10. A Glass Half Full…

Australian women’s health activists, in their long quest for the changes that will improve women’s health—and the health of the whole population—have reason to feel both gratification and disappointment. For although they can lay claim to remarkable achievements, some of the most important goals are yet to be achieved. Moreover, along the way, crucially important opportunities for structural health reform have been missed. In the early days, movement members identified a set of problems, many of them rarely discussed in public, and then worked persistently until community attitudes shifted, decision makers took notice and policy responses were made. As a result, new laws and new programs to advance women’s health were devised and funded across the country. The movement itself set up an infrastructure of community-based healthcare centres and services to support women in their daily lives and at times of distress and crisis. This infrastructure serves as an institutional base for the movement, supporting intelligence gathering, information sharing, policy development and advocacy work. Taking up the health reform ideas of the 1970s and applying a gender lens, the concept of a social health perspective was developed and disseminated. Arguably, wider understanding and acceptance of the social view of health is the movement’s most important accomplishment. Unfamiliar in the early 1970s when the comprehensiveness of hospital and medical services was rarely questioned, the social perspective now explicitly informs most Commonwealth, State and Territory health policy documents.

On the other side of the ledger, the women’s health sector has always been seriously under-funded, which has restricted its capacity to meet immediate needs and to develop innovative and collaborative health-promoting strategies. It also restricts its capacity to expand its constituency because, being thinly scattered, only a few women can have access to the services it provides. While the mainstream health system has responded to some aspects of the feminist critique, it remains heavily centred on the medical model, with its focus on treatment services. The best-practice models of preventive health care developed in the community sector have not yet had a system-wide impact, mostly because structural incentives steer provision in the direction of high-turnover treatment services. Health reform has been high on the national agenda since 2007, where policy documents recognise social determinants and talk about the importance of prevention. Yet proposals to strengthen primary health care—the locus of any significant preventative effort—have so far been restricted to supporting the services provided in general practitioners’ surgeries on a fee-for-service basis. The 1970s vision of a holistic, prevention-focused, primary healthcare system is still the stuff of dreams.
Nevertheless, innovative models of practice continue to be developed in the small community-based worlds of women’s health, Aboriginal health and community health. The States and Territories, within the limited finance available to them, are generating innovative approaches to primary health care through partnerships and collaborations with the community sector and others. And after a small injection of extra funding that came with the Emergency Response, policymakers in the Northern Territory’s Aboriginal medical services are leading the way in Australian health reform, as the Aboriginal health movement led the way in the 1970s.

This concluding chapter looks at the achievements of the women’s health movement and the goals that are still to be reached. It then examines the reasons that structural reform has been so hard to achieve, returning to the last question posed in the introduction: why, despite the wealth of evidence and the advocacy of women and other public health reformers, have the key structures of the health system remained virtually unchanged since the 1970s?

**Two Steps Forward**

At the local level, in female-run centres and services, women participate in health decision making, which is held to be the gold standard by health experts. The services provided are highly valued by those who use them, particularly by disadvantaged and marginalised women. Primary prevention undertakings, infrequently available in the hospital and medical systems, are tailored to meet local needs. Self-help is supported, health literacy is promoted and group programs are developed. Support and referral services and community-development projects are part of everyday practice, along with interaction and collaboration with local service providers.

Currently, 65 community-based, feminist women’s health centres are providing services nationally, along with almost 400 refuges, shelters, safe houses and information and referral services for women escaping violence. Sexual assault services have been established in all States and Territories. Some are still independent and community based, others are government run, sometimes informed by feminist principles, sometimes with community representatives on their boards. There are approximately 150 community-controlled Aboriginal health centres, in which women play important roles. In addition, there are specialist centres, such as Children by Choice in Queensland, the Multicultural Centre for Women’s Health in Victoria and Aboriginal women’s health centres. Informed by a social perspective of health and illness, these organisations provide an extensive range of medical and non-medical services, tailored to respond to the expressed needs of the communities in which they are located.
In women's health centres, participation in health decision making is a daily reality. Clients are familiar with the concept of participation and they feel a sense of involvement with the centres they attend and a capacity to influence what happens there. Community women are often involved in centre management, and participation in the many group programs on offer opens the way for health development, empowerment, companionship, and the giving and receiving of support (Broom 1996:24–5, 1997:278). This is all the more valuable because women's health centres serve a clientele that is markedly disadvantaged compared with the female population overall. Clients are significantly more likely to have been born overseas, to identify as being Aboriginal or Torres Strait Islander, to have lower education levels and below-average incomes, to have been unemployed in the past year, to be lone mothers and not to be buying their own homes (Broom 1997:277). These are the women who are least likely to participate in civil society and most likely to have poor health outcomes. Women's health centres also undertake outreach work enabling them to make contact with women who might otherwise be excluded and whose needs often go unrecognised. Workers in women's health centres are caring for women while at the same time assisting them to gain skills to care for themselves. And judging by the popularity of the centres, they are doing these jobs well.

The number of women's health advocacy groups continues to grow, supporting more women and drawing attention to an ever-broadening sweep of health issues. Professionals, including legal, law enforcement, allied health and medical professionals, have received training in feminist health perspectives and cultural competence. The latter now appears in the curriculums of some medical schools (Ambanpola 2005).

Influenced by other social changes as well, the way women experience encounters with medical and hospital systems has shifted in response to the feminist critique. Professional attitudes are less patronising and judgmental and women's health concerns are less likely to be trivialised. Finding a woman doctor, particularly a general practitioner, is likely to be easier, as women now enter medical training in much the same numbers as men. Raising public awareness of problems, such as the over-prescription of tranquillisers and the dangers of certain drugs, has resulted in increased health literacy and more careful practice. Following earlier overseas developments, moves are at last being initiated in Australia to ensure that appropriate numbers of women are included in research projects.

The hundreds of refuges scattered across the country provide essential services for women and children, where previously there were almost none. Since the early days, when volunteers responded as best they could to the needs of the women and children landing on their doorsteps, feminist refuges have undertaken political advocacy as well as providing support services and crisis
accommodation. As the expertise and professionalism of workers increased, the range of services was broadened and became increasingly sophisticated. Where budgets allow, refuges provide child care, children’s programs, child-protection services and programs to enhance parenting skills. They assist with legal and financial matters and with access to long-term housing. Counselling services are provided and families are assisted to deal with health issues. As well as advocacy and community education, refuges provide outreach and training. Staff regularly contribute to policy development and interact with a plethora of government and non-governmental agencies as part of efforts to coordinate complex sets of services (Gander and Champion 2009).

Peak bodies, at both the sub-national and the national levels, support the sectors and act as a conduit to government. WESNET, the national peak body representing almost 400 agencies, identifies areas of unmet need, draws attention to new and emerging issues and stimulates debate within the sector through its newsletter and through forums and conferences. It lobbies governments to improve policies and expand services and undertakes research, including research on needs in rural and remote communities. The links between homelessness and violence have been explored and publicised and model national domestic violence laws have been drawn up (WESNET web site). State and Territory peak bodies also play crucial roles. In New South Wales, for example, the Women’s Refuge Movement has operated for more than 30 years, advocating for the needs of the sector and the clients of the 57 refuges it represents.

Since the first faltering efforts of volunteers to respond appropriately to the often desperate women who contacted them, sexual assault centres have been slowly transformed into highly professional agencies in all jurisdictions, although there is considerable variation from place to place. Victoria, for example, has a statewide network of hybrid services that are government run but have community boards, while New South Wales has a mix of government and non-governmental agencies.

Significant attitudinal changes to violence and sexual violence against women and children have been realised, largely through the efforts of the movement and the policies formulated in response. A large national survey undertaken by VicHealth in 2009 found that 98 per cent of respondents recognised domestic violence as a crime—an increase of 5 per cent from a 1995 benchmark survey. People were also more likely to understand that domestic violence takes a variety of forms. As well as actual physical harm, it includes threats of harm and psychological, verbal and economic abuse. In 1995, one in seven respondents thought that women who are raped ‘ask for it’. By 2009, however, only one in 20 people took this view (VicHealth 2010:8, 37, 42). Thus, as Alexandra Neame argues: ‘Historical explanations of the causes, characteristics and prevalence of
sexual assault have changed dramatically over the past three decades, primarily in response to effective campaigning by feminists to challenge the many myths surrounding rape and other forms of sexual violence’ (Neame 2003:6).

The movement can count among its achievements Australia’s two national women’s health policies, the NWH Program, the National Plan to Reduce Violence against Women and their Children, the National Disability Strategy and the many crucial State and Territory policies and strategies. Since 2007, violence against women has been a priority item on the Commonwealth’s policy agenda. Of developments in this area, Leslie Laing wrote in 2000:

Within a quarter of a century, a subject once shrouded in secrecy has assumed a prominent place on the agenda of all State and Territory governments, and the Federal government. It is salutary to recall that, less than a century before the first feminist actions to place domestic violence on the political and social agenda, it was lawful for a man to beat his wife; women could not own property, nor could they have the custody of children. Clearly much has been achieved. (Laing 2000:5)

Since 2007, the profile of gender-based violence as a women’s health issue has been raised by the leadership of the Commonwealth Labor Government and the report of the National Council. A national plan is now in place that offers the possibility of sustained action across jurisdictions.

A social view of health, promoted consistently by the movement for 40 years, has now entered the health policy lexicon. For example, the National Health and Hospitals Reform Commission (NHHRC) report commends the work of WHO’s Commission on the Social Determinants of Health and supports its call for governments to take action in addressing those determinants. Some of the objectives identified by the NHHRC, such as strengthening consumer engagement and voice through increased health literacy, fostering community participation and empowering consumers, follow women’s health principles and are well established in practice in the women’s health and Aboriginal community-based sectors (Commonwealth of Australia 2009c: 7, 96).

The gains of the past 40 years are all the more impressive because pioneering women had so few resources, so little knowledge about the operation of government and policymaking and were novices when it came to submission writing and advocacy work. What has been said of the women’s health movement in the United States can equally be said of the Australian movement:

Few other recent social movements have addressed questions of health and medical care so directly, and few have contributed a practice so relevant to changing health beliefs, health practices and health care
institutions…the totality of the feminist contribution to public health practice is greater than the sum of its individual parts. (Freudenberg 1986:30)

Yet the precious opportunities to achieve population-health gain opened up by the movement and its allies have been largely wasted. Funding for the women’s health sector has always been niggardly, crushing its potential to make a greater contribution to population health. Most importantly, the structural reforms needed to redress the imbalance between medical and hospital services and community-based primary health care have been absent from the Commonwealth agenda for decades, except for a brief moment when it was raised by the Rudd Government only to fade into oblivion as vested interests in health took up their battle positions. Moreover, as well as failure to invest in primary health care (as opposed to primary medical care), successive Commonwealth governments have presided over glaring structural impediments to the accessibility of conventional hospital and medical services, undermining the universal access that Medicare is supposed to provide.

One Step Backwards: Under-funding

The women’s health sector has always been run on a shoestring. The needs of even the small number of women who have a service located nearby and want information, advice and care have never been adequately met, even under the Whitlam Government. Since then, no government has been prepared to provide funding at more than a minimal level. For clients, frustration, unnecessary suffering, traumatised children and avoidable ill health are some of the penalties being paid. For the Australian public purse, the costs are high. Medicare foots a large bill for avoidable illness and unnecessary hospitalisation. In the violence area alone, Access Economics calculated the cost at $8.1 billion per year in 2004 (Commonwealth of Australia 2004a:64–8).

Under-funding of the women’s health sector results in high levels of frustration among women working at the coalface because they cannot provide the services that are patently needed. Managing in straitened circumstances contributes to poor morale and cynicism. Professional development is thwarted and recruitment is always a problem because the pay on offer is unattractive. Forward planning is impossible without financial security and even simple matters, such as leasing premises, can become a major stumbling block. Policies, especially pilot programs, are often largely symbolic and leave a local vacuum when they terminate. In some jurisdictions, women (both inside and outside government) feel that the women’s health movement has been ‘used’ by political parties and bought off cheaply. At the sub-national level, political mileage has
been gained from the announcement of new but minimally funded services in marginal seats. At the national level after more than a decade of hostility, the movement has no choice but to settle for the 2010 NWHP, released in the dead of night, which does not acknowledge the contribution of the community-based sector, much less provide funds to sustain it.

The situation of the Hunter Women’s Centre in New South Wales illustrates the dilemmas that accompany financial parsimony. The centre has been unable to attract a doctor since 2003 and therefore cannot provide medical services, despite high demand. The absence of medical staff also means that the centre is unable to employ nurse practitioners, who are permitted to work only with the backup of a doctor. Moreover, because rates of pay are low, it cannot attract allied health professionals, such as dieticians. In 2008, the waiting list for counselling services was approximately six months. The centre was forced to reduce the length of appointments and refer women elsewhere. Another strategy is to try to promote more self-help skills. Only a partial response can be made to expressed need and only a minimal response to requests for outreach services in surrounding regional areas. The planning question is always which services can be cut, rather than how services can be organised to meet client needs.

A similar situation prevails at Leichhardt Women’s Community Health Centre and most other centres, including those that provide crisis services, such as family violence outreach. At Leichhardt, waiting lists are not kept because there are no resources to manage them. Appointments are given on a first-come, first-served basis. The centre would like to employ a domestic violence counsellor and a counsellor familiar with the needs of adult survivors of childhood sexual assault but has no money to do so. Salaries are based on the social and community services (SACS) award, which results in lower pay rates than in either the government or the private sectors, so it is difficult to attract skilled professionals. The centre survives because older, experienced staff members are strongly committed to its philosophy. Staff members report, however, that a partner earning a good income is an essential support mechanism.

Funding to support women and children who have experienced violence remains inadequate. If it was shocking that there were virtually no services for women escaping violence in the 1970s even when their children were being sexually assaulted, it is a national disgrace that almost 40 years later women and children are still turned away because services are not funded to cope with demand. In rural and remote areas, there are very few support services. Unable to access crisis accommodation, women and children often return to violent situations, with all the painful and wasteful health problems that follow. The best available data indicate that one in every two women escaping violence and looking for accommodation in domestic violence homelessness services is turned away (Gander and Champion 2009:25). Nor, amazingly, do refuges receive funding to
cover the cost of accompanying children, although governments acknowledge the value of investing in young people. Accommodation shortages result in many women and children being referred to motels and caravans, sleeping in cars, staying temporarily in overcrowded housing and/or returning home to perpetrators (Commonwealth of Australia 2009a:76).

Moreover, homelessness policies do not take sufficient account of violence against women. Crisis service providers still struggle to persuade governments at all levels that domestic violence is the major cause of homelessness in Australia (Gander and Champion 2009:25). There are very few crisis services for older women, so that older homeless, single women are in no better position in 2011 than they were in the 1970s (McFerran 2009:5–7). In addition, acute shortages of affordable housing nationwide mean that bottlenecks develop and extreme pressure is put on refuges with the result that client recovery is delayed. The National Council’s finding that refuges, shelters and outreach services are inadequately funded has not so far resulted in any significant increase in resources. Staff shortages are such that there is often only one domestic and family violence ‘safe at home’ worker to cover a whole rural region or only two workers for an entire metropolitan area.\(^1\) The connections between homelessness, domestic violence and sexual assault are not sufficiently recognised in policies. The incidence of sexual assault amongst homeless people is high, especially for women and young people, but there are no specialist services to meet their needs. Indeed, while policies generally note the position of groups that experience higher levels of violence, including women with disabilities, Aboriginal and Torres Strait Islander women, women in rural and remote areas and so on, the women’s services sector cannot respond appropriately to clients with complex needs.

Sexual assault services have developed priority criteria to help manage heavy demand with the result that women categorised as non-urgent might have to wait months for counselling. In some jurisdictions, rape crisis facilities have been asked to provide services for men without additional funding. Some services are forced to close on one or more days a week and many have difficulty offering adequate after-hours services, court support, legal advice, services for children, preventive resources, community-development initiatives and advocacy in relation to issues such as child protection. The capacity to collaborate effectively with other organisations is reduced, finding time to offer student placements is difficult and staff training is limited due to resource constraints. In some places, there are even long waiting lists for support group programs. In such circumstances, the capacity to undertake prevention work is limited. As Carmody (2009:16) argues, if primary prevention is to be taken seriously, ‘we need a skilled and adequately remunerated workforce that not

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\(^1\) These issues are discussed in Barrett Meyering (2009); Braaf (2008); Morrison (2009); Oberin (2009).
only understands the content of the programs they are delivering but have a clearly articulated theoretical stance to the work they do and understand why they do it’. The inability to obtain post-violence accommodation, counselling and support and the lack of well-funded prevention programs lead to high and avoidable ill health, which extends into old age. Community-sector workers continually operate at the limits of their capacity—a workplace situation that is not health enhancing.

There is strong agreement that services in the violence sector need to be coordinated and integrated. The National Council (Commonwealth of Australia 2009a:7,187) argues that integrated strategies and action plans need to be developed at both sub-national and local levels. Plans should reflect input from the police and justice systems, and from education, community, health and human services, it is argued, and should include performance indicators, targets and time lines. Currently, only Victoria, Tasmania and the Australian Capital Territory are attempting to coordinate their responses (Willcox 2008:5). The National Council’s recommendation that mechanisms be put in place to ensure that systems work effectively together has been omitted from the new National Plan to Reduce Violence against Women and their Children.

Inadequate funding limits the extent to which services can carry out prevention work. There is agreement that educational efforts need to include school students, university students, community leaders and service providers and they need to be expanded. The present Commonwealth Government recognises this problem and is currently supporting ‘Respectful Relationships’ programs. As with so many past efforts, however, the present projects are pilots—they might not continue and are unevenly spread across the country. Only $9.1 million over four years has been allocated to cover projects in various settings (Plibersek 2009). The new national plan envisages that prevention programs will be continued but no announcement has been made about funding allocations at the time of writing.

In terms of appropriate training, a 2009 consultation in New South Wales found that the police and general practitioners still lacked important knowledge about domestic violence, healthy relationships and women’s rights (Peters 2009:3). Existing services are not adequately funded to do the training, protocol development and integration work that is required to ensure that the mainstream and community agencies respond appropriately to violence against women and children. Experts argue that training for judges, magistrates, registrars, court volunteers and the like must be made compulsory (Oberin 2009:6).

Another problem is that research has been so under-funded that information about violence against women and the services they seek is limited. We are not even sure whether levels are lower, stable or increasing (Commonwealth of
Oberin (2009:4) argues that intimate partner homicide might be increasing. Information is not collected consistently across the country and the data that exist have serious limitations. National data are currently too poor to be used to measure and evaluate the effectiveness of interventions.

At a time when violence against women occupies an important place on policy agendas, women’s services workers report feeling sidelined and undervalued (Gander and Champion 2009:26). Refuge workers are experts in the complex needs of women and children who have experienced violence and in the strengths and weaknesses of service systems. They have a long history of contribution to policy, legislation and research. But this expertise is not utilised: leading advocates argue that there is still a lack of systematic and meaningful consultation. They point out that neither WESNET nor Homelessness Australia is represented on the Prime Minister’s Council on Homelessness (Oberin 2009:10). As Gander and Champion conclude: ‘It appears that the breadth and depth of our interventions, and the multilayered nature of our work, is not worth mentioning, building upon, or even maintaining with adequate funding’ (2009:26).

This argument is underscored by the lack of reference to the work of the women’s health sector in the 2010 NWHP. Given that dozens of submissions from the sector were received, the oversight cannot be unintentional.

Because primary prevention efforts in the violence sector have been weak and sporadic, it is not surprising that many old myths and beliefs remain strong, despite positive attitudinal change. Moreover, some attitudes are shifting in directions that are not supported by evidence. Almost half (49 per cent) of Australians in the VicHealth survey cited above still believe that women could leave violent relationships if they really wanted to and 80 per cent said they found it difficult to understand why women would remain. Twenty per cent of men and 17 per cent of women believe that domestic violence is excusable when perpetrators get so angry they temporarily lose control and 27 per cent of men and 18 per cent of women would excuse domestic violence where perpetrators are genuinely sorry afterwards. Thirteen per cent of people still agree that women ‘often say no when they mean yes’ and more than one-third of Australians believe that rape results from men being unable to control their sexual urges! Further, the belief that women lie about violence is still strong: 49 per cent agreed that women make false statements in order to improve their chances in custody cases. Only 61 per cent of respondents agreed that women rarely make false claims about rape, with men and boys more likely to support or excuse violence than women and girls (VicHealth 2009:7–9).

In relation to attitudes that persist despite significant social changes, it appears that many doctors still approach women in a disrespectful manner. The major
finding of a 2011 health survey undertaken by Equality Rights Alliance is that women, especially young women, experience the services they receive as poor in terms of the negative way they are treated by medical professionals. Open, non-judgemental communication, respect and willingness to listen were identified as positive elements of medical encounters that were often missing. 55.3 per cent of the women surveyed would not recommend their general practitioners to other people! Women were also concerned about financial, geographical and physical barriers that reduced access to services.2

Sexual assault remains one of the most under-reported crimes in Australia, with an estimated reporting rate of less than one in five (Commonwealth of Australia 2009a:19). Social stigma, which flows from longstanding myths and the perception that legal processes are overly concerned with the rights of the accused, operate to deter reporting. Other problems include non-supportive environments for complainants, lack of expertise amongst relevant professionals and the unpredictability of judicial discretion. Women whose first language is other than English, Aboriginal women and women with disabilities experience even greater barriers (Neame 2003).

In summary, then, the National Council (Commonwealth of Australia 2009a; 2009b) confirmed what the women’s services sector has been saying for many years: serious problems arise from under-resourcing, including difficulties accessing crisis and emergency services. There are long waiting lists for all kinds of services and support, including housing, and difficulties accessing legal advice and timely forensic examinations. Moreover, resource constraints prevent women’s health workers from developing innovative responses to the needs that women living in their areas express. All of which is very bad not only for women’s health but also for everyone’s health. As a recent WHO report on women’s health argues, ‘improving women’s health matters to women, their families, communities and societies at large. Improve women’s health—improve the world’ (WHO 2009:6).

Explaining the Half-Full Glass: Constraints on policy advancement

How do we explain the less than full support of successive Australian governments, national and sub-national, for the women’s health enterprise? How do we explain the lack of progress towards the structural changes necessary to create a more comprehensive health system when the evidence so clearly

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supports such a direction? In answering the first question, it is hard to escape the conclusion that women's health is still not seen as fully legitimate. Indeed, at times, suggestions are made that separate women's health services are no longer needed. Having usefully blazed a trail in the early years, the argument goes, these relics of a bygone era should be incorporated into the wider health system. If the mainstream health system had embedded ‘prevention and early intervention into every aspect’ of the system, as suggested by the NHHRC (Commonwealth of Australia 2009c:95), the argument might have some validity. The community-based sector and the hospital and medical sectors, however, still provide very different sets of services, as we have seen. And even where secondary and tertiary prevention are practised, there is enormous variation across the country. For example, a few divisions of general practice have been innovative, improving the comprehensiveness of their services, as have a few group practices. For the most part, however, the mainstream operates firmly within a medical, individual treatment model.

Second, the under-funding of the sector means that it has been unable to expand its support base, which, in turn, limits its political relevance. While extremely popular with clients, the spread of services is too small to reach more than a tiny proportion of Australian women, so limiting the number of women supporters. Moreover, because many clients are disadvantaged, they are less able than advantaged women to exercise their political voice. The women’s health sector therefore is a political lightweight, dependent on government largesse and struggling to lobby effectively for its own expansion.

Third, while some sub-national jurisdictions have shown considerable support for women’s health, the financial centralisation of the Australian federation renders them unlikely to be generous funders, even under buoyant conditions. Moreover, the Commonwealth can, and does, manipulate the federal financial balance at will: the Howard Government, for example, reduced the national share of hospital funding from 44.3 per cent in 1998–99 to 38.6 per cent in 2006–07 (AIHW 2010c:iix), leaving the States and Territories seriously short of discretionary spending capacity. Fiscal centralisation, then, is a large part of the reason that the States and Territories have kept a tight rein on women’s health funding.

In summary, less than complete legitimacy, low political resources and the Australian federal financial imbalance combine to undermine opportunities for policy expansion. The advance of neo-liberal ideas and the relatively new phenomenon where both major political parties seem able to ignore voters’ preferences for well-funded public health and education systems have resulted in to a poorly funded sector that struggles to meet even urgent needs. Turning to probe the second question concerning the slow progress towards a more comprehensive health system, we find a somewhat different set of forces at work.
Structural Barriers to Improved Population Health

As well as political barriers to greater government investment in primary health care, there are also entrenched structural barriers that impede full access to treatment in the hospital and medical systems. While treatment systems are only part of what it takes to improve population health, they are nevertheless a key element of any health system. Structural barriers include (but are not limited to) the fee-for-service system of doctor remuneration, the Australian preference for small medical practices, increasing user charges and imbalance in the geographical spread of services. Financial barriers also inhibit access to allied health services, including dentistry, physiotherapy, dietary advice and the like. Further, there is still excessive emphasis on a medical model of care in medical and nursing education with insufficient emphasis on training to increase awareness of cultural, sexuality and gender differences. Culturally inappropriate services are a barrier to access.

Barriers to Accessing Medical Services

The fee-for-service method of payment works as an economic incentive for doctors to see as many patients as possible, as quickly as possible, producing high turnover, curative medicine. It discourages the longer appointments necessary for thorough check-ups, for the management of complex and chronic conditions and to engage in primary prevention work. Internationally, fee-for-service remuneration has come under heavy criticism. One OECD assessment argues that it gives physicians ‘full discretion’ over the level and mix of services and creates incentives ‘to expand the volume and price of the services they provide’ (OECD 2003). Policy in a number of European countries is moving away from fee-for-service towards other forms of payment and it has been replaced completely with contract and salaried payment in New Zealand. Recent research shows that the percentage of New Zealanders who go without care because of cost has fallen since 2004 when this change came into operation (Schoen et al. 2010:2327).

Although Medicare is a type of national health insurance, it provides only partial coverage against the cost of medical services outside hospitals. Australian user charges—that part of the cost of a service paid for by the user—have been allowed to increase steadily and are now among the highest in the world (Schoen et al. 2010:2327). There is a large international literature showing that user charges constitute a serious financial barrier to access, especially for low-income people (reviewed in Gray 2004:65–77). In 2009, 22 per cent of Australians went
without care because of cost, 21 per cent paid user charges of $1000 or more and 8 per cent reported being unable to pay medical bills or having serious problems paying (The Commonwealth Fund 2010). Moreover, the cost of accessing the services of allied health professionals, including dieticians, physiotherapists, psychologists, counsellors, podiatrists, dentists, midwives and alternative therapists, is beyond the financial capacity of a great many Australians and is especially difficult for low-income women. These structural impediments mean that those lower down on the social gradient are often missed by conventional medical systems, bringing to mind ‘the inverse care law’ coined by Welsh doctor Julian Tudor Hart some 40 years ago. ‘The availability of good medical care’, Hart argued, ‘tends to vary inversely with the need of the population served’ in systems where market forces are allowed to operate (Hart 1971:405).

Some people are deterred from accessing services because health professionals are not trained in cultural or gender competence or trained to understand the health problems faced by those with non-heterosexual orientations. Aboriginal people report experiencing racism when using mainstream services, while people from backgrounds other than Anglo-Australian often find that the circumstances of their lives are misunderstood. For similar reasons, GLBTIQ people identify appropriate health services as a priority.

The inverse-care law operates strongly in relation to residents of rural and remote areas. There, services of all types are in short supply, despite evidence that rural people suffer poorer health than people living in metropolitan areas.\(^3\) If we were to take population health seriously, reforms would need to be implemented to modify and, in an ideal world, eventually eliminate, all of these structural barriers. Australian health policy has failed to deal with the overt barriers that impact adversely on access to hospital and medical treatment, which does not augur well for the prospect of introducing the structural changes needed to strengthen the primary health care system.

**Structural Barriers to a Stronger Primary Health Care System**

The important barriers weighing against the development of a more comprehensive healthcare system include cultural factors, financial forces and the stake that powerful medical unions and other groups have in preserving the system as it stands. Ideas about what is appropriate and necessary in a health system take a long time to change. The century-old idea that a health system

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\(^3\) We do not have problems of such magnitude in education because educators do not operate as private business entrepreneurs.
provides hospital and medical services and not much else is taking a long time to fade. Because there are so few comprehensive primary healthcare centres in Australia, most people have no experience of the care on offer and are probably unfamiliar with what is done in the name of holistic primary health care. What we do know, however, is that when people have an opportunity to access such services, they are prepared to line up on the pavement outside to do so.

In the 1970s, government members and committed bureaucrats ‘talked up’ the value of primary health care, whereas in the twenty-first century most health debate centres on hospitals and their waiting lists—a situation that vested interests find easy to manipulate. Despite passing discussion of preventive health care, recently focusing narrowly on chronic disease and ‘lifestyle factors’, opinion leaders are not promoting the value of community health care. When it comes to taking concrete, funded action, most policymakers, it seems, still see health policy as predominantly about hospital and medical services. Cultural factors are important as well, especially in maternity care: Australian women have become accustomed to having their babies in hospitals since there are so few alternatives. Perhaps they are about to become accustomed to having their babies by caesarean section. While RANZCOG defends Australian levels of caesarean section, these rates are high by international standards. Indeed all the English-speaking industrialised countries have high rates, except for New Zealand, which is now placed about the middle. The OECD country with by far the lowest caesarean section rate is the Netherlands, where medicalisation is less than anywhere else and where approximately one-third of babies are born at home (OECD 2011).

A preference for solo or small group practice, supported by the financing system, is another structural barrier to comprehensive, primary health care. Evidence shows that teams of health professionals are necessary to deliver an integrated range of preventive, educational, counselling, caring and social advocacy services, as well as conventional medical services, as the NHHRC recognised. Another problem with solo or small group practice is lack of accountability. Peer review of work is uncommon and the sharing of ideas and collegiality that comes with teamwork is not available. Health teams have been introduced in some European countries and in New Zealand and Canada.

Money is another factor militating against investment in primary health care. Even for the Commonwealth, the cost of hospital and medical services, which has increased faster than other prices for decades, is a large budget item. Containing hospital and medical costs is a major objective in all OECD countries and has not been fully achieved. Under these circumstances, it is difficult for governments to find new money to invest in community-based services. Delaying investment, however, ensures the continuation of a destructive spiral: low spending on primary health care results in avoidable illness and unnecessary hospitalisation,
which leads to unnecessarily high cost to the public purse and, in turn, results in low spending on primary health care. The NHHRC drew attention to this dilemma, commenting on the lack of any nationally coordinated mechanism to deliver preventive health care. In relation to chronic disease, it argued that Australia spends less than 2 per cent of the health budget on ‘a problem which consumes a major proportion of health expenditure’ (Commonwealth of Australia 2009c:51). The Commonwealth responded by setting up the National Preventive Health Agency in 2010 with the aim of driving the Australian prevention agenda. It is too early to see if it will have an impact.

Finally, powerful interests vehemently resist structural reform. Health is an area where there exist exceptionally powerful vested interests. Medical professionals are respected, influential and have abundant resources to devote to political campaigns. Doctors’ trade unions regularly and consistently attack governments that want to make changes that might undermine medical interests. In the Australian case, this is any policy that might threaten or even encroach upon private, fee-for-service medical practice. In addition, the private insurance industry, pharmaceutical companies and makers of high-tech medical equipment, like doctors, want to see continued high investment in curative medical care; investment in primary health care is not in their interests. At the Commonwealth level, what passes for health policy—and what is sometimes even called health reform—is mostly about the supply of hospital and medical services, about how they will be paid for (from the Treasury or from private pockets) and how much medical professionals will be paid for providing them.

Although the Commonwealth decides policy about hospital and medical services, the States and Territories do make health policy. All jurisdictions provide at least some community health services, including early childhood health centres, community nursing and the like. Some have a network of community health centres, preserved since the 1970s, as in Victoria. Constitutional power for community health primarily rests at the sub-national level, so, in theory at least, the States and Territories should be the innovators in primary health care. The fiscal imbalance in the Australian federal system is, however, a strong disincentive to infrastructure expansion.

4 They also run the hospitals, of course, but even though they pay for more than half of the costs of hospitals, it is the Commonwealth that sets the parameters of both the financing system and overall policy.
The Rudd/Gillard Governments and Health Reform

The election of the Rudd Commonwealth Government in 2007 on a platform of health reform held considerable promise. As well as a second national women’s health policy and a men’s health policy, the Government committed itself to ‘Closing the Gap’ between the health outcomes of Aboriginal and Torres Strait Islander people and other Australians. In an important respect, present-day Australian governments wishing to strengthen the primary healthcare system have an advantage over the pioneers of the 1970s because there are now many successful models in the community sector. In addition, epidemiological evidence is much more robust and we now know more than ever before about ‘the causes of the causes’ of poor health outcomes. Evidence supporting reform is available in abundance: the Australian Institute of Health and Welfare (AIHW 2010b), for example, argues that cardiovascular disease, which it calculates is suffered by two million Australian women, is highly preventable and treatable. The institute has also identified ‘potentially preventable hospitalisations’—hospitalisations that would probably have been unnecessary if timely and appropriate non-hospital care had been available. In 2008–09, there were approximately 690,000 potentially preventable hospitalisations, which represent 8.5 per cent of all admissions. Apart from pain, suffering and death, unnecessary hospitalisation is enormously expensive, given that in 2008–09, Australian spending on hospitalisation totalled $31.3 billion.

In pursuit of its health reform agenda, the Rudd Government established the National Health and Hospitals Reform Commission (NHHRC) in 2008, with terms of reference that included ‘a greater focus on prevention’. The commission’s final report, A healthier future for all Australians (Commonwealth of Australia 2009c), drew attention to growing inequalities in access to services, particularly for Aboriginal and Torres Strait Islander people, rural dwellers and those needing dental, mental health and aged-care services. It emphasised the need for wide-ranging reforms, including stronger preventive health care and the need to embed preventive health services in hospital and medical systems. It argues that we have a ‘health system skewed to managing sickness rather than encouraging wellness’ and that ‘when it comes to funding community-based activities, allied health care and preventive activities compared with funding pharmaceuticals… and medical services’, the playing field is not level. It recommends ‘significant investment in primary health care infrastructure’ through, among other things, the establishment of multidisciplinary, comprehensive primary healthcare centres and services (Commonwealth of Australia 2009c:51, 102–4).

5 Some 17.6 per cent of women suffered from cardiovascular disease compared with 15.3 per cent of men, both mostly in older age groups.
The National Primary Health Care Strategy and the National Preventive Health Taskforce were also established. The National Preventive Health Taskforce emphasises the importance of strengthening Australia’s primary healthcare system and expanding community-based preventive and outreach services, particularly in low socioeconomic communities. It argued that ‘action and leadership on preventive health is urgent and long overdue’ (Commonwealth of Australia 2009d:6). Stephanie Bell, Chair of the Aboriginal Medical Services Alliance, NT, remarked that the task force had drawn ‘strongly on 30 years of work by Aboriginal community-controlled health services’ (Bell 2010:4).

The recommendations of these reviews, at a time when the Commonwealth was committed to reform, created a favourable political opportunity structure for investment in health, as well as in hospital and medical services. Many of the initial proposals, however, including the key undertaking that the Commonwealth would assume responsibility for all primary health care, have been modified or abandoned in response to political manoeuvrings. The assumption of responsibility for primary health care by the Commonwealth had the potential to promote structural change since a single level of government would be steering policy. Moreover, the machinations of fiscal federalism would have been eliminated, although it would still be possible to shift costs, this time onto consumers, by increasing user charges or allowing them to creep upwards as the Commonwealth has done for many years.

Members of the health research community who are committed to structural reform have been highly critical of the Rudd/Gillard reform package. For example, Armstrong (2010) argues that

> [t]here has been an unnerving willingness to ignore the advice of countless experts regarding the need for substantial investment in primary health care and prevention and early intervention in mental health and dental health and to address underpinning issues, such as the social determinants of health to reduce demand for hospital care.

The major spending decisions announced in 2010 and 2011 support such an analysis, since most of them are directed towards strengthening hospital and medical services. There were no new allocations for community health or for the women’s health sector.

Two areas, in particular, of the reform proposals attracted vociferous criticism for their omission: mental health and Aboriginal health. Current research shows that only one of every three Australians with mental health problems receives treatment. Fifty-four per cent of people who have been homeless and 41 per cent of people who have been in prison have a mental health disorder. In Victoria, one-third of the people shot by police had been diagnosed previously
with mental illness. Estimates show that mental ill health costs the economy $20 billion per year. Australian of the Year in 2010, Patrick McGorry, a mental health expert, claimed the sector had been locked out of the health reform processes and the head of the National Advisory Council on Mental Health, John Mendoza, resigned in June 2010, arguing that Commonwealth parsimony was incomprehensible, given that 1200 people are turned away from public and private psychiatric units every day. Eventually, the Commonwealth responded positively to this blistering criticism: it allocated $1.5 billion over five years to mental health in the 2011 Budget—a modest enough sum considering the shortcomings that have been allowed to build up for more than half a century.

Commonwealth policy has been criticised on two main counts in relation to Aboriginal and Torres Strait Islander health. First, the continuation of the NT Emergency Response has been condemned by a range of bodies and individuals for its human rights violations and lack of effectiveness. Critics include Aboriginal leaders, the United Nations, Amnesty International, the Australian Indigenous Doctors’ Association and the AMA. Second, the funding commitments announced as part of ‘closing the gap’ have been deemed inadequate and misleading. And although almost half of Australia’s Aboriginal people live in cities and suffer avoidable health problems, no new spending has been allocated (Russell 2009).

The political exigencies of Labor’s health reform efforts since 2008 are too complex to relate here. In relation to primary care, the Commonwealth is establishing two new sets of institutions: GP Super Clinics and Medicare Locals. Both sound as though they might be authentic primary health care organisations. Theoretically, both entities have the potential to operate as such. Under the right sets of rules and with the right leadership, both might adopt a population-health focus and develop innovative, participatory, health-promoting programs for their local areas. Fee-for-service medical practitioners providing fee-for-service medical services have, however, been positioned at the centre of both organisations, which does not augur well for the adoption of a social health perspective unless we conceive of change in terms of geological time.

Significant structural changes are required if the Australian health system is to be made more effective and more equitable and if it is to devote more energy and resources to improving population health. Population-health strategies need to be planned over the long term, which is a requirement that is difficult to achieve if governments are listing from crisis to crisis in treatment services provision, real or perceived. As the WHO reminds us, health systems do not automatically ‘gravitate towards the goals of health for all through primary health care’. Rather, without planning, trends are towards a disproportionate focus on specialised curative care, fragmentation and commercialisation (WHO 2008b:xiii).
Meanwhile, in the Northern Territory, primary health care reform in the Aboriginal community-controlled health sector is proceeding apace on the basis of the additional $50 million per year allocated under the Emergency Response. While condemning the loss of identity and the disempowerment that flows from many aspects of the Response, especially from lack of community ownership, a group of doctors and administrators quickly saw a window of opportunity to strengthen primary healthcare services (Boffa et al. 2007). Because well-developed structures and relationships were already in place, the increased funding could be managed within the existing system. Under the scheme, the health workforce has been increased by 251 full-time equivalent positions. A 2011 evaluation found that despite ongoing challenges, the new initiatives are proving to be extremely successful (Commonwealth of Australia 2011a). Watch this space!

Conclusion

While experience shows that major health system change is difficult in Australia, as elsewhere, it also shows that it is not impossible: major structural changes were introduced in the 1970s and at several points since. The women’s health movement, the Aboriginal health movement, the community health movement and key policymakers recognised 40 years ago that treatment services are only a part of what a good health system should provide. Therefore, women’s health, community health and Aboriginal health infrastructure was established. The 1970s left a positive legacy for the Australian health system: the infrastructure might have been preserved and expanded incrementally without undue political fuss or financial cost. Having structures already in place is a major political advantage because the fiercest battles generally take place around new ventures.

It has been open to any Commonwealth government since the 1970s to make incremental investments in the community health sector, including the women’s health sector. Small but regular funding increases would have become substantial over time. Before it came to office, the Hawke Government made a commitment to restore the Community Health Program funding that the Fraser Government had withdrawn. In government, however, it restored funding only to 1975 levels, which meant a large shortfall since the interim period had been one of very high inflation. Moreover, no adjustment was made for population increases. Political exigencies did not pressure that government to go back on its commitment and it could have supported growth in the community-based sector without undue budgetary stress. Aboriginal community-based health services could have been expanded incrementally, as is happening in the Northern Territory at present. The women’s health sector need not be so short of money that it has to stretch to meet the most urgent needs of the women who
queue up outside. It may be a long-term process to change community attitudes and to realise the benefits of violence-prevention programs but refuges should not be forced to turn away women and children who need shelter and support. This only adds to the burden of ill health, with all the unnecessary pain and expense that that involves. In the scheme of total health expenditure, spending on community health is tiny. Even small funding increases over the years would have made a significant difference and would almost certainly have reduced overall health expenditure by preventing unnecessary illness. The pity is that leadership, commitment and political will have been wanting.

So while the Australian women’s health movement has some remarkable achievements of which it can be justly proud, opportunities have been created to achieve a great deal more. The movement remains strongly committed to a social view of health and will continue to insist that the 1970s vision of a health system providing comprehensive, community-based primary health care as well as hospital and medical services is not beyond the capacity of Australian governments. The survival of a strong, activist women’s health movement in a ‘post-feminist’ era demonstrates the priority that Australian women place on health. It also demonstrates the inability of hospital-based systems to respond appropriately to the need for strong primary health care. The women’s health movement, along with like-minded activists in Aboriginal health and public health, is carrying forward the struggle to have a social determinants perspective take its place beside a biomedical perspective in mainstream health policy. The health of all Australians stands to gain.