

Towards Unity for Health applied—the pentagon of partnership as a basis for a regional workforce structure

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INTRODUCTION

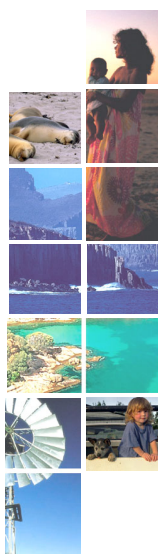
The ability of communities and consumers to be actively involved in planning and implementing health systems which effect them has always been difficult. One of the most common methods used has been a top down approach where consumers have advocated for effective policy and programs at a high level, and monitored the implementation of those policies. The so called “body part” NGOs and local government have been particularly adept in this field. The other major way in which communities and consumers have been involved especially by health departments has been in commenting as programs are developed and implemented. This has taken a range of forms from stakeholder consultation to steering group membership. While useful, both have often suffered from a lack of inclusiveness of all “stakeholders” and a lack of effective tools for ensuring input is both comprehensive and acted upon. Both tend to be linear in form with advice being sought from (and sometimes offered to) either Ministers or their Departments.

An alternative form of community (and consumer) participation has been proposed through what was initially a World Health Organisation project, “Towards Unity For Health”. Part of this concentrated on the formation of a “pentagon of partnership” in planning and administering health services, part on raising the level of partnership from ad hoc through formal organisational to legislative or regulatory.

The NSW Rural Doctors Network (RDN) is an NGO funded by both the Commonwealth Department of Health and Ageing (DHA) and the NSW Health Department. Since 1988 it has facilitated recruitment and retention of doctors in rural New South Wales. In the project described here, RDN actively used the pentagon instead of the more linear stakeholder input model in successfully developing a local Health Forum that lead to directions for formal contractual partnerships. Ultimately this led to a large increase in the number of doctors and services to patients in a remote region, and a structure that could be used as a platform for combined primary health care, acute health care and population health initiatives.

THE PLACE

Walgett is a town of some 2,000 people in the remote North West of NSW. It is 750km from Sydney, 350 km from the nearest medical specialists in Dubbo. The economic basis for the region was originally around grain and wool agriculture, and now includes cotton production. 35% of the population is Aboriginal, and the town has the health and social problems that have come with a marginalised and disempowered



group. Walgett has some of the worst health outcomes in NSW and Australia, particularly for Aboriginal people.

Seventy-four kilometres to the north of Walgett is Lightning Ridge. “The Ridge” is an opal mining and tourist-based community which has expanded greatly over the last 30 years. In a small claim mining town with a sometimes transient group population is difficult to measure, but is variously estimated at between 2,000 and 10,000. The population includes a large number of people from culturally and linguistically diverse backgrounds, now living in a culture that is often defined by the mining background and a harsh physical environment. Collarenbri is 75 km east of Walgett. It is demographically similar to Walgett but with a smaller population.

Historically Walgett, Collarenebri and Lightning Ridge have had General Practitioner services supplied by GPs working in a small business structure where the doctor owns the practice and is responsible for the physical infrastructure and practice management.

THE PROBLEMS

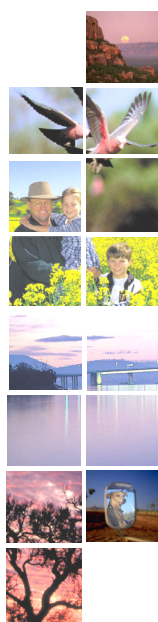
The Shire of Walgett exemplifies the problems of both health service delivery and workforce planning in remote areas. The largest direct problem is the recruitment and retention of all health professionals, including doctors, nurses, allied health and administrators.

This is on a background of a health system that lacks cohesion even at the local level. The NSW Health Department through the Far West Area Health Service (FWAHS) is responsible for hospital inpatient and outpatient treatment and GPs receive a fee for service for their work. General Practice as such is run as a small business and doctors (or their patients) receive a rebate from the national Health Insurance Commission, again on a fee for service basis. The doctor is responsible for all practice management, employment and billing. Within Walgett there has been for many years an Aboriginal Medical Service providing GP services and administering a range of other health programs funded by both the Commonwealth and NSW Governments. Community nursing and allied health is administered by NSW Health, although there has been an increasing Commonwealth input into nurses and allied health professionals based in GP practices.

This adds to an historical shortage of both housing and surgery accommodation. Local Government is often called upon to support the physical infrastructure, but the Shires in these more remote areas are often already over committed in what funds they have available. The housing shortage spreads across all professions, including nurses and allied health.

THE TRIGGER

In May 2001 Walgett was down to one doctor resident in town providing both community and hospital-based services, one doctor providing services from the Aboriginal Medical Service, and one doing occasional fly in fly out services. Lightning Ridge had one resident Doctor but he had been unwell and ceased practice shortly thereafter. There was no GP resident in Collarenebri. Residents from these towns often

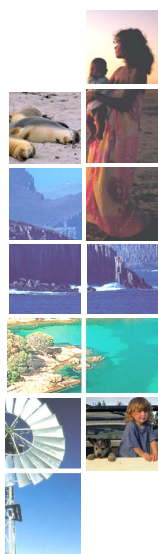


had to travel many hundreds of kilometres for primary medical care. The provision of after hours and emergency care by a single hard working doctor was unsustainable.

THE PROJECT

The Far West Area Health Service (FWAHS) had been developing a medical service plan for the area, with some RDN involvement. As the workforce crisis became apparent there was a change in emphasis from service planning to workforce planning that could enhance the ability of a service plan to succeed.

In 1999 I had presented one of the developmental papers to the first meeting of Towards Unity For Health in Phuket (with Professor Max Kamien)¹. This had given me an opportunity to participate in discussions on two of the central principles to TUFH, the pentagon of partnership and the progression in an hierarchy of partnership². From the time of the Phuket meeting RDN has been actively using and promoting the partnership pentagon.

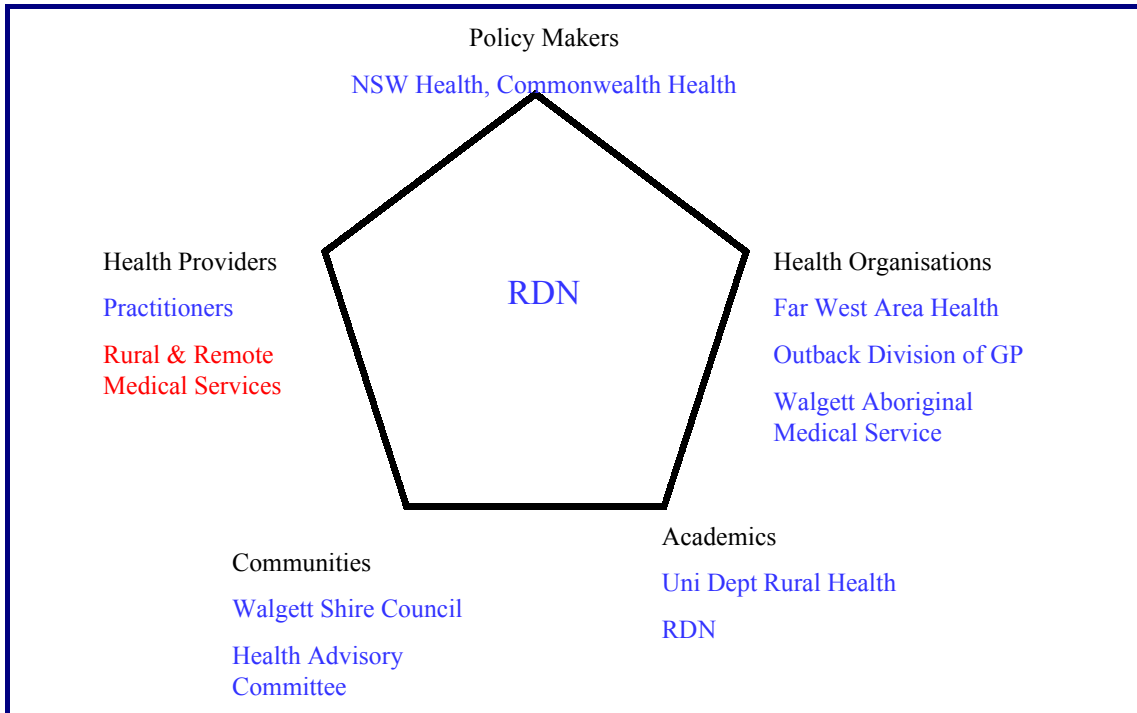


As the focus changed from FWAHS service planning to RDN workforce planning, RDN established what was to become the Walgett Shire Health Forum along the lines of the pentagon. Health Service Organisations are integral, including FWAHS, the Walgett Aboriginal Medical Service, the Outback Division of General Practice and the District Hospitals. Communities were represented by Local Government (Walgett Shire Council), the three Health Advisory Committees in the Shire, by individuals, and to a certain extent WAMS as an Aboriginal Community Controlled Health Organisation. The medical practitioners were represented by themselves and to some extent by the Division. Health Policy Makers from both the Commonwealth and NSW Health attended at various times. Academics from the Broken Hill University Department of Rural Health had been involved in early discussions, and RDN itself took on some of these academic roles. RDN's position as a non- service provider has been very much as the central facilitator and as the academic history taker.

In addressing the shortage of doctors in the remote and rural areas it had been becoming obvious that many doctors wanted to move away from the traditional doctor owned small business model to one where the infrastructure and practice management were provided, allowing the doctor to concentrate on clinical work. The area around Walgett and near by Bourke is probably the only remote area in Australia where primary medical services are not provided in total through a State Government instrumentality, Aboriginal Medical Services or mining companies (with a few remarkable exceptions). RDN had become involved in providing infrastructure a few months before in a similar workforce crisis in the nearby town of Brewarrina.

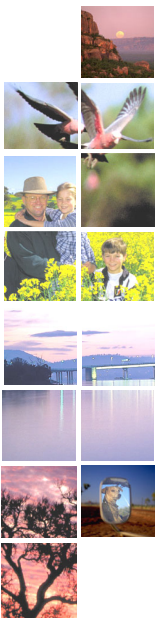
On this occasion RDN felt that there was a possible conflict of interest in becoming the employer with its state-wide role in support, recruitment and retention. RDN facilitated the formation of a separate not for profit company to provide services in the area. Rural and Remote Medical Services (RARMS), with Board representation from RDN, The Division, Walgett Aboriginal Medical Service (WAMS) and the NSW Rural Doctors Association (RDA) was established as the practice management and employment entity for the Walgett Shire.

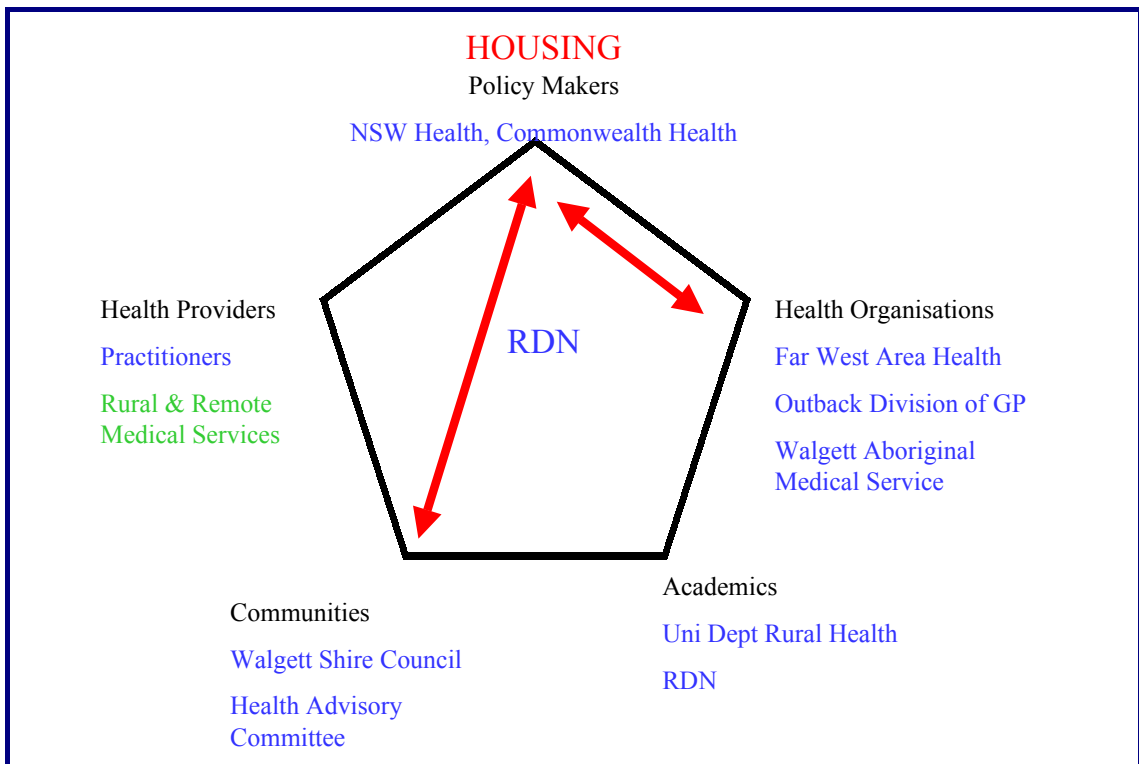
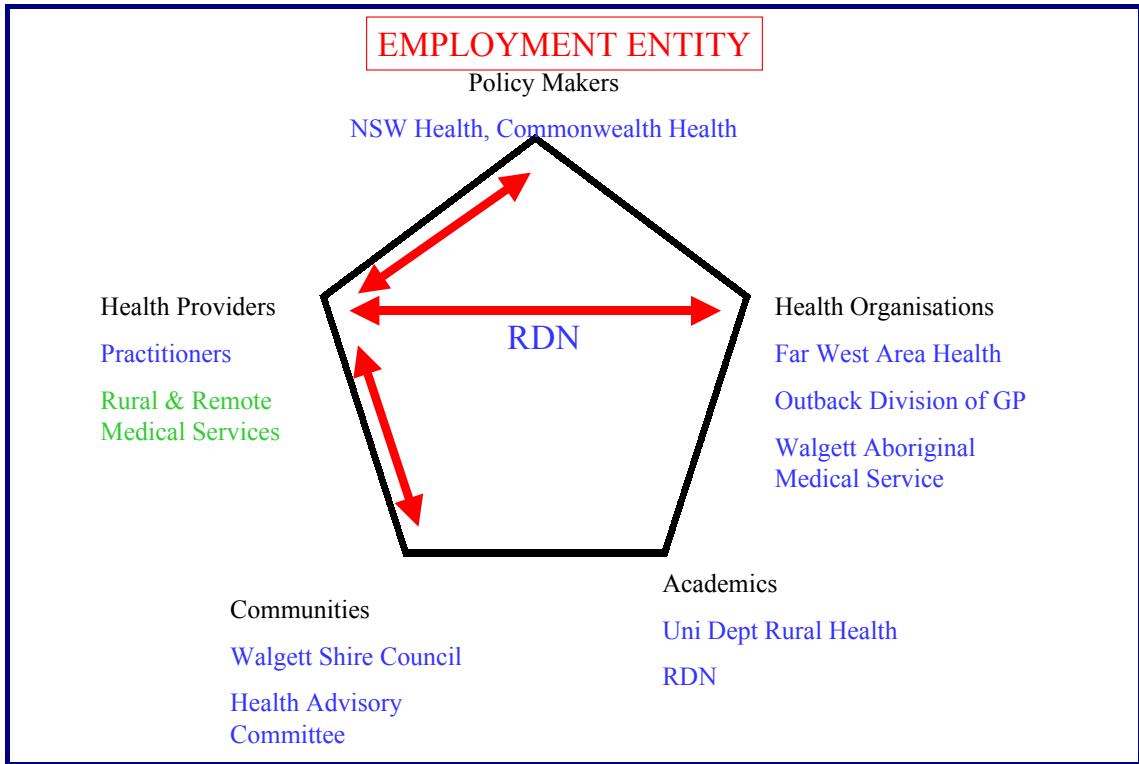
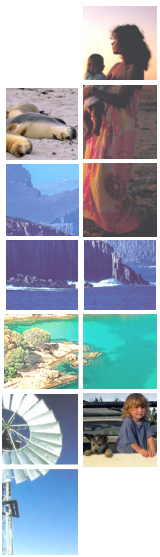




The formation of RARMS allowed the pentagon of the Walgett Shire Health Forum to lift the quality of partnership from the ad hoc partnership in the pentagon to formal and contractual bilateral partnerships. The Commonwealth Department of Health and Ageing contracted funds to RDN and then RARMS for physical “tools of trade” in the surgeries and the development of sustainable practice management. From within the forum RARMS was able to contract with local Government for surgery accommodation. The Forum was able to act as a platform for contracts between the Shire and the Commonwealth Department of Transport and Regional Services for extra funds for doctor accommodation. The Division of General Practice contracted with the Commonwealth Department of Health and Ageing (DHA) for funds for student and registrar accommodation. All of these are examples of the ad hoc partnerships in the pentagon becoming the basis of formal contractual relationships amongst its members.

Probably most important was the contractual partnership that then developed between FWAHS and RARMS in the supply of “in hospital” services. Because this had been based on fee for service for individual doctors it had been difficult for RARMS to give firm income commitments to the GPs that RARMS in turn contracted. The bundling of “in hospital” funds into a service contract between RARMS and FWAHS allowed this step of providing income certainty to recruited GPs.



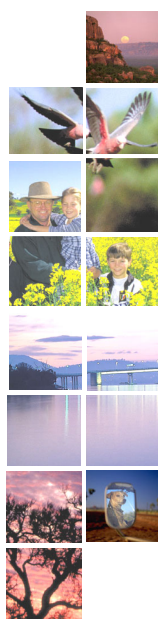
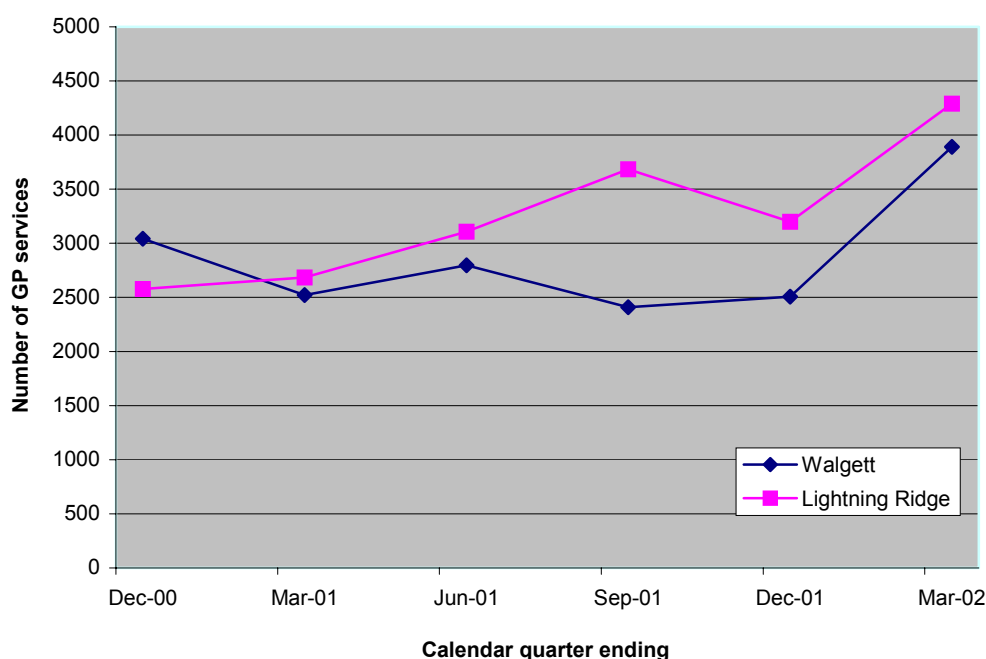


OUTCOMES

The Walgett Shire Health Forum as a pentagon had promoted development of formal bilateral organisational partnerships that in turn had led to:

- the creation of a stable and sustainable practice (RARMS) as an employment and infrastructure entity
- sustainable practice management through RARMS and practice management development by University of New England Partnerships
- an increase in GPs in Walgett and Lightning Ridge from one and a half to six full time equivalent doctors
- an increase in the number of GP services (Figure 1)
- a platform for a more integrated primary health care system
- a platform for a more formally constructed integration of individual and population health strategies
- a pilot of a web-based patient record system funded by DHA
- the formation of a Bourke and Brewarrina Shires Health Forum to apply the Walgett experience in a similar area but with different components
- an opportunity to help other organisations with the benefit of the Walgett Shire experiences.

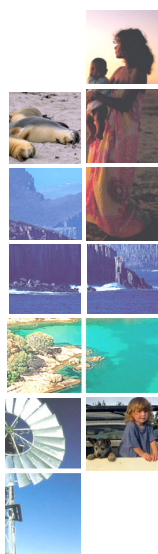
Figure 1 GP services billed to Health Insurance Commission by calendar quarter from last quarter 2000 to first quarter 2002³



DIFFICULTIES

None of the above was easy and required immense effort and goodwill from all involved. At the time of writing RARMS is consolidating as a practice and moving towards more local control and long-term independent sustainability. Areas that have produced tension during the process have included

- the need to balance the independence and sense of ownership of the individual GPs of the practice with their desire not to be overwhelmed by administration or infrastructure costs
- the sheer amount of work in moving to formal contracts that are legally reasonable within a time limited by an ongoing workforce crisis
- the tension between the need for local management in a resource poor area and the loss of control to distant but capable organisation
- the blurring between the excitement of the vision of a locally based primary medical and health care system and the need for a practical, stable and consolidated local entity
- the concurrent medical indemnity crisis and the refusal of NSW Health to extend Treasury Managed Fund cover to Visiting Medical Officers in Walgett and Lightning Ridge if they are employed by RARMS has meant that RARMS has reverted to being closer to a medical practice company. This has in turn led to less possibility of the new structure and the Forum becoming the platform for a wider locally based Primary Health organisation
- community involvement was very active during time of crisis. It will be important to maintain the level of community input to the Forum.



THE FUTURE

Hopefully the consolidation of RARMS as a locally managed practice, the finalisation of contracts, and the commitment of RDN to facilitating the more generic and state-wide aspects of the process will allow these tensions to be overcome. The Walgett Shire Health Forum will continue as the all encompassing ad hoc partnership which sustains the formal partnerships and has the creativity to develop new ones.

LESSONS

- The *Pentagon of Partnership* as developed through TUFH provides a basis for the development of bilateral contractual partnerships from the ad hoc partnership represented in the pentagon.
- This can happen at local level, as well as at regional, state and national levels.
- The pentagon needs an “anchor organisation” to become effective.
- The ad hoc personal and professional partnerships need to continue as the formal, organisational and contractual partnerships are developed.



- The basis for public and population health lies in the provision of excellent and accessible individual care.
- The partnership pentagon allows greater participation and better harnessing of the energy of the community than linear “stakeholder consultation” models.

REFERENCES

1. Cameron I, Kamien M *The Arid Zone Project, Towards Unity For Health*, Phuket,1999
2. Boelen, C *Challenges and Opportunities for Partnership in Health Development – A Working Paper*, World Health Organisation, Geneva,2000
3. Unpublished figures from Department of Health and Ageing

PRESENTER

Ian Cameron is CEO of the NSW Rural Doctors Network, an NGO that receives funding from both NSW Health and the Commonwealth Department of Health and Ageing to facilitate recruitment and retention of doctors in rural and remote NSW. He comes originally from Bourke in western NSW, where he practised as a GP, and he has been involved for many years in efforts to help improve the health of remote, rural and Aboriginal people, especially in western areas. The project he describes here is based on a World Health initiative to improve both the quality and level of partnerships in health development.

