Response to Consultation on Thin Markets in regional and remote Australia

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Executive Summary

The PHN Cooperative was formed in 2017 by the CEOs of the 31 PHNs as a joint initiative and commitment to collaboration and delivering on the national agenda in primary health priority areas. Together with the PHN Regional Health Working Group, we submit this paper to support the current efforts of the Department of Health and Aged Care's Health Workforce Division to develop responses to thin markets in regional and remote locations across Australia.

In recognition of the complex policy, service and community environments that affect thin markets in regional, rural, and remote Australia, the PHN Cooperative has coordinated PHN contributions to provide local context and models of care from relevant markets and regional/rural jurisdictions. Through the PHN's varied presence, we straddle and extend beyond jurisdictional arrangements and boundaries and as such have focussed our consultation and this submission on contextualising and creating consistency – to effectively drive a 'one system' approach.

To this end, the PHN Cooperative believes there is a genuine need to examine impacts on thin markets at the macro-, meso- and micro-level to understand the likely impact of policies and funding mechanisms on thin markets, particularly as they relate to potential unintended outcomes.

Whilst the PHNs support the macro-level reforms and directions of the *Strengthening Medicare – Support for Health, Care and Support Services in Thin Markets Measure*, we are cognisant of the inequity of funding and policy levers that negatively impact reform in areas of market failure. These competing levers significantly impact ability to effect change, particularly for primary care.

Alongside wider policy, such as the Stronger Rural Health Strategy and the continued investment in increasing opportunities for rural health and medical training, aeromedical and health outreach services, the Measure's commitment to reviewing policy and program levers to support thin markets is therefore a key focus.

Through our contribution, we aim to supplement micro-level consultations and information, translating the data and needs presented by practices and communities we engage. The submission considers the system, service and community-level barriers and enablers associated with addressing thin markets in a sustainable, consistent manner.

To achieve this, the submission outlines the PHN Cooperative's recommendations:

1. Establish a **unified model and definition** of the spectrum of capacity exhibited by thin markets;
2. Set out defining **parameters for thin markets** that can be gathered through repeatable data-driven assessment processes to establish consistency of definition;
3. Establish a set of **core design principles** for methodologies/approaches to thin markets based on successful models that PHNs have observed/incepted, that can then be adapted or innovated upon to address localised context; and
4. **Key enablers of success** in the short- to medium-term alongside areas of concern, barriers or implementation that will affect thin market methodologies.

This work has been developed alongside interrelated evaluations of issues and challenges that span the primary care sector, such as the PHN's Unleashing the Potential of our Health Workforce (Scope of Practice Review) (Appendix A).

Furthermore, the PHN Cooperative is aware of work currently being undertaken by Minister Butler's office to detail and report on thin markets. We put forward this paper to further supplement the consultations and information gathering that is currently underway.

We welcome the opportunity to leverage the PHN's experience, data, and learnings to support the Health Workforce Division and the Department of Health and Aged Care to develop a coherent approach across jurisdictions that focusses on quality and consistency.

Section 1: Introduction and context

This submission is made by the Primary Health Network (PHN) Cooperative in response to the current consultation and evaluations regarding thin healthcare markets in regional, rural, and remote Australia.

Since 2020, there has been a noticeable rise in communities experiencing 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:

- Smaller rural and regional communities where there was only one general practice, or a single practice that dominated the market were most at risk.
- Challenges facing general practices in these communities often related to critical mass, and these challenges were experienced by other health, care and support services.
- Competition with block funded services such as ACCHOs, and State or Territory run services using 19(2) exemptions has also threatened practice viability.
- 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 Department of Prime Minister and Cabinet has acknowledged the complexities of thin markets and has emphasised that *"nuanced approaches to market stewardship are required in thin markets, and across the care and support economy, to ensure people have access to the care and support they need."* In rural areas where challenges are significantly worse, market failure has led to inequity of access to primary care in remote rural communities. This has had a consequent impact on emergency presentations and the well-being of these local communities and priority populations.

The PHN Cooperative commends the Government's intention to embed a more nuanced approach, and the PHNs have been actively involved in consultations held in thin markets across Australia. Therefore, the PHN Cooperative and PHN Regional Health Working Group call on the Federal Government to ensure funding for thin markets is prioritised according to equity and need, and consequently that the first tranche of funding is effective and appropriate.

Aligned to the Department of Health and Aged Care Health Workforce Division's current goals, we have used this paper to address the regional/rural perspective in response to the current policy drivers. We recognise that the regional and rural context are areas that need particular attention and additional support. However, we feel it important to recognise that primary care markets exhibit sustainability challenges and declining patterns of services even in peri-urban areas.

Through this response, the PHN Cooperative has endeavoured to support a common understanding of thin markets, present key design principles for successful models of care, identify enablers of success and areas of immediate action to address thin market challenges.

We look forward to continued discussion to achieve these objectives and have developed this paper to provide further support to the development and roll-out of any thin market measures.

1.1 Establishing a uniform model to define market capacity

Observing market changes and the evolving landscape of primary health care in Australia over the past eight years, the PHNs and the PHN Cooperative firmly believe there must be an evidence-based, and uniformly agreed definition and parameters of 'thin markets' to drive sustainable outcomes.

The PHN Cooperative supports a tiered approach to defining market capacity, recognising the spectra of need from *Stable Market, Thin Market, Thin Market at Risk of Failing, Failing Market, Market Failure, and No Market.*

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Based on a range of previous works undertaken, we have adapted a simplified Market Capacity Framework per Table 1.

Table 1. Modified market capacity framework based on model from Reeders et al 2019.

		Market Diversity	
		Non-diverse	**Diverse**
Market Sufficiency	**Insufficient**	**Failing Market** • Few or no providers. • Little market incentive for responsiveness. • No dynamic market function and inefficient prices.	**Thin Market** • One or few providers meeting client needs (incl. complex needs). • Limited diversity of services and suppliers. • High level of fragility in market.
	Sufficient	**Thin Market** • Multiple providers offering similar or 'standardised' services. • Limited drive to meet client needs or choice, therefore no meaningful level of patient control. • Limited sustainability in market.	**Stable Market** • Diversified supply. • Multiple providers offer qualitatively different approaches. • Client needs-based approach. • Incentives to drive responsiveness.

Building on this model the PHN Cooperative believes that there are six key 'stages' of market capacity, with specific factors that define the various markets including:

- **Stable Market** – where community and provider populations are sufficient and appropriately diverse to enable market competition and client-centric care.
- **Thin Market** – 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.
- **Thin Market at Risk of Failing** – where indicators demonstrate increasing fragility of the market, with often single or few primary care providers, many practices at significant risk of closure, and long-standing challenges in attracting and recruiting a workforce. Service sufficiency and diversity are notably inadequate to meet consumer needs.
- **Failing Market** – where indicators demonstrate an irreversible or near irreversible decline in market capacity, practice closures due to financial unviability, poor access to services and extreme challenges meeting workforce needs. Demonstrated by inadequate service sufficiency and diversity.
- **Market Failure** – when community populations are too small to support private provider business models, there are shortages of GPs and other health professionals, restricted access to Medicare funded services, a disproportionate number of elderly, poor and underinsured residents, and high rates of chronic illness.
- **No market** – a systemic inability for clients to access effective primary care services or Medicare funded services. This designation comes with an inherent recognition that there are instances where a market cannot exist in the traditional sense and should not be forced. In these cases, a specialist tailored response is typically in place, such as Royal Flying Doctor Services.

We have used these definitions to structure the development of this paper, as well as in our review of successful models to support thin markets and the subsequent development of core design principles.

1.1.1 What parameters define thin markets?

To support these definitions, parametric bounds are required to ensure that market definitions can be effectively assessed and applied in any jurisdiction. This is crucial to providing objective indicators of market capacity for policymakers and stakeholders to ensure quality, equity, and accessibility.

Delineating a thin market in primary care involves balancing market-related metrics with consumer and provider-related perceptions of service adequacy. Further, it is important to not simply take a snapshot of the market as it exists but assess the fragility and sustainability of the market to design and implement successful models.

Whilst not an exhaustive list, we believe these parameters should include:

- **Population demographics** – such as population size, indicators of aging workforce, community and consumer health needs, levels of disadvantage, population socio-economic status, presence of large vulnerable populations, commercial viability of primary care provision and patient feedback and satisfaction surveys.
- **Practice and clinical metrics** – such as numbers of providers, provider diversity/choice, waiting times, practice and clinical quality indicators, health outcomes, population health management and prevention measures.
- **Workforce capacity and capability** – such as availability of general practitioners, staffing levels and workload, diversity of healthcare professionals, reliance on work-in-work-out workforces, training and professional development opportunities.
- **Consumer service metrics** – such as diversity of services, service accessibility, waiting times for appointments, consumer perception of choice and adequacy of access and accessibility for patients with specialist needs (e.g. disability or transport). Community engagement will be a key evaluation area to identify consumer service metrics.
- **Markers of existing service fragility** – such as age of practitioners, financial viability (e.g. revenue sources, operational costs and sustainability), regional economic status, competition from State services for general practitioners, or proportion of providers/services that are wholly reliant on State/MBS funding. An assessment of ecosystem fragility is critical, to demonstrate where a change in circumstances would threaten practice viability.
- **Care coordination and integration –** including evaluation of collaboration between specialists, hospitals and other healthcare providers, transition of care, referral patters, integration with social services and community organisations, and targeted support such as Work-in-Work-out.
- **Geographic coverage of jurisdiction –** such as the Modified Monash scale balanced against a range of other factors identified here, including access to services within pre-defined distances (e.g. ‘easy distance’).
- **Forward risk profiling** to assess market fragility, including practice closure risks, operational costs, environmental scanning, emergency preparedness, participation in quality improvement, practice financial and quality reporting, regulatory compliance, and workforce wellbeing efforts.

These parameters could have scaling or weighted values assigned for each ‘stage of market’ to delineate clear boundaries for each.

Section 2 – Taking learnings from successful models

To support the activities of the Health Workforce Division and assist to inform the development of proposed procurement activities to address thin markets, the PHN Cooperative has presented below six principles of successful design. These have been taken from observations across numerous successful small-scale models and trials to address thin markets in regional or remote areas.

From these service models and case studies, the PHN Cooperative has distilled a set of principles that underpin the foundation of success. Implementing these principles or drawing on them as the foundation for further programme/project design would drive consistency and quality.

The six principles include:

Build local capacity and enabling access to multidisciplinary care.

Build collective primary care capability through partnerships, networks, consortia, mergers, amalgamations - organised regionally, distributed and delivered locally.

Leveraging existing capability and capacity to leverage assets-based approaches (e.g., hub and spoke models).

Working with local leadership and local healthcare providers and enabling them to support development of new models or solutions.

Integrating primary care and acute services to enhance wrap around support.

Recognition that patients seek continuity of care at three levels: relational (preferred provider), informational (exchange), and management (coordination of care).

Optimise primary care relationships at a community level and generate scale and capacity to enhance localised service provision and support.

Care is provided holistically and considers social determinants.

Effectively integrating systems, funding and people will drive improvements in equity of access and enable patients to derive greater value at the point of care.

Team-based employment settings

Provide attractive and supportive environments for teamed healthcare delivery with providers working collaboratively to and at the top of scope of practice.

Structural changes to primary care entity ownership

Provide an attractive employment setting that offers rewarding positions, employment arrangements and career options.

A variety of clinical and professional experiences in settings and situations that support career satisfaction progression and mobility with opportunities aligned to professional and personal choices and lifecycles/stages.

Re-organise funding to support care provision

Pooled funding regionally, blended funded at patient care level to allow greater viability, coordination and support, responsive, sustainable, and targeted patient care.

Digitally enabled delivery

Integration can occur through virtual co-location.

Use of digital tools and models of care such as remote patient monitoring, technology etc

Sharing of health records and information seamlessly so that information collection is not duplicated, and patients don’t have to repeat their story.

Leveraging these design principles to inform measures such as the proposed Thin Markets Grant has the potential to inform ready-made solutions and improve access to market capability.

Furthermore, broad-scale application of the principles will enable greater cohesion between responses, jurisdictions, and levels of the health system. This will ensure place-based solutions can be prioritised to address the challenges of thin markets and improve our ability to invest appropriately and respond rapidly.

Provided in short form as case studies below, the models from which we derived these principles can provide exemplars or frameworks to inform the forthcoming Grants and longer-term procurement activities to address thin markets.

2.1 Models used to inform the principles

The case studies noted here reinforce the complexity inherent in meeting the needs of thin markets, and highlight the need for coherent, consistent design principles to inform quality outcomes-based procurement. These should not inform prescriptive models.

Service Model 1: Leveraging principled models through local Alliances to address thin market challenges

In 2022, North Queensland PHN (NQPHN) in partnership with Cairns and Hinterland Hospital and Health Service (CHHHS) established a local advisory group to collaboratively examine the needs of the Tablelands community and primary health care providers. Ultimately this group commissioned research and consultation work to produce the Tablelands Primary Care Enhancement Project Final Report and Recommendations.

The report and recommendations were endorsed by the advisory group with the key recommendation being that a long-term local alliance be formed to oversee development of a workplan to enhance primary health care services in the region.

Better Health North Queensland (BHNQ) is witnessing a critical primary care market failure across many of our rural and remote communities, resulting in poorer health outcomes and increasing burden on hospital facilities. Since 2021, ten general practices have closed and the BHNQ has identified seven local communities experiencing significant market failure. In parallel to the Alliance formation, BHNQ developed the Rural Primary Health Hubs model (Appendix B).

Whilst currently in feasibility stages, the model provides an agile framework to address community and thin market issues in FNQ. For example, the foundational principles of the model informed NQPHN's support for the Cassowary Coast thin market region and Cardwell. The work by Townsville Health and Hospital Service and the Department were supplemented by a range of health workforce interventions such as the NQ Health Workforce Alliance collective, relocation incentives with Health Workforce Queensland, and a Virtually Integrated Practitioner trial alongside Grow Rural.

Embracing the diverse capabilities of Alliance members, Better Health North Queensland and other stakeholders, underpinned by the principles of the Hub Model enable us to address complex challenges in multi-dimensional partnerships.

Service Model 2: Designing a sustainable Rural Health Project

The Murray PHN has submitted this model for the rural farming and food production region (MM5) of central/northwest Victoria, which is bounded by the Shires of Buloke, Loddon and Gannawarra. With a small and ageing (median age 55+) population, the region demonstrates increasingly complex healthcare needs including higher rates of chronic conditions as well as socio-economic disadvantage.

The region is serviced by 12 general practices, of which the majority are privately owned solo practices and two which are locum models. With an aging GP workforce (over 60 for the majority), and continuing workforce shortages, no contingency or success plans, community access to care is increasingly becoming compromised.

To address these challenges, the Integrated Health Network Alliance was formed in 2019. Working in partnership to address shared sustainability pressures and workforce concerns, the Alliance's aim is to create networked services and co-plan integrated healthcare. Through community research and local co-design, the Alliance develops tailored models, such as the Nurse Practitioner Rural Outreach Model (the first pilot model).

Launching in 2022, the Model was designed to better use existing nurse practitioner (NP) workforce capacity in the region, within private general practice and community health settings, to support the solo GPs and enhance patient care through team-based care.

The model takes a systems approach with multiple interventions, drawing on key design principles of:

- Coordinated, centralised governance that leverages local leadership and networks.
- Digital enablement, using health information technologies and better data sharing to enhance services.
- Leveraging local capability and workforce to deliver services through innovative mechanisms using a hub and spoke model.
- Long-term service planning and a drive for sustainability that draws on short-term funding.

Two NPs deliver primary care clinics at four sites (Kerang, Boort, Charlton, Quambatook) through a hub and spoke model at a rate of one day per fortnight per site. The NPs are supported by a locally employed Care Coordinator (CC) who supports the NPs and GP to collaborate and supports patients with health system navigation. The CC also supports administrative tasks to maximise NP's clinical time and MBS billing for sustainability.

In these small rural towns, the general practice and hospital are co-located, and the NP provides services into the hospital in-patient, outpatient, and residential aged care services alongside the GP (who is the VMO).

Murray PHN appointed a project lead to support the IHN Alliance with co-planning and to provide practical assistance for the co-design of models. Murray PHN has also funded the establishment costs for the NP model and provide implementation and evaluation support, with the goal of refining the model to be sustainable in isolation after the pilot.

The NPs see 10-14 patients per day per site, providing longer appointments for comprehensive primary health care. Since 2022, over 262 consultations have occurred, with 90% of patients reporting strong or very strong levels of satisfaction with their care, interactions and availability. In surveys, patients noted seven key quality themes of **patient-centred care, high quality care, accessibility, length of availability, choice, effective service delivery** and **appropriateness as an alternative to a GP.**

This is an example of place-based commissioning through co-design for the development of a sustainable primary care service that utilises all existing resources and workforce capacity.

Service Model 3: Community-led Integrated Health Care Program

Gippsland has a high prevalence of chronic conditions, high levels of socio-economic disadvantage and lower access to allied and other health services when compared to other regions in Victoria. During 2022, Gippsland PHN undertook co-development with the local Gippsland community and service providers to design an integrated, place-based model of primary care as a service model to be applied in thin market circumstances.

Our goal was to trial the delivery of an innovative multi-disciplinary team-based care service to meet local community need:

- be underpinned by Australia's Primary Health Care 10-year Plan 2022-2032 and Deloitte Australia's Health Reimagined White Paper; and
- be future-focused to address regional access barriers and disparities in health outcomes.

The model (Appendix C) provides team-based, person-centred care through a health care Hub model staffed by a shared and integrated workforce. The Hubs can be integrated physical services, co-located services or use virtual integration to enable practitioners to work at full scope of their practice, supported by service provider partnerships. The model also centralises Care Coordination (CC) and accessibility via face-to-face and supported telehealth (or other digital means).

Commissioned models

Following the PHN's commissioning process, for which the tender specifications were codesigned by community members and health practitioners, two services were awarded contracts and commenced service delivery in July 2023.

One model is an Integrated Health and Welfare Service for vulnerable children and families in an area of high social and economic deprivation through a partnership between a community health service and an NGO. The vulnerability profile of the youngest community members continues to impact health and wellbeing outcomes throughout their lifespan, with significant individual, family and community costs.

The clinic provides care coordination, transport assistance and a multi-disciplinary approach which addresses some of the social determinants of health that can impact on access to health services. The service includes a full-time care coordinator and social service navigation role and supports access to digital health services should external telehealth meeting/s be required (e.g. a review with the Royal Children's Hospital).

The second model is a partnership between a small rural hospital and a remote community group to deliver care coordination and nursing services to residents in surrounding remote communities. Services are delivered in local care hubs (neighbourhood centres) and include allied health, pathology services, and medication services for complex case follow up, locally focused and targeted prevention and health promotion projects that support the social determinants of health, and home visits where appropriate. The local care hubs are connected to the rural hospital using HoloLens telehealth technology.

Extensive community consultation and collaboration ensured communities were empowered to design tailored solutions that reflect local strengths, challenges, and needs. The Community Led Integrated Health Care model is specific enough to ensure that the design principles are consistent whilst allowing flexibility for communities and markets to determine the most appropriate configuration for their needs.

The program highlights the value of embedding community leadership and collaboration to drive fit-for-purpose commissioning and program design. Evaluation is currently underway through a PRIMM grant.

Service Model 4: Virtual Integrated Practice Program

Submitted by the Darling Downs and West Moreton (DDWM) PHN, the model was developed to address challenges of access to health workforces in remote and rural communities in Queensland, particularly primary healthcare.

The Virtual Integrated Practice Program (VIPP) leverages digital technology to enable access to a broader workforce pool and allow rural practices to continue to deliver services to patients locally within the general practice environment. To supplement the rural workforce, the VIPP has two core mechanisms:

- Introduction of fit-for-context, high-end video telehealth equipment (VisionFlex Carts) and training on their use and telehealth protocols for GPs; and
- Facilitating links between rural/remote practices and metropolitan practices through the PHN's networks to enable shared practice and capacity models.

The model enables metro-based practitioners to work remotely, as part of the rural practice team through integrated team-based settings. Importantly, the metro-based practitioners are encouraged to become 'part of the rural practice', visiting regularly to establish relationships with practice staff and to see patients face-to-face.

Video conferencing plays an integral role, improving access to general practice care for rural patients, without compromising the quality and efficiency of healthcare. Video telehealth (and associated MBS item numbers) enable general practices to adapt to new collaborative workplace models, and extend the reach of healthcare providers. In addition to this, it involves practice nursing staff and / or other multidisciplinary team members in the delivery of care.

For example, a metro-based GP would join a rural practice to provide remote care to patients one or two days per week via secure telehealth. The VIPP GP joins the practice for a minimum of 12 months and works onsite for a short period (3-5 days) every 6-months. Participating practices offer telehealth appointments with the VIPP GP to known patients, and patients are encouraged to attend these appointments from the practice. The VIPP GP is provided with secure, remote access to the practice software/medical records to enable comprehensive, quality primary care.

The impact of the VIPP

Seven practices have now joined VIPP and been provided with VisionFlex Carts across rural and remote areas of DDWM. Key indicators of success from some of these practices include:

- Clifton Medical Practice has four virtual GPs and is using video conferencing / the VisionFlex cart daily. Since late May 2023, they have supported 1500 patients through VIPP.
- Clifton Medical Practice is now providing video consultations to other rural practices e.g. Pittsworth and Killarney.
- Nanango Medical Practice has been able to re-open a sister practice in nearby Yarraman, that had been closed for 2 years and has taken on additional patients in the Wondai Aged Care Facility due to the increased capacity.
- First Avenue Health Hub entered the program in September 2023 and has commenced recruitment of additional staff within the practice to facilitate use of the VisionFlex cart.
- Goondiwindi Medical Centre has partnered with metro-based Redbank Plaza Medical Practice, which will see three GPs visit the practice in Goondiwindi to orientate and then commence Video consultations.

2.2 Supporting the Health Workforce Division to create successful strategies

The PHN Cooperative recognises that a range of consultations are in progress to facilitate the Thin Markets Measure and agree a basis for guiding a procurement process in 2024. Throughout these, the PHN Cooperative has received positive feedback from individual PHN's attendees regarding the Health Workforce Division's open and collaborative approach to deriving solutions.

We support the agenda at these consultations, and the value that has been extracted from the scenario-oriented workshops.

The PHN Cooperative has developed this response to further assist the Health Workforce Division to understand potential challenges, exemplars, and develop criteria for subsequent grant or procurement activities. Our goal is to support the Health Workforce Division to incorporate the successes of existing initiatives or models and co-design a coordinated and organised approach.

Approaches derived from this process could then be used to remodel broader grants or procurement activities to support thin markets at the national level, or across other health disciplines.

From this point, our response highlights key challenges, opportunities, and areas of need that the PHN Cooperative believes are necessary to achieve sustainable, coherent, and quality outcomes in the short to medium term.

2.2.1 How PHNs will add value to this process

The PHN Cooperative believes that there are solutions that are available now that can be tapped into. Many PHNs are already working in this space, leveraging existing funding, partnerships, and other approaches to deliver or co-design successful models. To date, responsiveness of PHNs' and primary care providers' support has been centred around urgency of need and crisis responses, responding with limited capacity and resources. The introduction of targeted, secure funding to address thin markets is a welcome addition to these efforts.

Across the 31 PHNs, we will leverage our position and networks to highlight successful and innovative strategies, models or approaches that are developed. This will enhance the primary care sector's ability to both scale at pace and scale sustainably. The ability to draw on our knowledge base and regionally responsive and place-based commissioning structures will ensure outcomes are achieved.

In particular, the PHN Cooperative and the PHN Rural Working Group believe that we can add value to the consultation and solutions to thin healthcare markets through:

1. Key data streams and Health Needs Analyses
2. Commissioning structures
3. PHNs Networks with community, health stakeholders and practices.
4. Workforce Planning and Prioritisation
5. Practice Quality Improvement
6. PHN's expertise in co-design and collective impact
7. Expertise in delivering flexible, principle-based and place-based solutions to address targeted health needs.

Recognising the PHN's centrality to the various health reforms and our ability to coordinate and contribute to the wider policy and primary care context, we welcome the opportunity to support the Health Workforce Division to develop the procurement guidelines in the short-term.

Section 3: Enablers to success in short- to medium-term strategies

The Primary Care Conference held in September 2023 brought together key leaders in Primary Health Care to discuss Healthcare Reform. Across three days, these leaders demonstrated a commitment to a one system approach that is underpinned by flexible and transparent funding opportunities for evidenced based, systemised solutions.

The PHN Cooperative has drawn on the outputs of the breakout sessions and the thought leadership of industry leaders at the Conference into this paper, contextualising key themes, drivers, and strategies from the Conference to the challenge of thin markets and the design principles.

Further, the case studies and project briefs detailed in Section 2 above demonstrate that, across Australia, there has been some success to mitigate the challenges of thin or failing healthcare markets and meet patient need.

From these sources, we propose that there are certain **key enablers** necessary to drive successful design and adoption that PHN's can coordinate, including:

- Recognition in funding and policy of the differing place-based contexts and opportunities in regional, rural, and remote settings.
- Local community leadership and provider co-design must be incumbent to models to ensure sustainability and fit-for-purpose.
- Increasing accessibility and equity of service provision by incorporating technology, data, telehealth, and digital capability.
- Leveraging PHN's coordination role to develop and build place-based and co-designed innovative workforce solutions.
- Implementing structured co-commissioning models that address inequity of funding models for regional, rural, and remote markets to enable models to be designed and implemented.
- Collaborative/sectoral focus to build scale between providers and integration between the State and community level.
- Flexibility of policy to recognise critical dimensions of local markets (not necessarily time-sensitivity) whilst prioritising inter-connectedness of enablers.

These enablers can be leveraged to inform opportunities, innovation, and sustainability in locally contextualised manner. Furthermore, over the medium to long term, we believe that similar design principles (if tested and evaluated appropriately) will enhance other sectors including NDIS, Aged Care and national program priorities.

3.1 Embedding a principled approach to enable consistency

The design principles and enablers highlighted above could be used as a foundation for establishing structured commissioning and procurement models. A set of agreed principles will enhance consistency across the health system by presenting a framework for organisations to adapt, innovative and expand proven models of care.

Building on the principles of effective model design that were laid out in Section 2 above, pilot projects should be implemented to validate said principles. Incorporating structured evaluation within the pilots will then enable identification of a 'principled approach' to drive consistency of responses to thin markets or market failure.

Any approach must be responsive to the key challenges and issues that are consistency identified as barriers to market stability, including:

- **Financial viability of models -** exacerbated by low client numbers and/or a highly dispersed client base, resulting in higher per-client operational costs. Inequity of funding models and attribution is

a key determinant of provider sustainability and market stability. The current range of competing funding and policy levers that negatively impact viable primary care in certain locations has propagated a situation where often, State services are seen to effectively cannibalise primary care.

- **Workforce capacity and availability** – including challenges in recruiting and retaining qualified and appropriately diverse workforces. Provision of learning and development opportunities are a secondary challenge, with gaps in supervision or trainer capacity/capability and opportunities. There is an opportunity to bring State health stakeholders in to support market adjustment strategies, for example leveraging employment opportunities in MPS or Hospitals for generalists to enable flexible delivery.
- **Geographic distribution and isolation** - recognising that the risk of market failure in *Thin Markets at Risk* is highly dependent on where practices are physically located. Physical distance and travel time result in higher costs for service delivery for isolated or highly dispersed communities. PHNs are well placed to understand and identify risks at a locality level through our networks, Health Needs Assessment and practice improvement and quality services.
- **Vulnerability of clients** – the communities that some providers service may have complex and higher needs, including isolation, complex disability support needs, and challenges in self-determination of needs. These clients require more highly qualified staff to service their needs.

These issues are not new, representing ongoing challenges in the healthcare sector. However, they must be considered alongside key design principles and frameworks to identify fit-for-purpose solutions for each market. For example, the trade off between Market Facilitation and Market Deepening in rural or remote areas will underpin long-term sustainability of any model.

Comparatively, alternative commissioning models (such as community-led responses) and Single Employer Models have the potential to introduce economies of scale to mitigate challenges of distance and financial viability.

3.1.1 Striking a balance between immediate need and capability-building to achieve 'quick-wins' over the short to medium term

The PHN Cooperative believes it is necessary to develop ready-made solutions or operating models that enable immediate application. Through pilot evaluation (under the forthcoming Thin Markets Grant), there is an opportunity to develop evidence-based 'stock models' to improve access to market capability and incorporate existing capability that can then be tailored by local stakeholders to meet local needs.

Compared to instances where no market exists and a model must be ideated, implemented and proven, this approach would enable a systematic deployment through established local- or co-design processes. Our assessment is that this would support both the current policy context (addressing thin markets) as well as setting a framework for success for failed markets.

We believe there are immediate actions and areas of concern in regional, rural and remote markets that should be reviewed to drive quick wins in the space. Regardless, planning is required to map available health services in a region and understand the integration of services in the market. Alongside this, an evaluation of other successful initiatives and key areas that can affect change, is necessary such as:

1. Evaluation of successful initiatives that can affect change, such as the funding methodology applied to the ACCHOs. This demonstrated the ability to lift access for vulnerable groups and could be leveraged to form future funding models.
2. Evaluation of mechanisms to support Doctors in the hospital system wanting to move to general practice who don't receive a funded GP registrar placement.

3. Evaluation of the 19.2 exemption, which does not appear to be working according to its original intent to utilise revenue to enhance private primary care.
4. Evaluation of the mechanisms by which the Department systematically engages (including authorisation and funding) with PHNs and the primary care sector in addressing the market continuum.
5. Evaluating rural generalist retention by Hospitals which results in fewer taking up positions in rural private primary care.
6. Evaluating access to procedural immersion in a hospital setting for private practice GPs working in these thin market areas.
7. Evaluating current inability to facilitate shared workforce with state bodies in rural areas.

The PHNs welcome the opportunity to work with the Department of Health and Aged Care and the Health Workforce Division to guide procurement activities and the prospective Thin Markets Grant.

3.1.2 Designing flexibility into funding to drive place-based solutions

Flexible, innovative solutions are required to improve provision of primary health care across the diverse regional, rural, and remote communities of Australia. We believe that place-based models provide the flexibility and adaptation to allow local communities to develop tailored models of care and workforce solutions that will address their specific challenges.

They provide the opportunity for innovation, as local areas can try new approaches that can be taken up by other areas and scaled up if appropriate. The contextual and population needs in communities across Australia are varied, and not only due to geography, but also community demographics and need, population density and ethnicity.

There is an opportunity to look at a range of options to incorporate supplementary funding from alternative sources, especially in communities where major industries are involved, such as mining, defence, and farming. This would also enable us to effectively link grants and funding arrangements across measures or programs (for example the *Innovative Models of Care Grant and Strengthening Medicare)*.

Person-centred approaches, which are responsive to community need and supported by flexible and sustainable funding, result in the development of effective, team-based primary health care. Place based solutions have the potential to be both deep (building responsive and sustainable primary health care models) and broad (building care models and workforce solutions that include multidisciplinary and culturally appropriate care).

Successful models require an enabling policy environment, where collaborations between primary, secondary, and tertiary health services are codified in Commonwealth and State/ Territory agreements and are:

- Multidisciplinary, to consider all health needs and provide continuity of care.
- Actively engaging of general practitioners, recognising their central role in primary health care co-ordination and delivery in an integrated and inclusive primary care system.
- Inclusive of all team members working at the top of scope, to be most effective and efficient.

With more flexible funding models, and an agreed set of design principles, PHNs will be able to accelerate and scale up their work with local communities, supporting co-design of pilots to improve delivery, integration, and viability for local primary health care, ultimately improving health outcomes for the community. Alongside this is a need for genuine investment in the change management needed to support this work, ensuring the model is fit-for-purpose and sustainable.

3.2 The need for a shift in culture

A key theme throughout the Primary Care Conference in September 2023 was the need to embrace change in the health sector and drive transformational changes in the primary care sector. Throughout discussions on Healthcare Reform, it was clearly articulated that "primary care providers can no longer work as lone rangers and need to be supported every step of the way."

From his presentation on Primary Care Reform and Change Management, Dr. Walid Jammal strongly encouraged:

- A shift towards **transparency** of data and information.
- A shift from **individual** to **population** management.
- A shift to blended funding
- A **cultural** shift towards **trust** between a) citizens and government; b) providers and government; and c) providers and providers to work better as teams.

Workforce reform and drawing down on place-based solutions were key themes that emerged during the Conference breakout sessions. Industry leaders identified numerous focus areas for these reforms, many of which align directly to the six core design principles and the key enablers detailed above. However, local leadership and community activation were recognised as central to any transformative change.

Whilst we have briefly highlighted sectoral transformation here, the PHN Cooperative firmly supports the need for such a shift. The unsustainable nature of reallocating underspend is one such example, essentially seeing primary care stakeholders prioritising emergency mitigation strategies to avoid market failure.

We believe that the current set of budget measures and commitments made under Strengthening Medicare can, in combination, be enablers of this change through aspects such as the Single Employer Model, Digitally Enabled Care and the Thin Markers measure.

3.3 Building capacity and capability to drive sustainability

Addressing policy and funding levers is necessary to enable nuanced responses to individual localities and their needs. However, without accounting for the capacity and capability of the primary care sector to capitalise on available resources, models of care have a high likelihood of failure. Understanding the fragility of markets and the capacity of providers is critical to building sustainable solutions to thin market challenges.

In line with the quintuple aim, PHNs can leverage our core capabilities to drive outcomes for thin markets, including:

- **Coordinate** and integrate local health care services in collaboration with Local Hospital Networks to improve quality of care, people's experience and efficient use of resources.
- **Commission** primary care and mental health services to address population health needs and gaps in service delivery and to improve access and equity.
- **Capacity-build** and provide practice support to primary care and mental health providers to support quality care delivery.

PHNs support the health care workforce to build capacity and capability and are positioned to support coordinated primary health care responses to emergency and natural disasters. PHNs are intermediaries and coordinators of the primary health care system, with unique local knowledge, understanding for the national context, and the ability to generate insights and interpret local data, are an important stakeholder in the development of well-being measures.

PHNs are uniquely positioned to deliver value to the health system in a range of areas:

System coordination and integration to reduce fragmentation and enhance coordinated, integrated care by working collaboratively across services and sectors.

- Collaboration and building relationships with providers and health services within, and external to, the primary health care sector.
- Collation of statistics and data insights to inform planning, and to monitor and evaluate sector performance within the local area. This includes engaging with local stakeholders to obtain high quality qualitative data.
- Communication and engagement with the community and primary health care providers, including education and workforce development.
- Bridging the jurisdictional, hospital-community-primary health care and cross-sector divides through collaborative commissioning and co-design.

Every PHN can demonstrate significant gains in system coordination and integration; work which continues to build on successes to date.

3.4 Embedding a data-led approach

To support the Department of Prime Minister and Cabinet's objective of creating a more nuanced approach to market stewardship, data are needed to inform and drive policy in a nuanced manner, with objective indicators to ensure quality, equity, and access.

Quality, accurate data is also necessary to set and feed the parameters of market definition. Without a consistent and reliable stream of health, community and primary care data, any benchmark of market capacity will be limited in its application. Decision-making based on poorly scoped statistics or spatial interpretations (a common methodology for extant market analysis) will not provide sufficient depth to flexibly respond to the challenges of primary care markets.

Leveraging PHNs' existing data streams alongside those of the Rural Workforce Agency and local Government data offers a foundation from which to build accurate and targeted datasets. The PHN Cooperative envisions that key data streams would include, but not be limited to:

- Workforce data including leveraging the Workforce Planning and Prioritisation Office (WPPO) will be critical to any dataset. These datasets should include but not be limited to the National Health Workforce Dataset, HeaDS UPP, and the Aboriginal Health Training data sets.
- Regional and geographic patient information, accessibility (e.g. virtual or digital access), service demand and breadth of primary care needs.
- Market diversity and sufficiency measures linked to geographic or spatial indicators (e.g. Modified Monash, Remoteness Levels or locality).
- Billing data such as treatment access, PBS and Practice Quality Improvement data.
- General Practice data (e.g. Primary Sense). We suggest efforts need to be taken to integrate ACCHO data into any models.
- Practice quality data, practice demographics and location gaps.
- PHN Health Needs Assessments which detail a range of social and community determinants.

Agreeing a clear dataset and implementing clear protocols for data sharing and governance is a necessary enabler to inform and drive effective policy, models, and service. Ultimately, quality consistent data streams will also facilitate analysis of the outcomes and impact of the thin market measure and programs.

The PHN Cooperative welcomes the opportunity to work with the Health Workforce Division and other key stakeholders to identify appropriate data and embed protocols and data governance to safely share information.

Appendix A. Submission to Unleashing the Potential of our Health Workforce (Scope of Practice Review)

Appendix B. Better Health North Queensland Rural Primary Health Hubs Model

Rural Primary Health Hubs

A local solution to the critical primary health shortage in rural and remote North Queensland

The Better Health North Queensland Chairs and CEO Forum collectively urge the Federal Government to prioritise the funding of a new rural primary health care solution to address the growing crisis in primary care workforce and primary care access in Modified Monash Model (MMM) 4-7 rural and remote areas of North Queensland (NQ).

Current situation

Better Health North Queensland is witnessing a critical primary care market failure across many of our rural and remote communities, resulting in poorer health outcomes and increasing burden on hospital facilities. Local governments report that inequity of access to primary care in rural and remote locations has become the top issue for these communities.

Since 2021, ten general practices have closed (six per cent) and Northern Queensland Primary Health Network (NQPHN) has identified seven local communities that are experiencing significant market failure in primary care – where the local general practice has closed or is at a high risk of closure.

NQPHN will address these critical shortages by working with local Hospital and Health Services (HHSs), Local Government, key local partners (clinicians and community members), rural and remote workforce agencies, and universities to develop local solutions unique to each community and leverage off existing health infrastructure and community strengths.

Funding requirements

An investment of $308,000 is required for NQPHN to lead the development of a tailored place-based solution for each hub site and prepare a recurrent funding submission (over 6-9 months).

Our proposed solution

Rural Primary Health Hubs

Primary care team (GPs, nurses, allied health professionals) working at top of scope – a mix of in situ, outreach, and virtual.

Place-based and localised
Tailored to local health needs and leveraging local health infrastructure already available

Technology enabled
Telehealth and remote monitoring, shared medical record, shared care plan platform

Support for clinicians
Relocation, housing, training and development, and peer and community networks.

Embedded in community
Community engaged through the Local Governance Group and co-design processes

Multi-disciplinary team
Emphasis on coordination of care; led by GP or nurse/ nurse practitioner

Clinical supervision
Virtual supervision and specialist consults with the local HHS

Blended funding model
Blended at the patient level to support affordable care; pooled across all levels of government to support flexible and mixed employment models

Established networks
Strong links and referral pathways to existing services

Priority locations in the NQPHN region

Localised implementation strategy (Led by NQPHN)

Feasibility study: 6-9 months

- **NQPHN will establish a Local Governance Group**
  NQPHN, HHS, Local Government, Health Workforce Queensland, local clinicians, and local community
- **Understand local needs and strengths**
  Map existing services, clinicians (in situ and outreach), available supports, and community assets (facilities, housing, etc.); analyse local health needs data
- **Co-design a local solution**
  Engage with local clinicians, community, and stakeholders to explore options that meet community needs, optimise community strengths, and are viable
- **Develop the business case**
  Finalise the proposed hub model; agree on a single employer model; develop detailed costings for a blended funding model (including MBS and State contributions)
- **Secure funding**
  Prepare submission to Federal Government for recurrent funding

Implementation: 3-4 months

- **Co-commission the Hub**
  NQPHN will lead the co-commissioning of the local solution with the relevant HHS
- **Establish the Hub**
  NQPHN and HHS will support the successful tenderer in establishing the Hub

BetterHealth NQ — A partnership between

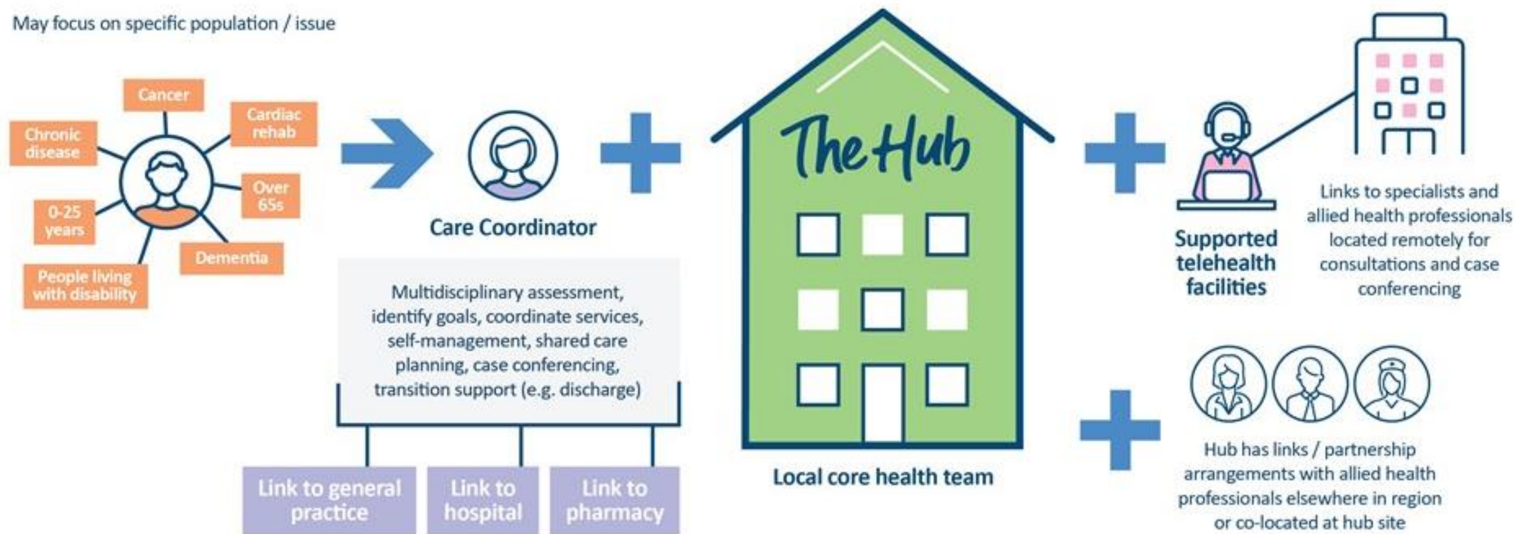
phn NORTHERN QUEENSLAND · Cairns and Hinterland · Townsville Hospital and Health Service · Torres and Cape Hospital and Health Service · Mackay Hospital and Health Service · North West Hospital and Health Service

Supported by

Australian College of Rural & Remote Medicine · Queensland Minister for Health Hon Shannon Fentiman MP · Labor Michael Healy ALP Member for Cairns · SHANE KNUTH KAP for Hill · Cynthia Lui MP · North Qld Health Workforce Alliance · Cassowary Coast Regional Council · Hon Curtis Pitt MP · Les Walker MP State Member for Mundingburra

Appendix C. Community-led Integrated Health Care Program Model

Community Led Integrated Health Care Program



The model will support:

- Integrated service delivery
- Care coordination
- System navigation
- Data sharing
- Continuity of care
- Discharge gaps
- Addressing social determinants
- Consumer satisfaction
- Workforce satisfaction
- Integrating pharmacy
- Reducing avoidable hospitalisations