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Women's health in a changing state

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> One great gift of the women's movement has been its insistence that there is no neutral genderless, objective position from which to view the world or speak about it.
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> (Broom 1991: p vii)

The emerging women's movement of the late 1960s and early 1970s, both incorporating and sparking the women's health movement, launched a fundamental challenge at the institution of patriarchy (the structured system of power that supports white men in Western society). It insisted that the so-called 'reality' espoused by its agents, made up of particular assumptions, knowledges and beliefs, was in fact inherently biased through the factor of gender (as well as factors such as race and class). Accordingly, women's liberationists argued that there was a need to acknowledge both a 'women's reality' (including the existence of different experiences) and, therefore, women's distinctive requirements of the health system.

Health itself is a crucial area in the life of any society: among other things it describes the wellbeing of its citizens, it measures some outcomes of its particular social structures, it reflects a society's interactions with the physical environment, and it is a vital part of the economy of Western societies. The particular health needs of women are determined by biology and by the social, economic, political and psychological factors that mediate and shape the experience of health and illness. These factors mean that women have different patterns and experiences of health from men (Webster & Wilson 1993). For instance, some conditions, such as eating disorders, are particularly prevalent among women, while issues that affect both men and women, such as cigarette-smoking, may have different causal factors and require different responses. Recent research has suggested that smoking in women is intrinsically linked to the gendered meanings afforded to smoking (Greaves 1996).

The debate about women's morbidity (or illness and injury incidence) relative to that of men has stopped focusing on the question of more or less, and turned instead to actual differences (Dennerstein 1995). Penny Kane has found that 'women have a very different health profile to men in the illnesses they suffer and those from which they die' (1994: 94). Women's usage of the health system is also patterned differently from that of men (Broom 1991; Health Sharing Women 1990; Stanton 1996). It often involves maintenance of wellness, as with routine screening for such health conditions as cervical and breast cancer and contraception. Women often seek assistance for problems such as family violence, sexual harassment, stress and unhappiness. Women interact more with the health system on behalf of others—as carers of children, the aged and those with disabilities (Webster & Wilson 1993; also see chapter 14). However, women less often receive health care from a provider of the same sex or, if from a non-Anglo-Saxon background, from a practitioner of similar cultural background. As noted by Webster and Wilson (1993: 3), this affects the 'extent to which women can confidently act as equal partners in their own health care'.

Overarching concerns that women have expressed regarding health care include: their exclusion from how health care is delivered and managed; trivialisation and negation of their self-defined health concerns; high levels of medical intervention; the focus on specific diseases/conditions at the expense of the 'whole' person; high levels of sex-role stereotyping by health care providers, especially doctors; the intersection of social factors such as income, housing and education in relation to health and wellbeing; the undue emphasis on reproductive health and on women in their reproductive years; lack of recognition of the needs of particular groups of women (e.g.

those from non-English-speaking backgrounds, lesbians and rural women); lack of acknowledgment of the realities of women's lives; the need for access to information and resources to support informed choice; and the need for provision of locally based, primary care health services. This is especially the case in rural and remote areas, but applies also to those from lower socioeconomic areas in larger Australian cities (Davis et al. 1996; People Together Project 1997).

Taking up these concerns, the women's health movement has challenged the fundamental tenets of the biomedically dominated health system and the economic, political and social structures that impinge on the health of women. Despite their dominance as workers in the health sector (AIHW 1996; 1998) and as health care service users, a dominant theme in the women's health movement has been women's relative lack of power within the health system (Broom 1991; Doyal 1983, 1994).

In order fully to appreciate both the depth of achievement of the women's health movement, and the challenges of the work still ahead, this chapter charts the development of the women's health movement; the achievements of the National Women's Health Policy; the dual emphasis on alternative women's health practices; changing mainstream medical practices; the impact of broader consumer and feminist movements on women's health; and the challenge of preserving women's health services against ideological challenges based on antidiscrimination and, more recently, the agenda of current economically driven reforms.

Reforms associated with the market state indicate the vulnerability of the broader women's health agenda in the current climate of funding cuts and the reshaping of community and women's health services to cater for increased acute care within the community, with early hospital discharge and 'hospital in the home' policies.

The development of the women's health movement

A range of sources chronicle the key outcomes, stages and events relating to the achievements of the women's health movement and its derivatives, both in Australia (Broom 1991; Commonwealth

Department of Community Services and Health 1989; Alcorso & Schofield 1991) and in other developed countries (Doyal 1983; Philips & Rakusen 1978; Ruzek 1978). Rather than summarise or repeat these events, we present an episodic analysis of past and current critiques offered by the women's health movement. In doing so, we can illustrate the activist beginnings, the recognition afforded by the development of national policy on women's health, the innovations produced in putting the policy into action; the debates around the effectiveness and continuity of specifically targeted health policies within changed federal/state funding agreements concerning women's health; and the impact of funding cuts and downscaling of programs coordinated nationally—including the Office of the Status of Women, the broadbanding of women's health funding and devolution of women's health to state and local levels (thus diluting national oversight of adherence to national women's health goals).

The specific history and ideological underpinnings of women's health are crucial to understanding its proponents' defence of standalone women's health funding and services. 'Bucket' or broadbanding funding (including a whole range of programs in one grant to states) and integrating a wide range of primary health and community support services, including women's and community health (as in Victoria), are seen as threatening the maintenance of the unique nature of women's health programs and services. First, however, the background and history of women's health is essential to understanding why it is different from mainstream health.

Until the late 1960s, the biomedically dominated health system existed on the premise that the male-defined reality of health that it espoused was true for, and relevant to, all people. Such a belief created and sustained a closed and rigid system of health service provision that disregarded complaints, maintained an illusory mindset of medical provider superiority and promoted a system where privilege begat health (Ehrenreich 1978; Doyle 1983).

This system had a long-established set of beliefs and practices through which all information was filtered and all understanding and knowledge derived. As with all systems, it was sustained by the process of ensuring that it excluded, trivialised and marginalised those ideas and practices that it could not comfortably incorporate (Broom 1991; Graham & Oakley 1981).

Erupting into the 1970s, the women's health movement challenged the notion of a single, defining reality or perspective in relation to health. It proposed multiple realities in terms of experiences of health and illness, where health status was viewed as being inextricably linked to social and cultural determinants such as gender, class, race, ethnicity and disability. The health arena became a major area of feminist analysis and activism, as women's bodies were understood as theoretical and political sites (Broom 1991; Doyal 1983; Ehrenreich 1978; Graham & Oakley 1981).

In 1975 the first Women's Health in a Changing Society conference was held in Adelaide as part of International Women's Year—shortly after the United Nations Decade for Women commenced in 1976—with international calls to address the status of women and the broader parameters of women's health.

Feminist critiques throughout the 1970s and early 1980s developed a framework by drawing on the commonalities of women's experiences (even at the expense of differences) to define medical practices that confined, endangered and maligned women. Such practices were seen to represent potent forms of medicalisation of previously socially defined natural conditions and life events, such as menstruation, pregnancy and childbirth. For instance, in the introduction to the *Spare Rib Reader* on women's health, a collection of 15 years of published writings, O'Sullivan (1987) explained how women's health had primarily been defined through biology and sex-role stereotyping, where natural biological events in women's lives—such as menstruation, pregnancy and childbirth—were regarded as pathological conditions needing treatment. The dominant medical approach to such events thus represents potent forms of medicalisation of previously socially defined natural conditions and life events. The contradictions between societal expectations of women's role in providing services to others, while remaining infirm by virtue of being female, are made clear (O'Sullivan 1987: 3):

> . . . women are usually expected to soldier on in these male defined roles, both because of and despite this female 'infirmity', and so we often find the situation where men think women are

> 'diseased' when we are not, and will not believe us when we say we are ill. The case of premenstrual tension is a case in point: our biology does incommode us on occasion, but by the same stroke it does not completely incapacitate us. We are no more automatic or perpetual victims of our biology than men.

What was radical in feminist critiques of the health system was the primacy given to the authority of women's expressed views of their health experiences. A scepticism developed towards new technologies such as IVF, with demands either that it be stopped or become women-friendly and controlled by women (Arditti et al. 1984; Corea 1985; Koval 1986; Franklin 1997; Meyer 1997; Rowland 1992; Stacey 1992). By challenging the hierarchical notion embedded in the dominant biomedical model of health, of the doctor as sole expert and proprietor of knowledge about health and illness, feminism sought to undermine the very premise of the prevailing system—medicine's ownership and control of knowledge and wisdom (Broom 1991; Ehrenreich 1978; Harding 1986; Rose 1993). As Broom (1991: 58) comments:

> [W]omen are not only the objects of medicine: they are also active agents in the constitution of their bodies and themselves, participating in other (sometimes conflicting) discourses, at times accepting and at other times resisting medicine's impositions.

Dominant themes in women's health

Drawing on feminists' critiques of positivist methodology and quantitative research, and an emerging qualitative feminist methodology (Roberts 1981; Harding 1992), the women's health movement focused on legitimising women's voices. It thus drew on a broad range of feminisms and direct consultations with women, enabling articulation of their expressed complaints and needs. As early as 1973 women packed out the Assembly Hall in Collins Street in Melbourne to 'speak out' about the health system. As Bon Hull (1994) said at the opening of the Health Sharing Women's Health Resource Service in Melbourne:

> . . . the dominant issue was poor health care and the lack of information to women. Many of the testimonies were unbelievably

> shocking, but doctors, nurses and health workers also came to the microphones to endorse the disclosures . . .

Thus, a dominant theme has been women's relative lack of power in the health care system, despite their numerical dominance as workers within the health sector and as health care service users. Other public meetings occurred around Australia, particularly in New South Wales. Such consultations found that women understood 'health' and its causative factors much more broadly than did orthodox medicine, and that women easily and readily defined their health within much broader parameters than those traditionally recognised, such as reproductive and gynaecological issues. By the 1980s the power of this strategy gained official endorsement: the first government-funded consultation was held, resulting in the report of the Victorian Ministerial Women's Health Working Party (1987).

The outcomes of this extensive consultation with Victorian women indicated that health services were seen by most women as inaccessible, inappropriate, unresponsive to their needs, and devaluing of their experience and knowledge. Further, the specific effects of gender inequalities on women's lives were seen to mediate and define the experience of health as expressed in the Victorian Ministerial Women's Health Working Party (1987: 1):

> The overriding and fundamental principle of this report is that the health and well-being of women is directly related to the social context in which women live their lives.

When Australian women were, and are, asked about what they want from a health system, the responses are remarkably consistent across time and geography. The list includes a desire for the health system to provide women with opportunity to be:

- treated with dignity and respect;
- allowed access to informed decision-making;
- offered improved access to services;
- offered greater choice of practitioner, particularly in relation to gender; and
- provided with information based on relevant, women-focused research.

The achievements of policy development: the National Women's Health Policy

The Australian government's adoption of the National Women's Health Policy (NWHP) (Commonwealth Department of Community Services and Health 1989) was preceded by consultations around Australia with over one million women. Its clear focus, reconfirmed in 1993, centred on the social context of women's health (AHMAC 1993b; Commonwealth Department of Health, Housing, Local Government and Community Services 1993).

The NWHP incorporates a number of commitments to principles of access and equity, which include: enhancing participation of women in both health service delivery and decision-making about their own health care; a focus on health promotion and illness prevention; understanding the social view of health; reducing sexism and sex-role stereotyping in health service delivery; and managing and strengthening the focus on primary care, as the most appropriate sector for meeting women's health needs. The policy also outlines seven priority issues that recognise women's social roles as well as the concerns of women throughout the life cycle. The priority issues are reproductive health and sexuality, occupational health and safety, health of aging women, the health needs of women as carers, violence against women, women's emotional and mental health, and the health effects of sex-role stereotyping. As a Victorian evaluation stated (Success Works et al. 1997: 34):

> The philosophy of women's health services can be summarised as being based on feminist principles, within a social context that recognises access, equality and equal participation for all and allows control and closure for service users in all aspects of service provision.

Australia has been internationally recognised as the first country to develop such a policy (Doyal 1994), and was influential on other countries', such as Canada's, subsequent formal adoption of similar policies.

Recognition of structural barriers to quality care, beyond the identification of specific health concerns, has enabled the identification of five key action areas within the policy to inform strategies for effecting change. These structural issues include the need for improvements in health services for women, the provision of health information, research and data collection on women's health, participation in decision-making, and the training of health care professionals.

The dual strategy of women's health

Both the national and the Victorian approach to reform of the health system has been based on the concept of a 'dual strategy'. This approach provides for the reform of the mainstream health system while resourcing the establishment of separate and specific health services for women in the community, run on feminist principles (Stanton 1996: 47).[1]

Women's health services. The Women's Health National Funding Strategy recognised that, while greater sensitivity and responsiveness to the needs of women was the principal goal of national policy, autonomous services for women could hasten such change by highlighting particular health concerns and developing innovative approaches to particular issues.

The emergence of a funded network of women's health services across Australia from the late 1980s was fundamentally about identifying and developing alternative models, practices and resource materials in relation to health. The rationale was based on the view that women's health services could provide a number of services and direct links to women and, at the same time, promote improvements in services for women provided by existing mainstream services. The services could also provide a key vector for women's voices, and hence maintain a clear advocacy role and watching brief within the health system. Draper notes (1991: 331):

> In short, the aim was not to build an infrastructure of women's health services parallel to mainstream health, but to use women's health services to catalyse and model changes in mainstream services.

The nature of services provided, and to some extent the model adopted in women's health organisations, has varied from state to state. Consistently across states, however, all have offered information and education to women and training to health professionals. With the exception of Victoria, they have also provided clinical services of a reproductive and screening nature. The design of such services provided an opportunity fundamentally to challenge established clinical modes of practice that women had found so unsatisfying. For instance, the Melbourne Women's Health Collective encouraged women to write their own medical histories, which remained the property of the women. Such practices were (and are) considered heretical by medical practitioners, who have viewed women as ignorant and unreliable informants on their own lives, and medical records as the private and inaccessible property of the medical profession or institution.[2] Such notions are still firmly entrenched among the medical elite today, despite 20 years of women's protestations. For instance, the account by Stephanie Brown and colleagues of the response to their recent research on women's experience of motherhood is eerily familiar (Brown et al. 1994: 2):

> Our assumption that women could be believed when they report on their lives—that their reports have indisputable authenticity—is still seen as extremely dubious. This is illustrated by the letters we received from professional journals rejecting a paper . . . about the links between post-natal depression and women's obstetric experiences. A fundamental objection to the paper was that we relied on and believed what women told us.

Changing mainstream medical practices. At the centre of women's health services have been attempts to redefine and recreate the role of the doctor in health consultations. While feminist discourse has generally been anti-doctor, the presence of women doctors in feminist services has highlighted tensions and forged changed relationships. Rosemary Pringle (1996) argues that such renegotiation has occurred in three ways. First, medicine has been practised differently within women's health services, and women doctors have significantly contributed to this through the process of articulating and working through the tensions with other non-medical workers. Second, women doctors are expected to practise differently from men, and have often believed in and responded to this expectation. Third, women doctors have challenged the way medical work is organised and the barriers imposed on them and not their male colleagues.

Women's health services have also strongly argued for the promotion in status and role of nurses and midwives—predominantly female professions, and long-viewed as 'handmaidens' to the doctor. Recent successes in credentialling 'nurse practitioners' (nurses trained to provide pap smears and other preventive health care to women) has capped a long and arduous process (Buckenham & Parsons 1993; Lorentzon & Hooker 1996). The determination of nurses to be more autonomous of doctors and to have more control over their practice has met with fierce resistance by various professional bodies representing the medical fraternity. Commenting on the introduction of women's health nurse practitioners in New South Wales, Cox notes that economic recession and the oversupply of doctors have exacerbated medical resistance to these independent practitioners, despite the finding of higher levels of skill in taking pap smears compared with other practitioners. Similarly, midwives' efforts to expand their authority and provide pregnant women with a greater range of birthing options has sparked trenchant opposition from these bodies and indeed state governments (Bennett 1995). Despite the wishes of women that an extended role for midwives be supported (Health Department of Victoria 1990), and research indicating that midwifery care results in lower monetary cost and less frequent medical intervention in birth, the management of birth remains a largely specialist medical perogative in Australia (Bennett 1995; Robinson 1989).

The philosophy and practice of women's health services also reintroduced historical notions of self-care (self-diagnosis and self-medication) and shared health knowledge based on women's collective experiences, which again challenge the sole authority of traditional medical practice. For instance, information leaflets on herbal remedies for a range of 'women's problems' were widely distributed. Services went further in either employing alternative practitioners—long before they were socially acceptable—or promoting the existence of alternative health modalities modelled on holistic or 'whole-body' constructs of health and illness. Women's health activists have recognised women's profound dissatisfaction with the limitations of the mechanistic, biologically deterministic disease model of conventional medicine, which disallowed a recognition of the interaction of emotional, physical and social factors in health (Broom 1991; Dennerstein 1995; Webster & Wilson 1993).

Today, alternative modalities of health have gained greater legitimacy, used either singly or in tandem with mainstream medical treatments. It is apparent that women are the primary users of alternative remedies and therapies and that they continue to do so in the context of significant resistance and suspicion from conventional medicine practitioners, and significant financial disincentives (Crook 1995; Harrison 1996; Smith 1989). For instance, an Adelaide study found that Australians expended a total of $621 million on alternative medicines and $309 million on alternative therapists in 1993. The study also found that women were more likely to consult naturopaths, iridologists and reflexologists than men, and were the greater users of non-medically prescribed alternative medicine (MacLennan et al. 1996). The researchers asked what induces people to spend large amounts on alternatives to allopathic medicine. They suggest that lacking in the normal doctor–patient encounter are time, empathy, personalisation, expectation of a cure in chronic disease states, counselling, and a general emphasis on health rather than disease. These concerns echo those consistently raised by women in the past two decades of public consultations.

In developing models of service provision, women's health services have intervened in highly protected areas of the medical establishment, such as research and training for health professionals. Again, the focus has been on mining the wealth of knowledge held by consumers and a training framework based on a collaborative relationship between women and their practitioners, based on mutual respect and listening. For instance, the National Women's Health Program-funded project, *Being Our Age: Older Women's Voices* (Elliott 1994), embarked on an ambitious process of mutually consulting and training both older women and health practitioners to encourage more positive health outcomes.

Women's health and broader consumer and feminist movements

It is no accident that the rise of the consumer health and feminist movements have paralleled the rise of women's health activism, resulting in recognition of the right of consumers to participate in the development of health policy and in decisions on the allocation of research funding, and the right to informed decision-making regarding illness treatments.

Feminist interventions in research methodology have been central to the arguments mounted by the women's health movement and the policy directions taken. It is possible to indicate some of the broad tenets of these interventions, but important not to overstate the level of agreement about them. Ongoing debates on the usefulness of scientifically approved methods, such as randomised controlled trials (Westbrook 1996; Shelley 1996), recreate and renegotiate the terms and ideas through which women's health policy is evaluated and understood.

The overriding concern in the women's health movement has been the participation of women and women's perspectives in the health system. The explicit inclusion of women's voices—hence their values, concerns, priorities, needs, politics and so on—has been a central aim in the policy strategy of providing centres run for and by women and, at the same time, attempting to influence mainstream services to be more appropriate and responsive to women. Feminism's challenge to the development of knowledge about health has involved demonstrating the ways in which women have been excluded from research and modelling new ways in which participation can occur.

Systematic bias in the form of exclusion of women from major clinical research trials has been identified as a significant problem (see also chapter 12). Many drug trials are based on male population data, with doses prescribed for the 'standard 70 kilogram male'. Johanna Westbrook (1996) reminds us that some of the largest and most important medical studies in recent years have not included any women. She cites a 1988 US health study which concluded, on the basis of research on 22 000 men and no women subjects, that taking an aspirin a day might reduce the risk of heart disease. The 'Mr Fit' study on the interrelationships between heart disease, life-style and cholesterol intake studied 15 000 men (Freedman & Maine 1993, cited in Doyal, 1994: 147). Further, a review of research published in the *The New England Journal of Medicine* in 1989 found that over 60 per cent of articles displayed gender bias. A similar review in the journal *Hypertension* found that 40 per cent of the studies included no women (Westbrook 1996). Doyal (1994:

146) argues that because medical researchers tend to overlook female health problems unless they are related to reproduction, chronic and disabling illnesses often suffered by women, such as dysmenorrhoea, cystitis and incontinence, receive little attention. The preferred methodology favours medical orthodoxy. A researcher taking a qualitative and participatory approach to a study of women's mental health reported difficulties in gaining ethics clearance from a mostly male and medically trained committee, critical of the non-representative sample, qualitiative research methods and the researcher's lack of clinical experience (Stanton 1996: 29).

Only 1.9 per cent of $42 million of funds expended by the NH&MRC between 1986/87 and 1988/89 was allocated to women and health projects and, given the biomedical research focus of the funding body, these focused on clinical research programs on reproductive health rather than on wider issues of concern to women's health (Melbourne District Health Council 1990; Stanton 1996: 29).

A review of expenditure on Australian research on women's health found that there was a paucity of funding to women's health generally, and that the research that was funded tended to be biomedically oriented (Melbourne District Health Council 1990). Research funding for consumer organisations was the most scarce, but also the most likely to fund projects conducted according to action research, participatory and community development principles. The smallest slice of the research funding pie went to projects explicitly designed to address the expressed health concerns of women. Less than 1 per cent of the annual federal health budget goes explicitly to women's health programs.

The challenge of preserving women's health services

The existence of Australia's National Women's Health Policy is an open acknowledgment that the medical system is not and should not be the only site of knowledge about health. Notwithstanding its low levels of funding, the policy and funded program has been an expression and recognition of different realities based on gender. After the successful evaluation of the first four years of the program (Commonwealth Department of Health, Housing and Local

Government 1993), the policy was endorsed and funding reconfirmed for a further four-year period (1993–97) and, later, for 1997/98 and 1998/99.

The continuation of the Women's Health Policy and program has met significant challenges. First, the 'Proudfoot case': in 1991–92 Dr Alex Proudfoot, a Commonwealth bureaucrat, joined by two other male complainants, challenged the legality of women-only health services before the Human Rights and Equal Opportunity Commission (HREOC) on the grounds of discrimination and lack of men's access to services under the Sex Discrimination Act. The gendered nature of health and access to health services had to be re-argued, and the president of the HREOC ultimately found that the complaints were unsubstantiated and women's health services are exempted under s.32 or s.33 (the 'affirmative action' or special measures section) of the *Sex Discrimination Act 1984* special measures (Broome 1992). Nonetheless, the case demonstrates the vulnerability to challenge of women's health and, for that matter, other services targeted at disadvantaged or special needs groups.

Second, funding and system changes represent a potential challenge to women's health. The 1993 Medicare Agreement committed Commonwealth and states to the development of an outcomes-based health system. Further, funding for women's health will be 'broadened' and devolved in a block grant to states/territories that brackets funding for a list of specific-purpose public health programs. Under this arrangement, the objectives of the Women's Health Program will be maintained through a regulatory framework agreed to by state health ministers. Each of the key objectives of the national program will be monitored through the collection of health outcomes indicators and underpinned by research, including a three-yearly population survey on women's health; the 20-year Longitudinal Study on Women's Health (at the University of Newcastle); and information held by the Centre for Outcomes and Understanding of Gender (Differentials) in Health. However, the efficacy of such a framework for achieving the qualitative objectives of the women's health agenda will need careful monitoring. As chapter 12 points out, the development of 'women-sensitive' health indicators is an evolving process.

Other issues that cloud the horizon include:

- questions over whether the national longitudinal study funding will be maintained;
- the risk that women's health program objectives will be marginalised if other programs in a broadbanded funding pool under the Public Health Funding Agreement are given priority;
- the possibility of state political agendas undercutting service funding to the point where workers are unable to deliver needed services;
- the risk that outcomes-based funding might divert workers' productivity into measuring outputs; and
- the risk that quantitative output measures might end up driving the direction of women's health service delivery.

Already in Victoria, funding cuts and service changes are undermining workers' capacity to deliver effective quality services (People Together Project 1997). Both the Women's Health and Community Health Programs are to be 'bundled' into the Primary Health and Community Support (PHACS) integrated delivery platform (Department of Human Services 1997), along with community rehabilitation centres, aged care social support, psychiatric disability, drug treatment, dental health, aged care, post-acute care, hospital in the home, family planning, sexual assault and innovative health services for homeless youth.

These shifts in the way the Women's Health Program is funded and organised have been perceived as a threat to maintaining and supporting the integrity of targeted programs. As pointed out in earlier chapters, the health sector has undergone major turbulence and is experiencing massive review and restructuring at both state and federal levels. The role of policy covering specific, targeted populations is increasingly unclear, although linking funding to health outcomes in an outcomes-based health system is firmly on the national agenda (Rubenstein & Sansoni 1996: 5). The upshot is unclear of developments such as competition policy and market state reforms, broadbanded funding and proposals by the Council of Australian Governments (COAG) to adopt overriding notions of 'population health' (Duckett et al. 1995). The emphasis is less on access and more on outcome, less on service providers and more on 'streams of care'. While the theoretical focus of COAG's reform proposal is on the coordinated integration of the acute and primary health sectors, greater efficiency and quality, and acknowledgment of the perspective of the consumer—all reforms applauded by women health activists—it remains to be seen how such a 'global' perspective will address the systemic disadvantage experienced by many groups with specific needs, such as women. The demise of special-purpose grants may mean fewer innovative programs to fill the needs of those most at risk.

Indeed, one of the plenary recommendations of the Third National Women's Health Conference in November 1995 (Davis, Andrews & Broom, 1996: 14) noted with concern:

> the potential of reforms of the Australian health system, such as those currently proposed by the Council of Australian Governments (COAG), to dismantle Special Purpose Programs, including the National Women's Health Program.

A significant criticism levelled at the women's health services, policies and programs has been the relative lack of success in changing the mainstream health system. While the Women's Health Program has developed products and services that are innovative and have even been recognised as examples of best practice in primary health care provision, there are questions as to how effectively the implicit models and philosophy of 'women's health' have been adopted by the core of mainstream services, which are not particularly gender-sensitive. One example is the ongoing focus of national health goals and targets on the traditional concerns of childbirth, gynaecological health and women's cancers. While women's health services have begun to meet this challenge of tackling the gendered nature of all illness, there has perhaps been some reluctance on the part of both women's health and the mainstream to take on so large an agenda.

The dual strategy has been a potent and powerful concept, allowing the privacy and power of separatism and at the same time granting a legitimate position of influence in relation to the mainstream. The practice, however, has proven complex and, at times, questionable in its impact. In the British context, Doyal (1994: 140) doubts whether medical opinion has altered to acknowledge women's changed perceptions of health and healing. She argues that feminist analysis has had little impact on British doctors' practice. There is an ongoing need to build and maintain networks into core areas of resistance, such as the acute health sector, and find ways to collaborate. For instance, if women's health services were recognised as unique sources of quality data about the needs of particular groupings of women, this could form a basis for collaboration within the increasingly market-driven, customer-focused health system.

Interestingly, this policy framework is now being paralleled in the men's health movement. The Draft National Men's Health Policy acknowledges that (Commonwealth Department of Human Services and Health 1996: 45):

> an analysis of the interaction between gender and health has proved extremely useful in the area of women's health. It afforded a new insight into the health of a significant segment of the population. By extending this analysis to . . . men it may be possible to achieve further improvements in health.

The Draft proposes the adoption of a policy based on the social model of health, the links between masculinity and men's health, and strategies including the establishment of 'targeted initiatives and services aimed at meeting men's health needs and modelling best practice for promulgation in mainstream services', both key platforms of the NWHP.

There are concerns held by some women's health activists as to whether the imitation is a form of 'flattery', or is in fact a key challenge to the complex notion of inequity on which the women's health policy was framed, and a bid for the scarce resources allocated to women-specific health services (Moore 1994). However, many women's health activists, while questioning the reliance of the men's health movement on simple mortality data, see positive signs in the developing recognition of gender as a social determinant of health status (Moore 1994; Broom 1995), a trend that may trigger the better development of both women's and men's health policies.

Conclusion

Whatever form it takes, policy in relation to women's health in the future will need to continue its links with the expressed needs of women in the community if it is to have an ongoing impact on the delivery of better health outcomes for women. The past 20 years of activism by Australian women has inserted and consolidated the view that women have common (though diverse) needs that are not the same as those of men. The future challenges will encompass a maintenance of the social view of health, the integrity of women's experience, as well as greater understanding of the complexity of difference and diversity within the gendered health arena. It also entails the inevitable necessity of taking on contradictions and ambivalences—of being in constant renegotiation of positions and meanings as previous blindspots and points of exclusion are brought into view.

The women's health movement has struggled to challenge and change entrenched patriarchal medical practices, to instil the importance of listening and responding to women's voices, to view women's health holistically and not just in terms of biological and medically defined models, to provide services by and for women, and to cater for women's cultural and ethnic diversity. The Proudfoot challenge to specific women's health services has now been overtaken by market reforms, funding cuts and changes to women's health funding mechanisms. Cuts to services—especially for rural women—and 'capture' by the acute care sector (with early hospital discharge) has the potential to undermine the gains made over 20-plus years. Although the rhetoric of market reforms preaches responsiveness to consumer demands, these may be limited to the minority who can pay for services.