9. Explaining Australia’s Policy Responses

Having surveyed the history of women’s health policy development since the 1970s, it is now time to return to the questions posed in the introduction. Why is Australia the only country to have enacted two national women’s health policies? Why is it also the only country to have attempted to establish a national network of community health centres? Why is it a leader, internationally, in developing public responses to domestic violence? And what are the conditions that have come together at different times to create windows of opportunity for structural health reform? As in most areas of public policy, the reasons for particular outcomes are multidimensional, directed and shaped by numerous pressures. As well as facilitating factors, there are almost always countervailing forces, particularly in a policy area such as health—the largest industry in all OECD countries. It is an area where ethical issues abound, where large incomes are at stake and where profits depend on the policies adopted. In the Australian federation, health is particularly complex, not just because nine governments share responsibility but also because of the peculiar Australian arrangements where most doctors operate as private businesspeople, outside the control of government, while drawing the lion’s share of their income directly from the public purse, with virtually no conditions attached.

Before attempting to answer the questions posed, this chapter examines the main forces that came together to facilitate the policy uptake of women’s health concerns. The last two questions, concerning the main obstacles to policy reform and the reasons that the structures of the health system remain intact despite strong evidence in favour of change, are addressed in the final chapter.

There is no question that the Australian women’s health movement has been relatively successful in comparative terms. No other country has developed two national women’s health policies and multiple sub-national policies and very few have national strategies or even women’s health plans. Internationally, a few national women-specific health initiatives have been taken. The Irish Department of Health developed its Women’s Health Plan in 1995, when the permanent Women’s Health Council was established. In Canada, the first national women’s health statement was released in 1990; however, because the Provinces have constitutional responsibility for health, there was no national policy. The Health Minister at the time, Mary Collins, was influenced by Australian developments and owned a copy of the NWHP. The Glasgow Women’s Health Policy was launched in 1992 and updated and relaunched in 2002. WHO Europe has designated the Glasgow work, which was influenced by Australia’s first
NWHP, an example of good practice. New Zealand, the United States and the United Kingdom all had strong women’s health movements but none has made policy responses that compare with Australia’s.

Moreover, Australia stands out in the area of direct service provision: no other country has a network of publicly funded, independent women’s health centres and services. In the four other major English-speaking democracies, women did attempt to set up separate health centres but on a smaller scale and only a handful remains. Violence against women in its many forms has been put on policy agendas in many countries but research published in 2002 shows that the Australian effort compares well with other countries (Weldon 2002). The policy responses developed since Weldon’s study mean that Australia is probably still among the leading nations.

Perhaps most importantly, the social view of health or socioeconomic-determinants perspective that has guided the movement’s actions and advocacy since the 1970s is more widely understood and is now acknowledged regularly in major Australian health policy documents. The vexed question of why a social perspective is not more prominent in actual health policy decisions will be addressed in the final chapter.

Health policymaking is notoriously difficult and generally undertaken amid intense controversy. A leading Canadian economist has called it ‘the issue from hell’ (Evans 1993). Women’s health policy fits into the same mould and movement members faced many obstacles when trying to get their concerns heard. In the early years, the ideas being put forward were unfamiliar and often seen as extremist. Women’s groups lacked authority, status, legitimacy, political experience and resources. The men in the senior positions in the bureaucracies frequently resisted the new ideas and others were dubious about the wisdom of establishing separate services. Medical unions have always opposed any form of alternative services that might reduce the size of private medical markets by substituting for doctor-provided services. Since the rise of women’s health activism, many women doctors appear to have taken the movement’s criticisms personally. It took time, energy and considerable perseverance therefore to persuade policymakers of the validity of the claims. Even where acceptance emerged, it was often fragile and transitory.

A number of forces were, however, working in the opposite direction to facilitate policy expansion, as summarised below.
Factors Facilitating Policy Adoption

- A strong, grassroots movement able to put effective pressure on political parties.
- The first centres and services established in a radical change context.
- Women working for change, often behind the scenes, in political parties and trade unions.
- The Australian practice of employing feminists in advisory and policy development roles: the femocrat phenomenon.
- Women’s policy machinery installed in all nine government bureaucracies.
- The election of responsive governments that believed they needed the women’s vote.
- The underdevelopment of the Australian health and welfare system.
- The openness of Australian government, allowing activists access to decision makers.
- Programmatic Australian political parties.
- Federalism perhaps a facilitating factor, perhaps not.
- The strong strand of social liberalism in Australian political culture.

These influences are now examined in turn.

Grassroots Activism

The early Australian women’s health movement comprised strong, broad-based grassroots groups. In her study of 36 democratic governments to explore the reasons for responsiveness to the problem of violence against women, Weldon found that the mobilisation of a strong, autonomous women’s movement was a major factor in explaining successful outcomes. By ‘autonomous’, Weldon means independent of political parties and other organisations. She also suggests that a proliferation of groups is a sign of strength and, as we have seen, there has been a remarkable proliferation of women’s health groups over the past 35 years. Self-governing women’s movements are effective because they are able to articulate problems on their own terms and exert outside pressure on political parties to take up their issues. Women’s movements that are organised mainly from within political parties, such as in Italy, have been less successful in having violence taken up as a political issue (Weldon 2002:79–86). The Australian women’s health movement, being grassroots based, is quite independent in Weldon’s sense, although some members belonged to political parties, unions and the like as well.
The achievements of the movement suggest a very strong commitment among grassroots women; some were health professionals and others had special skills but, on the whole, ordinary women mobilised in numbers to work for better health services and social change. In no other country did so many passionately committed women determine to set up their own health services. Australian women were prepared to take whatever forms of direct action seemed necessary to establish services where women’s bodily integrity, views and decision-making rights would be respected. If, after testing conventional avenues, it was felt necessary to break the law, they did so. Nardine refuge workers in Perth, for example, squatted in an empty State-owned house with a woman and her children who had been waiting for months for public housing. The police were called, the family was evicted and several Nardine workers were found guilty of trespass and put on good behaviour bonds (Murray 1999:8). But women’s housing problems were publicised.

Women went to extraordinary lengths to sustain the services they created, giving hours of their time and often their own money, working through all available channels to influence decision makers. As well as marches and other forms of direct action, they held forums and speak-outs, wrote letters and petitions, circulated policy papers, made appointments with politicians and bureaucrats and sought media coverage. As services became established, an institutional base from which to work became available and action tended to take more conventional forms; however, street marches and demonstrations, such as the ‘Mother of All Rallies’ staged by homebirth advocates in 2009, are still held in support of reproductive rights. Such visible activism, especially when it is electorally close to home, is not easy for politicians to ignore. A strong women’s movement alone, however, is not sufficient to shape public policy, as periods of government inaction and regression demonstrate. It was necessary for a number of other influences to be operating simultaneously.

Favourable Political Opportunity Structures

The policy context in which the early movement operated was extraordinarily favourable for the introduction of new policies, especially those that would benefit the least advantaged. Radical equality-seeking social movements were active across the OECD, calling for everything from minority rights, industrial democracy and environmental protection to disarmament and a new world economic order. In Australia, community health, public health and Aboriginal health movements were emerging, buttressed by accumulating evidence that a biomedical model of health care was unnecessarily and dangerously limited. Extensive disquiet about Australian health and welfare services grew as research showed that people, especially the elderly, were living in dire poverty and
were unable to access basic services, despite the impact of one of the longest
economic booms in Australian history. The publicly subsidised private health
insurance system, of most benefit to the well-off, came under heavy attack.
In this context, a Labor government was elected in 1972, after 23 years in
opposition, on a platform of extensive social policy reform. The political climate
of the day was conducive to sweeping policy change—an opportunity as radical
as it is rare—and its impact continued well into the 1980s. The converse, of
course, is the steady emergence of neo-liberalism as the dominant discourse,
which supplanted the social justice emphasis of the preceding period. The
support of the Whitlam Government at a formative stage was fundamental to
the women’s health project because it established an institutional foundation
for the movement. The institutional base was expanded and consolidated under
supportive sub-national governments and the Commonwealth in the 1980s and
early 1990s but the early support was crucial.

**Women in Political Parties and Trade Unions**

Women in political parties and trade unions frequently cooperated with
grassroots health groups and worked hard within their organisations to create
the conditions where women’s health concerns would be reflected in policy.
Arguments have been made that a greater proportion of women in legislatures
facilitates policy advancement. In Australia, however, the movement’s greatest
policy successes were in the ‘golden’ 1980s before women entered legislatures
in large numbers. As more women entered parliaments at both sub-national
and national levels, women’s health slipped rather than advanced as a policy
priority, suggesting other, more powerful forces at work, such as the advent
of neo-liberalism. This finding is consistent with that of Weldon in her cross-
national study of policymaking on violence. She found no relationship between
the percentage of women in legislatures and government responsiveness to

This finding does not, however, negate the very important role that numbers of
women played within parties and trade unions in the pursuit of women’s health
concerns. Nor does it negate the role that women parliamentarians still play on
selected issues. In the early days, women set about educating party and union
men concerning feminist perspectives—a process that involved hard work and
often required written papers. Political party women had to explain the meaning
of a women’s health perspective. In trade unions, women worked to change
the ambit and the meaning of OHS and to promote the principles of industrial
democracy. The influence that they were able to exert sometimes did depend on
their numbers: more women in unions meant that ‘new’ issues such as workplace
sexual harassment were able to be raised and pursued. For women in political
parties, their low numbers were perceived as a barrier to change. According to one party member, women’s issues often placed women parliamentarians in an uncomfortable position of opposition to their male colleagues. Moreover, the few women who were elected were contacted about everything feminist, which was a heavy load. On issues other than abortion, however, male politicians were generally prepared to accept women’s perspectives in the 1970s and 1980s. But this was not always the case and the role of women parliamentarians, working collaboratively, was sometimes crucial. For example, in Victoria, a small group of women parliamentarians, in close connection with outside groups, women in the bureaucracy and women in ministers’ offices, pushed hard against very strong male opposition to have the Women’s Health Program adopted in the mid-1980s. In Queensland, it was very difficult for women to persuade male members of the Goss Government to participate in the NWH Program because women’s health was so closely associated with abortion in many minds.

From the mid-1970s until the early 1990s, there was a strong perception among members of both major political parties that the women’s vote had to be courted (Auer 2003), a perception at least partly created by the findings of opinion polls. The ability to persuade male party members that electoral advantage would follow from women’s health innovations was crucial to success. As a New South Wales female parliamentarian told me in the early 1990s, the men in the party were aware that the women in the party could deliver the women’s vote. But where men were not so convinced, the political battle was harder.

Party structures through which women might have worked had existed within the major parties for decades but the role that women played had been largely auxiliary (Sawer and Simms 1984:131–40). Women were instrumental in having new committees and caucuses established in State and Territory ALP branches in the 1970s and 1980s, which facilitated issue articulation. The National Labor Women’s Conference and National Status of Women Policy Committee were established in 1981. In the Liberal Party (LPA), a number of feminist groups were established in the early 1980s, including the Liberal Feminist Network in Victoria, with counterparts in New South Wales, South Australia and Queensland. The first National Liberal Women’s Conference was held in 1986. The National Country Party, now The Nationals, similarly made changes to increase the representation of women in party structures. In some jurisdictions, women were able to ensure that they were represented on policy committees, including health committees. Labor women tried to push policies through at every level: at national conferences, State and Territory conferences and at national women’s conferences. Many LPA women supported women’s health issues within their parties but often faced strong opposition from men. For example, the LPA had been in power in South Australia for almost three years before Health Minister, Jennifer Adamson, was able to announce that a women’s health policy would
be developed, fulfilling an election commitment. Women from the conservative parties were sometimes able to prevail, however. One such instance occurred when female members actively opposed National Party government efforts to tighten, rather than liberalise, abortion laws in Queensland in the 1980s. Party women were able to garner enough support to defeat the proposed legislation.

In unions, as in political parties, women worked to ensure that they were represented on committees and elected as officials. As we saw in Chapter 5, women in unions created networks with women’s organisations, community organisations and political parties. In many cases, union women were also Labor Party members and sometimes members of the women’s health movement as well. Women in unions constituted part of a health movement that succeeded in having workers’ health and working women’s centres established.

Opportunities to progress women’s health varied from jurisdiction to jurisdiction, depending, in part, on political culture. Queensland was widely viewed as ‘a bit of a backwater’ until the 1990s. In Western Australia, the sections of the ALP platform that dealt specifically with women were only an outline of principles until the mid-1980s, when they were rewritten to include feminist concerns. The difficulties of achieving attitudinal change were immense in a State such as Tasmania, where the entire health system had centred on hospitals for decades. Tasmanian political party women struggled to gain legitimacy for the unfamiliar concept of a social view of health. In some cases, the appointment of party women to key health positions produced results. For example, Anne O’Byrne was appointed Chair of the Tasmanian Northern Region Health Board in the mid-1990s and was able to establish a women’s health issues subcommittee, which was given responsibility for administration of women’s health financing.

Many women in political parties worked closely with grassroots women. Senators such as Patricia Giles (1981–93), Margaret Reynolds (1983–99) and Dr Rosemary Crowley (1983–2002) worked extensively with women’s groups on a wide range of feminist issues, including women’s health. Particularly in small jurisdictions such as South Australia, women politicians from all parties invited women’s health movement members to contact them and sometimes offered to speak on their behalf. Political party women were sometimes willing to collaborate with NGOs when shaping the questions to be asked in parliament. Where minor parties have been a significant political force, women’s health generally gained active allies, both at the Commonwealth and the State and Territory levels. For example, Christine Milne was able to influence a review of the Tasmanian Department of Health in the late 1990s in ways that would support women’s health. Greens Senators Christabel Chamarette and Dee Margetts facilitated a number of Health Policy Think Tanks at Parliament House in the mid-1990s, at which a social view of health was explored and endorsed. Senator Kerry Nettle (2002–08) was a strong supporter of women’s health and worked with
the movement wherever possible to promote issues and perspectives. The predominantly female parliamentarians of the Australian Democrats were generally strong movement allies. Senators Natasha Stott Despoja and Lyn Allison supported women’s health perspectives throughout their time in the Senate from the mid-1990s until 2008. Senator Stott Despoja put forward a number of health-related Private Member’s Bills, including legislation intended to regulate pregnancy counselling services and ensure the provision of full information about options, a Bill in support of stem-cell research and a Bill with significant women’s health implications intended to prevent patent law from applying to naturally occurring genes.

Marian Sawer (2011) suggests that the increasing numbers of women in legislatures and in high office have often ‘had to leave feminist values at the door’, due to the changing political context where equal opportunity and social justice issues have been steadily pushed off political agendas. The women’s health experience bears this out at the national level in view of its lost salience after the mid-1990s. Women are, however, still playing an important role. At the national level, female parliamentarians, regardless of party, have been far more likely than their male colleagues to support health-related reform legislation where a conscience vote has been allowed. Between 1996 and 2006, conscience votes were taken on five pieces of legislation, relating to four issue areas: euthanasia, research involving embryos, human cloning and the importation of RU-486. The most striking feature of voting was the extent to which women supported the Bills in both Houses. On average, 86 per cent of women in the Senate and 80 per cent in the House of Representatives voted in favour, compared with 44 and 61 per cent of men, respectively. In the case of LPA senators, 87 per cent of women supported the Bills, compared with 32 per cent of men (McKeown and Lundie 2009).

An infrequent but nonetheless productive development has been the emergence of cross-party political action by women in the national Parliament. In 1983, LPA Senator Kathy Martin, Democrats Senator Janine Haines and ALP Senators Patricia Giles and Susan Ryan banded together to support ratification of the UN Convention on the Elimination of All Forms of Discrimination against Women (CEDAW). The Pregnancy Counselling (Truth in Advertising) Bill 2006 was co-sponsored by Senators Stott Despoja, Judith Troeth (LPA), Carol Brown (ALP) and Kerry Nettle (Greens). Party collaboration is a regular feature of the operation of the Parliamentary Group on Population and Development (PGPD), formed in 1995, which raises awareness about international population and development issues, especially sexual and reproductive health issues. It works with the United Nations and with NGOs, such as the Australian Reproductive Health Alliance (ARHA), Sexual Health and Family Planning Australia (SH&FPA) and the International Planned Parenthood Federation. Membership includes
representatives from all parties, including men. The most celebrated instance of cross-party collaboration between women, discussed in Chapter 5, took place in 2006 in relation to the removal of the Harradine amendment, which had restricted the importation of RU-486. In this instance, political party women worked extensively with NGOs, particularly the many groups represented by Reproductive Choice Australia (RCA).

To summarise, in the early years when a feminist health perspective was being articulated and disseminated in organisational structures and beyond, small numbers of women in legislatures and trade unions, in cooperation with femocrats and grassroots women, played a crucial pioneering role. At a time when feminist issues have been driven off agendas, the role that women parliamentarians have been able to play is more limited, despite their increasing numbers. As in all areas of public policy, multiple influences are at work and the proportion of women in legislatures is but one.

### The Work of Femocrats

There is general agreement in the literature that femocrats—feminists who took positions in bureaucracies and worked for reform from inside rather than outside government—succeeded as agents of policy change (see, for example, Eisenstein 1996; Sawer 1990). The evidence of women’s health experience supports such a view. Neither feminist critiques of bureaucracy nor the difficulties of working in less than friendly structures prevented Australian feminists from entering the public service in increasing numbers from the 1970s onwards. Following the lead of the Commonwealth, which appointed the first adviser on women’s affairs, Elizabeth Reid, in 1973, all jurisdictions appointed women’s affairs specialists during the next two decades and all, at some time, appointed women’s health advisers. Most of these women had experience in the women’s movement, the the women’s health movement, or both. And while this phenomenon facilitated policy advancement in one sense, it deprived the movement of some of its energies (Lynch 1984:38).

The first women’s health adviser was Liz Furler, appointed Ministerial Adviser in South Australia in 1984. She later worked as a femocrat in Tasmania before being appointed to the Commonwealth Health Department. Carla Cranny was the first Women’s Health Adviser in New South Wales, appointed in 1985. A women’s health advisory position was created in the Australian Capital Territory in the mid-1980s, filled by Marilyn Hatton. In Victoria, Christine Giles was appointed to manage a new women’s health unit, set up in 1987, and Thea

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1 Discussed in Chapter 1.
Mendelsohn took a similar position in Western Australia in the same year. The position of Senior Policy Officer, Women’s Health, was established in Tasmania in 1989, with Vicki Pearce the first incumbent. Jude Abbs became Queensland’s first Women’s Health Adviser in 1991, and Jen Roberts was appointed to head the single-position Women’s Health Strategy Unit established in the Northern Territory in 1992. Feminist ministerial advisers were also key players in policy advancement in some jurisdictions, operating in much the same ways and within the same set of opportunities and constraints as femocrats.

Given that key stakeholders compete for position in policymaking processes, feminists in senior bureaucratic roles are in a position to advance a women’s agenda. Femocrats played crucial roles on numerous occasions in promoting women’s health issues. In New South Wales, for example, feminists working in the bureaucracy are held to have been invaluable to the early women’s health centres, especially when Commonwealth funding was slashed and the State was being asked to pick up the shortfall. Femocrats were crucial to the passage of the first NWHP through policy development processes in the Commonwealth bureaucracy and important in gaining support for it at the State and Territory level. In New South Wales and Victoria, at least, femocrats cooperated with maternity consumer groups and offered them increased access to policymaking in the 1990s. Members of the Australian Midwifery Action Lobby Group (SA) and Mothers and Midwives Action (Victoria) were in ‘regular contact’ with women in the bureaucracy and the politicians who supported reform (Reiger 2006:333).

Even where femocrats were unsuccessful in achieving immediate gains, as in women’s health in Western Australia in the mid-1980s, their work can be seen as having advanced issues and paved the way for future policy expansion. In women’s health units, women were in a good position to choose the most appropriate strategies for the situation. For example, during lean times in Western Australia, femocrats decided to focus on one or two issues rather than try to advance the whole women’s health agenda. They put themselves in a position to take advantage of opportunities, major and minor, that presented themselves. One women’s health service is said to have been established because a femocrat inserted its announcement into a minister’s speech.

One of the recurring themes in the scholarly literature (see, for example, Dowse 1984; Eisenstein 1996; Sawer 1990; Summers 1986) is that femocrats faced serious dilemmas. Their working environments were often hostile to feminism but at the same time they were expected to maintain close connections with ‘sisters’ outside—a relationship considered conspiratorial in some quarters. It is generally thought that to be successful, the trust of key people had to be gained, inside and outside government, which was an objective not always achieved. In the early days, in particular, many community women were suspicious of the
role of femocrats, while at the same time seeing them as a possible buffer between themselves and male politicians (Smith 1984:5). At the same time, the femocrats in the Commonwealth Women’s Health Unit were viewed with suspicion in their own workplace during the formulation of the NWHP. There was a belief in the department that they were in league with community women and that far too much money would be expected for the project. Another concern was that the unit did not have the confidence of medical unions.

Some femocrats report having been fortunate enough to find mentors who encouraged, supported and advised on how best to pursue their aims. Senior personnel in finance were considered to be crucial allies since, ultimately, their approval or at least acquiescence was needed. One strategy devised in one State to promote trust was to take key departmental men out to lunch, where they were introduced to feminist friends and colleagues, thus demonstrating that feminists were real people!

Femocrats had different views about the appropriateness and usefulness of relationships with grassroots groups. Some experienced women regarded themselves as accountable to the women’s movement and thought grassroots support was essential to pressure policymakers. Other femocrats found it difficult to keep contact with the movement outside and believed it was impossible to maintain friendships. They feared being isolated from departmental information if they were seen to be too close to community women. Responses tended to vary from jurisdiction to jurisdiction. In some places, it was felt that no hint of a connection with outside groups was acceptable. Elsewhere inside/outside relationships could be maintained in a state of delicate balance. One femocrat told me she never openly acknowledged outside groups although she worked with them extensively. While some information could never be divulged, ways could be found of releasing information without breaking rules or betraying ministers, including participation in public seminars and forums. Femocrats in the Commonwealth Women’s Health Unit were in frequent touch with the media, giving out information about policy developments. Articles were also supplied for magazines, including medical journals.

Networking was an important element of the work of most femocrats, who report enhanced effectiveness through links both inside and outside the bureaucracy. Inside, femocrats established ongoing links with each other and with key people in other departments. For example, staff of the Commonwealth Women’s Health Policy Unit worked closely with the OSW and other relevant departments, including social security and finance. In the health sector at the State and Territory level, femocrats often attended women’s health network and health service provider meetings. Interaction was also facilitated by overlapping organisational membership: some femocrats were also members of political parties, NGOs and so on.
Other constraints within which femocrats worked were the inability to speak out publicly and the requirement that policy proposals be moderate. They also found it difficult to work in the face of frequent departmental restructures that occurred, for example, during the development of the NWHP and in New South Wales in the 1980s. Frequent restructuring also made life difficult for community women because working relations were disrupted. As neo-liberalism became more prominent and feminist ideas lost some of their salience, organisational changes resulted in women's health units being located far from the top levels of policymaking, whereas initially they had been considerably closer.

While there is general agreement within the movement that women's health femocrats played a positive role, occasional criticisms were expressed, illustrating the contradictions of the role. In one jurisdiction, community women felt that the women's health unit had achieved little, and it has been argued that towards the end of the 1980s the feminist bureaucracy in New South Wales appeared to be ‘less of an interpreter for the grassroots and more of a publicist for the Labor government’ (McFerran 1990:203). McFerran also acknowledges, however, the contributions made, especially to the refuge program, and she argues that ‘turning the state back on itself’ is ‘an artful game’ in which the relationships between femocrats and community groups are crucial (McFerran 1990:191).

**Women’s Policy Machinery**

The influence of femocrats is closely related to the impact of the policy units in which many of them worked. As discussed, women’s health units or dedicated policy positions were established in all jurisdictions in the 1980s and 1990s. This type of machinery was more extensively developed in Australia than in comparable countries, with perhaps the exception of Canada (Sawer 1989:427, 1990:xv–xvii). The original proposals to set up special institutional structures came from the women’s movement itself. In 1974, ACT WEL wrote a submission to the Royal Commission on Australian Government Administration, suggesting that permanent task forces on women’s issues, staffed by senior officers, be established in government departments. Functions were to monitor activity and policy and program development, to initiate research and to liaise with target groups, interdepartmental committees and advisory councils. The royal commission accepted the proposal and recommended that departments be ‘encouraged to develop women’s units on an experimental basis’ (Sawer 1990:28–9). Thus, the machinery itself resulted from feminist advocacy.

In her 36-country study of policy responses to violence, Weldon found that women's policy machinery was an important factor in making political institutions more responsive to women's claims. Policy units had introduced
the category ‘women’ as a policy priority and had provided a basis for policy administration, research and review that would have otherwise been lost in the spaces between government departments. Women’s policy machinery, Weldon found, ‘partially corrects for the organisation of government around the priorities of historically dominant groups of men’ (Weldon 2002:135). The general assessment of the women interviewed was that women’s health policy machinery had performed an extremely useful role.

A major piece of women’s health policy machinery was the Australian Health Ministers Subcommittee on Women and Health, set up to help coordinate the development of the NWHP. As a Commonwealth, State and Territory body, with NGO and professional representation, it operated as a forum where women’s health experts from across the country could meet, bring ideas from their constituencies, learn from each other, formulate new ideas and develop strategies. During the implementation of the NWH Program, it reviewed and monitored progress and accepted references from AHMAC. Other roles were to produce and disseminate information and monitor and evaluate mainstream health policy for its impact on women (Commonwealth of Australia 1993). An effective body for advancing women’s health policy, it was disbanded in 1998 by the Howard Government.

Women interviewed for this book also remarked upon the difficulties that emerged from not having sufficiently strong women’s health policy machinery. In one jurisdiction, having only two women’s health positions devoted to policy development, implementation, contract management and evaluation of services was a serious constraint. The arguments from this study support the findings of others that special units facilitated the development of women-friendly policies and contributed to positive attitudinal and behavioural change (Sawer 1990). Some of the examples discussed by Eisenstein include rape law reform, the positioning of violence against women on the national policy agenda, the establishment of women’s health centres and services and the development of the NWHP (Eisenstein 1996:43–64). Only in one jurisdiction was it felt that women’s health policy machinery had not been particularly useful.

Responsive Governments

The election of sympathetic governments stands out above all others as the key factor facilitating the progress of the movement’s aims. This finding is contrary to that of Weldon, who found that office-holding by parties ‘on the left’ could not explain policy variation. Weldon does find, however, that it is interaction between a strong women’s movement on the outside and sympathetic policymakers on the inside that has produced the most robust policy responses,
responses that were strengthened further where women’s policy machinery was in place. To partly reconcile the two positions, it could be argued that the sympathetic policymakers that Weldon found to be crucial have been more often found in the Australian case in the ALP (and the minor parties). Moreover, ‘sympathetic’ insiders have been more numerous under Labor governments, which appointed most of the femocrats. In any case, Weldon’s study is narrower than this one in the sense that it covers only one policy area, violence, whereas we have been able to observe the approaches of the two main parties across the gamut of women’s health concerns. Whether it be at the State, Territory or national level, it is clear that Labor regimes have been more interested in introducing policies in response to women’s health concerns.

The orientation of government is one of the central features of ‘political opportunity structure’ as identified by social movement theorists (Gray 2008). Favourable political opportunity structures operated in most jurisdictions at some point during the first 15 years of the movement, which was a crucial time for getting ideas accepted and services established. At the national level, the ALP supported women’s health each time it held office after 1972. Although supportive of refuges, the Fraser Coalition Government cut funding for women’s health centres, the Community Health Program and for feminist refuges between 1975 and 1981. The Howard Coalition Government was openly hostile to women’s health, resiling from any policy role and passing program responsibility to the sub-national level. An example of its intransigent opposition to feminism is its attempt to suppress the Access Economics report that showed that domestic violence cost the Australian economy $8 billion per annum. The report was not released until *The Australian* newspaper filed a successful freedom-of-information application. The previous year the Government had taken money from the violence and sexual assault budgets to pay for the postage of anti-terrorism fridge magnets (Sawer 2008a:7).

A similar pattern is evident in the States and Territories, where ALP governments have taken a more positive stance than their Liberal or Coalition counterparts. Queensland provides a clear example. After 32 years of non-Labor government, which had opposed all policies on women’s health, including OHS reform, the Goss Labor Government was elected in 1989. In quick succession, a women’s health policy unit, a domestic violence policy unit, a gender equity unit, a women’s safety program in the Queensland Police Service and a women’s policy unit in the Office of Cabinet were established. A women’s health policy and a violence against women policy were developed in 1993 and a range of special women’s health projects was funded, including a secretariat for the Queensland

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Women’s Health Network (Mason 1994). These efforts might have been less expansive than feminists had hoped but they stand in sharp contrast with the record of preceding governments.

This is not to argue that all Labor governments have enthusiastically supported women’s health reform or that all non-Labor governments resisted. Occasional innovations were made by non-Labor governments, such as the decision to develop a women’s health policy in South Australia in 1982. The Greiner Government in New South Wales in the late 1980s and early 1990s, neo-liberal in orientation, saw no need to expand women’s health services but continued to support them at existing levels. And while the Greiner Government began to dismantle the women’s policy machinery, the incoming Labor Government completed the process. In one jurisdiction, women reported that non-Labor governments very quickly realised the political and service provision value of cheap and popular women’s health services. It was also realised that a political backlash would follow any attempt to dismantle them.

Some Labor governments have resisted reform. The Dunstan Labor Government in South Australia was reluctant in the 1970s to ‘buy into’ Commonwealth programs, such as community health centres and women’s health centres. Some members of the Western Australian Labor Government in the late 1980s and early 1990s approached the women’s health project with either hostility or indifference. And, as discussed, Labor governments have engaged in symbolic politics, giving the impression of substantive action, as in the case of a second NWHP. After 1986, it took six years of intense daily struggle for the movement in Adelaide to persuade a Labor government to support the Pregnancy Advisory Centre. Reproductive rights are always controversial but the press was supportive, there was strong support from women in the Liberal Party and committed feminist bureaucrats were working on the case, yet progress was very slow. Notwithstanding exceptions, the majority of key Australian women’s health initiatives have been taken under Labor regimes.

The electoral success of the ALP in the 1970s and 1980s was crucial in setting women’s health services on a relatively strong foundation. The level of commitment that the Whitlam Commonwealth Government displayed has not been seen since. Addressing the First National Women’s Health Conference in Brisbane in 1975, Prime Minister Whitlam said:

The basic problem...resides in the attitudes which individuals and institutions within our society have towards women, their health and their bodies...the aim of this conference must be to understand, challenge and change these attitudes...Good health care for women...must be based on adequate and sensitive research into causes and methods of
treatment but ultimately it can only come from a correct understanding of how women feel about their bodies and a correct understanding of the lives they live. (Commonwealth Department of Health 1978:18)

One of the femocrats of the early years takes the view that without the Whitlam Government and supporters in the Health and Hospitals Services Commission (HHSC), the women’s health movement might have quietly faded away.

The steady decline in the salience of women’s issues can be seen in the reduced support for national women’s health conferences since the 1970s. Prime Minister Whitlam opened the first conference in 1975, which was organised and funded by the Commonwealth as its ‘special contribution to International Women’s Year’. The call for papers prompted ‘a massive response’ and 950 women and men attended (Commonwealth Department of Health 1978). Five volumes of proceedings were produced and published by the Commonwealth, producing a valuable resource. A senior Commonwealth Health Department official worked with the organising committee for the second conference in 1985, together with several officials from the South Australian Government. The Commonwealth and South Australian governments, both Labor, provided financial support. The conference was opened and closed by Senator Pat Giles, who conveyed apologies from Health Minister, Neal Blewett (Kirby-Eaton and Davies 1986:3–7). Senator Giles also opened the third conference, in Canberra in 1995, which was closed by Health Minister, Carmen Lawrence, whose department provided financial support (Broom 2001:100–1). The Howard Commonwealth Government refused to contribute financially to either the fourth or the fifth conferences and chose not to send representatives. All senior Commonwealth politicians, including senior Labor women and the Prime Minister, declined AWHN’s invitation to attend the Sixth National Women’s Health Conference in 2010; however, the Commonwealth made a financial contribution of $50 000 and was represented by Senator Claire Moore. Nevertheless, since the early 1990s, Commonwealth interest has fallen steeply. This decline is not so apparent at the sub-national level where, in some cases, good working relationships are in place.

Labor held power for a considerable part of the 1970s in New South Wales, South Australia and Tasmania. In the 1980s, the years of significant policy advance, Labor held office for most of the decade in all States except Queensland. From the sub-national level, momentum steadily percolated upwards to culminate in the first NWHP and Program under the Hawke Commonwealth Government. This period of Labor Party dominance was not only unusual in Australia; it was also counter to international trends at the time. In other large English-speaking democracies, except New Zealand, the 1980s was a period of conservative party dominance. The Conservative Party was in power in Britain from 1979 until 1997, in Canada from 1984 until 1993 and, in the United States, Republican administrations ruled from 1981 until 1993. Women’s health policy did not
advances markedly under the Lange Labour Government in New Zealand, which became an adherent of neo-liberal ideas and seriously alienated traditional supporters, particularly women. Thus, when national and sub-national women’s health policies were being advanced in the 1980s, Australia was the only OECD country with a strong women’s health movement as well as a preponderance of responsive governments, which is a situation that can be classified as a very favourable political opportunity structure.

The Australian Party System

The Australian party system is another factor that seems to have contributed to the achievement of women’s health policy objectives. Political parties that have reasonably well-developed sets of policies, as in Australia, play a key role in policy advancement. In the predominantly two-party system, politicians use policies to differentiate themselves from their opponents and to compete with each other for electoral support. In this process, a level of consensus is reached within parties and relatively detailed policies are produced and presented to the electorate. There is considerable exposure of issues and policy alternatives, which are scrutinised by the media and promoted and defended by leaders.

Britain, Canada and New Zealand, like Australia, all have strong, programmatic political parties, with the result that different experiences in these countries cannot be attributed to the nature of parties. The absence of this type of party system in the United States, however, helps to explain why that country, despite its strong women’s health movement and the early focus on separate services, did not develop women’s health policies. Parties in the United States exist primarily to choose candidates and facilitate their election, not to be agencies of policy advancement. Further, party structures are decentralised and non-hierarchical, making agreement on policy unlikely (Herrnson 1994:83).

Australian parties, particularly at the sub-national level, have regularly announced advances in women’s health policy as part of their election strategies, as did the Rudd Government when it promised a second NWHP and a focus on violence against women during its 2007 election campaign.

The Women’s Health Movement and the Australian Health and Welfare System

One of the reasons for the relative strength of the Australian women’s health movement, I suggest, was uncertainty of access to publicly provided services,
including hospital, medical and social services. The publicly subsidised system of private health insurance left approximately 20 per cent of the population with no insurance and another group of similar size with serious underinsurance in the early 1970s. A study in South Australia in 1973–74 found that the main reason for imprisonment for debt was unpaid hospital bills (Scotton 1978:130). National health insurance was introduced in 1975 but the system was steadily dismantled by the incoming Coalition Government, which reintroduced user charges and reinstated private health insurance (Gray 1984). Uncertainty about access prevailed again until 1984 when national health insurance was reintroduced.³

Strong women’s health movements emerged in Britain, New Zealand, the United States, Australia and, a little later, in Canada. When measured in expenditure terms, the English-speaking democracies all have relatively weak welfare systems. It might be that women in continental European and Scandinavian countries felt less disadvantaged because they had more secure access to health and social services. Further, it is plausible that a social view of health is more likely to develop in the context of welfare state weakness, where, when all other things are equal, the poorer conditions of women’s lives lead to poorer health outcomes.

The connection between welfare state development and the strength of women’s health movements is speculative⁴ and needs further study; however, some corroborative evidence exists. Although there has been an active women’s health movement in Britain, women set up few separate services. An exception is the Women’s Therapy Centre in London, which was established because psychotherapy was difficult to obtain under the National Health Service (NHS) (Broom 1991:63). Otherwise, women in Britain were reluctant to set up separate services for fear of appearing to promote private medicine at a time when the NHS was under threat from conservative forces (Doyal 1983:23; Elston 1981:203). The situation is entirely different in Australia where women from low socioeconomic groups—the main users of services provided free in feminist health centres—have always been less likely to hold private health insurance.

Relatively good access to hospital, medical and other services might be part of the reason New Zealand and Canadian women also set up fewer separate services. In the United States, women did set up their own services in the early years; however, public funding was not available as it was in Australia, so maintaining the services was more difficult.

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³ National health insurance has lowered financial barriers to access; however, because successive governments of both persuasions have allowed out-of-pocket expenses to increase, serious obstacles to access have developed again.

⁴ Other factors could be differences in the degree to which medical attitudes are patronising, better access to reproductive health services, greater economic security through access to well-paid work and so on.
Access to Government

Australian political institutions have a reputation for being relatively accessible,\textsuperscript{5} which has contributed to policy advancement. A former femocrat expressed the view that a person does not have to be an Oxbridge graduate to get access to senior levels of government. This might be related to the relative youth of Australian political institutions and the relative weakness of perceptions of social class. Professor Lesley Doyal, a British women’s health expert who is familiar with Australian experience, is of the opinion that the relative openness of Australian government is an important factor in explaining different policy outcomes in Australia and Britain. In her assessment, members of the movement in Britain do not expect to have access to senior politicians and public servants, nor do they expect the creation of special women’s policy machinery. And they certainly do not expect to be recruited to fill positions at senior levels of the bureaucracy.

Access to policymakers is particularly open in smaller jurisdictions, where people sometimes wear more than one hat and often know each other personally. Movement members in South Australia and Tasmania reported generally being able to arrange meetings with politicians and bureaucrats when they wanted them. Access depends partly on the political persuasion of the government in power. A government generally responsive to equality-seeking movements is more likely to permit access for women’s groups. And none of the factors that impact on policymaking operates independently. Rather, they interact together so that the presence of femocrats working in women’s policy institutions facilitates access for outside groups in a political culture that endorses consultation and some level of citizen engagement with government.

Relatively easy access to policymakers might help explain why the Australian women’s health movement has been more successful than its British counterpart but further study is needed to answer the question of whether Australian government has been significantly more open to women’s groups than governments in other English-speaking countries.

\textsuperscript{5} Evidence shows that different groups have very different access, both formal and informal, to Australian government. Matthews (1976) found that there was a massive over-representation of producer groups in Australian government institutions, such as advisory committees, and a serious under-representation of other groups, particularly disadvantaged minorities, including women, Aborigines, welfare recipients and immigrants.
The Role of Australian Federalism

In other studies of the impact of federalism on public policy, including women’s policies, I have found that federal institutions can be both an asset and an obstacle. My argument has been that the way federalism works depends on its interaction with a range of other forces in the policy development environment and that its operation changes from time to time and from place to place (Gray 1991, 2006, 2010). Evidence from this historical study supports my earlier conclusions.

It has been argued by some that federalism impedes the development of public policy. The system, it is said, fragments the power of government, gives rise to conflict and controversy between levels, allows interest groups greater opportunities to obstruct policy processes, creates overlap and duplication and generally results in weak, conservative government (reviewed in Gray 1991:9–10).

Federalism does increase policy complexity. In the case of the first NWHP, activities that fed into the policy process took place in nine jurisdictions over nearly two decades. Activists had formed a multitude of groups, organisations, networks and centres at the community level and worked for reform in all jurisdictions. In each place, governments responded differently and each had their own policy agendas, sometimes innovative, sometimes not. Before the NWHP could be launched, endorsement was required from all nine Australian health ministers, advised as they were by nine different sets of bureaucrats. Until the last minute, health movement members, national and sub-national officials and Commonwealth and State and Territory femocrats had reason to fear that the policy would not be endorsed.

Institutional arrangements can have a different impact at different times depending on the other forces operating. For example, Australia is noted for its federal financial imbalance, which gives the Commonwealth control of the purse strings. This is a decided advantage for women’s policies, including women’s health, when a sympathetic government holds power at the national level. Conversely, it can be an enormous disadvantage, as when the Fraser Government slashed its funding for women’s health centres, community health centres and feminist refuges. Generalisations therefore are likely to be fragile; however, one generalisation that can be made for the Australian federation—but not for all federations—is that the federal financial imbalance restricts the capacity of State and Territory governments to make policy innovations, especially where large outlays are required.

Complexity notwithstanding, a federal division of power can, at times, facilitate the maintenance and/or advancement of policy. When the Northern Territory Government was unwilling to support the establishment of the Central Australian
Aboriginal Congress health centre in the mid-1970s, funding was obtained from the Commonwealth. Similarly, when the Commonwealth reduced funding for the Community Health Program and women’s health centres, women were able to appeal to the State level for assistance. In unitary systems, such options might not be available. The States eventually agreed, after a struggle, to support the centres from their own coffers. Another example of federal arrangements working well for women took place between 1996 and 2007 when women’s health centres, services and policies continued to be maintained or advanced in all jurisdictions, despite an antagonistic Commonwealth. These arguments are consistent with those of Louise Chappell (2001) who found that federal arrangements had allowed policy in relation to domestic violence to continue to develop at the sub-national level during the Howard years. Chappell reviews a number of studies that suggest a similar situation in relation to HIV/AIDS policy and policies for Aborigines.

The election of supportive governments at the same time in a number of jurisdictions can generate interest and create a favourable policy context, as in the 1980s. British observer Lesley Doyal is of the opinion that Australia’s federal institutional structure is another of the reasons that women’s health policy is far more developed than in Britain: it facilitated experimentation and innovation in a number of jurisdictions.

As well as creating opportunities, federalism can create obstacles to policy expansion. During the second half of the 1970s and in the 1980s, when the non-Labor government in Queensland refused to support women’s health, activists applied for Commonwealth funding through various avenues but were ineligible for national support because they were not national organisations. An example of sub-national obstruction took place during the Whitlam Government period when South Australia was governed by the Dunstan Labor Government, which was generally assumed to be reformist. For whatever reason, the South Australian Health Commission was allowed to strenuously oppose the Commonwealth proposal to fund the Hindmarsh Women’s Health Centre. As discussed in Chapter 1, the approach of the Victorian health bureaucracy was similar. Indeed, one of the major obstacles facing the Whitlam Government’s health reform program was created by federalism: its constitutional power to fund many of the projects it wished to support was limited.

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6 In unitary systems where regional and local governments have a measure of financial independence, however, the options are similar.

7 We need to be cautious, though, about such generalisations: federalism could equally provide an unfavourable opportunity structure depending on the stance of governments towards a particular issue. Moreover, in practice, very few nations have only one level of government. Experimentation and innovation are features of local government activity under favourable institutional arrangements.
While it allows for innovation and experimentation in different jurisdictions when conditions are favourable, federalism also contributes to an unevenness of services across jurisdictions. The Northern Territory has no women’s health centres in 2011, for example, and Tasmania has only one. There is also considerable variation in the sexual assault services across the country and in levels of funding commitment. New South Wales has many more agencies per capita than any other State. By 1990, it had 33 sexual assault services, one incest centre and one rape crisis centre, all of which received at least some public funding. At the same time, Western Australia, with almost one-third of the population, had only three publicly funded services. Queensland, which had more than half the population of New South Wales, had only two centres. There was no national policy overview at that time, with its potential to lead to more uniformity (Carmody 1990:304–8). Perhaps more seriously for the women’s health project, without the policy impetus and the money that came with the NWHP, it is safe to argue that the women’s health sectors in some States, notably Queensland, Western Australia and Tasmania, would be very much smaller than they are. By this point, they might even have disappeared. Thus, different political cultures in different parts of a federation generate unevenness in policy development, which also arises from experimentation and innovation. This is a problem if the dominant ethos is that citizens should have equal access to services, which tends to be the case in Australia and is certainly the position taken by the women’s movement.

Federalism, then, has shaped women’s health policies in different ways at different times. Like any other system of government, its operation depends upon the policy environment of the time and the impact of other interacting policy influences. A detailed examination of federalism is outside the scope of this book; however, many of the advantages and disadvantages so commonly claimed to emanate from federal institutions are features of unitary systems that have strong, relatively independent local or county government, such as in Scandinavia and many European countries. Moreover, all governmental systems create divisions of power when they divide responsibilities into separate portfolio areas. Such divisions might cause deadlocks and delays, as in the 1980s when the Commonwealth Department of Health approved and supported the establishment of Congress Alukura but the Department of Aboriginal Affairs tarried for some three years before committing the necessary funds (Carter et al. 1987). Departmental divisions certainly set up barriers to a comprehensive, whole-of-government response to problems such as violence against women. In summary, federalism is far from the only set of institutional arrangements that divides the power to govern. The way it operates depends on the interaction of many other policy influences so that it is very difficult to make firm generalisations about its impact even in a single federation.
Social Liberalism in Australia

A strong strand of social liberalism runs through Australian political culture. In contrast with its distant cousin, market or neo-liberalism, social liberalism is sympathetic to extensive government intervention in economic and social life and underpins the Australian practice of looking to government rather than to individuals or the private sector to help solve problems. A positive view of the role of the democratic state might be expected in a nation where white settlement was established by government, where extensive government intervention was necessary if settlements were to grow and where all the early institutions, such as hospitals, were government institutions. Since the nineteenth century, social liberalism has been an important force in Australia, and the policy responses called for by the women’s health movement fit comfortably within that philosophical perspective.

Social liberal ideas in Australia derive from the work of English thinkers, including T. H. Green, L. T. Hobhouse, J. A. Hobson and J. M. Keynes, who developed a sustained critique in the late nineteenth and early twentieth centuries of laissez-faire or market liberalism. Their work provides a philosophical foundation for the welfare state. These thinkers held that the role of government should be expanded to ensure a decent standard of living for all citizens and to provide the conditions under which individuals could reach their maximum potential. Rather than the minimal government role of laissez-faire liberalism, the democratic state, it was argued, has a moral duty to create the conditions for equality of opportunity and freedom from insecurity and deprivation.

Over the past century, many observers of political life have remarked on the extensive use that is made of the Australian state (government). Australian democracy has come to look upon the state as a vast public utility, whose duty is to provide the greatest good for the greatest number’, wrote historian W. K. Hancock in 1930 (Hancock 1961:55). More recently, A. F. Davies (1964:4–5) argued that ‘Australians have a characteristic talent for bureaucracy…[which] is exercised on a massive scale in government, economy and social institutions’. As Marian Sawer has shown, strong social liberal ideas have influenced Australian public policy for more than a century. Australian feminists, for example, have never trusted free markets and have espoused social liberal ideas and supported state intervention since the first wave of the movement (Sawer 2003). The calls that second-wave feminists made upon the state, then, are in keeping with an established and important seam in Australian political thought.

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8 Neo-liberalism is the modern manifestation of laissez-faire or classical liberalism.
Reaching for Health

The deeply embedded support for social liberal ideas helps to explain, first, the relative success of the Australian women’s health movement, especially in the early years, and, second, why the movement’s approach has differed from that in countries where more individualistic, market-liberal ideas are stronger. Marian Sawer (1994:162) has drawn attention to an important difference between the Australian and US women’s movements:

Because of the tradition of seeking reform through political action rather than litigation, the language of Australian feminism has drawn upon shared value systems (the dominant social liberalism) both to mobilise supporters and to persuade power-holders. Australian feminism has not split like the American women’s movement over issues of equal rights versus issues of special needs or individual autonomy versus the ethic of care because social liberalism contained all these elements. The Australian women’s movement has been able to draw upon them as required for the political purposes of the day.

Social liberal ideas are embedded in the political cultures of other countries, including Britain, Canada and New Zealand. As discussed, however, when women’s health movements were at the peak of their strength, political opportunity structures were unfavourable in those countries because conservative governments held power.

Despite the strength of the tradition, social liberal ideas have been strongly challenged by neo-liberalism in recent years, which is a large part of the reason that the commitment to social justice and feminist objectives has visibly weakened. The popularity of neo-liberal ideas among politicians and other opinion leaders in Australia over the past three decades might suggest that social liberalism is no longer an important political force. Australian opinion polling, however, consistently shows support for high levels of public spending on health, age pensions and education. A 2004 review of major polls found that in the previous 15 years, when faced with a choice between tax reductions and increased spending on social services, Australians increasingly favour the latter. One of the conclusions was that ‘a government which cuts taxation while eroding the standard of health, aged care and education services is unlikely to have the support of public opinion’ (Grant 2004:26). An explanation for this paradoxical situation is not attempted here, except to say that the interests with the resources to place their views on political agendas and to make contributions to the campaign funds of political parties appear to be the voices that are being heard. There is still strong support for women’s health policies and programs, which the Commonwealth is currently choosing to ignore, except at a symbolic level. Present-day neo-liberal leanings aside, a majority of citizens consistently supports well-funded health and education services.
Conclusion

A combination of forces and influences interacted together to put women's health on Australian policy agendas and to induce governments to act. The strength and tenacity of the grassroots movement were very important factors, together with the dedication and commitment of women working in women's services over almost four decades. The context of a strong reform environment in which the early movement worked was important, as were related factors such as the relative weakness of Australian social policies and programs, which meant that there was significant community support for general social policy reform. The relative openness of Australian government helped the movement to put its claims before senior personnel and, once issues found their way into party platforms, at least some of them were implemented when a party came to power. Women in political parties and unions worked hard to persuade the men in their organisations to accept women's health ideas. The early and extensive establishment of Australian women's policy machinery and the appointment of femocrats in key positions were distinctive Australian developments that promoted policy uptake. The strong relationship that often existed between feminists in the bureaucracy and feminists outside was often used to promote policy advancement. Although it is impossible to measure the independent impact of separate influences, the strength of the Australian women's health movement, the election of supportive governments and a political culture that endorses social liberalism were key factors. Moreover, all these influences interacted together in various ways, sometimes reinforcing each other and constituting a countervailing force to opposing interests.

To return to the questions posed in the introduction, a complex array of interacting influences is the reason that Australia is the only country to have enacted two national women's health policies and to have attempted to establish a strong national network of community health centres. Policy development was supported by a community health movement and an Aboriginal health movement and led by strong exponents of structural reform—the same policymakers who supported women's health. And, of course, the women's health movement and the community health movement provided support and legitimacy for each other. One difference between the two areas is that health policy experts led developments in community health whereas women at the grassroots led the charge in women's health, as they did in the Aboriginal health movement. A similar set of policy forces has placed Australia among the leading countries in its response to violence against women.

Finally, what are the conditions that came together at different times to create windows of opportunity for structural health reform? In the case of the introduction of national health insurance and the Community Health Program in
the 1970s, the first facilitating factor was that the Commonwealth Government was strongly committed to policy action and actively led public debate. That is, the ALP had formulated relatively detailed, evidence-based policies and had explained them to the community over several years. Because the proposals were controversial, debate had been long and intense and party members had worked hard to articulate the policies. By the time the party came to office, significant numbers of Australians understood and supported the proposals. Second, the activism and support of the health reform movement, including the women’s health movement and the Aboriginal health movement and mobilised general women’s and welfare reform groups, made it easier for the Commonwealth to pursue major change and harder for the Opposition to oppose, although oppose it did very strongly. Outside support, national and international, helps to shore up the political determination necessary to succeed against powerful opposing medical unions and other interests, such as the insurance industry. Thus, a reform-oriented policy environment, featuring strong support for social liberal rather than neo-liberal policy responses, strongly mobilised community support groups, evidence-based policies with supporters and a political party with strong political will, prepared to take the role of opinion leader, were crucial elements of policy opportunities. The planets in the policy universe rarely line up so well.