



## Cape York Health Reform

Queensland Health State-wide Conference

4 March 2008

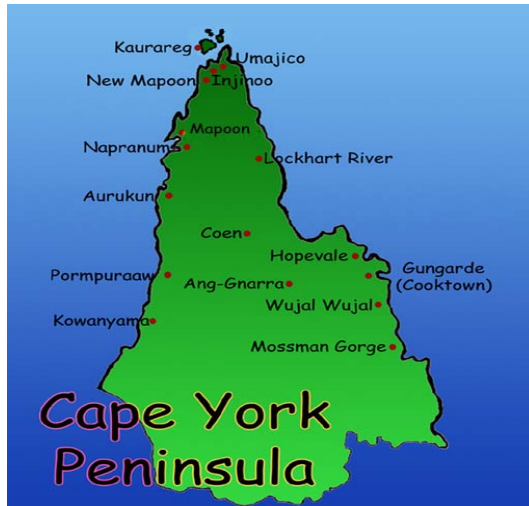
Brisbane

## Reason



- Difference of life expectancy of Aboriginal and Torres Strait Islander people of at least **17** to **20** years
- Community control in Canada has demonstrated that over time through community control, the difference in life expectancy can be reduced significantly
  - Canada – difference in life expectancy is now 5 – 7 years
- Consider using the same principles to achieve this in Cape York communities

# Cape York Profile



- 17 Aboriginal Communities
- 6 Towns
- Over 14,000 people of which 60% are indigenous
- Mainly primary care services with some secondary care in Weipa and Cooktown
- Partner Service Providers – QH, RFDS, FNQRDGP and Specialists

## 2006 - 2007

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- Started working on health reforms in 2006
- The initial focus was too ambitious but was refined in 2007
- Focus in 2007 was on
  - Governance reform
  - Organisational capacity
  - Community engagement
  - Health Service Systems



## 2008

5

- ◉ Health Reform's main focus is now on development of community health systems
  - ◉ Comprehensive primary health care
- ◉ Working closely with Cape York HSD to implement the required changes

## Environmental Scan

1. High burden of chronic disease
2. Limited available workforce
3. Geographical remoteness = increased costs of services
4. Stricter Alcohol Management Plans
5. Welfare Reforms
  - ▣ Family Responsibility Commission
  - ▣ Focus on development of social norms
6. Need to increase community capacity and advocacy
7. Health Reform

# What does health reform mean?

Reforming the health system and service delivery

**through**

Cape York Health Reform

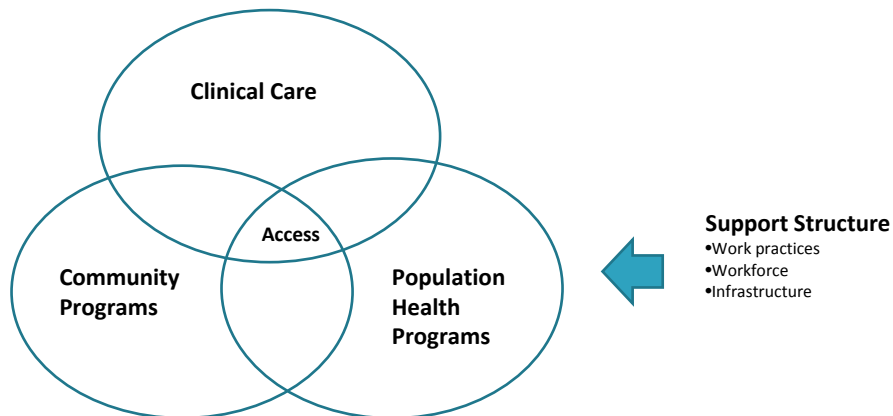
**by**

Developing the right health system delivered by the right organisation in the right way to the right part of the community

# Cape York Health System

- Takes a comprehensive primary health care approach
- Aligns programs to specific community health issues
- Identifies programs that target specific population sections in the community at 3 levels [individual (primary care and brief intervention), family, community]
- Addresses health status holistically
- Able to identify health programs that result from other reforms
- Able to provide co-ordination of ALL health programs into the community

# Community level health system



## How to Achieve?

- Phase 1
  - Mapping all health services
- Phase 2
  - Designing the ideal community health system
- Phase 3
  - Identifying the workflow/practices through the health system
- Phase 4
  - Overlaying the current staff positions into the workflow and identifying the critical success points [referral points and case management points]
- Phase 5
  - Developing co-ordination of all health services

# Phase 1 & 2

Complete mapping of all health services into the community

Desktop analysis of ALL previous reports, consultations that have occurred

Develop the "ideal" community health system

### Involve right people

- HAT Members
- QH Nursing and Health Workers
- Technical Experts
- Welfare Reform

Overlay community health mapping to identify gaps

Endorsed and mandated by the community [capacity development]

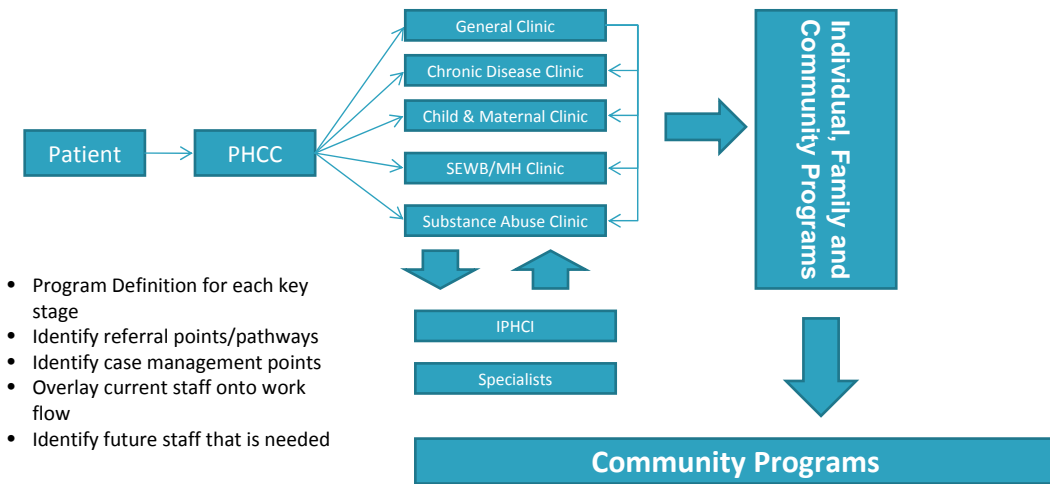
# Phase 2 – Child & Maternal Health

## Example only

POPULATION SECTIONS	Types of Program		INDIVIDUALS	FAMILIES	COMMUNITY	OUTSTATIONS	ACCESS
	Health	Community					
Female Students	Health		Women's Health Checks	Smoking Nutrition Alcohol Physical Activity			Deliver programs at school
	Community			Sporting activities FIMS Cooking	Sporting programs		
Young Women	Health		Women's Health Checks	Family Planning Sexual Health FAS	Stop Smoking Programs Alcohol Programs		
	Community			Sporting activities FIMS Cooking	Sporting programs		
Women	Health		Women's Health Checks	Family Planning Nutrition	Family Responsibilities		Home visits
	Community			Sporting activities	Women's Groups		
Pregnant	Health		Antennal programs				Home visits
	Community			Cooking			
After Birth	Health						Home visits
	Community				Counseling		
1-5 yrs	Health		Child Health Checks	Growth Programs			Home visits
	Community				Cooking	Sporting programs	
5-10 yrs	Health		Child Health Checks				Home visits
	Community				Cooking	Sporting programs	
10-15 yrs	Health		Child Health Checks				Home visits
	Community				Cooking	Sporting programs	



# Phase 3 & 4



- Program Definition for each key stage
- Identify referral points/pathways
- Identify case management points
- Overlay current staff onto work flow
- Identify future staff that is needed

# Phase 5

	Monday	Tuesday	Wednesday	Thursday	Friday
AM	<ul style="list-style-type: none"> <li>• General Clinic</li> <li>• Chronic Disease Clinic</li> <li>• IPHCI</li> </ul>	<ul style="list-style-type: none"> <li>• General Clinic</li> <li>• Women's Clinic</li> <li>• Chronic Disease Clinic</li> </ul>	<ul style="list-style-type: none"> <li>• General Clinic</li> <li>• Men's Clinic</li> <li>• Aged Care/HACC</li> </ul>	<ul style="list-style-type: none"> <li>• General Clinic</li> <li>• Diabetes Clinic</li> <li>• Outstation Visits</li> </ul>	<ul style="list-style-type: none"> <li>• General Clinic</li> <li>• Counselling</li> <li>• Outstation Visits</li> </ul>
PM	<ul style="list-style-type: none"> <li>• General Clinic</li> <li>• Child &amp; Maternal Clinic</li> <li>• IPHCI</li> </ul>	<ul style="list-style-type: none"> <li>• General Clinic</li> <li>• Child &amp; Maternal Clinic</li> <li>• Home Visits</li> </ul>	<ul style="list-style-type: none"> <li>• General Clinic</li> <li>• Home Visits</li> <li>• School Visits</li> </ul>	<ul style="list-style-type: none"> <li>• General Clinic</li> <li>• Diabetes Clinic</li> <li>• Home Visits</li> </ul>	<ul style="list-style-type: none"> <li>• General Clinic</li> <li>• Counselling</li> <li>• School Visits</li> </ul>

- Allows for co-ordination of all services
- Time for school, home, aged care and outstations visits
- Better use of limited facilities [PHCC space and accommodation]

# This is the Reason Why.....

