The Torres model of primary health care—the gap between reality and rhetoric

Christine Giles
Portland District Health in South West Victoria

The health budget is under pressure with demand growing and costs escalating, every person working in the system has a responsibility to ensure the services delivered are effective and efficient. If a part of the system or model of health service delivery is flawed it should be challenged and remedial actions taken, but in politically sensitive areas such as Indigenous health this is rarely achieved. Health care service provision is about individuals and communities accessing a range of services that enables them to maintain happy healthy lifestyles or maximise their quality of life. It is not appropriate that politicians, bureaucrats, local community leaders or senior health service staff are able to manipulate, run personal agendas or withhold information about the local health services. Communities should have a totally transparent system, which allow both internal and external stakeholders the ability to scrutinise, development and refine service delivery models. Torres Strait Island and Northern Area Peninsula (TS & NPA) communities and individuals are no different with the expectation that their health services be of the same standard as is seen across Australia yet in the past this has not always been the case.

Setting the scene

The district

The Torres Strait and Northern Peninsula Area Health Service District (TS & NPA HSD) an area of approximately 2400 square km is located at the Northern most part of Queensland containing a chain of islands from the top of mainland Cape York to within three kilometres of Papua New Guinea (PNG). The TS & NPA HSD is the northern most public health service within Queensland Health.

The District has two hospitals, Bamaga on Cape York Peninsula and Thursday Island, the administrative centre of the Torres Strait. The Thursday Island Hospital has a range of visiting specialty programs and runs an operating theatre both for elective and emergency surgery including Obstetrics.

The TS & NPA HSD provides all primary health services in the district with programs funded both via the state and federal governments. On the mainland there are five primary health clinics one in each community, the remaining sixteen are located on islands providing health care to the island community which range in size from populations of less than 100 people to more than 3500 on Thursday Island.

The district is represented by three local government entities:

- Northern Peninsula Area Council, containing five Indigenous communities, three of which are principally Aboriginal and two Torres Strait Islander. The whole local government area is designated Indigenous Lands subject to Native title.

- Torres Strait Islands Regional Council, which administers all of the inhabited islands from Hammond Island in the South to Boigu in the North. All of which are designated Indigenous land subject to native title and are principally Torres Strait Islander Communities. A free movement treaty exists between the Australian Northern Island communities and the Western Province coastal communities of PNG, which can markedly change the numbers of people in any of the communities at any time.

- Torres Shire Council (TSC), a mainstream Queensland Council based on Thursday Island administering all of the remaining islands and several small parts of Cape York Peninsula. Predominately the TSC population is based on Thursday Island, Horn Island and Prince of Wales Island, with all habited islands having both native title and freehold land. The traditional owners of these islands are the Kaurareg Aboriginal peoples (a minority and marginalised group within their
own lands) not Torres Strait Islanders as is widely thought. Torres Shire Council islands are not closed Indigenous communities.

**The population**
The population living in the Health District is made up of Torres Strait Islanders, Aboriginals and Non-Indigenous peoples. Torres Strait Islanders represent about sixty percent of the population; non-Indigenous peoples sixteen percent the remainder are Aboriginal peoples (Australian Bureau of Statistics, Census of Population and Housing, 2006 [5]).

**Logistics**
Thursday Island is the administrative centre for the district and has a large number of federal, state and local government agencies with offices on the island, an International airport is located on adjacent Horn island with regular ferry services to Thursday Island. Travel within the district is predominantly air travel with a regular ferry service to the mainland. During the wet season the Cape York road is closed and all travel to and from the district is by ship or air with Qantas flying from Cairns to Horn Island and return two or three time daily.

All goods such as food, fuel, building supplies etc. are shipped from Cairns to Horn Island and then by barge to the outer islands. All of the habited Islands have a supermarket, however the variety and freshness of food varies from island to island. The cost of groceries and supplies is markedly inflated when compared against prices in Cairns. It is argued, (not successfully), that freight costs are a major factor affecting this. Indigenous people in the Torres Strait regularly supplement their diet with fish, dugong and turtle all caught locally and at low cost.

The main employers in the district are Government agencies with fishing and tourism being the major (but not significant) industries.

**The Torres model of care**
In 1996 the then Queensland Health District Manager Mr. Phillip Mills developed an implementation plan for the Torres Model of Primary Care which he conceived, to progress the Torres Health Strategy (1993). The Torres Model of Primary Care plan was formally launched by the Hon. Mike Horan Minister for Health in 1996. The model aimed to address the poor and worsening health of the districts Indigenous people by changing the governance, management structures and service delivery mechanisms for health care provision within the local communities. The model included working on the social determinants of health in a holistic manner. (Schmidt,B. Mills,P, 2012, Review of the Torres Model of Care Torres and NPA Health Service District)

The model (as proposed) was underpinned with sound principals including, Community leadership, clinical, community and corporate governance systems, a chronic disease data base, service provision close to home, self determination and shared responsibility for health between the health care provider and the individual. It was designed to be culturally and gender sensitive and aimed to promote professional collaboration within the health arena. The model supported an Indigenous management structure for Indigenous health workers (IHW) which has been partly incorporated into the state based IHW award and EBA processes.

**Rhetoric vs reality**
While much has been published and researched about the Torres Model of Care seeking to confirm the models claim to be a best practice model for primary health care, (i.e. Review of the Torres Model of Care Torres and NPA Health Service District 2012), this research, has not always been managed using methodology the researcher designed and the data sets used have not always been complete. Local clinicians cite examples where the research was meant to exclude certain patients based on past clinical history this was not consistently done across all research sites. The database used to collect patient clinical data was an electronic database, it is widely known throughout the health district that this...
database was difficult to access and use on most of the islands and therefore was not consistently used to keep patient data making some data unavailable to the researchers.

The Torres model of primary health care when first introduced achieved a reduction in the complications associated with diabetes such as blindness and lower limb amputations through better control of diabetes and hypertension however this reduction was not evident after 2005. (Queensland Health 2011). The Torres model of care however was not the only change implemented in the district at the time, the district moved to supply all prescription medications to people living in the district free of charge, it could be suggested that free access to medications improved peoples compliance to taken the medications which resulted in a lowering of morbidity associated with the disease process.

The model improved client attendance at clinics and lead to good results for health screening tests and vaccination rates all of which are clearly of benefit to the individual.

The model however has not impacted on the prevalence of chronic disease in the health district, additionally it has not lowered the instance of sexually transmitted disease. If the model was a best practice model which has been in place in the district since 1996 (15 years) it could be expected that both the prevalence of chronic disease and the incidence of Sexually transmitted disease would be declining in the populations of the district. The Queensland Health population health data (Queensland Health Population Health website) for the district validates that this has not happened and the health status of the district population continues to worsen.

A review of North Queensland Indigenous Health Indictors 2011, a Queensland Health publication, shows that for Type 2 Diabetes the rate of Hospitalisation in the 25-44yr old age group in 04/05 was 6.6 per 1000 in 08/09 this rate rose to 8.1 per 1000, in ischemic heart disease the rate for the same age group 04/05 was 7.5 per 1000 rising to 9.2 per 1000 in 08/09. Queensland Health. Indigenous Health Indicators 2011: North Queensland 2011. Tropical Regional Services. Cairns 2011

Queensland Health have published two series of Burden of disease and health adjusted life expectancy in Health Service Districts one in 2003 and one in 2006 both available on the Queensland Health website, in the TS & NPA HSD the average life expectancy at birth in 2003 was 67.7 years in 2006 this fell to 67.4years. The Health Adjusted Life expectancy was in 2003, 59.5 years falling to 59.3 years in 2006, in 2011 it had fallen further to 55.5 years according to the Queensland Health, Torres Strait Health Profile: Health snapshot for Torres Strait and Northern Peninsula Area Health Service District 2000/01 - 2009/10, 2011 the lowest health adjusted life expectancy in Queensland.

The incidence of sexually transmitted infections has followed the same pattern of non improvement with data published on the Queensland Health Public Health website showing the crude rate for chlamydia infections in 2002 was 298 rising markedly in 2008 to crude rate of 358, likewise the crude rate for hepatitis B infections was 14 in 2002 rising to more than double in 2008 at 29.

Anecdotally when asking local community members across the district if they think health is improving in the community they consistently answer no.

Clearly the Torres Model of Primary Health care is no longer effective in improving the health and wellbeing of local community members. Why?

Unfortunately the Torres Model of Care was never fully documented as senior Torres Strait Islander Health staff at the time felt that documentation would lead to loss of cultural integrity and loss of intellectual property. This failure however has seriously impacted on the provision of health services to both the individual and local communities. The model has been passed on to local health staff orally, becoming open to personal interpretation with no definitive core or structure to provide guidance. It has fragmented health service teams into those that understand the processes and aims of the model, those that don’t but use their best efforts to meet individual and community needs and those who seek to redefine the model to suit their personal agendas. This has in turn created professional silos,
divisions and turf wars within and between the clinics and has lead to serious flaws in the delivery of primary health services throughout the district.

The major issues with the model are not the principles but the methodology of its implementation including:

- Non-documentation of the model and its structures leading to local Indigenous leaders and senior Indigenous staff manipulating the model to achieve their individual needs.
- No clear understanding within the structure of whom is the lead clinician—manager in the areas of clinical client care, professional management, administration and cultural management.
- No ongoing education program to support development of current leaders and emerging future leaders.
- No systems to provide assistance and guidance to local managers to enable them to be effective either as managers or to engage the local community.
- No effective orientation to the model of care or local cultures for non local staff.
- Total reliance within the model of Indigenous Health Workers to provide leadership in the district across all levels—effectively removing the management career pathways from all disciplines except Indigenous Health Workers.
- Ongoing manipulation by politically motivated community leaders and senior health workers to stifle any growth or change in the model thus preventing innovation and evolution of the model.
- No rigor in the education processes for the clinical development of Indigenous health workers and no process to measure or maintain professional competency.
- Very little clinical teamwork, with no practice management or case-care coordination systems many of the clinics therefore were autocratically managed with harassment and bullying regularly used to achieve outcomes.
- Lack of accountability and responsibility within parts of the IHW managers group dependent on their personal needs and agendas.
- System dominated with poor human resource processes and high levels of nepotism and cronyism—Queensland Health seen as an employment agency rather than a primary health care provider.

Queensland Health, the funded health provider, had placed to a heavy reliance in a model of care that sounded good and was a political winner rather than properly monitoring and questioning service delivery outcomes and ensuring that the district had an appropriately skilled health workforce with the right tools and equipment to perform their roles. The evidence that the system was in crisis was there for everyone to find.

Clearly the health district was failing in its obligations to the communities but why? The premise the structure was built on was one of good principles ticking all the right boxes, but no health improvement was being realised.

**A snapshot of the health service in 2010**

A close examination of the health service showed a systemic pattern of failings:

- Failure to meet legislative and regulative requirements—i.e. ignored that it was non-compliant with the Queensland drugs and poisons act since it was updated (1996).
• Non-compliance with Australian standards—ie failed to maintain air handling systems in theatre and CSSD, had isolation rooms to manage multi drug resistant tuberculosis that when tested provided positive pressure instead of negative pressure.

• Australian Council of Healthcare Standards (ACHS) survey had been abandoned in 2002 when is became clear that to undertake an ACHS survey would lead to non achievement of accreditation a politically undesirable outcome.

• Non-complaint with Queensland fire and safety standards, i.e. missing smoke alarms corroded fire reels.

• Issued a mandatory undertaking by Workplace Health and Safety Queensland for failing to meet occupational health and safety requirements—staff safety

• Breached medicines prescribing guidelines frequently—staff citing medications ordered by Doctor but drug charts prescriptions not signed by doctor

• Staff Qualifications where not available on personal files, and many staff where unable to furnish human resources with copies of formal qualifications citing they never received them from the TAFE or had lost them.

• An internal assessment of the island Nursing, Medical and IHW workforce against the annual mandatory competency basic life support showed only one out of 65 in the IHW group was competent where-as all nurses and medical staff were assessed competent.

• Bullying and Harassment of both Indigenous and non-Indigenous personnel was unchecked in the district to the point of individuals being assaulted, receiving death threats or finding evidence of black magic interventions against themselves. Non Torres Strait Islander staff frequently suffered racial motivated abuse.

• IHWs spending hours inputting data into an end of life chronic disease management (CDM) database, to make sure that for each client the software traffic light system was green with management reports neat and tidy. Within the district IHW clinician’s maintained the CDM database with the remainder of the clinical team using a paper based patient information system. It was far less demanding to sit at a desk and enter data, convinced a valuable role was being performed than to consult with individuals and engage communities using a range of evidence based health intervention strategies to effect real change.

• Evidence of fraud, crime and misconduct from both within the workforce and within a group of people able to apply influence and pressure on the workforce.

The health service was in fact operating in a constant state of chaos with staff and facilities all reactionary to crisis rather than being organised and systems driven.

**What was needed?**

The Torres Strait and Northern Peninsula Area Health Service District needs the same level and approach to management that is routinely found in any other public health service in Australia. Skilled strong consistent leadership and management focusing on providing a safe accredited public health service underpinned with good processes and systems. Support from bureaucrats and politicians to fix the issues rather then hide them from public scrutiny or bend to local coercion.

The range of services and skill sets needed to deliver the services urgently needed in the local communities are not unique to the district, they are the same as is found across the rural and remote sector of all public health services. The education sector in Australia provides an excellent diverse range of skilled individuals very capable of meeting the health care needs within the district and with the
advent modern internet and computer access and good transport options this education is able to be sourced locally even in the remotest parts of the country. There is no reason that health care in the district can not be provided to the same standard that is applicable in all Australian communities.

In the district the time had arrived to move forward and provide services consistent with those found in health services across Australia.

In order to achieve the change the communities and individuals sought, management found themselves working within a industrial relations framework that continually interfered in areas outside of its regulatory scope, undoing wrong appointments from the past, and clearly articulating minimum skill sets, competencies and standards that the workforce must meet without compromise. Responsibility and accountability was made an important part of all management levels and performance management introduced.

Change was happening locally, mainstream systems and approaches being implemented and used. Unfortunately support from the wider corporate Queensland Health was fickle and apt to be more interested in serving the politicians needs than the health needs of local communities. This forced the senior executive team to battle both the bureaucrats and local resistance (self serving pockets) to improving the model, back room deals being done in Brisbane with no regard or idea of the impact in the district.

For members of the senior executive taking this stand was extremely traumatic, non-Indigenous members each regularly received death threats, racial motivated harassment was ever present, Indigenous members suffered worst with continual pressure at work and outside work to make changes fail, to passively resist if active resistance failed, not complying was met with abuse and threats.

The executive team took their leadership and management responsibilities seriously and their duty of care to provide the best health care possible to both individuals and local communities was of utmost importance. The senior management of Queensland Health lacked understanding of the district issues and culture, as long as the district stayed out of the media and off the political radar no one enquired or wanted to get to involved. When it became political or public the district was not consulted, a back room deal was stuck or another audit was ordered, a plan produced with no resources or skilled professionals willing or able to be found to assist in its implementation.

The actions
What the Torres Strait and Northern Peninsula Health Service District local Senior Executive Staff did:

- Introduce a business planning framework commencing with a district clinical service plan and a strategic directions plan.
- Clearly articulate the workforce hierarchy with a lead manager/clinician for the four core management streams, Clinical, Professional, Administrative and Cultural. Provide education to these managers and clinicians and hold them to account against their responsibilities.
- Reorganised the delivery of services to functional streams, primary health care, population health, acute care and support services, with clearly set out performance measures to be achieved in each area.
- Removed quality, safety, and audit / risk programs from within the stream management structure to a standalone unit reporting directly to the executive negating the ability of the programs to manipulate or hide results.
- Each functional stream and program area held to accountable to meet state and national recognised standards of service delivery, for example the mental health service in the acute stream was required to meet the national and state mental health standards which it had never met since its was first
provided in the district 10 years prior. The quality team provided compliance reporting across the
district.

- Completely redesigned workforce education, critically reviewing facilities and deliverables against
there effectiveness. Commissioned and built an education facility on Thursday Island complete
with simulation learning, developed a package of 19 core competencies every clinical staff member
was required to meet. Facilitation for Indigenous Health Workers to obtain their diploma and
medication endorsement to comply with Queensland drugs and poison legislation (first introduced
in 1996). Without these qualifications IHW’s were not permitted access to or granted the ability to
supply any medications.

- Implement the Queensland Health systems available to the district but previously opposed to by
local management to manage supply change, asset, accommodation, motor vehicles, IT,
communication and human resources.

- Commenced development of a local community engagement and participation strategy.

- Develop policies and procedures to manage the presentation at health clinics of patients from PNG
in breach of immigration guidelines.

What was introduced into the health service district was what would already have been in place for at
least a decade across the rest of Australia, a proven robust clinical and corporate governance and
management system focusing on health outcomes.

**The result**

Achieving ACHS accreditation for the whole district and every service provided within it for the first
time in over a decade—this gives the public some assurance that standards of care and health practices
meet national guidelines and they are therefore receiving services at the same standard as every other
Australian citizen.

Financially the district was markedly over budget, with the executive team in a position of deciding to
either improve the finances and lower health outcomes or run over budget and at least maintain health
outcomes. There was no support at the time to tackle the real problem—A core group of Indigenous
health workers backed by local community leaders who did not have the skills and / or will to
comprehensively provide the health services needed in the local communities. In order to address this
skills deficit in core clinical service delivery nurse numbers increased across the islands (not supported
by the model of care proponents) to ensure communities and individuals had safe vital health services.
The budget meeting target was impossible to achieve, despite numerous meeting with Bureaucrats in
Brisbane about the issues and promises of support finance and politics was deemed the priority over
health outcomes with corporate office turning back the clock and putting the district into a holding
pattern until after the 2012 state election.

It is too early to measure changes in the population health data results most will not show marked
changed for the current generations, it is widely recognised that these health indicators change over
decades or generations not years.

It needs to be noted that the early phases of these changes in the Health District where hard fought
gains, with little support from the Government or policy makers, but enormous support from local
communities and individuals not previously heard from or consulted. These hard fought gains were not
sustained as the then labour government (leading up to the state election) in order to appease vocal and
connected minority power groups on Thursday Island imposed a new management structure designed
to keep them happy. As a result the district reverted back towards a system of failings.

With a change in Government in Queensland in 2012 support for providing an outcome focused well
managed and governed organisation is now very apparent with the Health Minister and corporate
Queensland Health active in facilitating change and ignoring the need to appease vocal Thursday Island focused minority groups rather seeking to work with all communities.

**Recommendations**

- As a matter of fact assume that Indigenous individuals and communities expect, want and need their local health services to be provided to the same standards and with the same skilled competent professionals as every other Australian citizen expects.

- Federal and State Governments develop transparent published outcome results for the provision of primary health clinics available to local individuals and communities, including the minimal education and competencies standards of the workforce.

- Significant Investment be made by Government to provide clinical education teams for the primary health sector, with simulated and hands-on learning of core learning sets and mandatory competencies for all clinical staff.