focusing on the establishment of a number of working groups on single issue campaigns as a way of organizing activity within the union. This would include issues such as equal pay, taxation reform and child care to name a few. While obviously such a union would not be industrially based, it was felt that organizing as a union was important so as to establish identification with both the labour movement and the feminist movement. While no details were finalised and no clear consensus emerged it was obvious that considerable excitement and enthusiasm was generated by the idea. The conference organizing collective is to co-ordinate ongoing discussion around this idea.

Socialist Feminist Conference participants.

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Linnell Secomb

Medicare Under Siege

Health issues have become a political battlefield over the past decade. One of the major developments in that period has been the changing terrain of that battlefield itself. The health system has more openly become a tool of economic policy, with the provision of services overshadowed by issues of regulation, control of profiteering, and disputes between federal and state governments and the private sector over how to redistribute the burden of paying for services.

The introduction in 1973-75 by Whitlam, Evingham and Hayden of the community health program and Medibank signalled a new emphasis on ease of access and increasing government intervention in health policy. Reactions were swift and polarised. The medical establishment targeted Medibank. The specialist's attack ended the long-standing system of free outpatient clinics in hospitals.

Trade unionists and the rank and file of the ALP expressed strong support for Medibank and community health. These groups led opposition to Fraser's attacks on the reforms, attempting to maintain the social wage in the face of cutbacks, freezes, and a regressive tax system. In addition, the women's lobby of the ALP has consistently supported community health services.

When the Fraser government set about its systematic dismantling of Medibank, the union movement responded with a 24-hour general strike. A dramatic raid on the Sydney stock exchange following the federal budget of 1978 led to this report in the Australian Financial Review the next day:

The trading floor, warned minutes previously, was barricaded but glass doors were kicked in by demonstrators. During the melee a protester armed with spray cans wrote 'Make the rich pay' on lift doors ....

Among the leaders of the charge on the stock exchange trading floor were two men carrying a large red banner with the words 'ICI construction workers'. Another banner, which was wracked from demonstrators after it had smashed through a glass partition read: "Australian Paper Mills Combined Unions - Medibank, yet another promise broken'.

The basis of the ALP's health policy in the lead-up to the 1983 election had been announced a year or two previously as 'The Hayden Health Plan' ('Cheaper for Australia, Cheaper for Australians'). This was the plan which has become known as Medicare.

Funded by a one percent levy on taxable incomes over $6,697 a year, Medicare is a national health insurance scheme which will cover 80 percent of scheduled medical fees. Medicare also provides an economic basis for expanding community health services through its allocation of $20 million to the states, earmarked specifically for community health. A third feature of Medicare's implementation is the insistence on limiting charges by specialists in public hospitals to the scheduled fee.

It is this third and seemingly minor aspect of Medicare that is the pretext for the present militant outburst by some of the most highly paid specialists in the country, in support of their continuing right to profit from the use of publicly funded hospitals. An alliance of medics, private health funds and private hospitals has, for some months, been running a series of media propaganda campaigns against Medicare in support of private health insurance and medical practice.

Although the public is far more sceptical about the motivation of the medical profession than ten years ago, the impact of these scare tactics has been noticeable in the numbers of people maintaining private health insurance which they can ill-afford and may not need.

For all this, Medicare is a far from ideal health
the existing fee-for-service comprehensive than the excludes most paramed­ system of health care, and the extremes of the taxable original Medibank, and its entrenched structure of practic) and preventive service payment, run-down to the Australian Council of (e.g. dental, chiro­ incomes. It largely bolsters in the la rg e ly ad hoc system of convalescent private medical fee-for­ "Medicare", according to the Australian Council of Social Service, "sits perched on top of an entrenched structure of private medical fee-for­service payment, run-down community and preventive services, a struggling system of convalescent and community care and the largely ad hoc geographical distribution of health services."

The key to Medicare's promise lies in its potential to further improve access and equity in the health services, and to provide real alternatives to the current system of medical and institutional domin­ance. The Australian Community Health Association has proposed that community health ser­vices, now receiving just $20 million out of the vast Medicare budget, constitute the embryo from which a new order could be developed.

Medicare is a potentially powerful tool for gradually bringing about a redistribution of resources and priorities in the health system. The movement from reimbursement of privately-produced serv­ices to the provision of salaried practitioners can be a parallel development to a redistribution from institutional to community­based care. Strengthening the base of community services would also serve to consolidate the gains in public opinion that will be necessary to protect future developments against further rounds of cutbacks and attrition.

There have been important developments in community services in the last decade that now need to be consolidated and built upon. There is now a consistent and coherent set of policies with broad support among a range of interest and consumer groups, and these policies, as they develop, point beyond hospital dominance. There are proposals for area health board structures to move towards community­controlled and more accessible services. New services would be funded through Medicare 'ear­marked' monies. Future federal guidelines for the allocation of this slice of the Medicare pie will need to emphasise accountability to the local community through monitoring at a local level. This is a base on which a national preventive health strategy can be built, and it would be one that won't wither at the first change of political climate.

What is needed is a consciously planned social intervention into the organisational and econom­ic structure of the health care system itself, using the community health program to both strengthen Medicare and reorient the priorities of the health system.

Despite a lot of rhetorical support for community health services, they are currently at a historically low ebb. Each state has adapted in its own way to the rigors of the Fraser federalism strategy, and now the imagination that is required for service development has been stunted by years of ad hoc changes and 'attrition' policies that have left the community health program in the bottom drawer, as far as priorities go.

In most states the community services are under increasing pressure to provide medically oriented curative services and to integrate with hospitals. Victoria's community-controlled health centres maintain their pre­eminence in community involvement. In New South Wales, virtually all money being allocated for community health, whether through reallocation or from Medicare, is being given to hospitals to spend on community outreach programs. Women's health services are receiving no additional support, despite ALP promises, and together with the original community­ health centres they are feeling increasingly besieged.

The federal ALP and Health Minister Neal Blewett are aware of the need to take some action on community health. The Labor Party was to develop its community health policy in 1983, but was overtaken by the election and the immediate need to get Medicare running, as well as make some strings be tied with guidelines for a national preventive and educational strategy. But support for community health and salaried doctors in health centres also seems to mean an increasing integration with hospital services. On the other hand, the area of community control is relatively under­emphasised, and the continued dominant role of the states is, at this early stage, too difficult to tackle head-on.

The Caucus sub­committee has reported its findings to the Health Minister who now has to argue for the development of the program in the future. The political commitment required for building on Medicare will be generated, in part, by the outcome of the battle against the medical specialists and private health funds. Although it is only a minor skirmish in itself, a victory for entrenched interests and privilege at this early stage of Medicare would dampen enthusiasm for more imaginative and far­reaching reforms.

So far, Neal Blewett has stood his ground and is successfully implementing one of the few reforms of the Hawke government. The unions and the left have been surprisingly quiet on the subject. While Medicare appears to be a genuinely popular scheme, it may be that widespread perceptions of its limitations have dampened public enthusiasm.

As ACOSS has said, Medicare can be the start of something better. We should not allow the loud protests of the privileged to distract from its wider potential for promoting equity, access, and accountability in the health system. A clear victory for Medicare and a strong follow­through from progressive consumer groups and unions could have some chance of redirecting the health system. 1984 will be a crucial year for such a program.

Rick Mohr and Alan Owen