FOI 27-3503 - Document 1

Australian Government

Department of Health, Disability and Ageing

General Practice Incentive Fund: Preliminary discussion with Jurisdictions

Western Australia

Date: 4 August 2025, 1100-1200 (WST)

Location: Online (Teams)

Attendees:

- DOHDA: s22
- WAPHA: s47F
- WA Department of Health: s47F
- WACHS: s47F

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1. Welcome

s22 welcomed members and provided the opportunity for introductions.

2. Presentation

s22 discussed the side deck, outlining:

- Background and issues defining a "thin market"
- Current state with 11 sites across Australia underway
- Requirements for eligibility and funding
- Proposed new GoGS and changes to make it more streamlined
- Site selection as a flexible a process

3. Discussion

a. Newman

s22 presented information about Newmans current situation

- 1 Locum and a nurse 3/7, is supplied by a corporate company.
- Population is 7246 (approx. 40% Aboriginal and Torres Strait Islander)
- Low rates of CMPs (13%) and MH plans (7%)
- About 2% of private practice patients identify as Aboriginal and Torres Strait Islander.
- s22 is well managed and resourced but does not provide services for non-only indigenous patients.

FOI 27-3503 - Document 1

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- Uncertain of occupational medicine and bulkbilling rates at this stage.

Attendees discussed that Newman has a stable hospital staff currently with a new hospital and low activity.

Shared employments and staffing models –

- May enhance attraction of younger drs and
- Has worked (e.g. RFDS and AMSs) and are being trialled (e.g. Kununurra) in other places.
- It could include different professions.
- May be well placed as a teaching hub.
- Would need to be discussed with the corporate provider before any deliberations.

Does not have a *s19(2)* exemption.

Newman is considered a large town with many supports. It has a large contingent of industry generating good income levels. This should be considered when deliberating site selection.

b. Carnarvon

Overall Carnarvon is considered an attractive place to work, however some instability in the healthcare workforce and social issues have promoted a poor public image. The town is considered a hub for surrounding areas and has access to valued coastal areas.

WACHS have governance of the Coral Bay nursing post and ETS in Denham, with a Nurse Practitioner available. There is ongoing pressure for a GP to visit Denham.

Although Carnarvon may have more to offer health staff than Newman it is unclear if it is a thin market.

The background work is underdevelopment and will be provided at the next meeting.

c. Northampton/Kalbarri

Northampton practice is closed with Kalbarri soon to follow suit. Although Northampton is a 50km drive to the large, well-serviced city of Geraldton, some people will not have transport to appointments.

Kalbarri is more isolated than Northampton and is a long drive off the main highway with many nighttime risks.

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s47G

d. Wheatbelt

Issues have been raised by the LGA's concerning large contracts they have with a commercial provider of GP services across many towns. The private enterprise has provided 31 drs over 27 towns and anecdotally appears to have been successful in preventing avoidable transport and hospital activity.

The LGAs are workshopping for new models and are in contact via several avenues to raise the issue of the ongoing use of rates for this purpose.

Using a commercial enterprise may be a good model for other situations, however it was decided that GPIF may not be the right program to assist the LGA's with this issue.

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4. Outcomes

- More information is required to uncover the issues at Carnarvon and Newman to decide if either of these sites is a thin market.
- Kalbarri is near to closing and may prove to be a successful site to support.
- Only one invitation will be issued to WA.
- Wheatbelt will not be considered for this program at this time.

5. Next Steps

s47F will follow up on information around Carnarvon and Newman.

s22 will organize a follow-up meeting for next week.

6. Attachments:

a. Slide deck
b. Email from LGA

FOI 27-3503 - Document 2

Australian Government

Department of Health, Disability and Ageing

GPIF: Monthly Meeting
Jurisdiction: Western Australia – WAPHA
Sites: Kununurra and Newman

Date: 3 February 2026, 10:30 – 11:00AM AEDT
Location: Online (Teams)

Attendees:

DHDA – s22 (Minutes)
WAPHA – s47F

Introductions:

s22 welcomed members and provided an opportunity for introductions.

Meeting notes:

Kununurra – Phase 2

1. Change Management & Site Visit Update (s47F)

Overview of Visit

- s47F from s47G (evaluator) visited Kununurra last week for two full days of meetings, including 1:1 consultations and engagement with local health services.
- Meetings included Newman Hospital, WACHS allied health service team, s47G, headspace, the Kununurra withdrawal intervention centre, and met new staff at s47G the chronic disease nurse and s47F the allied health program manager.

Change Management Progress

- Met with s47F, now leading change management.
- s47 has already achieved significant progress, attended all key meetings and working closely with the s47G team and evaluators.
- Improvements observed in staff communication, role clarity, and process alignment.

Discussion

s22

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2. Allied Health & Podiatry Workforce (s47F

Locum Workforce Coverage

- s47F a locum podiatrist brought in from outside the region, provided her first locum in January completing 59 occasions of service over 3.75 clinical days.
- Another podiatrist is in negotiation with s47G to provide the ongoing FIFO service,
- Due to workload and limited capacity, s47F is unlikely to be able to support Newman.
- s47F (Allied Health Program Manager) has worked with s47G to clear a large referral backlog and transfer patients so they could be seen sooner.

Discussion

s22 noted locum arrangements are standard in remote areas.
s22 highlighted the importance of PHN linkages in maintaining cross-site workforce stability.

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3. Financial Review & Sustainability (s47F

Key Outcomes

s47G

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Issues Identified

s47G

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s47G

Next Steps

s47G

- An updated Project Status Report (PSR) will be provided.

Action

- WAPHA to send funding-extension advice for WAPHA Executive consideration.

Newman – Phase 1

1. Service Model & Stakeholder Consultation (s47F

SSRP Status

- SSRP remains on track for 13 February.
- Letters of support obtained from all attendees consulted through the co-design workshops.
- Stakeholders were advised the SSRP is de-identified for commissioning purposes .

---

2. Dental Services

Key Issues

- s47F met with Dental Health Services (DHS), s47F and the executive team, and was advised that government dental facilities cannot be used by private providers as planned.
- s47G
- Previous State block-funded dental services were delivered in 2024 and 2025, with another block scheduled for 24 March 2026.
- s47G
- Alternative facility options were briefly discussed; further assessment is required to determine feasibility and long-term sustainability.

Discussion

- s22 noted this may require a community media release to clarify removal of dental from scope if confirmed.

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- s47F meeting again with DHS for model and to discuss longer-term sustainability.

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3. Workforce, Model Costs & Sustainability

Current Workforce Model

- s47G
-
-

Costing

- Current model cost: s47G
- Consumables and associated costs are still being finalised and may change once dental requirements are confirmed.

Discussion: Program Management Roles

- Question raised relating to funding of PHN staff through the Grant. This is being followed up directly with the thin markets team and PHN Branch. There was discussion about whether a full-time manager could be repurposed to provide program management functions rather than short-term local arrangements, and s47F will explore this further.
- Clarification was sought regarding the function of the 1.0 FTE Aboriginal Coordinator, with s47F noting broad unmet allied health needs across the community.
- Recruitment timeframes need to align with the requirement that activity concludes by 30 June 2027, with differing views expressed on whether recruitment should commence in March or later to support a full 12-month tenure.

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4. Contracts & Delegations (s22

Update

- No DOV yet for Phase 1 Newman. s22 expects it will arrive before 13 February.
- s22 noted program funding assessments may not allow for front-loaded payments; milestone structure may be more appropriate.

Action

- s22 to send funding-extension advice for WAPHA Executive consideration.

Other Business: Expansion Opportunities under GPIF Program

- Potential WA locations were discussed, including the Wheatbelt as per previous email in December and options such as Halls Creek or Fitzroy Valley were internally discussed and not supported .

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- It was noted that any expansion should take account of PHN resource constraints, and that further exploration should occur only after discussions with the WAPHA Executive team.
- Broader service requirements for remote areas, such as Halls Creek, were highlighted as a factor in determining site suitability.

Action Register

- s22 **to send funding-extension advice for WAPHA Executive consideration:**
  Owner: s22
  Due: 4 Feb 2026
- **WAPHA to provide the updated Project Status Report (PSR)**
  Owner: s47F
  Due: After meeting
- **Circulate updated media story draft for review**
  Owner: s47F /s22 to review
  Due: Completed
- **Update Terms of Reference and confirm governance reporting approach in writing**
  Owner: s47F /s22 to review
  Due: Completed
- **Track contract delegation process and prepare communications noting expected January sign-off**
  Owner: s22
  Due: Ongoing
- **Explore WA expansion options (e.g., Wheatbelt and test viability with** s47F
  Owner: s47F
  Due: Feb / Mar

Minutes reviewed by s22 *and* s47F *10/02/2026*

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Australian Government
Department of Health, Disability and Ageing

Ministerial Information Request
MB26-001629
Version (1)
Date sent to MO: 30 June 2026

To: **Minister Butler**

Subject/Issue: **MIR - WALGA 2025 General Practice Support Survey Report**

Comments:			
Contact Officer:	s22	Director, Workforce Distribution Branch, Workforce Division	Ph: (02) s22 Mobile: s22
Clearance Officer:	Stewart Webster	Assistant Secretary, Workforce Distribution Branch, Workforce Division	Ph: (02) s22 Mobile: s22

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Response:

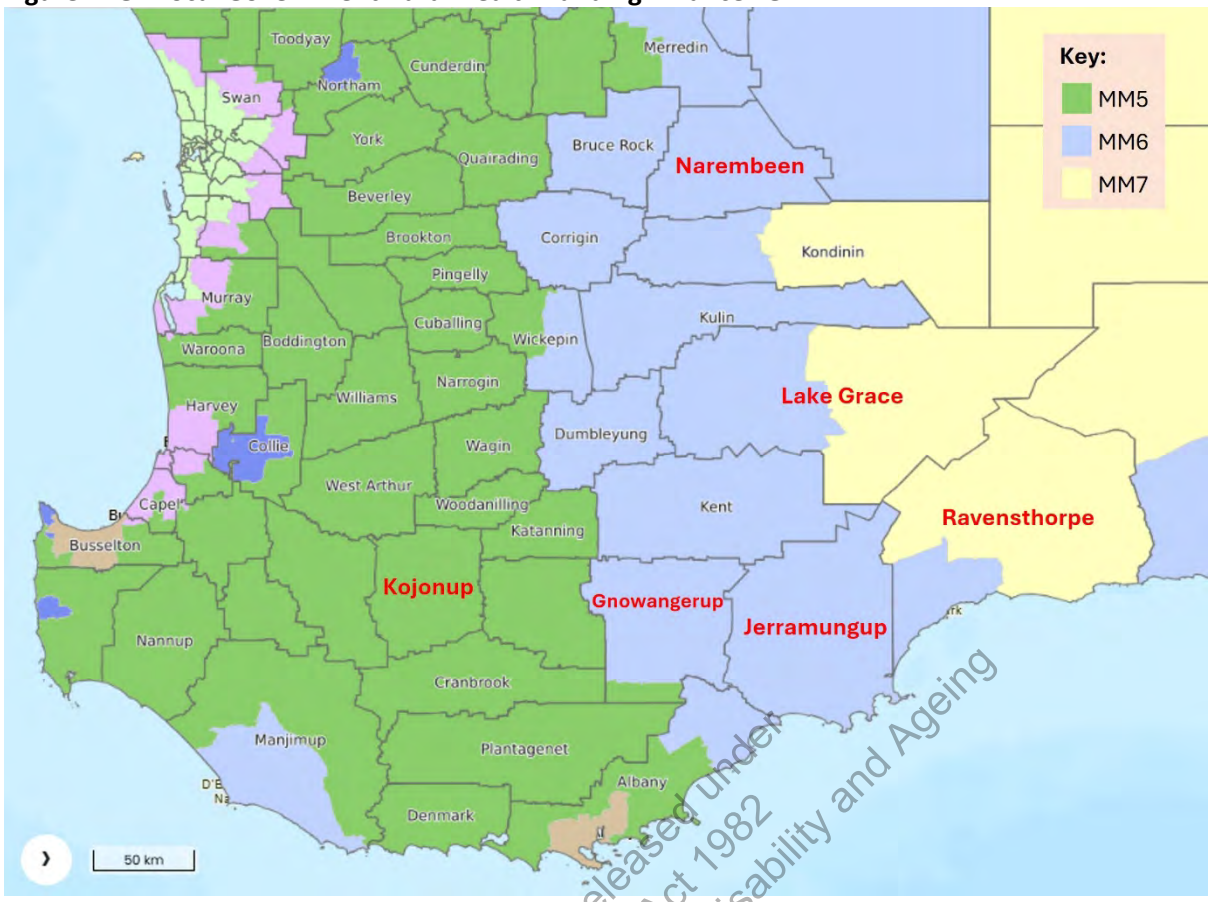
- The Local Government Rural Health Funding Alliance (Alliance) is a collaboration of six rural Western Australian local governments that formed in 2024 to address the cost of attracting and retaining GPs in remote and very remote communities.
- Each of the Local Government Areas (LGAs) that form the Alliance lie primarily in remote communities (Modified Monash Model (MMM) 6 areas) - refer to Table 1 and Figure 1.

Table 1: GP data in the Local Government Rural Health Funding Alliance region

Alliance LGA	GP FTE (2025)	GP FTE per 100,000 residents (2025)	Number of GP clinics (2026)	Estimated Resident Population (2024)
Gnowangerup (MM6)	0.9	71.6	1	1,271
Jerramungup (MM6)	0.6	47.0	2	1,217
Kojonup (MM5)	2.1	105.4	1	1,965
Lake Grace (MM6-7)	0.5	36.5	2	1,319
Narembeen (MM6)	0.8	88.8	1	1,319
Ravensthorpe (MM7)	1.5	67.8	3	2,280

**Data sourced from HeaDS UPP 22 June 2026*

Figure 2: GP Local Government Rural Health Funding Alliance LGA



**Data sourced from HeaDS UPP 22 June 2026*

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Standard words:

- The Australian Government is committed to improving access to health services for all Australians. The Government recognises the unique challenges facing the health system in regional, rural and remote areas, and is focused on improving the capacity, quality and distribution of health services to meet the needs of these communities.
- General practices are private businesses and make their own commercial decisions on how they operate.
- The Government funds a range of targeted programs to provide incentives for doctors to move to, and remain working in, areas of workforce shortage in Australia.
    - These programs also aim to support health professionals and practices to recruit, retain, and upskill staff.
    - Eligibility for incentive programs is based on the MM classification system. As MM 5-7 areas, general practices located across the LGAs within the Alliance are eligible for greater support than other parts of Australia.
    - A comprehensive list of incentives and support available to practices and doctors in MM 5-7 areas can be found at www.health.gov.au/resources/collections/incentives-and-support-for-gps-and-general-practices-in-mm-locations.
- The Government funds a network of Primary Health Networks and Rural Workforce Agencies, to provide support for GP practices and communities to ensure service continuity.
    - The PHN for Western Australia (WA) is the WA Primary Health Alliance and can be contacted on (08) 6272 4900 or via their website at www.wapha.org.au

    - The RWA for WA is Rural Health West and can be contacted on (08) 6389 4500 or via their website at www.ruralhealthwest.com.au.
- The Government has invested in the Bonded Medical Program and its predecessor programs since 2001. The Program increases the number of Commonwealth Supported Places (CSP) for medical students at Australian universities. These extra CSPs are funded on condition that participants complete 156 weeks work as a doctor in in regional, rural or remote (MM2 to 7) locations, or an MM1 outer metropolitan Distribution Priority Area (DPA - for GPs) or District of Workforce Shortage (DWS - for non-GP specialists) after they graduate. Australian universities must allocate 28.5% of CSPs to the Program, meaning approximately 900 new Bonded medical students each year, who will later provide healthcare services in areas of need.
- The DPA classification system identifies areas experiencing lower levels of GP services compared to a benchmark level of access.
    - DPA status means general practices have access to an expanded pool of doctors from which they may recruit, including overseas trained doctors and Australian trained Bonded doctors.
    - As MM 5-7 areas, all LGAs within the Alliance are automatically DPA.
- In late 2024, the Government published the final reports from four reviews that made recommendations to strengthen Australia's primary care system and health workforce, including for rural and remote communities
    - The Government will continue to consult with the health sector as it considers the findings of these reviews
    - Further information and copies of the reports are available at www.health.gov.au/committees-and-groups/primary-care-and-workforce-reviews-taskforce.

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Sensitivities:

- The Department of Health, Disability and Ageing met with the Alliance in September 2025 to discuss funding opportunities available to them. The Alliance were specifically seeking the General Practice Incentive Fund (GPIF) grant funding. The Alliance were:
    - informed that the Wheatbelt and Great Southern regions of WA were considered for intervention under the GPIF; however, were not prioritised for funding
    - directed to GrantConnect to locate any grant opportunities that may be appropriate to support them
    - advised of the annual Budget submission process through Treasury.

Consultations: The department's Primary Care Division, Workforce Data Intelligence Unit and Rural and First Nations Workforce Branch were consulted in the development of this brief.

Minister	**Minister Butler**
PDR Number	**MB26-001629**
Subject	**MIR - WALGA 2025 General Practice Support Survey Report**
Contact Officer	s22
Clearance Officer	Stewart Webster s22
Division/Branch	|Health Resourcing| Workforce Division| Workforce Distribution
Has Budget Branch been consulted if there are financial implications?	Not Applicable
Ensuring connected products across the Portfolio	Have disability/NDIS linkages been considered and outlined as relevant? YES ☐ NO ☐N/A ☒ Have aged care linkages been considered and outlined as relevant YES ☐ NO ☐ N/A ☒

Adviser/DLO comments:	Returned to Dept for: REDRAFT ☐ NFA ☐

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From: s47F
To: s22 ; s47F
Cc: Thin Markets Development and Implementation; s22 ; s47F
Subject: RE: General Practice Incentive Fund Grant Opportunity. [SEC=OFFICIAL]
Date: Monday, 28 July 2025 12:23:46 PM
Attachments: image001.png
WA Primary Care in Thin Markets_March 2024.docx

OFFICIAL

Hi s22
s47F and I will be the WA contacts for the Department of Health.
I have attached a draft document from March 2024 that was developed in collaboration with WAPHA.
It identified Newman and Carnarvon as potential 'thin market' sites also.
As well as WACHS representatives, it would also be worth including WAPHA (s47F) and Rural Health West (s47F) in early discussions as this was beneficial in the past round of discussions.
Many thanks,

s47F
A/Director | Strategic Workforce & Development Directorate | Clinical Excellence Division
Department of Health
2nd Floor C Block, 189 Royal St, EAST PERTH WA 6004
T: 08 9222 s47F
E: s47F @health.wa.gov.au
If my email arrives in your inbox outside your usual working hours, please know that I do not expect you to read, act, or reply until you are back in the office.

From: s22
Sent: Monday, 28 July 2025 9:09 AM
To: s47F
Cc: Thin Markets Development and Implementation ; s22
Subject: General Practice Incentive Fund Grant Opportunity. [SEC=OFFICIAL]

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Good morning, s47F and s47F
I hope you are both well. Apologies if you have received multiple emails.
The purpose of this email is to explore early discussions with jurisdictions and PHNs regarding the potential establishment of new sites under the General Practice Incentive Fund (GPIF).
The objective of the GPIF grant opportunity is to improve the provision of, and access to, primary health and care support services in areas where there is limited or unstable access to health, medical, care and support service systems.
Further information on the GPIF opportunity is available here:
Current Grant Opportunity View - GO6695: GrantConnect

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To date GPIF work has commenced in relation to 10 sites across QLD, NSW, VIC, WA, TAS, NT and SA with implementation of recovery plans progressing in Far North Queensland (Cassowary Coast), Victoria (Loddon Mallee), Northern Territory (Berry Springs and Nhulunbuy), Tasmania (Huon Valley), and Western Australia (Kununurra) . These efforts have supported the maintenance or resumption of services that were otherwise at risk of closure and provided valuable insights into scalable models of care.

In Western Australia, Kununurra has been established as a GPIF site focusing on increasing allied health access and practice review and support. The Service System Recovery Plan has been approved and funded and will commence implementation in the next few weeks.

We are now exploring the possibility of additional GPIF sites, and your input will be critical in shaping decisions. Please note:

- **These discussions are exploratory only** – no guarantees can be made at this stage regarding site selection or funding.
- **Funding availability remains uncertain**, and any future investment will be subject to further assessment and approval.
- **New Grant Opportunity Guidelines (GoGs)** are being developed, the new GoGs are proposed to streamline the phase 1 process and require a 12-week period of Service System Recovery Plan co-design.

Next Steps: We would welcome the opportunity to engage with you to:

- Identify potential site opportunities aligned with GPIF objectives
- Undertake preliminary site assessments
- Collaborate with jurisdictions, PHNs and other partners to understand local needs and readiness

We believe early engagement will help ensure any future proposals are well-informed and grounded in local context. Please let us know a suitable contact person from your team so that we can commence these discussions as soon as possible.

Thank you for your continued partnership and support.

regards

s22

Director

Thin Markets

Workforce Distribution Branch | Health Workforce Division

Australian Government, Department of Health. Disability and Ageing

s22 @health.gov.au

40 The Esplanade, Perth, Western Australia, 6000

The Department of Health and Aged Care acknowledges First Nations peoples as the Traditional Owners of Country throughout Australia, and their continuing connection to land, sea and community. We pay our respects to them and their cultures, and to all Elders both past and present.

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Western Australian Primary Care in Thin Markets

Background

During 2022-23, a number of communities experienced a loss of general practice services where existing providers ceased operating at short or no notice, leaving communities without access to GP services. Review of these events and ongoing monitoring of communities that were perceived to be at risk highlighted:

a) Smaller rural and regional communities where there was only one general practice, or a single practice that dominated the market were most at risk;
b) Challenges facing general practices in these communities often related to critical mass, and these challenges were experienced by other health, care and support services.
c) Any response to these communities where failure occurs needs to be timely and ideally will involve support for the health, aged care and disability system serving the community, rather than just one component.

The 2023-24 Budget included the Strengthening Medicare – Support for Health, Care and Support Services in Thin Markets measure which provides for:

- Funding of $16.55m for 2023-24 to extend the GP Incentive Fund. This will allow resources to be allocated to PHNs where market failure occurs to commission additional services.
- Scoping and developing an innovative approach to increase capacity through PHNs in thin markets to be presented in the 2024-25 budget process.
- A stocktake and review of policy and program levers to support responses in thin markets to be presented in the 2024-25 Budget process.

In commissioning additional services, PHNs will be required to work closely with local service providers, including LHNs/LHDs/HHS, aged care, disability and key community stakeholders to develop a plan to support recovery and stabilising the local service system. The PHN will be funded to commission the range of additional services and support encompassed by the approved recovery plan. Interventions that may occur over the coming 12 months will provide an opportunity to test current thinking about thin markets and inform the development of a longer-term approach to enhance the capacity of health, care and support service systems in thin markets.

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Purpose of this document

To determine a path forward for WA Primary Health Alliance (WAPHA), WA Country Health Service, (WACHS), Rural Health West and WA Health to work cooperatively in pursuing Commonwealth support for communities where there may be interventions and governance arrangements. This includes agreeing on circumstances that WA would want to prioritise in putting forward proposals to the Commonwealth for intervention in the thin markets, under its 2023/23 Budget initiative. This document will provide an initial identification of a priority community for WA, in being proactive in responding to the Commonwealth, when further eligibility criteria is received.

What do we know as of November 2023?

- Commonwealth are finalising the grant guidelines to form and shape where DHAC might intervene in thin markets.
- No decisions have been made yet re what level of deployment there will be this financial year, will not roll something out across every PHN region in this FY, and do not have a number or quota they are working to.
- Grant opportunity guidelines should be released in approximately 4 weeks (but can't promise that).

Update on findings and consultations (s47F)

- Viewing primary care in isolation doesn't make sense - need to consider all sectors particularly in smaller communities.

- Economics - in some areas access to bulk billing difficult to find. Where that situation occurs, access issues for disadvantaged populations occur.
- Specialist areas - procedural specialities - lack of access outside of metropolitan areas - affordability - significant gap payment.
- No market.
- Shouldn't wait for markets to fall over - There was some suggestion to pick a difficult place so that conceptual frameworks can be tested.
- Lack of access was suggested as the priority topic. (overarching theme)
- Process - service system recovery plan. Discussed who does the planning - different in each setting, reliant on organisation or stakeholder who is trusted and respected by the stakeholders in that area vs. ordaining an organisation to do this from a blanket perspective.

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Western Australian Primary Care in Thin Markets

WAPHA Thin Market Definition

Where the market is typically characterised by limited number of services with longer than average wait times. Ease of access is compromised and there is limited-service diversity or sufficiency.

Stakeholder Consultation Document Phase 1: Indicators of thin and failing markets

Over the past 12 months there have been situations where the operation of health (primary and acute), care and support service markets have failed, or experienced ongoing challenges. The characteristics of these settings include:

- smaller communities
- two or less practices
- limited interaction between related services (primary, acute, aged care and support services)
- limited access to alternative services within easy distance
- an ageing workforce.

WAPHA recommended pilot sites

Based on the above characteristics of the thin market settings, WAPHA has utilised both quantitative data measures such as: having an ERP of less than 10,000, have two or less general practices, and have an ageing workforce whereby general practitioners have indicated the intention to retire/relocate in the next 1 to 5 years, and overlayed qualitative data to determine the top 3 locations for rural and remote areas of Western Australia. These are:

1. **Newman:** ERP of 7171, one AMS and one GP practice, noting that one GP practice closed on 21st July, and another opened on 26th July 2023. This may be indicative of the challenges within the region to sustain the practice business. Further, one GP has expressed the intention to retire/relocate in the next five years. The town is located approximately 452 km from the nearest hospital of Port Hedland.
2. **Kununurra:** ERP of 8053, one AMS and one GP practice, eight GPs with the intention to retire/relocate in the next five years. The town is located approximately 1051.2 km from the nearest major service of Broome.
3. **Carnarvon:** ERP of 5706, one GP practice and one AMS, six GPs with the intention to retire/relocate in the next five years. The town is located approximately 476 km to the nearest hospital in Geraldton.

Norseman exploration: a population of 699 and one private general practice I-Medical.

	Inflow Geography	Number of Services (flows)	Percentage of Total Services
1	Esperance	602	14.9

	Outflow geography	Number of Services (flows)	Percentage of Total Services
1	Kalgoorlie - Boulder	348	10.2

WACHS recommended pilot site/s

DRAFT
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From: s47F
To: s22
Subject: FW: Local Government Rural Health Funding Alliance - Preferred GP Service Model
Date: Thursday, 18 September 2025 8:15:42 AM
Attachments: download_bf192ed7-f23c-46a8-8474-cdc200798582.jpg
phone_6d15a229-3492-44cd-9ab9-d785972ec022.png
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facebook_eeba47a2-77eb-42f0-8449-4c1fe0d0acf9.png
image233507.png
image801398.png
image345388.png
image520720.png
image481284.png
image756228.png
image280010.png
LGRHFA_Preferred GP Service Model_Final.pdf

REMINDER: Think before you click! This email originated from outside our organisation. Only click links or open attachments if you recognise the sender and know the content is safe.

Good morning s22
WAPHA has been contacted again by Cr Len Armstrong, Shire President of Lake Grace in relation to the Alliance of Shires seeking funding for their new model of care.
As you are aware Len knew about the thin markets funding for Kununurra from his meeting on 24 June 2025 with the National Rural Health Commissioner, Professor Jenny May AM and to approach WAPHA and others to discuss this.
Len called me on 27 August to advise they were finalising the model of care. I was clear the decision in relation to thin markets funding is directed by the DHDA, not WAPHA.
I also advised s47F from RHW advised s47F from WALGA is leading a workshop in collaboration with Rural Health West in October. My advice to Len was to work with WALGA as they have the advocacy role, there is nothing WAPHA can do to fund this.
The party line I have utilised so far is from the Grant:
The identification of sites where the grant may be applied will rest with the department and be informed through negotiation with relevant jurisdiction (state or territory government) and PHN, RWA specific to the location) giving consideration to potential risk of sites losing access to services or the sustainability of local service systems.
Given we have discussed this together, and Len is contacting all and sundry, is there any further update from DHDA from our previous conversations prior to WAPHA responding to his email below.
Kind regards

s47F
| **Senior Manager - Workforce Prioritisation and Planning**
My pronouns are she/her
s47F @wapha.org.au | www.wapha.org.au
08 s47F
On Yamatji Country | s47F , Geraldton WA 6530

Linkedin Twitter Facebook Youtube

We acknowledge and pay respect to the Traditional Owners and Elders of this country and recognise the significant importance of their cultural heritage, values and beliefs.

We acknowledge and welcome all members of the LGBTIQA+ communities and celebrate the extraordinary diversity of people's bodies, identities, relationships and experiences.

We gratefully acknowledge the financial and other support from the Australian Government Department of Health, Disability and Ageing.

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From: Cr Len Armstrong
Sent: Wednesday, 17 September 2025 3:16 PM
To: s47F
Subject: Local Government Rural Health Funding Alliance - Preferred GP Service Model
Good morning s47F
I have attached the Preferred GP Service Model prepared by the Local Government Rural Health Funding Alliance.
In addition the Alliance would like to formally request funding for the model as a pilot under the WA Primary Health Alliance Innovation Funding. Please let me know if this is possible and if so what would need to be done to achieve this.
Kind regards,
Cr Len Armstrong
Shire President

download.jpg



Shire of Lake Grace
Address: 1 Bishop Street, Lake Grace WA 6353
Postal Address: PO Box 50, Lake Grace, WA 6353
Phone: (08) 9890 2500
Fax: (08) 9890 2599
Website: www.lakegrace.wa.gov.au
Facebook: www.facebook.com/ShireofLakeGrace

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PREFERRED

GP SERVICE MODEL

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Prepared By

LOCAL GOVERNMENT RURAL HEALTH FUNDING ALLIANCE

LOCAL GOVERNMENT RURAL HEALTH FUNDING ALLIANCE

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

Local governments in remote and very remote areas (traditionally classified as Monash Model 5, 6 and 7) are increasingly stepping in to fund and manage primary healthcare services—an area under the purview of State and Commonwealth governments. Collectively, the six Shires contribute over **$1.475 million annually** in cash. These cash contributions are directly from rates – for some in the Alliance it accounts for 16% of their rate income. Housing, vehicles, fuel cards, facilities, and telecommunications are also provided to attract and retain GPs.

The National Rural Health Alliance recently released a report detailing the comparative Government health spend between major city residents and rural and remote Australia. It showed a gap of $6.55 billion, which is a health spend shortfall of $848 per person in rural and remote Australia. Given the challenges, those that live in rural and remote Australia should be seeing a greater investment in health service expenditure by the State and Commonwealth governments, instead the third tier of government is paying the gap.

The Alliance was formed because the provision of a GP is not their legislated responsibility, yet without their intervention, communities face poorer health outcomes, reduced life expectancy by 7yrs, and economic vulnerability.

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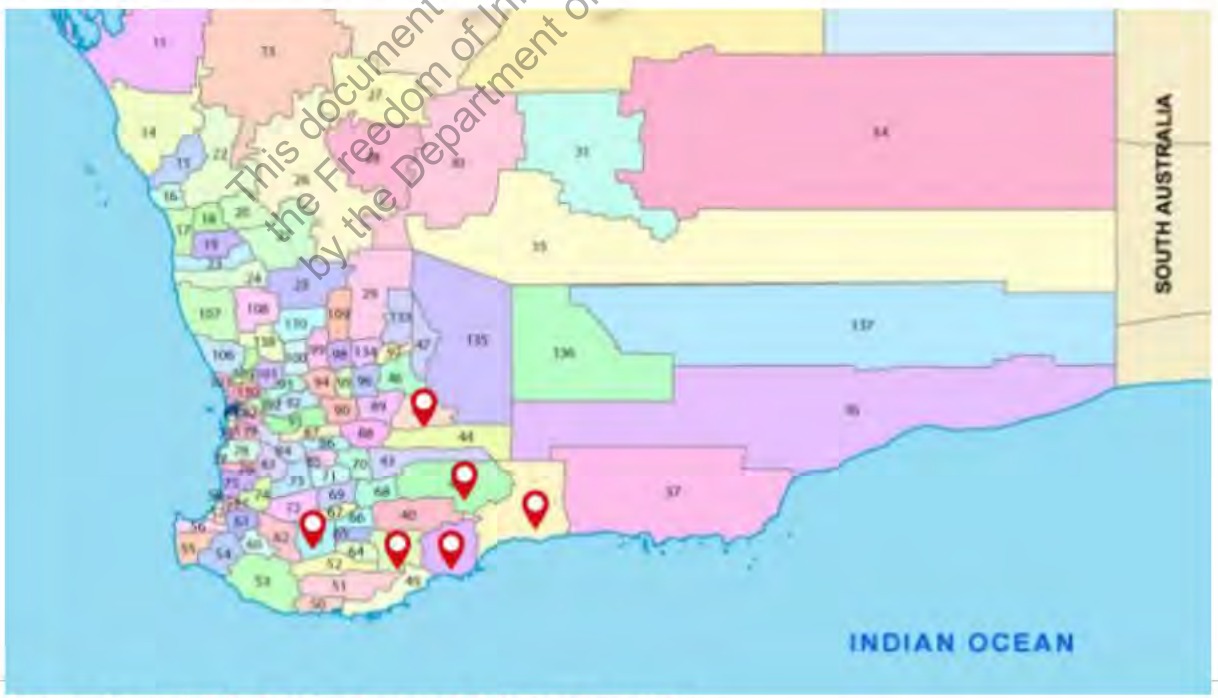


Figure. Founding Local Government Alliance members

Executive Summary

The Challenge

- Rural and remote Australians experience poorer health outcomes due to limited access to primary care.
- They have **higher rates of chronic disease, avoidable deaths, and shorter life expectancy** than urban Australians.
- The funding gap is stark: **rural Australians receive $8 billion less per year** in health funding, with per capita deficits continuing to widen (National Rural Health Alliance, 2025).

Local Evidence (Study Area: 6 Wheatbelt & Great Southern LGs, WA)

- Potentially avoidable deaths are consistently higher than national averages, with no clear downward trend.
- Coronary heart disease is the leading cause of death (mirroring national rural trends).
- **Hospital admissions are declining in most sites, suggesting service improvements**.
- Conservative estimates of 31 aeromedical retrievals and 112 road transfers per year at a combined cost exceeding $390,000 per annum.

Preferred Model

- **Rural generalist-led integrated care model** whereby doctors provide general practice, emergency, and procedural services across multiple communities.

Sustainability of the model

- This model is currently sustained by local governments, who in some cases contribute **up to 16% of their total rates**.
- This is financially unsustainable and risks service collapse.

The Proposal

- **Federal/State block funding of $300,000 per MM5–7 local government** to support integrated rural generalist services.
- Benefits:
- Relieves pressure on local governments.
- Secures long-term viability of rural GP services.
- Continuity of care (local GPs who know their patients) and improved equity in access compared to similar rural/remote areas.
- Improves health outcomes at lower overall cost.

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Introduction

According to the Australian Institute of Health and Welfare (AIHW) the 28% of Australia's population that live in rural and remote areas face unique challenges in accessing primary health care services due to their geographic location and as a result often have poorer health outcomes than people living in metropolitan areas[1].

A report commissioned by the National Rural Health Alliance (August 2025)[2] underscores the persistent inequities in health outcomes for regional Australians, revealing higher rates of hospitalisation, chronic disease, and premature and preventable death outside major cities. These outcomes are compounded by restricted access to timely healthcare and delayed disease management.

Despite these challenges, rural Australians remain underfunded. In 2023–24, they received approximately **$8.35 billion less in healthcare funding** than urban populations. The gap translates to **$1,090.47 less per person annually**. Comparatively, the 2023 report *Evidence Base for Additional Investment in Rural Health in Australia*[3] found a $6.55 billion shortfall, or $848 per capita. Even after adjusting for inflation, the latest figures show that the funding gap has grown by an additional $110 per person, highlighting a widening inequity in rural health investment.

The disparity is greatest in remote areas (MMM 5–7), where per capita health spending is $4,701 less than in metropolitan regions. The report highlights that, although targeted programs improve access in some locations, systemic challenges such as service shortages, workforce constraints, and limited infrastructure, continue to drive inequities, emphasizing the need for "***coordinated, region-specific solutions***".

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[1] Rural and remote health - Australian Institute of Health and Welfare

[2] Nous Group (2025). The Forgotten Health Spend: A Report on the Expenditure Deficit in Rural Australia

[3] Evidence base for additional investment in rural health in Australia

Preferred Service Model

A preferred provider has been operating in the Great Southern and Wheatbelt regions of Western Australia since 2013. They provide GPs to local governments under a **rural generalist hub model**, which includes working with doctors in training and providing ongoing support to GPs taking on roles in regional and remote areas. Operating across multiple sites, the model leverages shared systems and technology to deliver timely care with minimal downtime as well as economies of scale which is necessary in thin markets.

Rural generalists are general practitioners who provide primary care services, emergency medicine and have training in additional skills like obstetrics, anaesthetics or mental health services. The Australian Government Department of Health, Disability and Aging recognises the importance of rural generalists to the regional, rural and remote health workforce – "*They broaden the range of locally available medical services for rural Australians and work as part of health care teams. This helps these communities to access the right care, in the right place, at the right time, as close to home as possible. Growing the rural generalist workforce will reduce hospital admissions, reduce the use of locum services and limit the need for patient travel*"[4].

This report presents health data from six outer regional (MMM5), remote (MMM6), and very remote (MMM7) Local Governments in the Wheatbelt and Great Southern regions (Gnowangerup, Kojonup, Ravensthorpe, Narembeen, Lake Grace, and Jerramungup), where the rural generalist hub model operates, to demonstrate both the need for and benefits of this primary health care approach.

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[4] National Rural Generalist Pathway | Australian Government Department of Health, Disability and Ageing

Health Outcomes

Mortality

Deaths

According to the Australian Institute of Health and Welfare (AIHW), death rates vary significantly depending on where people live. In summarising mortality patterns from 2021–23, AIHW reported that:

- Crude death rates were highest in Inner regional areas (895 deaths per 100,000 population) and lowest in Very remote areas (606 per 100,000).
- Age-standardised death rates increase with remoteness.
- The age-standardised death rate in Very remote areas was 1.6 times higher than in Major cities (779 versus 499 deaths per 100,000).

Age-standardised death rates are not published where data is too sparse (fewer than 20 deaths in an area or populations below 30 in any age group by year and sex). For this reason, they are not available for the Local Governments in the study area. Instead, crude death rates are used as a baseline indicator of mortality levels.

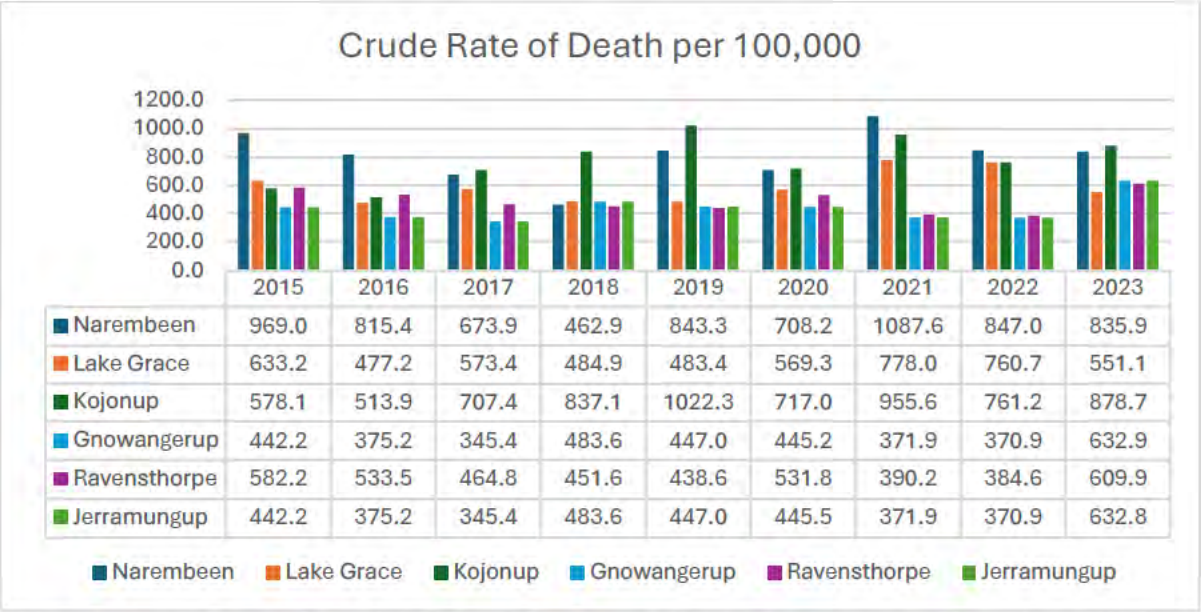
In 2023, the crude death rate was 687.1 per 100,000 for Australia and 606.5 per 100,000 for Western Australia. As shown in Figure 1, most Local Governments in the study area recorded crude death rates below the national average, with Lake Grace also sitting below the State rate.

Trend analysis over the past decade reveals:

- Ravensthorpe has had a sustained decline in crude death rates.
- Gnowangerup and Jerramungup have relative stability.
- Narembeen has seen an overall decline, aside from a spike in 2021.
- Lake Grace has experienced a downward trend since 2015, though with significant year-to-year variability. This is suggestive of sensitivity to small changes in the number of deaths due to the population size.
- Kojonup shows a pattern of sustained increase. This may be reflective of changes in the population profile (e.g., aging population), increased disease incidence, or a combination thereof.

Overall, the stable or declining crude death rates in several communities is suggestive of improvements in service accessibility.

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	2015	2016	2017	2018	2019	2020	2021	2022	2023
Narembeen	969.0	815.4	673.9	462.9	843.3	708.2	1087.6	847.0	835.9
Lake Grace	633.2	477.2	573.4	484.9	483.4	569.3	778.0	760.7	551.1
Kojonup	578.1	513.9	707.4	837.1	1022.3	717.0	955.6	761.2	878.7
Gnowangerup	442.2	375.2	345.4	483.6	447.0	445.2	371.9	370.9	632.9
Ravensthorpe	582.2	533.5	464.8	451.6	438.6	531.8	390.2	384.6	609.9
Jerramungup	442.2	375.2	345.4	483.6	447.0	445.5	371.9	370.9	632.8

Figure 1. Crude Rates of Death 2015 – 2023. Source: Australian Institute of Health and Welfare, Mortality Over Regions and Time, Local Government Area 2015-2019 and 2019-2023

Potentially Avoidable Deaths

Between 2021 and 2023, the proportion and rate of potentially avoidable deaths increased with remoteness[5]:

- 47% of deaths in Major cities compared with 61% in Very remote areas were potentially avoidable.
- The age-standardised rate of potentially avoidable deaths in Very remote areas was three times higher than in Major cities (245 versus 87 deaths per 100,000).
- Potentially avoidable causes accounted for 49% of male deaths and 44% of female deaths in Major cities, rising to 62% of male deaths and 61% of female deaths in Very remote areas.

The National Rural Health Alliance notes that these higher rates reflect both a greater burden of disease in rural and remote Australia and higher mortality from conditions that could be effectively managed with timely health care[6].

In line with national findings, most Local Governments in the study area (except Narembeen) report proportions of potentially avoidable deaths above the national average (see Table 1). Unlike the national trend of gradual improvement, local outcomes show limited sustained progress, pointing to persistent disparities despite efforts to improve health care access. However, it is important to note that the strong year-to-year fluctuations are likely a result of small population sizes and low numbers of deaths, which means caution is needed when interpreting long-term patterns.

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[5] Deaths in Australia, Remoteness area - Australian Institute of Health and Welfare

[6] Nous Group (2025). The Forgotten Health Spend: A Report on the Expenditure Deficit in Rural Australia

Local Government	ASGS Remoteness Classification	Potentially Avoidable Deaths as % of Total Deaths								
		2015	2016	2017	2018	2019	2020	2021	2022	2023
Narembeen	Remote	12.5%	14.3%	16.7%	0.0%	14.3%	16.7%	22.2%	28.6%	14.3%
Lake Grace	Very Remote	12.5%	33.3%	28.6%	33.3%	33.3%	57.1%	20.0%	30.0%	28.6%
Kojonup	Outer Regional	8.3%	40.0%	14.3%	18.8%	20.0%	42.9%	15.8%	26.7%	29.4%
Gnowangerup	Remote	40.0%	40.0%	25.0%	50.0%	60.0%	40.0%	40.0%	20.0%	50.0%
Ravensthorpe	Very Remote	45.5%	33.3%	37.5%	25.0%	33.3%	45.5%	25.0%	37.5%	35.7%
Jerramungup	Remote	100.0%	75.0%	75.0%	40.0%	40.0%	40.0%	50.0%	25.0%	50.0%
Australia	**NA**	**17.3%**	**17.2%**	**17.3%**	**17.2%**	**17.0%**	**17.0%**	**15.9%**	**15.2%**	**15.4%**

Table 1. Potentially Avoidable Deaths. Source: Australian Institute of Health and Welfare, Mortality Over Regions and Time, Local Government Area 2019-2023

Leading Causes of Death

According to the AIHW, the leading causes of death vary depending on where people live. In major cities, dementia (including Alzheimer's disease) is the leading underlying cause of death. In contrast, in inner regional, outer regional, remote, and very remote areas, coronary heart disease is the leading cause (see Figure 1 in supplementary information). Across all remoteness areas, the five most common causes of death consistently include coronary heart disease, dementia, chronic obstructive pulmonary disease (COPD), and lung cancer, with diabetes also featuring among the top five in remote and very remote areas.

Reflecting this national pattern, coronary heart disease is the leading cause of death in most Local Governments in the study area (see Table 2). Dementia, lung cancer, and diabetes also appear prominently in local mortality profiles.

A comparison of data from 2015–2019 (see Data Table 1 in supplementary information) shows some variation in the leading causes of death across these Local Governments over the past decade; however, coronary heart disease has remained a consistent leading cause. This reinforces research[7] which suggests that improving access to health care resources in regional areas is critical to reducing heart disease risk and achieving better outcomes.

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	Jerramungup	Kojonup	Narembeen	Lake Grace	Gnowangerup	Ravensthorpe
1	Coronary Heart Disease (6%)	Coronary Heart Disease (15.4%)	Dementia including Alzheimer's disease (8.2%)	Land transport accidents (11.7%)	Coronary Heart Disease (6%)	Coronary Heart Disease (15.6%)
2	COPD (6%)	Lung Cancer (8.2%)	Coronary Heart Disease (8.2%)	Coronary Heart Disease (9.5%)	COPD (6%)	Lung Cancer (11.5%)

[7] Mary MacKillop Institute for Health Research (2017). The Heart of Inequality

3	Land transport accidents (6%)	Cerebrovascular disease (5.5%)	Lung Cancer (7.3%)	Heart failure and complications and ill-defined heart disease (5.1%)	Land transport accidents (6%)	COPD (6.3%)
4	Suicide (6%)	Dementia including Alzheimer's disease (4.4%)	COPD (6.8%)	Colorectal Cancer (3.6%)	Suicide (6%)	Diabetes (5.2%)
5	Diabetes	COPD (4.4%)	Colorectal Cancer (4.1%)	Dementia including Alzheimer's disease (3.6%)	Prostate Cancer (4.5%)	Cerebrovascular disease (5.2%)

Table 2. Leading Causes of Death 2019 – 2023 (Top 5). Source: Australian Institute of Health and Welfare, Mortality Over Regions and Time, Local Government Area 2019-2023

Hospitalisations

The Australian Bureau of Statistic's 2023-2024 Patient Experience Survey[8] found that people living in outer regional, remote or very remote areas were more likely than those living in major cities to visit a hospital Emergency Department (20.4% compared to 13.8%) and be admitted to hospital (14.2% compared to 12.1%).

A 2023 report released by the National Rural Health Alliance, providing the evidence base for additional investment in rural health, highlighted evidence that when primary care is lacking, patients are more likely to turn to emergency departments for care[9]. The report highlighted that a shortage of primary care in MMM 5, 6 and 7 is consistent with delayed access to care and heavier reliance on hospital-based services, contributing to poorer health outcomes for rural and remote communities.

Between 2015 and 2024, the Estimated Resident Population (see Figure 3) increased across all Local Governments except Kojonup. Over the same period, hospital admissions declined at all facilities except the Ravensthorpe Health Centre, which recorded a sharp increase in admissions from 2020 to 2023, followed by a reduction in 2024, though still above 2015 levels (see Figure 4). The ratio of non-emergency to emergency admissions also fell across most hospitals (see supplementary data tables 2 and 3). These trends in hospital utilisation may indicate improvements in the availability of services within these communities over this period.

Over the past decade, Narembeen Memorial Hospital recorded the largest decrease in medical emergency admissions, alongside one of the most significant increases in non-emergency admissions. A similar pattern was observed at Lake Grace Hospital, which saw a notable reduction in emergency admissions paired with the highest increase in non-emergency admissions. Anecdotally, this trend has been linked to several factors, including challenges in accessing primary care (such as long wait times for GP appointments and cost barriers for some

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[8] Patient Experiences, 2023-24 financial year | Australian Bureau of Statistics

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

community members) as well as the role of local medical centres in serving not only their immediate communities but also neighbouring populations, some of which lack access to a General Practice.

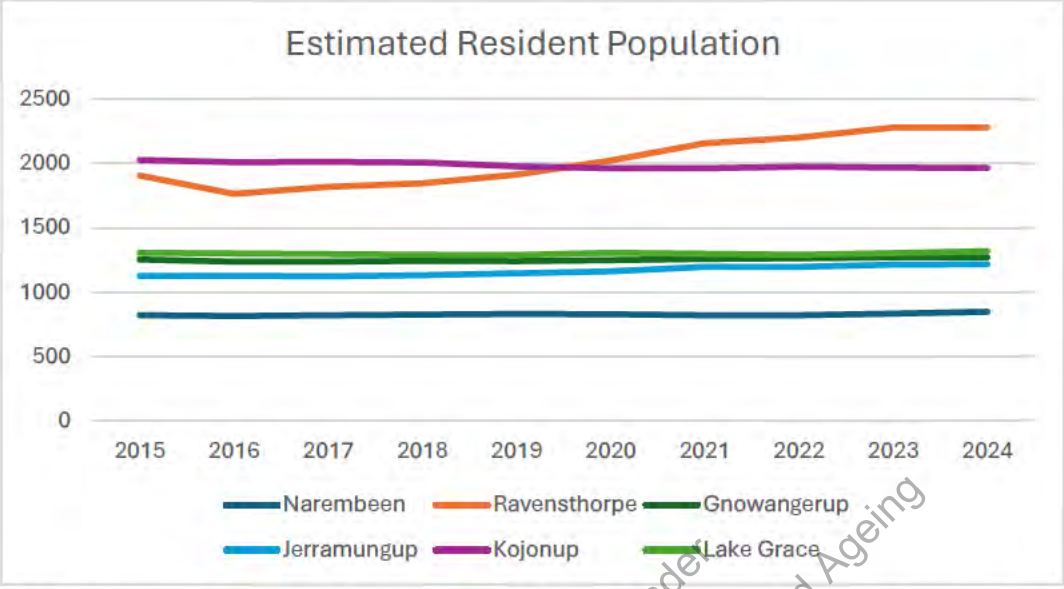
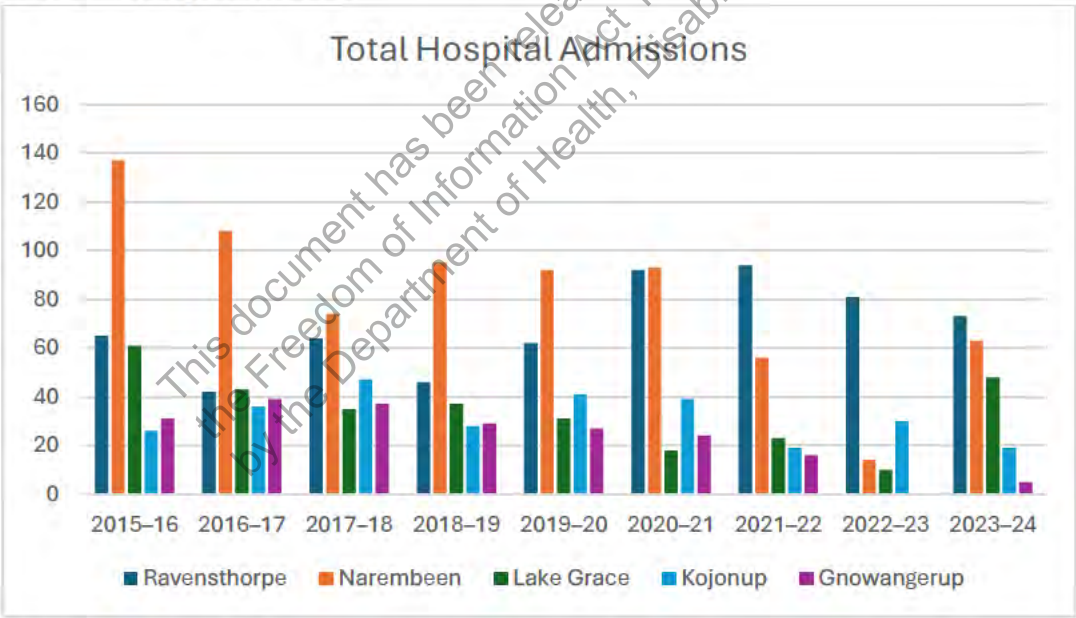


Figure 3. Estimated Resident Population by Local Government Areas. Source: Australian Bureau of Statistics, March 2025



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Figure 4. Total Hospital Admissions (stays). Source: Australian Institute of Health & Welfare, My Hospitals. Data as of May 2025.

Retrievals & Transfers

The *Best for the Bush* report (Royal Flying Doctors, 2023)[10] highlights compelling evidence that provision of regular primary healthcare services and continuity of care within the health system are key to improving health outcomes for patients. As such, strengthening access to primary care in rural and remote areas is likely to improve health outcomes and reduce the need for avoidable aeromedical and road retrievals.

In 2023–24, the RFDS conducted 10,376 aeromedical retrievals in Western Australia. At 30 June 2024, the state's estimated resident population was 2,965,078[11], of which the six Local Governments in the study area accounted for 8,900 people (0.3%). Applying this share of population, it is assumed that at least 31 of the recorded retrievals originated from the study area.

A 2020 RFDS research report estimated the average cost of an aeromedical retrieval at $8,500[12]. Adjusted for inflation, the cost today is approximately $10,153[13]. On this basis, a minimum of 31 retrievals would represent an estimated cost of $316,212. This figure likely underestimates the true cost, as it excludes factors like longer distance retrievals and the cost if more advanced medical staff are required to crew the flight.

Data on inter-hospital patient transfers carried out by St John Ambulance WA from regional hospitals is not publicly reported. However, it is known that the Acute Patient Transfer Coordination program managed by WA Country Health Service in collaboration with RFDS and St John WA, facilitates approximately 7,500 intra-regional and regional-to-metro transfers each year (based on 2022-23 data)[14].

As of June 2024, the estimated resident population of regional WA was 580,707. The study area accounts for 1.5% of this population. Applying this share of the population to the total number of regional transfers equates to an estimated 112 patient transfers within the study area, annually.

The cost of a St John patient transfer in country WA is $673[15]. On this basis, 112 transfers would amount to $75,376 per year. This is a conservative estimate, as the $673 fee only applies to transfers under 200 km, while longer journeys attract higher, distance-based charges.

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[10] flyingdoctor.org.au/download-document/best-bush-rural-and-remote-health-baseline-2023/
[11] ABS Estimated Resident Population by Statistical Areas Level 2, Western Australia
[12] RFDS Research: Aeromedical retrieval for suspected appendicitis | Royal Flying Doctor Service
[13] Inflation Calculator | RBA
[14] WA Country Health Service - Successful patient transfer coordination service extends to 24 7 coverage of regional WA
[15] St John WA - Ambulance Fees

Cost of Care

Bulk Billing

The GP bulk billing rate represents the proportion of bulk billed GP attendances out of all GP attendances. According to the AIHW[16], bulk billing rates have declined since the COVID-19 pandemic. In 2019, prior to the pandemic, the annual bulk billing rate was 86%. This rose to 89% in 2020, partly due to a short period of mandatory bulk billing for telehealth consultations. However, following the initial pandemic response and the rollout of COVID-19 vaccines, bulk billing rates declined steadily, reaching 77.9% in 2024–25.

Bulk billing varies by location. AIHW data shows that **people in more remote areas are more likely to be bulk billed but also face higher out-of-pocket costs when they are not**. The data also shows that patterns in the GP bulk billing rate vary considerably across Local Government Areas[17]. The Royal Australian College of General Practitioners (RACGP) warns that while higher bulk billing rates in rural and remote areas may benefit patients, they can undermine the financial viability of practices in these regions, compounding existing challenges around service access and workforce shortages[18]. This likely accounts for variability in regional bulk billing practices and higher out of pocket costs.

In 2024-25, nationally the bulk billing rate for people in very remote communities was 88.7% and in remote communities was 80.1% compared to 74.7% in metropolitan areas. This trend was replicated in Western Australia where the bulk billing rate in the Perth North Primary Health Network was 66.5%, in Perth South it was 71.8% and in Country WA it was 76%[19].

Bulk billing rates in the Local Governments within the study area ranged from 66.59% (Lake Grace) to 81.8% (Ravensthorpe) as of March 2025 (refer to Figure 5). The majority of Local Governments had higher bulk billing rates than the State rate of 70%, with Jerramungup (66.6%) and Lake Grace (66.59%) being the exception.

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[16] Medicare bulk billing and out-of-pocket costs of GP attendances over time, Summary - Australian Institute of Health and Welfare

[17] Medicare bulk billing of GP attendances: monthly data, About - Australian Institute of Health and Welfare

[18] RACGP - Cost of care

[19] Medicare quarterly statistics by state and territory July 2024 to June 2025

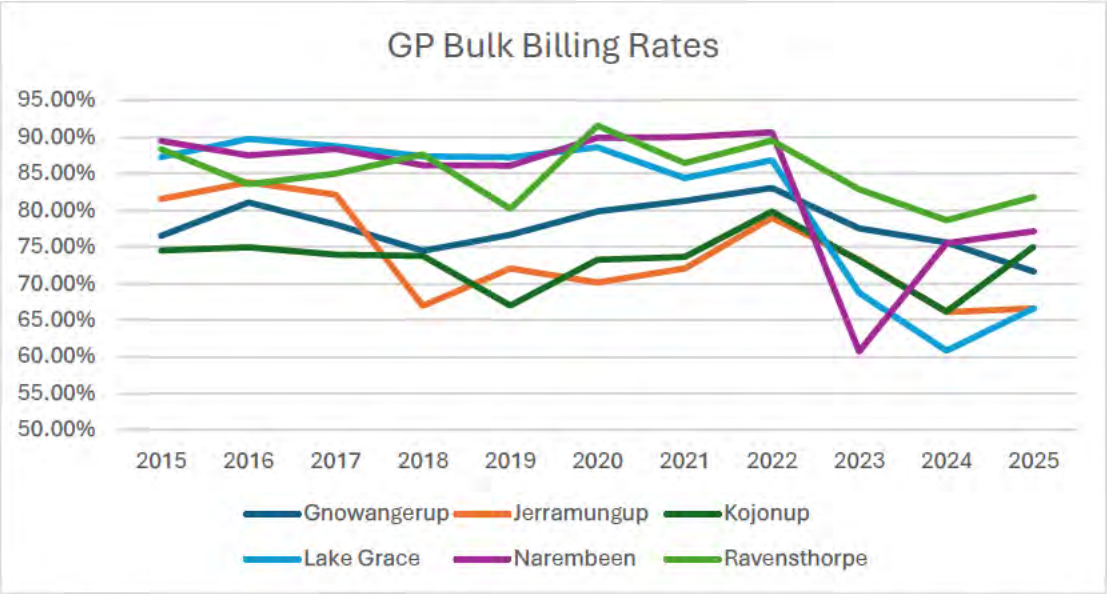


Figure 5. Bulk billing rates by Local Government Area 2015-2025. Source: Australian Institute of Health & Welfare, Medicare Bulk Billing Rates for GP Attendances.

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Out of pocket expenses

According to the ABS's latest Patient Experience Survey[20], in 2023-2024 people living in outer regional, remote or very remote areas were more likely to delay or not see a GP when needed than those living in major cities (30.8% compared to 28.6%). Of those who reported that they had delayed or did not see a health professional when needed, **20.4% said it was due to cost**. The proportion of people who reported that cost was a reason for delaying or not seeing a GP when needed increased to 8.8% in 2023-24, from 7.0% in 2022-23.

Medicare statistics for July 2024 to June 2025[21], show that for non-bulk billed (non-hospital) GP attendances, patients paid an average of $53.69 in out-of-pocket costs in very remote areas and $53.92 in remote areas, compared with an average of $48.61 in metropolitan areas. In Western Australia, in 2024-25 the average patient contribution per service in the Perth North Primary Health Network was $49.78 and in Perth South it was $46.45. This compares to Country WA which was $52.05.

AIHW report on the Top 10 and bottom 10 out-of-pocket cost per GP attendance for Local Governments, States and Territories[22]. Between 2019 and 2023 two of the six Local Governments in the study area featured in the Top 10 list. In 2019 Lake Grace had the 10th highest out of pocket GP expenses per attendance in WA at $55.10. In 2020 Narembeen had

[20] Patient Experiences, 2023-24 financial year | Australian Bureau of Statistics

[21] Medicare quarterly statistics – State and territory (July to June 2024-25) | Australian Government Department of Health, Disability and Ageing

[22] Medicare bulk billing and out-of-pocket costs of GP attendances over time, LGAs with 10 highest and lowest out-of-pocket costs for GP attendances 2019–2023 - Australian Institute of Health and Welfare

the 7th highest out of pocket expenses in WA at $55.53 and in 2021 Narembeen had the 4th highest out of pocket expenses per attendance at $56.55.

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Cost of providing a GP service

The RACGP note that that the growing gap between the Federal Government's contribution to the cost of general practice care and the cost of providing that care is affecting the sustainability of the primary care sector and putting a greater financial burden on households[23].

The estimated cost per hour of running a single medical practice in the study area is calculated below. A conservative, moderate and high hourly salary for a mix billing GP is presented. The higher end would reflect a GP undertaking procedural work.

Assuming clinic opening hours of 8.5 hours per day, conservative cost estimates indicate an average daily running cost of close to $4,000 and an annual running cost of close to $1 million for a single clinic. These figures do not take into account travel between sites (which doctors, and staff are paid for if they need to move between locations), the cost of locum cover, equipment purchases, loss of vaccines and medical equipment, or corporate overheads.

From 1 November 2025, all Medicare-eligible patients will be eligible for bulk billing incentives. Medicare bulk billing incentives are scaled and increase in regional, rural and remote communities, as determined using the Modified Monash Model location classification. Under this scheme the Medicare payment for a standard GP consultation at a bulk billed, city practice will increase from $42.85 to $69.56. The Medicare payment for the same consult at a bulk billed regional or rural practice will be almost double what it is now, increasing from $42.85 to up to $86.91, depending on location[24] (refer to Figure 3 in supplementary information).

The Australian Government believe that the clear majority of general practices in the country will be better off if they bulk-bill all of their patients under the new incentive program, however RACGP have cautioned that the "*Medicare rebate still may not cover the cost of care*" [25]. Similarly, the Royal Flying Doctors Service, 'Best for the Bush' report[26], notes that "*Medicare is not a viable model in some areas of rural and remote Australia, owing to thin markets and/or market failure. Small populations spread across vast areas in parts of rural and remote Australia mean some regions may be unable to provide the economies of scale required for clinicians to provide services funded only through Medicare*".

To demonstrate this point, if the medical practices in the study area were swapped to bulk billing clinics, and assuming up to 30 patients per day could be seen to by a single GP, even applying the MMM7 bulk billing incentive of $86.91 would result in a daily shortfall of $1,141 and annual shortfall of around $300,000 based on conservative cost estimates. The previous section showed that some Local Governments in the study area have lower bulk billing rates than the Country WA average and higher out of pocket expenses. These figures help to demonstrate why this is the case and also why it is not viable for these practices to bulk bill all of their patients.

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[23] RACGP - Cost of care
[24] Microsoft Word - 2. FACT SHEET - BULK BILLING - FINAL to clear.docx
[25] RACGP - Historic $8.5b Medicare investment explained
[26] flyingdoctor.org.au/download-document/best-bush-rural-and-remote-health-baseline-2023/

Expense item	Estimated hourly cost (conservative)	Estimated hourly cost (moderate)	Estimated hourly cost (high)
Doctor Salary P/H	$180	$300	$500
Doctor Super	$22	$36	$60
Receptionist Hourly rate	$34	$34	$34
Receptionist Super	$4	$4	$4
Practice Manager Hourly Rate	$52	$52	$52
PM Superannuation	$6	$6	$6
Nurse Hourly Rate	$50	$50	$50
Nurse Superannuation	$6	$6	$6
Utilities	$2	$2	$2
Accounts Department	$22	$22	$22
Payroll Tax @5.5%	$21	$21	$21
Software	$2	$2	$2
Medical Consumables	$5	$5	$5
Stationary/ink/tea coffee/milk	$1	$1	$1
Clinical Waste	$2	$2	$2
Cleaning @$68 per day	$9	$9	$9
Accreditation Fees	$2	$2	$2
Supervision/Clinical Compliance	$5	$5	$5
Maintenance of equipment	$1	$1	$1
Telephones and internet	$3	$3	$3
Insurances	$9	$9	$9
SMS comms (patient reminders)	$2	$2	$2
Online booking platform	$2	$2	$2
TOTAL per hour cost	**$441**	**$576**	**$800**
TOTAL per day cost (based on 8.5 hr day)	**$3,748**	**$4,896**	**$6,800**
TOTAL per week cost	**$18,742**	**$24,480**	**$34,000**
TOTAL per annum cost	**$974,610**	**$1,272,960**	**$1,768,000**

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Preferred GP Service Model: Rural Generalist-Led Integrated Care

Model Overview

A Rural Generalist model of care—where highly trained medical practitioners deliver comprehensive general practice, emergency care, and essential components of other medical specialties. These services are provided across both hospital and community settings, tailored to the unique needs of MM 5,6,7 rural and remote Australian communities.

This model is delivered through a locally engaged business entity which owns the practice and manages multiple sites under a unified structure. The business provides:

- Practice management
- A pool of doctors and locums
- Allied health services
- Centralised administration and financial oversight
- A single annual service fee

Current Situation

For many MM 5,6,7 communities, private practice is not sustainable under the traditional small business model. These communities are typically under 1000 people, both in the town site and catchment area.

These communities are also typified by a shortage of GPs willing to practice in a remote or very remote community as a single doctor, so too there are usually a shortage of skilled practice managers. Without some sort of financial contribution by local government (which should be by the Commonwealth), as highlighted in the previous section, income generated through bulk billing does not sustain general practice and its administration.

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Key Features and Advantages

- Reduced Hospital Transfers and Emergency Retrievals: Local access to emergency and specialist-level care reduces the need for costly and disruptive patient transfers.
- Protected Specialist Title: Rural Generalists are recognised as specialists, enhancing professional status and recruitment appeal.
- Integrated, Multi-Site Coverage: Doctors can support patients across multiple towns, ensuring continuity of care and reducing reliance on locums. Patient records are also available across sites (cloud based service).
- Technology-Enabled Care:
  - eScripts, eReferrals, and My Health Record integration
  - Cloud-based systems ensure continuity during power or telecom outages
  - Telehealth support enables cross-site collaboration and emergency backup
- Workforce Sustainability:
  - A pool of doctors with diverse skillsets and backgrounds
  - Shared caseloads and second opinions

- Robust training and peer support systems in a traditionally isolated region
- Doctors are part of a larger, supportive network with access to city-level infrastructure—remotely
- The business employs all of the staff – receptionist, nurse practitioner, doctor etc.

• Patient-Centered Benefits:

- Access to care at any site, from any location
- Continuity of care for local patients presenting to ED
- Patient choice and improved service quality

Strategic Benefits

- This model of care is closely aligned to the Australian Medical Associations Easy Entry, Gracious Exit model.
- Doctor Attraction and Retention: The model has proven effective in attracting and retaining doctors in MM5, 6 and 7 communities and prioritises continuity of practice or practice management structure over continuity of the doctor. When a doctor leaves the community, the service does not cease under this model.
- Primary Care Reduces Secondary Care Demand: Early intervention and local management reduce pressure on hospital systems.
- Scalable and Resilient: The model is adaptable to other rural 5,6,7 regions and offers a sustainable alternative to 24/7 telehealth-only solutions. It also does not require doctors to be small business owners and managers. It allows them to focus on clinical care and reduces the financial risk on the provision of doctors in 5,6,7 communities

Despite institutional cynicism about affordability, this model demonstrates that high-quality, locally delivered care is both feasible and cost-effective—offering a superior alternative to telehealth-only services.

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Funding

Currently this model receives core funding from local governments. This is unsustainable however as it diverts funding away from core local government services and facilities. Some local governments using this model presently are contributing up to 16% of their rates to attract and retain a doctor.

Local governments provide an annual cash payment and may also include housing, a vehicle and surgery to support the service. This model enables doctors to focus on clinical care and a high standard of care rather than generating multiple appointments to underline base funding.

The financial burden of supporting a practice should not be the sole responsibility of local governments.

The Commonwealth should jointly fund with the State, a $300,000 block payment to MM 5,6,7 local governments who meet this criteria;

- issue a tender request;

- for a preferred entity (private or not for profit) ;
- providing a rural generalist service
- where there is no existing practice in the 5,6,7 community or within a 50km radius of the town;
- and the preferred entity must provide on call service to the state hospital access and emergency service.

Local governments can continue to provide a house, vehicle and surgery premise for the doctor. Local governments can also work in collaboration with each other to attract a rural generalist practice.

Alternatively if the Commonwealth and State wish to engage directly with the rural generalist practice and provide a block payment of the same value, this can also be considered however planning and monitoring the service should include local community members to ensure the services match the community.

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Conclusion

Australians living in rural and remote areas face poorer health outcomes due to limited access to primary health care, higher rates of chronic disease, and greater prevalence of potentially avoidable deaths. Reports by the AIHW and the National Rural Health Alliance highlight significant inequities, with rural Australians receiving over $8 billion less in healthcare funding annually compared to urban populations, and per capita spending deficits widening over time.

Health data from six Local Governments in WA's Wheatbelt and Great Southern regions (MMM 5–7) shows variable but persistent challenges: crude death rates have mostly stabilised or declined, yet potentially avoidable deaths remain above national averages. Coronary heart disease is the leading cause of death, reflecting national trends in rural areas. Hospital admissions have declined in most sites, suggesting improvement in service accessibility, which by and large is attributed to the preferred providers **rural generalist hub model** which has improved access and continuity of care for residents in these Local Government areas.

Despite the evident benefit of the model, currently it is only sustainable because of local government contributions (sometimes up to 16% of rates). Federal and State government block funding of $300,000 per qualifying MM5–7 local government is proposed to secure long-term viability. This would reduce pressure on local governments, strengthen rural GP services, and improve patient outcomes while lowering system-wide costs through reduced hospitalisations and retrievals.

Ultimately, the evidence shows that **investment in rural primary health care delivers better health outcomes at lower long-term cost**. Sustainable funding for rural generalist-led integrated care is critical to addressing inequities and ensuring that rural Australians can access the right care, in the right place, at the right time.

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Supplementary Information

Mortality

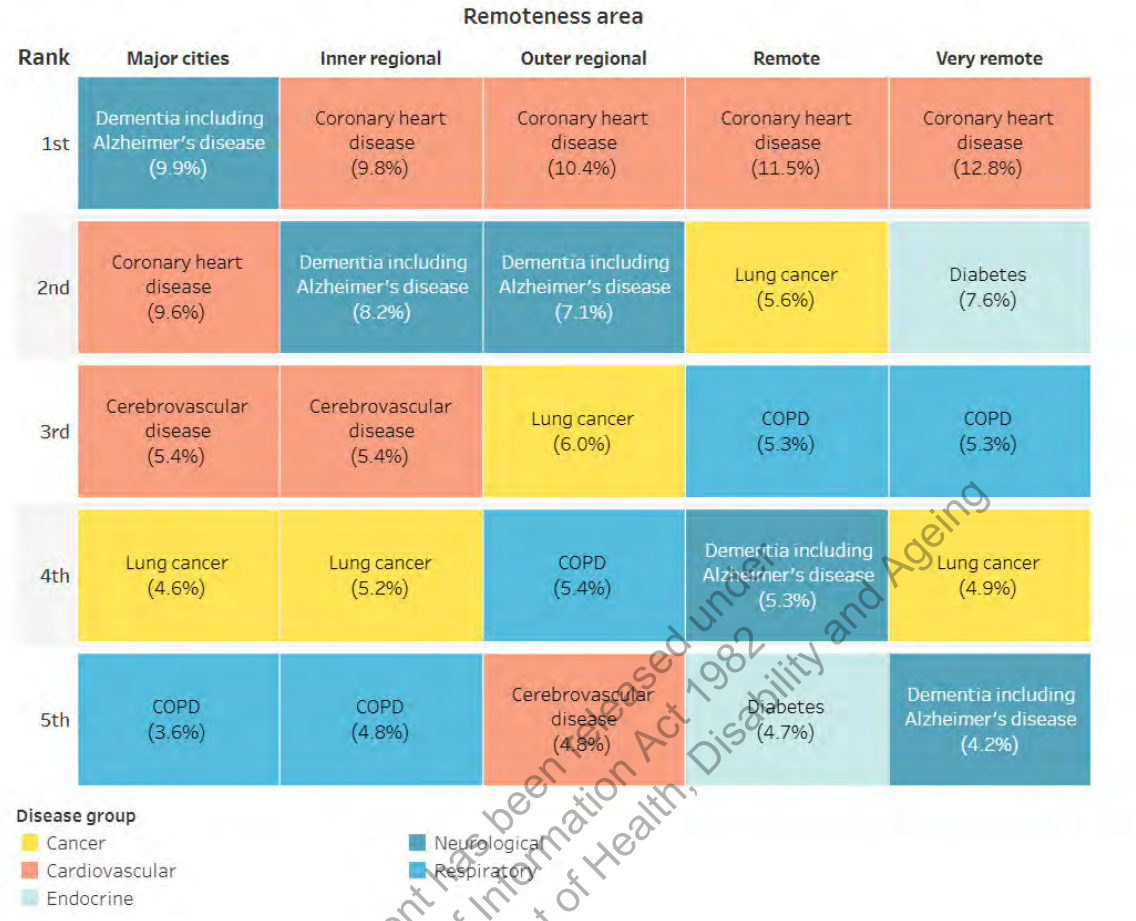


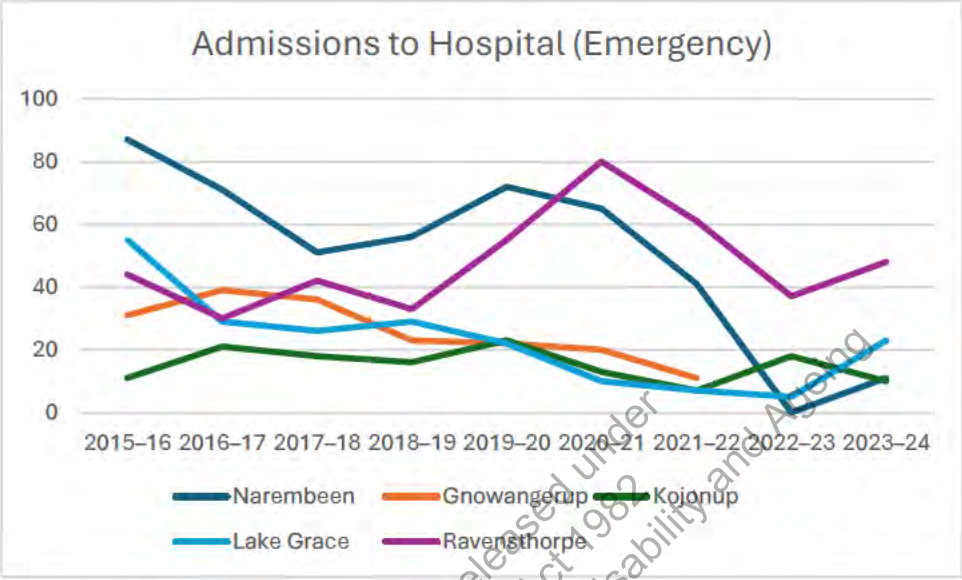
Figure 2. Leading Causes of Death by Remoteness Area. Source: Deaths in Australia, Remoteness area - Australian Institute of Health and Welfare

	Jerramungup	Kojonup	Narembeen	Lake Grace	Gnowangerup	Ravensthorpe
1	Data not available prior to 2018-2022 release	Coronary Heart Disease (14.2%)	Lung cancer (10.3%)	Coronary Heart Disease (6.9%)	Land transport accidents (11.5%)	Lung cancer (10.3%)
2		Land transport accidents (5.8%)	Coronary Heart Disease (7.7%)	Lung cancer (6.9%)	Coronary Heart Disease (9.8%	Coronary Heart Disease (9.3%)
3		COPD (5.2%)	Colorectal Cancer (5.2%)	Heart failure and complications and ill-defined heart disease (6.9%)	Lung cancer (6.6%)	COPD (6.2%)
4		Colorectal Cancer (5.2%)	Dementia including Alzheimer's disease (4.6%)	Cancer of unknown or ill-defined primary site (5.2%)	Diabetes (6.6%)	Colorectal Cancer (4.1%)

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5		Lung cancer (5.2%)	Influenza and pneumonia (3.6%)	Dementia including Alzheimer's disease (4.3%)	Lymphomas (4.9%)	Oesophageal cancer (3.1%)

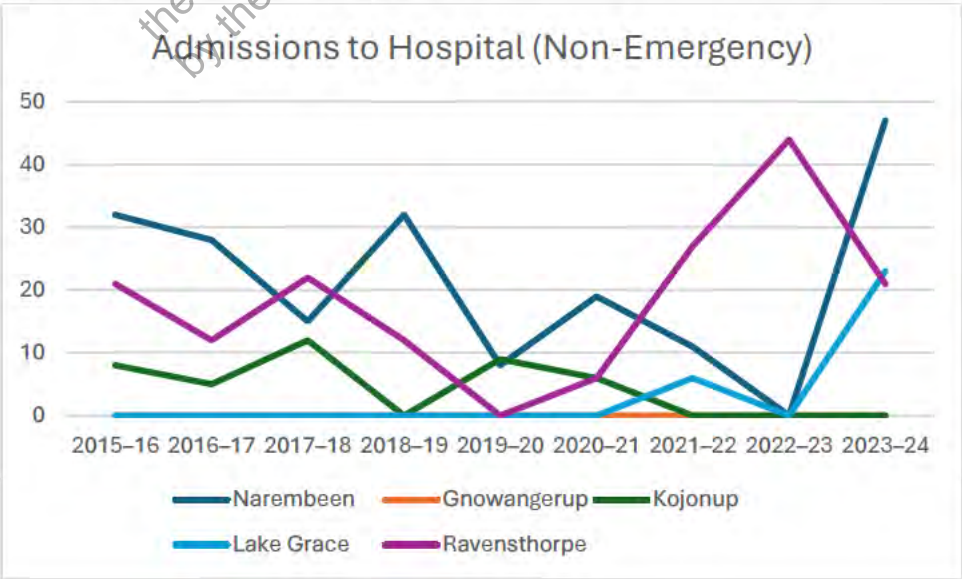
Data Table 1: Leading Causes of Death 2015-2019 (Top 5). Source: Australian Institute of Health and Welfare, Mortality Over Regions and Time, Local Government Area 2015-2019



	2015–16	2016–17	2017–18	2018–19	2019–20	2020–21	2021–22	2022–23	2023–24
Narembeen	87	71	51	56	72	65	41	<5	11
Gnowangerup	31	39	36	23	22	20	11		<5
Kojonup	11	21	18	16	23	13	7	18	10
Lake Grace	55	29	26	29	22	10	7	5	23
Ravensthorpe	44	30	42	33	55	80	61	37	48

Data Table 2: Admissions to Hospital Medical Emergency. Source: Australian Institute of Health & Welfare, My Hospitals. Data as of May 2025.

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	2015–16	2016–17	2017–18	2018–19	2019–20	2020–21	2021–22	2022–23	2023–24
Narembeen	32	28	15	32	8	19	11	<5	47
Gnowangerup	<5	<5	0	<5	0	0	<5	0	0
Kojonup	8	5	12	<5	9	6	<5	<5	0
Lake Grace	0	<5	0	<5	<5	<5	6	0	23
Ravensthorpe	21	12	22	12	<5	6	27	44	21

Data Table 3: Admissions to Hospital Medical Non-Emergency. Source: Australian Institute of Health & Welfare, My Hospitals. Data as of May 2025.

	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025
Gnowangerup	76.50%	81.06%	78.04%	74.47%	76.63%	79.82%	81.30%	83.04%	77.51%	75.61%	71.63%
Jerramungup	81.54%	83.81%	82.12%	66.95%	72.06%	70.14%	72.05%	78.96%	73.25%	66.10%	66.60%
Kojonup	74.51%	74.95%	73.94%	73.78%	66.98%	73.23%	73.64%	79.82%	73.13%	66.16%	75.04%
Lake Grace	87.27%	89.73%	88.73%	87.33%	87.24%	88.57%	84.40%	86.81%	68.72%	60.82%	66.59%
Narembeen	89.45%	87.47%	88.35%	86.14%	86.10%	89.88%	89.99%	90.64%	60.71%	75.53%	77.13%
Ravensthorpe	88.31%	83.57%	84.98%	87.62%	80.17%	91.55%	86.43%	89.52%	82.85%	78.63%	81.80%
Western Australia	78.13%	80.73%	82.47%	84.27%	85.01%	86.76%	85.90%	85.03%	72.87%	70.10%	69.61%

*As of March each year

Data Table 4: Bulk billing rates by Local Government Area 2015-2025. Source: Australian Institute of Health & Welfare, Medicare Bulk Billing Rates for GP Attendances.

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Common GP visits	Current Medicare rebate	New total Medicare payment at a Bulk Billing Practice*				
		Cities & metro areas	Regional centre	Large & medium rural towns	Small rural town	Remote
Standard consultation *6 to <20 minutes (Level B)*	**$42.85**	**$69.56** *(up 62%)*	**$80.71** *(up 88%)*	**$82.71** *(up 93%)*	**$84.86** *(up 98%)*	**$86.91** *(up 103%)*
Long consultation *20 to <40 minutes (Level C)*	**$82.90**	**$114.61** *(up 38%)*	**$125.76** *(up 52%)*	**$127.76** *(up 54%)*	**$129.91** *(up 57%)*	**$131.96** *(up 59%)*
Longer consultation *40 to <60 minutes (Level D)*	**$122.15**	**$158.77** *(up 30%)*	**$169.92** *(up 39%)*	**$171.92** *(up 41%)*	**$174.07** *(up 43%)*	**$176.12** *(up 44%)*
Mental Health Plan *20 to <40 minutes*	**$81.70**	**$99.06** *(up 21%)*	**$102.71** *(up 26%)*	**$103.36** *(up 27%)*	**$104.11** *(up 27%)*	**$104.76** *(up 28%)*
Mental Health Plan *40+ minutes*	**$120.25**	**$142.43** *(up 18%)*	**$146.08** *(up 22%)*	**$146.73** *(up 22%)*	**$147.48** *(up 23%)*	**$148.13** *(up 23%)*

* Totals include item Medicare rebate, Bulk Billing Incentive item rebate, and 12.5% Bulk Billing Practice Incentive Program payment.

Figure 3. Bulk Billing Practice Incentive. Source: RACGP - Historic $8.5b Medicare investment explained

From: s22
To: s22 ; s47F @health.wa.gov.au; s47F @health.wa.gov.au; s47F @health.wa.gov.au; s47F
Cc: s22
Subject: General Practice Incentive Fund Grant Opportunity [SEC=OFFICIAL]
Date: Wednesday, 30 July 2025 10:50:07 AM
Attachments: image001.png
image002.png

Good morning, everyone

The purpose of this email is to establish discussions with you regarding the potential establishment of a new WA site under the General Practice Incentive Fund (GPIF).

The objective of the GPIF grant opportunity is to improve the provision of, and access to, primary health and care support services in areas where there is limited or unstable access to health, medical, care and support service systems.

Further information on the GPIF opportunity is available here:

Current Grant Opportunity View - GO6695: GrantConnect

You have been nominated by your agency or colleagues to attend a joint discussion to explore a potential new GPIF site for Western Australia. Please visit the link below to indicate your availability to attend a Teams meeting in the near future:

https://doodle.com/group-poll/participate/b6KkZMNd

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regards

s22
Director
Thin Markets

Workforce Distribution Branch | Health Workforce Division
Australian Government, Department of Health. Disability and Ageing
s22 @health.gov.au
40 The Esplanade, Perth, Western Australia, 6000

The Department of Health and Aged Care acknowledges First Nations peoples as the Traditional Owners of Country throughout Australia, and their continuing connection to land, sea and community. We pay our respects to them and their cultures, and to all Elders both past and present.
***Making flexibility work** - if you receive an email from me outside of normal business hours, I'm sending it at a time that suits me. Unless I reach out to you via phone or text, I'm not expecting you to read or reply until normal business hours.*

From: s22
To:
Subject: FW: Local Government Rural Health Funding Alliance [SEC=OFFICIAL]
Date: Tuesday, 25 August 2026 8:31:57 AM
Attachments: image007.png
image008.png
image009.png
image010.png
image011.png
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image014.jpg
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image017.png
image018.png

OFFICIAL

s22
Director
Thin Markets

Rural & First Nations Workforce Branch |Workforce Division
Australian Government, Department of Health. Disability and Ageing
☏ s22 @health.gov.au
40 The Esplanade, Perth, Western Australia, 6000

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OFFICIAL

From: s22
Sent: Monday, 4 May 2026 10:15 AM
To: Caroline Robinson <caroline@150square.com.au>; s22 @health.gov.au>
Cc: s47F @lakegrace.wa.gov.au>
Subject: RE: Local Government Rural Health Funding Alliance [SEC=OFFICIAL]

Hi Caroline

Thank you for your email, and I apologise for the delay in responding.
As I have detailed previously, we work with jurisdictional health departments and PHNs to identify priority sites for intervention.
The region identified by the Alliance has been included in discussions, but to date has not been agreed as a priority for the General Practice Incentive Fund.

regards

s22

Director

Thin Markets

Rural & First Nations Workforce Branch |Workforce Division
Australian Government, Department of Health. Disability and Ageing
s22 @health.gov.au
40 The Esplanade, Perth, Western Australia, 6000

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From: Caroline Robinson <caroline@150square.com.au>
Sent: Monday, 4 May 2026 9:01 AM
To: s22 @health.gov.au>; s22 @Health.gov.au>
Cc: s47F @lakegrace.wa.gov.au>
Subject: Re: Local Government Rural Health Funding Alliance [SEC=OFFICIAL]

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OFFICIAL

REMINDER: Think before you click! This email originated from outside our organisation. Only click links or open attachments if you recognise the sender and know the content is safe.

Hi s22 ,

Just following up the email below on behalf of the Alliance. We have engaged with WAPHA's, s47F and have been directed through to your team again.

Can you please advice the process for identifying priorities for Thin Markets.

We have raised this issue with WAPHA, WACHS and RHW. I also attach correspondence from the WA Minister for Health to our local member.

CAROLINE ROBINSON
Director

s47F
www.150square.com.au
PO Box 309 | Narembeen WA 6369

OFFICIAL

From: Caroline Robinson <caroline@150square.com.au>
Sent: Friday, April 17, 2026 11:02 AM
To: s22 @health.gov.au s22 @health.gov.au>
Cc: s22 @Health.gov.au s22 @Health.gov.au>; s47F @lakegrace.wa.gov.au>
Subject: Re: Local Government Rural Health Funding Alliance [SEC=OFFICIAL]

Hi s22

Hope you are well. Just touching base on the below email trail on behalf of the Local Government Rural Health Funding Alliance.

I'd like to update you on a few activities the Alliance has progressed with.

In 2026, the Alliance has continued to build the policy and evidence base for reform through submissions to the Commonwealth Inquiry into Local Government Funding and Fiscal Sustainability and we made a submission to the Federal Budget 2026/27, seeking support for a pilot project to fund local governments currently underwriting GP services.

The Alliance has also commissioned and released an economic impact report examining the consequences of local government involvement in GP service delivery. I have attached the economic impact assessment.

We have met with WACHS and WAPHA as well as a number of other agencies, and we are seeking another meeting with WAPHA to continue to update them.

I have copied s22 into this email, as we would again like to see this issue prioritised and potentially addressed in the General Practice Incentive Fund grant (GPIF).

This issue is growing in regional WA, and other states. This is a thin market issue - residents in remote and very remote are paying three times to access a GP, once through rates, secondly through Medicare and lastly when they pay the consultation fee. We are seeking to work on an improved model - as currently this is heavily weighed in the favour of GP's/service providers.

This issue featured in the Regional Australia Institute's Ambition report (2026) and The Australian covered the issue too - Australian-22-Feb-advocacy-continues-for-regional-healthcare.pdf

As mentioned we are touching base with WAPHA again, and keen to also discuss with John or yourself. Many thanks.

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CAROLINE ROBINSON

Director

s47F

www.150square.com.au

PO Box 309 | Narembeen WA 6369

From: s22 @health.gov.au>
Sent: Thursday, 25 September 2025 11:04 AM
To: s47F @lakegrace.wa.gov.au>
Cc: s47F @wapha.org.au>; s22 @Health.gov.au>
Subject: RE: Local Government Rural Health Funding Alliance [SEC=OFFICIAL]

OFFICIAL

Hi s47F

Thank you for your email and for your paper. I have forwarded this information to s22, the director responsible for the General Practice Incentive Fund grant (GPIF) process for his awareness. In relation to the GPIF, I understand s22 team has continued to engage with jurisdictions and other relevant stakeholders to prioritise GPIF sites. This has included consultation with WA Health, WA Country Health Service (WACHS), and the WA Primary Health Alliance (WAPHA).

I understand the Wheatbelt and Great Southern regions were considered along with many others across WA. However, as you are aware, funding is limited under the GPIF grant opportunity and your region has not been prioritised at this time. Should additional funding become available, the department will continue to work with jurisdictions and relevant stakeholders to determine next priorities.

With regard to other opportunities for funding, the government funds a range of initiatives through grant arrangements. All Grant Opportunities are published on GrantConnect by Commonwealth Agencies to make it easier for individuals to locate opportunities and submit applications. You may be interested in registering with GrantConnect to receive grant opportunity information and updates. More information is at www.grants.gov.au.

Similarly, each year government calls for submissions from individuals, businesses and community groups on their views regarding priorities for the annual Budget. When open, the Treasury will invite stakeholders to share their pre-budget submissions via their website at www.treasury.gov.au. All submissions are considered and decisions announced by government in the context of the relevant Budget.

Kind regards

s22

Director

Workforce Distribution Branch | Health Workforce Division

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Australian Government Department of Health, Disability and Ageing

E: s22 @health.gov.au

PO Box 9848, Canberra ACT 2601, Australia

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OFFICIAL

From: s47F @lakegrace.wa.gov.au>
Sent: Wednesday, 24 September 2025 1:08 PM
To: s22 @health.gov.au>
Cc: s47F @wapha.org.au>
Subject: FW: Local Government Rural Health Funding Alliance

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Hi again s22

Further to the below we would like to request the Thin Markets Team negotiate with the WA Department of Health and WA Primary Health Alliance. Both agencies are aware of our position.

s47F
Executive Assistant

download.jpg

Shire of Lake Grace
Address: 1 Bishop Street, Lake Grace WA 6353
Postal Address: PO Box 50, Lake Grace, WA 6353
Phone: (08) 9890 2500
Fax: (08) 9890 2599
Website: www.lakegrace.wa.gov.au
Facebook: www.facebook.com/ShireofLakeGrace

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From: s47F
Sent: Wednesday, 17 September 2025 11:03 AM
To: s22 @health.gov.au
Subject: Local Government Rural Health Funding Alliance

Good morning s22

I have attached the Preferred GP Service Model prepared by the Local Government Rural Health Funding Alliance who have been engaging with the Department of Health & Aged Care on this subject.

In addition the Alliance would like to formally request funding for the model as a pilot, this request is also being made to WAPHA under the WA Primary Health Alliance Innovation Funding. Please let me know if this is possible and if so what would need to be done to achieve this.

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From: s22
To: s22
Cc: s22
Subject: FW: MC25-013764 - For Input. [SEC=OFFICIAL]
Date: Thursday, 7 August 2025 11:25:00 AM
Attachments: image002.png
image003.png

Hi s22

Approved words for GPIF activity in Western Australia.

Cheers

- The Australian Government has committed $49.76 million over 4 years from 2023-24 to improve sustainable access for health services in thin markets. The General Practice Incentive Fund (GPIF) grant opportunity (GO6695) seeks to minimise disruption of access to health services in identified communities where primary care and related markets have failed or are at imminent risk of failure.
- To date, the program has funded service system recovery planning through Primary Health Networks in 11 sites across Australia, including one site in WA commencing implementation of a service system recovery plan.
- The DOHDA is currently working with the WA Primary Health Alliance, WA Department of Health and WA Country Health service to identify an additional site that may benefit from this grant.

s22

Assistant Director - Thin Markets
Workforce Distribution Branch

Health Workforce Division | Health Resourcing Group
Australian Government Department of Health, Disability and Ageing
☏ (08) s22 | s22 @health.gov.au
40 The Esplanade, Perth, Western Australia, 6000

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Please note I work part time due to study commitments W1: Mon,Tues and W2: Mon,Tues, Wed

---

From: s22
Sent: Wednesday, 6 August 2025 7:09 AM
To: s22
Cc: s22
Subject: FW: MC25-013764 - For Input. [SEC=OFFICIAL]

Approved

s22

Director

Thin Markets

Workforce Distribution Branch | Health Workforce Division
Australian Government, Department of Health. Disability and Ageing
☏ s22 | s22 @health.gov.au
40 The Esplanade, Perth, Western Australia, 6000

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From: s22 @Health.gov.au>
Sent: Tuesday, 5 August 2025 1:36 PM

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To: s22 @Health.gov.au>
Subject: RE: MC25-013764 - For Input. [SEC=OFFICIAL]

- The Australian Government has committed $49.76 million over 4 years from 2023-24 to improve sustainable access for health services in thin markets. The General Practice Incentive Fund (GPIF) grant opportunity (GO6695) seeks to minimise disruption of access to health services in identified communities where primary care and related markets have failed or are at imminent risk of failure.
- To date, the program has funded service system recovery planning through Primary Health Networks in 11 sites across Australia, including one site in WA commencing implementation of a service system recovery plan.
- The DOHDA is currently working with the WA Primary Health Alliance, WA Department of Health and WA Country Health service to identify an additional site that may benefit from this grant.

From: s22 @Health.gov.au>
Sent: Tuesday, 5 August 2025 1:05 PM
To: s22 @Health.gov.au>
Subject: FW: MC25-013764 - For Input. [SEC=OFFICIAL]

HI s22

Some standard words re GPIF intent plus mention of one WA site nearing implementation (no names), and currently working with WA and PHN on an additional site

Email dot points are fine

s22

Director

Thin Markets

Workforce Distribution Branch | Health Workforce Division
Australian Government, Department of Health, Disability and Ageing
☏ s22 @health.gov.au
40 The Esplanade, Perth, Western Australia, 6000

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From: s22 @Health.gov.au>
Sent: Tuesday, 5 August 2025 1:00 PM
To: s22 @Health.gov.au>; s22 @Health.gov.au>; s22 @Health.gov.au>
Cc: s22 @health.gov.au>
Subject: MC25-013764 - For Input. [SEC=OFFICIAL]

Good afternoon,

Please see attached Ministerial correspondence from the Hon Melissa Price MP regarding funding support for primary healthcare service in rural Western Australia.

We would be appreciative if your area could please provide a line or two on any GPIF activity in Western Australia.

Apologies for the tight turn around, can we please receive relevant EL2 cleared input by **12pm Friday 8 August**.

Thank you in advance.

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Kind regards,

s22
(she/her)
PHN Policy
PHN Partnerships Branch | Primary Care Division
Australian Government Department of Health and Aged Care
T: 02 s22 @health.gov.au

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From: s22
To:
Subject: FW: GPs - RM6 and RM7 MMM Local Governments [SEC=OFFICIAL]
Date: Tuesday, 25 August 2026 8:34:29 AM
Attachments: image015.png
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OFFICIAL

s22
Director
Thin Markets

Rural & First Nations Workforce Branch |Workforce Division
Australian Government, Department of Health. Disability and Ageing
s22 @health.gov.au
40 The Esplanade, Perth, Western Australia, 6000

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OFFICIAL

From: s22
Sent: Friday, 17 April 2026 12:25 PM
To: s47F @wapha.org.au>
Cc: s22 @Health.gov.au>
Subject: RE: GPs - RM6 and RM7 MMM Local Governments

Kununurra and Newman set for tougher liquor restrictions amid soaring violence - ABC News

s22
Director
Thin Markets

Rural & First Nations Workforce Branch |Workforce Division
Australian Government, Department of Health. Disability and Ageing
s22 @health.gov.au
40 The Esplanade, Perth, Western Australia, 6000

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From: s47F @wapha.org.au>
Sent: Friday, 17 April 2026 12:08 PM
To: s22 @Health.gov.au>
Cc: s22 @Health.gov.au>

Subject: FW: GPs - RM6 and RM7 MMM Local Governments

REMINDER: Think before you click! This email originated from outside our organisation. Only click links or open attachments if you recognise the sender and know the content is safe.

Hi s22

I have just received this email from Caroline seeking WAPHA support again.

Our last communication regarding this work was on 18 September 2025 with our agreed holding line being: The identification of sites where the grant may be applied will rest with the department and be informed through negotiation with relevant jurisdiction (state or territory government) and PHN, RWA specific to the location) giving consideration to potential risk of sites losing access to services or the sustainability of local service systems.

Is there any other insights WAPHA should be aware of given Caroline advised she has provided this to you.

This will assist me in providing our response.

Many thanks
s47F

| **Senior Advisor - Thin Markets**
My pronouns are she/her
s47F @wapha.org.au | www.wapha.org.au
08 s47F
On Yamatji Country | s47F , Geraldton WA 6530

Linkedin Twitter Facebook Youtube

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We acknowledge and welcome all members of the LGBTIQA+ communities and celebrate the extraordinary diversity of people's bodies, identities, relationships and experiences.

We gratefully acknowledge the financial and other support from the Australian Government Department of Health, Disability and Ageing.

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From: Caroline Robinson <caroline@150square.com.au>
Sent: Friday, 17 April 2026 11:14 AM
To: s47F @wapha.org.au>
Cc: s47F @lakegrace.wa.gov.au>
Subject: Re: GPs - RM6 and RM7 MMM Local Governments

Hi s47F

Hope you are well.

Just touching base, as I'd like to update you on a few activities the Local Government Rural Health Funding Alliance has progressed with.

In 2026, the Alliance has continued to build the policy and evidence base for reform through submissions to the Commonwealth Inquiry into Local Government Funding and Fiscal Sustainability and we made a submission to the Federal Budget 2026/27, seeking support for a pilot project to fund local governments currently underwriting GP services as we understood the General Practice Incentive Fund had been exhausted for the 25/26 year and WAPHA had a project in the north it was progressing with the Thin Markets team.

The Alliance commissioned and released an economic impact report examining the consequences of local government involvement in GP service delivery. I have attached the economic impact assessment.

We have also shared this with s22 from the Thin Markets team with the Department of Health and Ageing.

This issue is growing in regional WA, and other states. This is a thin market issue - residents in remote and very remote are paying three times to access a GP, once through rates, secondly through Medicare and lastly when they pay the consultation fee. We are seeking to work on an improved model - as currently this is heavily weighted in the favour of GP's/service providers.

In the background we are also reviewing the National Health Reform Agreement / Schedule F as we believe this applies to our work.

This issue has also featured in the Regional Australia Institute's Ambition report (2026) and The Australian covered it too - Australian-22-Feb-advocacy-continues-for-regional-healthcare.pdf

It would be good to touch base with WAPHA again and on behalf of the Alliance, I'd be keen to catch up.

Thanks s47F appreciate you receiving this and considering.

CAROLINE ROBINSON
Director
s47F
www.150square.com.au
PO Box 309 | Narembeen WA 6369

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---

From: s47F @wapha.org.au>
Sent: Monday, July 21, 2025 12:14 PM
To: s47F @lakegrace.wa.gov.au>; Cr Len Armstrong <crarmstrong@lakegrace.wa.gov.au>
Cc: Councillor Kate O'Keeffe <crkokeeffe@gnowangerup.wa.gov.au>; Caroline Robinson <caroline@150square.com.au>
Subject: RE: GPs - RM6 and RM7 MMM Local Governments

Good afternoon s47F

Happy Monday!

Thank you for letting me know, that is great news.

I will send through a calendar invitation with the information requested below.

If you could please let me know if it will be Len, or others attending please.

Kind regards

s47F | **Senior Manager - Workforce Prioritisation and Planning**
My pronouns are she/her
s47F @wapha.org.au | www.wapha.org.au
08 s47F
On Yamatji Country | s47F, Geraldton WA 6530

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From: s47F @lakegrace.wa.gov.au>
Sent: Friday, 18 July 2025 4:18 PM
To: s47F @wapha.org.au>; Cr Len Armstrong <crarmstrong@lakegrace.wa.gov.au>
Cc: Councillor Kate O'Keeffe <crkokeeffe@gnowangerup.wa.gov.au>; Caroline Robinson <caroline@150square.com.au>
Subject: RE: GPs - RM6 and RM7 MMM Local Governments

Good afternoon s47F

I'm responding on behalf of Len as he's away from his computer today.

Thank you for this offer, Len would like to meet you at your Subiaco office on the proposed date and time. Please advise the address and any parking or building access requirements.

Thanks and have a great weekend,

s47F
Executive Assistant

download.jpg

Shire of Lake Grace
Address: 1 Bishop Street, Lake Grace WA 6353
Postal Address: PO Box 50, Lake Grace, WA 6353
Phone: (08) 9890 2500
Fax: (08) 9890 2599
Website: www.lakegrace.wa.gov.au
Facebook: www.facebook.com/ShireofLakeGrace

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signature25.png

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From: s47F @wapha.org.au>

Sent: Friday, 18 July 2025 10:55 AM
To: Cr Len Armstrong <crarmstrong@lakegrace.wa.gov.au>
Cc: Councillor Kate O'Keeffe <crkokeeffe@gnowangerup.wa.gov.au>; Caroline Robinson <caroline@150square.com.au>; s47F @lakegrace.wa.gov.au>
Subject: RE: GPs - RM6 and RM7 MMM Local Governments

Good morning Cr Armstrong,

It is lovely to hear from you.

I will be happy to meet with you in the first instance, as our Executive General Manager, Chris Kane is currently on annual leave until mid-August.

I am based in Geraldton and will be travelling to Perth for workshops next week. If you would like to meet in person, I have capacity to meet you at our Subiaco Office on Thursday 24 July from 1:00pm – to 2:00pm. If this is not a suitable time, I can arrange to meet you via MS Teams the week after.

Please let me know if the time suggested is suitable.

Kind regards

s47F | **Senior Manager - Workforce Prioritisation and Planning**
My pronouns are she/her
s47F @wapha.org.au | www.wapha.org.au
08 s47F
On Yamatji Country | 80 B, Forrest Street, Geraldton WA 6530

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From: Cr Len Armstrong <crarmstrong@lakegrace.wa.gov.au>
Sent: Thursday, 17 July 2025 9:07 AM
To: s47F @wapha.org.au>
Cc: Councillor Kate O'Keeffe <crkokeeffe@gnowangerup.wa.gov.au>; Caroline Robinson <caroline@150square.com.au>; s47F @lakegrace.wa.gov.au>
Subject: GPs - RM6 and RM7 MMM Local Governments

Hi s47F

Thank you for your correspondence to Caroline.

The group of local governments that commissioned the report has met with the Federal Department of Health and Aged Care, the National Rural Health Commissioner and National Rural Health Alliance in Canberra, as well as a number of other agencies in this space. Across the engagement it was highly recommended to meet with WAPHA.

The group of local governments acknowledges the reviews being undertaken at Federal levels as well as the work undertaken by WAPHA, however the issue is not solely a workforce issue (training pathways, recruitment, supply) - it is block / blended funding shortfalls, it is the economic viability of Practices and proximity to access services particularly as in each of the towns party to the report there is a State Government Hospital with an A&E.

The group would like to meet with yourself or a WAPHA representative to discuss this and help contribute to WAPHA work in the area.

Yours Sincerely,

Len Armstrong

Cr Len Armstrong
Shire President

download.jpg

Shire of Lake Grace
Address: 1 Bishop Street, Lake Grace WA 6353
Postal Address: PO Box 50, Lake Grace, WA 6353
Phone: (08) 9890 2500
Fax: (08) 9890 2599
Website: www.lakegrace.wa.gov.au
Facebook: www.facebook.com/ShireofLakeGrace

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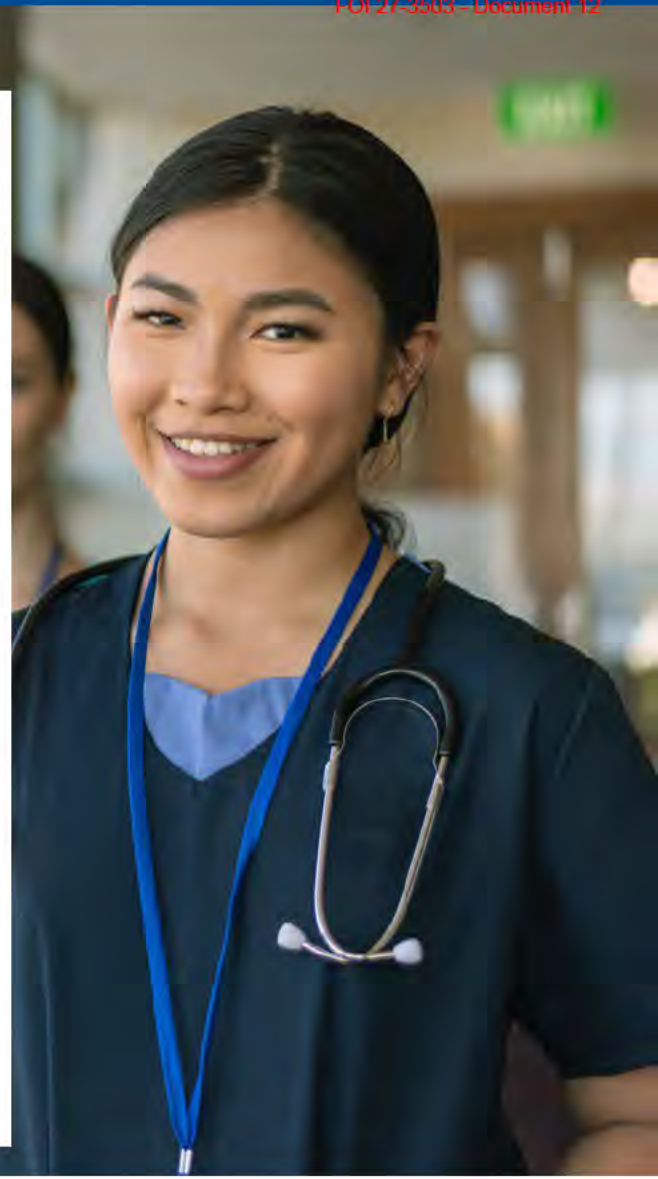
General Practice Incentive Fund (GPIF)



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Background

- $49.76 million committed over 4 years from 2023-24 to improve sustainable access for health services in thin markets
- Close collaboration with states and territories to identify and prioritise sites recognises the interdependence of health, care, and support service systems
- The Grants support PHNs to respond to situations where primary care and related service systems fail, are at risk of failing or are unstable



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What is GPIF

A closed non-competitive grant opportunity

The objective of the grant opportunity is to improve the provision of, and access to, primary health and care support services in areas where there is limited or unstable access to health, medical, care and support service systems.

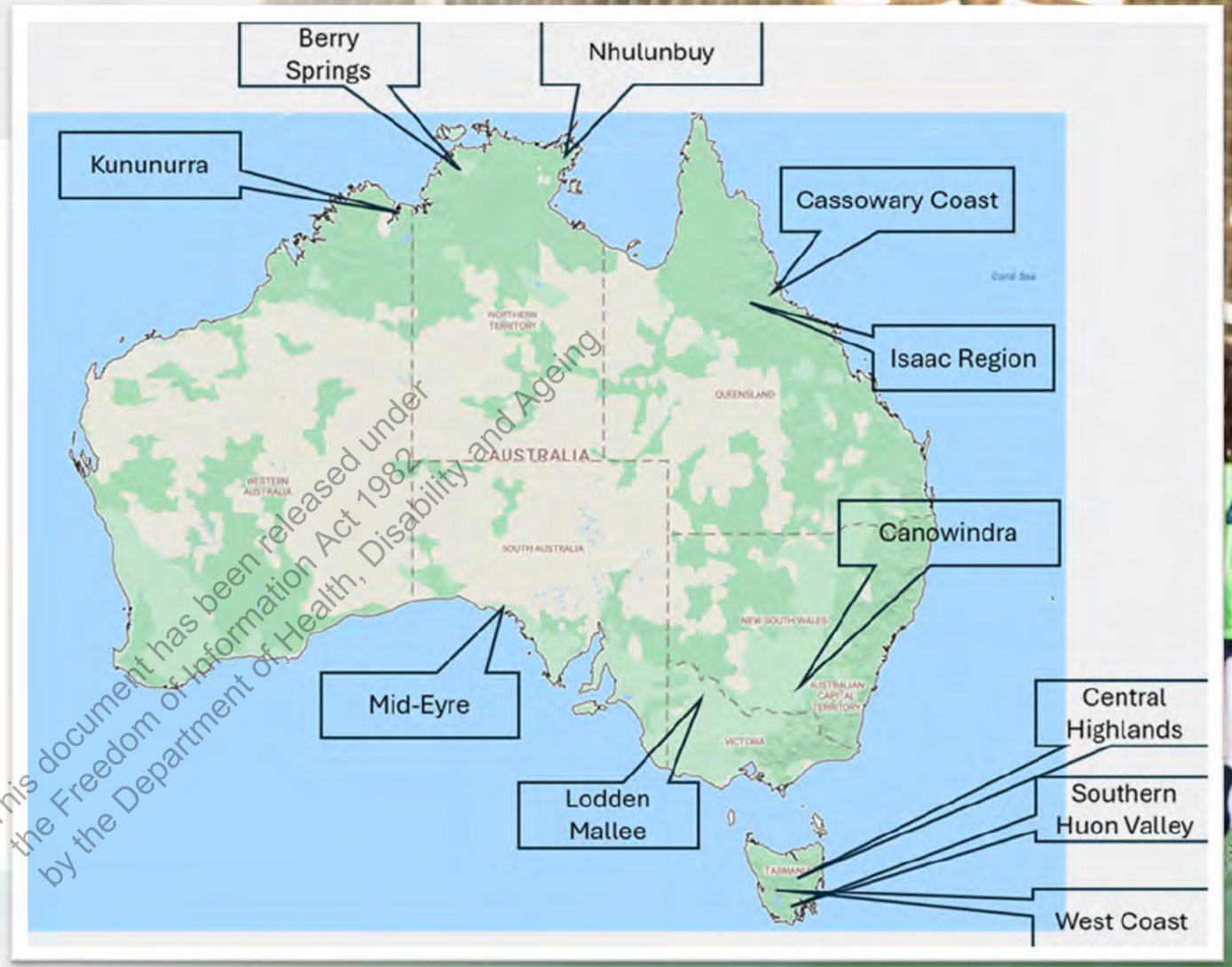
AKA – "Thin Market"



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Current Situation

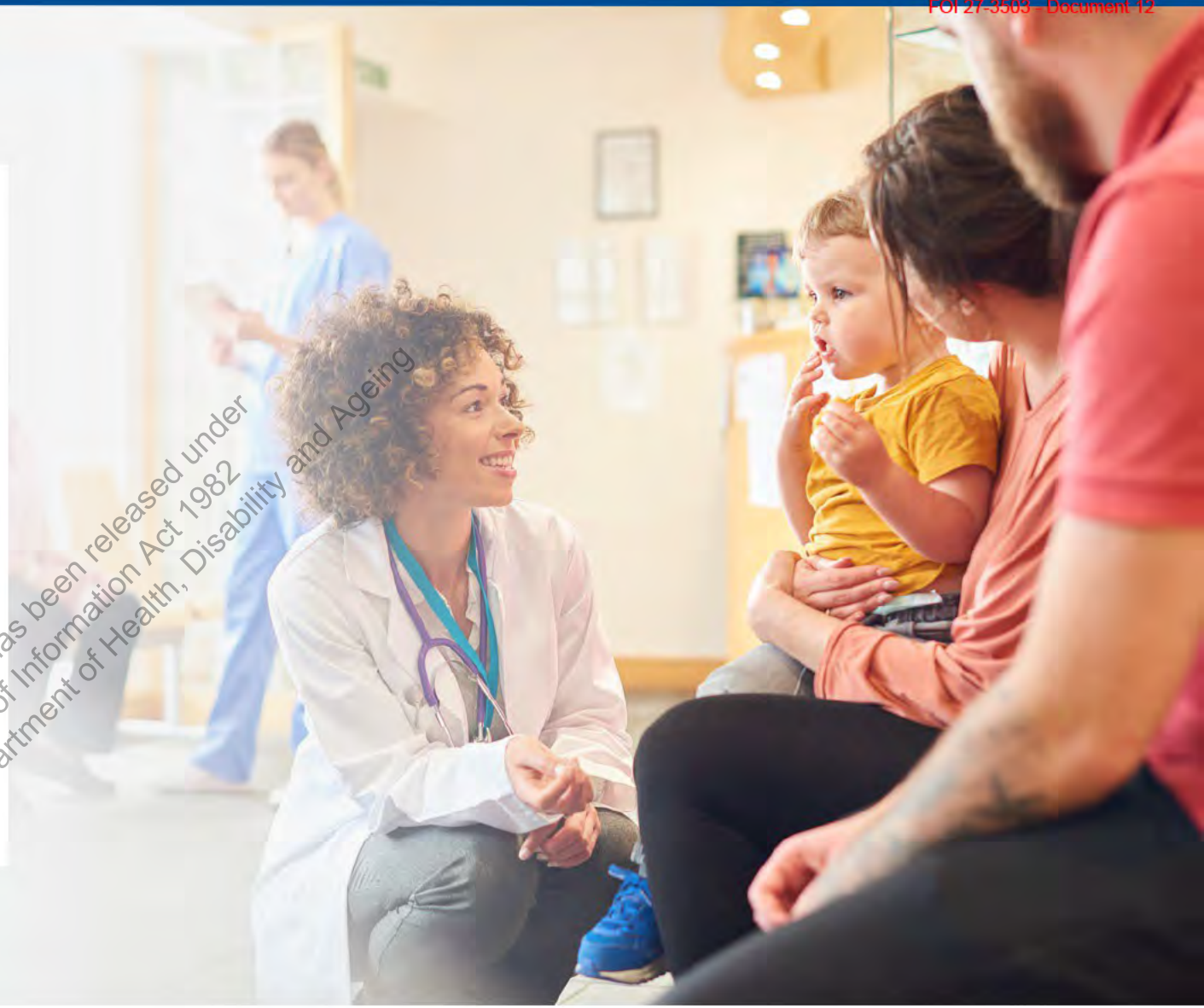
- *11 active sites nationally*



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Eligible organisations?

- *Listed organisations*
- *Letter of Invitation*



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Eligible activities

- *Enhance access in an identified location*
- *Address barriers to sustainable service*
- *Contribute to long-term sustainability*



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Eligible Expenditure

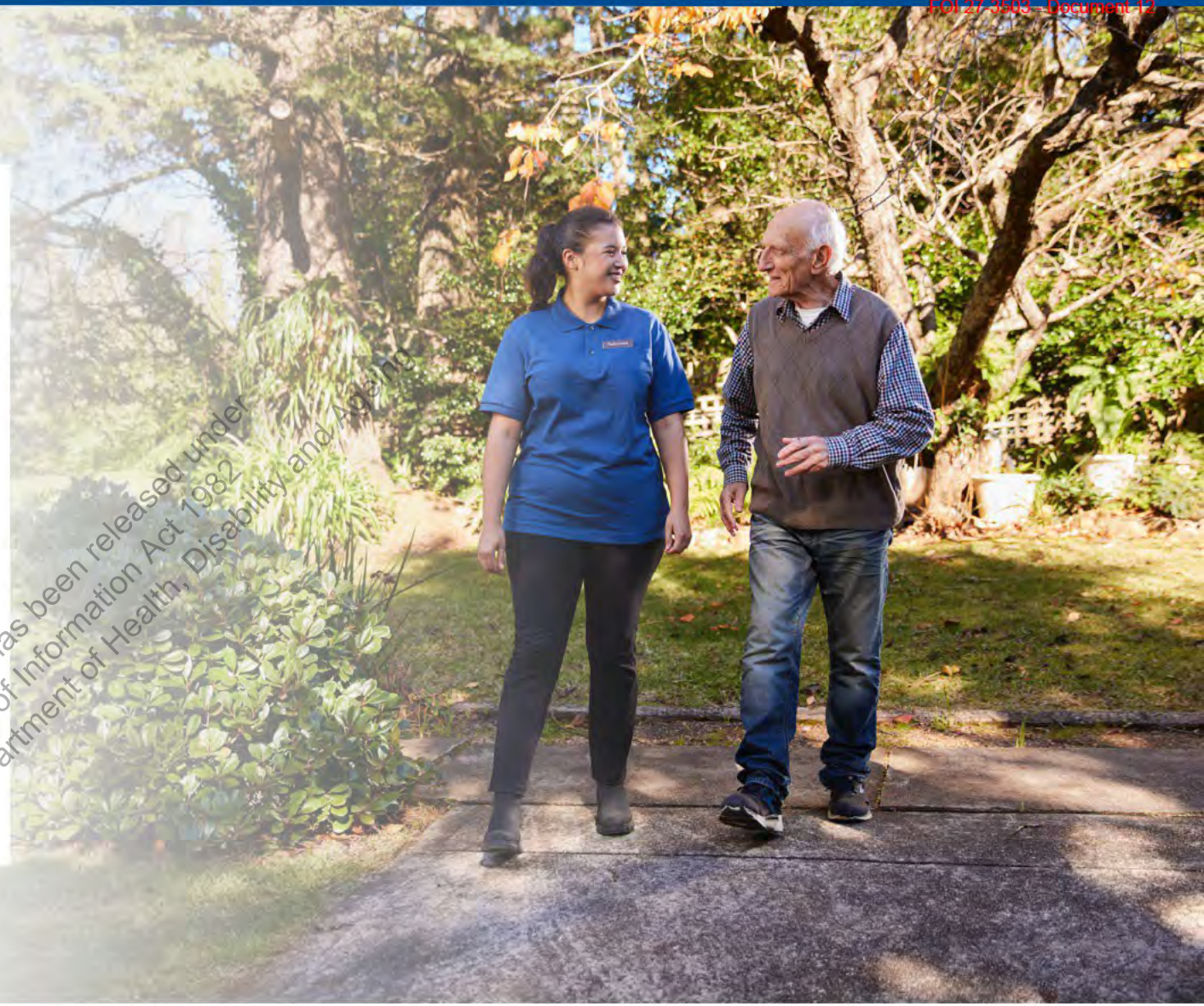
- *Co-design and delivery*
- *Consultation*
- *Travel*
- *Commissioning primary care services*
- *PHN project management (10%)*
- *Minor capital*
- *Training*



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Ineligible Expenditure

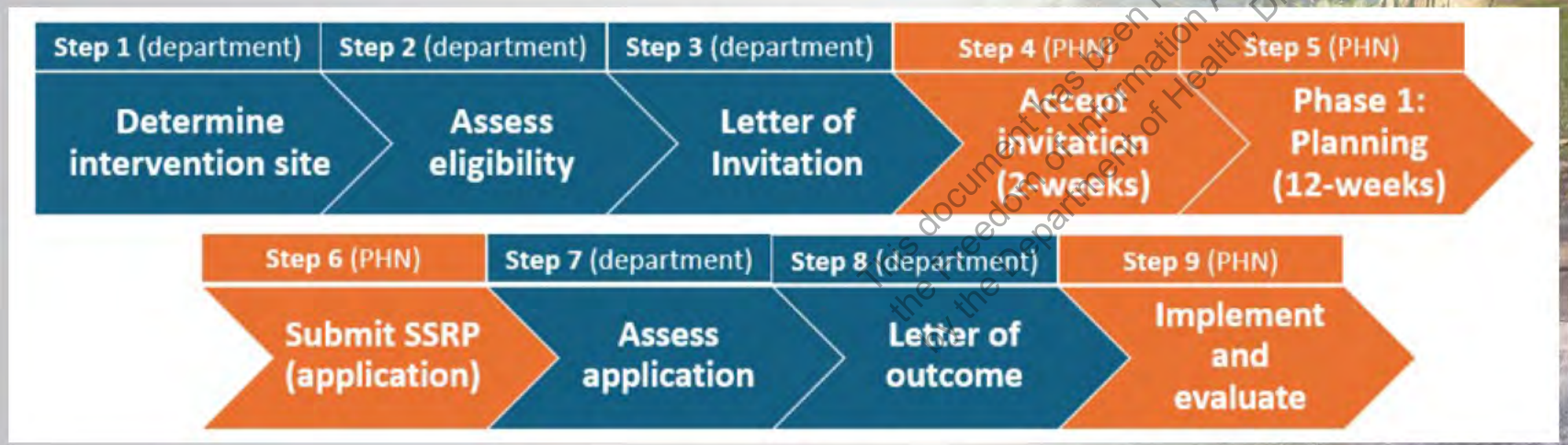
- *Land, ransomware*
- *Major capital/construction*
- *Wages and salaries not related*
- *Retrospective costs*
- *General administration – electricity, rent*
- *Overseas travel*
- *Government responsibilities*



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New Grant Opportunity Guidelines***

- *Phase 1 by invitation and offer of funding*
- *12 weeks to develop plan*
- *Phase 2 Service System Recovery Plan*
- *Revised and streamlined assessment criterion*





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