Building a Medicare Local as unique as the Territory itself

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Northern Territory Medicare Local

As I’m sure you will have all heard before... the Northern Territory is different...or at least that’s what we all like to think up there, so when presented with the opportunity to form a new primary health care organisation for the whole of the Territory, we started with the premise that a unique set of circumstances required a unique solution. In the Northern Territory Medicare Local, we believe we have created an organisation that will have the capacity to address the complex opportunities and challenges of our extraordinary region.

The first and most obvious challenge is that it’s big. The NTML boundary covers a land area of more than 1.3 million km², but the population is small.

There are only five urban centres, with populations of 120,000 in the greater Darwin area, under 30,000 in Alice Springs, 10,000 in the Katherine region, 5,000 in Nhulunbuy and 4,000 in Tennant Creek, plus a large number of remote and very remote communities varying in size from as small as 100 up to a few thousand.

We are young, having the lowest median age in Australia...and we continue to maintain a population of more males than females.

In comparison to the whole of Australia where the indigenous population is estimated to be less than three per cent, approximately 30% of the population is Aboriginal. Thirty per cent of the Aboriginal population live in areas officially classified as outer regional and remote. The other 70% of the Aboriginal population live in areas officially classified as remote/very remote.

Our residents live in very hot and very cold deserts, small tropical communities that can be cut off by road for a third of the year, isolated island communities, and Darwin—a small capital city with high living costs, big aspirations and the ever-present possibility of major infrastructure upheaval due to cyclones.

The Northern Territory is supposedly experiencing the economic benefits of a resources “boom”, with increasing numbers of fly-in, fly-out workers, yet much of the Aboriginal population lives conditions often described as third world and with the poorest health statistics in Australia.

Additionally, even the non-Aboriginal community experiences a lower life expectancy and poorer health than the majority of the rest of Australia.

I’m sure most people here are aware of the tragic large gap in life expectancy between Aboriginal and other Australians and the factors both within the health care system and the wider determinants of health that result in this premature loss of life.

The unique circumstances of the NT have however resulted in significant effort between different health service providers and Aboriginal people themselves to maximise the effectiveness of health resources available. The result is that despite a large gap between resources and need, joint development of systems between government and non-government providers including particularly Aboriginal Community Controlled Health Organisation has delivered recent improvements in health measures, including 2012 Closing the Gap Report data that demonstrates that the NT is the one jurisdiction on track to meet the COAG target to close the gap in life expectancy.

However as death by suicide data shows, not all the progress is in the right direction and over this period, while death by suicide for non-Aboriginal Territorians has fallen, for Aboriginal, people it has dramatically risen.
Over many years the NT has seen the development of two parallel systems of primary health care delivery, a “mainstream” system centred around private practitioners based in urban centres, and Aboriginal primary health care in remote and urban centres delivered by two main provider groups, that is a mix of Aboriginal Community Controlled Health Services (ACCHSs) and the Northern Territory Department of Health, at times with support from one sector to the other.

There are few resident GPs in remote communities and even less resident allied health providers, and no private general practice out of the five urban centres, with the predominant model being Nurse and Aboriginal Health Worker led care with the support of visiting providers who fly in for periods of hours or days. Adding to the richness of the mix, a number of individuals work across all the systems, bringing an informal sharing of knowledge and expertise across the systems.

There has been little after hours care in the urban centres out of the hospitals, although the Department of Health provides 24 hour a day telephone medical support and evacuation service or remote health centres and locations such as cattle stations and industrial sites. There has been very little, but now increasing rates of bulk-billing by private GPs, although official Medicare bulk billing rates for the NT appear to be high. GP shortages have resulted in “closed books” at many practices. There are very limited private specialists and only one private hospital with a limited range of offerings.

The structural separation of these parallel systems has been reflected in different funding arrangements and different models of care. There has been duplication, gaps, poor integration of different parts of the PHC system and at times forced competitiveness between provider groups. The federal health reforms offered an opportunity to create a structure that would bring these divergent systems together to maximise the resources, knowledge and skills of the three service delivery groups in the NT, with the vision of improved health and wellbeing for all Territorians.

In that context, in July 2012, the Northern Territory Medicare Local was formed, through a unique partnership of the previous division of general practice (General Practice Network Northern Territory and incorporating the NT member of the Rural Health Workforce Alliance), the NT government and the peak Aboriginal Community Controlled health organisation, AMSANT (Aboriginal Medical Service Alliance Northern Territory) with a mission to lead the development and coordination of an equitable, comprehensive primary health care system driven by community needs.

The NTML is built from the strengths of all three partners.

Key to what we are hopeful will be its ongoing success, is access to the body of knowledge and experience built by AMSANT and its member services in health systems that embed community control and community participation in health service management.

Joint work between the community sector and NT government has led systems improvements including continuous quality improvement, more equitable resource allocation and universal Aboriginal health key performance indicators.

The partnership also benefits from access to the NT government’s data and health planning expertise and many years of active collaborative work on primary health care reform.

The NTML was also able to commence business on 1 July 2012 due to the inheritance of the staff, infrastructure, systems and processes of GPNNT, “sold” to the NTML for a peppercorn amount in an agreement between the three partners. GPNNT had taken an early step towards an NT wide general practice and PHC organisation when it was created in 2008, and brought its relationship with over 700 primary health care providers in the Territory into the new partnership.

Our membership structure remains the only Medicare Local to include a government health department and an Aboriginal Health Service peak body as collaborative developers and founding members.
• AMSANT
• NT Department of Health
• Associate Member Committee, that is the representative body of the individual members of former GPNNT, which is in the final stages of formal wind up.

NTML is designed to address the complex challenges and opportunities for the delivery of comprehensive PHC services in the NT and incorporate the active partnership and engagement of ACCHSs and improve sharing of expertise across the three different service delivery groups.

The partners share a commitment to the achievement of genuine reform and improvement of primary health care that includes:

• a system wide equity based approach to resource allocation
• developing consistent regional models of health service management with community engagement, sustainability and capacity
• mechanisms for engaging public health and PHC practitioners in regional health service planning and development
• agreed definition of Core Comprehensive PHC Services
• health service performance indicators including the NT Aboriginal Health KPIs
• system wide Continuous Quality Improvement
• real engagement with PHC providers and consumers.

To drive this vision the partners believed there should be governance structures that reflected the true balance of the NT community. Therefore the commitment to real reform is demonstrated at the very top in the structure through the membership of the independent skills based board.

The Constitution of the NTML mandates the inclusion at least three directors of Australian Aboriginal decent. There are no other specified skill sets of positions. Our current Board includes as mix of skill and expertise in private and community controlled general practice, pharmacy, governance, financial management, public health, the administration of community controlled health services, chronic disease advocacy and consumer advocacy combined with overall strong governance skill level with most directors having completed AICD training.

In forming the NTML it was felt that robust mechanisms would be required to hear and act upon the advice of those parts of the NT community that are directly involved in identifying health needs in community. In order strengthen the capacity of the Board to take strategic advice from acknowledged leaders in the their fields, the NTML Constitution also mandated the formation of the Aboriginal Health Committee and the Community Advisory Committee. These two committees will have direct reporting lines to the Board as our most trusted advisory structures. Each committee will have a directors included in its membership to ensure the close relationship between the Board and committee is maintained.

In keeping with other Medicare Locals, we are developing additional mechanisms to build relationships with our stakeholder groups such as:

• clinicians
• consumers
• service providers
The formation of advisory groups in these, and other areas, will provide advice to the organisation through the CEO to inform operational requirements.

In developing our Vision, “Improved health and wellbeing for all Territorians” and Mission, “Leading development and coordination of an equitable, comprehensive primary health care system driven by community needs”, the NTML has made a commitment to comprehensive primary health care and driving service delivery improvements to meet the needs of the diverse communities of the Northern Territory.

Our first goal is to improve equity and service capacity in primary health care systems through identification of the health needs of local areas & development of locally focused and responsive services, the enhancement of Aboriginal community control of comprehensive PHC and support the growth of the general practice & allied health sector in comprehensive PHC.

Our key advisory committees will play an important role in the identification of both the critical health issues in our area, and in suggesting innovative and locally appropriate solutions to them.

The NTML also seeks to strengthen the service capability of the primary health care system by providing support to clinicians & service providers to improve patient care through the provision of culturally appropriate comprehensive PHC.

Our third goal to improve the coordination and integration of the primary health care sector with other sectors by improving the patient journey will not be possible with the input and advice at the service delivery level from our network of advisory groups, in particular sound and well-resourced consumer & clinicians groups. If the NTML is to really contribute to reducing health disadvantage for all Territorians, while supporting Aboriginal and Remote PHC it will also require solid evidence on which to base some of the big tough questions about where the greatest need lies, and the best ways to equitably address those needs.

Finally, because we can't do this work without a solid organisation to work from, the NTML must be efficient and accountable with strong governance and effective management.

The Northern Territory Medicare Local has now been operational for 10 months, and in that short time has responded to the requirements of our funding agreements in undertaking the consultations and drafting of its

- Annual Plan
- Strategic Plan
- After Hours Services Sub-region Plan for the East Arnhem Region
- After Hours Services for the whole of the NT

The mandatory Comprehensive NT Needs Assessment is in its final stages following Territory-wide consultations and the NTML has taken the lead role in developing the PIR (Partners in Recovery) proposal. We have undertaken a collaboration with 4 other Medicare Locals in Western Australia and South Australia to support the adoption of the PCEHR initiatives.

All of this has been achieved while working with our new CEO to develop an organisational structure with new skill sets that will support not only the current and on-going projects, but also build our capacity to be innovative and responsive to the specific needs of the NT.
The complex health needs of the population and the social and physical geography of the Northern Territory pose unique and diverse challenges. One of our aspirations is the transfer of knowledge around PHC systems, including and especially community engagement, from the NT Aboriginal health sector to the whole of our community’s primary health care system.

Three partners with the common vision to improve the health and wellbeing of all Territorians have created the NTML, one of a kind in the country. Its governance structure was designed reflect its population and health need. Its two key advisory structures will deliver strategic advice to complement the knowledge, skills and background of its Board and ensure the Board has the ability to scan the (endless) horizon for opportunities and risks in the NT environment.

We are confident that in creating the NTML, with mandated structures to hear from our community, we have created a pathway towards an equitable, comprehensive primary health care system that will meet the needs of the community we serve.

**Recommendation**

Governance structures for health organisations should be designed to reflect the population and health needs of the community they serve.