting information.

We confirmed that the GP clinics were indeed running at a loss.

Early on, we identified four factors that, together, meant that the GP clinics were not viable under existing funding and delivery arrangements: aspects of cohealth's management oversight and governance; the cohealth model(s) of care; the client base of cohealth; and the MBS funding model.

Contrary to the views expressed publicly by cohealth – that the MBS funding model was the main cause of the clinics' losses, and that Medicare did not provide funding for appropriate services for the population served by cohealth – we found that ineffective governance and management had also contributed significantly to cohealth's financial problems. We concluded that the clinic losses were partly driven by cohealth's management of GPs and clinics, the way it schedules patient appointments, and its allocation of overhead costs to clinics.

Nonetheless, even with the best management in the world, the three clinics would still run at a marginal loss as other CHCs that run GP practices reported to us. So, Medicare funding arrangements do indeed need to change. The good news is that perceived weaknesses in Medicare – primarily a lack of weighting for complexity and need, incentives for shorter GP consultations, and lack of support for multidisciplinary care – are issues that are now widely recognised. The last of these weaknesses — the lack of an effective funding model for multidisciplinary care — has already been identified in policy, if not yet addressed with funding. That funding is necessary, and we believe that cohealth could be a pilot for a new funding scheme for multidisciplinary care.

Negotiating such an arrangement will take time, as will changes to strengthen cohealth management.

The extra multidisciplinary team funding we propose should only flow if there are clear signs that cohealth can use that money wisely. Much will need to change.

We assessed cohealth's management and governance of the general practices in question against the Performance Standards for Victorian community health services as specified in the Victorian *Health Services Act,* which regulates community health services. We found a number of weaknesses and opportunities for improvement.

We made recommendations to the Victorian and Commonwealth Governments, and to cohealth itself. These are summarised below.

Management oversight and governance	cohealth model of care	Client base of cohealth	MBS funding model
•**Finding:** governance and oversight of the GP clinics is ineffective •**Recommendation:** consider new governance arrangements; strengthen governance and management arrangements and organisational culture; rebuild stronger links with local communities	•**Finding:** No consistent model of care •**Recommendation:** co-design new multidisciplinary model of care; strengthen clinical leadership and engagement	•**Finding:** clients from lower socioeconomic status areas, more at risk of hospitalisation •**Recommendation:** co-design new multidisciplinary model of care	•**Finding:** GPs not working to top of scope of practice •**Recommendation:** more support for expanded multidisciplinany teams

List of recommendations

Recommendations to the Victorian Government

Recommendation 1: We recommend that the Victorian Minister for Health formally provide a copy of this Report to cohealth and invite cohealth to show cause why the Minister should not form the view that cohealth:

- is ineffectively managed; and/or
- has failed to meet one or more performance standards

Recommendation 2: We recommend that the Victorian Government agree to allow cohealth to pool some of its current community health funding with proposed new Commonwealth multidisciplinary team funding in primary care.

Recommendation 3: We recommend that the Victorian Government reconsider the proposal from cohealth for redevelopment of the Hoddle St Collingwood site, or development of an alternative nearby location that will allow access for the Collingwood community.

Recommendations to the Commonwealth Government

Recommendation 4: We recommend that the Commonwealth extend its support to cohealth for a further two-year period in which a new funding basis (as we have recommended) can be introduced, and internal changes in cohealth can be embedded to ensure practice viability.

Recommendation 5: We recommended the Commonwealth consider using cohealth as a pilot for a new approach to funding multidisciplinary teams in primary medical services. Specifically, we recommend that:

- The Commonwealth Minister for Health and Ageing provide a Health Program Grant to cohealth under Part IV of Health Insurance Act in lieu of Medicare rebates and the full bulk-billing incentive payments.
- The basis for the grant would be rebates calculated according to the cost to the government if services provided by cohealth GPs were billed on Medicare. That is, services provided by cohealth would be notified to the Commonwealth as currently, with the Health Program Grant being based on those notifications.
- The grant would be conditional on cohealth not charging any co-payments for medical services, and on appropriate accountability to North Western Melbourne PHN.

Recommendation 6: We recommend that the cohealth Health Program Grant incorporate, in addition, a multidisciplinary team payment based on the number of cohealth clients registered with MyMedicare. The basis of the payment (per patient) should have two components:

- 85% of what might have been able to be billed by allied health, psychologists or other health professionals under chronic condition and Better Access psychology items. This discount of the allied health and psychology items is to recognise that these items are rarely used to 100% of their value and that some patients may choose or require services outside cohealth.
- An amount equivalent to the Workforce Incentive Program – Practice Stream that might otherwise have been paid to cohealth.

Recommendation 7: We recommend that cohealth account to North Western Melbourne PHN (NWMPHN):

- Prospectively, for how it proposes to spend that allocation; and retrospectively, for how it spent the grant, including number of clients seen and outcomes achieved.
- The nature of its community engagement: cohealth should establish robust client and community engagement processes at the municipal level (Maribyrnong, Melbourne and Yarra), and proposals to NWMPHN for use of the multidisciplinary grant should be co-designed using these processes.
- Guidance for the approval process might include:
    - at most 30% of the funds allocated to corporate overheads and receptionist staff
    - a provision for medical practitioners for clinical governance, including a sessional allocation for a medically qualified Director of Primary Care
    - at least 10% allocated for activities focused on prevention, including social prescribing, and for supporting community groups.

Recommendation 8: As part of the approval of a pilot of multidisciplinary teams at cohealth, there should be a clear, funded, independent evaluation strategy.

Recommendation 9: We recommend that the Department of Health, Disability and Ageing adds community health services (and other not-for-profit practices) serving high need communities to the list of area of need settings that must be included in GP training.

Recommendations to cohealth

Recommendation 10: We recommend that

- cohealth employ a sessional medically qualified Director of Primary Medical Care
- cohealth management co-design with clinical staff (GPs and nurses, for example), a single model of care for all of cohealth's GP clinics that will ensure practice viability in the context of the new revenue streams.
- cohealth management set clear revenue targets for GPs that are consistent with the revenue streams and the new model of care, and can cover GP salaries, support staff, and a contribution to legitimate overheads.

Recommendation 11: We recommend cohealth resubmit its proposal for redevelopment of the Hoddle St Collingwood site for a GP clinic with social housing above.

Recommendation 12: We recommend cohealth rigorously review levels of overheads and develop a strategy to reduce them in line with levels seen in other Victorian community health services. Overheads should be allocated on a basis more clearly aligned with use.

Recommendation 13: We recommend cohealth formally acknowledge the trauma caused over the last few months to both the communities it serves (and its staff), and a) undertake a review of its local engagement processes with a view to rebuilding trust and reestablishing strong local links, and b) develop new mechanisms for staff engagement.

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1. Introduction

1 On 18 September 2025, in a letter to the Federal Minister for Health, Disability and Ageing, the Hon Mark Butler MP, cohealth advised it would commence activity to close its general practice clinics in Fitzroy, Collingwood, and Kensington in Melbourne.

2 Through subsequent engagement and negotiation, agreement was reached for cohealth to delay these closures until February 2026. The Commonwealth Government agreed to further support the pause on planned closures, through funding of up to $1.5 million provided via the North Western Melbourne Primary Health Network (NWMPHN), to ensure services remained available to clients until 31 July 2026. As agreed by parties, an independent review was established on 20 November with membership announced on 5 December 2025.

Objective and scope of this Review

3 The Terms of Reference for the Review are at Appendix A. Essentially, they direct the Review to focus on the overall service model at cohealth's general practices, including its clinical service model, and financial viability, in the context of the overall funding operations of the organisation and its governance, and the client base it serves.

4 Importantly, the Terms of Reference direct the Review to propose recommendations 'that ensure continued access of vital general practice service to these communities'.

Background of cohealth

5 cohealth is a registered Community Health Service (CHS) in Victoria, registered under the Health Services Act 1988 (Vic). It was created in 2013 through the merger of three preexisting organisations (Doutta Galla Community Health Service, North Yarra Community Health, and Western Region Health Centre), two of which themselves were created from mergers. The preexisting organisations had very proud histories that were rooted in their communities and in the trade union movement.[1]

6 One of the predecessor organisations, North Yarra Community Health, had incorporated Collingwood Community Health Centre, which was perhaps the cradle of community health in Victoria, dating back a century to the Singleton Free Medical Mission Dispensary.[2] Another part of North Yarra was Fitzroy Community Health Centre, formed when the Fitzroy community took over the former De Paul Centre, part of St Vincent's Hospital, and created a community-based Committee of Management to manage community health in Fitzroy. Doutta Galla Community Health Service traced its history back to local community groups that were among the first to lodge submissions for funding under the then Whitlam government's new Community Health Program.[3]

7 The 'Umbrella Deed', which legally documented the foundational agreement by the preexisting organisations to establish the new entity that became cohealth, included a 'shared vision' of those preexisting services. The Umbrella Deed envisioned the new entity as one that would, through 'stewardship of… shared values' be an entity that:

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[1] Felicity Bartak and Phillip Deery, *A Unique Endeavour: A History of the Western Region Health Centre, 1964-2004* (Melbourne: Western Region Health Centre, 2004).

[2] Hamish Townsend, *Missionaries, Radicals, Feminists: A History of North Yarra Community Health* (PsychOz Publications, 2012).

[3] Aron Paul, *Health to the People: Kensington to Doutta Galla 1974-2014* (Moonee Ponds: Doutta Galla Community Health Service, 2014).

- Continues to provide quality local services with strong connections in its local communities;
- Is based on the community health principles of the social model of health and health promotion and prevention;
- Is a strong and robust strategic advocate for those in the community who have no voice, overtly aiming to reduce health inequalities at the highest level of systems and government policy;
- is a leader in the sector with determination to make a real difference to the health outcomes of the most disadvantaged in the community at local, state and national levels;
- Is an investor in research and producer of best practice evidence that fundamentally shifts the way governments think about service provision; and
- Values its staff and maintains positive organisational culture as a key driver of strategy.[4]

8 Many involved in those negotiations to establish cohealth saw (and still see) the Umbrella Deed as a contract between the community and the new entity about how cohealth would work.[5]

9 Medical services (general practices) were a core part of each of cohealth's predecessor organisations, with primary medical care provided at Footscray, Kensington, Fitzroy and Collingwood.[6]

10 The provision of primary health care including medical programs is still enshrined as one of the 'purposes' of cohealth. The current Constitution of cohealth, which establishes it as a 'public company limited by guarantee', states:

> The Company is a not-for-profit charity established and operated in Australia to promote the prevention or control of diseases, including by operating a community health service. In pursuit of this purpose, the Company's supporting purposes are to:
>
> - establish, promote and operate a community health service that contributes to improved health outcomes for the public;
> - provide a range of health care responses including, *primary health care*, *medical, dental, mental health programs*, chronic disease programs, nursing care, drug and alcohol services, disability services, aged care services, allied health and counselling;
> - deliver a range of programs and services which aim to improve the determinants of health, promote wellbeing, prevent ill health and to slow the progression of existing conditions;
> - give priority to disadvantaged members of the community in the provision of all services and programs;
> - provide support to clinicians and health service providers to improve their patient care; and

[4] From Section 1.3 of the Umbrella Deed.
[5] The Umbrella Deed is not formally legally binding on cohealth, but what is reported here is community sentiment and expectations.
[6] These services generally also ran at deficits.

- do all lawful things consistent with, necessary or desirable to support and further the above purpose (*emphasis added*).[7]

11 The announcement of the closure of primary medical care at three sites (Kensington, Fitzroy, and Collingwood) in September 2025 was met with a significant community response that included public meetings, and vocal commentary from those involved in the previous negotiations. In one of our consultation meetings, we were told that the closure of the Collingwood clinic in particular 'was the most passionate issue' ever seen in the city, more energising than other famous local campaigns such as the proposed closure of the Fitzroy swimming pool.[8]

12 The time between the announcement and the date given for the clinic closures was less than three months. This was apparently driven by 'consultation' requirements in industrial agreements.

13 The closure decision prompted action by the Commonwealth and Victorian Governments, including the commissioning of this Review of cohealth's primary medical care and related services.

14 cohealth public statements argue that the decision to close was driven by exogenous factors, primarily by failings in Medicare funding arrangements that meant the services were not viable in their existing configuration and practice style. This Review considered both endogenous and exogenous factors identified in its Terms of Reference.

15 The members of the Review panel are:

> *Dr Stephen Duckett (Chair)* is an Honorary Enterprise Professor in the Department of General Practice and Primary Care at the University of Melbourne and Chair of the Board of Directors of Eastern Melbourne Primary Health Network. He was a member of the Strengthening Medicare Taskforce and the Review of General Practice Incentives. Dr Duckett is a Fellow of the Australian Institute of Company Directors.
>
> *Dr John Furler* is a general practitioner at North Richmond Community Health Centre and Honorary Professorial Fellow in the Department of General Practice and Primary Care at the University of Melbourne. His research interests include health equity in chronic disease care. Dr Furler is a Graduate of the Australian Institute of Company Directors.
>
> *Ms Jane Seeber* is a Chartered Accountant with extensive executive and governance experience in a range of health, disability and community service organisations, including at Access Health and Community, and Better Health Network (BHN). In these roles she led corporate, clinical and service delivery teams including general practice, working closely with medical directors, GPs, nurses and community representatives. Jane is a resident of the City of Yarra and volunteers with organisations working in the Yarra community. Ms Seeber is a Member of the Australian Institute of Company Directors.

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[7] cohealth has highlighted to us that 'Even after the general practice closures, cohealth will continue to have GPs on staff and embedded in health care teams e.g. at Innerspace. Therefore cohealth will continue to provide primary health care including medical programs'. (Note that Innerspace provides health services for people who use drugs ie an index condition and is not accessible to the general community)

[8] Hannah Lewi and David Nichols, ""You Never Appreciate What You Have Until There is a Chance You May Lose It"," *Fabrications: The Journal of the Society of Architectural Historians, Australia and New Zealand* 24, no. 1 (2014).

16 All three members of the Review panel live on the unceded lands of the Wurundjeri Woi-wurrung people of the Kulin Nation. We pay our respects to elders, past and present. We particularly acknowledge the pioneering work done by Aboriginal and Torres Strait Islander communities throughout Australia in creating and implementing Aboriginal Community Controlled Health Organisations as a model for the provision of primary health care to those communities.

17 We thank all those who made submissions, and everyone who met with us – all of whom were very open and obviously committed to helping us find a way forward for the GP clinics. We thank the Board and staff of cohealth and NWMPHN, and the staff of the Victorian and Commonwealth departments.

Review approach

18 A key question facing the Review was whether cohealth's situation is unique, or whether it is common across other primary medical care services serving similar populations, especially other Victorian community health services located in close proximity to public housing estates.

19 The Review adopted a 'realist evaluation' framework, focusing on 'what works (or not), for whom and in what circumstances':[9] The realist evaluation framework directs attention to how context and mechanisms lead to outcomes.

20 What was critical to this Review was to '*explain* how and why context *shapes* the mechanisms through which the intervention works and thus explain why an intervention might work differently in different contexts.'[10] Specifically, we aimed to address how the cohealth *context* was (or was not) different from other Melbourne community health centres and what governance, management (including financial management), and practice *mechanisms* influence the application of Medicare and other funding sources to achieve the *outcome* of sustainable health services working for the populations.

21 The Review relied heavily on documentation of cohealth's processes (including financial management and governance processes). Unfortunately, the work of the Review was delayed over the Christmas break, with document requests and provision proceeding across the review period into February.

22 The Review was supported in its analysis of cohealth's finances by McGrathNicol, who completed a historical financial analysis and modelled viability options for the future.

23 In addition to meeting with stakeholders and staff, the team met weekly to discuss what we were hearing and share our tentative, iterating conclusions. Some or all of the Review team also met McGrathNicol each week to monitor progress and review findings.

24 We started writing early with each team member taking a lead on some sections, and all commenting on and critiquing others. We had a writing workshop on 18 February 2026 to finalise the core text which was then sent to members of the steering committee for fact checking.

25 Recommendations were developed from the core text, which provided the evidence base. The community-facing report and the executive summary were completed at the end of the whole process.

26 Consistent with a realist approach, we took into account the context of the cohealth board decision. This included the history and community expectations of the services,

[9] Ray Pawson and Nick Tilley, *Realistic Evaluation* (London: Sage, 1997).
[10] Joanne Greenhalgh and Ana Manzano, "Understanding 'context' in realist evaluation and synthesis," *International Journal of Social Research Methodology* 25, no. 5 (2022).

and cohealth's own information. Although the revenue streams for cohealth's GP services are the same as for private general practices, cohealth is a not-for-profit organisation. It does not exist only to make a profit on the care it provides, but rather it exists for a public purpose. Many of its public documents assert these broader goals (see section 7. There was inadequate and ineffective management oversight of the clinics).

Engagement activities

27 In addition to desktop review and analysis, the Review team met with:

- cohealth Board and management
- Medical site leads and other medical staff, nursing and other clinic staff, and practice management staff
- Senior staff of the Victorian and Commonwealth departments responsible for primary care issues
- The Lord Mayor and staff of the City of Melbourne, and with the Mayor and staff of the City of Yarra
- Leaders of other community health and primary care centres in Victoria and other states
- Stakeholder groups including Community Health First (the organisation of Victorian independent community health centres), Victorian Healthcare Association (VHA) and the Royal Australian College of General Practitioners.

28 The members of the Review team have extensive contacts across Melbourne with local residents, community health leaders, and general practitioners. Unstructured contacts with community members and other informants provided another rich source of information.

29 One of the most valuable sources of information was obtained from an open call for submissions posted on social media and on the Commonwealth department's Review website. Even though submissions were only open for one month (during January 2026), 326 submissions were received, of which more than half came from patients or clients; 26 came from staff. Some of the submissions incorporated multiple patient testimonials.

30 The call for submissions was only published in English but assistance with submitting was offered. We received a number of submissions from groups whose name suggested they were from a culturally and linguistically diverse background. However, we acknowledge that the English-only call for submissions may have limited the representativeness of submissions.

31 The Review held three online consultation meetings in February to which all patients who submitted to the Review were invited. There were about 40 attendees across all three meetings.[11]

32 The Review conducted a survey of Community Health First member health services to get comparative information about GP provision in other like services.

33 The Review was also able to obtain comparative data from the MBS, subject to appropriate privacy protections. cohealth approved the identification of its data.

[11] Some people attended more than one meeting.

2. What is cohealth and what does it do?

34 As mentioned in the Introduction, cohealth has a proud history as the successor organisation to a number of health services that were established in the 1970s as part of the Whitlam government's Community Health Program.[12] The objective of the Program was

> the provision of:
>
> - services that incorporate the most up-to-date knowledge and techniques available, provided by an appropriate range of medical, nursing and allied staff;
> - services with an emphasis on prevention;
> - readily accessible primary services available equally to all, and a comprehensive range of facilities, backup resource and supportive services coordinated according to function at local, regional and state level;
> - continuity and coordination of service;
> - efficient management to support the professional teams and to ensure courteous and prompt care for the public.

35 The Program was the implementation nationally of an initiative developed by Dr Sidney Sax in New South Wales for comprehensive, neighbourhood health services.[13] Employment of (salaried) general practitioners was a core part of the program from the beginning, although not every community health centre had GPs.

36 The Program also drew on the contemporary international thinking which led to the World Health Organization's Declaration of Alma Ata.[14] The aim of both the global movements and the Australian Community Health program was to revitalise integrated, community-based primary care. It saw primary medical care as part of this, emphasising holistic care and rejecting silo-based care such as separate provision of alcohol and drug services, even if they have GPs as part of those specialist teams.

37 Fast forward 50 years, and cohealth continues to provide holistic primary medical care on four sites: Collingwood, Fitzroy, Footscray, and Kensington.[15]

38 cohealth is no longer just the amalgamation of community health centres; it has diversified well beyond those earlier origins, which has caused some of the tensions discussed below.

39 In 2024-25, cohealth had revenue of almost $120m, for a diverse range of programs including alcohol and other drug services, mental health, refugee health and justice (prison) health care. It also manages the Medicare Urgent Care Centre associated with the Royal Children's Hospital and runs community health programs funded by the State government and general practice services funded through Medicare. The GP clinics now represent only about 5% of revenue.

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[12] Hospitals and Health Services Commission (Interim Committee), *A Community Health Program for Australia* (Canberra: HHSC, 1974). See also Fran Baum et al., "Medicare Without a Strong Community Health Sector Is a Loss to the Australian Health System," *Journal of Australian Studies* (2026 (in press)).
[13] S. Sax, *Medical Care in the melting pot: An Australian review* (Melbourne: Angus and Robertson, 1972).
[14] World Health Organization, *Declaration of Alma Ata: Adopted at the International Conference on Primary Health Care, Alma Ata, USSR* (Geneva: WHO, 1978).
[15] The Collingwood site can trace its origins to prior to the Whitlam program, but was revitalised and expanded as part of the Whitlam-era Collinwood Community Health Centre see Townsend, *Missionaries, Radicals, Feminists: A History of North Yarra Community Health*.

40 cohealth is one of Australia's largest community health organisations, delivering a wide range of primary health care services across Melbourne's CBD and in the city's inner north and west, as well as statewide services. It also delivers primary care services in Tasmania. cohealth has around 1,000 staff working across more than 40 sites. It receives funding from local governments, the Victorian Government and the Federal Government.

41 This Review is focused on just one of the range of services cohealth offers – general practice clinics. These are, however, an iconic part of cohealth's services, and in the communities they serve, are widely considered a vital and irreplaceable service.

42 At our first meeting with the cohealth Board, we suggested that, based on its decision to close the services, cohealth must not see the GP services as 'core'. To some extent reassuringly, the Board repeated their commitment to GP services.

Clients seen by cohealth GPs

43 If one defines cohealth's general practice client base as patients who had three or more visits in the previous two years,[16] the most recent data shows cohealth's primary medical services had 7,071 separate clients who had 100,048 attendances, averaging 22 minutes each (see Table 1).

Table 1: Clients seen at cohealth GP services, 2024-2026 (two years)

`	Clients	Attendances	Attendances per client per annum
Collingwood	1,593	21,345	6.7
Fitzroy	1,669	22,965	6.9
Footscray	2,219	34,837	7.8
Kensington	1,616	20,901	6.5
TOTAL	7,097	100,048	7.0

Source: cohealth data provided to the Review. Note: 26 clients visited two or more sites

44 On average, according to this data set,[17] cohealth clients visited a general practitioner (GP) just over once every two months, about 10-12% more often than the average Australian, who – on average – saw a GP 6.1 times in 2023-24.[18]

[16] In line with RACGP definition of an active patient see The Royal Australian College of General Practitioners, *Standards for general practices (5th edition)* (East Melbourne: RACGP, 2020).

[17]

[18] https://www.aihw.gov.au/reports/primary-health-care/general-practice-allied-health-primary-care

45 [redacted]

Figure 1: Proportion of services by SEIFA decile, at Statistical Area 1 level, 2024-25

Source: Commonwealth Department of Health, Disability and Ageing, special analysis for this Review. 'cohealth clinics' are only cohealth's generalist clinics.

46 [redacted]

47 As cohealth's submission highlighted

> Compared with national data, cohealth's client population includes a high prevalence of chronic disease, multimorbidity and mental health conditions, which are known to drive higher service utilisation and require coordinated, longitudinal care

19 [redacted]

Table 2: Complex health and social needs supported by GPs at Victorian general practice clinics in 24-25

Challenge	Description	Cohealth Data / National Average
Chronic Disease condition	Prevalence of one or more long-term conditions such as diabetes, cardiovascular disease, respiratory illness, and multimorbidity	56.6% / 49.9%
Multimorbidity	Prevalence of two or more chronic conditions	27.8% / 22%
Chronic Mental Health condition	Prevalence of long-term anxiety, depression, trauma-related disorders, and unmet mental health support needs	56.5% / 26.1%
Financial hardship	Clients experience financial hardship (represented by health care or pension card)	71.2% / 20%
Refugee status	Recent migrants and refugees, with specific health access needs	18.5% / 0.73%
Aboriginal or Torres Strait Islander	Identifying as Aboriginal or Torres Strait Islander	2.1% / 3.2%
Homeless	Clients experiencing homelessness or housing insecurity	7.7% / 1.1%

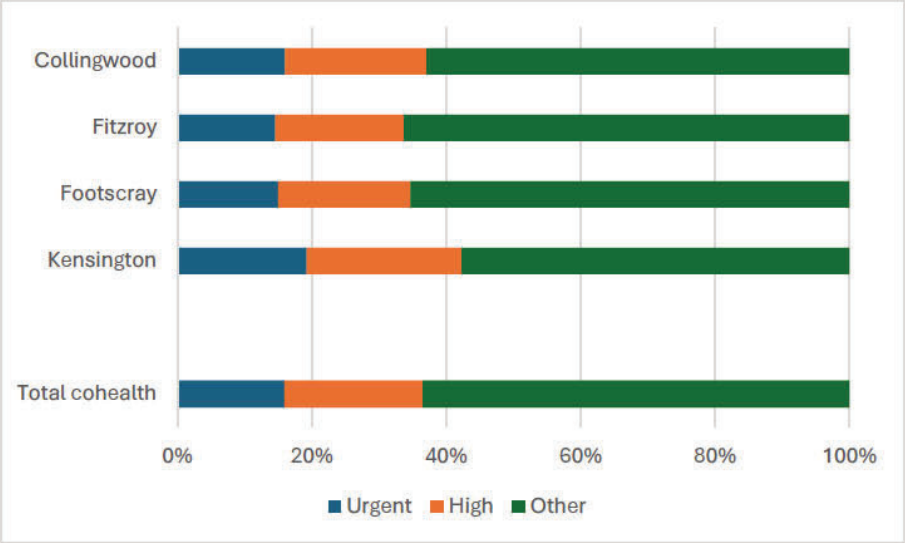
Source: cohealth submission, page 10

48 Three factors stand out in this table: the rate of chronic mental health conditions, refugee status, and homelessness. We heard in our consultations that the rate of mental health conditions is increasing in the inner city, and how important it is that a network of services exists to address this growing need. Community health, providing holistic GP services, is core to that network of services.[20]

49 Another indicator of complexity is the risk of hospital admission. Outcome Health's (POLAR) Hospitalisation Avoidance Tool report calculates the risk of hospitalisation or emergency presentation within 12 months.

[20] Rather than GPs only providing services for a specific condition such as related to alcohol and other drugs.

Figure 2: Patients at risk of hospitalisation in next twelve months, as at 1 January 2026



Source: POLAR Reports for clinics. Note, Total Active Patients follows RACGP definition of three or more visits in last two years. Some patients may be counted at more than one site, see note at Table 1[21]

50 It can be seen that almost 40% of cohealth's clients are at 'urgent' or 'high' risk of hospitalisation.[22]

51

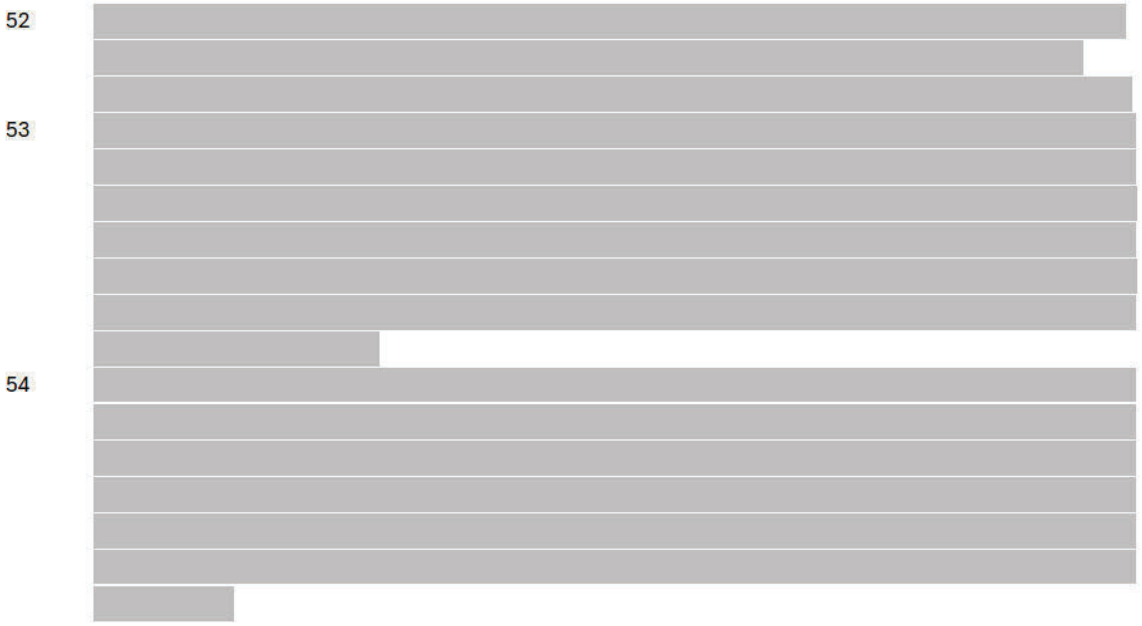
[21] The Review team was unable to obtain comparative data from POLAR for this metric

[22] Ten submissions mentioned the impact of clinic closure on hospitals (mostly St Vincent's e.g., 'If Collingwood and other community health centres are closed, where will vulnerable members of our community go? The answer is that they will increasingly present to hospital emergency departments in an advanced state of ill health and therefore be more expensive to treat (I'm assuming that the ED managers of St Vincent's and RMH are wondering how their departments will cope).'

[23] See Figure 7.

Figure 3: Billing patterns, attendance items, 2024-25 (%)

Source: Commonwealth Department of Health, Disability and Ageing, special analysis for this Review. 'cohealth clinics' are only cohealth's generalist clinics. Figure shows share of attendance items only (Level A – E).



[redacted]

55 The clinics have different support structures, differing roles for nurses (clinical vs care co-ordination) and different staffing mixes for support staff but show consistent visit length. While the ***longer*** consultation length is likely in part related to the high levels of clinical complexity and social disadvantage noted above, the remarkable ***homogeneity*** of visit length in the varying clinic settings is consistent with a hypothesis that visit length is driven to a significant extent by booking schedules or GP preference rather than patient need or available supports.

56 We are not arguing here that longer appointments are intrinsically bad. They are not. Some are an essential part of good care. As another community health service told us:

> Community health services care for people who are least able to engage with time-limited, transactional models of care. These patients require time, trust, flexibility and persistence — not because they are 'difficult', but because their lives have been.

57 [redacted]

58 In summary, cohealth clients have substantially longer visits, and, for a significant proportion of the client base, substantially more visits per year.

59 The issue for cohealth and its GPs is the appropriate balance of appointment lengths and frequency of attendance. This is an issue that goes to both clinical complexity and need (as described above), and to financial viability, since the current Medicare Benefits Schedule (MBS) rebate structure that pays a higher per-minute rebate for short consultations (Level B) compared to longer consultations (Level C/D/E), see Figure 7.

60 This is an issue highlighted in a 2021 VHA paper on sustainable models of GP in CHCs.[24] Both clinical and social complexity as well as viability need to be considered in how best to meet the needs of this community with ongoing sustainable general practice services.

[24] Victorian Healthcare Association and Victorian Department of Health, *Increasing access to affordable primary care in community health services* (Melbourne, 2021).

61 [redacted]

62 [redacted]

63 [redacted]

cohealth's patients report that the services are good

64 More than half the people who provided submissions to the Review were current or former patients of cohealth.

65 Patients were invariably positive about their interactions with cohealth GPs, and the other services provided by cohealth. Many told stories of the excellent care they received from cohealth.

66 An artificial intelligence analysis of submissions conducted by McGrathNicol for this report (see **Table *5*** below), shows that there were 125 expressions of views ('sentiment') about cohealth staff and service delivery, of which 120 were positive. The summary of the sentiment was clear:

> Submissions with a positive sentiment towards cohealth staff and services present a highly consistent and strongly favourable view of cohealth's frontline workforce. Across these submissions, GPs, nurses and the wider clinical and allied health team are described as compassionate, highly skilled and deeply trusted, with care characterised as holistic, trauma-informed and relational rather than transactional. A central theme is the value of the multidisciplinary model, with respondents emphasising seamless collaboration across clinical roles as critical to managing complex and chronic health needs. Staff are repeatedly credited with preventing hospitalisation, stabilising health conditions and materially improving quality of life, particularly for vulnerable and marginalised populations. Positive sentiment is closely linked to accessibility and equity, with cohealth staff recognised for providing culturally safe, non-judgemental care to people who face significant barriers in mainstream health settings. Overall, these submissions consistently portray cohealth' s clinical workforce as an essential, trusted and high-performing component of effective community-based care.

67 There were only five expressions of negative sentiment, but these predominantly reflect concerns about reduced access, capacity constraints and loss of continuity of care, rather than dissatisfaction with clinical quality.

68 cohealth provided a supplement to its submission to the Review which reported the results of a survey conducted after the closure was announced. This survey also reported a positive sentiment from respondents and highlighted the importance of the services provided by cohealth.[25] Importantly, it highlighted that while patients value their continuous relationship with their GP, they also report high levels of comfort with a team-based approach to their care and a strong interest in other team members being involved in their care.

[25] The submission did not record the number of respondents.

69 In addition, GPs at cohealth's Kensington site provided us with more than 30 testimonials from patients about their positive perception of the services provided.

70 Staff from other local services also spoke to the importance of cohealth more widely, some specifically mentioning cohealth's role in preventing admissions to public hospitals or mental health services.

71 All of this evidence speaks to the view that cohealth's primary medical care is perceived by patients as good. The critical question is not whether it can be better, but rather whether it can be organised differently, so that the same high quality of care noted in patient comments can be achieved in a financially viable way. Both model of care and funding arrangements may need to be considered.

cohealth's finances

72 Like those of many health sector organisations, the activity and finances of cohealth were profoundly affected by COVID, particularly in the first two years of the pandemic.

73

Figure 4: cohealth revenue and expenses, 2014-2025, $m

Source: cohealth published statutory accounts, note truncated axis

74

75

76

[26] In addition, there were asset revaluations in the first two years of the pandemic which improved its recorded financial position,

77 [redacted]

Figure 5: cohealth deficit position, three GP clinics (cohealth internal reporting) and organisation as a whole (audited public accounts), FY23-FY25

78 A more detailed review of finances is in a subsequent section (see section 5. The Review confirms that cohealth is making a loss on its GP clinics).

Then and now: conflicts of vision

79 As we outlined above, cohealth can trace its origins to the Community Health Program of the 1970s and to the radicalism and vision of social justice that animated it.

80 The histories of the predecessor organisations point to locally led attempts to improve the lot of local residents through outreach and social action, as well as 1:1 primary medical care clinical services. Individual services and preventive action are not in conflict, of course – emphasis on prevention should mean that one leads to the other, as was theorised at Fitzroy Community Health Centre.[28]

81 This local involvement is still embedded in the memories of local activists, who see cohealth as the old services writ a bit larger. The old mandate of outreach and action was drawn to our attention in a number of submissions.

82 In our view, preventive action – both at an individual level and more broadly – should continue to be part of the mandate of cohealth and like organisations that distinguishes them from private general practices.

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[27] Another factor was that the Collingwood site is no longer fit-for-purpose, and the cash that could be released by sale of two properties (Collingwood and Kensington).

[28] One of the predecessors of North Yarra Community Health Service. See Terri Jackson, Sally Mitchell, and Maria Wright, "The community development continuum," *Community Health Studies* XIII, no. 1 (1989).

83 We are seeing in health services policy generally a revival of this emphasis on 'neighbourhood' – see, for example, VicHealth's priorities[29] and the recent English National Health Service Plan[30] – and on the importance of outreach in local communities. These approaches should continue to inform cohealth's work into the future.

84 There is also a clear link between the 'old' community health view of the world and the new emphasis on multidisciplinary teams. This link was clearly articulated by Health Minister Butler on an event to celebrate the 50th Anniversary of the Community Health Program:

> Strengthening Medicare for the next 40 years will mean reviving the principles of Whitlam's other foundational health reform, the Community Health Program and weaving them deep into the fabric of Medicare.[31]

85 But the neo-liberal turn of the 1990s tended to squeeze out the radical aspirations of community action and systemic change, despite its benefits,[32] and corporatisation produced larger and more distant organisations which increasingly chased tenders and contracts.

86 So cohealth evolved, as did most other community health centres in Victoria. Organisations became larger by necessity. Victorian policy required them to become companies. Their original place-based names were lost in a series of mergers and replaced with new ones chosen as part of marketing or branding exercises.

87 One person described this context in their submission to the Review:

> Due to policy changes by governments of different persuasions over a number of years, many community health services are largely unrecognisable from the independent, community-controlled organisations that were established decades ago. Many have become large, bureaucratic structures that now operate as an arm of government. They are removed from the communities they serve, and provide services on the basis of funding opportunities rather than community need. The current issues at cohealth are emblematic of this policy environment.

88 In a similar vein, one staff member lamented the change apparently underway:

> cohealth is moving/has moved to a corporate model of 'community health' where they manage disparate small non-longitudinal health-related services at multiple sites.

89 With the growth of work funded through aged care, the National Disability Insurance Scheme, and other contract-funded activity, the 'old' community health role of cohealth has come to represent an ever-smaller part of its activity – probably less than 10% by revenue, with general practice included. As we shall see, however, it unfortunately accounts for a larger proportion of cohealth's expenses.

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[29] https://www.vichealth.vic.gov.au/our-focus/neighbourhood-built-systems

[30] United Kingdom. Secretary of State for Health and Social Care, *Fit for the future: 10 Year Health Plan for England* (London: National Health Service, 2025).

[31] Mark Butler, *Speech at the Whitlam Institute to celebrate the Whitlam Community Health Program (3 November 2023)* (2023). https://www.health.gov.au/ministers/the-hon-mark-butler-mp/media/minister-for-health-and-aged-care-speech-3-november-2023.

[32] Hal Swerissen and Beth R. Crisp, "The sustainability of health promotion interventions for different levels of social organization," *Health Promotion International* 19, no. 1 (2004); Virginia J Lewis, Jenny Macmillan, and Ben Harris-Roxas, "Defining community health services in Australia: a qualitative exploration," *Australian Journal of Primary Health* 28, no. 6 (2022).

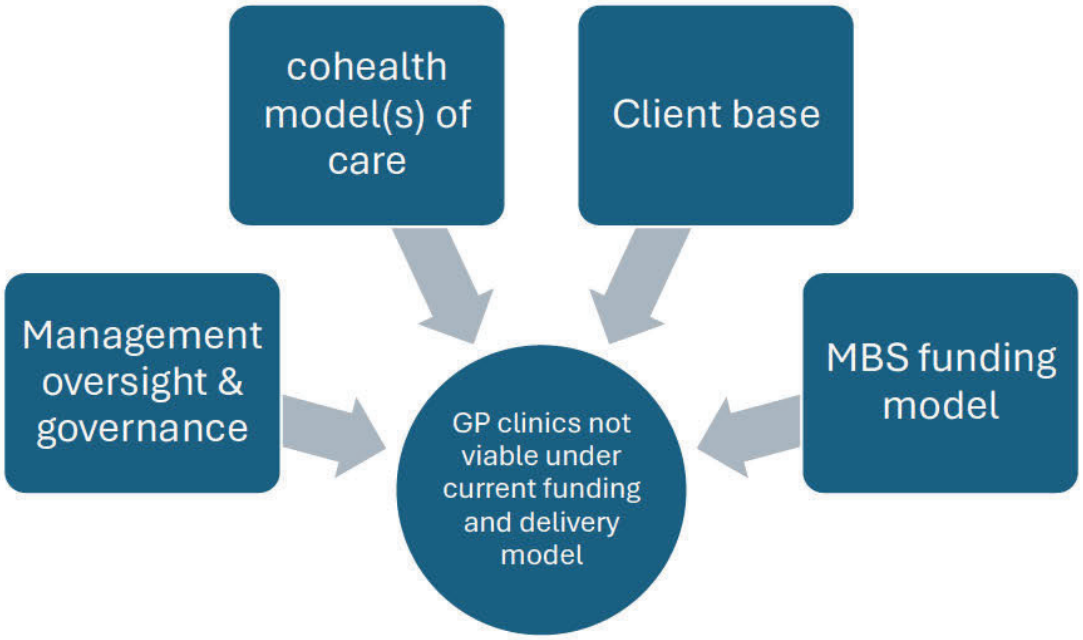
90 In its submission, cohealth described itself as ‘a community-based not for profit organisation’ (page 6). The words ‘community health’ do not appear (although they do on the cohealth website). In their discussions with us the cohealth executive referred to ‘expectations of a company like cohealth’, making explicit its corporate orientation (and obligations).

91 The historic origins of cohealth, and the community-service ethos valued by many of its employees, perhaps made it harder for cohealth leadership to gain traction in internal efforts to ensure viability of the general practice services – for the relevant staff, it was unthinkable that cohealth would ever vacate this field.

3. The problem in a nutshell

92 What we will show in this report is that there are four factors that determine the viability of GP services run by cohealth and like organisations. Two are external, or exogenous: the client base, and the MBS funding model. Two are internal, or endogenous: the cohealth model(s) of care,[33] and governance. These factors (see Figure 6, below) led to cohealth's decision to close the GP clinics.

Figure 6 Key factors influencing GP clinic viability



93 These factors are somewhat interrelated but, as we will show later in this report, not equally important as they applied in the cohealth situation.

94 Submissions from other community health services often highlighted that the two exogenous factors (client base and the MBS funding model) created difficulties for their services too:

> There is a three-way 'tug-of-war' in community health between practitioner retention, complex patient management, and financial surplus. We are of a view that it is possible to deliver bulk-billed medical services as a community health service and break-even. But it is more difficult than it needs to be.

95 A key response of cohealth to the financial situation was to focus on an exogenous factor: the MBS funding model.[34] We were told that [redacted] visited Canberra a number of times to lobby for change in the MBS, with limited apparent impact.

96 To the extent there were efforts made internally to address the model of care they were also unsuccessful. The view of the Board and management was that they did as much as

[33] As we will show, there is no single model of care which applies in all the GP clinics.

[34] The cohealth Board was also advised of internal projects to improve financial viability. These were ineffective too. The use of the word 'key' in this paragraph refers to how cohealth positioned its efforts publicly. We discuss this issue in more detail in the section Effectiveness of business systems and procedures.

they could on this front, and that the decision to close the GP services was taken as a last resort and only after all other efforts proved futile. We will discuss the effectiveness of internal controls and processes later, and whether this was a reasonable response.

97 In the next section we will describe the financial position of the clinics and cohealth overall. As we have phrased it in the above Figure, what we see is that the clinics are not viable under the current funding and delivery model.

98 We then look at the causes. We first look at management oversight and governance with a focus on the GP clinics as required by our scope, which we find is ineffective. This exacerbated cohealth's situation.

99 Next, we examine cohealth's client base and model(s) of care.

100 Many submissions argued that the Medicare Benefits Schedule is not well suited to dealing with the client base that cohealth (and other community health services) deal with. We will show that this is partly true.[35]

101 cohealth's varied history and the inability of the management to drive change has meant that it doesn't have a single, coherent model of primary care across all its GP sites. In general, it employs a GP-centric model rather than a team-based model in the clinics.[36] This may be partly because the MBS doesn't facilitate a team-based model (specifically, it underfunds multidisciplinary care) and partly because of (perceived) constraints relating to Victorian community health funding for this purpose.

102 We conclude with recommendations to governments and cohealth.

[35] GP services at cohealth predecessor organisations also ran deficits.

[36] Measuring the productivity of primary care services must be based on the productivity of the primary care team – all of whom contribute to the work of a primary care service see Lisa V. Rubenstein et al., "Measuring Primary Care Productivity in the Era of Interprofessional Team Care: Stakeholder, Scoping Review, and Implementation Perspectives," *The Milbank Quarterly* 103, no. 4 (2025).

4. What we heard

103 All members of the Review Panel read all the submissions received. The Panel acknowledges the extensive work that some people and organisations put into formulating their submissions. The panel has drawn on the submissions in formulating this report and quoted directly from submissions to illustrate points.[37]

104 Midway through the Review process, the Review panel identified several themes that we were hearing about consistently. The Table below shows how the submissions sorted into those themes, with some submissions counted more than once if they mentioned more than one theme.

Table 4: Number of submissions which addressed each category (by relationship to cohealth)

Categories	Patient / Client	Other	Total
Community Need	137	125	262
GPs & Service Model	142	61	203
Governance	39	29	68
Future Models	17	37	54
Management - organisation	18	16	34
Financial	11	16	27
Sectors and systems	1	20	21
Management - clinics	-	7	7
TOTAL NUMBER OF SUBMISSIONS	**178**	**148**	**326**

Source: Analysis of submissions undertaken by McGrathNicol for Review

105 The overwhelming majority of submissions mentioned issues related to 'community need', and this was the case for both patients/clients and other submissions.

106 As mentioned earlier, McGrathNicol also undertook an automated, artificial intelligence sentiment analysis of the submissions (see Table 5).

[37] The voice of the cohealth Board and executive was primarily incorporated through statements from the Board and Committee papers and minutes.

Table 5: Sentiment Analysis of Submissions' Categories (by relationship to cohealth)

Categories	Patient / Client Sentiment Analysis	Other Sentiment Analysis
Community Need	Overwhelmingly negative sentiment towards the cohealth closure, driven by concern, alarm, and frustration about the impacts of service withdrawal or change. This negativity is consistently framed as constructive advocacy, with submitters emphasising the value of existing services and calling for their continuation, reform, or proper funding rather than expressing general dissatisfaction.	Mixed to neutral sentiment overall, with substantially less emotional intensity than patient/client responses. These submissions tend to be more descriptive, procedural, or informational, and where views are expressed, they are typically measured, qualified, or exploratory rather than strongly oppositional or advocacy-driven. The submissions focus on practical implementation and system readiness, including clarity about how changes will work, how continuity will be maintained, and whether alternative arrangements are viable. Rather than expressing alarm, these submissions seek assurance that decisions are evidence-based, well-planned, and operationally sound, with attention to downstream risks if execution is weak.
Financial	Sentiment is clearly negative but more evidence-led than emotive, combining concern with deliberate and reasoned critique. These submissions focus on concrete risks such as financial sustainability, governance credibility, and system-level consequences, often drawing on professional experience, data, or specific examples to support their views. Overall, the tone reflects serious concern and reduced confidence, expressed through analytical argument and calls for corrective action rather than purely emotional opposition.	Sentiment is generally neutral to mildly negative, with a restrained and pragmatic tone. These submissions tend to avoid strong critique and instead focus on describing context, outlining observations, or noting issues without assigning blame or expressing urgency. Overall, they reflect limited concern or uncertainty rather than alarm and often read as informational or cautiously reflective rather than advocacy-driven.
Future models	Strongly negative, expressed with higher emotional intensity and clear urgency compared to non-patients/clients. These submissions convey alarm and frustration about the anticipated impacts of decisions, particularly the harm to vulnerable clients, service continuity, and system capacity, and they frequently reflect a breakdown in trust in current processes or leadership. Overall, the sentiment is explicitly oppositional and advocacy-driven, calling for reversal, retention of services, or significant reform rather than reassurance or incremental adjustment.	Moderately negative to mixed, expressed in a controlled and analytical tone rather than overt opposition. These submissions acknowledge risks and shortcomings—particularly around system capacity, sustainability, and implementation—while stopping short of outright rejection, instead signalling concern that current proposals may underestimate complexity or lack sufficient safeguards. Overall, the sentiment reflects qualified caution, with an emphasis on the need for stronger evidence, clearer planning, and risk mitigation rather than resistance to change itself.

Governance	Sentiment is strongly negative and highly charged, with clear urgency and moral emphasis. These submissions express deep concern about harm to people and communities, often framing the issue in terms of duty of care, equity, and ethical responsibility, and they typically call for decisive action such as reversal of decisions, protection of services, or accountability from leadership.	Sentiment is negative but more restrained and reflective in tone than clients/patients. While values such as equity, access, and responsibility remain central, these submissions tend to articulate concern in a more measured way, focusing on principles and potential consequences rather than alarm, and often seeking reassurance, mitigation, or better alignment with stated values rather than immediate reversal.
GPs & Service Model	Sentiment is strongly negative and assertive, with a high degree of confidence in the concerns being raised. These submissions tend to present firm judgments about impacts or failures, often grounded in direct experience or professional authority, and they convey urgency around the need for corrective action, protection of services, or substantive change rather than further review or reassurance.	Sentiment is negative but more controlled and deliberative in tone. While these submissions still identify significant concerns, they are more likely to frame them as informed critique or expert caution, focusing on risks, inconsistencies, or misalignment with stated objectives, and often implying that outcomes could be improved through better design, evidence, or governance rather than outright reversal.
Management - clinics	Sentiment is strongly negative and system-focused, expressed with urgency and a sense that wider sector impacts are being insufficiently acknowledged. These submissions emphasise consequences beyond the organisation itself, such as pressure on hospitals, other providers, or the broader service system, and often argue that the proposed changes will shift risk and cost elsewhere, prompting calls for decisive intervention or reconsideration.	Sentiment is negative but more measured and analytical. Concerns centre on system-level flow-on effects, coordination between services, and capacity across the sector, but they are framed as risks to be managed rather than inevitable failures, with an emphasis on better planning, alignment, and mitigation rather than immediate reversal.
Management - organisation level	Sentiment is strongly negative and focused on tangible impacts, expressed with urgency and a high level of certainty. These submissions typically emphasise direct consequences for service delivery, client outcomes, or organisational functioning, and often argue that the effects are already evident or inevitable, leading to calls for immediate action, reversal, or decisive intervention rather than further analysis.	Sentiment is negative but more measured and pragmatic in tone. While concerns about impacts and consequences are clearly identified, they are usually framed as risks or emerging issues rather than certainties, with an emphasis on mitigation, adjustment, or improved planning to avoid harm rather than an outright demand for reversal.

Sectors & systems	Sentiment is strongly negative and directed at organisational leadership and decision-making, expressed with urgency and low tolerance for ambiguity. These submissions assert that failures at the organisation-wide level—such as leadership judgement, strategic direction, accountability, or internal governance—are actively contributing to harm, and they frequently call for decisive intervention, leadership change, or fundamental organisational reset rather than incremental adjustment.	Sentiment is negative but more restrained and evaluative. Concerns focus on organisational capability, oversight, and decision quality, but are framed as systemic weaknesses or risks rather than outright failure, with an emphasis on the need for improved governance, transparency, and strategic competence to restore confidence and avoid negative outcomes.

107 This summary shows the strong negative sentiment expressed about the closure decision by both patients and clients, and the broader community.[38] The strong positive sentiment patients/clients reported toward the services themselves probably was a major contributing factor toward their dissatisfaction with the decision to close the services.

[38] Although the Review offered to facilitate submissions in other languages, no such submissions were received.

5. The Review confirms that cohealth is making a loss on its GP clinics

108 A detailed analysis of the organisational and clinic financial results reported by cohealth for the period July 2022 to December 2025 is provided as Appendix B: cohealth - Historical Financial Analysis Report.[39]

109 [redacted]

110 [redacted]

111 [redacted]

112 [redacted]

113 [redacted]

Projecting cohealth's financial position

114 The key drivers for clinic sustainability are:

- GP utilisation (ratio of available appointment time GPs were able to bill for)
- GP appointment billing mix (ratios of A-E appointments)
- management of corporate overheads and non-clinical staff costs (practice management and reception staffing)

115 The demographic data, GP interviews, and public submissions show that in order for the cohealth GPs to reach the MBS benchmarks they would require significant additional support in the clinic.

[39] The Review was assisted by McGrathNicol in this analysis.

[40] Voluntary benchmark survey of independent community health services with GP clinics, 9 respondents across Victoria

116 The services cohealth GPs currently provide in longer appointments include psychological, practical, and administrative supports; these would need to be provided elsewhere in the clinic (or service sector) so that GPs could be 'freed-up' to work at the top of scope – that is, to provide services that only qualified doctors can provide. Funding options for these supports are considered elsewhere in this report.

117 We have noted earlier the differences between cohealth's client mix and the general population (see Clients seen by cohealth GPs), later parts of this report outline the health and socio-economic needs of the communities served by cohealth and find that, due to the specific health and socio-economic conditions in those areas, there is greater need than in other community health clinics (except possibly others near public housing) and significant differences to general private practice.

118 GP utilisation is a particular challenge. This is currently measured on billable time vs paid time, and cohealth GPs report significant unpaid or unbillable time due to longer appointments or time spent supporting patients with work that is outside the usual role of a GP. This is difficult to verify quantitatively, but it aligns with the Review's findings in regard to the service model, which are discussed later in this report. In interviews with the Review panel, some individual GPs reported ratios as low as two patients per hour, which is not sustainable under current or proposed MBS structures.

119 Similarly, cohealth's use of practice management and clerical/administrative support staff (CSOs), as well as more consistent billing of overhead costs, could be changed to reflect ratios seen in most other clinics. But such changes would require new investment – in alternative roles, perhaps in technology to support GPs, and in a broader care team capable of supporting patients in a safe and welcoming environment.

120 So, while there may be a theoretical path to viability for these clinics, it would require either additional supports to enable the GPs to work effectively with the existing cohort of patients, or a major change in the mix of patients seen in the clinic. The latter possibility lies outside the scope of this Review. We note, however, that a significant change in the patient mix does not align with the community and patient sentiment expressed so clearly in the panel's consultations (see Table 5).

121 That said, it is clear that the deficit of the clinics could have been reduced with improvements in the service and staffing models, clearer KPIs, and improved understanding of where GPs could be most effective. While GP productivity alone would not address the gap, it could have reduced the losses and impact on the broader organisation and community.

6. There was inadequate risk management and ineffective governance/oversight of cohealth's financial situation

122 cohealth is registered as a community health service under Division 6 of Part 3 of the Victorian *Health Services Act 1988* and must comply with the Performance Standards issued under that Act.[41]

123 Performance standards relate to governance, management, financial management, and risk management. We will discuss management and financial management issues in the next section. In this section we will consider risk management.[42]

124 The Performance Standards require cohealth to 'effectively manage the risks associated with its business to ensure continuous, safe, responsive and efficient services'.

125 The standards identify two indicators against which performance is to be judged:

- The agency has a risk management strategy that includes identification and assessment of the likelihood and impact of various strategic and operational risks and a risk mitigation strategy.
- The agency actively manages its risks through regular review and monitoring

126 In its submission to this Review, cohealth effectively identified the operation of the primary medical care services as an existential risk (our language).

127 [redacted]

Table 6: cohealth's operating results ($)

[redacted]

Source: cohealth submission, page 44

128 For the last few years, most of cohealth's financial woes have been largely attributed to the performance of the GP clinics. The significant, ongoing and likely longstanding deficit in clinic performance has certainly been a large contributor to cohealth deficits.

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[41] See Sections 51 – 53 of the Act. if a community health service is a registered community health centre under Division 6 of Part 3 of the Health Services Act 1988 (Vic), the regulatory provisions of that Division apply to the entity as a whole, including the GP services it provides. The Performance Standards were published in the *Victorian Government Gazette*, 5 March 2009, page 537. It must also comply with Service Agreement Requirements published by the Victorian Department of Health see https://fac.dffh.vic.gov.au/service-agreement-requirements-dffh-and-dh. Because cohealth self-certified that it held current organisation-wide accreditation against the National Safety and Quality Health Service Standards or the National Safety and Quality Primary and Community Healthcare Standards, and that it had met all financial accountability requirements as outlined in section 8.4 of its service agreement, it was not required to certify whether in its opinion it met the Performance Standards. In addition, cohealth has to meet standard regulatory expectations of any not-for-profit company.

[42] In line with our terms of reference, we are focussed here on risk management as exemplified in its management of the GP clinics. (We discuss financial oversight of the whole organisation). We have no reason to believe that the cohealth Board and management was any more (or less) effective in its management of other aspects of the organisation.

129 The cohealth submission described the consequence of that poor performance in these terms:

> The Board made the deeply difficult decision (to close) these services because the scale of the threat to cohealth's ability to continue delivering the many other essential services that thousands of people rely on every day. (page 1)
>
> The decision to close the services reflected the obligation of cohealth's Board of directors to protect the organisation's overall financial viability and its capacity to maintain the remaining 95% of cohealth's broader range of essential health services to vulnerable communities (page 7)

130 cohealth identified in its submission that the financial problems of the clinics were not new. In fact, the primary medical care services

> deficits have deepened year on year (with the exception of the pandemic which brought with it new funding opportunities) and have lead to a lack of viability in the current model, without system change.

131 The critical question for this review is whether cohealth had an effective risk management strategy and whether it actively managed its risks.[43] Given that the financial problems had persisted for more than a decade (see Figure 4), the issue was clearly not effectively managed over that period.

132 Here our assessment is not based on whether or not cohealth had the typical multi-coloured risk matrix familiar to every board and every senior executive in Australia. What matters is whether there was effective 'active management' of the risks.

Effectiveness of identifying and managing the risks associated with the financial situation

133 The decision-making process of the cohealth Board and its Finance and Audit committee over the last few years is documented in Appendix D: The decision to close general practice services. Other Board committees (Client Advisory and Quality) did not consider any aspect of the closure decision before the decision was made. Nor was any documentation provided showing that the cohealth executive had considered the closure decision.

134 Despite an apparently general understanding that the service was operating at a structural deficit, neither the Board nor the Finance and Audit Committee received any routine reporting of specific service performance or of services operating at a deficit. Routine Finance and Audit Committee reports related to the whole organisation and were summarised at a very high level, with no detail on the performance of individual services or service types. The performance of the GP clinics in particular was not clearly apparent.

135 The Board advised the Review that the Strategic Planning process was linked to detailed, multi-year financial plans that drove budget processes; organisational performance was reported to the Board at a high level when outcomes varied from budgets. This implies that where a service was budgeted at a deficit – as the clinics reportedly were – its

[43] Including whether cohealth correctly identified whether the underlying risks were exogenous or endogenous (or a mix of both).

financial situation would have been brought to the Board's attention only when it varied from budget expectations.

136 During the several years in which COVID supports and growth in funded services created an organisational surplus that covered the deficit (see Figure 4), the Board and its Finance and Audit Committee had no visibility of the performance of the clinics.

137 The Australian Institute of Company Directors' Not-For-Profit Governance Principles includes a recommendation that:

> Core financial or management reports that should be presented to the Board at each meeting include the balance sheet, statement of profit and loss and the cash flow statement. (Principle 5 – Performance and accountability, page 50)[44]

138 The cohealth Finance and Audit Committee's routine reporting appears to consist of very high-level financial summaries, dashboards and narrative management commentary. Profit and Loss and Balance Sheet figures were presented in summary, with key metrics at a whole of organisation level. Board reporting was summarised further unless as part of specific reports, as detailed in Appendix D: The decision to close general practice services. From the information provided, Cash Flow reporting was reported at a high level through key metrics, with limited detail regarding cash flow and liquidity until recently.

139 *While the Board and Finance and Audit Committee discussed the ever-worsening cash position, there is limited evidence of requests for detailed information or for regular reporting on the services causing this, despite increasing concern and management failure to meet commitments.*

140 *It is difficult to see how the Board could effectively manage the financial risks of a large organisation operating in deficit without consistent, detailed, and regular reporting on the performance of the services driving the deficit. What information was received by the Board about under-performing services was largely in narrative form, and rarely in consistent formats that would allow for comparison month-to-month.*

141 Despite acknowledging long-standing clinic deficits in their submission, and in several interviews with the Board and staff, the first mention of the clinic deficits in the information provided to the Board or its Finance and Audit Committee appears in June 2023, and comments positively on improvements in revenue.

142 Due to the high-level nature of the reports, it does not appear that the GP clinics net effect on cohealth's position was reported consistently – if at all – to the Finance and Audit Committee or the Board until February 2024. In the period from July 2023, the Board received multiple reports from management which, in relatively reassuring language, identified problems with the clinics but asserted that management was taking action to address the situation.

143 In a well-functioning organisation, where the Board was aware of ongoing problems in part of the organisation which contributed in a material way to the organisation's overall financial health, one would expect the Board to be apprised of the situation by management, or if not, to request such information.

144 There is no record that the Board asked for any reports about precisely what actions management was taking, nor for any details about their effectiveness. In fact, it should

[44] Australian Institute of Company Directors, *Not-for-Profit Governance Principles (Third edition)* (Sydney: AICD, 2024).

have been evident to the Board at the time that management's actions were not effective since there was no turnaround in performance.

145 We will show below that these management actions could not have been expected to be significant, sustainable, or timely because of the disconnect between management and the medical staff.

146 Despite apparent general understanding of the long-standing clinic deficits, we saw limited evidence prior to February 2024 that management highlighted for Board consideration the risks associated with the poor financial performance of the GP clinics or that the Board discussed them in detail, which would have been a sign of an effectively managed organisation. We cannot tell from the documentation provided to us what the basis for regular reporting was or see evidence about the extent to which information provided was discussed.

147

148 This data showed clearly that the clinics' deficits were driving the precarious financial situation of cohealth overall. Managing the risks associated with the clinics was thus inextricably linked with managing the risks associated with the whole organisation.

149 There is no record of any action the Board took in response to the concerning report of February 2024. There is no record of any Board subcommittee being established to provide additional oversight, nor any other strategy put in place to hold management to account. Indeed, there is no evidence of any new sense of urgency in the Board papers.

150 Directors' duties to act when something is awry were nicely summarised by Mr Justice Lee in a recent court case:

> If facts have come to the director's attention that have awoken their suspicion that something is amiss, or would have awoken the suspicion of a prudent director, then the director has a duty to enquire into the matter.[45]

151 Even the rudimentary reporting which underpinned the cohealth Board's oversight, should 'have awoken the suspicion of a prudent director'. We found no evidence that the documented GP clinic financial situation led to any enquiries from the Board.

152 The Board and Finance and Audit Committee papers over the period of review include quite varied assessments of the likelihood and impact of financial risks.

- The July and October 2022 Strategic Risk Reports phrased the financial risk as 'cohealth's financial capacity to respond to opportunities and disruptive factors impacts the sustainability of cohealth over the long term'. The likelihood of this was identified as 'possible' (3/5) and the consequence 'major' (4/5), with risk rated as 'High'.
- In November 2022, there was a shift in the language, with the relevant risk phrased as 'Operational and financial sustainability – failure to achieve operational excellence and financial sustainability'. The residual risk relating to this new

[45] Australian Securities and Investments Commission v Bekier (Liability Judgment) [2026] FCA 196, at para 365

phrasing of the relevant risk was rated as medium ('unlikely and moderate consequence').

- The July 2023 Strategic Risk Review Report maintained the residual risk rating of the same risk (no change to the phrasing) as medium ('unlikely and moderate'). The associated management comments noted that:

> Management is strengthening existing controls for risks to financial sustainability including refreshing cohealth's Financial Plan and close monitoring of performance reporting to support improvement.

- The September 2023 Financial Strategic Risk Report ranked that same risk ('Operational and financial sustainability') as amber ('High') on a four-point scale, with 'likelihood' rated as two on a five-point scale, and consequences as three on a five-point scale. Control effectiveness for both 'Financial management framework' and 'Performance framework and governance' were both ranked as adequate.
- The April 2025 Strategic risk report maintained the September 2023 'Operational and financial sustainability' risk rating as amber (2/5 on likelihood, 4/5 on consequence) in its detailed analysis (slide 12/15) but the overview now labelled the risk as high (slide 4/15). Only 'Planning Framework' had an 'inadequate' ranking on the control effectiveness scale.

153 It is difficult to reconcile these later rankings of risk (both likelihood and consequence), with the reality set out in the financial statements and with subsequent statements about the need to close the clinics to protect the organisation.

154 Note that these risk ratings are phrased in terms of overall organisational performance and are not limited to the performance of the general practice clinics.

155 Finally, to the extent there was recognition of the financial risks associated with the GP clinics, the Board's response was either to accept management's assurances that action was being taken to improve the situation (with the implicit promise that a turnaround was possible) or to accept management's view that, since the problems were entirely exogenous, an external mitigation strategy based on lobbying and advocacy should be prioritised.

156 The purpose of a risk matrix and identification of summary risk rankings is to highlight where management or board attention should be focused, and what the nature of that focus or action should be.

157 Given the February 2024 papers showed the size of the contribution of the GP clinics to the organisation's overall difficult financial situation, it is hard to see how the Board could reasonably accept a consequence rating of 3 or 4 out of 5. There is no evidence in the Board papers that the Board challenged management on the assignment of risk ratings.

158 In any event, a risk rating of amber with a high consequence should have led to increased Board and management oversight of the management of these risks.

Effectiveness of identifying and managing the risks associated with the consequences of the closure decision

159 The April 2025 Finance and Audit Committee papers included a summary table about cohealth's risk appetite. The relevant sections of the table are shown in Table 7.

Table 7: Risk appetite for cohealth Board and executive (April 2025)

	Very low risk appetite or zero tolerance for:	Low risk appetite for:	Moderate risk appetite for:	High risk appetite for:	Very high risk appetite for:
Client experience	• Harm from our services • Enduring negative impacts on community relationships and client experience	• low value, low quality, non-evidenced informed activities that cannot be mapped to outcomes	• short term change related impacts on experience	• innovation	
Staff experience	• harm while at work • poor staff conduct • enduring negative impacts on culture		• short term change related impacts on experience	• change projects	• the investment required to support and develop our staff
Brand identity and reputation	• non compliance behaviours (including fraud, harassment bully and discrimination)	• actions that diminish cohealth's reputation	• short term negative publicity where the long term impacts to reputation can be managed		• Growing profile with community • Influencing public policy

160 The announcement of the closure of the three GP clinics led to widespread community outrage. Well-attended public meetings were held to protest the decision.

161 cohealth told us

> It should be noted that cohealth has previously closed financially unsustainable general practices including our Laverton general practice only last year (2025). The communication plan and transition arrangements for Laverton were similar to those used for Collingwood, Fitzroy and Kensington. Like when we previously have had to close services, we knew we were delivering bad news so decisions were not made lightly or abruptly, and our priority was a staged and clinically managed transition with risk stratification and patient communication carefully planned.

162 The situation of Laverton – a relatively new and small clinic – and that of Collingwood, Fitzroy, and Kensington are quite different. In contrast to the others, there was limited community involvement or history with Laverton. While aspects of the Laverton process could inform stages of the process, the number and complexity of the patient cohort at the impacted clinics requires greater clinical handover, community engagement and time for change.

163 The review received some items relating to transition planning, dated after the announcement had been made.

164 Submissions to this Review were uniformly highly critical of the implementation process.

165 Our interviews with staff suggested that the decision and the way it was communicated led to a massive loss of trust between the executive of cohealth and the medical staff.

166 As one patient phrased it:

> The way that the executive and Board have managed the news of their decision has been totally irresponsible. They have not considered people who have English as a second language who make up a large proportion of the clients at Collingwood or elderly people who rely on cohealth in so many ways.

167 Another told us that the decision had '[left] long-term service users weeping and numb'.

168 Another patient described the experience of many:

> I'm giving my experience as a patient, which points to serious failures of Cohealth's management, performance and accountability. The closure of services across 3 centres was reported by The Age on October 16, just over 2 months before the intended closure date of December 19. This is a shockingly short time-frame to announce the end of vital services with huge repercussions on individual patients and other services that would have to fill the gaps left by these closures. I follow the news so found out on October 16. However, for those who don't follow news the direct communication from cohealth to patients gave them even less time. The first personal communication I received about the closures was a text message on 12 November, just over 5 weeks before December 19. Firstly, the 2 months between the initial public announcement and the planned closure demonstrates staggering incompetence by cohealth senior management. If cohealth had no choice but to close the services they should have known about the problem much more than 2 months ahead. They should have had information on their website on October 16 about the next steps for patients. I looked, and could not even find any information about the closures. Secondly, further incompetence is demonstrated by not having a plan in place to immediately notify patients, which took another 4 weeks.

169 Lack of planning for transition was an ongoing issue for many patients into February 2026. As one person told the Review team at a consultation meeting: 'I've called every doctor in the area, and they don't want to take me on'.

170 A simple search of the Healthdirect website reveals that there are no other fully bulk-billing practices in Collingwood (postcode 3066), Fitzroy (3065), or Kensington (3031) that are taking new patients. cohealth's suggestion that patients could transition easily, is disingenuous and shows a lack of good planning and thinking about the consequences of the closures.

171 The clinical safety and quality issues related to this lack of planning for transition were highlighted in the AMA submission to the Review

> Professional standards require health services to maintain systems that ensure clinically significant results are reviewed, acted upon and communicated, and that continuity of care is actively maintained during periods of transition. The circumstances [of the closure process and communication] raise questions as to whether governance arrangements in place at the time decisions were taken included adequate planning, oversight and controls to maintain safe general

practice service delivery, or whether these risks were addressed only after external intervention occurred.

172 Staff also recognised the reality of the poor transition 'planning'. As one staff member phrased it in a submission: 'The reality is that there is no service in existence for them to "transition" to'. Another staff member described what a good process would look like:

> Closing practices which have run for 50 years (40 years for Fitzroy) requires a huge amount of work and could not be done in nine weeks. The gold standard way of closing a practice from my understanding is to enter into an agreement with another practice which then takes over the patient files and patients of the closing practice, and any of the GPs who wish to continue on with the takeover practice. Patients of the closing practice can go elsewhere as well but will be informed that they can request a copy of their file from that practice. What was apparent to me on that day was that management may well not have considered any of these issues but also that it seemed they didn't care about these issues, let alone about what would happen to our once and future patients

173 This 'gold standard' is not what happened at cohealth.

174 cohealth acknowledged in its submission to this Review (page 28) that 'aspects of the process leading to the decision to close GP services at those sites, could have been better sequenced and communicated'.

175 In fact, cohealth produced detailed communication plans, but they appear to have been produced *after* the decision was made,[46] and thus could not be taken into consideration during the decision-making process.

176 There was no engagement with formal client/community groups before the closure decision was made, nor, apparently, any canvassing of options. No steps were taken to acquaint the Board committees with the gravity of the financial situation. This appears to be contrary to good practice as articulated in the Australian Commission on Safety and Quality in Health Care's 'Partnering with consumers standard'.[47]

177 In terms of the risk appetite statements, it is too early to tell definitively whether the negative impacts on 'relationships and client experience' and 'culture' will be ongoing or merely short-term, but the tenor of the sentiment in submissions and interviews about cohealth management was certainly very negative. For example:

> The current Board and management have brought opprobrium on the name cohealth and allowed the organisation's name and reputation to be trashed. The community of current and potential clients and service users no longer can hold the cohealth 'brand' in good regard.

178 Another submission made the same point:

> There can be no doubt that the very name of 'cohealth' has now become closely associated (at least in Collingwood, Fitzroy and Kensington) with an organisation which is no longer respected or held in the previous high regard of its community. Instead it is now associated with an organisation which is not

[46] The 'cohealth changes: client and community communication approach', for example, was dated October 2025.

[47] See Standard 2.11, Australian Commission on Safety and Quality in Health Care, *National Safety and Quality Health Service Standards. 2nd edition*, ACSQHC (Sydney, 2021).

> trusted by either the community or its staff and one which is seen as unconnected to local communities and intent on expansion into non-community health activities.

179 Another submission was more succinct: 'The name cohealth itself has become almost toxic in the "healthcare space".'

180 Although every patient/client submission argued for keeping cohealth's GP services open, almost 10% of the patient/client respondents made negative comments about the Board and management of the organisation.

181 In the AI analysis of submissions, there were 64 expressions of sentiment toward the cohealth management or Board. None were positive. The summary was as follows:

> Submissions with a negative sentiment towards cohealth management and the Board consistently express concern about governance, decision-making and accountability. Negative sentiment centres on perceptions that major decisions – particularly clinic closures and service reductions – were abrupt, poorly communicated and undertaken without meaningful consultation. Submitters frequently cite a lack of transparency and engagement with patients, staff and communities, which is associated with confusion, distress and a loss of trust. Concerns are also raised that decisions did not adequately consider local community need, continuity of care or impacts on vulnerable populations. Overall, these submissions reflect diminished confidence in management and the Board, driven by perceived failures in consultation, communication and governance during critical decision-making processes.

182 At the very least, the closure decision was one that 'diminished cohealth's reputation', an outcome for which, according to their own risk appetite statement, the Board and executive had a 'low' appetite.

183 Importantly, this impact on reputation is not simply about impact on reputation of the clinics; rather, the closure decision affected the way the whole organisation is perceived.

184 The Minutes of the June 2025 Finance and Audit Committee meeting that considered the clinic closure noted that the committee was aware of 'the clear impact on the community and people around medical needs to be considered along with the reputational dimension'.

185 The Board paper about the decision contains three paragraphs about the 'reputational dimension' that note the potential for negative impacts on reputation. But they downplay any community reaction by emphasising that negative impact was influenced by whether the changes had a 'direct impact on them' – that is, on individual clients and patients. This statement has proven to be not well founded. As was shown in Table 5, the submissions to this Review show an overwhelmingly negative sentiment: all are critical of the decision to close and argue for its reversal.

186 The June 2025 Board paper also suggested that the decisions could enhance cohealth's reputation:

> As these changes enable cohealth to demonstrate leadership in delivering cost-effective and better targeted services, there is scope for cohealth's reputation to be enhanced over the longer term.

187 Again, in the experience of the Review team, service closures are almost invariably received poorly in the community.

188 Mitigating negative reputational impacts of service closures takes time and extensive consultation. Importantly, management had identified the need for consultation when discussing decanting options for the Collingwood site a year earlier.

189 The closure decision was not accompanied by extensive consultation. At best the strategy was one of 'informing' staff and community after the decision, not 'consultation' as defined on the 'Spectrum of Public Participation'.[48] The time between the announcement and scheduled closure was also short.

190 This lack of consultation – together with the scale of the change, the culture and history of cohealth, and the perception that the decision breached the original merger 'umbrella agreement' – provoked the community response and the adverse impact on reputation.

191 All of this was predictable for anyone with a good knowledge of the community and good links with community leaders. Alas, those links appear to be missing at cohealth's Board and management levels, at least as evidenced in the closure decision. One submission phrased it this way:

> Management is disconnected from service delivery, and seems more focused on satisfying the whims of funders than advocating for the communities it is meant to serve. The decision to close general practice services, with little or no consultation with affected communities or staff, and their surprise at the community's response, reflects this disconnect.

192 Given that the Board and executive had, according to the risk appetite statement, a low appetite for 'actions that diminish cohealth's reputation', sound management would have involved a more extensive risk mitigation strategy.

193 The risk appetite statement identifies a 'very low risk appetite or zero tolerance' for 'Harm from our services or enduring negative impacts on community relationships and client experience'.

194 If the closure had gone ahead, harm and enduring negative impacts on patients would have been almost inevitable.

195 The very limited apparent planning for impacts on clients led to the devastating consequences described above. As noted, the only documents that 'planned' how implementation was to proceed appear to have been produced *after* the public announcement, so it is difficult to see how they could have been meaningfully used for assessment and handover.

196 The sections of the Board and committee papers canvassing impacts assert, without any apparent evidence, that existing cohealth clients should be able to find other services nearby: 'The potential closure of some clinics will not result in the overall denial or inaccessibility of healthcare to those communities and therefore does not infringe on human rights'. Again, it is hard to see how such a statement could be reasonably made.[49]

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[48] International Association for Public Participation, *IAP2 spectrum of public participation*, International Association for Public Participation (Louisville, CO, 2007).

[49] Interestingly, in subsequent advice to us cohealth stated: 'We knew that it would not be easy to transfer responsibility back to the health system and we actively engaged with the local Primary Health Network on transition planning'. As with other elements of transition planning, engagement with the Primary Health network first occurred after the closure announcement. Further, there is no documentation that,

197 We were told that immediately after the announcement, one of the clinic managers walked around the neighbourhood to see if any local GPs were accepting new patients. None were. This was done on the manager's own initiative, without any central planning, direction, or coordination.

198 The assertion that there would be little or no impact on the communities served by the GP clinics is inconsistent with the tenor of cohealth's own rhetoric: that is, that cohealth's service is unique, and that it treats a particular patient mix that other practices don't.

199 It is also inconsistent with the experience of the impacted clients. The very first submission received by the Review told us:

> cohealth is vitally important to me and this local area. All the GPs in this area have full patient lists, so without cohealth you cannot go to the doctor.

200 This reality is not reflected in the risk assessments presented to the Board nor in any documented risk mitigation strategy.

Assessment of cohealth's performance in identifying and managing risks

201 *It is obvious in retrospect that cohealth did not manage oversight of financial risks well. The poor financial performance continued too long – decades according to some people interviewed by the Review, at least one decade as recounted in cohealth's submission.*

202 But the relevant test is not what we know in hindsight, but rather what the Board – as constituted - knew at the time, and what it did about it.

203 *What the record shows is that the Board was advised a number of times by management of the poor financial performance of the clinics from 2023 and advised quite starkly of the contribution of the clinics to the challenges to organisational financial viability in February 2024.*

204 Reporting to a Board or Committee is not an end in itself. As we have seen, there was reporting, but it was often at a high level and did not lead to purposeful action or accountability.

205 *The Board and committee papers reveal a Board that did not engage with the clear financial challenges of the clinics, even though the clinics represented a significant proportion of the organisation's overall operating deficit. Nor did the Board hold management to account in terms of actions taken to rectify the situation.*[50]

206 *Even as the poor financial performance continued, the Board did not challenge management to provide additional reports about the clinics*[51] *or question the effectiveness of the management strategies reported to it. There is limited evidence of effective or consistent attempts on the part of the Board to drive changes in the way the clinics were managed.*[52]

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at the time, management or the Board acknowledged that transition planning would not be easy. Rather, as the Board papers cited above, the reverse appears to be true.

[50] At least as can be seen in Board or Committee papers.

[51] The April 2024 Finance and Audit Committee minutes that management agreed to prepare a report on a pathway to break even in the medium term. The discussion that led to that commitment may have highlighted clinic performance, but this is not documented in the minutes.

[52] Our conclusions are limited to what we can find evidence for in Board or Committee papers and minutes. There may well have been discussions at Board or Committee, or outside those forums, but we have no evidence of those. If those discussions did occur, there is no evidence they led to any

207 In one of our meetings with the Board, we were told that the Board did not get involved in operational issues, that there were 'hundreds of programs' managed by the organisation, and that detailed oversight of them all was not possible. We were also told by cohealth that 'Boards govern the organisation not specific programs.' All this is, of course, true. But it seems lax not to take a 'noses in'[53] approach to the one program that accounted for half of the organisation's operating deficit (see Figure 5).

208 The same can be said of the management of the risks associated with the consequences of the closure decision.

209 The risk appetite statements adopted by cohealth seem to have had – at best – only a tangential impact on the decision-making process.

210 Assessment of reputational impacts seem to have been naïve. No clear risk mitigation strategies were developed, despite the fact that the Board had identified the importance of managing community expectations a year earlier.

211 There was no comprehensive strategy to mitigate the impact of closures on clients. Transition challenges were addressed with an optimistic and simplistic plan that had limited connection to the local realities or the clinical requirements of primary medical care provision. The confidence that cohealth clients would find alternative services in the area was not only unfounded, but contrary to cohealth's own current and previous rhetoric. The only specific report about transition planning was prepared and presented to the Board after the decision was made.

212 It seems clear that the risk appetite statements were not a core element of the decision-making process, and that this important component of the management of risk was either ignored or ineffective, contrary to the obligations under the Performance Standard.

213 On 13 November 2025, after the decision was announced, a group of cohealth GPs met with the Board, with management present, to present GP concerns. This was the first time that any GPs we consulted recall a meeting between GPs and the Board, despite the critical financial risk the GP clinics posed to the organisation overall.

214 [redacted]

215 There is no mention of a specific risk assessment in the Board documentation.

216 One submission summarised cohealth's risk challenge thus:

> The governance challenge facing cohealth's general practice services was not routine. These services deliver care to highly vulnerable populations, operate

improvements. Given the scope of the review, our queries and the information provided related to the GP clinics.

[53] Here we are referring to the board governance aphorism that boards should have 'noses in' and 'fingers out'

[54] On 19/2/26 the Review was provided access to a paper titled Agenda Item 3.1 to the November Board meeting 'General Practice Closure: Discussion with cohealth GPs' that contained a table outlining management actions being taken to satisfy obligations and manage residual exposure. A 'medico-legal risk assessment' was provided to the GPs, but no full risk assessment has been provided.

through complex multidisciplinary models, and depend on continuity, trust and workforce stability to manage clinical risk.

In this context, effective governance required more than periodic oversight of budgets and performance. It required early recognition of emerging financial and operational stress, rigorous examination of alternative scenarios, meaningful engagement with clinicians, and proportionate responses aimed at stabilisation rather than late-stage service withdrawal.

The relevance of governance to this review lies in whether systems were in place, and activated, to surface risk early enough to preserve service viability and continuity of care.

217 Our answer to this question is that such systems were obviously not in place

218 *In our view cohealth did not have in place an effective strategy to manage the risks associated with its business to ensure continuous, safe, responsive and efficient services, and did not actively manage the relevant risks.*

219 *cohealth was therefore not meeting the relevant performance standard for community health services.*

220 As we mentioned above, the poor financial situation of the GP clinics had persisted for some time. In advice to us, cohealth stated:

> The review examines how the Board governed the risk of the general practices in particular their loss making. We think it is important context to stress that the annual financial losses for these general practices predated the merger of the 3 organisations into cohealth (i.e., pre 2013). Documentation has been provided to reviewers showing that each organisation was making losses in their general practice services prior to merger. The reason that this is important is that the report examines the governance of these loss-making services over recent times, but the services have consistently made losses over the decades with different Board members, with different Executives and with different CEOs. So the losses cannot be attributed to the current leadership and Board.

221 Contrary to this view that somehow a history of loss-making reduces or absolves the organisational governance and leadership from responsibility, the responsibility of Board and management is to manage the situation as they find it. Ineffective management of a situation in the past is not an excuse for ongoing ineffective management

7. There was inadequate and ineffective management oversight of the clinics

222 cohealth's oversight of its general practice services reveals a somewhat fragmented pattern of uncoordinated and poorly communicated attempts to address individual issues without any recording or assessment of effectiveness. There is little evidence of any systematic, sustained attempts to engage the GPs in change management.

223 Even where comprehensive reviews were conducted – in 2014 and 2020-2022 – there is similarly little to no evidence of *collaboratively developed* action plans, for the implementation of recommendations.

224 We were provided with a document headed 'Primary Care Remediation Action Plan FY24' that outlined a series of short-term actions, all of which, except 'Advocate for alternative sources of funding given the increased complexity when compared to peer and benchmarked groups across Australia', were to be completed within six months.

225 No cohealth GP we spoke to seemed to be aware of this plan nor referenced it in discussions.

226 cohealth reported to us that it chose to embed the review actions in existing operational, planning, management, and governance structures.

227 Nevertheless, it seems most of the plan's actions have had little practical impact.

228 The summary of these embedded actions notes that support for GPs in optimising billing commenced in 2024 (see GP comments in relation to this below) and that a Daily Operating System to support practices was implemented in 2025. (The Review team's understanding is that the Daily Operating System only commenced in 2026).

229 In general, there is no single coherent model of care across the clinics, with each site largely doing its own thing (see below for discussion of nursing roles at different sites).

230 The unique historic identity of each clinic was noted as a potential strength in the 2014 review. The 2022 review, by contrast, recommended greater consistency and coherence across all the clinic sites, both in the lead GP role and nursing roles. Nevertheless, while it was reported to us that lead GPs meet on a semi-regular basis, in general there is no ongoing or systematic sharing of lessons between the clinics.[55]

231 A number of GPs commented that it was unclear why, if Footscray was to remain open, there had not been open discussion about how to learn from the local model of care at Footscray and how to implement that more widely across all cohealth clinics.

232 Further, roles of team members such as care coordinators vary across sites and there seem to be no mechanisms to bring sites together to learn from one another. It appears that nursing staff at different sites craft their own roles with no consistency across sites, which again makes team working more difficult.

233 Similarly, we have little evidence of systematic training of practice management staff to help them work to their full scope of practice or maximise patient outcomes, productivity, or billing.

234 All of this exacerbated cohealth's financial situation.

[55] In the latter stages of the review (19/2/26) documents relating to one GP clinic's planning day from November 2024 were provided to the review

235 The governance challenge that faced cohealth was significant: many of its services were losing money. Perhaps the most succinct summary of the challenge came from a submission we received from 'a long-term patient and community stakeholder' who summarised the challenge in this way:

> Strong governance does not imply the absence of financial pressure or difficult decisions. Rather, it is demonstrated by clear accountability for financial decisions, robust oversight arrangements, transparent reporting, and the capacity to respond constructively when decisions do not deliver the intended outcomes.

236 As we have suggested, and discuss in more detail below, strong governance was not demonstrated at cohealth.

237 In this section we will assess cohealth's performance against two other Performance Standards it is required to meet: management and financial management. The relevant performance standards are phrased as follows:

Management

The agency must be effectively managed at all times.

Indicators

- The agency has documented staffing and organisational structures, business systems and processes and business planning and reporting.
- The agency ensures that the physical resources are managed to ensure an effective, safe and efficient service
- The agency has policies to deal with employment, occupational health, conflicts of interest and safety and discrimination that comply with relevant Acts.
- The agency has policies addressing matters in relation to clients including privacy, human rights, and dealing with consumer complaints that comply with relevant Acts.

Financial Management

The agency must maintain effective financial management at all times.

Indicators

- The agency maintains financial policies, procedures and reporting frameworks.
- The Directors of the agency act to prevent the agency trading while insolvent.
- The Directors of the agency discharge their fiduciary duties.

238 Here we will assess the evidence in terms of three indicators:

- The agency has documented staffing and organisational structures, business systems and processes and business planning and reporting.
- The agency ensures that the physical resources are managed to ensure an effective, safe and efficient service
- The agency maintains financial policies, procedures and reporting frameworks.

239 The first and third of these indicators are related so we will deal with them concurrently.

Effectiveness of staffing structures

240 In this section we will assess one aspect of 'effective management', namely 'staffing and organisational structures'. This refers to the structure of the primary care workforce at

cohealth as well as management engagement with the whole staff complement in the clinics.

241 We comment on the challenges facing multidisciplinary teams in cohealth elsewhere in this review (see section on cohealth's model(s) of care).

242 In this section we specifically examine the 'physiology' of the structures – how they work in practice, and whether the relationship between cohealth leadership (management and Board) and GPs and other clinic staff was fit-for-purpose in relation to the financial risks posed by the clinics and the attempts to identify solutions. Our interest here is in the context that the financing of the clinics was dependent on MBS billing which is done in the name of the individual employed GPs..

243 It is worth noting that cohealth does not have a GP/Medical Director position, although the importance of such a position was flagged in both reviews of the clinics. Cohealth did, however, appoint lead GPs at each clinic. We understand that this role was allocated a 2-hour period each week but that, at least as far as some appointees understood it, no clear job description for the role existed.

244 A significant disconnect and lack of trust between cohealth management on one hand, and GPs and other clinic staff on the other, was evident both in our interviews with GPs and clinic staff and in the submissions they made to the Review. This situation clearly became more acute in the period immediately leading up to and following the announcement of the closures.

245 As one GP noted:

> there is a considerable organisational, power and cultural distance between the clinician doctors and those making the decisions which affect the clinical and financial effectiveness of a clinic

246 In one of our meetings with the Board, we were told that the Board believed there was an intractable culture problem in the GP clinics that made it impossible to make changes to address the significant financial issues, and that some GPs were simply 'rusted on' to a particular – unsustainable – way of working. This seemed, however, to be the view of management, since we were told that the Board had no direct engagement with the GPs in relation to the clinics' financial problems prior to the November 2025 meeting (see paragraph 212).[56] As noted, GPs were particularly concerned at the lack of risk identification and management of risk in relation to the closure decision that they observed at that November meeting.

247 Most GPs and other clinic staff described a long-term background awareness across the organisation that the clinics were not breaking even and that at some level, cross-subsidisation – or drawing on reserves -- was occurring. This is consistent with cohealth's own view of the long-standing losses attributable to the GP clinics.

248 However, there was a consistent view among the GP group that management did not actively engage with them to address the financial problems in the clinics. One told that 'no systematic program [existed] to involve GPs in a plan to improve clinic viability'. Another GP noted

[56] The only papers provided to the Review under the heading 'Board Discussion with cohealth GPs' were associated with this November 2025 meeting, after the closure was announced.

> We had annual GP meetings with middle and senior management, 'Planning Days', which in the last few years, GPs were allowed to suggest topics and agenda items. However, suggestions made at GP Days were never acted upon …

249 Another GP reported that:

> cohealth senior management did not approach GPs to work on ways to optimise income. Neither did they consider waiting to evaluate the impact of the Universal Bulk Billing Practice Incentive Program (UBB PIP) on revenue. Instead, they proposed to close the clinics just seven weeks after the PIP was to commence.

250 We found little evidence of sustained formal efforts to engage and support GPs in increasing clinic viability. One GP reported that in 2024 a 2-hour presentation, 'Business for Doctors', was made available, but without any follow-up or further engagement on the issue. There was also a brief presentation to GP leads by management in February 2025 that highlighted the clinics' financial situation, but we were not told of any engagement activities with GPs arising from that.

251 As we discuss in the next section, a key theme that emerged around local clinical management was a lack of transparency at the local level of clinic budgets, lack of clarity on billing KPIs, and a lack of consistency across the clinic sites.

252 In contrast to the cohealth submission to this Review, which stated that the Health Performance Board (an internal reporting mechanism) set consistent KPIs across the medical clinics, many of the GP interviews and submissions reported a lack of clarity about billing KPIs over a long period (certainly since 2022).[57]

253 Words used by GPs to describe revenue targets in our consultation meetings included: 'quite vague', 'fuzzy', 'inconsistent', unclear', and 'indistinct'.

254 [redacted]

255 GPs told us targets varied over time and changed depending on 'who was talking' – practice manager, Enabling Lead Manager, and so on. According to the GPs, targets were not explained and no clear rationale given.

256 There was, however, a consistent account across the GP group of a series of meetings between management and lead GPs in September 2025 in which management conveyed a clear sense of urgency about the financial viability of the clinics.

257 However, it was also consistently reported to the Review team that while a range of options was canvassed at those meetings, wholesale clinic closure was neither suggested nor discussed – not until the final meeting of September, when closure was presented as a *fait accompli*.

258 GPs who told us they valued being part of a committed and collegial clinical environment, and one focused on serving a high-need community, experienced this abrupt announcement as akin to being 'sacked while working so hard for the organisation'.[59] This may have contributed to the attrition of the GP workforce since the

[57] Targets seem to have been produced for utilisation (i.e. billed hours) but these have a variable relationship with actual revenue.

[58] [redacted]

[59] In the words of one GP.

announcement to close the clinics, especially since – as one GP reported – it was made clear to GPs that cohealth would proceed with clinic closure whatever the outcome of this Review.

259 Nurses working across the organisation described similar experiences. They reported the lack of a consistent nursing model across the practices, and difficulties in clarifying a shared understanding of funding and billing targets and in developing enhanced integration with the GP practices. A number reported individual efforts to start nurse-led models that were not supported by management.

260 Reflecting on possible underlying causes of the varied models and the disconnect between GPs and management, one GP and another clinic staff member characterised the problem as 'lack of clinical leadership at all levels' and 'people in positions of authority without appropriate skills, qualifications and knowledge to do their work'.

261 There was a widespread view that GPs, along with nursing and allied health staff, needed a voice at senior management level to feed into critical decision-making about the clinics and clinical services.

262 One GP described a possible way forward that would involve

> foregrounding of clinical services, patient care and community engagement in the community health service. ... a medical doctor, preferably one with experience in primary care in underserved communities, to be on the Board, ... regular communication between clinicians and management, and clinician involvement in decision making and direction of the service. ....

263 *In summary, it is clear that the Board and management did not engage with GPs in developing effective, codesigned strategies for clinic financial viability, despite the importance of doing so. The Board appeared to be satisfied with second- or third-hand reporting of GPs' views, neither engaging themselves directly or through subcommittees, nor holding management to account for failing to create effective engagement structures.*

Effectiveness of business systems and procedures

264 Overall, cohealth appears to allocate an unusually high cost of corporate overheads, with overheads allocated based on expenses. In some internal reports, Customer Support Officer (CSO) costs, for example, have been added after overhead costs, in what seem to be ad-hoc manual adjustments that have little regard to actual use by the GP clinics specifically.

265 We have not conducted a review of precisely where the overhead is excessive. We note, however, that a typical community health service[60] reports in the range of 10-30% overhead charges to GP clinics, based on revenue rather than expenses; 20-30% is the most common estimate. We also note that internal cost allocation methods vary, and that treatment of organisational costs such as management, IT, reception, and intake support as overheads or direct costs can vary across organisations and sectors.

266 *cohealth appears to have a generous provision of corporate staffing as measured by the proportion of expenditure charged to business units for overheads.*

[60] Voluntary benchmark survey of independent CHS with GP clinics, 9 respondents across Victoria

267 A 2022 review of cohealth GP clinics by Kokkin and Brown identified a range of structural, governance and process improvements'.[61] cohealth noted in advice to the Review team that

> Given the systemic nature of these recommendations, cohealth did not treat them as discrete projects or standalone action plans. Instead, actions were incorporated into routine operational management, annual planning cycles and standing governance forums. This approach reflects the view that sustainable performance improvement in primary care requires ongoing adjustment of systems, workforce design and processes, rather than time limited implementation activities.
>
> As a result evidence of implementation is reflected through embedded practices, role changes, governance controls and performance monitoring mechanisms rather than static completion reports.

268 cohealth's executive may well have formulated budgets and targets; they may have had improvement plans as they advised the Board. There is limited evidence, however, that these actions were effective.

269 *GP clinic budgets were set at deficit levels for a number of years, which means – as management and the Board observed – that even if the clinics had achieved the budget set in the most recent financial year, they still would not have been viable. It is difficult to see how budgets, KPIs, and targets that do not achieve sustainability are effective.*

270 Good business systems and planning require that budgets are passed down and shared throughout an organisation so that there can be monitoring and reporting against budgets, and people can be held to account for managing them.

271 The GP clinic financial reports involve three spending lines:

A. GP salaries
B. The salaries and other expenses of directly supporting the clinics (e.g. the salaries of clinic nurses
C. Legitimate overheads (e.g. a fair allocation of corporate overheads).

272 In most organisations, reception staff (CSOs) would be allocated to section B, to the costs of directly supporting the clinics, but cohealth does not automatically allocate these costs. CSO staffing costs appear to be allocated manually to the final system reports on an *ad hoc* basis.

273 The apparent lack of automated allocation of CSO costs means that even when considering the internal reporting of financial performance, clinic staff were probably unable to see the financial performance of the clinics as reported to the Board. It appears that these reports were prepared manually for management and the Board, a practice that complicates both ongoing monitoring of clinic performance by staff and assessment of organisational risk by the Board.

274 GP KPIs (discussed in detail elsewhere in this Report) appeared to have little connection to revenue targets or the budget. Noting that:

- Board and senior management felt that the approved budget was insufficient to sustain viability,

[61] From a document cohealth prepared for this Review: General Practice Continuous Improvement and Operational Controls (2022 and beyond).

- middle management and clinic staff would have found it difficult to review the total budget deficit or cost allocation for the clinics including the CSO costs, and
- even if approved budgets or KPIs were clear and were achieved, significant deficits remained

cohealth's business systems cannot be considered to be effective.

275 The clinics have one main revenue line: MBS rebate revenue.

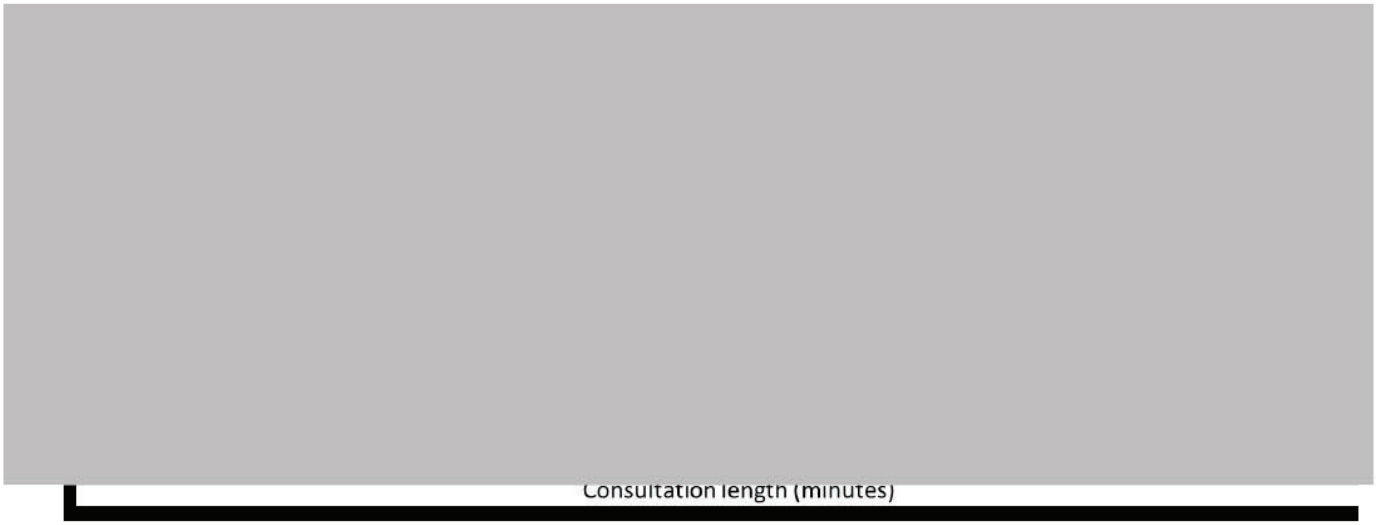
276 As we have shown earlier, the MBS rebate revenue did not even cover clinical salaries (predominantly GP and nursing wages, see 'Salary Expenses' and Chart 5 in Appendix B – Historical Financial Analysis).

277 The amount of rebate revenue is determined by how many patients a doctor sees, and how long the doctor sees the patient for, which is reflected in the MBS billing item applied.

278 The Figure below shows that, on average, longer consultations attract lower rebates per minute.

Figure 7: MBS revenue per minute earned by GPs, by consultation level and length

MBS benefit per minute with tripled bulk billing incentive and additional 12.5%



Source: Grattan Institute analysis provided to Review. Note: $/minute includes bulk billing payment and 12.5% incentive payment

279

280 Since consultation length essentially determines revenue per hour it is a critical factor in clinic viability.[62]

[62] Note, the relationship between consultation length and revenue is discontinuous, that is, for example, and so quite complex.

281 An effective business planning and reporting system would establish clear revenue targets per hour.[63] Because consultation time is determined by GPs, such targets would need to be communicated clearly to GPs and built into a clinic service model that provides systemic support and involves engagement with the GPs.[64] As discussed above, they were not.

282 Importantly, 'Inconsistent KPIs and fragmented oversight' was identified as a 'Risk/Issue to be managed' arising from the 2022 Kokkin and Brown report. The cohealth summary of its response provided to the Review identified one operational change implemented in response to the Kokkin and Brown report as being 'Performance Board meets regularly to review utilisation, access and financial results'. The 'Operational effect' of this change was reported to us as 'Standardised metrics and whole of organisation line-of-sight across all practices'.

283 This intervention was clearly not effective in addressing the underlying identified problem of inconsistent KPIs and oversight.

284 Even if KPIs were clear, however, they would need to be embedded in practice to have any meaning. It appears that they weren't.

285 One GP told us: 'over the last five years there have been no real conversations about billing' and 'no negotiations'.

286 Revenue targets that are vague or non-existent obviously can't be clearly transmitted to individual GPs, which in turn makes those targets very hard to achieve.

287 It is also impossible to effectively report revenue against revenue targets if those targets are not clearly communicated. And, of course, there was no evidence of regular performance conversations with GPs, contrary to good clinical governance.[65]

288 In essence, the story here is one of no real financial reporting to the people who mattered (GPs, in the case here of revenue targets); no meaningful Key Performance Indicators to hold GPs accountable against targets; no reporting systems involving the GPs; no financial planning involving the GPs; and no reporting frameworks about revenue involving the GPs.

289 To the extent that revenue had been discussed with GPs, the conversations were sometimes described as being about covering their salaries (A in paragraph 271 above), sometimes about covering salaries plus direct support staff (A + B above), and sometimes about all three elements of the true cost of provision of services (A+B+C above). It is unclear whether the final option would have included CSO costs or not.

290 The approach adopted by management about communicating targets was quite complex and essentially devolved to Practice Managers (and to a lesser extent GP leads).

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[63] cohealth argues that it set clear appointments per hour targets which (assuming homogeneity of appointment length) lead to clear revenue targets. GPs who met with the Review generally were very disparaging of the appointment scheduling processes set by management – and this was also evidenced in emails provided to the Review by management. Our focus on revenue targets is partly because we believe it would be easier to get commitment to revenue targets and is clearly linked to financial viability.

[64] Good practice would also engage GPs in determining these targets.

[65] See Standard 1.22 'The health service organisation has valid and reliable performance review processes that: a. Require members of the workforce to regularly take part in a review of their performance', Australian Commission on Safety and Quality in Health Care, *National Safety and Quality Health Service Standards. 2nd edition*. We were advised by cohealth management that a Performance Development Review process did exist, but it was suspended in 2025 because 'the existing (process) did not adequately meet GP needs. Rather than continuing a process that was not fit for purpose, the organizationally intentionally paused the … cycle while reviewing and redesigning the approach'.

291 cohealth adopted a two-tier approach to revenue: budgets were set on a revenue target which covered salaries only (A in paragraph 271 above), $250 per hour.[66] As best we can tell from reporting, from the organisation's point of view, reporting against budget meant reporting against this figure, a stated Key Performance Indicator.

292 But the cohealth executive thought this revenue was 'intolerable'. That is, to be viable, the revenue target should cover the total operating costs of a service, in this case, salaries, support staff, and a contribution to overheads (A+B+C + a CSO charge).

293 Communicating this two- or three-tier approach – *on the one hand we have a set a budget target of X, and that is what you are supposed to be held to account for, but that is an 'intolerable' target, and your service is not viable with the budget target we have set* – would test an organisation with even the best communication skills and channels.

294 It is therefore no surprise that we heard a thesaurus of synonyms for 'confusion' to describe the advice about revenue targets and viability from the GPs we interviewed.

295 In the absence of effective financial accountability systems and clearly communicated revenue targets, a gap between revenue and costs of GP services was predictable.

296 It is not our view that simply determining and agreeing revenue targets, and then clearly communicating them, would solve the GP clinic financial problems; but rather, that in the absence of that step it is almost impossible to imagine how the GP clinics could be actively managed to be viable. Stated more directly. failure to meet the basic preconditions of good financial management (clear reporting, clear targets, clear accountability), has contributed to the financial situation facing cohealth.

297 As we highlighted in Figure 6, there are four main underlying causes of the poor financial performance of the GP clinics. We have outlined above the management and governance issues that seem to have exacerbated the problem. Poor relations between management and medical staff (see the discussion above) meant that model of care issues were unaddressed and possibly dismissed or misunderstood at executive and Board level.

298 Leadership energy seems to have instead been invested in an exogenous factor over which cohealth has no control – namely the design of Australia's MBS.

299 We have no measure of how much time was invested in these efforts, but the Board highlighted to us the [redacted] advocacy activities, which included trips to Canberra and ministerial correspondence.

300 The communication planning of the closure announcement emphasised this exogenous cause, with a proposed slogan of 'We have fought'.[67]

301 We have no evidence of whether or not [redacted] also engaged with GPs to emphasise the importance of changing the model of care, ideally through a process of co-design and change management. Nor can we be certain that such engagement would have been effective. But what we do know is that there does not appear to have been as much focus on achieving necessary internal change as there was on campaigning for external change.

302 *In our view this account of financial management, communication and accountability of GP services shows that cohealth:*

[66] In our meeting with the cohealth executive, they were clear about this quantum.

[67] The other proposed slogan was 'change is necessary for us' see Report (Powerpoint deck) on Stakeholder Engagement and Communication Workstream.

- *Was not 'effectively managed at all times' as it did not have effective documented staffing and organisational structures, business systems and processes and business planning and reporting; and*
- *Did not have 'effective financial management at all times' in that it did not maintain effective 'financial …. reporting frameworks'.*

303 *cohealth was therefore not meeting the management and financial management performance standard for community health services.*

304 The case study we have used here is of the GP clinics. Although some of the evidence we have seen is specifically about the clinics, some is also about financial reporting across cohealth generally.

305 Our conclusions also apply to cohealth generally, not only because of the evidence of the whole-of-organisation financial reporting we have seen, but because management of the clinics speaks to management of the whole organisation – that is, if cohealth were meeting the Performance Standard generally, we would see it meeting the Standard in respect of its management of the GP clinics. It demonstrably was not.

The capital stock: managing physical resources

306 cohealth's capital stock is not in good shape. This has been known for at least ten years.

307 In a normal business, management would ensure that its premises were fit for purpose: that is, the business manages its capital stock.

308 This is not what has happened at cohealth. To some extent, this is because of the complex nature of community health funding – is it government's role to address fully all community health capital needs? What role is there for the organisation?

309 A Capital Infrastructure Plan presented to the cohealth Board in 2016 identified the Collingwood (Hoddle St) site as its highest priority. It was described as

> Aged and in very poor condition. The design of the existing facility is outdated, resulting in an inefficient floor plan given the size of the land.
>
> The building is no longer fit for purpose.

310 An independent Victorian government body, Infrastructure Victoria, recently produced a report on the capital stock used by community health services.[68] It concluded:

> Our infrastructure survey found that many registered community health organisations use buildings that are old or not fit for purpose. It found that many need maintenance or upgrades. The quality of infrastructure is affecting the ability of registered community health organisations to deliver health and social support services. It is also restricting the number of services that they can offer and the number of people they can serve.

311 The Infrastructure Victoria report used the Hoddle St site as a case study, under the title 'Old buildings impact cohealth's ability to provide efficient community health services'.

312 The Hoddle Street site is iconic. Its history and its association with the Singleton Clinic and the Whitlam-era grants for development were frequently mentioned to us at our consultation meetings. Particularly evocative was a description of the site as being 'part

[68] Infrastructure Victoria, *Investing in community health infrastructure* (Melbourne: Infrastructure Victoria, 2025).

of the dowry that was brought (to cohealth) as part of the merger', an indication of how wedded the community is to the community health service.[69]

313 cohealth has proposed a redevelopment that would involve sharing the site with a new multi-storey social housing development. But this proposal was not funded as part of the Victorian government budget processes.

314 If general practice services are to continue on the Collingwood site, then a major redevelopment may be required. The cohealth proposal to construct a joint primary care-social housing development appears to have merit. In terms of the Performance Standards, we are of the view that cohealth has acted appropriately in terms of advocating for funding for redevelopment of the site and the management of its physical resources.

315 cohealth owns or occupies many facilities, some of them acquired since cohealth's last infrastructure plan. We were told that some are not fully utilised. This points to the need for cohealth to regularly refresh its capital infrastructure plan.

[69] In a similar vein, an obituary notice was posted in *The Age* on 21 February 2026, to the Collinwood Pharmacy (1869-30 January 2026), thanking it for its 'outstanding service to the Collinwood community over all these years, RIP.'

8. The clinic financial loss was also partly driven by factors beyond cohealth's control: the client mix, cohealth model(s) of care, and the MBS

316 cohealth's client base is very different – sicker, at higher risk of hospitalisation, poorer – to the population served by the average private practice. It also appears that it has greater need than is typical of the average Victorian community health service, although this may simply reflect the fact that our data is for *all* community health services, not just those located near public housing estates.

317 It is therefore undoubtedly the case that some of the financial difficulties that cohealth had to grapple with were outside its control.

318 In our survey of other Victorian community health services, six of the eight respondents reported that their GP services were not in good shape.

Figure 8: Estimated GP clinic(s) overall financial performance for the financial year 2024-25 after operational overheads are charged, selected Victorian community health services

Source: Review survey of Victorian community health services conducted under auspices of Community Health First

319 Only one of our respondents reported a surplus,[70] another predicted a break-even result. None reported the size of the deficit faced by cohealth.

320 This suggests that although cohealth is unique in terms of its financial situation, exogenous factors common to most of the clinics serving marginalised populations may also be relevant.

321 Several submissions from outside Victoria highlighted similar issues in providing GP services in low socio-economic communities or to populations with complex issues.

[70] Another community health service, not in our survey, reported a small surplus in a separate submission.

These services are often supported by philanthropy and/or additional grant funding on top of MBS revenue.

The client mix: the population served by cohealth

322 One submission identified a number of clinic-wide challenges in meeting the needs of the cohealth client mix:

> *Higher amount of non-face-to-face time*. This is caused by the higher levels of interactions with other agencies, and involves more writing reports (e.g. Centrelink), responding to corrections/ courts/ police/ prisons/ child protection/ public health workers (e.g. infectious diseases units) coroners, lawyers, psychiatry units, and housing organisations.
>
> *Higher incidence of failure to attend* caused by client 'chaotic lives', incidence of dementia. Some failure to attend can and should be managed by bookings management, but the higher incidence makes it harder to manage.
>
> *Requirement for more reception staff time*. More requirement to coordinate interpreters, follow ups, referrals.

323 Many submissions also suggested that patients with multi-morbidity require longer consultations. Given Australia's changing epidemiological profile, multi-morbidity is increasingly the norm, with multiple issues typically discussed in a single consultation.[71] It is now well accepted that Medicare has not adapted well to this epidemiological transition to patient populations with more chronic conditions.

324 The main adaptation over the decades since Medicare was introduced has been the addition of fee-for-service items designed to respond to the change in morbidity, such as chronic disease management plan items that provide access to allied health items.

325 However, the fundamentals of Medicare haven't changed since Medicare's predecessor, Medibank, was designed in the late 1960s. The vast bulk of GP revenue and client experience involves episodic visits that Medicare pays for on a time-tiered basis (Level A for brief attendances, through to Level E for prolonged attendances).

326 Government has recognised the benefits of multidisciplinary care in the management of chronic illness and the need to enhance multidisciplinary team care through its Strengthening Medicare Task Force and the Advisory Committee on General Practice Incentives.[72] However, the timeline for implementation of revised funding arrangements is as yet unclear.

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[71] Kimberley Norman et al., "What happens in general practitioner consultations?: A study of video-recorded Australian general practitioner consultations," *Australian Journal of General Practice* 54, no. 10 (2025).

[72] Strengthening Medicare Taskforce, *Report*, Department of Health and Aged Care (Canberra, 2023); Expert Advisory Panel for the Review of General Practice Incentives, *Report to the Australian Government*, Department of Health and Aged Care (Canberra, 2024). Stephen Duckett was a member of both of these. GPs also recognise the benefits of multidisciplinary care see Royal Australian College of General Practitioners, *General Practice: Health of the Nation 2025*, RACGP (East Melbourne, 2025). as do private health insurers see Medibank Better Health Research Hub, *Primary Care Symposium 20 June 2025 Communique*, Medibank Private (Melbourne, 2025).

cohealth's model(s) of care

327 cohealth's current model(s) of practice involves a heavier reliance on longer GP consultations than we see in similar community health services. Longer consultations attract lower remuneration per minute, which makes it harder for cohealth to make ends meet.

328 Although socio-economic drivers result in a much more complex medical environment for cohealth's GPs to negotiate, not all of a patient's needs are best provided by specialist general practitioners. Many of the needs arising from the socio-economic environment may be best met by other members of the team.

329 cohealth's patients recognise this. One of the 'key takeaways' from the survey cohealth undertook as part of its submission to this Review was that:

> There is support for a 'team of carers' approach to healthcare, with strong interest in nurses, allied health, community health workers, navigators and peer support being part of that team.

330 Further, not all longer consultations are due to client-related factors, such as the need for interpreters or multi-morbidity. Some are due to weaknesses in multidisciplinary care that see GPs performing tasks that other health professionals could just as easily perform.

331 We heard a number of stories about this situation. In many cases the GP was narrating a story that reflected compassion and responsiveness to patients' needs. For example:

- GPs spend some of their time dealing with patients' energy bills — an example cited by cohealth in the debate about the viability of their general practice.
- One GP told of spending time accompanying a patient to a pathology appointment for fear that the patient might not wait.
- One GP said some of their consultations run longer because they are dealing with patients' mental health issues. They pointed out that this was due to policies that limit the number of consultations a patient can have with a psychologist, or because of out-of-pocket charges that make specialist psychological care unaffordable to the patient.

332 Seen from another angle, however, these stories can also be seen as failures of service provision (lack of appropriate members of the team), failures of funding design, or failures of internal communication and team functioning. So, for example:

- Helping patients with energy bills is well within the scope of practice of a welfare worker.
- For pathology, even recognising the nature of the patients involved, and the potential benefit of a pathology result in guiding treatment, other strategies can be pursued to address a patient's failure to present for an appointment.
- The mental health story as told to us above was of tale of direct substitution: a GP doing the work of a psychologist.

333 These are therefore all examples of care that is important and valuable to the patient,[73] but that does not need to be delivered by the doctor personally.

334 Locally-developed nursing roles also reflect these challenges. At one cohealth site a nurse works closely with one or more GPs to actively scan the patient group for high-need clients who may benefit from care coordination, while at another site the nurse

[73] And so is not 'low value care' as it is defined in health policy debates.

role may focus on developing care plans and health assessments for sign-off, a task often done while working from home. One GP commented that a care coordinator at each site would contribute significantly to addressing these challenges.

335 In a community health service, holistic care that addresses the socioeconomic drivers of health, and is responsive to a patient's needs, is the responsibility of the whole multidisciplinary team. Every member of that team, including the GP, should work to their full scope of practice. The stories we heard suggest that this is not the case at cohealth.

336 The net result is that GPs are doing work that could be done by others. Because GP remuneration is significantly higher than for other staff, this is inefficient. It may also mean that patients are deprived of specialist services (such as mental health treatment) that could more effectively meet their needs.

337 The time GPs spend not working to the top of their scope of practice is time they could spend treating other patients who might otherwise miss out on care altogether. It also results in lost revenue for cohealth and so undermines the overall viability of the clinics.

338 A recent study of general practice in the England showed that it was more efficient to improve access to care by expanding nursing staff within a general practice than by increasing general practitioner time.[74]

339 The extensive use of longer attendance items (C, D and E) – which, as noted, generally have a lower remuneration per minute than the shorter items – will be in part the result of the fact there is simply no alternative, given cohealth's staffing profile and model of care. The lack of funding to support the multidisciplinary care that is particularly needed when dealing with CHS population cohorts is one of the legitimate exogenous factors that exacerbates cohealth clinics' financial problems. That is, this lower remuneration per minute contributes to – though is not the sole cause of – the viability problems of cohealth's GP clinics.

340 At least part of cohealth's existing resources – such as $2m per annum community health funding[75] – that are currently used elsewhere could be used to support multidisciplinary care appropriate to the needs of cohealth's patients. We note, however, the range of restrictions and system challenges around the use of state funding, and a commendable sector-wide reluctance to risk 'double dipping' – that is, using state and federal health funding for the same service provision. We have considered this in our recommendations.

The current MBS approach

341 There is now a plethora of planning and assessing items, and incentive payments, that recognise multi-morbidity and are designed to encourage holistic care.

342 [redacted]

[74] Tianchang Zhao, Rachel Meacock, and Matt Sutton, "Scale, Skill-Mix, and Access Implications of the Production of Appointments by Primary Care Practices in England," *Health Economics* n/a, no. n/a (2025 (in press)). It is acknowledged that there are differences between the NHS in England and Medicare in Australia, but these particular findings may still be relevant.

[75] [redacted]

343 It can be seen that cohealth's use of specified items (e.g. 75+ Assessment) is higher than in other practices, while its use of chronic condition management items is somewhat similar.

344 Using client-level data, the Review team also analysed the potential for more MBS billing in cohealth clinics (see Appendix C: Opportunity for additional MBS billing). That analysis suggested that cohealth could generate approximately $800,000 of additional revenue through the MBS. However, for reasons discussed in the Appendix, we suspect that additional billings of this order are not realistic.

345 Accordingly, we do not believe there is extra MBS revenue that could be billed for completed activity and currently isn't – certainly not enough that would be sufficient to address all the clinics' financial issues.

346 In addition to these MBS items, all general practices, including cohealth, are eligible for Workforce Incentive Payments (Practice Stream) to support the employment of nurses and allied health staff including social workers. The size of the payment is based on the number of patients in the practice,[76] and is capped at $130,000 per practice.

347 cohealth is the perfect example of a service where multidisciplinary care should be the norm but isn't – largely because existing Commonwealth rules do not facilitate the funding of all the types of professionals who could contribute to the effective care of cohealth's patients. For example, funding rules for Workforce Incentive Payment (Practice Stream) do not appear to allow for employment of a welfare worker.[77]

348 In our view, cohealth could be an appropriate site to test some very new approaches to primary care, such as an expanded role for paramedics and nurses/nurse practitioners.

349 We received an innovative submission that proposed a mixed paramedic + GP alternative provision. This approach is modelled on a cost-effective Canadian implementation[78] that has been shown to be accepted by clients.[79]

350 An Australian adaptation of this model was funded under the Commonwealth Government's Innovative Model of Care Program in Mildura by Sunraysia Community

[76] Patients in a practice are measured in 'Standardised Whole Patient Equivalents (SWPEs)', that is, if a practice shares care of a patient with another practice, they get a share of the SWPE.

[77] Disability and Ageing Department of Health, *Workforce Incentive Program - Practice Stream: Guidelines* (Canberra: DoHDA, 2025).

[78] Gina Agarwal et al., "Cost-effectiveness analysis of a community paramedicine programme for low-income seniors living in subsidised housing: the community paramedicine at clinic programme (CP@clinic)," *BMJ Open* 10, no. 10 (2020).

[79] Francine Marzanek et al., "Perceived value and benefits of the Community Paramedicine at Clinic (CP@clinic) programme: a descriptive qualitative study," *BMJ Open* 13, no. 11 (2023).

Health Services,[80] and that, too, has been evaluated positively.[81] We were told another similar implementation is being planned in Melbourne using existing funding programs.

351 A number of submissions highlighted the value of nurse-led models of care,[82] which have also been evaluated positively.[83]

352 The Commonwealth Government has started on a program to boost multidisciplinary care in general practice, but it is unclear when the program might be rolled out. In any case, new policy is unlikely to be implemented in a timeframe consistent with this review.

353 Nonetheless, we believe that cohealth could act as a testing ground for a new model of multidisciplinary team payments and for new models of care such as those discussed above.

354 As is the case in all general practice, the prolonged Medicare rebate freeze[84] has opened up a widening gap between higher clinic costs and steady clinic revenues. Private practices in wealthy areas have been able to cover this by increasing fees payable by patients, but that option is not available to services in low-income areas. As a result, the freeze has had a greater impact on services such as cohealth.[85]

Is Medicare well designed for cohealth's population?

355 cohealth emphasises the impact of another exogenous factor on its financial viability: Medicare itself. Cohealth argues that Medicare is not well designed for the types of clients that use cohealth, and that it needs reform. cohealth's submission to this Review, for example, argued that

> National reviews have consistently found that Australia's primary care funding system has not kept pace with contemporary models of care, workforce realities or the needs of people with complex and intersecting conditions.
>
> The Strengthening Medicare Taskforce identified that the current Medicare funding system does not effectively support team-based integrated primary care and requires significant reform to enable high quality, person-centred care. The Taskforce noted that fee-for-service service funding settings prioritised short episodic consultations and provide limited recognition of complexity, coordination and multidisciplinary care (page 9).

[80] See https://www.health.gov.au/resources/publications/imoc-cpclinic?language=en

[81] Evelien Spelten et al., *Community Paramedicine in Australian community health: Implementation of the CP@ clinic program (full report)*, LaTrobe University (Bendigo, 2024).

[82] Jarrod Clarke et al., "Defining nurse-led models of care: Contemporary approaches to nursing," *International Nursing Review* 72, no. 1 (2025).

[83] Julia Lukewich et al., "Effectiveness of registered nurses on patient outcomes in primary care: a systematic review," *BMC Health Services Research* 22, no. 740 (2022/06/03 2022).

[84] Helen Dickinson, "What is the Medicare rebate freeze and what does it mean for you?," *The Conversation* (2019), https://theconversation.com/what-is-the-medicare-rebate-freeze-and-what-does-it-mean-for-you-114169.

[85] Shalika Bohingamu Mudiyanselage et al., "Impact of the Medicare Benefits Schedule Rebate (MBSR) freeze on General Practice (GP) use: multivariable regression analysis," *BMC Health Services Research* 23, no. 588 (2023).

356 It is well recognised that shorter consultations pay a higher rebate per minute than longer ones.[86] Cohealth further argues that more complex patients, with more multi-morbidity, require more longer consultations. In cohealth's words:

> National and international evidence demonstrates that social complexity significantly increases consultation length, care coordination effort and service intensity, even where clinical presentations are similar. These demands are largely invisible within current Medicare funding arrangements.
>
> cohealth's experience is consistent with these findings, with clinicians reporting that supporting clients with complex social needs requires extended consultation time and substantial non-billable work to ensure safe and effective care (page 10)

357 Again, it is true that more medical complexity requires longer medical consultation time.

358 But this phrasing obscures the complexity of the issue. cohealth's clients have high levels of multi-morbidity, but they also have higher levels of social complexity. Which brings us back to the question of model of care.

359 The cohealth client base – similar to other community health services located near public housing estates – includes a revolving door of newly arrived refugees, people who are often affected by trauma and dislocation, and who face language and other barriers to accessing care. The priority populations for cohealth based on its mission and Deed of Agreement are those on low incomes, in public housing, with lower levels of health literacy, with substance use and mental health problems, past histories of trauma, and other similar communities impacted by socioeconomic drivers of ill-health.

360 Although gentrification is changing the demography of some neighbourhoods in cohealth areas, a large proportion of clients are still impacted by socio-economic drivers of ill-health.

361 To the extent that meeting these needs requires a medical response, Medicare is not a good vehicle. Medicare was designed in an era where Australia was more homogeneous culturally, and had an epidemiological profile of more acute, episodic illness.

362 But a *medical-centric* response is probably not the best option for people with complex multi-comorbidity or those whose ill-health is driven by socio-economic disadvantage.

363 The direction of national policy – supported by key professional organisations such as the Royal Australian College of General Practitioners[87] – is towards providing a better, *person-centric* response, one that involves a multidisciplinary team of professionals all working to their top scope of practice and bringing a range of skills to bear to assist and treat the patient.

364 Responding to socio-economic drivers of ill-health requires looking beyond 1:1 services.[88] The drivers are common to many patients and should be addressed – at least in part – with collective responses.

365 cohealth supports outreach to marginalised communities by facilitating groups in a number of local communities. We received submissions from a number of culturally and linguistically diverse community groups attesting to the value of cohealth's role in this area.

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[86] Stephen Duckett, Hal Swerissen, and Greg Moran, *Building better foundations for primary care* (Melbourne, Vic.: Grattan Institute, 2017).

[87] See 6 March 2026 RACGP President's Update: Your 'Friday Facts' on all things advocacy and reform

[88] Jackson, Mitchell, and Wright, "The community development continuum."

366 This group-support function is not funded under Medicare but is a cost-effective way of improving health outcomes. 'Social' prescribing has also been proposed as a desirable part of the range of services which should be locally available to address socio-economic drivers of ill-health.[89]

367 cohealth's financial problems can therefore in part be attributed to problems with Medicare, in that Medicare has not adapted to meet important multidisciplinary and preventive approaches. We will address this issue in our recommendations.

368 But it is also true that cohealth has not effectively utilised the resources currently available. For example, cohealth receives 'Community Health' funding from the Victorian Government; it could have – within certain constraints – mobilised some of that funding to address the complex health care needs of its client base through enhanced models of multidisciplinary team care. It also could have better used funding available under chronic disease management plans or mental health plans to support its multidisciplinary teams.

369 VHA undertook a project 'to document and analyse existing GP models in registered and integrated community health services, and to identify opportunities and enablers to support the establishment and embedding of sustainable GP models in community health services'.[90]

370 That project engaged with the majority of community health services across Victoria. Many community health services felt that existing Victorian department rules precluded deploying Community Health funds to integrate with general practice activity. Our own discussion with the Victorian department, together with funding guidance provided to us, has clarified that there is more local autonomy regarding the use of Community Health funds to develop a flexible workforce and structure than is widely understood in the community health sector. That said, we note that the reporting requirements to the Victorian department to account for use of Community Health funding could be challenging to implement in a GP clinic setting. We have considered this in our recommendations.

371 We showed earlier that almost 40% of patients in cohealth's GP clinics are at Urgent or High risk of hospitalisation (see Figure 2).

372 Ensuring that cohealth's clinics work effectively is essential to ensure that St Vincent's emergency department, in particular, does not come under further pressure with the closure of the Collingwood and Fitzroy clinics. This is another reason why effective use of community health funding to improve the function of multidisciplinary teams associated with cohealth's clinics is vital.

373 Unfortunately, as discussed above (see subheading cohealth's model(s) of care), cohealth has relied on specialist general practitioners to meet needs that could have been better met by other health professionals. It is the use of this *medical-centric,* instead of a community-health approach, that was probably the main driver of the financial problems. That is, the extensive use of longer consultations billed at a lower per-minute rate was in part a consequence of local service models, rather than an inevitable consequence of client characteristics.

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[89] But see Matthew Cooper et al., "Effectiveness and active ingredients of social prescribing interventions targeting mental health: a systematic review," *BMJ Open* 12, no. 7 (2022)., and also Lisa McNally, "Time to go beyond social prescribing? Rethinking public health through relationships," *Healthcare Management* (2026 (in press)).

[90] Victorian Healthcare Association and Victorian Department of Health, *Increasing access to affordable primary care in community health services*.

374 The submissions from patients to this Review highlight the very high levels of dedication and commitment of cohealth's GPs. The medical-centric model may have been seen by the GPs as the only ethical way to manage the patient mix they were seeing.

375 That is, in the absence of more effective service models, management, or consultation processes, cohealth's GPs defaulted to longer consultations. Confronted by the patient mix, practising without clear financial KPIs to ensure sustainability, and with limited team configurations to draw on, the GPs drifted – with the very best of intentions – towards longer (and lower-revenue) consultations as an entrenched model of care.

376 It is our view that the GPs did indeed have 'the very best of intentions'. Many of those we talked to were keen to be involved in solving the clinic viability problem. But they did not have access to good data to formulate strategies, and there was no organisational mechanism in place to allow them to be heard or to suggest better ways of working.

377 The work of the Strengthening Medicare Task Force, and the Review of General Practice Incentives, have made it clear that the national policy direction is toward strengthening multidisciplinary teams in primary care.[91] We believe this policy direction is particularly relevant to cohealth and its client base, for the reasons we have argued above.

378 But broad policy directions have to be translated into specific changes on the ground.

379 To reap the benefits of multidisciplinary teams, cohealth will need to make specific changes its 'model of care' and the ways that GPs work within it. As one GP phrased it, moving to a model in which cohealth GPs can work more at top of scope will require clear articulation of 'What a community health centre GP should do, What they should not do, and Who is responsible for the displaced task'.

380 In our view, development of a new model of care – including consideration of the nurse-led and community paramedic models mentioned above – should involve a process of codesign, preferably one that involves all members of the multidisciplinary team (or their representatives) as well as patients.[92]

381 The new model of care should also consider inefficient frictional points, such as internal and external referral processes, and ensure that these are addressed, where possible, and considered in service model design (e.g. through appropriate administrative supports).[93]

Sustainability of the GP workforce into the longer term

382 As we have seen above, there has been an attrition of the GP workforce at cohealth since the closure announcement.

383 We are aware of the challenges facing organisations such as cohealth in attracting and retaining GPs, and in sustaining a viable workforce to provide ongoing GP services through financially viable clinics.

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[91] A recent paper reviewing community health in Victoria saw enhanced multidisciplinary care as part of the future. See Virginia Lewis et al., "Community health in Victoria: a history of challenges, adaptations and potential," *Australian Journal of Primary Health* 31, no. PY24194 (2025).

[92] Codesign can draw on existing thinking about multidisciplinary working e.g. Peter Breadon et al., *A new Medicare: Strengthening general practice* (Carlton: Grattan Institute, 2022). Conceptions of what a 'team' is may vary. There is an important distinction between 'work groups' which focus on individual accountability to and through a leader, and 'teams' which have both individual and mutual accountability, see Jon R Katzenbach and Douglas K Smith, *The discipline of teams* (Boston, MA: Harvard Business Press, 2008); Jon R Katzenbach and Douglas K Smith, "The discipline of teams," *Harvard business review* 71, no. 2 (1993). Resources for codesign include https://codesign4all.com/framework-overview/

[93] An issue raised in a submission.

384 Other community health services have illustrated how a pipeline of GP registrars in training can be a critical element in building a sustainable GP workforce. Bringing on GP registrars, and having them stay into mid-career, can improve quality of care. It can also help refresh relations between management and GPs and build a culture of collaborative co-design in service improvement.

385 But a recognisable career structure is important if more GP registrars are to be attracted to the community health sector. We are aware that while the pool of training registrars is increasing with significant Commonwealth investment, persuading them to train in challenging settings such as cohealth remains difficult. Exposure to the potential rewards of practising in high-need populations and communities can be instrumental in building such a workforce.

386 The Department of Health, Disability and Ageing requires all registrars on the Australian General Practice Training program to undertake 12 calendar months of their GP term or extended skills training in any of the following areas of need:

- a rural location classified Modified Monash Model (MMM) 2-7
- an outer metropolitan location
- a non-capital city classified as MMM 1
- an Aboriginal and Torres Strait Islander health training post in an Aboriginal Community Controlled Health Service or other approved Aboriginal Medical Service
- two six-month terms in any combination of the above locations.

387 We believe that adding community health services (or other not-for-profit practices) serving high-need communities to this list of areas of need could play a role in creating and sustaining a GP workforce in these settings.

What cohealth needs to do

388 It is hard to see a path to viability for cohealth's GP clinics absent new Commonwealth support for multidisciplinary care as proposed in multiple policy reviews in addition to renewed governance and management processes within cohealth to support effective service delivery.[94]

389 cohealth has consistently argued that the closure decision was necessary to protect the whole organisation – what we referred to as an 'existential risk' earlier.[95] Cohealth pointed out to the Review that:

> The financial risk to solvency was given precedence [in its risk assessment processes], acknowledging that it would have impact in other areas. Fiduciary duties are a critical responsibility of the Board and Company Officers as well as a legal requirement exposing Directors and Company Officers to personal liability.

390 This has to be acknowledged. All boards are acutely aware of the risks to an organisation and its directors of trading while insolvent. That said, cohealth's own submissions acknowledge clinic deficits as long-standing, but the available Board papers appear to only show specific review since February 2024.

391 As considered earlier in this report, documents suggest that rather than consistent monitoring of the financial impacts and risks of ongoing deficits over an extended

[94] Strengthening Medicare Taskforce, *Report*; Expert Advisory Panel for the Review of General Practice Incentives, *Report to the Australian Government*.
[95] See paragraph 126.

period, escalation occurred relatively recently. By this point there were limited options available to cohealth to correct the situation.

392 At its meeting of February 2024, the Board was clearly advised of the size of the ongoing deficit of revenue against recorded expenses for the GP clinics, and, importantly, the apparent contribution of the GP deficit to the overall financial situation for cohealth

393 Other things being equal, one can see why the cohealth Board might have made the decision to close the clinics and to stop the financial impact caused by long term deficits and the clinic funding gap.

394 The Board has a clear fiduciary duty to the organisation and to its long-term viability. But in this instance, other things are not equal. Overheads are higher than comparable organisations and Appendix B sets out the reduction in deficit if overheads are adjusted.[96] After management reform, cohealth would be faced with a lower clinic deficit and (if our recommendations are accepted) financial support to manage this change. The Board could then take the time to make a more considered decision about the future of the clinics and the extent to which they should be supported by cohealth, given community need and the synergistic benefits they provide.

With proper management and governance, it is not the case that the Board's fiduciary duties lead inevitably to a 'close the clinics' solution.

395 Additional funding for multidisciplinary team working is an important part of ensuring clinic sustainability, but there are multiple interventions within cohealth's power to implement immediately, including:

- addressing the relatively high rate of overhead charging that we have identified (see Effectiveness of business systems and procedures);
- reviewing the mix of support staff across clinics;
- setting clear, reasonable revenue targets that align with budget and service model targets;
- engaging strong meaningful clinical leadership at a high level in the organisation; and
- facilitating clinics' learning from each other about what works and what doesn't.

396 While it is probable that these would not return the clinics to full viability, they would reduce the significant deficits currently impacting cohealth's overall viability

397 Changes of this kind will be more effective if codesigned with all staff involved.

[96] We were advised that cohealth would consider how to manage the gap in contributions to overheads caused by the clinic closure after the closure was completed.

9. Organisational options for cohealth

398 A number of submissions lamented the loss of connection between cohealth and its local communities.

399 The strong community links documented in the histories of cohealth's predecessor organisations have dissipated over time. In the past, under a 'community membership' structure, members of the company (cohealth) were drawn from local communities; these members elected the Board. The Board, therefore, was in a very real sense accountable to the community.

400 One submission described the problem thus:

> The current proposal by cohealth for Collingwood, Kensington and Fitzroy indicates a complete disconnect between the cohealth Board and management and communities, at least in those three communities that it serves. If community health centres are going to be (or become) large organisations with multiple sites covering geographically large catchments, they need to consider governance and management structures that maintain the core principles and philosophy of the community health model. They need to do more than just ensure the services they deliver reflect needs of the communities; they need to make sure that these communities have a true ability to influence decisions that are made about WHAT, WHERE and HOW services are delivered.

401 Currently, the Board of cohealth is accountable only unto itself. That is, the Board is self-elected, that is, it is elected by a membership that consists solely of existing board members.

402 In the private, listed company world, share price fluctuations provide a form of instant accountability. Accountability in not-for-profit organisations is more complex,[97] and even in for-profit organisations, contemporary best practice recognises accountability beyond shareholders.[98]

403 cohealth took no action to develop any effective *community* accountability mechanisms when the former membership-based structures were replaced by the current 'self-referential' processes.[99] This probably contributed to the lack of trust clearly demonstrated in both the public meetings that followed the closure announcement, and in our consultations and in the submissions made to this Review. We were even told that the Board Community Advisory Committee was not consulted about the clinic closures because some of its members were patients. If an advisory committee is unable to comment on the services it uses it would appear to have a limited scope.

404 Submissions generally only posited one alternative to the current situation: divestment.

405 Under this model, cohealth would be broken into three to aligned with the city boundaries of Maribyrnong, Melbourne, and Yarra (from west to east, and in

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[97] Jonathan Kugel and Julie M Mercado, "Good Governance in not-for-profit organizations: A review of the literature on boards of directors," *Journal of Governmental & Nonprofit Accounting* 13, no. 1 (2024).
[98] Oliver D. Hart and Luigi Zingales, *The New Corporate Governance*, NBER (Cambridge, MA, 2022), http://www.nber.org/papers/w29975.
[99] Here we are emphasising accountability to local communities. We acknowledge that there are other engagement mechanisms.

alphabetical order).[100] Different submissions proposed different options for municipal involvement.

406 As one submission noted:

> The first solution of devolving cohealth into multiple smaller organisations would forego the (perhaps illusory) benefits of scale and ability to reproduce success across an entire organisation. If, in the future, there is a sustainable financial model for providing team-based care for 'complex' patients, it is perhaps inevitable that larger organisations – which can manage a large number of employees – will be attracted to the management of complex patients.

407 As can be seen from a number of recent mergers in the community health world in Victoria, most community health services believe that viability at smaller scale is not possible, and that independent community health services must become ever larger in order to survive. Perhaps inevitably, this shift to larger organisations tends to be accompanied by a loss of local identity and decline in community engagement.

408 A potential compromise between divestment and the existing model would be a 'holding company' model, in which one central organisation is responsible for strategy, finances, and people functions, while 'divisions' (or other units) are responsible for local delivery, and have significant autonomy.

409 The Review team could not undertake a full analysis of the various options in the limited time and resources available.

410 However, what is obvious is that cohealth needs to reinvigorate its relationships with its local communities and establish robust community *and* patient engagement processes.[101]

411 As one submission put it:

> We urge the State and Commonwealth governments to establish stronger mechanisms to support effective governance of community health services, including clear accountability to governments and the communities they serve. They should include requirements for boards to reflect the communities they serve and formal mechanisms to embed community voice in decision making.

412 We share the view that a stronger community voice should be part of the cohealth future and will be critical to reestablishing trust.

413 We are not saying here that there should be a return to a community-elected board rather than the self-elected board currently in place. Instead, we believe that cohealth needs to develop purposive strategies to ensure that effective community engagement occurs and receives appropriate support. These strategies should draw on some of the experiences and character – appropriately contextualised and updated – of the predecessor organisations.[102]

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[100] One submission proposed merger with other community health services in the City of Yarra and Port Phillip.

[101] Tanya Rong, Eli Ristevski, and Matthew Carroll, "Exploring community engagement in place-based approaches in areas of poor health and disadvantage: A scoping review," *Health & Place* 81 (2023).

[102] And 'advice' to new participants in community health boards which were structured as community elected see David Legge, "Community management: open letter to a new committee member," in *Community health; Policy practice in Australia*, ed. Fran Baum, Denise Fry, and Ian Lennie (Leichhardt: Pluto Press Australia, 1992).

414 We also believe that cohealth needs to acknowledge the trauma – to patients, staff, and the wider community – that has been inflicted in the past few months. Such an acknowledgement can provide a starting point for a new, engaged, future for cohealth, one that is based on a new relationship with staff and with the communities it serves.

10. cohealth and the broader community health world

415 Community Health in Victoria is, to some extent, unique. It has a proud history – indeed proud histor*ies* – as locally led, organic responses to community need.

416 Importantly, community health in Victoria is to some extent a social movement that is facilitated by shared goals, animated by a co-operative spirit – despite the depredations of the 'contract state'[103] – and held together by supportive common membership organisations, specifically Community Health First and the VHA.

417 Victorian community health centres are one of the last remaining legacies of the Whitlam Government's Community Health Program. Their continued inclusion of general practice, supported by the Victorian Government,[104] ensures access to primary care for populations that otherwise would go without.

418 The work of this Review was strongly supported by community health services that provided advice, submissions, and data. All community health services have a vested interest in cohealth's survival, and there is a strong commonality of interest in the outcomes of this Review. As noted previously, services in other states that are encountering related issues are also keenly interested in the Review.

419 We showed earlier that most community health services providing GP services are sustaining losses, albeit not to the same extent as cohealth (see **Figure *8***). Our recommendations have therefore been constructed to recognise that what we recommend in the particular case for cohealth could be seen as a precedent for other funding requests.

420 In our recommendations we have emphasised the importance of getting cohealth's internal management right and developed recommendations that are consistent with existing policy directions.

[103] J. Alford and D. O'Neill, eds., *The contract state: Public management and the Kennett government* (Melbourne: Deakin University Press, 1994).

[104] Victoria. Department of Human Services. Primary and Community Health Branch, *General Practitioners in Community Health Services - Strategy Development Update. February 2004* (Melbourne: DHS, 2014). This document articulated its aim as to ' *Improve the health, wellbeing and quality of life for Victorians through increased access to medical services integrated with Community Health Services.'*

11. Where to from here? Recommendations

421 Something has to change.

422 We have shown that the issues with cohealth's GP services are neither simple, nor the result of a single root cause.

423 While it is true that the current design of Medicare doesn't facilitate multidisciplinary care, it is also true that the current governance and management of cohealth has been ineffective in monitoring and managing this challenge.

424 It is our view that addressing cohealth governance without also addressing Medicare funding would mean ignoring the underlying dynamic that has led to the proposed clinic closures.

425 We do not believe, however, that the existing governance and management of cohealth will be able to effect the changes to model of care that are necessary for cohealth's services to function effectively and sustainably.

426 Figure 6 shows the four key factors influencing the viability of cohealth's GP clinics. We have made recommendations to address all of these factors (see Figure 9 below). Our recommendations are addressed to the Victorian and Commonwealth Governments (in line with their responsibilities and powers) and to cohealth.

Figure 9: Summary of findings and recommendations

Management oversight and governance	cohealth model of care	Client base of cohealth	MBS funding model
•**Finding:** governance and oversight of the GP clinics is ineffective •**Recommendation:** consider new governance arrangements; strengthen governance and management arrangements and organisational culture; rebuild stronger links with local communities	•**Finding:** No consistent model of care •**Recommendation:** co-design new multidisciplinary model of care; strengthen clinical leadership and engagement	•**Finding:** clients from lower socioeconomic status areas, more at risk of hospitalisation •**Recommendation:** co-design new multidisciplinary model of care	•**Finding:** GPs not working to top of scope of practice •**Recommendation:** more support for expanded multidisciplinany teams

Recommendations to the Victorian Government

On cohealth governance

427 We used the relevant Performance Standards for community health services in Victoria as the standard against which to judge the adequacy of cohealth's governance

arrangements. We have carefully considered cohealth's compliance with the Standards in earlier sections.

428 Our conclusions are summarised in the Table below.

Table 9 Assessment of cohealth against Performance Standards

Performance standard	Review conclusion	Review consideration
Management The agency must be effectively managed at all times	• In summary, it is clear that the Board and management did not engage with GPs in developing effective, codesigned strategies for clinic financial viability, despite the importance of doing so. The Board appeared to be satisfied with second- or third-hand reporting of GPs' views, neither engaging themselves directly or through subcommittees, nor holding management to account for failing to create effective engagement structures. • cohealth has a generous provision of corporate staffing as measured by the proportion of expenditure charged to business units for overheads. • cohealth was not 'effectively managed at all times' as it did not have effective documented staffing and organisational structures, business systems and processes and business planning and reporting	7. There was inadequate and ineffective management oversight of the clinics
Financial Management The agency must maintain effective financial management at all times	• While the Board and Finance and Audit Committee discussed the ever-worsening cash position, there is limited evidence of requests for detailed information or for regular reporting on the services causing this, despite increasing concern and management failure to meet commitments. It is difficult to see how the Board could effectively manage the financial risks of a large organisation operating in deficit without consistent, detailed, and regular reporting on the performance of the services driving the deficit. What information was received by the Board about under-performing services was largely in narrative form, and rarely in consistent formats that	6. There was inadequate risk management and ineffective governance/oversight of cohealth's financial situation

	would allow for comparison month-to-month. • It is obvious in retrospect that cohealth did not manage oversight of financial risks well. The poor financial performance continued too long – decades according to some people interviewed by the Review, and at least one decade as recounted in cohealth's submission. What the record shows is that the Board was advised a number of times by management of the poor financial performance of the clinics from 2023 and advised quite starkly of the contribution of the clinics to the challenges to organisational financial viability in February 2024. The Board and Committee papers reveal a Board that did not engage with the clear financial challenges of the clinics, even though the clinics represented a significant proportion of the organisation's overall operating deficit. Nor did the Board hold management to account in terms of actions taken to rectify the situation. Even as the poor financial performance continued, the Board did not challenge management to provide additional reports about the clinics or question the effectiveness of the management strategies reported to it. There is limited evidence of effective or consistent attempts on the part of the Board to drive changes in the way the clinics were managed. • cohealth appears to have a generous provision of corporate staffing as measured by the proportion of expenditure charged to business units for overheads. • GP clinic budgets were set at deficit levels for a number of years, which means – as management and the Board observed – that even if the clinics had achieved the budget set in the most recent financial year, they still would not have been viable. It is difficult to see how budgets, KPIs, and	

	targets that do not achieve sustainability are effective. • cohealth did not have 'effective financial management at all times' in that it did not maintain effective 'financial .... reporting frameworks'.	
Risk Management The agency must effectively manage the risks associated with its business to ensure continuous, safe, responsive and efficient services	• cohealth did not have in place an effective strategy to manage the risks associated with its business to ensure continuous, safe, responsive and efficient services, and did not actively manage the relevant risks.	6. There was inadequate risk management and ineffective governance/oversight of cohealth's financial situation

429 We are aware that critical conclusions of this kind are confronting.

430 Essentially the Act allows for two options following such a conclusion:

- Option 1: Give cohealth an opportunity to improve itself (Section 54 of the Act)
- Option 2: Refresh cohealth with new governance and potentially, new management. This is done by standing down the Board and appointing an Administrator (section 57A of the Act) in its stead.[105]

431 The path chosen should be based on what is in the long-term interest of cohealth's clients and of Victorians generally.

432 We are charged in our Terms of Reference to develop options 'to support long term arrangements that ensure continued access of vital general practice service to these communities'. Which of the two governance reform options might best do that?

433 Revitalisation of cohealth's governance and management to address the current weaknesses will take time, and during that time the organisation must continue to be effectively managed and function in the interest of the people it serves.

434 Option 1 is less disruptive, but it assumes that 'the leopard can change its spots': that is, that the existing governance and management teams can heed the lessons of this Review, learn, and change their *modus operandi*.

435 That task, however, is daunting. Among other things, it will require new financial management approaches, better engagement with general practitioners, and active management that takes responsibility for problems and acts on them. It will also require a massive organisational culture change, something that can partly be led – the 'tone from the top' approach[106] – but, more importantly, must also involve an organic shift in the organisation's fundamental sense of what it is.[107]

436 Board or management might want to retain advisers who can help with all this: people (or organisations) who have done this before, and who can help quickly with a reset.

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[105] None of the members of the Review are lawyers and so this is phrased in 'lay' terms. Importantly, decisions of this kind are the responsibility of the Secretary of the Victorian Department of Health or the Victorian Minister for Health. What we are providing here is our advice on these matters.

[106] Edgar H. Schein, *Organizational culture and leadership* (San Francisco: Jossey Bass, 1992).

[107] Russell Mannion, *Making Culture Change Happen* (Cambridge: Cambridge University Press, 2022), Cambridge University Press.

437 Option 1 would be facilitated by the [redacted] as we were finalising this report. Several executives and senior managers in place when the decision to close the clinics was made will not be in place at the end of this financial year.

438 [redacted]

439 Option 2 is more disruptive. It would involve bringing in a 'new broom' at the top of the organisation: effectively, a new individual (or group) would assume the responsibilities of the Board.

440 We have shown that the financial and governance issues facing cohealth and its general practice services are significant. The services are losing money every day, which is impacting organisational viability. Culturally, there is a breakdown in the relationship between GPs and management which will make the necessary reform more difficult.

441 The Board's consistent public statements over the last few months have been focused predominantly on exogenous factors. The solution consistently proposed focuses on increased external funding. cohealth's submission to this review contained eight recommendations. All of them relate to additional targeted funds to support cohealth's general practice services. None of them related to internal changes.

442 We have not seen any recognition from the Board as a whole, or from cohealth's management, that poor internal governance and management have contributed to cohealth's situation. Where deeper reflection from Board and management *is* evident, it focuses almost solely on community and client communication.

443 Even as late as January 2026, a pamphlet handed out at the Collingwood site described the issue thus:

> Why our health centre is closing?
>
> We have tried for many years to get funding to make the Collingwood health centre safer and better for everyone.
>
> The building now needs a lot of repairs to stay safe, but we don't have the money to do this. Because of this, we cannot keep providing care from the building safely so it will have to close.

444 The consistent message from cohealth since this Review was announced has been that general practice services will close in July. Recent messaging has, if anything, reinforced this message.

445 We were told that this emphatic messaging was partly a response to the identified problem of insufficient clarity in previous messaging.

446 When pressed, management indicated (though acknowledging it was a Board decision), that services might be able to continue if (and, implicitly, only if) all the recommendations in cohealth's submission were accepted.

447 This position is incompatible with our obligations under our Terms of Reference to develop options 'to support long-term arrangements that ensure continued access of vital general practice service to these communities'.

448 cohealth has acknowledged that there are lessons to be learned, both in its submission to this Review and in our discussions with the Board and management. But the lessons cohealth has described as needing to be learned are the easy ones: failures around poor

'engagement' and 'consultation'. No lesson needs to be learned, apparently, about culture, internal management, or governance.

449 There seems to be no acknowledgement that there have been fundamental failures of governance, including failures as measured against the Performance Standards.

450 We therefore have limited confidence that the Board of cohealth will engage with or correct the underlying issues.

451 It is our view that there needs to be fundamental change in the way cohealth is governed. This goes well beyond the general practice and related services.

452 We have shown above (paragraph 138) that the limited financial reporting to the Board does not appear to meet contemporary governance standards or fundamental risk management.

453 For general practice services to continue, let alone become viable, there needs to be a significant culture change involving medical staff, practice managers, and management. This is not a trivial exercise and will take time. Given the evidence provided, we have limited confidence the existing management can be effective in undertaking this task.

454 In the end we have decided to recommend the more transformational of the two future governance options: that the Victorian Minister for Health commence the processes under section 57A of the Victorian *Health Services Act* to dismiss the Board of cohealth and appoint an Administrator to take over the Board's function.

455 **Recommendation 1: We recommend that the Victorian Minister for Health formally provide a copy of this report to cohealth and invite cohealth to show cause why the Minister should not form the view that cohealth:**

- **is ineffectively managed; and/or**
- **has failed to meet one or more performance standards**.[108]

456 We include the word 'formally' here because cohealth was provided with a copy of this report (without this recommendations section) as part of the Review process so that it could verify the 'facts' and evidentiary basis we have used in formulating these recommendations.

457 It will be the job of the Administrator (in the event that an Administrator is appointed) or the Board to direct the significant changes in the model of care and relationship management that are necessary to ensure the continuing provision of primary medical care in cohealth clinics.

458 If an Administrator is appointed, that person, together with management, will need to be supported by people skilled in the turnaround required. Such support could be obtained by entering into a management contract with an existing, well-functioning, community health service, or via a partnership of community health services with complementary skills.

459 All this will take time.

460 We recognise that the choice between Option 2 ('the Administrator path') and Option 1 (the 'give cohealth an opportunity to fix') is a matter of judgement. If our recommendation to appoint an Administrator is rejected, then the Secretary should initiate the alternative self-improvement process outlined in Section 54 of the *Health Services Act* with clear performance targets, enforced through conditions on Victorian Government funding of cohealth, perhaps a refresh of some of the Board membership, and more detailed oversight of cohealth's operations. If this 'fix itself' path is followed,

[108] We are using the language of the Victorian *Health Services Act* here

the Victorian Department of Health must ensure that GP services continue in line with Commonwealth support for the clinics.

On community health funding

461 We have recommended below that the Commonwealth establish a pilot multidisciplinary team funding grant for cohealth. This would lead to a significant boost to multidisciplinary work at cohealth and improve services for the community.

462 The new model of care that we envisage for cohealth will be facilitated if some existing Victorian community health funding could be pooled with the new Commonwealth funding into a single integrated approach.

463 Under this arrangement, which would be cost-neutral to the Victorian Government, the design of the new model of care would pool the funds to create a budget envelope, with accountability back to the state Health Department for the subset of funds provided by Victoria. This would be retrospective accountability – that is, cohealth would report back to the department in line with the overall agreed plan, rather than through existing community health minimum data set requirements. Representatives of the Victorian department should participate in the design of new accountability relationships for the multidisciplinary team funding we have proposed.

464 Recommendation 2: We recommend that the Victorian Government agree to allow cohealth to pool some of its current community health funding with proposed new Commonwealth multidisciplinary team funding in primary care.

On capital funding

465 We noted earlier that the Hoddle St Collingwood site has long been recognised as no longer fit for purpose. cohealth does not have the funds to redevelop the site. We note that a proposal has been submitted to the Victorian Government to fund a redevelopment of the site involving facilities for the GP clinic and new social housing. The current site – adjacent to the public housing estate – is a good one, but if an alternative location in the immediate area was preferred, that would also be a good option.

466 Recommendation 3: We recommend that the Victorian Government reconsider the proposal from cohealth for redevelopment of the Hoddle St Collingwood site, or development of an alternative nearby location that will allow access for the Collingwood community.

Recommendations to the Commonwealth Government

467 cohealth is not a unique organisation: it shares many similarities with other Victorian community health services and, indeed, with some services in other states. [109]

468 Solutions developed for cohealth may therefore apply – to a greater or lesser degree – to other community health services around the country. We have heard from a wide range of community health services and similar primary health providers across Australia who report that while viability may be possible for some services, remaining viable in the sector is increasingly challenging, and requires clear, consistent, and ongoing work. Some organisations working with similar populations report smaller operating deficits from GP revenue that may be offset by organisational reserves or by other, better funded, services they provide. However, many similar providers reported that without

[109] Health Equity Coalition, *Investing in Comprehensive Primary Care: Proposal for establishing health equity as a core element in general practice funding models*, Health Equity Coalition (Brisbane, 2025).

changes to current funding levels and structures, they expect to face viability concerns in the future.

469 As the submission from one organisation challenged us:

> While cohealth has specific organisational characteristics, the structural funding and governance issues identified have broader relevance to community health general practice. The Review's findings should therefore be framed with a view to informing how similar services are supported and governed nationally, rather than treating the current circumstances as isolated or exceptional

470 We concluded early in the Review process that there were many factors which led to cohealth's poor financial situation (see **Figure 6**). In our recommendations to the Victorian Government, we address the identified failures in governance and management of cohealth. But they alone do not account for the GP clinic deficits. There are MBS issues too, which will take time to negotiate, design, and implement.

471 It is now well accepted that there needs to be a different approach to funding multidisciplinary care in significantly disadvantages communities. We have argued above that cohealth's current model of care is not financially viable partly because of current MBS funding design.

472 Unfortunately, cohealth's need is urgent. The current model of care is well embedded, and the clinics are impacting organisational viability. Even with effective management that can drive change towards a more effective model of care cohealth's underlying viability requires a different MBS. We know that change in the MBS is coming, but there is no certainty about how soon.

473 But in the meantime, the clinics need to stay open.

On the need for interim support

474 We have argued throughout this report that there are significant cultural issues at cohealth that need to be addressed. The GPs need to be re-engaged; new, clear revenue targets need to be set, communicated, and used for accountability. The excess overheads need to be reined in.

475 There will also be transition issues as cohealth moves to a new funding basis. This transition will need support.

476 Given the size of the culture change required, and the fact that cohealth , the changes we have recommended should be expected to take time. An extension of the interim Commonwealth support funding will be required while these internal changes are put in train, and while funding for more support for multidisciplinary teams is negotiated.

477 Recommendation 4: We recommend that the Commonwealth extend its support to cohealth for a further two year period in which a new funding basis (as we have recommended) can be introduced, and internal changes in cohealth can be embedded to ensure practice viability.

On a new approach to supporting multidisciplinary care, piloted at cohealth

478 Our job is not to redesign the MBS, so we are conscious of a need to chart a course between the Scylla of recognising and addressing cohealth's immediate needs, and the Charybdis of creating an unsustainable precedent in the event that new multidisciplinary payments are introduced in the future.

479 A number of independent experts have suggested potential models for multidisciplinary payments,[110] that would be consistent with a new policy focus on multidisciplinary teams.

480 A new model for multidisciplinary care needs to balance the view that any practice treating patients with multiple chronic conditions – that is, every general practice in Australia – would benefit from better access to multidisciplinary care, against the reality that needs are greater in some populations compared to others.

481 Whatever the future model, it will presumably involve some weighting for practices with higher proportions of more marginalised and sicker patients, recognising the particular importance of multidisciplinary care in these communities. Practices such as cohealth that have a significant proportion of clients living in the two most disadvantaged deciles, defined as greater than 75% of patients drawn from two lower Socio-Economic Indexes for Areas (SEIFA) deciles measured at the lowest geographic area level, would seem to be obvious first priorities.[111]

482 We sketch out below a new, holistic approach to funding. This approach essentially retains elements of item-related billing for attendance items but supplements it with a multidisciplinary care grant based on what otherwise would have been paid as fee-for-service payments.

483 We propose doing that through an existing legislative mechanism, the Health Program Grants, which were introduced as part of the original Medibank implementation to provide flexibility in MBS-like payments.[112]

484 Health Program Grants can be very flexible. We will propose that these Grants replace Medicare billing for GP items (including attendance, assessment, and care planning items) but that cohealth be funded as if those items had been billed in the usual way. We ensure appropriate oversight through the involvement of NWMPHN.

485 The value of the Health Program Grant approach really comes to the fore in the funding multidisciplinary teams where the grant will be determined by 'what might have been' – that is, the cost to the Commonwealth of services that haven't actually been billed for because some cohealth clients facing difficult circumstances are not in a position to avail themselves of their entitlements.

486 Although we have developed separate recommendations for the medical and other team components, we see the Health Program Grant as one pot, which cohealth will have flexibility to allocate, while remaining accountable to NWMPHN both for how they *plan* to spend it and how they *actually* spend it in practice.

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[110] Breadon et al., *A new Medicare: Strengthening general practice*; Health Equity Coalition, *Investing in Comprehensive Primary Care: Proposal for establishing health equity as a core element in general practice funding models*.

[111] SEIFA is calculated by the Australian Bureau of Statistics see https://www.abs.gov.au/websitedbs/censushome.nsf/home/seifa. The lowest geographic area is SA1, much smaller than postcodes see https://www.abs.gov.au/statistics/standards/australian-statistical-geography-standard-asgs-edition-3/jul2021-jun2026/main-structure-and-greater-capital-city-statistical-areas/statistical-area-level-1.

[112] See R. B Scotton and C. R. Macdonald, *Medibank Sources: Unpublished documents relating to the establishment of national helath insurance in Australia* (Fairfield: Centre for Health Program Evaluation, 1995).. ; Neil Thomson, "Australian aboriginal health and health-care," *Social Science & Medicine* 18, no. 11 (1984)., D. Hailey, "Health care technology in Australia," *Health policy* 30 (1994).

487 **Recommendation 5: We recommended the Commonwealth consider using cohealth as a pilot for a new approach to funding multidisciplinary teams in primary medical services.**

488 **Specifically, we recommend that:**

- **The Commonwealth Minister for Health and Ageing provide a Health Program Grant to cohealth under Part IV of Health Insurance Act in lieu of Medicare rebates and the full bulk-billing incentive payments.**
- **The basis for the grant would be rebates calculated according to the cost to the government if services provided by cohealth GPs were billed on Medicare. That is, services provided by cohealth would be notified to the Commonwealth as currently, with the Health Program Grant being based on those notifications.**
- **The grant would be conditional on cohealth not charging any co-payments for medical services, and**
- **appropriate accountability to North Western Melbourne PHN**.

489 This recommendation is cost-neutral but establishes a framework for other payments.[113] Its main purpose is to put in place a mechanism for 'the next step' – that is, to introduce a multidisciplinary team payment in line with the findings and recommendations of the recent swathe of taskforces and reviews. Our proposal will free up cohealth GPs to work at top of their scope of practice, recognise the complexity of their client base, and ensure holistic care.

490 For this to work, cohealth will need to significantly improve its governance, management, and clinical governance processes. We have set out a roadmap for those improvements in our recommendations to the Victorian Government. Indeed, our recommendations for increased Commonwealth investment are predicated on improvements in governance arising from the implementation of our Recommendations to the Victorian Government.

491 A multidisciplinary team payment will allow a shift from a GP-led approach – which is partly driven by weak funding for multidisciplinary care – to an approach centred around primary care teams and community health teams.

492 What we suggest is clearly an interim solution that is specific to cohealth. But any cohealth payment should be absorbed into the general multidisciplinary team framework when it is established.

493 **Recommendation 6: We recommend that the cohealth Health Program Grant incorporate in addition a multidisciplinary team payment based on the number of cohealth clients registered with MyMedicare. The basis of the payment (per patient) should have two components:**

- **85% of what might have been able to be billed by allied health, psychologists or other health professionals under chronic condition and Better Access psychology items. This discount of the allied health and psychology items is to recognise that these items are rarely used to 100% of their value and that some patients may choose or require services outside cohealth.**
- **An amount equivalent to the Workforce Incentive Program – Practice Stream that might otherwise have been paid to cohealth**

[113] Any future model facilitating multidisciplinary care should not involve payments based on pseudo-billing as we have proposed, as the whole point would be to allow greater levels of substitution. We have proposed a pseudo-billing model as we expect cohealth GPs to increase billing in the future to increase their viability.

494 cohealth clients eligible for the multidisciplinary component of the Health Program Grant would not be able to receive rebates for allied health or psychology items at other practices until they ceased their MyMedicare registration at cohealth.[114]

495 This approach to determining the multidisciplinary grant will increase funding flowing to cohealth.

496 It will also probably increase costs to the Commonwealth – but only up to a limit that the Commonwealth was always at risk of spending. That is, because we have based the allocation on existing funding arrangements, this approach effectively 'cashes out' money that has been left on the table by cohealth and its clients.

497 Because these allied health and psychology items are 'Special Appropriations' or 'standing appropriations', a visit to an allied health professional or psychologist automatically generates an obligation to pay a rebate, with no further Parliamentary approval required. What we are suggesting is this notional obligation (if and when a visit occurs) be converted to an actual obligation, to respond to the very clear needs of the cohealth cohort.

498 This would be a pro-equity reallocation, recognising that existing MBS allied health and psychology items entail a co-payment if used, whereas this approach will not.

499 Our proposal builds on the strengths of cohealth: it provides the basis of a best-practice, integrated, multidisciplinary team approach to health care provision. cohealth already has some co-located allied health and counselling services[115] – our proposal will strengthen those and add new dimensions to patient care, especially in care coordination, care navigation, and social work services.[116] All of these respond to the particular needs of the cohealth client base.

500 The new multidisciplinary team approach would support a new model of care in which the proportion of 'Level B' activity provided by cohealth GPs would increase,[117] hence improving practice viability, while at the same time ensuring that the complex needs of cohealth patients are met by health professionals working to their top scope of practice.

501 In this model, GPs would not need to do some of what they currently do because other staff will be able to do work that doesn't require a GP's skills and training. Quite clearly, a GP doesn't need to be in the room for every patient problem. The multidisciplinary payment is designed to facilitate this new model of care that is consistent with the general policy direction towards ensuring that all health professionals work to the top of their scope of practice.[118]

502 The multidisciplinary payment will free up time for GPs to see other patients who could also benefit from their skills, and who are currently missing out on care.

503 cohealth should have considerable autonomy in determining the mix of staffing funded under the multidisciplinary grant. The new grant should not have the same restrictions as apply to what staff can be employed funded from the Workforce Incentive Program – Practice Payment. Rather, the mix should be based on needs, and consistent with a new co-designed model of care. There should be prospective and retrospective

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[114] Alternatively, there may be some mechanism to allow cohealth patients to opt out of this arrangement, whilst retaining the other benefits of MyMedicare registration at cohealth.

[115] Although we recognise that recent decisions appear to weaken multidisciplinarity and colocation.

[116] Colocation is particularly relevant and appropriate for the cohealth client bases.

[117] And as notified to the Commonwealth under the first component of the Health Program Grant

[118] Scope of Practice Review (Reviewer: Mark Cormack), *Unleashing the Potential of our Health Workforce - Final Report of the Scope of Practice Review* (Canberra, 2023).

accountability for the choice of staffing mix to the NWMPHN (and, if Community Health funds are pooled, as we recommend, jointly to the Victorian department).

504 We also recommend specific accountability arrangements for the multidisciplinary component of the Health Program Grant.

Recommendation 7: We recommend that cohealth account to North Western Melbourne PHN (NWMPHN):

- **Prospectively, for how it proposes to spend that allocation; and retrospectively, for how it spent the grant, including number of clients seen and outcomes achieved.**
- **The nature of its community engagement: cohealth should establish robust client and community engagement processes at the municipal level (Maribyrnong, Melbourne and Yarra), and proposals to NWMPHN for use of the multidisciplinary grant should be co-designed using these processes.**
- **Guidance for the approval process might include:**
    - **at most 30% of the funds allocated to corporate overheads and receptionist staff**
    - **a provision for medical practitioners for clinical governance, including a sessional allocation for a medically qualified Director of Primary Care**
    - **at least 10% allocated for activities focused on prevention, including social prescribing, and for supporting community groups.**

505 The goals of this funding structure are:

- to allow medical practitioners to focus on their most value-added roles, by providing funding for nursing, allied health, psychologist, and other professionals such as welfare and social workers who can bring their skills to bear as part of the multidisciplinary team;
- to recognise the additional clinical governance functions involved in multidisciplinary working, and to address the need for increased clinical supervision and governance in work of this complexity;
- to recognise the important role of the group work and community resilience building that was undertaken by cohealth's predecessor organisations and that appears to have diminished over time;
- to reintroduce a form of meaningful community engagement to help redress the severe reputational loss caused by the decision to close general practice services;
- and to achieve this without creating administratively burdensome structures. In particular this model does not require any legislative change, and accountability models should be considered carefully to avoid added administrative burdens.

506 If this pilot were to be rolled out more generally, the grant allocation should be determined on a different basis from that outlined above for potential allied health and psychology billing. The policy direction appears to be toward a 'blended payment' including both funding for the GP time and for the multidisciplinary team. This might include different payment rates for people registered in a practice with one, two, or more chronic conditions; it might involve more sophisticated risk adjustment approaches.[119]

507 If and when a new multidisciplinary team funding approach is rolled out nationally, the interim/pilot funding for cohealth should be rolled into that.

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[119] Stephen Duckett and Paul Agius, "Performance of diagnosis-based risk adjustment measures in a population of sick Australians," *Australian and New Zealand Journal of Public Health* 26, no. 6 (2002). See also Breadon et al., *A new Medicare: Strengthening general practice*.

508 Australian health policy appears addicted to 'pilots' which never proceed to implementation -- 'more pilots than Qantas' – is the refrain.[120] – and we are wary about proposing yet another one. But taking into account that a new multidisciplinary model of care for cohealth is so clearly required, and that a new multidisciplinary team policy is in any case just around the corner, it seems sensible to recommend such a 'pilot' program at cohealth.

509 But if there are to be lessons from the pilot, a clear, funded, evaluation strategy must be put in place, along with, perhaps, an Advisory Panel to oversee the evaluation.

510 The evaluation should cover acceptability and sustainability of the new model of care, and explore measures of impact and effectiveness, where they can be measured in the short term.

511 Recommendation 8: As part of the approval of a pilot of multidisciplinary teams at cohealth, there should be a clear, funded, independent evaluation strategy.

512 A number of submissions from cohealth GPs – and other GPs or GP groups who made submissions to us – proposed new or revised item numbers to deal specifically with clients such as those seen at cohealth. While we have not taken up those suggestions – we have no way of evaluating them in the time available – we suggest that the department reach out to these groups to discuss their proposals.

513 A well-functioning cohealth could be a good training site for general practice registrars. A steady stream of registrars flowing through a revitalised cohealth would benefit the broader primary care system and likely facilitate recruitment to cohealth.

514 Registrars should be encouraged to attend community health services, such as cohealth, where they serve very marginalised populations as part of their training experience.

515 Recommendation 9: We recommend that the Department of Health, Disability and Ageing adds community health services (and other not-for-profit practices) serving high need communities to the list of area of need settings that must be included in GP training.

516 This recommendation could (and should) be implemented quickly.

Recommendations to cohealth

On the service model

517 We observed a significant disconnect between the executive management of cohealth and its medical staff. This contributed to the financial situation created in and by cohealth.

518 In the medium term there needs to be a new approach to provision of primary medical care at cohealth that involves:

- Medical staff working to the top of their scope of practice;
- Integrated multidisciplinary teams providing care;
- Medical staff being held to account for practice styles and billings, including clear billing targets matched with planned and documented supports to assist

[120] See Lauren Richardson, Danielle Romanes, and Peter Breadon, "Six lessons Australia needs to learn from three decades of general practice reform," *Croakey*, 12 January 2023, 2023, https://www.croakey.org/six-lessons-australia-needs-to-learn-from-three-decades-of-general-practice-reform/. Also referenced by Health Minister Butler: Mark Butler, "Address to the Royal Australian College of General Practitioners GP24 Conference," (2024). https://www.health.gov.au/ministers/the-hon-mark-butler-mp/media/minister-for-health-and-aged-care-speech-22-november-2024.

practitioners to achieve their targets without compromising safety and quality of care. The new service model should be co-designed with medical staff and other members of the multidisciplinary team;

- A new role of Director of Primary Medical Care (or similar title), held on a fractional basis, by a specialist general practitioner, preferably one with governance or management qualifications.

519 Our recommendations to the Commonwealth are designed to facilitate this new model of care through multidisciplinary team funding.

520 The creation of a strong system of multidisciplinary care means that longer consultations will no longer be necessary for such a high proportion of clients. This means a greater proportion of a B and C attendances could be 'charged'.[121]

521 With a consistent model of care and team approach, GPs should also be able to reach effective utilisation rates in line with sector norms. This will also improve viability.

522 We have shown above that cohealth's internal management and financial reporting processes are ineffective. Simple standards for good management accountability are not being met.

523 Holding doctors to account is not a straightforward task. Holding them to account when there is no-one medically qualified in the executive team is even less straightforward. This gap needs to be addressed. The role of Lead GPs also needs to be developed. One GP told us

> We had Lead GPs who were paid slightly extra for two hours per week, whose roles were mainly supportive of colleagues, who had little training in reviewing and administering budgets, and who had no decision-making capacity, and essentially reported to middle management

524 Current and former Lead GPs we spoke to had divergent views on whether or not a Position Description existed for the role.

525 The current system of engaging GPs at cohealth is on the basis of salary, which is not atypical in community health services in Victoria.[122]

526 We have no reason to recommend a change to this model. In our view the issue is not one of salary vs contract, but rather how the performance of the GPs is managed and supported, and what billing expectations are.

527 In the absence of clear performance indicators and revenue expectations, it is no wonder that vague 'targets' are not met, or that the clinics are in a poor financial state.

528 With changes in the availability of other team members, longer, less well-remunerated items will not have to be billed so often. This will increase long-term practice viability. But there also crucially needs to be tighter management of the general practitioners, with both clear revenue expectations and appropriate support.

529 **Recommendation 10: We recommend that**

- **cohealth employ a sessional medically qualified Director of Primary Medical Care;**
- **cohealth management co-design with clinical staff (GPs and nurses, for example), a single model of care for all of cohealth's GP clinics that will ensure practice viability in the context of the new revenue streams; and**

[121] Or shadow billed. Strictly speaking, notified to the Commonwealth under the Health Program Grant arrangements.

[122] In our survey of Victorian community health services about half were revenue split, about half salary.

- **cohealth management set clear revenue targets for GPs that are consistent with the revenue streams and the new model of care, and can cover GP salaries, support staff, and a contribution to legitimate overheads.**

530 As we noted above, the Collingwood (Hoddle St) site has not been fit-for-purpose for a decade.

531 Recommendation 11: We recommend cohealth resubmit its proposal for redevelopment of the Hoddle St Collingwood site for a GP clinic with social housing above.[123]

532 cohealth has a higher rate of overheads than is typical in other community health services in Victoria, and this contributes to the financial loss incurred by the GP clinics.

533 Recommendation 12: We recommend cohealth rigorously review levels of overheads and develop a strategy to reduce them in line with levels seen in other Victorian community health services. Overheads should be allocated on a basis more clearly aligned with use.

534 Submissions received by this Review demonstrated the very negative sentiment toward the existing cohealth management from members of the community (see **Table *5***). Community confidence will take some time to rebuild. But it would be facilitated by an honest review of how cohealth engages with local communities, and by finding ways to strengthen that engagement (for example, establishing municipal engagement processes.

535 Recommendation 13: We recommend cohealth formally acknowledge the trauma caused over the last few months to both the communities it serves and its staff, and a) undertake a review of its local engagement processes with a view to rebuilding trust and reestablishing strong local links, and b) develop new mechanisms for staff engagement.

[123] We have included a parallel recommendation to the Victorian Government as recommendation3.

Appendix A: Terms of Reference

Context:

On 18 September 2025, in a letter to the Federal Minister for Health and Ageing, the Hon Mark Butler MP cohealth advised it would commence activity to close its general practice clinics in Fitzroy Collingwood and Kensington in Melbourne.

Through subsequent engagement and negotiation, agreement was reached for cohealth to delay these practice closures until February 2026. The Commonwealth Government agreed to further support the pause on planned closures, through funding of up to $1.5 million provided via the North Western Melbourne PHN, to ensure services remain available to clients until 31 July 2026. As agreed by parties, during this time, an independent review will be undertaken to inform the development of options to support long term arrangements that ensure continued access of vital general practice service to these communities.

Scope of review:

The review will focus on the overall service model at cohealth's general practices, including the clinical service model, operations, governance and financial viability, in the context of the overall funding operations of the organisation. It will enable an informed assessment of suitable longer-term funding options to ensure sustained services to clients. The review will seek to understand the following as they pertain to the clients who access cohealth's GP services:

- understand relevant factors that have contributed, or are contributing to, financial degradation of the general practices, including understanding key drivers of costs, income and expenditure
- understand the impact of the general practice services on cohealth's broader financial outlook (cash flow, liabilities, solvency)
- understand cohealth's approach to budgeting and management of funded activities across the organisation, including activities funded by the Commonwealth and Victorian Governments
- consider the effectiveness of cohealth's governance systems and frameworks, including management, performance and accountability
- consider cohealth's use and design of a multidisciplinary teams in delivering its general practice services
- consider cohealth's client demographics, workforce profile and operating model to understand if it effectively balances client need and administrative efficiency
- identify any opportunities to deliver more efficient clinical service models and operations, and strengthen long term viability, without compromising patient care
- assess whether potential revenue streams from Commonwealth primary care programs are being fully maximised and identify options to improve billing arrangements if required (includes MBS billing, Practice Incentives, Workforce Incentives and Bulk Billing Practice Incentive Payments)
- consider levers/options available to relevant parties (cohealth, the Commonwealth Government, the Victorian Government and the North Western Melbourne Primary Health Network) to improve the capacity, capability and sustainability of the care provided to clients currently utilising the GP clinics.

Desired outcome:

All parties are committed to support people in Fitzroy, Collingwood and Kensington and neighbouring communities to continue to have access to vital general practice services. The desired outcome of the review is to identify options to support the continuation of these services to the community.

Process:

The review will be led by an independent review team with relevant expertise in:

- Health systems
- General practice management
- Community health service models serving populations with complex medical and social needs
- Financial management, in a health services context

The reviewer/s will have a strong understanding of the Australian Health system. The reviewer/s should also have a strong understanding of the funding mechanisms that underpin primary care specifically, as well as innovative funding model solutions that could be applied. The reviewer/s will have experience or understanding of the Victorian Health system, particularly the community health service model, to ensure recommendations align with the system capability.

The review will include assessment of information and data to be provided by cohealth that sufficiently informs the areas in scope of the review, including as they pertain to clients of the general practices:

- Detailed financial information including revenue streams, Australian and Victorian Government funding and operating costs
- Detailed, deidentified, staffing information (e.g. staffing numbers, workloads, functions, classification, salaries and bands)
- Deidentified information about client needs, disease burden, MBS billing and services provided
- Other organisational information identified as relevant and/or necessary to informing the review's purpose and scope including but not limited to organisational governance and internal controls.

The review will also consider the uptake and/or availability of non-monetary supports which may improve the capacity or service offer of cohealth general practices (for example, capacity support provided through Primary Health Networks as well as alternate clinical models and associated funding approaches)).

The review will include a schedule of interviews with key stakeholders including (but not limited to) cohealth Board and Executive, cohealth general practice staff, the North Western Melbourne Primary Health Network and, with appropriate protections and sensitivities, clients/patients.

The review will be supported by a Steering Committee of senior representatives from the Department of Health, Disability and Ageing, the Department of Health, Victoria and the North Western Melbourne Primary Health Network. The reference group will guide the review to ensure it is progressing effectively and on time (noting the urgency of the review), and to provide relevant context or information required to inform the review and provide transparency to all parties. The reference group will maintain regular engagement with the cohealth Executive and Board.

Assumptions:

The following assumptions relevant to the success of the review are made:

- persons undertaking the review will have suitable expertise and knowledge to undertake relevant assessment and provide advice
- persons undertaking the review will have access to all relevant information from cohealth to inform their assessment and recommendations
- cohealth GP services will remain open until at least 31 July 2026, allowing this work to inform future options to sustain services into the future
- the Commonwealth, through the Department of Health, Disability and Ageing, and the Victorian State Government through Department of Health, Victoria, will provide relevant information / documentation, to support the review.

Outputs:

The review will provide a report jointly to the Commonwealth Department of Health, Disability and Ageing, and the Department of Health, Victoria. The report should provide key insights and observations relevant to the scope of the review.

The review should provide options, and make recommendations to all parties (cohealth, Commonwealth and State Governments) that will serve to address the key purpose of the review, that is, to support sustained and continued access of general practice services to people in Fitzroy, Collingwood, Kensington and neighbouring communities.

The review will deliver a final report by 28 February 2026, to be held in confidence by departments, in addition to a summary report, which on agreement of all parties, may be subject to public release.

General Requirements:

- The reviewer/s will work in a respectful, culturally appropriate and sensitive manner with cohealth Board, executive management and staff
- the reviewer/s will engage sensitively with staff and others affected by, and under pressure due to, the instability of cohealth's general practice services and high community interest and concern
- the reviewer/s will provide regular updates, oral and written, on progress of the review and to address any significant matters limiting progress
- reviewer/s and other parties as required, will attend specified meetings with the Department of Health, Disability and Ageing and Department of Health, Victoria and/or cohealth
- the reviewer/s will uphold standards of probity, transparency and accountability, consistent with existing Commonwealth Procurement Rules, regulations and integrity frameworks.

Mapping to the terms of reference

Table 10 maps where we have addressed each of the items in our terms of reference.

Table 10: Mapping of Terms of reference to sections of the Report

Terms of reference	Relevant Report sections
understand relevant factors that have contributed, or are contributing to, financial degradation of the general practices, including understanding key drivers of costs, income and expenditure	See section 5. The Review confirms that cohealth is making a loss on its GP clinics and Appendix B: cohealth - Historical Financial Analysis Report
understand the impact of the general practice services on cohealth's broader financial outlook (cash flow, liabilities, solvency)	Appendix B: cohealth - Historical Financial Analysis Report
understand cohealth's approach to budgeting and management of funded activities across the organisation, including activities funded by the Commonwealth and Victorian Governments	See sections 6. There was inadequate risk management and ineffective governance/oversight of cohealth's financial situation and 7. There was inadequate and ineffective management oversight of the clinics
consider the effectiveness of cohealth's governance systems and frameworks, including management, performance and accountability	See sections 6. There was inadequate risk management and ineffective governance/oversight of cohealth's financial situation and 7. There was inadequate and ineffective management oversight of the clinics
consider cohealth's use and design of a multidisciplinary teams in delivering its general practice services	See subsection on cohealth's model(s) of care
consider cohealth's client demographics, workforce profile and operating model to understand if it effectively balances client need and administrative efficiency	536 See section 2. What is cohealth and what does it do? And section cohealth owns or occupies many facilities, some of them acquired since cohealth's last infrastructure plan. We were told that some are not fully utilised. This points to the need for cohealth to regularly refresh its capital infrastructure plan. 8. The clinic financial loss was also partly driven by factors beyond cohealth's control: the client mix, cohealth model(s) of care, and the MBS
identify any opportunities to deliver more efficient clinical service models and operations, and strengthen long term viability, without compromising patient care	See section What cohealth needs to do
assess whether potential revenue streams from Commonwealth primary care programs are being fully maximised and identify options to improve billing arrangements if required (includes MBS billing, Practice Incentives,	See subsection The current MBS approach and Appendix C: Opportunity for additional MBS billing

Workforce Incentives and Bulk Billing Practice Incentive Payments)	
consider levers/options available to relevant parties (cohealth, the Commonwealth Government, the Victorian Government and the North Western Melbourne Primary Health Network) to improve the capacity, capability and sustainability of the care provided to clients currently utilising the GP clinics.	See section 11. Where to from here? Recommendations