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Defining community health services in Australia: a qualitative exploration

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ABSTRACT

Background. The Community Health Program of the 1970s was an attempt to introduce a national community health model. However, although community-based health care is an important element of the health systems of all Australian states and territories, the definition of what constitutes a 'community health service' in Australia today is not clear. **Methods.** A search of government websites failed to provide information about the types and characteristics of services that would be included in the term. Therefore, semi-structured interviews were conducted with 13 key informants in roles with responsibility for primary and community health services from health departments in all Australian states and territories. Questions explored their understanding of community health services as they operated in their jurisdiction. The study adopted a blended inductive and deductive orientation within a qualitative descriptive method. **Results.** There was little consistency in the way community health services were described across jurisdictions. The defining attributes of a 'community health centre' described by an international peak body did not apply to services in the majority of jurisdictions in Australia. Victoria was more aligned with the description than other jurisdictions, with organisations defined through legislation and a separate funding stream to support aspects of service delivery. **Conclusions.** Those designing and implementing national health system programs and reforms need to be aware that terms, such as 'community health', do not mean the same thing across jurisdictions; attempts to create consistency have to recognise differences that will affect new initiatives, as well as the spread of successful policies and programs from one jurisdiction to another. Without a consistent description, it is difficult to explore the current role of community-based health care across Australia in improving access to health care.

Keywords: Australian health system, community health characteristics, community health models, community health planning, community health services, defining health care terms, description of community health, health care reform, primary health care.

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Introduction

The Australian Government Primary Health Care 10 Year Plan (Australian Government Department of Health 2022) recognises the importance of primary health care services 'provided through general practices, Aboriginal Community Controlled Health Services, community pharmacies, allied health services, mental health services, community health and community nursing services and dental and oral health services' (p. 4). There is no definition of the term 'community health', and there are only general references to current 'best practice models of care for people with diverse backgrounds and lived experiences and at risk of poorer health outcomes' (p. 26). Although the Plan recognises the national Aboriginal Community Controlled Health Services model, it does not acknowledge other community health service models that have persisted or been developed in states and territories since the National Community Health Program (CHP) was introduced in 1973 as 'an innovative program designed to extend and reform the existing health system by encouraging a shift towards prevention, a focus on local communities and emphasis on primary health care' (Baum *et al.* 1992). The Whitlam

Government introduced the Medibank Program at the same time, to reduce cost barriers to access to primary medical and pharmacy services.

The opportunity presented by the national CHP was used by some states, most notably NSW, SA and Victoria, to continue or expand existing community-initiated health services, and develop a range of other primary health care services, but it was never taken up in other states and territories. Although there were differences between the states and territories in the way services funded through the CHP were designed and delivered (Milio 1984), the models were seen to share a focus on multi-disciplinary comprehensive primary health services, community development and universal access, but with a focus on disadvantaged communities, responding to local needs, and local control and management (Milio 1983*a*, 1983*b*, 1984). These characteristics are reflected in the International Federation of Community Health Centre's operating definition of a 'Community Health Centre', with five core attributes that reflect the current Primary Health Care Plan (De Maeseneer *et al.* 2019; Table 1).

Commonwealth policy focused on implementation of Medibank (which later became Medicare), and the CHP disappeared as a policy and funding stream by 1985, leaving states and territories to decide whether to continue supporting community health centres. Victoria is the only state to have maintained a statewide network of generalist community health services that can be traced back to the national CHP (and sometimes before). Services described as 'community health services' remain a key element of the health systems of all Australian states and territories; however, the definition of what constitutes a 'community health service' in each state and territory in Australia today is not clear. It is beyond the scope of this research to explain how these services have evolved since the 1980s. Nationally, organisations included under the term 'community health service' in each state and territory jurisdiction deliver a range of services in different ways, and have diverse management and funding structures. This lack of clarity in the characteristics of services that are described using the same term makes it difficult to explore the current role of community-based health care across Australia in improving access to health care for vulnerable populations. In addition, a better and shared understanding of what a 'community health service' is in each state and territory may help to inform policy and strategic initiatives, particularly at the national level and when seeking to adapt successful programs from one jurisdiction to another.

Table 1. Core attributes of a community health centre.

(1) Interprofessional, team-based primary care
(2) Integration of primary care with other health services, health promotion and social/community services
(3) Action on social determinants of health through inter-sectoral services and cooperation
(4) Ongoing engagement of community members in health, and planning of health and social services
(5) Having responsibility for a defined local population, either geographical or by population group(s)

The aim of the project was to identify and document what the term 'community health' represents in each state and territory in Australia, highlighting the similarities and differences to contribute to a better understanding of the context for ongoing health sector reform.

Methods

An initial search of government websites failed to find information that clearly articulated what types of services were included under the term 'community health services', and whether there were any core common characteristics that would define them. Therefore, we undertook a qualitative study using semi-structured interviews to gather descriptions of community health services (CHS) from purposively selected key informants (Neergaard *et al.* 2009), with one representative from each of the eight Australian states and territories. Participants were required to be government officials in positions with responsibility for primary and community health care policy and/or service delivery. The Commonwealth was not included in the study, as the focus was on considering the differences and similarities in the way states and territories conceptualise and operationalise their role in providing community health services.

Interview guide

A semi-structured interview guide was developed by the authors based on their experiences as health services researchers, and descriptions of CHS in the literature (cited above) and the International Federation of Community Health Centre. Questions were designed to generate information about the characteristics of CHS in each jurisdiction. Examples of domains and questions asked are provided in Table 2. The full guide is provided as supplementary material. Questions were not trialled; however, regular meetings of the researchers as interviews were conducted considered whether other questions or common prompts should be added.

Participants

Participants were identified through the National Primary and Community Health Network (https://www.latrobe.edu.au/aipca/about/primary-And-community-health-networks). In some cases, the National Primary and Community Health Network member identified themselves as the person in the relevant role, whereas others proposed a more appropriate person in their jurisdiction for interview. Thirteen people

Table 2. Content domains in semi-structured interview schedule.

Overall definition/description
What kinds of organisations are described as 'community health services' in your jurisdiction?
How is a community health service identified in your jurisdiction? What are its defining features?
Is there an identifiable community health sector? How big is it? What defines it as a sector?
How are community health services funded?
Services provided
What kinds of services do community health services provide?
If GPs are part of the community health services in your state/territory, how are they funded?
What kinds of relationships do community health services have with other agencies – hospitals/GPs/other health care providers/community services/government?
How crucial is the colocation of free or low fee services to the success of community health services in your jurisdiction?
Clients and access
What kinds of clients do they provide services to? (Are there criteria/ requirements?)
Involvement of community members in governance
What governance arrangements do they have? Do any have community boards of management?
Action on social determinants of health
What role if any do they play in population health?
Is health promotion core business?
What role if any do they play in advocacy?

from all (eight) Australian state/territory jurisdictions took part in interviews.

Procedure

Participants identified were contacted by email. Following receipt of signed consent forms or within 2 weeks of the email being sent, interviewees were contacted by phone or email to arrange a suitable time for a Zoom interview. In some instances, multiple people were proposed for the interview and this was agreed to. Where prior consent had not been given by a returned signed form, interviewees were asked to provide verbal consent, which was recorded. Zoom interviews of approximately 1 h were then undertaken based on the semi-structured interview proforma and notes taken. Interviews were conducted by an interviewer (JM) with a background in community health in Victoria, including convening state and national Networks of jurisdictions and peak bodies in the primary and community health sectors for 20 years. In some instances, the interviewer knew the participant through their role in the National Primary and Community Health Network. These prior relationships may have contributed to the willingness of people to participate. All authors have more than 25 years of experience as qualitative researchers, and two co-authors have been managers within community health systems in two different states. Interviews were recorded using a mobile phone or zoom recorder to support note taking if this was agreed by the interviewee.

Data analysis

The study adopted a blended inductive and deductive orientation within a qualitative descriptive method (Sandelowski 2000; Neergaard *et al*. 2009). The interviewer reviewed interview notes and listened to audio recordings repeatedly to summarise responses within the key domains covered by the interview questions. The approach was deductive in the sense that initial summaries of content were structured around the interview guide, which was based on prior definitions and descriptions of 'community health'. The approach was inductive in that we looked for content and concepts that may not be included in the domains of the interview guide. All authors read notes and reviewed the descriptions to confirm they captured the information available in the interviews.

Ethics approval

Ethics approval was obtained through the La Trobe University College of Science, Health and Engineering Low Risk Human Ethics Committee (HEC20326).

Results

As noted above, interviews were conducted with at least one participant from all eight state/territory jurisdictions. In four states, one person was interviewed, in ACT, SA and Vic two interviewees participated, and in Tasmania, three participated.

Overall definition/description

Defining features of community health services

Most of those interviewed were unable to provide a clear description of the core characteristics of a CHS within their jurisdiction, and few could estimate the number in their state. One interviewee commented: 'Depends if you're asking how many community health centres we have, or how many community health services we have' (ACT). They clarified that in the ACT, community health centres were single entity organisations that offered a range of services delivered in the community at a fixed site or through outreach at people's homes or other sites. In contrast, a community health service described the service being delivered. When asked to define or describe community health in their state, another interviewee responded that: 'Community health is

not a term that is used currently in South Australia'. However, they also stated that:

> I think of community health as loosely things that are not part of the hospital and are embedded in local communities and designed for local community access that support people to live and be healthy in the community. (SA)

Other states referred to the idea that a community health service is focused on meeting the needs of people in a geographically defined catchment, with some emphasising that these services were publicly funded.

> The main defining feature I think is that we're providing services to the general public within the region that the clinics are based, whether urban or remote. And the services can be anything from child health through to health promotion, education around care, palliative care, emergency services as well in the remote settings. So quite a varied service. (NT)

> Close connection to local community is definitely a defining feature. (Victoria)

> Largely it's about public care in the community. (NSW)

Only Victorian interviewees had a clear definition of a CHS, which was basically administrative: CHSs are those in receipt of Community Health Program state funding. They reported there were 28 Victorian CHS registered as such under the state Health Services Act, with government funding for specific services flowing to them.

Most interviewees reported that in their jurisdictions, the defining feature of a CHS was that the service was delivered in the community, as opposed to being delivered in a hospital; for example, 'non-specialist out-patient clinic services that are delivered in an out-of-hospital environment' (ACT). For some, however, a CHS could be an outreach service offered by a hospital: 'A lot of the services operate as a community-based arm of the acute services' (ACT). One interviewee in particular (NT) stressed that hospital outreach was a common part of their model of community health delivery, including for oral health, audiology, dialysis and medical services. It was also reported that a CHS could be under a hospital governance structure; for example, an 'integrated' CHS in Victoria.

Some interviewees reported that in their jurisdictions, a primary feature and role for community health services was hospital avoidance: 'Community health can be regarded as another strategy to ease the pressure on the acute sector and that's all they do in some people's minds' (Tas). Perhaps related to this goal, several interviewees commented on community health services commissioned by Primary Health Networks (Australian primary health care organisations).

> From a PHN perspective, a community-based service would be any of the services that they commission. (Qld)

> A community health service that's funded through the Primary Health Networks, which ... for me that's more of a primary care service, a primary integrated care service, they would definitely be collocated with GPs and be very GP focused. But for me that's a bit different to a community health service. I would call that an integrated health care centre. (WA)

Funding

Although most interviewees reported that in their jurisdictions CHS received state and federal funding, only Victoria had a specific Community Health Program funding stream. Several interviewees (including Victoria) referred to their CHS having multiple funding sources and some, (WA, Qld) referred to community-based health services funded through Primary Health Networks (PHNs).

Some interviewees reported that government funding was provided to organisations for the delivery of specific services through service agreements rather than a specific community health funding stream. The NSW interviewee reported that funding was through service agreements with Local Health Districts, rather than individual services. Local Health Districts were established in 2011 to operate public hospitals and institutions, 'and provide health services to communities within geographical areas' (NSW Health 2022). The Local Health Districts decide what will be allocated to their CHS. The SA interviewee reported that there was no defined funding stream, as: 'they're not an entity. Programs and services are funded' (SA).

Tasmanian interviewees referred to block funding through the state from the Commonwealth Home Support Program (which is a home care service only available for people aged ≥65 years). The Queensland interviewee was not sure if there was a specific state community health funding program.

Identifying a community health sector

Interviewees were asked if community health was considered an identifiable sector (set of services) in the health system in their state/territory, and whether there was a peak body that represented the sector and through which services were linked. Victorian interviewees reported they did consider CHS a sector in their state, adding that although it was not a large part of the public health system, it was important because of the focus on vulnerable populations. The reason they gave for identifying community health as a sector was based in part on its historically high level of community ownership and accountability; however, they expressed some uncertainty as to whether this was still the case, given some services

are now very large. Victorian interviewees did not mention whether or not there was a peak body.

> We don't really have any comparable services in Victoria that bring together health and social care services in one location and service .... Someone can go there, and they may be presenting or attending for a podiatry appointment but while they're there it's found that they have drug and alcohol problems or they're experiencing family violence and that they can then be hooked into these other social supports and other health care services that can address their needs. I don't think we have anything equivalent. There's also a visibility in the community and so it punches above its weight.

The NT interviewee also responded that community health was always seen as a sector in NT, with remote and urban each being unique, but under the one banner. Although it was reported that 'individual clinics' did not meet, there were meetings at management level. ACT interviewees reported that their CHS were a sector, but that it was 'tangled up' with hospitals and the health service system, and that as it is part of the public service, there was no peak body.

The NSW interviewee reported that although community health is identifiable, there is a peak body for women's health, but not for community health: 'The community health sector is largely our state health services, but there are other providers and partnerships that happen locally in NSW'. Interviewees reported that although it may have been a sector previously in SA, community health was no longer considered a sector in SA, or in WA or Queensland.

Services provided

In describing the kinds of organisations they considered to be CHS and what services they delivered, most interviewees listed a range of possible services delivered at one site or across multiple sites in the community. For some interviewees a CHS could also be a stand-alone specialist service; for example, mental health, alcohol and other drugs, youth or refugee health service at one site, provided it was delivered in the community, and not a hospital or sub-acute setting. Most interviewees stressed the variation in services provided through CHS across their state, particularly where decision-making was devolved to local regions or districts. Wide variations were also often reported between rural and urban areas.

Child health was the CHS most frequently mentioned by interviewees when asked what services were provided, although it was variously described as child and adolescent health, maternal and child health and child and family health. 'All have a function around the women and baby services' (ACT). Other services reported as provided by CHS – or as a community health service – included dental, allied health, community nursing, chronic care, home care, palliative care, social work, wound care, housing, family violence, general practice, aged care, disability care and health promotion.

Inclusion of general practice

GP services were not reported to be an essential component of a community health service by any jurisdiction.

> Some people ... would classify GP as one component in the community and they would use community health service as a collective noun for everything that is not GP. (Qld)

Where GPs were described as part of CHS, there were a range of funding models for this, including salaried, Medicare funded, subcontracting arrangements and collocation. Several interviewees expressed concern at difficulties with the viability GPs within CHS: 'Can do [include GPs] – but you'll go broke doing it' (Vic).

Tasmanian interviewees reported that their jurisdiction previously had salaried GPs, but in the 2000s, 'it was decided to get out of the GP space.' They commented that now in Tasmania, there are only some salaried GPs in inpatients in district hospitals and some out of hours services. GPs were reported to not be part of the structure of CHS in the ACT, but that private GPs were reported to be linked in through clinical pathways.

The NSW interviewee reported that although GPs are not seen as part of CHS, HealthOne services in NSW were developed focusing particularly on provision of GP services. HealthOne Service Models are described as 'integrated primary and community health services' (NSW Health 2020). Some other services, such as child and family, may also employ local GPs through a variety of models.

The Queensland interviewee also reported various models for provision of GP services, but stressed that in general, it could be difficult to recruit GPs, and that current Medicare rebates were low and not viable. The NT interviewee commented that NT has no GPs in their urban services; however, some remote services have GPs and some fly in/fly out. Some NT remote services were also reported to have government salaried doctors employed as 'District Medical Officers', with a range of skills that may include general practice.

Clients and access

All interviewees reported that their CHS were free or low fee, although there was less certainty about the fee structure for those services called community health services, but commissioned through PHNs. The fact that services were low cost or free, and their geographic location, usually in areas of low socioeconomic status, was reported to be

aimed at assisting access for vulnerable populations. Targeting of particular population groups was, however, not referred to by interviewees as a defining feature of CHS.

The majority of interviewees reported that although most CHS were available to all, some services were only available to certain populations. Dental services were most commonly mentioned, with services usually only available to those with a health care card. Some children's services and some nursing services were described as having criteria for access, such as age, holding a health care card, homelessness or having a chronic condition.

Although interviewees reported that there is universal access to Victorian CHS funded through the state community health program, these funding agreements identified priority populations and a small charge is levied for services based on ability to pay. The NT interviewee reported that their CHS are accessible to all those with a Medicare card or from a country with a reciprocal agreement with Australia.

Most interviewees assumed that those using CHS came from or worked in the local area; however, this was not usually mandated. The ACT interviewee reported that you could usually only access your local service, but that access to other services was allowed for specific or specialist services not available locally.

Involvement of community members in governance

Due to the structure of health service delivery in their state, not all of those interviewed were aware of the governance structures of their CHS or the degree of community engagement. Of those who were able to report on this, references were commonly made to community advisory committees, inter-agency meetings and client surveys (NT, WA, Tas, Qld interviewees), although some of these mechanisms were reported to be undertaken by PHNs or centrally by government, rather than at service level. Some also commented on local involvement through community development activities or working with schools (Tas interviewee). The NSW interviewee reported a 'high level of engagement' through boards and advisory bodies at district level. Victorian interviewees reported that a 'close connection to local community is definitely a defining feature (of a community health service),' but also that community engagement is variable across services. In Victoria, interviewees reported that 28 'stand-alone' community health services have Boards of Management with a balance of skills and community involvement among members; however, it was also reported that others may be less engaged. Interviewees reported that the Victorian Health Department requires CHS funded under the CHP to submit a quality account each year that includes how they engage with communities.

Action on social determinants of health

Role in population health and health planning

The WA interviewee reported that population health was core business for CHS, although the WA Health Department has policy oversight. Each health service has a population health directorate responsible for population health and health planning, and health services work on this with local government and local health planners. The NT interviewee also reported that NT services have a large role in population health, although not a planning role, as this is undertaken centrally. In ACT, health promotion and prevention, and population health and planning are also a central responsibility for the Directorate, although services are consulted. In Victoria, each local government area is required to develop health and wellbeing plans, and local CHS participate in this. CHS were also reported to do their own catchment planning.

The SA interviewee commented that their jurisdiction has a 'Health in All Government Policies' approach to addressing the social determinants of health through Wellbeing SA. Wellbeing SA undertakes health promotion and prevention and population health and planning rather than health services. This may however be undertaken in partnership with local government.

Tasmania reported that their health services may be consulted regarding local needs and issues, and participate in health needs surveys; however, this was not a structured process, and they do not otherwise have a role in health planning.

In NSW, there is an expectation that CHS will be involved in population health and planning; however, the devolved structure in NSW leaves this up to the individual districts.

Role in health promotion and prevention

In Victoria, interviewees reported that most CHS funded through the state community health program receive Integrated Health Promotion funding from the state government, and that although the amount varied, health promotion was considered core business. The NT interviewee also reported that health promotion and prevention was essential in both their urban and remote arms: 'Our aim is to keep people out of hospital.' They also cited the important role of elders, particularly women, in local health promotion and prevention program delivery.

ACT interviewees reported that health services in ACT were not funded for health promotion and prevention, and that this was a role for the ACT Health Directorate. They commented that Individual health services have more of a role in the community in secondary and tertiary prevention. The NSW interviewee reported a role for CHS in health promotion and prevention, and that this may be undertaken by an individual service or in collaboration with others, or by others in the district.

The WA interviewee reported that CHS had a role in health promotion and prevention, but that each service had a different focus. The Queensland interviewee reported variation in CHS involvement in health promotion and prevention, and population health and planning: 'the main finding that you'll see with community health services is that they can be anything and everything.' (Qld)

The SA interviewee stated that health promotion and prevention was no longer the role of CHS, but was the primary role for the Population and Prevention Health Directorate at Wellbeing SA. They reported that since the department restructure, services in the community were now less a community health model and more clinically focused under the GP+ arrangements. Tasmanian interviewees reported that health promotion and prevention was not core business, and although it might be encouraged, there were few staff available for this work.

Advocacy

Other than services commissioned by PHNs, CHS are publicly funded and, in all jurisdictions but Victoria, interviewees reported that community health staff were government employees. As such, most commented that it was not appropriate for CHS to advocate directly to government. The NSW interviewee reported that CHS services had a 'huge role' in advocacy, although this was through meetings between community health CEOs and department representatives, rather than through politicians or media. A similar process for advocating through the government department was also reported by the ACT interviewees.

The Queensland interviewee reported that some CHS undertake advocacy, and some do not. They commented that publicly funded agencies do 'very little', with more done by the private sector – both formal and informal, and some national and some just local. One Tasmanian interviewee responded that there was: 'very little and probably not enough (advocacy)'.

The NT interviewee reported that their CHS do not advocate to government, but they do advocate within their local communities. Victorian interviewees reported that CHS had a large role in advocating around the social determinants of health with social care agencies and health services operating collaboratively on this.

Discussion

This study found little consistency in the way CHS were described across Australian states and territories. The defining attributes of a community health centre described by the International Federation of Community Health Centre and traceable to the Commonwealth's CHP did not apply to services in the majority of jurisdictions in Australia. The description of CHS given by Victorian interviewees was more aligned with the international characteristics than other jurisdictions, and included reference to ongoing government support for the model through the state's CHP. The Victorian government funds a statewide network of 26 non-government registered organisations to deliver allied health services to priority populations within a community health model. The same registered organisations are also funded to deliver other recognised elements of the model, such as health promotion. These organisations are also commissioned alongside others to provide a wide range of services, similar to CHS in other jurisdictions. However, although other states and territories identified some services that had characteristics of community health, there was no coherent set of organisations operating an identifiable community health model outside the commonwealth funded national Aboriginal Community Controlled Health Organisation program.

The study makes it clear that policy advisors and those implementing health system programs should not assume that they are meaning the same thing when they are using terms, such as 'community health', across jurisdictions. The lack of clarity also makes it difficult to explore the current role of community-based health care across Australia in improving access to health care for vulnerable populations. Part of the rationale for the study was to help to develop a better and shared understanding of what a 'community health service' is in Australia. The findings highlight how difficult it would be to have a consistent national definition, given the high degree of variability in these services. Only Victoria identified a defined state-wide community health sector. Awareness of this sector nationally is very low, as indicated in the Steering Group Discussion Paper to inform the development of the Primary Health Care 10 Year Plan (Australian Government Department of Health 2021). Although Aboriginal Community Controlled Health Organisations were recognised as a model to deliver accessible community-based comprehensive primary health care, there was no mention of the Victorian CH sector.

As the Primary Health Care Plan is being implemented, any efforts to create a national health system that includes primary health care models that meet the needs of diverse and potentially vulnerable populations need to recognise the complexity of the multi-jurisdictional context, and consider how to adapt policies and programs in such a way that they build on the strengths in each state and territory. Similarly, policies and programs that are successful in one jurisdiction may not adapt and apply easily to another.

Study limitations

The lack of information available on government websites to answer the research question led to the use of interviews for data collection. This paper provides a summary of the information that was provided by participants, without

arguing that the description of community services in each state/territory is comprehensive or necessarily accurate in all respects. Almost all interviewees were from policy areas, and struggled to respond to some of the questions or responded in the broadest terms. This was noticeable in jurisdictions where decision-making and service delivery were separated or devolved activities.

The study did not explore Aboriginal Community Controlled Health Organisations, as it sought to focus on generalist community health services provided by states and territories.

Conclusion

The findings of this study reinforce concerns about designing policies and programs at national and jurisdiction levels in the absence of a strong understanding of the existing health system contexts, and confirm that the context for implementation of national programs should not be assumed to be the same across Australia. The role of community health services, whether they align with international models or not, is essential to a well-functioning and comprehensive health system. To design and implement programs and policies in different contexts, policy advisors need to be aware of the potential of these differences to influence delivery and outcomes.

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Data availability. Data are not available, because they are potentially identifiable qualitative data.

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