Lessons drawn from a history of community health services to inform current Australian primary health care policy

Australian Community Health Policy Brief, January 2024

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1. Introduction

The 1973 Community Health Program - rationale and development

The federal Whitlam government of 1973-75 established the Community Health Program (CHP) in order to remedy a series of acute shortcomings in the Australian health system in relation to access, cost, range of services, insufficient attention to prevention, and under recognition of the social dimensions of health and illness. It recognised fundamental reform of health services was needed.

The resulting network of community health services and Medicare have addressed some of these shortcomings to some degree, but access to multidisciplinary health services, a focus on prevention and early intervention, and attention to social and emotional health remain limited, especially for communities disadvantaged by income and location.

The 1973 Community Health Program was underpinned by a set of core principles, which need to work together to maximise their effectiveness. Some of these principles have been eroded or lost in subsequent decades except in the Aboriginal Community Controlled Health Organisations. These principles are supported by the World Health Organization's policies on Primary Health Care and Health for All, first described in the WHO Declaration of Alma Ata 1978, some of which were reaffirmed in the 2018 WHO Astana Declaration on Primary Health Care.

Since the introduction of the 1973 Community Health Program community health services have developed in different ways in each State and Territory. Many continue to provide a wide range of services and programs in Australia, but their role and extent is not well understood by governments, and their considerable potential in addressing contemporary health issues receives inadequate attention in national and state health policies and funding priorities. In this brief we describe the principles of the original Community Health Program and consider how the development of community health services since then offer lessons for contemporary health policy reform including the Strengthening Medicare agenda.

Principles

The following best practice principles are important as a conceptual and practical foundation for community health centres and services, and their effectiveness is increased when all principles are present and they interact synergistically. Together they represent the implementation of Comprehensive Primary Health Care.

1. Community health centres and services aim to improve the health of identified communities, not simply those who seek care. Services and proactive approaches are tailored to meet those communities' health and wellbeing needs and issues.
2. Community health services and resources are universal, provide a generalist entry point to the health system, and should be designed to be accessible to all, in convenient locations close to where people live or work, not require a referral from a health or other professional and be at low or no cost.
3. A comprehensive model of health includes consideration of the interaction of physical, cultural, commercial, emotional, economic and social determinants of

health in communities and individuals and ways in which they affect the community's health.
4. Services have a duty to advocate on behalf of the health of their community when determinants threaten health.
5. Multi-disciplinary teamwork is vital and needs to be well co-ordinated.
6. Services offered should be of a high professional standard and health care professionals should be "on tap, not on top".
7. Programs and services reach across the community health continuum – including disease prevention and health promotion, assessment and management of health problems, early intervention, support, treatment and rehabilitation. Community health services and programs should include work with individuals, groups and community organisations.
8. Programs and care are provided from the one coordinated service.
9. Community engagement is vital and drives identification and assessment of health issues, informs advocacy and community development, enables group programs to build individual and social capacity, sensitises and links to individual treatment services, and influences the management of the organisation to ensure programs are relevant and locally responsive.
10. Community solidarity is a valuable resource which community health services can build and mobilise to improve the health of individuals and communities. Hence community health services work with other agencies, sectors and local government to advocate on and address local social determinants of health and health equity.
11. Education and training for all health professionals about community health principles and comprehensive primary health care is essential.

There is an overlap between these and the visions of the Strengthening Medicare report, especially concerning increased access to lower income and populations in disadvantaged circumstances, the core community health model of multidisciplinary care, and the capacity of community health services to adapt and be responsive to their communities through strong community engagement with diverse populations, something that was vitally important in Victoria's response to Covid-19.

As well as working with Medicare funded fee-for-service general practices to implement the principles of the Strengthening Medicare Report, the federal government should work with state and territory governments to expand public-funded salaried community health centres and services.

2. What services are based on community health principles in 2023?

145 Aboriginal Community Control Health Services across Australia and the 24 independent Victorian community health services embody most of these principles.

Other Victorian services and the network of community health centres and services in other states reflect some but not all of these principles. In some places, organisations provide a number of pre-determined services rather than having the capacity to respond flexibly to current and emerging community needs. Some community health services offer only individual clinical services and not the range of other services on the community health continuum.

No Australian government has an explicit community health policy but Victoria does have a community health program and guidelines (Community Health Program in Victoria) which enacts some of the principles. The National Aboriginal Community Controlled Health Organisation offers national guidelines for their service partners.

3. Why was the momentum of the 1973 Community Health Program curtailed?

1970s

By 1976, the Community Health Program had funded over 700 projects, including community health centres in metropolitan and rural areas, women's refuges and health centres, family planning services, Aboriginal community health services, workers' health centres, specialist training for general practitioners and foundation chairs of Community Medicine in universities. Federal funding to state governments was reduced and then ceased after the 1975 Fraser government election, resulting in curtailed services. A national Community Health Program continued until 1991, which funded some national projects (such as the Family Medicine Program of the Royal Australian College of General Practitioners) but not local services. The development of community health services in each State and Territory diverged from the early 1980s.

1980s

The incoming Hawke government (elected in 1983) committed to restoring federal community health funds to 1975 levels, and to fund some new services, but did not develop an overall policy or guidelines for states to direct their development. The Hawke and later Keating governments focused attention on establishing Medicare and the Home and Community Care (HACC) Program, and from 1991, the General Practice Strategy, which included Divisions of General Practice. The HIV/AIDS epidemic also dominated health policy in the 1980s and the principles of community involvement which were central to the CHP influenced Australia's effective response which involved partnerships with the most affected communities. Some additional funds for services such as women's health, HIV, and health promotion were provided, some of which were allocated to community health services. The Australian Community Health Association and the National Community Health Accreditation and Standards Program were funded from 1984 and 1987 respectively but were defunded by the Howard government in 1997.

1990s – to present

By the 1990s health policy in the Australian and State and Territory Governments became more focussed on access to hospital beds and structural and management reorganisations. The Federal Government also strengthened General Practice including through the funding and formation of Divisions of General Practice (subsequently transitioned to Medicare Locals and then Primary Health Networks). From this period onwards national policy attention was on the General Practice component of Primary Health Care to the detriment of community health centres and services. The differences between the States and Territories continued.

State and Territory Differences

Victoria and South Australia had the strongest community-managed community health centres from the late 1970s, until the early 2000s for SA, and continuing until the present day for Victoria. There has been a withdrawal by women's health services from providing local standalone direct health services in both SA and Victoria, and all of SA women's health services are now part of the government managed Women's Health Network. In Victoria a statewide independent not-for-profit women's health network continues to work in health promotion, women's health research and developing evidence for advocacy and policy.

NSW continued with state government provided community health services. From 1986, NSW passed legislation to establish shared management structures for public hospitals and community health services in defined geographic areas, first known as Area Health Services, and from 2011 Local Health Districts. This has led to hospital issues taking precedence, and community health services, while varying significantly in organisation and content across districts, have lacked the necessary policy attention and funds to respond to population needs and growth. However, women's health centres are unique in the NSW health landscape as they are an example of community health services which sit outside the bureaucracy. They are positioned as an essential part of the NSW health care system and are still based on women's health and community health principles. In September 2023 the Minns government allocated an additional $34.3 million over 4 years to the 20 women's health centres across NSW.

While we did not research specific development of community health services in Tasmania, Western Australia, Queensland, the ACT and the Northern Territory, our study indicates that the development of services in these states (with the exception of the ACCHOs) were more akin to those in NSW and so only embody some of the community health principles.

ACCHOs

The 145 Aboriginal Community Controlled Health Services across Australia have continued to grow in strength and embody the principles of the original CHP, mainly with federal funds. They represent the service model which most closely embodies the community health principles outlined above.

Social Movements

The social movements which supported the establishment of a range of community health centres in the 1970s are less evident today, with the exception of the Aboriginal health movement which has gone from strength to strength.

Funding was withdrawn from the Australian Community Health Association in 1997 which meant there was no organisation with a national perspective advocating for community health centres/services at federal and state levels.

International Developments

Internationally, the bold vision of comprehensive primary health care in the World Health Organization's Alma Ata Declaration on Primary Health Care was eroded by a selective model of primary health care which was disease focused and offered a set of pre-determined mainly specialist services, rather than developing a comprehensive response to local needs based on the full participation of community

members. The 2018 Astana Declaration on Primary Health Care did endorse the concept of Universal Health Coverage but has been critiqued for being more selective than the WHO Alma Ata Declaration.

4. What problems with the current Australian health systems were identified in our Community Health History?

Our assessment of policy documents, archival material and insights from the interviews, focus groups and workshops we conducted indicate the following problems with the health system, many of which have been posited as problematic over several decades.

1. The system is too hospital centric, missing opportunities to prevent and intervene early in the development of illness.
2. Co-ordination between components of the health system is weak: e.g. between acute and primary but also within primary health care.
3. A shift to privatised services is being seen in Australia through an increase in fees and gap payments which can reduce the accessibility of services for many.
4. The corporatisation of health services, including general practice, undermines the quality of health services generally and their capacity to implement community health principles.
5. Multi-disciplinary team-work is too rare in care and disease prevention and health promotion.
6. Fee-for-service medicine is fragmented, increasingly corporatised, costly and has little capacity to prevent illness at community or population level.
7. The health system is opaque to its users and difficult to navigate.
8. Increased specialisation fragments services and requires more complex coordination.
9. Citizens and health services users do not have a strong voice in the system.
10. For-profit services are not effective in terms of providing services for and improving the health of those most in need.
11. Health professionals need additional and specific education and support to work in multi-disciplinary teams and in services which emphasise prevention and promotion, and these functions are rarely sufficiently funded or valued in an acute care focused health system.

5. Recommendations: Key policy developments required to enact the community health principles in contemporary health policy

Our history of community health indicates that there are many lessons for contemporary health policy and service development. Below we summarise these lessons and suggest possible reforms.

5.1 National Policy Statement

A national policy statement on community health centres and services is required which is fit-for-purpose for the twenty-first century health challenges Australia faces. This policy should draw on the rich history of community health services in Australia including the Aboriginal Community Controlled Health Services Movement and recognise its place within the primary health sector and its alignment with the current Strengthening Medicare agenda**.** The statement should accommodate existing State and Territory differences while drawing on the principles for best practice community health outlined above. The policy should support an expansion of community health services through agreements with the states and through the Primary Health Networks.

Federal and state governments need to be better informed on the role of the community health sector, including its components, size, budget, reach, and potential for reforming the Australian health care system. The policy should support fundings models based on block funding rather than multiple project funding.

5.2 Dedicated Community Health Unit in the Australian Government Department of Health and Aged Care

A dedicated Community Health Unit would provide a mechanism to enable the Federal Government to understand the role of community health centres and services in each State and Territory in regard to these factors:

- what the main service components are and how do they differ between States and Territories
- how they interface with acute health care services and General Practice
- how they are organised between generic services and specialist (youth, women's, LGBTIQ+, Aboriginal and Torres Strait Islander, drug and alcohol, community mental health)
- the overall budget spend on community health services
- the numbers of people receiving clinical services
- waiting times for these services
- the types of services beyond clinical including groups, community development, health promotion, and advocacy
- how services are responding to population increases and emerging health issues
- determine how community health services can work with and support the Strengthening Medicare policies and Primary Health Networks

The proposed Community Health Unit could investigate the feasibility of a national program to support and extend comprehensive models of community health centres/services. It could work to ensure better inclusion of these services in national health policies and plans while taking account of the differences between States and Territories. In doing this the Unit would need to learn from and liaise with the Aboriginal Community Controlled Health Organisation sector. The Unit could also establish a national mechanism to bring together State and Territory Health Departments to discuss the ways in which their community health services can be recognised as important models and be supported to work with initiatives from the federal and state governments.

5.3 Collaboration between the federal government and States and Territories was an essential strategy in establishing the Community Health Program and the resulting network of existing community health centres and services. Such collaboration remains an essential strategy to extend multidisciplinary primary health care.

Collaboration between the federal government and states and territories to expand multidisciplinary community health teams is an important additional strategy for the federal government to implement recommendations of the Strengthening Medicare Task Force Report. This report's key principles of increasing access to multidisciplinary primary care, encouraging multi-disciplinary teamwork, modernising primary care, and supporting organisational and cultural change can be implemented by working with states and territories to expand salaried multidisciplinary teams within existing community health services. This collaboration could also consider alternative funding mechanisms to include primary medical care in multidisciplinary community health teams, enabling greater variety and options in health care delivery especially in locations with limited or no fee-for-service primary medical care.

A rigid divide between federal and state responsibilities (which assumes the federal government funds general practice and state governments public hospitals and community health services) is not only inaccurate (as the federal governments contributes 40% of hospital funding) but an obstacle to implementing the Strengthening Medicare Task Force Report principles. Health policy can benefit from organisational and cultural change in federal/state relations.

5.4 Recognition that community health services work best when there is strong consumer and community influence on how the organisation is managed and governed, rather than overly corporatised or government-run models.

Our study indicated this has been a core strength of community health over the last five decades, with significant experience for other health services to draw upon in implementing the Strengthening Medicare approach.

There were some concerns that some community health services are becoming increasingly large and complex, as independent companies or as part of larger government-run systems, with the consequence that they are less influenced by and accountable to the communities they serve. There was a significant worry that this trend might undermine capacity to implement community health principles, and this was the case for all jurisdictions. We identified many benefits of the early community management from the historical accounts as well as in the contemporary era of responsive, locally-connected governance by ACCHOs and some Victorian community health services. The historical accounts also identified the need for support, including training for community members where they are on boards of management and other advisory roles so that they are aware of their responsibilities and accountabilities, and to build their confidence in relation to managing the service to achieve the best community outcomes.

5.5 Services that are free or low cost at the point of use

Affordability is one of the most frequent barriers to health service access and community health services are generally free at the point of use or low cost. Most General Practice is fee-for-service, and although the majority of GP care for lower income consumers is free, there are costly gaps for everyone else and the number of practices offering bulk-billing is gradually reducing. However, in terms of multidisciplinary care, most private allied health care is not low-cost, and private dental care is expensive. Community health services could offer more publicly funded salaried allied health and dental care, as an alternative to private, for-profit services.

General practice is also increasingly shifting to larger corporate business models that emphasise different values. Problems of affordability and accessibility have grown and the current Federal government's suite of Strengthening Medicare measures, once implemented, could help primary medical care in Australia to move closer to the community health principles. These initiatives could be used to extend primary medical and other health care in community health centres and services using innovative funding models such as capitation, sessional or salaried or part salaried models. The inclusion of primary medical care is an important aspect of the community health service model and should be retained or introduced where not already part of service models.

5.6 Support for ACCHOs should be continued and strengthened

We found broad consensus that the ACCHOs model of primary health care provisions provide world leading examples of comprehensive primary health care services that provide culturally safe and effective services. Funding to these services should be increased as part of the national Closing the Gap policy. Providing streamlined funding models with appropriate rather than excessive accountability requirements will ensure services are not consumed with burdensome administrative requirements.

5.7 Fund fit-for-purpose community health research and evaluation and data collection

Funding should be provided for a ten-year rigorous research agenda to evaluate the establishment, progress and achievements of community health centres/services. This agenda would be best served by a consortium of university partners which could adopt methodologies relevant to the nature of community-based services. A program to develop the concept of teaching community health centres could be established in order to develop stronger relationships between research, teaching and practice. The program could include multidisciplinary placements, conjoint appointments between health centres and tertiary institutions, and a research and evaluation funding program.

The Australian Institute of Health and Welfare should be mandated to collect data on Australian community Health Service that can be used for Federal and State planning purposes.

5.8 Expand and strengthen multidisciplinary education

Funding should be provided to all universities with health sciences programs to establish multidisciplinary education programs for all health science students that are designed in collaboration with community health staff and include multidisciplinary placements in comprehensive community health centres/services. The concept of teaching community health centres could be developed.

5.9 National Community Health Advocacy Body

Funding should be made available for the formation of a national non-government organisation to encourage the development and growth of community health centres/services and to advocate on their behalf. The establishment of the organisation should draw on the lessons from the former Australian Community Health Association.

6. Study Methods

We assessed policies, service materials and local histories and interviewed 93 people who had worked in or had a significant relationship with community health services since the 1970s. We have also collected an archive of key documents relating to the history of women's, workers, and generic community health centres. Our research was funded by the Australian Research Council Linkage Special Initiative SR200200920.

7. Research Team

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