



Cape York Health Reform

Queensland Health State-wide Conference

4 March 2008

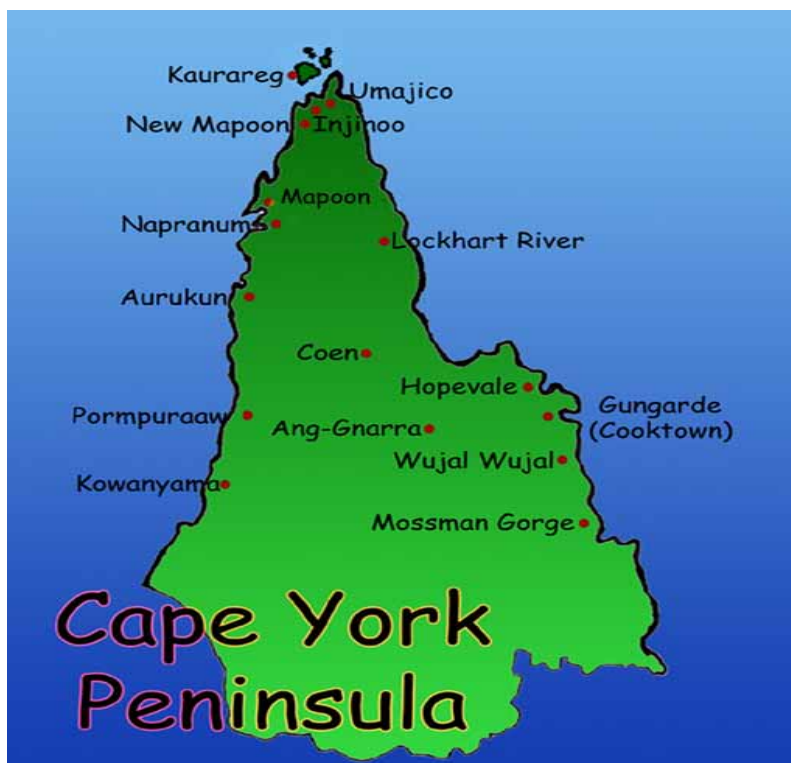
Brisbane

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

- 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

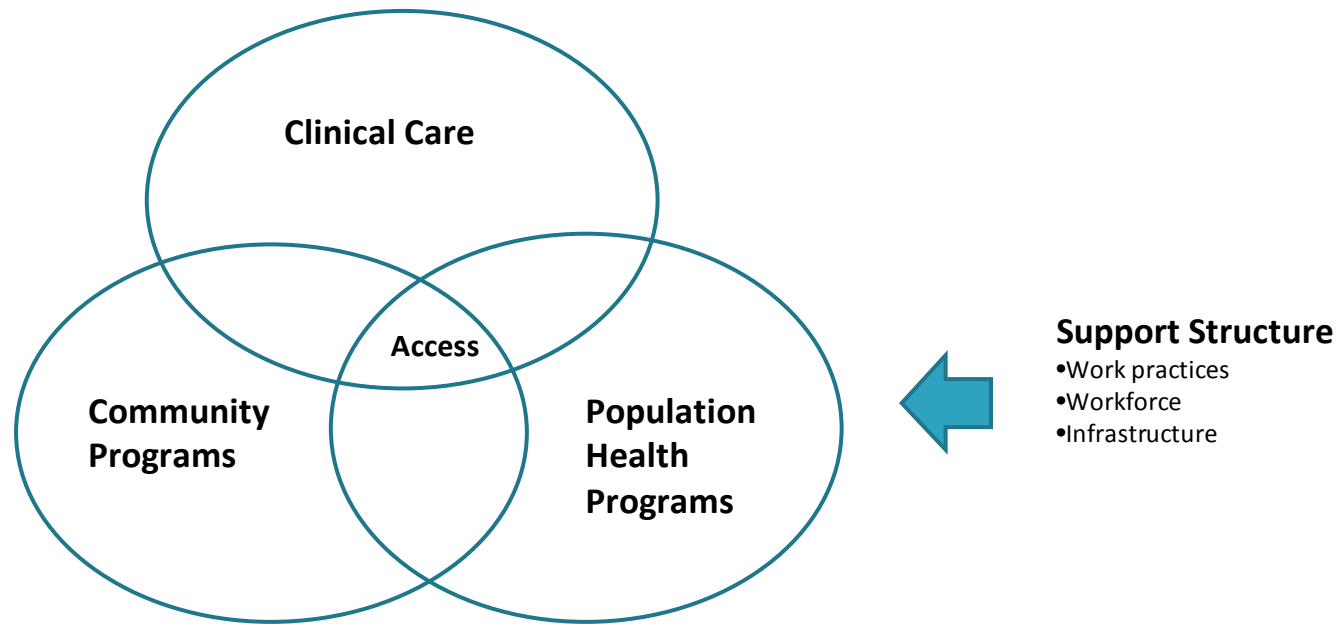


Cape York Health System

- ❑ 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 |
|---------------------|------------------|-----------------------|--|-------------------------|---|-------------|----------------------------|
| | | Clinical Care | Population Health | | | | |
| 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 | | |



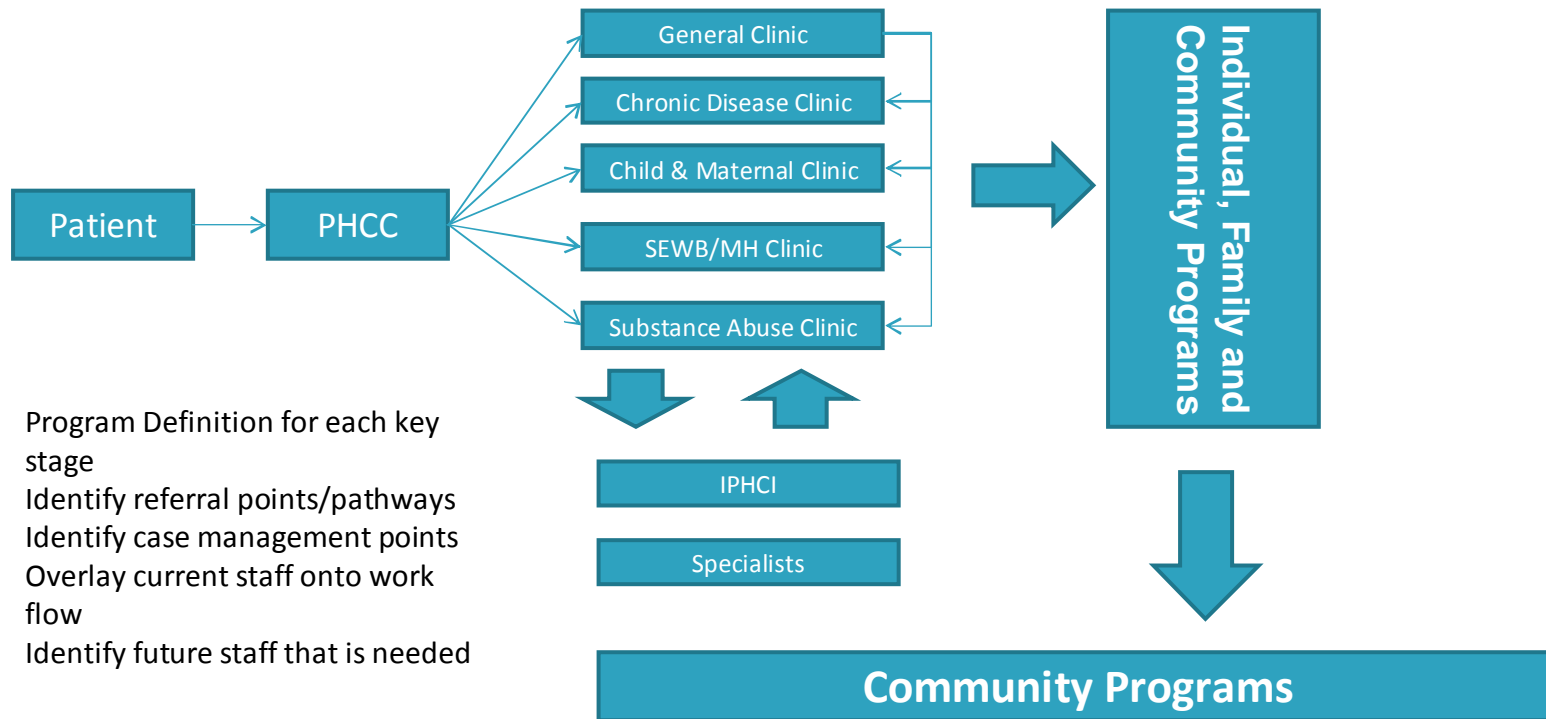
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Phase 3 & 4



- 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"> • General Clinic • Chronic Disease Clinic • IPHCI | <ul style="list-style-type: none"> • General Clinic • Women's Clinic • Chronic Disease Clinic | <ul style="list-style-type: none"> • General Clinic • Men's Clinic • Aged Care/HACC | <ul style="list-style-type: none"> • General Clinic • Diabetes Clinic • Outstation Visits | <ul style="list-style-type: none"> • General Clinic • Counselling • Outstation Visits |
| PM | <ul style="list-style-type: none"> • General Clinic • Child & Maternal Clinic • IPHCI | <ul style="list-style-type: none"> • General Clinic • Child & Maternal Clinic • Home Visits | <ul style="list-style-type: none"> • General Clinic • Home Visits • School Visits | <ul style="list-style-type: none"> • General Clinic • Diabetes Clinic • Home Visits | <ul style="list-style-type: none"> • General Clinic • Counselling • School Visits |

- 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.....

