Introduction

Once upon a time, before the feminists carried their banners emblazoned with the women’s sign and the inscription ‘Women’s Liberation’, there was a luxury tax on the contraceptive pill. (Stevens 1995:13)

When the women’s health movement burst onto the Australian political scene as part of the resurgent women’s movement, resentment about social arrangements was intense. Women knew how it felt to be trivialised, disbelieved and dismissed. They had experienced frustration, indignity and stigmatisation in their daily lives. For many, encounters with the health system were unsatisfactory and often humiliating and traumatising. In the early 1970s, the gatherings organised by mobilising feminists provided an opportunity for women to ventilate their concerns, often for the first time. The gender order would never be quite the same again.

At a packed public ‘speak-out’ organised by Melbourne feminists in early 1973, poor health care and lack of relevant information emerged as the dominant concerns. Women told stories that shocked those listening, stories that were confirmed by the doctors, nurses and healthcare workers who were present. Women’s health care was condemned as too often ‘demeaning, discriminatory, judgemental and of poor quality’ (Hull 1986:14). Sydney women reached a similar verdict at another gathering a few weeks later. Unmarried women told of lectures that implied immorality and promiscuity when they requested contraceptives, which were often denied them, and married women talked about the difficulties and the humiliation of requesting an abortion. Older women reported being unable to get information about menopause and of being summarily dismissed or referred to a psychiatrist. All women shared the distress they felt at being made to feel ‘dirty, shameful, unbalanced, neurotic, stupid and guilty’. Out of these meetings, the first dedicated women’s health groups were formed. The intention was to set up centres where skilled medical care would be available, where women could speak openly about their lives and share their experiences ‘in an atmosphere of warmth, acceptance and understanding’ (Cooper and Spencer 1978:149).

Feminists, as well as feeling anger about their encounters with the health system, objected strongly to the entrenched gender order. From the ‘best’ clubs to local pubs, women were frequently excluded from sporting and social venues. The bar obliging married women to resign from permanent jobs in the Public Service had been lifted in 1966 but women were still largely absent from public-sector life. Domestic violence, rape and child sexual abuse were not discussed openly. A feminist-produced sex education pamphlet for young women was branded ‘obscene’ by major newspapers in 1971 and abortion-squad detectives
carried out investigations at Sydney girls’ schools, even though the brochure had been approved by parents’ and citizens’ associations (Stevens 1995:14–15). Sanitary pads were wrapped in brown paper and hidden under pharmacy counters and women’s sexuality was still depicted in Australian obstetrical and gynaecological textbooks from a heterosexual perspective with women’s natural aspirations portrayed as marriage and mothering (Koutroulis 1990).

There were few publicly funded support services for women or anyone else who needed them. After more than 20 years of conservative national government, the Australian welfare system was in a primordial state, having missed out on most of the expansion that had taken place in comparable countries after World War II (Gray 2003; Jones 1990:29–48). The hospital and medical system was sorely in need of reform; financial barriers to access were high and the range of services was narrow (Gray 1984, 1991; Sax 1984). Aboriginal communities and Aboriginal health were ravaged by the combined impacts of colonisation, racism and government policies. Despite high immigration rates in the 1950s and 1960s, services for newly arrived people were scarce. It was extremely difficult to find an interpreter, for example, even in the largest hospitals in the country. There was no public income support for single parents, and about 80 per cent of court orders for family maintenance were never honoured. Only the wealthy could afford child care. Some lone mothers, who needed paid work to survive, took small children with them to early morning cleaning jobs. Others left them at home to take themselves to school, sometimes hours before the starting bell.

It was in this context that the embryonic women’s health movement made its first faltering efforts to respond to the calls for help that were being made. As one participant remembers the early situation: ‘the phone calls and letters were coming in from women everywhere…They desperately needed information on abortion, contraception, and many other things that were affecting their health so badly. And we didn’t know the answers!’ (Zelda D’Aprano, quoted in Robertson n.d.:Ch. 16).

With few resources and, in many cases, very little knowledge about politics or medical care, small groups of women set out not only to provide health services but also to achieve fundamental social change and public policy transformation. From the beginning, they knew that many of the circumstances of women’s lives, not least their second-class status, had a detrimental impact on their health and needed to be changed. They articulated the problems arising from gender roles, identified domestic violence as a serious women’s health issue and broke the silence surrounding sexual assault. Where they found glaring gaps in the services available they tried to fill them by establishing services themselves: health centres, sexual assault services and refuges for women and children who had nowhere to go were set up on precarious foundations. They set up telephone help lines to provide information and support. They took to the streets to fight
for a woman’s right to choose a safe abortion and they campaigned on factory floors and within the union movement to modernise occupational health and safety regimes. Mothers’ groups agitated for women’s control of childbirth and to achieve maternity-care reform. Feminist-inspired training modules for the police, the judiciary and other relevant professions were developed, so that sexual assault and violence services might be delivered more appropriately. Healthcare providers were trained and educated about feminist health perspectives. The underlying philosophy was to provide services and support ‘by women, for women’. Critiques of the social, political and economic organisation of society were developed, along with strategies for how to promote change. In carrying out this work, women faced huge obstacles, particularly a shortage of resources of all kinds.

As time went on, it became increasingly clear that the structural forces supporting the existing system were not going to be dislodged easily. In health, the power of organised medicine was brought to bear against every reform proposal, while pharmaceutical giants continued to peddle their wares. Bureaucracies—not accustomed to being challenged and comfortable with longstanding structures and practices—resisted new ideas, especially the notion that there should be separate women’s services. In the cultural sphere, ideas proved to be durable, especially discourses around domestic violence and rape. And when women suggested changes that would improve their economic position, the power of business and its acolytes mobilised against them. Whether it was community-based child care, national superannuation or paid maternity leave, the arguments against were that markets do a better job and are cheaper for the public purse. The political environment of the very early years was, however, a rare moment—one that was unusually favourable for the articulation of radical change proposals.

**Radical Reform on the Radar: The context of the early women’s health movement**

In public policy terms, the context in which proposals are developed has a strong impact on outcomes. Some political contexts facilitate change while others retard it. The environment in which the Australian women’s health movement emerged presented perhaps a ‘once in a lifetime’ policy opportunity. Internationally, change was in the air as radical challenges to the status quo were mounted in all Organisation for Economic Cooperation and Development (OECD) countries. Equality-seeking social movements—interested in such issues as civil rights,
peace, sexuality, the environment, self-help, and consumer, student, worker and women’s issues—were generating proposals for root-and-branch reform of existing power relations.

In Australia, the health system was highly controversial. The publicly subsidised private health insurance system was inequitable, unpopular, complicated and expensive. Approximately 20 per cent of Australians had no health insurance coverage and hundreds of thousands had inadequate coverage. Frustration was widespread because the Liberal Coalition Government\(^1\)—in power for more than 20 years—had failed to countenance reform except within the parameters of a private insurance regime. Competition between the major parties was intense as the Australian Labor Party (ALP), in opposition, developed a series of reform proposals that generated fierce public debates. Inside the ALP, opinions were divided between those who supported traditional Labor approaches to health, including a national, community-based medical service, staffed by salaried doctors, and those who supported the newer idea of universal health insurance. The former group opposed the entrenchment of the private fee-for-service medical practice that would come with national insurance because they thought it inimical to good health care. Many within the party, therefore, viewed health insurance as a transitional measure, a step along the way to a comprehensive public health service, which would have strong primary health care as its foundation (Gray 2003:274–5). Meanwhile, as well as women and other low-income groups, Aboriginal people found that the existing system failed to meet their needs for many reasons, not least of which was widely experienced racism. An Aboriginal health movement developed that led the way in establishing community-controlled primary healthcare centres, based on a social view of health. A social health perspective recognises the impact of political, social, economic, environmental and cultural factors on health outcomes. It points out that the full circumstances of people’s lives need to be taken into account when considering healthcare options. Because life circumstances can be altered, strategies to achieve that change need to be developed. Income security, housing security, physical security and the like are essential components of improved population health. Moreover, disease-prevention strategies are fundamental elements of a health system, alongside treatment services. A social view of health is part of the cultural heritage of Aboriginal people. The women’s health movement and the ‘new’ public health movement had to develop and articulate this perspective for themselves in the 1960s and 1970s.

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1 While several parties are usually represented in the national Parliament, in practice, Australia has a two-party system. The Liberal Party of Australia (LPA) is the major party of the ‘right’ and, when in office nationally, it forms a coalition with the small, rural-based party, The Nationals. The ALP is the major party on the ‘left’. The historical distance between the two parties on health and social policy has, however, gradually narrowed. Indeed, in 2011, analysts point to the centrism of both. There are two significant minor parties: the Australian Democrats (AD) and the Australian Greens. After 30 years of success, however, the electoral fortunes of the AD are presently in decline.
The Limits to Medicine

Internationally, health reform and healthy public policy movements were developing. Analyses of the limitations of modern, scientific medicine had been developing since the 1950s and provided a theoretical underpinning for structural change proposals. Twentieth-century advances in medical science, such as improvements in anaesthetics and blood transfusion, had helped to legitimise a focus on scientific medicine; however, epidemiological research suggested the need for a broader approach. Health experts began to argue that hospital and medical systems placed too much emphasis on treatment and high-tech cures and too little emphasis on prevention and support services. An individual explanation of the causes of health and illness was challenged by a social determinants approach, grounded in social, economic and political structures.

On the basis of work done in the United States, René Dubos drew early attention to the now well-known idea that medical science was not responsible for the nineteenth-century decline in mortality from infectious diseases. Rather, improvements came about as a result of public health measures, including improvements in water, air and sewage disposal (cited in Conrad 2004:6). This work was followed by that of McKeown and colleagues, who, in the 1950s, 1960s and 1970s, showed that declines in mortality in England and Wales in the nineteenth century were the result of social determinants: rising standards of living, including a healthier diet, improvements in housing and water quality and better sewerage and waste-disposal systems, accompanied by favourable trends in the relationship between some micro-organisms and human beings. Biomedical interventions had made little contribution (McKeown et al. 1975:391). Other work produced similar findings for Sweden, France, Ireland, Hungary and the United States (McKinlay and McKinlay 2004:8). Victor Fuchs’ (1974) well-known work in the United States found that the very different health outcomes in the neighbouring States of Nevada and Utah were attributable to social determinants and lifestyle factors, rather than biomedical causes or health system differences. The twentieth century probably presents a more mixed picture in that lifestyle factors, such as smoking cessation, and medical interventions have helped to improve population health.

The body of evidence about the importance of the social determinants has not been well accepted in scientific medical circles. As McKinlay and McKinlay (2004) report, the notion that modern medical care is not responsible for improvements in population health (as distinct from improving the outcomes

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2 Thirty years later, major differences remain between health outcomes in the two States (Rodwin and Croce-Galis 2004).
of individual episodes of disease), is seen as ‘heresy’. Lack of acceptance by the most powerful political group in the health landscape is the main reason that public investment in health services—beyond those produced in hospitals and doctors’ offices—is low.

Community Health Movements and the ‘New’ Public Health

On the basis of emerging evidence, proposals to change health system structures were gradually developed. It is often argued that the internationally influential Lalonde Report, released in Canada in 1974, marks the birth of what is loosely called the ‘new’ public health. As in public policy generally, however, radical proposals are invariably built upon previous experience and action. From the early 1960s onwards, Canadian health experts developed a critique that was sceptical of excessive reliance on hospital and medical services. They argued for the establishment of community-based, community-controlled health centres where care would be provided by teams of health professionals, including allied health professionals. A full range of preventive and support programs would be delivered alongside treatment services.

The community-health movement in western Canada has its foundation in the strong cooperative movement that emerged in the Prairie Provinces about the beginning of the twentieth century. A municipal doctor scheme was instituted in the town of Sarnia, Saskatchewan, in 1914. The scheme expanded steadily, operating in hundreds of towns and villages by 1948 with some services established in neighbouring Provinces. A network of between 30 and 40 community health centres was set up in Saskatchewan by the early 1960s, where doctors who wished to accept a salary could practice (Taylor 1979:319). In terms of the ideas of the day, Canadian health system thinking was radical. The benefits of community participation in health decision making were endorsed by the Minister for National Health and Welfare, the Honourable John Monro, in 1969. In a statement that the Australian women’s health movement would endorse, Munro argued that ‘the key is contact, the place is the community, the concept is preventative…group practice, community health centres, mobile outpatient clinics, increased case findings through home visitation, greater availability of local alternative institutions, better home care, increased teamwork with community social agencies’ (Munro 1969, quoted in Donner and Pederson 2004:5).

The Province of Quebec put many of these ideas into action. On the basis of recommendations in the Castonguay Report, released in 1967, a Province-wide network of community-controlled health centres was established from
1971 onwards (Government of Quebec 1970). The best centres provided comprehensive, holistic care and worked on an outreach model, making contact with the individuals for whom they were responsible in their catchment areas. In the same year, the health ministers of Canada set up an inquiry into community health centres, which reported in 1972 and recommended adoption by provincial governments (Health and Welfare Canada 1972). Community participation was stressed in the Manitoba Government’s White Paper on Health Policy, released in 1972. The Foulkes Report (1973) in British Columbia recommended that health and social services be integrated, that investment be made in preventive services and that care be coordinated, with patients assisted to traverse their way through the system. The Ontario Health Planning Task Force in its 1974 report argued that primary health care should be the centre of the health system and that services should be comprehensive, continuous and delivered by teams of health professionals.

Thus, when the Lalonde Report, A New Perspective on the Health of Canadians, was published, it built upon Saskatchewan tradition, Quebec innovations and a decade and a half of discussion about how to achieve a more comprehensive health system. It argued for broad reforms, including the establishment of networks of community health centres.

By the late 1960s, community health and new public health movements began to appear outside Canada. A resurgent community health centre movement emerged in the United States as the healthcare arm of the civil rights movement. An Aboriginal health movement and a community health movement developed alongside the women’s health movement in Australia. In turn, by the time the World Health Organisation (WHO) produced the Alma Ata declaration in 1978, there was Canadian and Australian experience on which to draw. A social view of health, preventive primary health care, and improved environments for health, community participation and inter-sectoral action were all central to the WHO strategy of ‘Health for All’ by the year 2000.

The Aboriginal Health Movement

The Australian Aboriginal health movement arose in part from intense dissatisfaction with mainstream hospital and medical care, where a ‘cultural chasm’ separated Aboriginal people and mainstream service providers (Palmer and Short 1989:235; Sagger and Gray 1991:144, 147). In addition to discrimination and racism, user charges prevented low-income earners from accessing services. Recent research shows that health spaces need to be

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3 There was a previous mobilisation in the 1920s.
'Aboriginal friendly', especially Aboriginal-women friendly, to allow people to feel welcome and comfortable. Where everything in the space pertains to the dominant culture, colonial stereotypes are ‘reinscribed’ (Fredericks 2009:41). In order to provide culturally appropriate and accessible services, the Aboriginal Medical Service (AMS) was set up in 1971 at Redfern, Sydney, by a community group that included Shirley Smith and Gordon Briscoe. Within a year, the Aboriginal population of Sydney had increased from a couple of thousand to 32,000 people as a result of freedom from confinement on reserves and subsequent congregation in cities in search of a means of survival (Foley 1984:112). Like early women’s health centres, Redfern AMS opened in extremely humble premises and relied on donations and volunteer staff. Also as in women’s health, it gradually secured precarious funding after extensive lobbying and submissions and, over the years, was able to expand. By 1974, Redfern was ‘a free first-class medical service, created by Aborigines for Aborigines in the Redfern area, with similar facilities at the La Perouse settlement and with medical teams, headed by Aborigines, visiting country settlements’ (Briscoe 1974:169).

Redfern AMS, the first community-controlled health service in Australia, was ahead of its time (Palmer and Short 1989:235) and it inspired Aboriginal communities across the country to set up their own health services. The Central Australian Aboriginal Congress Health Centre in Alice Springs, the Fitzroy Aboriginal Health Service in Melbourne and Derbarl Yerrigan Health Service in Perth were all established in 1973. In 1974, at a national AMS meeting in Albury, New South Wales, it was proposed that a national health organisation be established. The National Aboriginal and Islander Health Organisation (NAIHO) came into being in 1976—its first meeting funded by Redfern AMS. An office was established in Melbourne and the organisation survived on donations for nine years until it received its first government funds in 1985. In 1992, its name was changed to the National Aboriginal Community Controlled Health Organisation (NACCHO), and in 1997 it was funded to establish a secretariat in Canberra—a location that facilitates access to policymakers. Similar peak organisations have been established at the State and Territory levels (NACCHO web site).

The Aboriginal health movement takes a social health perspective, focusing on support, empowerment and community control through elected boards of management, local participation, disease prevention and provision of care by multidisciplinary teams. Aboriginal health is defined by NACCHO as

not just the physical wellbeing of an individual but the social, emotional and cultural wellbeing of the whole community in which each individual is able to achieve their full potential, thereby bringing about the total wellbeing of their community. It is a whole-of-life view and includes the cyclical concept of life-death-life. (NACCHO web site)
From the beginning, Aboriginal Community Controlled Health Services (ACCHSs) aimed to deliver holistic, comprehensive and culturally appropriate care, with a preventive and health education focus. The Central Australian Aboriginal Congress (CAAC), in a submission applying for Commonwealth funding in 1974, argued that the new centre being proposed should have ‘both a preventive and [a] curative approach’, should be oriented towards the community and should provide appropriate training for Aboriginal health workers (Perkins 1975:32). The emphasis on community participation and community control was partly based on awareness that such structures can readily respond to changing needs—a bottom-up rather than a top-down approach (Bartlett and Boffa 2001). In the view of the congress, health cannot be considered separately from people’s access to other resources, such as housing, education, employment, land rights, food, recreation facilities and community development (Rosewarne et al. 2007:10). The new centre was to have a good relationship with secondary and tertiary services to provide what, in present-day language, is called ‘continuity of care’.

The origins of a holistic health perspective among Aboriginal people appear to be embedded in the importance placed on each member of the community. When Grace Kong, an Aboriginal women’s health nurse practitioner in New South Wales, was asked whether her family was proud of her achievements, she replied: ‘I think that with Koories our outlook on life is very different from yours. Every single person that belongs to a Koori community is important, regardless of what their role is, so that the fact of what I have achieved is nice but so what?’ (Kong quoted in Smith 1992:27).

Moreover, it appears that there is no word meaning ‘health’ in Aboriginal languages. Words that might mean something like the English word suggest an approach to wellbeing that encompasses all aspects of life, including food, housing and family—a truly social perspective. The Redfern AMS founders thought that a health service should be able to meet the day-to-day needs of consumers (Briscoe 1974:170). A CAAC submission in 1974 recognised that the curative services provided by European medical systems ‘did not and could not’ meet Aboriginal needs. By 1976, it was being argued that ‘healthy living cannot be developed without total community development under total community control’ (Rosewarne et al. 2007:10).

The Aboriginal concept of community health is exemplified in the rationale for women’s stress-free days organised by Aboriginal health workers in La Perouse, New South Wales, in 2001. The primary concern in this case was not for women

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4 This conclusion was reached by Aboriginal people in Australia prior to and independently of the WHO’s adoption of a social view of health at the end of the 1970s. The WHO’s own revision of thinking was strongly influenced by the failure to improve population health in developing countries through the provision of conventional medical services (Cueto 2004).
but for local youth. The reasoning is that the best way to empower young people is to empower their mothers, who benefit from the support networks formed as they come together (Aboriginal and Islander Health Worker Journal 2001a:14).

About the same time that Aboriginal people were setting up their first community-controlled health services, health system restructuring plans were being developed in the States, particularly in New South Wales. Community-based services were being proposed, including aged care and mental health services. A few limited-scale community health centres were set up in New South Wales, providing child health services, dental and mental health care and rehabilitation, domiciliary nursing and home-care services. Health education outreach teams worked from some centres. In 1972, the Health Commission Act was passed, which was informed by social health principles and provided for the representation of consumer interests. Ideas from New South Wales spread to other States through a body of Commonwealth and State officials known as the Hospitals and Allied Services Advisory Council, set up to advise Australian health ministers (Sax 1980; Shea 1970). Other States gradually enacted similar legislation but the capacity of Australia’s sub-national jurisdictions to advance policy reform was severely constrained by the financial centralisation of the Australian federation. In other words, spare cash was, and still is, in short supply in State and Territory coffers.

The reforms being developed in the Australian States were in line with historical ALP support for locally based medical services. The new ideas found their way into ALP policy partly through the office of the leader, Gough Whitlam, who was keenly interested in the problems of the rapidly expanding, under-serviced, outer-metropolitan areas of Sydney and Melbourne. Members of Whitlam’s electoral office were in regular contact with officials in the Health Department of New South Wales. They were supplied with research papers and detailed policy proposals. By 1971, the ALP had developed plans for comprehensive health system reform, including regionalised, community-based services, community health centres, refurbished hospitals and national health insurance. ‘Preventive, occupational and rehabilitation services’ were to be ‘key elements’ of the health system (Sax 1984:100–3).

The women’s health movement in Australia, then, emerged at a time when ideas about the social causes of ill health were beginning to run hot. The movement drew upon these ideas, endorsed them and contributed to their development and expansion. Together with the Aboriginal and community health movements, it played a pioneering role in taking health and health care out of the personal

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5 Information about health policy developments in New South Wales and other Australian States and about contact between the New South Wales Health Department and Whitlam’s office was provided by the late Dr Sidney Sax, Director of Health Research and Planning in New South Wales in the 1960s and early 1970s and Chairman of the Hospitals and Health Services Commission, 1973–78.
sphere and into the public domain, understanding that good health for all is impossible without social and economic changes (Donner and Pederson 2004:2). As commentators have argued, the principles underpinning women’s health services are ‘almost identical’ to those of the new public health and community health (Auer et al 1987:2; Dwyer 1992a:212). In Table 1, the similarities between approaches are readily apparent.

Table 1

<table>
<thead>
<tr>
<th>OLD PUBLIC HEALTH</th>
<th>NEW PUBLIC HEALTH</th>
<th>FEMINIST HEALTH</th>
<th>ABORIGINAL HEALTH</th>
</tr>
</thead>
<tbody>
<tr>
<td>Focus on improving physical infrastructure to provide adequate housing, clean water and sanitation.</td>
<td>Focus on physical infrastructure, but also on social support, behaviour and lifestyle.</td>
<td>Focus on physical infrastructure, but also on social support and empowerment, especially through information provision and respectful interactions.</td>
<td>Focus on improving physical infrastructure to provide adequate housing, clean water, sanitation and so on, but equally on social support and empowerment through community development.</td>
</tr>
<tr>
<td>Legislation the key policy mechanism especially in the nineteenth century.</td>
<td>Legislation and policy rediscovered as crucial tools for public health.</td>
<td>Legislation and policy seen as crucial tools for women’s health, especially in relation to the social determinants of health.</td>
<td>Not much expected from legislation and policy in view of past experiences. Some emphasis on lobbying to change the shape of healthcare delivery system.</td>
</tr>
<tr>
<td>Medical profession has a central place.</td>
<td>Recognition of inter-sectoral action as crucial. Medicine only one of the many professions contributing.</td>
<td>Recognition of inter-sectoral action as crucial. Medicine only one of many professions and service providers contributing.</td>
<td>Recognition of inter-sectoral action as crucial. Medicine, including traditional medicine, only one of many professions and service providers contributing.</td>
</tr>
<tr>
<td>In nineteenth century, public health was one of a series of social movements that worked to improve living conditions. Primarily expert driven but some legitimation of community movement. Progressively more expert dominated in twentieth century.</td>
<td>Philosophy places strong emphasis on community participation, but, in practice, this is not often achieved, despite some real successes.</td>
<td>Philosophy places strong emphasis on women’s participation and community participation. Often achieved at the local level. Consumers and professionals considered to be equals.</td>
<td>Philosophy places strong emphasis on community control and community participation the sine qua non. Consumers and professionals considered to be equals.</td>
</tr>
</tbody>
</table>
In Table 1, feminist and Aboriginal health principles have been added to Fran Baum’s (2007) comparison of the main elements of the old public health and the new public health. The parallels are clear, especially between the Aboriginal health movement and the women’s health movement, as Jenny Baker (1998) has noted. In her view, non-Aboriginal women’s struggles for control over their bodies are similar to Aboriginal struggles for the rights of freedom and control over their own lives against Aborigines Protection Acts and other acts of ‘confinement and segregation’. She points out that collectives were set up and celebrated in both movements. Moreover, both movements, she argues, ‘fundamentally challenge the Australian health system to pursue primary health care and community development, based on community management, input and ownership’ (Baker 1998:92).
The harmony between the principles of the three movements was an important factor facilitating policy implementation in the early 1970s. Policymakers at the Hospitals and Health Services Commission (HHSC) had developed plans for a national community health scheme and women’s and Aboriginal health centres fitted comfortably into the framework. Officers of the commission helped, as far as possible, to overcome the obstacles put in place by sub-national bureaucracies and by antagonistic vested interests. Dr Sidney Sax, Chairman of the HHSC, had a strong background in primary health care. Along with Dr Gwen Greenman, his wife, he had provided medical services for poor people in South Africa. The two had set up a large community health centre in Alexandra Township, a violent, overcrowded settlement on the edge of Johannesburg (Royal Australasian College of Physicians web site). After arriving in Australia, Dr Sax participated in work to develop community health services for New South Wales, and, in his senior health policy position for the Whitlam Government, he was well placed to support strong primary health care, including separate women’s health centres. This policy direction was also championed by some members of the Labor Government. The reform ideas being articulated posed a major challenge to both health system structures and society’s wider institutions.

When the Whitlam Government lost office, there were six funded women’s health centres and 21 refuges approved for funding. The first national women’s health conference had been held in Brisbane in 1975 and was opened by the Prime Minister. The first Commonwealth funding had been provided for Aboriginal-controlled health centres and a network of community health centres had been set up. The period of the Fraser Commonwealth Government (1975–83), however, brought severe cuts in community health program funding under which most women’s health centres were supported. The centres were forced to turn to State governments for funding—a long process but one that eventually bore fruit.

Despite the unfavourable political climate at the Commonwealth level after 1975, the women’s health movement continued to expand and to campaign for policy reform on a number of fronts. Several State and Territory governments took positive action in the 1980s, developing women’s health policies and strategies. The movement staged a second national women’s health conference in Adelaide in 1985. Work at the grassroots level slowly percolated upwards, creating another policy opportunity when a second Commonwealth government willing to support women’s health came to power. The Hawke Labor Government, elected in 1983, found that women’s health, including maternity-care reform and occupational health and safety (OHS), was a major concern when it held consultations for its National Agenda for Women. Policy action was announced, a consultation and policy development process was undertaken and, in 1989, Australia became the first and only country to implement a national policy on women’s health.
Australia’s First National Women’s Health Policy

The 1989 National Women’s Health Policy (NWHP) is the high point of policy achievement for the movement. Indeed, the 1980s can be seen as the golden years of policy achievement. The NWHP identified six underpinning principles: a social view of health; a lifespan approach without undue focus on the reproductive years; participation by women in decision making as consumers and providers; women’s rights as healthcare consumers, including privacy, confidentiality, informed consent and the right to be treated with dignity; the right to accessible information in order to make informed decisions; and the need for accurate data and research, including women’s views about health. The seven priority issues selected were reproductive health and sexuality, the health of ageing women, emotional and mental health, violence against women, occupational health and safety, the health needs of carers and the health effects of sex-role stereotyping. The five key actions developed to advance the priorities were improvements in health services for women, provision of health information, research and data collection on women’s health, women’s participation in health decision making and the training of healthcare providers (Commonwealth of Australia 1989:78–81).

The development of affordable, acceptable, accessible and appropriate health services was to take place through a ‘dual strategy’. A separate women’s health sector would examine new issues and develop new models of practice in participation with women on a day-to-day basis in a ‘comprehensive and accessible’ network of primary healthcare services. Practice in the separate sector would lead by example, influencing the way the mainstream operated (Commonwealth of Australia 1989:82). During the consultations, women expressed strong support for separate women’s services that would be low cost, multidisciplinary, holistic, located in one place and would provide illness-prevention information and advice. Women said they wanted to participate in decisions about health and treatment and they looked forward to being able to choose services that had been tailored to meet their needs. A separate women’s health sector was essential to the improvement of mainstream services (Commonwealth of Australia 1989:60–1; Dwyer 1992a:213).

By the early 1990s, experience showed that changes had already been wrought. Feminist criticisms of inappropriate minor tranquilliser use, for example, had become respectable and were acknowledged in the mainstream after a decade of lobbying. Another example was that the work done in rape crisis centres had become a model for more appropriate policies and practices in mainstream...
services. In two decades, the ‘movement had extended the territory’ of what could be discussed ‘in mainstream debates about how to care for women’ (Dwyer 1992b:26).

The National Women’s Health Policy and Program continued to advance women’s health for years after its launch. Having the ideas and concerns of Australian women written in black and white in a national policy document not only increased their currency but also bestowed legitimacy. Policymakers and activists alike could refer to the principles enunciated and the evidence presented. The separate women’s health sector was enlarged and a wide assortment of projects and programs was supported, creating a strong basis for innovation and political action.

The election of the neo-liberal Howard Commonwealth Government in 1996, however, ushered in more than a decade of antipathy towards the women’s movement. In 1997, responsibility for the provision of women’s health services was handed over to the States and Territories, although the national share of funding was maintained. Shortly after the Howard Government was elected, a delegation from the Australian Women’s Health Network (AWHN) arranged a meeting with the Minister Assisting the Prime Minister for the Status of Women. Members of the delegation were taken aback when the minister opened the conversation by asking, ‘Well, girls, is there anything left to achieve in women’s health?’

In 2004, the Commonwealth made an unsuccessful attempt to exclude women’s health services from the funding flowing through public health financing channels. During this period, the States and Territories, for their part, all maintained existing services, although no conditions requiring them to do so were attached to Commonwealth funding. Although the Commonwealth policy environment was hostile, at the sub-national level, women in government and outside were able to use the policy to support their arguments and claims.

From 1995 onwards, the women’s health movement consistently called for revision and updating of the NWHP and for a resumption of Commonwealth responsibility but there was no policy response. A change in direction took place in 2007, however, when the ALP heard the message and committed itself to a new NWHP should it win the next national election. This was the only women-specific policy that the major parties took to the election—an indication of changing attitudes to women’s issues and the importance of women’s vote since the 1970s.
The Relevance of the 1970s for Present-Day Health Reform

The structural proposals developed in the 1970s have lost none of their relevance. Indeed, they might be even more relevant in the twenty-first century as lifestyle factors such as obesity increasingly undermine health at the same time as increasing the cost of hospital and medical services. Without structural change, a destructive spiral is created: more people suffer from more serious and chronic illnesses, the costs of treatment continue to climb, rendering the prospect of significant investment in primary health care and prevention increasingly unlikely.

Nor have women’s health priorities lost their relevance. Violence, sexual assault and sexual and reproductive health problems persist. Preventive health and support services are still in short supply. Mental health—long the Cinderella of health issues and a major concern for women, as the NWHP pointed out—is at last receiving more policy attention but huge shortcomings remain. The community-based primary healthcare sector is small and fragile, after many years of neglect. Financial barriers to hospital and medical services are not as high as they were in the pre-Medicare 1970s but steadily increasing user charges are preventing people, especially low-income earners, from using services. Geographical access remains a serious problem: all services are scarce outside the cities, while access to culturally appropriate care is still a priority for non-Anglo-Australian women.

All the while, the international health research community, including the WHO, continues to produce evidence endorsing a social health perspective. The WHO released an influential report in 2008 that argues that daily living conditions—including a healthy environment, the availability of fairly paid work, economic security, a fair distribution of resources and power and access to a comprehensive range of services—are essential for decent health. Recommendations include political empowerment for the marginalised, gender equity⁶ and greater equity in all public policies, including taxation. The report points to serious, avoidable health inequalities, not only between countries but also between different groups within single countries. It presents the astonishing example of a 28-year discrepancy in life expectancy between men living in different suburbs of Glasgow (WHO 2008a:32).

In keeping with this evidence, the social determinants of health are now more widely acknowledged in Australian policymaking circles. All the major policy...
Introduction

documents of recent years recognise the structural causes of ill health, including acknowledgment of gender as an important determinant. A gender perspective, like a diversity perspective, recognises that differently placed people—in this case, men and women—experience health and illness differently and that different expectations and norms influence experience and behaviour. Similarly, it is recognised that socially and culturally determined roles and expectations influence outcomes for people, including those with disabilities and those from different income and ethnic groups. Moreover, discussion documents argue that preventable health inequalities can—and should—be reduced.

So why is it, then, that although the need for structural reform through investment in preventive primary health care is recognised, so little action is taken? The answer lies chiefly in the immense political power of opposing interests. In the first place, there are the vested interests of providers, who benefit financially from the system as it stands. As the biggest single industry in OECD countries, the health sector provides high incomes and profits and prestigious positions for large numbers of service and technology producers. In Australia, system arrangements directly augment incomes and profits through hefty public subsidies. Change is vehemently resisted when it threatens to disturb existing distributions of income and status (see, for example, Alford 1975; Evans 1998; Sax 1984). Another barrier, as mentioned, is the increasing cost to the public purse of expensive hospital and medical services. A related factor is that business-sector interests are a less direct but nevertheless powerful set of opposing forces. By promoting the value of balanced budgets, low taxation and a market distribution of goods and services, they make it politically difficult for governments to find new money for investment in areas such as primary health care.

Under the Rudd and Gillard Commonwealth Governments, a small window of opportunity for reform was opened. The Commonwealth has claimed health reform as a priority since 2007 and incremental responses based on the recommendations of recent inquiries are beginning to be introduced. Action includes a commitment to ‘closing the gap’ between Aboriginal and non-Aboriginal health outcomes, for which some funding has been allocated. Ironically, it is under the top-down Northern Territory Emergency Response that Aboriginal-controlled health services are being expanded. While it is too early to assess the impact of the changes, the Rudd and Gillard health reforms are discussed further in the concluding chapter.
About this Volume

This account of the history and politics of the Australian women’s health movement traces its presence as an integral part of the wider reform movements of the 1970s, particularly the health reform movements. It provides a record of some of the work women have done and locates actions and events in the context of general political and social forces, including the opposing forces that have impeded the path to reform. It looks also at the way windows of opportunity for policy advancement opened in different jurisdictions at certain times, and offers an explanation of the reasons for this, with particular attention to the impact of feminist activism. Those readers who are primarily interested in the movement and its activism might wish to focus on the first six chapters. Those more interested in public policy and the influences that shape it will find this discussion from Chapter 7 onwards.

The story told here is only one among many possible accounts of the Australian women’s health movement and its impact on public policy. It draws upon a rich tapestry of experiences, which is open to interpretation from a variety of perspectives. I anticipate that some readers will disagree with some of my arguments and with the emphasis placed on some events and issues rather than others. This is unavoidable given that the movement encompassed diverse perspectives from the beginning. Some women might wish to focus on the uniqueness of the movement’s ideas. I have chosen to draw attention to the strong concordance between the principles of women’s health and other sets of reform ideas, including those that predated the movement, those that were at the cutting edge in the 1970s and those that are on international and Australian political agendas in 2011. In making these connections, the overlap between the principles of women’s health and those of the community health/new public health movements and the Aboriginal health movement is clear. What all these approaches have in common is a structural view of the causes of health and illness. Hence, they focus on improving the health of whole populations, especially those groups most at risk, through investment in community-based, preventive approaches, which would complement the system for treating individual episodes of disease. Persuading policymakers to adopt this comprehensive approach to the health system has been one of the major objectives of the women’s health movement.

The health centre movement, the movements against violence and sexual assault, the maternity-care reform movement and the movement for reproductive rights have been selected for discussion. Activism to achieve women’s reproductive
rights\textsuperscript{7} has been part of the work of all feminist groups. Initially, the women who set up centres and services were all feminists. Indeed, the movement ‘has its ideological base in feminism’ (Shuttleworth 1992:17). But as time went on, women who do not necessarily so describe themselves have promoted women’s health. Because of space constraints, however, discussion will focus mainly on feminist work and action—the driving forces of the movement, especially in terms of advocacy for structural change.

From the late 1970s onwards, there was a remarkable proliferation of women’s health groups—an indication of the strength of the movement. To name just a few in no particular order, groups for women with eating disorders, postnatal depression, HIV/AIDS and mental health problems have been established, alongside others focusing on lesbian health, maternity care, cancer support and the wellbeing of older women carers. Some work within an overtly feminist framework; others do not. While all are part of the modern women’s health movement, it is clearly beyond the scope of a single volume to examine them all.

One important grouping that I have left to one side is Australia’s network of Family Planning Associations, which have made a strong contribution to women’s health. Family Planning Associations have, however, never branded themselves as part of the women’s movement and they predate the second-wave movement.\textsuperscript{8} In 1960, the Racial Hygiene Association changed its name to the Family Planning Association of Australia and in 1961 it opened its first clinic in Melbourne. Men, as well as women, have always been part of the active membership (Siedlecky and Wyndham 1990). Space constraints prevent even a cursory glance at this movement’s multifaceted activities. The YWCA is another group whose work is not covered, despite having made a significant contribution. It works to facilitate community development and to provide support for young women and young families. Indeed, its focus on the many aspects of life that impact on wellbeing is consistent with a social health perspective. Moreover, the ‘Y’ has frequently worked with sections of the women’s health movement on specific projects. Other women’s groups that have worked to advance women’s health include the Country Women’s Association (CWA), the Catholic Women’s League and the National Council of Women of Australia. These organisations do not, however, always support feminist goals and are not primarily concerned with health.

A focus on ‘feminist’ women’s health groups raises the question of what I mean by the term in this book. There has never been a single feminism in Australia, as examination of serious disagreements in the following pages will show. Moreover,
from the 1980s onwards, the existence of many ‘feminisms’ was recognised. Some versions have lost support and new perspectives have emerged, so that any definition has to be flexible and inclusive. I favour the kind of portrayal developed by the editors of the *Oxford Companion to Australian Feminism*, because it seems able to account for multiple strands of thought. ‘Feminism’, the editors propose, ‘involves a sense of and concern with women’s oppression, an interest and engagement in addressing, altering, or reforming it and a concern about women’s claims to full citizenship and to recognise their social, economic, cultural and political participation’ (Caine et al. 1998:x). A feminist approach in women’s health has been described as one where there is an

emphasis on ‘empowering’ women rather than ‘helping’ them, of ‘engaging’ women in their own health care management, rather than ‘fixing’ them, and providing information so that women make their own informed decisions...the feminist/women-centred health model provides an active and equitable exchange where the health professional is recognised for her skill and expertise but the woman is recognised to be the expert in her own life and circumstances. (Cameron and Velthuys 2005)

What follows is a policy study, set in historical perspective, which seeks to answer major questions. 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? What are the conditions that have come together at different times to create windows of opportunity for structural health reform? And what are the major obstacles? Why, despite the evidence, the hard work of so many groups of citizens and acknowledgment by policymakers, do the structures of the health system in 2011 remain much as they were 40 years ago?

The organisation of the book is as follows. The first chapter examines the women’s health movement, the ideas that influenced it and that it developed further. It reviews feminist critiques of the conditions of women’s lives and of the conventional medical system. The unique Australian debate about whether or not to accept government funding to help run services is examined, along with criticisms that the Australian women’s movement is Anglocentric. Chapter 2 provides a glimpse of pioneering women in action at the grassroots level, as they organised, set up separate services and attempted to put women’s health on policy agendas. Chapter 3 examines the consolidation phase, when more health centres were established and women moved to work in funded services alongside their grassroots sisters. Chapter 4 looks at the growth and strength of the movement as groups within it proliferated and traces the networks, formal and informal, that women formed. The extensive collaborations between groups,
including inter-organisational action to advance occupational health and safety, are examined in Chapter 5. The struggle for reproductive rights, including maternity rights, is discussed in Chapter 6. State and Territory government responses to women's advocacy are examined in Chapter 7, and Chapter 8 traces Commonwealth policy responses, including the development of the two national policies. The ninth chapter is an analysis of broad policy determinants that have shaped responses to the movement. An evaluation of the social change and policy reform achieved is presented in the concluding chapter.