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Social movements and the Whitlam-initiated community health movement in Australia

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ABSTRACT

Background. This paper examines the social movements that influenced the development and implementation of the original Whitlam Government Community Health Program, the community health movement that emerged, and the opportunities it created for people to develop and deliver health programs in new ways. **Methods.** Oral history interviews with 93 people involved in community health in South Australia, Victoria and New South Wales, and 212 community health policy and archival documents were collected as a part of an Australian Research Council study documenting the history of community health services in Australia since the 1970s. **Results.** Ideas about community health in Australia were influenced by several social movements that had overlapping, but distinctive, contributions: (1) left-wing movements: political parties, workers' health; trade unions, anti-war and anti-establishment; (2) international social medicine and community-oriented primary care; (3) Indigenous rights/Black Power; (4) feminist; and (5) community development/community power. These movements influenced Australian community health to embrace community management, advocacy and community development strategies in addition to multi-disciplinary care. However, these progressive elements were undermined by neo-liberal management reforms and medical opposition to elements of the Community Health Program. **Conclusions.** The early passion for community health in the 1970s and 1980s was fuelled by social movements, but the inconsistent support from the federal and most state governments limited progressive and innovative community health practice. The window of opportunity for the Community Health Program was supported by progressive social movements, but restricted from the 1990s onwards.

Keywords: community health, health equity, health policy, health promotion, medical power, social determinants of health, social movements, Whitlam.

Introduction

In 1973, the incoming Whitlam Australian Labor Party (ALP) government established a national Community Health Program (CHP), with the aim of improving access to health services and promoting better health outcomes across Australia. Over 700 projects were funded, including community health centres in metropolitan and rural areas, women's refuges and health centres, family planning services, specialist training for general practitioners, foundation chairs of community medicine in universities, and multidisciplinary training. This development resulted from both the determination of the ALP to change how health services were delivered, and the advocacy and influence of a range of social movements demanding change, focused on expanding community-based health services, and adding their distinctive role and methods to existing health systems. Key features included:

1. **Establishment of community health centres**: The program funded the creation of community health centres, which were designed to provide comprehensive care, including preventive care, health promotion and community development, and to involve community members in the management of the services.

Collection: Models of Community Health in Action

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2. **Holistic approach**: It emphasised a more holistic approach to health care, addressing medical needs, and also social and environmental factors affecting health.
3. **Funding and support**: The program allocated significant federal funding to support the development and operation of these centres, with the goal of reducing the reliance on hospital-based care and improving healthcare accessibility.
4. **Primary health care focus**: The program highlighted the importance of primary health care as a foundation for the health system, aiming to provide services closer to where people live and work, and introduced multidisciplinary teamwork as part of health care.
5. **Collaboration with other services**: Community health services were encouraged to link with other services, including housing, social services and education, to address the broader determinants of health.

We understand a social movement as 'a loosely organized but sustained campaign in support of a social goal, typically either the implementation or the prevention of a change in society's structure or values' (Turner *et al.* 2020), and so can be applied to the groups that formed before and in response to the CHP, and evolved as the community health sector developed. McAdam *et al.* (2021) note three broad factors that are helpful in analysing social movements. First, political opportunities and constraints confronting the movement, and how social movements are shaped by the broader set of political constraints and opportunities unique to the national context in which they are embedded. They then note the importance of mobilising structures, which are the informal and formal types of organisation available to actors. Finally, they point to the framing processes, which are the collective processes of interpretation, attribution and social construction that mediate between opportunity and action. We will cover each of these features in our discussion of the Australian community health movement. This paper examines the social movements that influenced the development and implementation of the original CHP, and the community health movement that emerged, which created opportunities for people to develop and deliver health programs in new ways. In this paper, we examine the question of how a variety of social movements, active in the 1960s and 1970s were able to both contribute to opening a window of opportunity (Kingdon 2014) for a progressive health movement, and also respond to the open window for such reform offered by the reformist Whitlam ALP government.

Methods

This paper draws on oral histories and archival materials collected as a part of an Australian Research Council study documenting the history of community health services in Australia since the 1970s, based on oral history interviews with 93 people involved in community health in South Australia, Victoria and New South Wales (see Table 1) from the 1970s with all interviewees having at least 5 years, and in most cases many decades, of experience; and >212 community health policy documents and archival materials. This paper only reports on the material relating to the ways in which civil society supported and advanced the ideas of the community health movement.

Interviews

We selected interviewees who had extensive knowledge of the history in the community health sector in Australia federally and in three states (New South Wales, South Australia and

Table 1. Oral history interview and focus group participant characteristics and experiences.

Participant experience/characteristic	*N*	%
Gender		
Male	40	44
Female	53	59
Aboriginal	5	6
State/national/international experience[A]		
South Australia	31	34
Victoria	42	47
New South Wales	21	23
Other state/territory	4	4
National	15	17
International	21	23
Community health experience[A]		
Generalist community health	67	74
Aboriginal community health	11	12
Women's community health	22	24
Workers' community health	3	3
Community mental health	5	6
Profession[A]		
Medical doctor	21	23
Social worker	15	17
Psychologist/psychiatrist	3	3
Allied health[B]	17	19
Nurse	10	11
Academic/researcher	22	24
Government bureaucrat/advisor/policymaker	30	33
Former federal/state politician	6	7
Other	2	2
Total	93	100

[A]Categories are not mutually exclusive, totals >93.
[B]Allied health includes: nutritionist, health/health promotion education, teacher, physiotherapist, speech pathologist and Aboriginal health worker.

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Victoria) where the community health sector has been strongest. Contact details were retrieved from web searches or professional networks. Interviewees provided informed consent prior to the interview, with most waiving their right to anonymity. A semi-structured interview guide was developed that covered the interviewee's role over time in the community health sector, and their perspective on community health, equity, community development, multidisciplinary teams, governance, funding and political support. Sixty-eight interviews were conducted face to face or by videoconference and lasted approximately 1 h. Four focus groups were conducted (3 in South Australia and 1 in Victoria) with a total of 13 participants. An additional nine interviews conducted on the history of community health in Victoria prior to the research project were included in the analysis, making a total of 93 participants (details see Table 1).

Thematic analysis

Thematic analysis of the interviews was aided by QSR NVivo 12, and focused on the participants' comments on the early history of community health and the social movements they saw as important in its development. Archival materials were used to illustrate themes identified in the interviews.

Ethics approval

Ethics approval was received from the Flinders University Human Research Committee (Project No: 4168), Aboriginal Health Research Ethics Committee (AHREC Protocol: 04-22-974) and the Central Australian Human Research Ethics Committee (HREC Reference Number: CA-22-4379).

Results

Our analysis indicates the diversity of social movements that contributed to the development of the 1973 CHP and its implementation. We describe these movements and the ideologies they brought with them, and then examine how they shaped the CHP and the subsequent evolution of community health services in Australia and the Australian community health movement. These social movements were working against a background of broader politics shaping community health, which have been described by Sax (1984) and DeVoe (2003). Key policies and events shaping and supporting community health in Australia from the 1970s until 2020 are summarised in Table 2.

This timetable shows that what became the community health movement had strong government support from the Whitlam government, but little from the Fraser Liberal government. The following Hawke government's attention shifted to the establishment of Medicare and responding to the HIV/AIDS crisis. The subsequent period has been dominated by health policy focused on hospital and GP

Table 2. Key policies and events shaping community health in Australia from the 1970s until 2020.

1970s
• Establishment of first Aboriginal medical service in Redfern – first ACCHO and first community controlled medical service in Australia
• Aboriginal Tent Embassy erected in Canberra, outside former Parliament House
• After the 1967 Referendum, the 1971 census included Aboriginal and Torres Strait Islander peoples
• Election of Whitlam ALP government in 1972
• Establishment of Hospital and Health Services Commission established in 1973
• A Community Health Program for Australia – Report of the Interim Committee of the National Hospital and Health Services Commission in 1973
• Medibank established in 1974
• National Aboriginal and Islander Health Organisation established in 1974 (NACCHO's predecessor)
• Election of the Fraser Liberal/National Party Coalition government in 1975
• First national women's health conference held in Brisbane in 1975
• Medibank general strike called by ACTU in 1976 to protest changes to Medibank (first national strike in Australia's history)
• Women's health unit established in the Commonwealth Department of Health (1977)
• NSW Community health 'blue books' (1977)
• Opening of first workers' health centre in Sydney (1977)
• 1978 WHO Alma Ata Declaration on Primary Health Care outlined a comprehensive approach to primary health care
1980s
• 1981 saw the withdrawal of the Commonwealth from the Community Health Program subsumed in state health tax-sharing grants
• Introduction of Medicare universal health insurance scheme in 1984
• Formation of the Australian Community Health Association in 1984
• 1984: Commonwealth funding for Aboriginal health consolidated within Department of Aboriginal Affairs with a plan to fund ACCHOs directly
• Establishment of first National Women's Health Program in 1988
• National Women's Health Policy: Advancing Women's Health in Australia and the National Aboriginal Health Strategy released in 1989
1990s
• Decade in which neo-liberal measures were adopted by federal and state and territory governments, and undermined community controlled health centres, especially under Kennett in Victoria and Howard federal government, leading to increased corporatisation of community health
• ATSIC established in 1990 by Hawke government, bringing many Aboriginal and Torres Strait Islander programs and policies under the one portfolio agency
• Incorporation of National Community Health Program into Community Organisations Support Program 1990–1991
• Introduction of General Practice Reform Strategy in 1991
• NACCHO established in 1991 as the new national AMS umbrella organisation replacing the National Aboriginal and Islander Health Organisation

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Table 2. (*Continued*).

• Paul Keating's 'Redfern speech' in 1991 (first acknowledgement by an Australian Government of the dispossession of its First Peoples)
• 1992–93, the Australian Government committed funding for the establishment of the Divisions of General Practice
• Responsibility for provision of women's health services handed to states in 1997 although Commonwealth continued to contribute funding through National Public Health Partnership
• Defunding of Australian Community Health Association in 1998
• A Stronger Primary Health and Community Support System: Policy Directions, Victoria, 1998
2000s
• Introduction of private health insurance 'Lifetime Health Cover' legislation in 2000
• Abolition of ATSIC in 2004
• Launch of Close the Gap campaign in 2007
• WHO Commission on the Social Determinants of Health in 2008
• GP Super Clinics: Better health care for Australians. National program guide
• NSW Integrated Primary and Community Health Policy 2007–2012
• Creating a healthier Victoria: Community Health
• 'Towards a demand management framework for community health services', Victoria 2008
2010s
• Period of rapid change of federal governments and prime ministers
• GP Plus Super Clinics established in 2010
• Australia's first national primary health care strategy released in 2010
• Medicare Locals replaced Divisions of General Practice in 2011
• Australian National Preventive Health Agency established in 2011
• National Preventive Health Agency abolished by Liberal Abbott government in 2014
• Review of Medicare Locals in 2014 led to Medicare Locals being replaced by 31 Primary Health Networks in 2015
• South Australia Review of Non-Hospital Based Services (McCann review, 2012) which led to South Australian community health centres defunded and transformed into intermediate care centres
• Victorian 2015 Community Health Integrated Program Guidelines: Direction for the Community Health Program
• In 2016, Aboriginal and Torres Strait Islander leaders issued the Redfern Statement, calling for Aboriginal and Torres Strait Islander autonomy, and community control, and the Closing the Gap 'refresh' process commenced
• Community health Program – Victorian Auditor-General's Office, 2018
• Victorian Community Health Taskforce report 2019
• NSW Women's Health Framework 2019
2020s
• COVID-19 pandemic declared by WHO in 2020
• Community Health services in Victoria vital to COVID responses for marginalised communities
• Community Health services continue as key component of Victorian health system, as seen in Community Health Reform Plan 2020–2024; Community Health – Health Promotion 2025–2029.

care. The community health sector has been marginalised at a national level. There was some support in NSW through state health department services, and in South Australia (until 2010s) and Victoria (ongoing) through autonomous non-government community health centres. The Aboriginal community-controlled sector has grown from strength to strength from the 1970s until the 2020s (Mackean *et al*. 2025).

Social movements that informed community health

Ideas about community health in Australia were influenced by a diverse range of social movements that had overlapping, but distinctive, contributions. Our study indicates five broad groupings: (1) left-wing movements: political parties, workers' health movement, trade unions, anti-war and anti-establishment; (2) an international social medicine and community-oriented primary care movement; (3) an Indigenous rights/Black Power movement; (4) a feminist movement; and (5) community development/community power movements. An overview of what these movements brought to the Australian community health movement is shown in Fig. 1.

Left-wing movements: political parties, workers' health movement and trade unions, anti-war and anti-establishment

Throughout the 1960s, a range of left-wing movements argued for a universal affordable health system and drew on the social medicine ideas described in the following section laying the ground for the CHP. In Victoria, the community health movement was very entwined with the ALP. David Legge (established District Health Program in Victoria and subsequent health policy academic) describes how ALP members were important in many community organisations receiving federal CHP funds and establishing community health centres, as the Victorian Liberal Party government initially chose not to receive CHP funds directly. He also notes that a significant number of communists and ex-communists were involved in the community health program in Victoria, and brought organisational skills and a sharp political economy of health analysis to its development. Brian Howe (ALP Minister of Health 1990–1993) described how in the 1970s and 1980s, some in the ALP were influenced by Saul Alinsky's community organising ideas (Alinsky 1971) and 'were willing to join hands with the community health movement'.

In the 1960s in NSW and Victoria, trade unions recognised the impact work could have on workers' health, and formed health centres that provided models for subsequent community health centres. One of the first CHC in Australia was founded in Melbourne in 1964 by the Victorian Branch of the Australasian Meat Industry Employees Union as the Trade Union Clinic and Research Centre. The first medical director of this centre, Dr Moss Cass (from 1964 to 1969), subsequently became an MP, and was a minister in the Whitlam government. Cass was part of the left faction of the ALP, and championed the CHP. In the

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Fig. 1. Australian community health program and contributing social movements.

early 1960s, he had proposed a UK-style National Health Service for Australia (Cass 1964). The impact of the Trade Union Clinic and Research Centre was acknowledged by Dr Maureen Davy (GP) when she said: 'It always felt to me like the community health program, and the CHC were modelled on this health centre that had been set up by the Meat Workers Union'. She supported this view with the experience she gained in the centre:

> As a young doctor it was a very exciting place to work. I was one of seven GPs, there was a full-time physician, a full-time orthopaedic surgeon because of all of the meat workers being injured at work. The health centre also had its own pathology and radiology. Everything I needed as a young and inexperienced doctor was right there. Many of my peers were spending these early years in hospital training posts. I felt very fortunate to be able to gain general practice experience and skills in a community based, multidisciplinary and political environment.

Liverpool Women's Health Centre partnered with union and occupational groups to form the Industrial Health Group in 1975 and to establish the Workers Health Centre in Lidcombe, Sydney, in 1977. Ben Bartlett, a GP at both centres in the 1970s, spoke of the importance of organising multicultural workers:

> One of the first things that we did very early, with the Worker's Health Centre, was we got a small grant from the premier's office to produce multilingual leaflets about hazards, which I think is the first time that had happened. And that didn't come from our smartness, that came from the fact that we were dealing with Turkish workers and South American workers, and it was clear to them that they needed information to give to their community members, which I feel was actually quite a good example of why this interface with the community is really critical, in terms of the community being able to get some understanding and being able to organise amongst themselves.

The natural fit between the workers' health movement and emerging community health movement was evident when funding for community health services came under threat in 1978 in NSW. The Save Community Health Campaign mobilised in response to NSW government proposals to 'delete' 400 community health positions after the federal Fraser government cut its contribution to the CHP. As members of their trade unions, community health workers secured their support for the campaign. Michael Howard (NSW Department of Health public servant) recalled 'We held this big rally outside Parliament House. Macquarie Street was closed for 2 or 3 hours. It was on the evening news, the whole thing ... now there's only about 2000 community health workers in NSW. But what gave it much more potency was the NSW Nurses Association, the Assistant Secretary was quite sympathetic', and the deep links between it and the Public Service Association union with the ALP enabled a rapid

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meeting with Premier Neville Wran. Denise Fry (policy officer, Australian Community Health Association) remembers that 'The unions gave us money for the Save Community Health campaign, the Public Service Association and the Nurses Association gave us money to help us print things and produce a newspaper. The Railway Workers Union – I went to talk to them, and they stopped the trains for an hour for us'. A community health worker from Port Adelaide described how threats to the women's health centre were warded off when members of the Waterside Workers Union threatened to strike, highlighting how the solidarity between social movements based on shared ideals contributed to building and strengthening the centres.

Many of our interviewees commented on the zeitgeist of the 1960s and early 1970s with hippies and flower power. They referred to the anti-Vietnam war and conscription movement, green bans (especially in Sydney), and resident action groups, which were part of the building mood for change. Victorian GP, Nick Crofts, speaking of the 1970s recalled 'there was the Doctors Reform Society, there was the community health movement, I was a draft resister, and that was all part of the same package. And I think – I don't know that I distinguished the one from the other, they were all part of the same movement'. Peter Ruzyla (CEO community health service Victoria) spoke in a similar vein of the convergence of ideas from different directions, including Paulo Freire's book Pedagogy of the Oppressed, with its radical ideas for education and community development, and the establishment of neighbourhood houses in Victoria. He noted:

> So, you've got influential people in academia, in health, in senior bureaucratic positions in education and health. And I think the confluence of those things, and you have the power of the unions at that time – You've got this melting pot of existential, social justice, liberal sort of thinking going on – small l liberal thinking going on. So, I think the community health sector was almost bound to emerge out of that.

GP, Ben Bartlett, captured the general mood for change: 'the trade union movement was a lot stronger then, as well. A lot of those might not have been specifically involved in advocating particularly for community health, but the whole environment was open for these fertile debates and discussions and change'. He also spoke of the way in which the Liverpool Women's Community Health Centre 'was very supportive in doing a lot of the work to actually get the Workers' Health Centre going in Sydney' because of the number of migrant women with occupational injuries being treated in the staff visits to factories. Gary Foley (Foley 2001) has also commented on how international social movements were important to the Black Power movement:

> The late 1960s saw student rebellion in Paris, riots at the Democratic Convention in Chicago and the emergence of the American Black Power movement. In both America and Australia demonstrations against the War in Vietnam bought together elements of black and white political activists. … They were 'influenced by the anti-colonial movements in India and Africa' and writers like Franz Fanon, Jean Paul Satre and Camus.

Ian Lennie, former Executive Officer of the Australian Community Health Association (ACHA) summed up the convergence of social movements, saying: 'a lot of the driving force of community health needs to sort of be understood in the light of the late '60s and '68 and the student movement, the women's movement. A general feeling – not just in Australia but around the world that things were in a bit of a straitjacket and needed to change and, I think, community health is probably best seen as part of that'. The workers' health movement of the 1960s and 1970s laid the foundation for the occupational health and safety reforms of the subsequent decades (See Table 2).

Social medicine and community-oriented primary care

The international social medicine movement had deep roots from at least the 1930s, and was illustrated by the Peckham Health Centre (Pearse and Crocker 1985), formed in the 1930s to provide a holistic community health and community centre in a high deprivation area of southeast London. It was founded on the idea that only changes in a person's environment could create health. Former NSW Health Minister, Andrew Refshauge, noted the role of the Centre:

> I think the first community health service in an English-speaking area was the Peckham Experiment in Britain. Which was basically bringing doctors and allied health professionals together. So, saw that there was a broader issue rather than the doctor stuff. And I think that's been the guts of a lot of it for a long time.

Sidney and Emily Kark's development of community-oriented primary care at the Pholela Health Centre, South Africa, also had an influence in Australia (Tollman 1994). The centre focused on infectious diseases, maternal and child health, and prevention (especially regarding nutrition), with a focus on social and cultural determinants. The centre was successful in reducing infectious diseases and infant mortality, despite adverse social conditions (Kark and Cassel 1999). The main public servant who was the architect of the CHP, Dr Sidney Sax, had direct experience of the work of the Karks in South Africa (DeVoe 2003).

Greg Stewart, a public health physician and former director of planning in two NSW regional health authorities, noted the influence of Welsh GP, Julian Tudor Hart, 'whose articles in the early 70s, one called 'A New Kind of Doctor', and the other one about the inverse-care law …. was really influential in moving people along in the early 70s in the direction we're talking about here.' In the US, community health centres

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(CHC) were started in Mississippi in the 1960s by Jack Geiger, modelled after the Karks' South African centres (Lefkowitz 2007). The US centres not only treated sick patients, but also dug wells and privies, established a library, and a variety of other social, educational and economic services. Howard Gwynne, central to setting up community health in NSW, visited CHC in the US, and met and was inspired by Jack Geiger. The experience from the US was an ongoing influence on the community health movement in Australia. Elizabeth Furler (many senior public service positions, including Director of the South Australia Social Health Office in the 1980s) spoke of the influence of the North Carolina experience of Nancy Milio, who conducted an in-depth analysis of the CHP (Milio 1983). The 'community health centres and the way they provided organising points from black communities in particular but also under-resourced, socially and economically disadvantaged communities ... was a very important source of learning'.

Brian Stagoll, a psychiatrist and central figure in the Victorian community health movement, noted the importance of community mental health models from overseas: '...Kennedy's Community Mental Health Act, which set up community mental health centres all over America. I mean, this was a really enormous investment, and, I would say community mental health models often led the way in focusing on community and into the critique of medical dominance'. He also noted how 'legendary projects', such as the Martin Luther King Community Health Centre, the Lincoln Hospital in the Bronx and the Medical Community for Human Rights (which came out of the southern Civil Rights movements), had greatly influenced his approach in community health.

The influence of social medicine and community-oriented primary care was also seen in key figures in the Australian community health movement who had been engaged in missionary or development work in Papua New Guinea and the Pacific. Such experiences were spoken of by Dr Elizabeth Harris (a social worker who became a leading health equity and community health advocate in NSW), Professor Bob Douglas (Professor of Community Medicine), Dr Tony Adams and Dr Bill Piggott (first Director of the Foundation for Multidisciplinary Education in Community Health and subsequent long-term WHO staff member). Dr Tony Adams (who became the Australian Chief Medical Officer) described how, during medical school, he travelled to Asia and Papua New Guinea, and saw the need for prevention of communicable diseases, such as malaria and tuberculosis. A further key influence was Ken Newell's book, *Health by the People*. Dr Newell was from New Zealand, and had close ties to Australia through the ANZ Society for Epidemiology and Community Health. Through multiple pathways, the international social medicine and community-oriented primary care movement had a significant influence on the Australian community health movement, but never achieved the political influence the social medicine movement had in the US, as we have shown previously (Anderson *et al.* 2025).

The social medicine movement did, however, influence the World Health Organization's 1978 Alma Ata Declaration on Primary Health Care and 1986 Ottawa Charter for Health Promotion, which were important to the community health movement, as they linked Australia's CHP with international developments in primary health care. As Denise Fry stated, 'we looked to the WHO and to the Alma-Ata Declaration, and the Ottawa Charter – we used that as a scaffold for our work. Knowing that there was an international community health movement sort of carried us along – or gave us more confidence that community health wasn't our personal fantasy, but other people thought it was a good idea too'.

Indigenous rights and Black Power movement

Aboriginal and Torres Strait Islander peoples have always resisted the colonial invasion of Australia. A land rights and Black Power movement grew in strength throughout the 1960s, linked to international movements. Ian Anderson (key Aboriginal senior actor and bureaucrat) noted that the Aboriginal rights movement was linked with the US Black Panther Marxist-Leninist political movement. Gary Foley has written eloquently about the Black Power movement in Australia. He defined that movement as 'the loose coalition of individual young indigenous activists who emerged in Collingwood, Fitzroy, Redfern and South Brisbane in the period immediately after Charles Perkins' 'Freedom Ride' in 1965' (Foley 2001), and how it radicalised a generation of black activists, including in relation to health. The powerful ideology of self-determination led to a call for Aboriginal controlled health organisations (ACCHOs). The first of these was formed in Redfern in Sydney in 1970. Others followed, including the Central Australian Aboriginal Congress in Alice Springs, which drew explicitly on Gandhian decolonialising philosophy. These services recognised the importance of self-determination, and the need to act on social and cultural determinants of health to realise Indigenous peoples' right to health. The gap in life expectancy between Aboriginal and Torres Strait Islander peoples and non-Indigenous Australians in 1970 was estimated at approximately 17 years. ACCHOs provided long-term advocacy for Aboriginal health, especially through the National Organisation of Community Control Health Organisations (NACCHO). A GP who had worked most of his career in Aboriginal health observed 'I think it was a natural fit for Aboriginal activists in the 1970s, who were wanting to do something about a whole range of issues affecting Aboriginal people, but health was a major priority. They recognised that Aboriginal people were not being served well by the health system at the time. It was impacting on mortality and morbidity'.

Feminist movement

The women's health centres in Australia emerged from grassroots feminist movements, and its development and struggles have been described in full elsewhere (Broom 1991; Gray Jamieson 2012), and the movement of health

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professional and management staff from these centres into generalist centres reinforced the influence. In each state, Women's Liberation groups established volunteer- and women-led health and social services in the 1960s and 70s, which pre-dated, and advocated for, funding from the CHP. Most famously, in the early 1970s, 'Control', a women's health collective focused on abortion referral, contraception and women's health information, formed in Sydney. Control established the incorporated body, the Women's Health and Resource Foundation, to serve as an umbrella organisation for funding and administrating new women's health centres – including the Leichhardt Women's Community Health Centre in March 1974 (Leichhardt Women's Community Health Centre n.d.). As Table 2 shows, women's health became institutionalised through specific services, policies and advisory voices to government. Its importance in public policy has been detailed by Gray Jamieson (2012), and by Hester Eisenstein (Eisenstein 1996), who describes the development of the uniquely Australian 'femocrat' movement, which increased women's political representation and was key in the development of women's health policies, legitimising a feminist voice in parliament, and an avenue for women's health centres to influence policy and funding. Many interviewees commented on this influence to community health more broadly in terms of the model of care offered by CHC, management by boards of community members and the ways in which feminist approaches to health challenged standard medical care. Miranda Rowe (former director, The Parks Community Health Service in Adelaide) notes how she was influenced by the work of the Boston Women's Health Collective and the book, *Our Bodies, Ourselves*, they produced:

> Just even that notion of *Our Bodies, Ourselves*, that whole thing of 'I can. It's my business,' and that changes the relation with the expert, that was so significant and even to the unheard-of thing of asking somebody, 'What do you think? What's your experience of this?' Just at that level, that was a radical act to ask those questions rather than go, 'I can see you but what's the matter with you?'

Maureen Davey, who worked extensively as a GP in CHC, recounts '2 years later, for my medical school elective I went to Santa Cruz in California and worked in a feminist women's health centre there for a summer. So my involvement in community health was born out of feminism and women's health'. Chloe Mason spoke about the ways in which the feminist movement had made her aware of female disadvantage and the neglect of women's health needs by the mainstream medical system. She also said Aboriginal women in Redfern had a big impact on her understanding of community health. Our interviews contained many references to the importance of the feminist movement on understandings of sexual and reproductive health rights, and violence against women. Judith Dwyer (CEO, Women's Hospital and right to choose activist) spoke of the importance of the women's health movement to securing the right to abortion. Sue Rosenhain (women's health services executive) spoke of the importance of a group, Health Action, in the early 1970s that 'was kind of taken over by some amazing feminists, in particular Bonnie Hull and Zelda D'Aprano ... and insisted on – and it became, in a way, a feminist consciousness raising group, which was quite unique in terms of allowing men to participate'. The influence of feminism on government policy and funded services in Australia was greater than in other countries, according to Judith Dwyer (CEO, Women's Hospital), who referred to Eisenstein (1996), saying that in Australia 'the women's movement got its claws into government as a way of progressing its agenda'.

Community development and community power

The 1960s saw interest in applying community development and community power ideas across a wide field, including in improving health and wellbeing. This interest included the principle of community management of community health services (Laris 1995). The South Australian focus group members emphasised the importance of the radical social work movement in the emergence of community development as a crucial strategy, which was in the 1970s and 1980s accepted as legitimate by government. Community development provided an effective means of services reaching out to communities who otherwise found them inaccessible. The Australian Assistance Plan (another Whitlam government reform) was also based on community development principles and complemented the CHP (Collins and Oppenheimer 2019), with both receiving strong policy and political support.

The ideas of Paolo Freire (Freire 1972) influenced some in community health. Elizabeth Harris (social worker and researcher) described her membership of the Port Moresby Community Development Association, which invited Freire to their meeting, and how she was 'influenced by him quite a bit' in her subsequent work. Angela Lawless (speech pathologist and researcher) noted when she first worked at the Parks Community Health Centre, South Australia, in the mid-1980s, there was 'a strong sense of collective power, collective energy, collective responsibility to a group; not just to individuals'. In Victoria, the initial state government's decision not to accept federal CHP funds as part of its state health budget meant that, as an alternative, community groups organised to receive federal CHP funds directly. Anne Re, who worked at Sebastopol CHC, noted: 'the characteristic of Victorian society is for community-based action, and community people having a voice'. Vera Boston (CHC CEO) describes the feeling of the 1970s:

> It was all that, 'power to the people', it's part of the same kind of thing of devolution of services, local control, all of that. It was a huge social movement that had been building throughout the late 1960s and in a way the election of the Whitlam government in 1972 unleashed

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> all that pent up energy after I think, was 24 years of conservative governments in Australia.

The CHP embraced the importance of community involvement and many of the CHCs and services funded, especially those in South Australia and Victoria, used community organising and development strategies, and employed people in these roles. Paul (2014, p. 48) commented that in the 1970s and 1980s 'the community development paradigm reigned supreme' (p. 50). He describes how at the Kensington CHC in Melbourne, every staff member, even the doctors, had a component of community work in their week. The purpose he notes was 'to enact broader systematic change that would benefit not just individuals but the whole community'.

The women's health and Aboriginal health movements were examples of community power in action, as they emerged directly from community demand for different forms of health services. One GP spoke of how the ideas that influenced him 'were the ideas of our community, of people having control over their own lives, of the decisions which affect people's lives are better if they are made closer to where people are'. He said when he went to work at an Aboriginal community-controlled service, he found 'here is an organisation which is actually putting this into practice'. The influence of community development was highlighted by Bill Newton (CHC CEO) in his description of the range of activities at the West Heidelberg Community Health Centre:

> We had a whole lot of community services: we had an Auxiliary, we had an Op Shop, we had I think childminding all done by volunteers. We used to drive people to the Vic market on our bus, on weekly shopping trips, that sort of stuff. All with volunteers from the community. In those days it was the sort of place that, when something happened in West Heidelberg, people would say, 'well, what's the Centre gonna do about it?'. The assumption was, that was the body that did stuff for the people of West Heidelberg. … The place was always full of people coming in and doing stuff and providing a base for all sorts of small organisations.

Meredith Kefford, manager at Brunswick CHC in the 1980s, recalled how 'If the council, or any other group, was wanting to do, wanting advocacy, or to pick up an issue, community health was where you would go'.

Emergence of a community health movement

A community health movement emerged from the strands of the social movements and the experiences of people working to put into practice the community health approach, often against considerable odds. The ideas that coalesced and overlapped in the social movements provided a theoretical starting point for people to critique the health system and consider needed changes. Each movement challenged the existing distribution of power – the feminist movement in terms of patriarchy and men's power, the Black Power movement in terms of colonialism and white power, the workers' health movement through industrial rights to health and safety, and the community movements questioning the power of existing medical institutions. All emphasised the importance of social and economic determinants of health.

The influence of the contributing social movements was amplified by their overlapping and convergent nature. The community health movement specifically challenged private practice, for-profit health services, the biomedical and bureaucratic power structures of hospitals, and the lack of attention to prevention and social and emotional aspects of health. The most formal part of the movement was the establishment of community health associations. The state-based Community Health Associations, which were set up from the early 1980s in NSW, Victoria and South Australia, and later in Australian Capital Territory, Queensland, Tasmania and Western Australia were focal points for organising, exchange of information through newsletters, seminars and conferences, and advocacy with health bureaucracies, politicians, the media and communities. Broderick and Laris (1995) describe how the South Australian Community Health Association allowed its members (still largely government employees) a voice in public debates about health, and in lobbying government and bureaucracy to defend and advance community health. The national organisation, the ACHA, was formed in 1983 with the hope of influencing the recently elected Hawke ALP government and received secretariat funding from the federal Community Health Program from 1984 to 1997. It produced issues papers, conducted research and established the Community Health Accreditation and Standards Program (a national quality assurance program explicitly based on the principles and values of community health), and it was part of the Australian Healthy Cities program to develop local intersectoral collaboration. The ACHA also held conferences, and lobbied politicians, bureaucracies, and the public to promote and develop the community health approach (Baum *et al.* 1992). The roots of the community health movement in idealist and activist social movements can be seen in the South Australian Community Health Association's adoption of a flying pig as their logo (Fig. 2), to denote that community health services would be the dominant model when pigs did fly!

Many interviewees spoke of the importance of the ACHA as a focal point for organisation and advocacy. Sometimes this was tinged with regret that it did not survive to achieve more against the countervailing forces. Such views were summed up by Elizabeth Becker, a community health worker at Noarlunga Health Services: 'I was involved with that for a little bit, and I loved it. I enjoyed it a lot. But I kind of feel like we mustn't have made the most of it somehow, because where are we now – we failed, we must have. But it was good. But I guess, maybe we were on a hiding to nothing always, and that

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Fig. 2. Examples of South Australias Community Health Association badges from 1980s.

it was always going to be something that came and went'. The ACHA led to networks being formed that were nurtured and reinforced through shared experiences and values, facilitating collaboration within and across states. As Denise Fry, ACHA policy officer, commented, 'I suppose the other thing about the Community Health Association, and the Save Community Health campaign, is that they were social movements. And like all social movements, people developed friendships, networks, found more meaning, found personal development'. When asked why he stayed involved in the ACHA after he no longer worked in community health, Rick Mohr (NSW community health policy) replied, 'Oh, good friends, political commitment, feeling we still had work to do and try make community health what it should be, and take it up to the hospitals, and the medicos, and change the world'.

Not all people employed in community health services had been part of or identified with the social movements discussed above, but became activists in their community or their state Community Health Association through their experiences of the series of funding cuts, bureaucratic reorganisations and unsympathetic policies that threatened community health services from the mid-1970s. Many of the people employed in the CHP were recent graduates from the social sciences, had not previously worked in hospitals and were open to new ways of thinking about health. They spoke of how exciting they found the late 1960s and early 1970s to be, and how they were inspired by social movements and believed real progressive change was possible. Lyn McKenzie captured this feeling when she said that the early to mid-70s 'was one of the most exciting times I've experienced, and it's never been quite as exciting as that. Good things looked as if though they would happen. Around the community there was a sense of the need for change and the need for much more fairness and justice for all.' This excitement was seen in the organisation, Student Initiatives in Community Health, a network funded under the CHP. Paul Laris, a former community health centre director, remembers, 'It was great for developing networks across students, people who were doing their placements in community health centres from all over the country and I think we had several national conferences. I remember Neal Blewett (Federal Health Minister 1983–1990) came and spoke at one of them which was terrific'.

Challenging medical and other power structures

The support of broader social movements was especially needed because of the forceful opposition it encountered, particularly from the Australian Medical Association, which opposed the CHP (Sax 1984; Milio 1986). The CHP stated that community health centres should offer services without fees, and such salaried medical services with no fees were perceived as a particular threat to private medical practice.

Michele Herriot, a former Director of Health Promotion in South Australia, noted that community health centres were 'called socialist medicine or seen as quite radical by the conservative AMA'. Brian Stagoll (community psychiatrist) recalled that many GPs opposed the CHP, and told of a very prominent surgeon who 'became President of the Doctors' Reform Society for a short time until his colleagues stopped referring to him, and he had to – for his practice's sake – give up and recant I think. Which was a bit sad'. He also noted that social medicine 'was always an underground stream – mostly suppressed, mostly underground. Occasionally it comes to the surface like it did in the mid-1970s and early 1980s in Victoria and Australia around community health'. David Penington, Professor of Medicine at University of Melbourne from 1970 to 1987, and one of the founders of North Richmond Community Health Centre in Melbourne in 1973 and 1974 described how 'We were bitterly opposed by the St Vincent's establishment … I ignored them and the hospital opposition'.

The medical opposition lasted into the 1980s, as seen by the Australian Medical Association opposition to the South Australia Noarlunga Health Village on the grounds it would offer 'barefoot medicine'. Terri Jackson, a former director of a Victorian CHC, noted 'It's making certain doctors salaried. That's a big challenge to the rest of the health care system. It's interdisciplinary, which is even hard to sell to community health doctors. … It challenges a whole lot of things about the dominant medical culture'. Ben Bartlett, a GP with extensive experience in community health, noted the tensions, saying 'working in a health centre … how you try and structure programs and that, that actually encourage the community to take some leadership. I think that's a global battle, with the medical profession really thinking they should be in control. So that's a recurring issue, I think, at the World Health Organisation level, as well as at local levels'. As Table 2 shows, most federal policy developments in PHC in the 1990s and 2000s concerned development of the GP workforce rather than community health centres. Support from the NSW and the

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South Australian governments also declined during this period. Since the late 2000s, however, the Victorian government has continued to review and develop policy that includes the community health sector, albeit while corporatising the sector, but still providing a window of opportunity for the sector to continue and grow.

Advocacy

Much of the cutting-edge work of community health was concerned with advocacy on behalf of communities, which also reflects the influence of progressive social movements and community health workers' experience in them. Advocacy was included in the aims of the CHP (Hospital and Health Services Commission 1973, p. 4–6). Its value was described eloquently by Kristine Olaris (CEO Women's Health Service): 'Advocacy is one of those words that comes in and out of favour and I try to use it because I like it. I think it's an important health promotion approach. Like, it's the thing you do, that can affect change. I think it's an important part of a democracy that organisations should be able to advocate for the people that they're delivering their services to. Advocate for, advocate with, advocate alongside, all of those things, but I think it's a really important role'. Vera Boston captured a similar mood when she said 'so, we've always been a bit bolshie ... a bit argumentative, not so deferential to authority'. Paul (2014) recounts the many advocacy activities of the Kensington CHC in the 1970s, including, for example, direct action against an energy corporation over increasing gas bills. The South Australian focus group described the Parks CHC's advocacy campaign against industrial pollution. In NSW, CHC staff were government employees, which limited their capacity for advocacy, and so the NSW Community Health Association became their main vehicle for advocacy and commentary on health issues.

Fading social movements and growing neo-liberalism

Strong explicit decisions by federal and state governments, along with opposition from groups with markedly different health policy priorities, curtailed the development of the community health sector (Milio 1992). Over time, they made it more difficult for the community health movement to pursue the original goals of the CHP, and eroded much of its initial reforming zeal and passion. A series of neo-liberal measures changed the focus of health policy, so that it was less open to the comprehensiveness of community health (Baum *et al.* 2016). Given this, not surprisingly, many interviewees expressed disappointment that community health practitioners were no longer able to be such effective advocates on health issues compared with the 1970s and 1980s. Many in Victoria expressed disappointment at the amalgamation of many CHC into large, more corporatised entities that were potentially less open to the ideas of community development and empowerment. Bill Newton noted that in the early days of community health:

> We made ourselves a base for all community activities that take place in communities but didn't have a base. Small, local organisations and everything that happens in a real community. And it just seems to me that that's the aspect of it that's been lost in these huge, corporatized health services.

Tim Walsh similarly noted that corporate organisational structures make it harder for local people to interact: 'The local community health services, yes, where the local people know the local people, but then when you've got a large sort of corporate type health service, I'm not certain how they gain access to it because it's a corporate structure'. One former worker spoke of how in earlier days, deep values of 'humanness' had been prevalent in community health rather than the 'machineness' that had come with neo-liberalism. The introduction of co-payments in some Victorian centres was also regretted and seen as a move away from the original CHP philosophy. Even in the Aboriginal community-controlled services, corporatisation was seen as a threat, and older staff bemoaned the fact that younger staff did not know of the radical roots of the community-controlled movement.

The early community health activists saw poking the bureaucracy in the side as fair game. In NSW, however, CHC staff were government employees and never able to directly advocate. South Australian focus group members described how their strong advocacy in the late 1980s and a change of minister prevented government plans for an amalgamated Health and Welfare Commission, which they feared would result in a reduction of services. Others came to see such activity as prompting pushback from authorities. Michele Herriot noted, 'Another sort of policy factor is that they're often very strong personalities in community health and they were primed to be strong advocates. That became a bit of a thorn in the side of – if you've got a Minister that was not interested'. Judith Dwyer, a strong women's health advocate who became a hospital chief executive, questioned whether the advocacy activities of community health were likely to be effective or strategic in the more neoliberal environment of the mid-1990s to 2000s, saying 'and what government would pay you to do that? Like I'm going to pay you to make trouble for me?'. Many of our interviewees expressed considerable regret that the latitude to be an advocate for many social justice issues had been lost in all jurisdictions; however, some remained in Victoria. Phillip Bain (Victorian CHC CEO) noted that much of their activities were 'highly political' and out of step with the mainstream health: 'we were considered as – the words 'basket weavers' used to keep coming up all the time. I think they thought we were a fairly peripheral and marginal operation and that we actually had very little to offer. But I think we wanted to

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move away from a more medical model'. He also noted that 'we didn't mind biting the hand that fed us, which always meant playing with fire'. Bill Newton (CHC CEO) spoke of the suspicion that advocacy created when he said some people said 'oh, look at that rabble of activists doing things that aren't anything to do with health. Indeed, the health department, I think, they were a bit wary of the more activist community health services because we were doing things that were nothing to do with the Health Department'. Jill Miller thought that the radical edge was lost, because 'people thought to get the message across they need to look more and feel professional in the medical model if you like to be heard by the medical model, but I think we lost ourselves a bit in that'. Kristine Olaris (CHC CEO) believed that there is still advocacy in Victoria, but 'in a more kind of softer advocacy way', but despite this 'all of the sectors of our team still go and wave our organisation flag at a rally or march or whatever'.

Advocacy has also been central to defending the very existence of community health centres. Some community health staff learnt the methods and value of advocacy through defending their services, and then extended these skills to other health issues. When women's health came under threat in Victoria in the 1990s, there was a co-ordinated campaign to defend it. Helen Keleher (academic researcher community health nurse) explained the way in which women in each region were organised and 'we accepted every radio interview that we were given for that day saying why women's health was so important. We had our script. The pressure was so big that within 48 hours she'd (the minister) changed her mind and women's health services have persisted ever since'. This description demonstrates the ways in which community health advocates were sometimes able to move the political agenda.

Discussion

Our analysis of the impact of diverse social movements on the development of community health services and what became a distinct community health movement shows that it fulfilled each of the functions outlined by McAdam *et al.* (2021). It created and pursued political opportunities, provided a structure for mobilisation, and contributed to a collective framing of the reasons a community health program was needed in Australia. It was also able to leverage the window of opportunity afforded by the reformist Whitlam government with the support of public servants, such as Sidney Sax, who had earlier established community health services in NSW. Each of the strands of the CHP were supported by ideas drawn from the social movements we identified. Placing health services in the community with community ownership drew on the social medicine, Aboriginal and women's health, and the community power movements. The multi-disciplinary focus was especially important to women's health. The idea of prevention was common to all the movements we have discussed, and central to the community development and community power movements. Each of the movements provided a wealth of lived experience and theoretical knowledge that fed into the CHP and its subsequent roll out. Thus, the social movements inspired many of the workers in community health in the 1970s and 1980s to challenge the prevailing medical model and to utilise a range of different strategies, including community development, advocacy and direct social action.

The contributions of the social movements towards an intellectual and lived experience critique of the existing medical and hospital dominated system generated momentum, which helped provide an enthusiastic and passionate workforce to put the CHP into practice and advocate for its continuation. Given the power of organised medicine (Turner 1995), having these countervailing forces was extremely important.

A dynamic community health movement evolved during the 1970s and lasted through the 1980s to the mid-1990s, but faded after that, completely in South Australia and with significant modifications in Victoria in response to government pressures. In NSW, incorporation with hospitals in area health boards compromised its original goals. The limiting impacts of neo-liberal policies on comprehensive PHCs have been described by Baum and Freeman (2022) and shown in Table 2. These policies used narrow monitoring measurements that were unable to capture the complexity of comprehensive community health services and limited their scope, curtailing their groundbreaking work in offering groups, community development and advocacy. Most of all, corporatisation of the services and extending their responsibility from local communities to larger regional populations constrained their ability for community-based management and local responsiveness.

Conclusion

Despite the early passion for community health in the 1970s and 1980s fuelled by several social movements, the inconsistent support from the federal and most state governments, together with funding cuts, bureaucratic reorganisations and corporatised management styles, limited progressive and innovative community health practice. Although in contemporary Australia there are social movements supportive of community health, including on-going feminist, refugees rights and LGBTQI movements, other interest groups, such as organised medicine and hospitals, have many more resources at their disposal to persuade governments that a hospital-centric system that intervenes after illness begins should continue to dominate Australian health care.

The adoption of the CHP in the early 1970s represented the opening of a window of opportunity Kingdon (2014) describes as vital to enable policy change to happen. Our history of community health shows how the social movements described

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helped to create this opportunity and provided a supportive milieu for the CHP, and the resulting community health movement used this opportunity to extend and realise new ways of developing and promoting health.

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Data availability. Most of the interviews used in this paper will be available in an archive at the Whitlam Institute, Western Sydney University.

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