In June 1990 the ACT Minister for Health announced that joint Commonwealth/Territory funding had been granted to establish a community-based women’s health centre in Canberra. The very next month, Dr Alex Proudfoot (an adviser in the Commonwealth Department of Health, Housing and Community Services) filed a complaint with the Human Rights Commission alleging that special women’s health services are discriminatory under the Sex Discrimination Act because men cannot access them; there are no comparable services for men; men’s health is worse than women’s, and the services address problems that are not unique to women.

Proudfoot named the ACT government, the ACT Board of Health, and the Canberra Women’s Health Centre as respondents. Subsequent to the original complaint, two other men (a software consultant, Jack Smith of the ACT, and a Victorian anaesthetist, Dr Roger Henderson) filed related complaints concerning funding under the National Women’s Health Program.

The respondents have argued along three basic lines. First, they have claimed that the complainants have no standing; second, that no discrimination (as defined by the Sex Discrimination Act) has occurred; and third, that in any event, the activities are protected by the ‘affirmative action’ section of the Act. The underlying logic of the complaints is that women’s health is advanced at the expense of men’s. But it is simply fallacious to argue that devoting any resources specifically to women’s health must cause illness and premature mortality among men. Every health system in the developed world appropriately devotes substantial resources to preventing illness and death among men. Campaigns to reduce alcohol abuse, drunk driving, smoking, and consumption of salt and animal fats are all intended to diminish the main causes of premature mortality. Significant curative medical and hospital resources are also invested in the management of the major killers. Recent Australian death data indicate that the investment is paying off, particularly through reductions in early deaths from cardiovascular disease and lung cancer among men. That is, during the same period that women’s health centres have been established in Australia, the health of Australian men has been improving. We can be confident then that men’s health has not suffered as a result of the women’s health movement.

Women’s health centres have come into existence because, for the last 20 years, women all over the country have been willing to work to create and run them. Some men are now recognising the relevance of masculinity to men’s ill health, and they are benefiting from the work previously done by women. Such initiatives, in contrast to the complaints before the Human Rights Commission, can improve men’s health instead of trying to constrain or eliminate services that contribute to women’s health, and that provide models for others in the primary health care field.

None of the outcomes from the complaint can benefit men. Obviously, if the commission finds against the complainants, men’s health will have gained nothing. But even if the complainants win, men will not benefit from the decision. In the most extreme case, if all women-specific health services were found unlawful and were deprived of funding, men’s health would not improve as a result. The amount of public funding presently devoted to women’s health services is less than 0.5% of the health budget, so its reallocation would be unlikely to make a measurable difference. The complainants in this case say that they are not interested in seeing men’s health services established because such services would be, they claim, as discriminatory as women’s health services. It would seem that the only significant outcome of this inquiry would be the destruction of one of the most innovative and manifestly effective initiatives in Australian primary health care. The best possible result is simply ‘no change’. That Justice Wilson finds that women’s health services don’t discriminate against men, something the women involved—and many supportive men—already know.

Quite apart from the threat to women’s health services, the legal action constitutes a potential threat to other fundamental elements of primary health care. For example, in recent decades more and more services have been developed to target the needs of specific groups. Targeted services are widely recognised as highly effective because they can be tailored to meet them appropriate to people’s social and health needs.

Indeed, the most effective primary health care has been demonstrated to occur where attention is paid to the whole person, not just characteristics or conditions unique to their membership in a particular group. Treatment of older people would be vastly inferior if we restricted geriatric services to disorders that occur only among people over a certain age and required them to consult separate specialists for digestive problems, urinary problems, etc. on the grounds that younger people also suffer from those complaints. Special circumstances and needs are created by the intersection of membership in a group (elderly) and health problems that are common among (but not necessarily unique to) people in that group. Geriatric service provision has a long tradition of respecting and seeking to respond to those special circumstances and needs.

A similar basis underlies the success of such initiatives as Aboriginal and migrant health units, and Family
Planning clinics for adolescents. Like these services, women's health services are effective additions to other facilities provided by government, or provided by other agencies with partial or full government funding. Depending on the logic of the judgment, a decision for the complainants could open the door to attacks on all such services, since discrimination on the basis of race is also prohibited by Commonwealth legislation, and age discrimination is now prohibited in some states.

Another worrying aspect of the case is the possibility of formulating public health policies and priorities through recourse to law rather than through more appropriate avenues such as advocacy, research, consultation and community action. Legal bodies are poorly equipped to sift through the kinds of evidence and data required to make informed decisions about the allocation of resources for health services. A career on the bench may make a distinguished jurist, but no judge would claim that it develops a public health expert. If the complainants are successful in this case, a strange new avenue for the shaping of health policy would be opened, but only to the select few with the resources and the motivation to obtain access to it.

A decision for the complainants could also do catastrophic damage to the principle of community-based needs identification and service provision in primary health care. It would be a major triumph for the opposite principles of professional dominance and top-down policy formulation and service planning. Even in present circumstances, it is difficult for consumers and community groups to participate actively in much health policy formulation at any level. The Australian women's health movement—which goes back at least 20 years—and the National Women's Health Policy are outstanding exceptions to the general pattern of decision-making monopolised by health bureaucrats and medical practitioners. If legal action can limit their effectiveness, that will be a major setback for the Australian community health movement generally, not just the women's health movement.

Perhaps the most forceful message from the case is the danger to women of relying on a generalised 'sex-neutral' notion of anti-discrimination. Feminist philosophers and feminist legal theorists such as Carole Pateman and Ngaire Naffine have shown that the law is fundamentally gendered, and that the supposedly sex-neutral citizen is actually (though implicitly) male. This is nowhere more vivid, or more dangerous to women, than in the case of applying the Sex Discrimination Act to health matters. The Act allows exemptions for pregnancy and, more generally, for conditions that occur in only one sex. But these are, one discerns, conditions that occur among women, revealing the assumption that the body of the 'person' to which the Act refers is actually sexed male, and that special exceptions are made to deal with the aberrations of the female body.

The Sex Discrimination Act is currently under review by parliamentary committees. One hopes that the relevant sections of the Act will be amended so similar actions are more difficult in future. Women have been successful in seeking redress from discrimination in the courts, and it is therefore essential that the Act is revised so that it can serve more effectively its original intention, to eliminate discrimination against women. But this exercise, however important, will have its limitations. Ultimately we must be sceptical of how far women can be protected by a bloodless, sexless fiction of 'equality'.

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STOP PRESS: As this issue went to press the Human Rights Commission dismissed the Proudfoot complaint. This double-edged decision will be reported in next month's issue.

'Discrimination' under the Sex Discrimination Act

Two criteria must be met to sustain the definition of 'discrimination' under the Sex Discrimination Act. First, the person complaining must have suffered a detriment from the differential treatment. Second, the circumstances of the aggrieved party and the other sex must be "the same or not materially different". Witnesses for the respondents gave abundant evidence on the second point, showing that the circumstances in which women seek health care are not the same as the circumstances in which men seek care, so the charge of discrimination cannot be sustained. Advocates for the respondents also argued that men suffer no detriment from the operation of women's health services.

Even if it were established that women's health services are discriminatory, Section 33 of the Sex Discrimination Act provides a defence for discrimination. This is the 'affirmative action' section, and it allows that initiatives may be undertaken if one of their purposes is "to ensure that persons of a particular sex...have equal opportunities with other persons". If the Commission finds that women's health services are exempted under Section 33, that should be the end of the matter. In a climate where other affirmative action measures are under threat or being axed (for example, the ANU's special entry scheme for Aboriginal students), a decision of 'no discrimination' is preferable.